ATTACHMENT ONE

KEDREN COMMUNITY HEALTH CENTER, INC.

2016 CHNA

KEDREN COMMUNITY HEALTH CENTER, INC.

Response to Request Number IDR #1
Documents Requested

1. **Community Health Needs Assessment (CHNA)**

   (i) The Community Health Need Assessment was discussed with Collaboratives, and also, submitted to the Health Resources Services Administration (HRSA) as partial fulfillment of a 330 Federal Award and is available in Kedren's Handbook filed with HRSA.

   The CHNA was not uploaded to Kedren's Website as the contents were not finalized, and thus, not ready for posting. The Website (Kedren.org) is fully operational and the community Health Needs Assessment will be available forthwith.

   (ii) N/A

   (iii) A copy of the 2016 CHNA is included herewith under Attachment One.

2. Implementation Strategy to 2016 CHNA is included herewith under Attachment Two.

3. The Implementation Strategy for our CHNA was adopted by the Board of Directors on July 7, 2017. Please see Board Minutes and related documents adopted under Attachment Three.

2016

Kedren Community Health Center, Inc.
Acute Psychiatric Hospital
Community Mental Health Center

Community Health Needs Assessment (CHNA) and Implementation Strategy 2016 - 2018

4211 South Avalon Boulevard, Los Angeles, CA 90011

NEED

1) *Describe how the following characteristics of the target population impact access to primary health care, health care utilization, and health status, referencing/citing data sources.*

Kedren Community Care Clinic (the Health Center), a division of Kedren Community Health Center Inc., Acute Psychiatric Hospital and Community Mental Health Center (Kedren), has identified several core barriers to accessing health care from the California Office of Statewide Health Planning and Development's database, the U.S. Census Bureau American Community Survey 5-Year Estimates, and Centers for Disease Control. Core barriers include ratios between Full-Time Equivalent (FTE) providers and population (1 to 6,847 population), which is nearly twice the 1:3,500 Health Professional Shortage Area standard; percent of patients below 200% of the Federal Poverty Level (FPL) (68.8%); and the percent of the population medically uninsured (34.9%), though the latter is likely changing due to the Affordable Care Act.

While Los Angeles County is the second-most populous urban area, Los Angeles is the single most densely populated area and is home to 272 neighborhoods. One of the neighborhoods that are most near and dear to our organization is our beloved South Los Angeles, located in the geographical region of Los Angeles County Service Planning Area (SPA) 6, also located within the Service Area Identification No. 011 of the Federal Service Area Map. South Los Angeles is a 51.08 square mile region of Los Angeles County comprising 25 neighborhoods within the city of Los Angeles and three unincorporated districts. South Los Angeles has an estimated population of 1,347,888 with an average of 26,387 residents per square mile. South Los Angeles demographics comprise Latinos that represent 73% and African-Americans, which represent 22%. The median age is 26 with the average male population is 48.8% and female 50.2%.

South Los Angeles also holds the unique distinction of having the largest health disparities than any other SPA in the County. In September 2008, the Community Health Councils Inc. prepared the South Los Angeles Health Equity Scorecard, which revealed startling inequities in health compared with other communities and neighborhoods in Los Angeles County. The report states that the leading cause of death ranked (1) through (5) in South LA is as follows: (a) Coronary Heart Disease, (b) Stroke, (c) Homicide, (d) Diabetes and (e) Lung Cancer. The leading cause of pre-mature death ranked (1) through (5) is as follows: (1) Homicide, (2) Coronary Heart Disease, (3) Motor Vehicle Crash, (4) Diabetes, and (5) Stroke. South Los Angeles does not fare well either when it comes to the availability of physical environment resources, which are a good social determinants of health. South LA has the largest number of liquor retail stores per square mile (8.51) compared with the County (1.56). Supermarkets per square mile is (0.10) compared with fast food restaurants (71.80), and compared with the County (47.70) per square mile. Food facilities that are rated below grade "C" is (0.21) square mile compared with all of the County (0.05).

In March 2013, the Los Angeles County Department of Public Health published its Physical Determinants Social Outcomes; Key Indicators of Health Report for all SPAs in Los Angeles, including South LA, which in SPA 6 reported on social determinants for education, employment status, poverty, housing and food. With regard to education, South Los Angeles has (38.8%) of adults with less than a high school education (the highest percentage in the County) and only (11%) of adults with a college or post graduate degree (the lowest percentage in the County). Only (51%) of adults in South Los Angeles are employed (only second to the Antelope Valley, which has a lower population per square mile than South Los Angeles). South Los Angeles has (15.5%) of adults who are actively looking for work (second only to the Antelope Valley, (33.5%) who are not in the labor force, which includes disabled and retired persons (second only to Antelope Valley), and (39.3%) who are under-employed or employed part-time (highest in LA County).

With respect to poverty in South Los Angeles, 34.4% of individuals live below the poverty level. The average median household income in South LA is $34,562. According to the US Census Bureau's 2009 through 2013 American Community Survey 5-year Estimates report, 16.5% of households earned $35,000-$49,999, 17.0% of families earned $50,000-$74,999, 24.8% of married couples earned $50,000-$74,999, and 23% of nonfamily households earned 15,000 to 24,999 in South Los Angeles. Clearly, the statistics reflect that persons who are married have a higher earning probability then unmarried persons.

According to the County of Los Angeles Department of Public Health, 63% percent of households reported that they spent more than 30% of their income on housing (highest in the County), and 22.5% who reported they were unable to pay their rent or mortgage in the past two years (second only to Antelope Valley). Obtaining fresh foods and vegetables is also very difficult for residents in South Los Angeles. One-quarter (24.2%) of households with incomes below 300% of the Federal Poverty Level (FPL) and receive food stamps, and (77.9%) of adults report that it is easy to get fresh fruits and vegetables (the lowest percentage rate in the County). Neighborhood beautification is also a challenge in South Los Angeles. More than one-third (38.5%) of adults report little or no graffiti or vandalism in their neighborhood (the lowest percentage of dissatisfaction in the County), 56.6% of adults report little trash and litter in their streets or on their properties (the lowest rate of dissatisfaction in the LA County), and 70.2% percent of adults who report that their streets and sidewalks are well maintained in their neighborhoods (the lowest rate of dissatisfaction in the County. With regard to health status, (30.5%) of adults report their health to be fair or poor (the lowest quality of health in the County) and 59.9% of adults who receive the social and emotional support that they need (the lowest support in the County).

With respect to health outcomes in South Los Angeles, this community has the largest incidences of communicable diseases in LA County. According to the Los Angeles County Department of Public Health report, there were 999.5 incidents of chlamydia (annual new cases per 100,000 population), and 231.9 incidents of gonorrhea (annual new cases per 100,000 population). With

respect to respiratory illnesses, South Los Angeles has a pneumonia/influenza mortality rate (age-adjusted per 100,000 population). These percentages represent the highest rates in Los Angeles County. With respect to cancer mortality rates, the report reflects 39.9% lung cancer rates (age-adjusted per 100,000 population), 28.5% breast cancer mortality rates (age-adjusted per 100,000 population), 5.8% cervical cancer mortality rate (age-adjusted per 100,000) and 19.8% colorectal cancer mortality rates (age-adjusted per 100,000 population). These represent the highest mortality rates in the County.

Core health status and utilization indicators include: (a) percent of Medicare enrollees with diabetes not receiving a hemoglobin A1c (HbA1c) test (29.3% compared with the national benchmark of 18.0%); (b) age adjusted mortality from diseases of the heart (per 100,000) (222.7 compared with national benchmark of 203.2); age-adjusted colorectal cancer mortality (per 100,000) (16.7 compared with national benchmark of 14.0); (d) births to teenage mothers (ages 15-19; percent with all births) (14.6% compared with national benchmark of 8.4%); (e) percent of children (10-17 years) who are obese (29.5% compared with national benchmark of 15.0%); and (f) percent of adults with at least one major depressive episode in the year (7.31% compared with national benchmark of 6.6%). Lastly, other indicators include the influenza and pneumonia death rate (three year average per 100,000 population) with a high of 36.4, and percent of adults (18+ years old) that could not see a doctor in the past year due to cost at 20.0%.

a) *Geographical/transportation barriers to include the distance (miles) OR travel time to the nearest primary care provider accepting new Medicaid and uninsured patients (consistent with Attachment 1: Service Area Map and Table).*

Los Angeles County is one of the most culturally and ethnically diverse regions in the United States with residents originating from all over the world. In addition, Los Angeles County is rife with poverty, as approximately two-thirds (68.8%) of service area residents live below 200% of the Federal Poverty Level (FPL), and 35.6% of residents live below 100% of the FPL. For the County overall, approximately 40% of residents are below the FPL. With 2,419.6 people per square mile, Los Angeles County also has one of the highest population densities in the country.[1] With such a large concentration of diverse people in such an economically challenged area, the need for affordable, culturally appropriate health care is pressing. Kedren has 50 years of experience providing programs and services that address the diverse health needs of residents of South Los Angeles, which includes a portion of the Health Center's service area. The service area spans 21.98 square miles, and is made up of portions of 10 zip codes. They are 90001, 90003, 90007, 90011, 90015, 90021, 90058, 90089, 90255, and 90270, all of which are located in the city of Los Angeles.[2] *Please see Attachment 1: Service Area Map.*

[1] Census.gov Retrieved August 8, 2015 from http://quickfacts.census.gov/qfd/states/06/06037.html
[2] Service area analyzed by the Center for Economic Development, California State University, Chico

The Health Center service area is notably medically underserved with 84.4% designated as a Medically Underserved Area (MUA). It is home to 396,716 residents of whom more than 96% are persons of color. The service area has a large Latino presence, with 83.3% of service area residents classified as Latino. In fact, the percentage of Latinos in the service area more than doubles the rate of Latinos in the State as a whole (37.9%). Furthermore, while nearly one-half (47.9%) of County residents are Hispanic or Latino, the service area is home to a percentage which is nearly a third more than the County's concentration.

Additionally, with so many low-income residents in the service area, transportation poses a significant impediment to accessing care. According to the 2013 U.S Census Bureau American Community Survey, 5 Year Average Los Angeles Health Survey (see table), more than one-fifth (21.0%) of service area adults reported that they do not have access to a vehicle, while more than one-third (35.4%) of service area households report a vehicle shortage. These numbers indicate a significant transportation barrier to accessing health care services, as well as other needs. These high percentages may be indicative of service area adults not having a driver's license or a dependable vehicle.

Vehicles Available/Vehicle Shortage

	Service Area Number	Percent of Total		
		Service Area	Los Angeles County	California
No Vehicles Available	20,359	21.0%	9.7%	7.8%
2 Workers, 1 Vehicle Available	7,652	7.9%	4.1%	3.3%
3 or more Workers, 1 Vehicle Available	2,442	2.5%	0.7%	0.5%
3 or more Workers, 2 Vehicle Available	3,811	3.9%	1.9%	1.5%
Total Households /w Vehicle Shortage	34,264	35.4%	16.4%	13.1%
Total Households	**96,782**	100.0 %	100.0 %	100.0 %

Source: U.S. Census Bureau, 2013 American Community Survey 5-year average, 2009-2013, Table B08014

Though public transportation is available (see table), some service area residents have difficulty navigating the complex bus and subway system – especially after hours when streets are unsafe. Approximately 43 percent (42.7%) of service area adults utilize other means of transportation than their own personal vehicle, yet only 17 percent of these individuals utilize public transportation.

Means of Transportation to Work

	Service Area Number	Percent of Total		
		Service Area	Los Angeles County	California
Drove Alone	85,834	57.3%	72.4%	73.2%
Carpool	19,252	12.9%	10.6%	11.3%
Public Transportation	25,412	17.0%	7.1%	5.2%
Bicycle	3,447	2.3%	0.9%	1.1%
Walked	9,052	6.0%	2.9%	2.7%
Other	1,735	1.2%	1.2%	1.3%
Worked at Home	4,935	3.3%	5.0%	5.2%
Total Workers Age 16+	**149,667**	100.0 %	100.0 %	100.0 %

Source: U.S. Census Bureau, 2013 American Community Survey 5-year average, 2009-2013, Table B08006

Transportation barriers are complicated by the distance that individuals in the service area must travel (see table) to their employment during the day. As indicated in the table below more than one-half (51.1%) of service area residents travel to work from 20 up to 44 minutes away. Nearly one-fifth (18.3%) of service area residents spend an hour or more of travel time to work. The distance to places of employment, coupled with an overall lack of available transportation may create a significant barrier to accessing healthcare services, especially during normal business hours.

Travel Time to Work

	Service Area Number	Percent of Total		
		Service Area	Los Angeles County	California
Worked at home	4,935	3.3%	5.0%	5.2%
Less than 10 minutes	9,205	6.2%	7.7%	10.2%
10 to 19 minutes	31,725	21.2%	24.2%	27.6%
20 to 29 minutes	31,244	20.9%	18.8%	19.5%
30 to 44 minutes	45,182	30.2%	24.0%	20.3%
45 to 59 minutes	11,543	7.7%	9.2%	7.6%
60 to 89 minutes	11,192	7.5%	8.2%	6.6%
90 or more minutes	4,641	3.1%	2.9%	3.0%
Total Workers Age 16+	**149,667**	100.0 %	100.0 %	100.0 %

Source: U.S. Census Bureau, 2013 American Community Survey 5-year average, 2009-2013, Table B08303

Lastly, since many residents originate from countries where the importance of healthcare – and especially preventive healthcare -- is not emphasized as it is in the United States, they are

unfamiliar with the importance of regular check-ups or following up on warning signs, thus allowing treatable conditions to become chronic. High numbers of patients present with health issues that are more easily addressable with timely healthcare services.

*b) Percent of the **target** population that is uninsured.*

As shown on Form 4 – community characteristics – 36 percent of the target population are medically uninsured, though this is likely changing with the Affordable Care Act (ACA). The Health Center is following developments in this area, and is promoting the ACA among patients.

Due to the lack of employer-provided health insurance, as illustrated by the table below, more than one-third (34.9%) of service area residents are uninsured, which is substantially higher than the County rate of 22.0% and more than double the rate for the State at 17.5%. About one-third (37.2%) rely on Medi-Cal (California's Medicaid program), which is more than double that of the State or County. While nearly one-half of County (47.6%) and more than one-half (51.2%) State residents have private insurance, less than one-quarter (24.8%) of service area residents have private insurance.

Health Insurance

	Service Area Number	Percent of Total		
		Service Area	Los Angeles County	California
Medi-Cal (Medicaid)	147,703	37.2 %	21.0%	19.0%
Medicare	9,748	2.5 %	7.1%	7.9%
Other Public Insurance	2,329	0.6 %	1.5%	3.0%
Private Insurance, Only	98,332	24.8 %	47.6%	51.2%
None/Uninsured	138,604	34.9 %	22.0%	17.5%
New Eligible for Medi-Cal under ACA (Below 138% FPL)	10,708	15.0 %	8.7%	6.9%
Newly Eligible for Subsidized Health Insurance under ACA (138-399% FPL)	11,328	15.8 %	10.8%	8.4%
Total Population	**396,716**	100.0 %	100.0 %	100.0 %

Source: U.S. Census Bureau, 2013 American Community Survey 5-year average, 2009-2013, Tables C27006, C27007, C27010; and U.S. Census Bureau, 2013 American Community Survey 3-year average, 2011-2013, Table B27010

c) Unemployment and educational attainment.

Though most working-age service area residents are employed, unemployment in the service area (13.1%) is still higher than the State and County unemployment rates (both at 11.5%).

Unemployment

	Service Area Number	Percent of Total		
		Service Area	Los Angeles County	California
Unemployed	23,070	13.1%	11.5%	11.5%
Employed	152,538	86.9%	88.5%	88.5%
Total Labor Force	**35,702**	100.0%	100.0%	100.0%

Source: U.S. Census Bureau, 2013 American Community Survey 5-year average, 2009-2013, Table B23001

Employment is not synonymous, however, with a living wage or health insurance. As the table above shows, while the majority of service area residents are working, they remain impoverished. Among the reasons is that many residents of the service area lack the necessary skills and/or education requirements demanded for more lucrative positions. As a result, many service area residents work in industrial or labor positions, in which health insurance is limited or not offered. As the table below illustrates, nearly one-third (28.7%) of working age service area residents do not possess a 9th grade education. This is more than double the rates found in the County (12.1%) and State (9.1%).

Furthermore, among residents that attended high school (see table), more than one-fifth (20.6%) do not go on to obtain their diploma or GED. Compared with Los Angeles County and California as a whole, few residents of the service area attend college. Only 7.1% of residents obtain a bachelor's degree or higher, compared with 26.8% for the County and 27.5% for the State. Low educational attainment limits occupational opportunities, which, as described above, leads to low paying wages.

Educational Attainment for the Population 18 Years and Over

	Service Area Number	Percent of Total		
		Service Area	Los Angeles County	California
Less Than 9th Grade	79,128	28.7 %	12.1 %	9.1 %
9th-12th Grade, No Diploma	56,908	20.6 %	10.5 %	9.2 %
High School Graduate/GED	59,772	21.7 %	21.4 %	21.8 %
Some College, No Degree	51,081	18.5 %	22.7 %	24.9 %
Associate's Degree	9,078	3.3 %	6.5 %	7.3 %
Bachelor's Degree	14,999	5.4 %	17.9 %	17.8 %
Graduate Degree	4,623	1.7 %	8.9 %	9.7 %
Total Population 18+	**275,589**	100.0 %	100.0 %	100.0 %

Source: U.S. Census Bureau, 2013 American Community Survey 5-year average, 2009-2013, Table B15001

d) Income and poverty level.

As previously discussed and as shown in the table below, most individuals in the service area are employed (86.9%), and 78% rely on salary or wage-based income, yet due to disparities in type of employment available and the lack of attainment of education to seek advanced employment opportunities, many of the employed individuals in the service area work low-paying labor or entry-level jobs. Almost three-quarters (70.4%) of individuals employed in the service area are employed in positions such as production, transportation, and material moving, sales and office, building and grounds cleaning, food preparation and serving, and personal service. Many of these types of jobs offer compensation that falls far short of a living wage, which in turn places a tremendous financial burden on residents of the service area.

Employment and Wages by Occupation (sorted by Median Earnings in California)

	Service Area Number	Percent of Total			Median Earnings		
		Service Area	Los Angeles County	California	Service Area	Los Angeles County	California
Employed Population	**148,598**	100.0%	100.0%	100.0%			
Computer, engineering, and science	1,865	1.2%	4.4%	6.1%	$31,758	$73,809	$81,076
Healthcare practitioners and technical	2,075	1.4%	4.4%	4.8%	$37,292	$62,176	$67,471
Management, business, and financial	7,186	4.7%	14.0%	15.0%	$38,326	$62,380	$66,690
Protective service	2,911	1.9%	2.0%	2.2%	$23,125	$37,726	$53,489
Education, legal, community service, arts, and media	9,375	6.1%	12.5%	11.0%	$21,593	$47,009	$45,431
Sales and office	35,347	23.2%	25.0%	24.4%	$18,016	$28,950	$30,413
Natural resources, construction, and maintenance	18,023	11.8%	7.9%	9.2%	$19,036	$27,366	$30,340
Production, transportation, and material moving	44,032	28.9%	12.8%	10.9%	$18,336	$23,557	$26,781
Healthcare support	3,785	2.5%	2.0%	2.0%	$20,912	$23,082	$24,793
Building and grounds cleaning and maintenance	11,940	7.8%	4.8%	4.4%	$15,912	$16,862	$18,430
Food preparation and serving related	9,493	6.2%	5.4%	5.4%	$15,600	$16,344	$15,670
Personal care and service	6,506	4.3%	4.7%	4.5%	$11,991	$14,902	$15,118

Source: U.S. Census Bureau, 2013 American Community Survey 5-year average, 2009-2013, Tables C24010 and B24011

More than one-third (36.4%) of service area residents rely on income that is not employment-based such as social security income, supplemental security income and public assistance. The percentage of service area residents who utilize public assistance (10.2%) is more than double the rates for both Los Angeles County and California (4.3% and 4.0% respectively). A high utilization of low-fixed incomes has created a tremendous financial barrier to accessing adequate and comprehensive health care for service area residents.

Source of Income

	Service Area Number	Percent of Total		
		Service Area	Los Angeles County	California
Total Households	**96,782**	100.0%	100.0%	100.0%
w/ Wage or Salary Income	75,501	78.0%	77.4%	76.4%
w/ Self Employment Income	12,256	12.7%	15.4%	13.9%
w/ Interest, Dividends, Rent Income	4,063	4.2%	18.8%	21.9%
w/ Social Security Income	17,356	17.9%	23.0%	25.4%
w/ Supplemental Security Income	8,034	8.3%	6.5%	5.8%
w/ Public Assistance Income	9,837	10.2%	4.3%	4.0%
w/ Retirement Income	5,358	5.5%	11.7%	15.5%

Source: U.S. Census Bureau, 2013 American Community Survey 5-year average, 2009-2013, Tables B19052-B19059

Likely due to the lack of employment that provides a living wage, and education levels required to obtain such employment, the Health Center service area is rife with poverty, as more than two-thirds (68.8%) or 272,771 residents of the service area live below 200% of the Federal Poverty Level (FPL). This rate of poverty is considerably higher than in the County (39.7%) and nearly double the rate of California as a whole (35.2%). More than one-third (35.6%) of service area residents live below 100% of the FPL. This rate is double that of the State (15.6%) and nearly twice that of the County (17.6%). In essence, the majority of people living in the service area (141,034) are affected by poverty.

Percent of Poverty Level

	Service Area Number	Percent of Total		
		Service Area	Los Angeles County	California
Below 100% Poverty	141,034	35.6 %	17.6 %	15.6 %
100% to 199% Poverty	131,737	33.2 %	22.1 %	19.6 %
200% Poverty and Above	112,768	28.4 %	58.8 %	62.8 %
Poverty Status Not Determined	11,177	2.8 %	1.6 %	2.0 %
Total Population	**396,716**	100.0 %	100.0 %	100.0 %

Source: U.S. Census Bureau, 2013 American Community Survey 5-year average, 2009-2013, Table C17002

e) Health disparities.

Perhaps as an artifact of impeded access to care, several health disparities are found in the service area at higher rates than for the County or the State. There are a number of health disparities that the Health Center is committed to addressing following continuation of funding. According to the California Department of Public Health, Master Death Files, 2013, and the U.S. Census Bureau, 2010 Census Summary File (table below), 707.3 out of 733.2 per 100,000 (96.5%) of persons in the service area reported deaths by disease. Diseases of the heart were the leading cause of death in the service area at a rate of 217.6 per 100,000, which is much greater than for California (174.5 per 100,000). In addition, the service area lopsided statistics related to death by diabetes (43.5 to 23.2 per 100,000, which is more than double the California rate), pneumonia and influenza (36.4 to 19.0 per 100,000), and chronic liver disease and cirrhosis (24.6 to 13.6 per 100,000). The service area also reported higher rates cerebrovascular disease or stroke (43.9 to 39.7 per 100,000), and all other causes.

Deaths by Cause of Death, Age-Adjusted Rates per 100,000 Persons

	Age-Adjusted Death Rate		
	Service Area	**Los Angeles County**	**California**
Heart Disease	217.6	184.0	174.5
Malignant Neoplasms (Cancers)	145.9	158.6	167.7
Cerebrovascular Disease (Stroke)	43.9	37.7	39.7
Chronic Lower Respiratory Disease	25.8	34.4	39.7
Alzheimer's Disease	21.9	29.4	34.4
Unintentional Injuries (Accidents)	23.3	22.9	31.6
Diabetes Mellitus	43.5	24.8	23.2
Influenza and Pneumonia	36.4	25.9	19.0
Chronic Liver Disease/Cirrhosis	24.6	14.6	13.6
Hypertension	18.4	13.6	13.6
Intentional Self Harm (Suicide)	2.6	8.2	11.1
Nephritis and Nephrosis	15.0	10.7	8.2
All Other Causes	114.2	110.5	142.9
Total Deaths	**733.2**	675.2	719.3

Source: Gary Bess Associates, using California Department of Public Health, Master Death Files, 2013 and U.S. Census Bureau, 2010 Census Summary File 1, Table P12

Other indicators include prenatal/neonatal outcomes that show higher rates for low birth weight, infant mortality, births to teen mothers and late entry into prenatal care, which is represented by 7,211 live births (see table).

Prenatal/Neonatal Health Disparities

	Service Area Number	**Rate per 1,000 Live Births**		
		Service Area	**Los Angeles County**	**California**
Low Birth Weight (Under 2,500 grams)	541	75.0	69.3	66.9
Infant Mortality	47	6.5	4.3	4.5
Births to Teen Mothers	891	123.6	70.3	70.0
Late Entry Prenatal into Prenatal Care (After 1st Trimester)	1,298	189.8	149.5	162.3
Live Births	**7,211**	n/a	n/a	n./a

Source: Gary Bess Associates using Los Angeles County Department of Public Health, 2011 Los Angeles County Health Survey interpolation by service area zip codes

Rates for alcohol and substance abuse are also higher at per 10,000 population at 7.5% for the service area and 5.2% for the County. There is also a long list of other health disparities among adults where the County rates are substantially higher than for the Health Center service area (see table). Note, in particular, that the percentage of adults without a regular source of health care is nearly one-third (31.8%) for the service area compared with 20.9% for the County, a difference of more than 50 percent.

Barriers to Accessing Care

Health Disparity	Service Area Number	Total	
		Service Area	Los Angeles County
Children (0-17 years old) Who Reported Difficulty Accessing Medical Care	13,000	23.5 %	12.3 %
Adults (18+ years old) Who Reported that Obtaining Medical Care When Needed Is Somewhat or Very Difficult	68,000	49.2 %	31.7 %
Children (0-17 years old) Who Reported Having No Regular Source of Health Care	4,000	6.6 %	4.8 %
Adults (18+ years old) Who Reported Not Having Regular Source of Health Care (RSC)	44,000	31.8 %	20.9 %
Children (0-17 years old) Who Were Unable to Afford To See a Doctor for an Illness or Other Health Problem in the Past Year	7,000	12.2 %	6.1 %
Children (0-17 years old) Who Were Unable To Afford To See a Doctor for a Physical Exam or a Check-Up in the Past Year	7,000	12.6 %	6.4 %
Adults (18+ years old) Unable to See a Doctor for a Health Problem When Needed (in the past year) Because They Could Not Afford It	28,000	20.0 %	16.0 %
Children (3-17 years old) Who Were Unable to Afford Dental Care and Check-Ups in the Past Year	8,000	15.9 %	12.6 %
Adults (18+ years old) Unable to Obtain Dental Care (Including Check-Ups) (in the past year) Because They Could Not Afford it	50,000	35.8 %	30.3 %
Children (0-17 years old) Who Were Unable to Afford Prescription Medicines in the Past Year	4,000	7.3 %	5.7 %
Adults (18+ years old) Who Reported They Did Not Get Prescription Medication When Needed (in the past year) Because They Could Not Afford It	28,000	20.3 %	15.4 %

Source: Gary Bess Associates using Los Angeles County Department of Public Health, 2011 Los Angeles County Health Survey interpolation by service area zip codes

For children in the service area, rates are also substantially lower. For example, children (0-5 years old) who were breastfed by their biological mothers for at least six months is 38.5% for the service area compared with 44.9% for the County. For children (0-5 years old) who were breastfed by their biological mothers at least 12 Months drop significantly from 0.4% to 19.9%

f) Unique characteristics not previously addressed (e.g., ethnicity, sexual orientation, gender identity, disability, health literacy, language, cultural attitudes and beliefs).

Overall health status is lower for residents of the service area as the table below shows. There are high rates for limited activities due to poor physical or mental health, those reporting fair/poor health status, and obese adults.

Health Conditions

Health Disparity	Service Area Number	Percent of Total	
		Service Area	Los Angeles County
Average Number of Days in the past 30 Days that Adults' (18+ years) Activities Were Limited Due to Poor Physical and/or Mental Health	n/a	248.2 %	209.2 %
Adults (18+ years old) Who Reported Fair/Poor Health Status	46,000	33.3 %	20.7 %
Obese Adults (18+ years old)	41,000	29.8 %	23.6 %

Source: Gary Bess Associates using Los Angeles County Department of Public Health, 2011 Los Angeles County Health Survey interpolation by service area zip codes

Similarly, health screenings for osteoporosis are substantially lower in the service area.

Health Screening

Health Disparity	Service Area Number	Percent of Total	
		Service Area	Los Angeles County
Women (65+ years old) Ever Screened or Tested for Osteoporosis	1,000	21.1 %	72.9 %
Adults (65+ years old) Ever Screened or Tested for Osteoporosis	2,000	18.4 %	56.7 %

Source: Gary Bess Associates using Los Angeles County Department of Public Health, 2011 Los Angeles County Health Survey interpolation by service area zip codes

Lastly, although not unique in the conventional sense, it is important to note that the Health Center's service area is composed mostly of persons of color with less than four percent white. Hispanics or Latinos comprise 83.3% of service area residents, and Blacks or African-Americans, 9.2%.

Population by Race/Ethnicity

	Service Area Number	Percent of Total		
		Service Area	Los Angeles County	California
White alone (non- Hispanic)	15,322	3.9 %	27.5%	39.7%
Black or African American	36,476	9.2 %	8.4%	6.0%
American Indian and Alaska Native	2,083	0.5 %	0.5%	0.8%
Asian	12,539	3.2 %	13.9%	13.3%
Native Hawaiian and Pacific Islander	431	0.1 %	0.3%	0.4%
Other/Multiple (non-Hispanic)	2,529	0.6 %	2.3%	2.9%
Hispanic or Latino	330,587	83.3 %	47.9%	37.9%
Total Population	**396,716**	100.0 %	100.0 %	100.0 %

Source: U.S. Census Bureau, 2013 American Community Survey 5-year average, 2009-2013, Table B03002

2) *Describe health care access indicators of the target population, including:*

a) Other primary health care services available in the service area, including their location and accessibility by the target population.

There are several section 330 community health centers and Look-Alikes in the Health Center service area with whom the Health Center collaboratively works. Many of these relationships predate the Health Center's designation as a FQHC in 2013 as it has provided specialized mental health and psychiatric services for years for allied health centers, and had referred its patients to these health centers for primary care and specialty care services. All sites provide primary care and serve either general community or homeless persons.

In terms of accessibility by the target population, they, like Kedren, are easily accessible by public transportation and by residents in surrounding neighborhoods, though the increasing high numbers of patients requested care due, in part, to new Medi-Cal enrollees, impacts all agencies.

Site	Address
South Central Family Health Center	4425 S Central Ave, Los Angeles, CA 90011
JWCH Institute Inc. (Homeless Provider)	5132 S San Pedro St, Los Angeles, CA 90011
AltaMed Health Services (Huntington Park)	6330 Rugby Ave., Suite 200 Huntington Park, CA 90255
St. John's Well Child & Family Center (Magnalia)	1910 Magnolia Avenue, Suite 101 Los Angeles, CA 90007

Central Neighborhood Health	2707 So. Central Avenue Los Angles, CA 90001
Eisner Pediatric and Family Medical Center	1530 So. Olive Street Los Angeles, CA 90015
Universal Community Health Center	1005 E. Washington Blvd. Los Angeles, CA 90021
Northeast Community Health Clinics	4129 Gage Ave. Bell, CA 90201
Central City Community Health Center	5970 South Central Ave. Los Angeles, CA 90001
University Muslim Medical Center	7821 S. Avalon Blvd. Los Angeles, CA 90003
Family Health Care Centers of Greater Los Angeles	4943 Slauson Ave. Maywood, CA 90270

b) *The number of individuals in the target population for every one full-time equivalent (FTE) primary care physician as a ratio (i.e., number of patients: 1 FTE primary care physician).*

The ratios between Full-Time Equivalent (FTE) providers and KCHC's service area population one provider to every 6,847 residents, which is nearly twice the 1:3,500 Health Professional Shortage Area threshold.

3) *Describe the health care environment and its impact on the applicant organization's current and future operations, including any significant changes that affect the availability of health care services and patient characteristics, such as shifts in the number of patients served. Include external factors specific to the service area, including:*

a) *Changes in insurance coverage, including Medicaid, Medicare, and Children's Health Insurance Program (CHIP). Specifically discuss changes that have resulted from the implementation of the Affordable Care Act.*

The Health Center (KCHC) has been and will continue to be dramatically impacted by the changes in insurance coverage and by the implementation of the Affordable Care Act (ACA) and the state of California's 1115 Waiver program. The passage of the ACA resulted in mandated insurance coverage by all state residents resulting in an expansion of Medicaid and previously non-eligible Medicare individuals under age 65 which included children, pregnant women, parents, and adults without dependent children with incomes up to 133% of the federal poverty level. The ACA also resulted in a state requirement to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019. The provision of cost-sharing subsidies also allow for broader coverage which will increase Kedren's treatment population. The creation of health insurance exchanges to increase enrollment

whereby increasing healthcare access. The ACA offers individuals basic health coverage for uninsured individuals with incomes between 133-200% federal poverty level. The ACA also encouraged cost containment of prescription drug costs making medications more affordable for the newly ACA enrolled participants. It also discourages waste, fraud and abuse and created a quality health system improvement mandate to optimize patient quality of care. The ACA also addressed health disparities by requiring enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved communities and populations. Lastly, the ACA mandated illness prevention and health and wellness.

b) Changes in state/local/private uncompensated care programs.

In addition to the ACA, the state of California also has the 1115 Waiver, which built upon the 2010 1115 Waiver's "Bridge to Reform's" successful health coverage expansion and foundational managed care infrastructure development, California will transform and align the Medi-Cal delivery system around improving health outcomes for the member. The state of California is now advocating for the 1115 Waiver entitled "MediCal 2020". Some key strategies that will have an impact in Kedren's service delivery system include Delivery System Transformation and Alignment Programs, the nation's first Delivery System Reform Incentive Payments (DSRIP) to promote quality, improve health outcomes, expand access and promote cost efficiency through a series of programs aimed at delivery system transformation and alignment. The Public Safety Net System Global Payment for the Remaining Uninsured will transform California's public safety net for the remaining uninsured by unifying the disproportionate share hospital and safety net care pool funding streams into a global payment system. Shared savings is in support of California's efforts to achieve the goals stated above and to test new investment strategies in partnership with the Federal government by initiating a Federal-state shared savings model. Additionally, the 1115 MediCal 2020 Waiver are to improve health care quality and outcomes for the Medi-Cal population; strengthen primary care delivery and access; build a foundation for an integrated health care delivery system that incentivizes quality and efficiency; address social determinants of health and improve health care equity; and use California's sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care.

The last impact of the 1115 Waiver is the Mental Health Parity Proposed Rule for Medicaid and CHIP that require states to meet the parity requirements regarding financial and treatment limitations consistent with the regulation applicable to private insurers. California will have the flexibility to include the cost of providing additional services or removing treatment limitations in their capitation rate methodology. All of this enables Kedren to serve more of the un-served, inappropriately served and underserved populations as specified by the regulations in the FTCA Health Center Program Policy Manual.

Prior to the ACA, 34.9% of residents in the service area were uninsured, which is nearly twice the State's rate and more than one-third (37.2%) received Medi-Cal (see table).

Health Insurance

	Service Area Number	Percent of Total		
		Service Area	Los Angeles County	California
Medi-Cal (Medicaid)	147,703	37.2 %	21.0%	19.0%
Medicare	9,748	2.5 %	7.1%	7.9%
Other Public Insurance	2,329	0.6 %	1.5%	3.0%
Private Insurance, Only	98,332	24.8 %	47.6%	51.2%
None/Uninsured	138,604	34.9 %	22.0%	17.5%
New Eligible for Medi-Cal under ACA (Below 138% FPL)	43,927	11.1 %	6.3%	5.3%
Newly Eligible for Subsidized Health Insurance under ACA (138-399% FPL)	36,556	9.2 %	8.2%	6.8%
Total Population	**396,716**	100.0 %	100.0 %	100.0 %

Source: U.S. Census Bureau, 2013 American Community Survey 5-year average, 2009-2013, Tables C27006, C27007, C27010; and U.S. Census Bureau, 2013 American Community Survey 3-year average, 2011-2013, Table B27010

c) Economic and demographic shifts (e.g., influx of immigrant/refugee populations; closing of local hospitals, ambulatory care sites, or major local employers).

There have not been any demographic shifts in the service area since 2013 when the New Access Point was approved. One development, however, is the reopening of the previously county-operated Martin Luther King Medical Center in South Los Angeles this year. Its opening in 1972 was viewed as a victory of the civil rights era and a source of pride for Black Los Angeles. It was plagued in later years by poor medical care, staff errors and a series of controversial patient deaths, and it closed in 2007. The new community hospital is being operated by a nonprofit entity at about one-third of its former size with 131 beds. Once it is fully operational, Kedren will request a transfer agreement. While this presents increased health care access, the service area may also be impacted by the potential closure of St. Francis Medical Center resulting in reduced hospital access and increase burden on the Martin Luther King Medical Center in South Los Angeles.

d) Natural disasters or emergencies (e.g., hurricanes, flooding, terrorism).

There have not been any disasters or emergencies to report for the service area or the larger Los Angeles County region; however, in the event of a major disaster or emergency, the Health Center is the sole FQHC in its catchment area and will serve as the primary point for emergency care and disaster relief, and has a disaster/emergency preparedness plan.

e) Changes affecting specific populations (e.g., children experiencing homelessness, LGBT).

In May 2015, Los Angeles' biennial homeless census concluded that there are more people sleeping on the streets and in their cars than there were two years ago. The count found 44,359 homeless in Los Angeles County, a 12 percent increase since the last count in 2013. About 70 percent of those individuals were unsheltered — meaning they were sleeping on the streets or in cars — versus in homeless shelters. The census also found that fewer people were able to find temporary shelter in 2015 than two years ago, and across regions, South Los Angeles is among the most populated areas. The homeless in South Los Angeles, located in Los Angeles County Service Planning Area (SPA) 6, one of eight regions in the County, has the highest total homeless population among the SPAs, according to the Los Angeles Homeless Services Authority

4) ***Applicants requesting special population funding*** *to serve migratory and seasonal agricultural workers (MHC), people experiencing homelessness (HCH), and/or residents of public housing (PHPC):*

a) MHC: Describe the specific health care needs and access issues of migratory and seasonal agricultural workers, including the agricultural environment (e.g., crops and growing seasons, demand for labor, number of temporary workers); approximate migratory/seasonal residency period(s), including the availability of local providers to provide primary health care services during these times; occupational factors (e.g., working hours, housing, hazards, including pesticides and other chemical exposures); and significant increases or decreases in migratory and seasonal agricultural workers.

Not applicable.

b) HCH: Describe the specific health care needs and access issues of people experiencing homelessness, such as the number of providers treating people experiencing homelessness, availability of homeless shelters, and significant increases or decreases in people experiencing homelessness.

Not applicable

c) PHPC: Describe the specific health care needs and access issues of residents of public housing, such as the availability of public housing and its impact on the residents in the targeted public housing communities served, and significant increases or decreases in residents of public housing.

Not applicable.

RESPONSE

1) *Describe the proposed service delivery model and how it responds to the identified health care needs of the target population, including the specific needs of any special populations for which funding is sought (MHC, HCH, and/or PHPC).*

The Health Center uses a Patient-Centered Medical Home model that integrates patients as active participants in their own health and well-being. The physician leads a medical team that coordinates all aspects of preventive, acute, and chronic needs, using the best available evidence and appropriate technology to care for the patient. These relationships offer patients comfort, convenience, and optimal health throughout their lifetimes. Critical components include (a) Building patient provider relationships, (b) Maintaining a patient registry, (c) Reporting on performance systematically and at the population level, and (d) Managing care for individuals using a care team and collaborative action plan. The PCMH model provides extended access, links to community, preventive and public health services, and patient self-management support.

2) *Describe the proposed service delivery sites and how they are appropriate for the service delivery model. Specifically address:*

   a) *Site(s)/location(s) where services will be provided (consistent with Attachment 1: Service Area Map and Table, and Forms 5B: Service Sites and 5C: Other Activities/Locations).*

Consistent with Attachment 1, and Forms 5B and 5C, Kedren's Corporate Office, which also includes its medical services campus, is located at 4211 South Avalon Boulevard in Los Angeles, CA 90011 and the service delivery site is appropriate for the patient-centered model approach to health care.

   b) *How the type (e.g., fixed site, mobile van, school-based clinic), hours of operation, and location of each proposed service delivery site (consistent with Form 5B: Service Sites) assures that services are, or will be, accessible and available at times that meet the needs of the target population (consistent with Forms 5B: Service Sites and 5C: Other Activities/Locations).*

Kedren's primary care medical home model is accountable for meeting the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care and chronic care. The primary care medical home provides primary health care that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient's unique needs, culture values, and preferences. The primary care medical home coordinates care across all elements of the broader health care system including specialty care, hospitals, home health care, and community services and supports. The primary care medical home delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or

electronic access to a member of the care team, and alternative methods of communication such as email and telephone care. The primary care medical home demonstrates a commitment to quality and quality improvement by ongoing engagement in activities such as using evidenced-based medicine and clinical decision-support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management.

Within the context of a care continuum, services are offered that address the special needs of the low-income residents that live within service area. Where ongoing primary care management is an integral part of treatment, and the Health Center uses a chronic care model that relies on coordinated interventions at the individual, clinic and community levels, and enables patients to be confident that they have a medical home. To best assure that services are available and accessible at times that meet the needs of the population, the Health Center is open for 52 hours each week Monday through Friday, including evening hours:

Day of the Week	**Hours of Operation**
Monday	8:00 am to 5:00 pm
Tuesday	8:00 am to 8:00 pm
Wednesday	8:00 am to 5:00 pm
Thursday	8:00 am to 5:00 pm
Friday	8:00 am to 5:00 pm
Saturday (Pharmacy and Mental Health Only)	9:00 am to 1:00 pm
Sunday	Closed

c) *Capacity at the proposed service site(s) (consistent with Form 5B: Service Sites) to achieve the projected number of patients and visits (consistent with Form 1A: General Information Worksheet).*

Since designation as a FQHC, the Health Center has expanded its scope and service capacity for residents of its densely populated South Los Angeles service area. With 52 hours of operation each week and the range of services provided, enables the Health Center to provide accessible and appropriate services for residents. Building on its current capacity, the Health Center projects a total of 5,968 patients and 16,747 patient visits by the end of the project period.

d) *Professional coverage for medical emergencies during hours when service sites are closed and provisions for follow-up by the health center for patients accessing after hours coverage. Specifically, discuss how these arrangements are appropriate for the size and need of the target population.*

When the Health Center is closed, professional medical coverage is offered through on-call provider rotation. When a patient call comes in after hours, the call is answered by the 24-hour services and the on-call physician is contacted. The physician handles the call according to standard medical protocols and procedures and makes a determination for its resolution, and if necessary refers out to immediate emergency medical attention. This type of flexibility ensures that consumers of the Center's healthcare services will have adequate treatment with a reduction in barriers and issues that result from a lack of available care when needed. Having an on-call physician for afterhours health concerns is an additional support for persons who may have had difficulty accessing the health center during its ample normal hours of operation. Most of the support for patients is handled sufficiently during these regular hours, but this additional service ensures that adequate support is provided to meet the needs of the target population regardless of the time of day. The afterhours physician services thus handles a wide array of medical concerns for the resident population. This type of additional service helps to manage high-risk medical concerns for this population indicated by the need section.

Note: *New and competing supplement applicants must:*

- *Propose at least one full-time (operational 40 hours or more per week) permanent, fixed building site on Form 5B: Service Sites, with the exception of projects serving only migratory and seasonal agricultural workers, which may propose a full-time, seasonal (rather than permanent) service delivery site. A mobile medical van may be proposed only if at least one full-time (operational 40 hours or more per week) permanent, fixed building site is also proposed in the application.*
- *Upload Floor Plans as Attachment 12 for all new sites proposed. If the site is/will be leased, lease/intent to lease documentation must be included in Attachment 14: Other Relevant Documents.*

Not Applicable

3) *Describe how the proposed primary health care services (consistent with Form 2: Staffing Profile and Form 5A: Services Provided) and other activities (consistent with Form 5C: Other Activities/Locations) are appropriate for the needs of the target population, including:*

   a) *The provision of required and additional services, including whether these are provided directly or through formal written contracts/agreements or referral arrangements.9*

The service delivery strategy and model offered by the Health Center is designed to address the health problems and disparities for our target populations across their lifecycles. The Health Center's programs and services are thus designed to address the most common causes of morbidity and mortality in our community and among our target population in ways that convey to patients the staff's non-judgmental understanding of their healthcare needs. As described in the Need Section, major health care needs among the service region population are the

prevention, diagnosis, and management of chronic diseases, such as diseases of the heart, cancer, cerebrovascular disease (stroke), diabetes and chronic lower respiratory disease.

The Health Center currently provides a full range of primary care services either directly or through referral, which together comprise a comprehensive primary health care system. The range of primary care services currently offered include immunizations and diagnosis, and treatment of acute and chronic illnesses; communicable disease screening and counseling, testing, prevention education, and treatment of chronic conditions, such as hypertension, asthma, and diabetes; outreach and community education services; and health education and prevention services on site and in the community. For those services that are not provided directly, the Health Center refers patients to providers who treat and bill Medi-Cal (California's Medicaid program) or offer a sliding fee scale to those with incomes under the 200% Federal Poverty Level (FPL). The Health Center has several written agreements with allied services providers, including local FQHCs that will accept referrals for specialty care services, while Kedren's mental health program accepts referral for behavioral health issues. Additional non-clinical services include benefits establishment, employment counseling, housing assistance, and food subsidy programs, which are provided by Kedren and several of its community-based partners (see Collaboration Section).

b) *Method by which enabling services (e.g., case management, outreach and enrollment activities, transportation) are integrated into primary care. Describe any enabling services designed to increase access for targeted special populations or populations with identified unique health care needs.*

The Health Center's case management staff are responsible for locating, coordinating, and monitoring all medical and rehabilitation services on behalf of patients being treated, as well as monitoring patients' health status, health care needs, and utilization of health care services. Medical case management services include a comprehensive functional, social, health and resource assessment; interdisciplinary plans of care; ongoing case conferencing; monitoring of the patient's health, knowledge and progress toward goals; review of community and medical services, and discharge planning and transition from case management.

the Health Center routinely participates in collaborative outreach activities through the umbrella of programs established by Kedren. The Health Center and Kedren participate in a lengthy list of collaborative and organizational activities, which further its reach into the community. An extensive summary of collaborative relationships is in the Collaboration section of this application. The Health Center also conducts educational presentations to the community to increase awareness of various health issues and risky behaviors that are prevalent in the community, such as heart disease, obesity, diabetes, cancer, pneumonia among the elderly, and binge drinking that may lead to chronic liver disease and cirrhosis. Additionally, the Health Center employs a health educator specialist who provides education and awareness workshops at the clinic for residents.

The Health Center is located along major transit and bus arteries, including the Metro Blue Line Subway, which provides a direct link throughout Los Angeles County Service Planning Area 6 to Downtown Los Angeles, as well as links to the Metrolink and Metro light rail and bus network. The public transit system operates seven days a week and runs frequently with stops close to the Health Center. Vouchers for subsidized (free) transportation are offered to those in need.

Note:

- *Applicants requesting HCH funding must document how substance abuse services will be made available either directly or via a formal written referral arrangement.*
- *Applicants requesting MHC funding must document how they will address any occupational or environmental health hazards or conditions, as well as translation services when serving population(s) with limited English proficiency.*
- *Applicants requesting PHPC funding must document that the service delivery plan was developed in consultation with residents of the targeted public housing and describe how residents of public housing will be involved in administration of the proposed project.*

4) *Describe the proposed clinical staffing plan (consistent with Form 2: Staffing Profile and the Budget Justification Narrative), including how the mix of provider types and support staff is appropriate for:*

   a) *Providing services for the projected number of patients (consistent with Form 1A: General Information Worksheet) at the proposed sites (consistent with Form 5B: Service Sites).*

Based on an appropriate ratio of PCPs to patients, the Health Center will employ 1.25 FTE physicians, 3.5 FTE midlevel provider, and 4.0 FTE clinical support staff (medical assistants). This is predicated on projected 4,710 patients, representing 13,303 patient visits by the end of the first budget period. In addition to the clinical staff, there is now 1 FTE behavioral health specialist, 3.0 FTE case manager, and 5 FTE support staff.

   b) *Assuring appropriate linguistic and cultural competence (e.g., bilingual/multicultural staff, training opportunities).*

The Health Center is staffed by culturally and linguistically appropriate professionals who are committed to providing personalized service to all patients, respecting their cultural values and beliefs. Additionally, all staff members are required to attend a minimum of two cultural competency trainings annually. To better serve a predominantly Latino community, Spanish / English bilingual staff members will be recruited for each area of service and local residents will be hired whenever possible.

Clinical leadership for the Health Center is provided by Cadrin E. Gill, MD who is an incredible asset for ensuring appropriate linguistic and cultural competence for services provided by the Center. Dr. Gill has worked in general medicine for more than 40 years, bringing extensive experience and knowledge to his role as Medical Director at the Health Center. In this role, Dr. Gill is responsible for the Center's overall public health policy programs to ensure the provision of proven effective care. Additionally, he collaborates with industry leaders, executives, hospitals and national public and health care organizations to share an agenda for quality, patient safety, and clinical outcomes and to improve patient care and access to services. He routinely consults with the President/CEO on administrative and medical problems, and on matters of public relations and health promotion, as they relate to the Health Center programs and clients. Dr. Gill is fluent in Spanish and French, and has a working knowledge of German, Italian, Russian, Arabic, Swahili, Chinese and Garifuna. He is uniquely sensitive to the cultural and linguistic needs of patients who find it difficult to navigate the system and find the access to the care they need.

c) *Carrying out required and additional health care services (as appropriate and necessary), either directly or through established formal written arrangements and referrals (consistent with Form 5A: Services Provided).*

Those services which are not provided directly by the Health Center are currently referred to providers and specialists. Written arrangements between the Health Center and Kedren, and several health and human services agencies in the service area, are in place (e.g., substance use, oral health, and specialty care services). The Health Center benefits from and has access to Kedren's existing relationships and extensive network of specialists and referral agencies.

Note: *Contracted providers should be indicated on Form 2: Staffing Profile and the summary of current or proposed contracts/agreements in Attachment 7: Summary of Contracts and Agreements. If a majority of core primary care services and/or health center key management positions (e.g., Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Medical Officer (CMO)) will be contracted, include the contract/agreement as an attachment to Form 8: Health Center Agreements.*

5) *Describe how the service delivery model assures continuity of care for health center patients, including:*

a) *Arrangements for admitting privileges for health center physicians to ensure continuity of care for health center patients at one or more hospitals (consistent with Form 5C: Other Activities/Locations). In cases where hospital privileges are not possible, describe other established arrangements to ensure continuity of care (i.e., timely follow-up) for patient hospitalizations.*

The Health Center has adopted a service delivery model that fits the needs of its target population and establishes systems in place to ensure continuity of care. Inpatient care for medically indigent patients is provided by Los Angeles County's system of three public acute care hospitals (Los Angeles County+USC Healthcare Network, Harbor-UCLA Medical Center and Olive View-UCLA Medical Center), and Children's Hospital Los Angeles. For those with private insurance, Medi-Cal or Medicare, the Health Center's primary care physicians have admitting privileges to Hollywood Presbyterian Hospital and California Hospital Medical Center. Some hospitals have transitioned to a hospitalist model, and referring providers work closely with the assigned hospitalist.

Continuity of care is of utmost importance to the Health Center. Planning for appropriate continuity of care allows the Health Center and its network of specialty care providers to minimize resource and service duplication, while facilitating a seamless care among multiple providers and facilities. Through the Health Center's primary care providers' admitting privileges at local hospitals and network of specialists, the health center provides a continuum of care that enables patients to obtain inpatient and outpatient care, while being never disconnected from their medical home.

b) *How these arrangements ensure a continuum of care for health center patients, including discharge planning, post-hospitalization tracking, and patient tracking (e.g., interoperability of electronic health records (EHRs)).*

When the Health Center patients require inpatient medical care, the PCP communicates with the admitting physician / hospitalist who will summarize the case and provide all necessary medical records. For nonemergency admission, a written summary is prepared from the patient's electronic medical record. The patient is followed by an on-call physician and a case manager who reports on the patient's hospital course, anticipated discharge date and anticipated aftercare needs. Case management staff coordinates with the physician, hospitalist, and hospital discharge planner to arrange for the transition from discharge to resumption of timely and necessary ambulatory care. The Health Center also accepts urgent care walk-ins and arranges for transportation to the accepting hospital as needed. The Health Center tracks patients by way of checking contact information at the time of visit, by asking them to identify friends and family who will know their whereabouts should they move prior to their next visit, and requesting current email addresses, if available. There is also a system in place to identify high-risk patients who are known for not keeping their appointments, whereby additional notification reminders will be issued. The Health Center staff follow-up with "no-show" patients, encouraging them to reschedule their appointments.

6) *Describe policies and procedures used to implement the sliding fee10 discount program (consistent with Attachment 10: Sliding Fee Discount Schedule), including how these specifically address the following:*

a) *Definitions of income and family size.*

Income reviewed for purposes of sliding fee eligibility is annual income of an individual or family. Types of income that are counted for eligibility in the sliding fee discount schedule are based upon adjusted gross income on a federal tax return, excluded foreign income, nontaxable social security benefits, and tax-exempt interest received or accrued during the tax year. Family size is indicated by the number of family members comprised of a primary head of household or individual, spouses, and any dependents of the head of household or spouse.

b) *Assessment of all patients for eligibility for sliding fee discounts based on income and family size only. Note: No other factors (e.g., insurance status) can be considered.*

Kedren's Board of Directors has established policies and procedures to ensure that the sliding fee discount schedule is appropriately implemented. Billing clerks and front office staff are trained in fee schedule implementation and assess a patient's ability to pay during the patient's initial financial screening, and then reconfirm upon each subsequent visit. The ability to pay is determined by the patient's annual income and household size, which is applied to the schedule showing the income thresholds for the levels sliding fee discount levels. Kedren is committed to ensuring that no patient is denied service based on an inability to pay.

c) *Documentation and verification requirements used to determine patient eligibility for sliding fee discounts and frequency of re-evaluation of patient eligibility.*

Consumers applying for the sliding fee discount program must provide written verification of monthly income and family size. Examples of written verification include prior year's W-2 forms or the two most recent pay stubs. Consumers providing this level of income documentation must have their income verified no less than once each year, and billing clerks are trained in eligibility requirements for the sliding fee discount program and re-confirm eligibility each visit. If a patient has a permanent disability and receives SSI or other insurance, this is also noted along with income. A sliding fee application spells out all details.

d) *Language and literacy level-appropriate methods used for making patients aware of the availability of sliding fee discounts (e.g., signs posted in accessible and visible locations, registration materials, brochures, verbal messages delivered by staff).*

The availability of discounted services is posted in the Health Center's patient areas, including the waiting room and intake window. Additionally, informational materials are handed to patients in brochures and other written documents. These postings are written in a variety of languages, including Spanish, English, Chinese, Korean, Hindi, Tagalog, African, and Japanese languages, with basic and easy to read format. Receptionists are responsible for ensuring that signage remains visible, and that organizational brochures that include information about services and the fee structure are always available.

e) *How sliding fee discounts are applied to both required and additional services within the scope of project (consistent with the services and service delivery methods indicated on Form 5A: Services Provided, Columns I, II, or III).*

To honor the mission of the Health Center to provide comprehensive healthcare to all consumers in the service area the Board has established policies that create options for low-income persons to obtain medical care. A schedule of fees has been established for all services, discounted for persons with demonstrated incomes below 200% of current FPL, and available for a nominal fee to the patients with incomes below 100%. Persons with incomes above 200% of the current FPL are expected to pay full fees as determined by the Health Center's charge schedule, based on the cost of providing care. For those services that are not provided directly, the Health Center will refer patients to providers who treat and bill Medi-Cal or offer a sliding fee scale to those with incomes under the 200% FPL. Kedren has several written agreements with allied services providers, including local FQHCs that will accept referrals for specialty healthcare services, while Kedren's mental health program accepts referrals for behavioral health issues. Additional non-clinical services, including benefits establishment employment counseling, housing assistance and food subsidy programs, which are provided by Kedren and several of its community-based partners are equally applied to the sliding fee scale requirements (see Collaboration Section)

f) *Method and frequency of evaluating the sliding fee discount program from the perspective of reducing patient financial barriers to care.*

The Board of Directors evaluates and updates policies and procedures supporting the implementation of the sliding fee discount schedule on an annual basis. Kedren's Board of Directors is committed to ensuring that no consumer is unable to access care due to financial restraints and continually adjust the sliding fee schedule accordingly. The Board also continues to evaluate penetration rates for low-income populations and gaps in services that become evident while doing so via monthly briefings from the Chief Financial Officer and utilization of Electronic Health Record system dashboard updates.

7) *Describe the following aspects of the Sliding Fee Discount Schedule(s) (SFDS) (consistent with Attachment 10: Sliding Fee Discount Schedule):*

a) *Annual updates to reflect the most recent Federal Poverty Guidelines (FPG).*

Kedren's Board of Directors reviews, updates and approves the sliding fee scale on an annual basis to reflect the most recent Federal Poverty Guidelines.

b) *Adjustment of fees for individuals and families with incomes above 100 percent of FPG, and at or below 200 percent of the FPG, using at least three (3) discount pay classes.*

As is congruent with the sliding fee schedule, the Health Center offers adjustments of fees for individuals and families with incomes above 100 percent of FPG, and at or below 200 percent of the FPG. There are currently five pay classes: Class A is 100 percent or below, Class B is 101 percent to 133 percent, Class C is 134 percent to 150 percent, Class D is 151 percent to 199 percent, and finally Class E is 200 percent. With a graduated fee schedule every effort is made to ensure access to affordable health care for all residents of the service area.

c) *Provision of a full discount (or nominal charge) for individuals and families with annual incomes at or below 100 percent of the FPG.*

Nominal charges are determined by Kedren's Board of Directors, taking into consideration nominal costs for patients seen by other health centers in the service area. Receptionists collect a nominal fee of $20 from those who qualify unless it poses a barrier to the patient receiving the necessary care, in which case they will not be charged for services. Patients with sufficient cash immediately receive a receipt upon payment for services.

d) *If a nominal charge is applied for individuals and families with annual incomes at or below 100 percent of the FPG, how the charge is:*
   - *Determined to be nominal from the perspective of the patient (e.g., input from patient focus groups, patient surveys).*
   - *A fixed fee (not a percentage of the actual charge/cost) that does not reflect the true cost of the service(s) being provided.*
   - *Not more than the fee paid by a patient in the first SFDS pay class above 100 percent of the FPG.*

Those with incomes at or below 100% of the FPL are asked to pay a nominal fee that has been determined with input from the Board of Director's consumer members, comparisons of rates charged at other FQHCs and community clinics in the service area, and other analyses unique to the population of focus. Fee for services are only required if it does not pose a barrier to the patient receiving care. No one is denied healthcare services due to their inability to pay, such as homeless individuals who present at our health center and are not able to pay even a nominal fee.

8) *Describe the organization's quality improvement/quality assurance (QI/QA) and risk management plan(s) for systematically assuring and improving health care quality, including policies, procedures, and parties responsible for:*

a) *Addressing patient grievances.*

Kedren Quality Assurance/ Quality Improvement and risk management plans are designed to ensure that quality services are provided in a safe, effective, recipient-oriented, timely, equitable,

and recovery oriented manner. The Health Center is committed to the ongoing improvement of the quality of care its consumers receive as evidenced by the outcomes of care. Kedren continuously strives to ensure that the treatment provided incorporates evidence-based effective practices, and that treatment and services are appropriate to each consumer's needs and are available when needed. Risk to consumers and providers and others is minimized by ensuring safety in the environment of care, by preventing errors in the deliveries of services. The plan additionally ensures that consumers' individual needs and expectations are respected, and that they have the opportunity to participate in decisions regarding their treatment, and receive services that are sensitive and caring. Practitioners must adhere to procedures, treatments and services that ensure that they are provided timely and efficiently with appropriate coordination and continuity of care across all phases and all providers of care.

The Health Center encourages patients to participate actively in their care and to express dissatisfaction arising from problems with care or unfair treatment. Patient feedback is collected for each area by gathering input through patient satisfaction surveys, patient suggestions, and patient grievances. Responses/actions are coordinated with the Medical Director and performance monitoring activities are continually conducted throughout the Organization. If staff is involved or is witness to an incident (any unusual event that is not consistent with the facility's normal operation or the expected outcome of a treatment or procedure) the event is documented and a written memorandum is sent to his or her supervisor. Depending on the nature of the incident, the incident in investigated and recommendations are made for appropriate follow-up action.

b) Incident reporting and management.

All staff members are required to participate in risk management by reporting incidents, assisting in problem identification, and following policies, procedures and standards to prevent future incidents. Based upon evaluation of a problematic event, staff members follow procedures for managing client complaints or reporting unusual occurrences. If a sentinel event (death; serious physical injury, including loss of limb or function; serious psychological injury; or risk of any of the preceding consequences if a similar event were to reoccur) occurs, a response team comprising senior clinic management, the Health Center director, and other appropriate managers are informed as soon as possible. The team performs a detailed review of the event followed by immediate corrective measures to prevent recurrence. The effectiveness of those corrective measures is continually assessed to determine whether the response was sufficient or whether additional action is required. This process is performed on an ongoing basis until the issue underlying the event is resolved.

c) Patient records, including maintaining confidentiality of such records.

As the Health Center Medical Director, Dr. Gill ensures that all staff are trained in Health Information Portability and Accountability Act (HIPAA) confidentiality requirements either

before they begin working or within 30 days of hire. The Health Center patient records are kept in a secure location on the organization's servers to ensure the privacy, security, and confidentiality of its clients' records and HIPAA compliancy.

d) Periodic assessment by physicians (or other licensed health care professionals under the supervision of a physician) of service utilization, quality of services delivered, and patient outcomes.

The QM (Quality Management) Committee periodically reviews new and existing services, patient care delivery, work flows and support systems that maximize results and satisfaction on the part of the patients and their families, physicians and staff. A systematic evaluation of patient records is performed by the Health Center Medical Director or his clinical designee to identify areas for improvement in documentation of services on a routine basis, and not less than once each year.

e) Ensuring providers (e.g., employed, contracted, volunteers, locum tenens) are appropriately licensed, credentialed, and privileged to perform proposed services (consistent with Form 5A: Services Provided) at proposed sites/locations (consistent with Forms 5B: Service Sites and 5C: Other Activities/Locations).

The Health Center's credentialing process is clearly documented in the Policies and Procedures manual which contains the minimum standards and requirements for certifying and the re-credentialing of all medical providers The Governing Body has entrusted the Medical staff with the responsibility for assuring that all patients admitted or treated in any of the hospital services receive a uniform standard of quality patient care, treatment, efficiency and the level of professional performance consistent with generally accepted standards attainable within the Health Centers means and circumstances. To ensure that all health care practitioners are qualified to deliver quality health care, regular verification of their credentials and definition of their privileges are required to increase patient safety and reduction of medical errors. The Health Center has adopted the Health Care Standards outlined in 42USC233 (h)(2) that calls for the review and verification of the "professional credentials, references, clinicians history, fitness, professional review, organization findings, and license status of its physicians and other licensed and or certified health care practitioners." The procedures used for credentialing these practitioners shall follow the requirements of the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and query of the National Practitioners Data Bank. Accordingly, the medical staff ensures that competent health care providers possess the necessary education and qualification by verifying competency through the credentialing process confirmation of competence through the privileging process every two years.

f) Utilization of appropriate information systems (e.g., EHRs, payment management systems) for tracking, analyzing, and reporting key performance data, including 1) reporting required clinical and financial performance measures and 2) tracking

diagnostic tests and other services provided to ensure appropriate patient record documentation and follow-up.

The Health Center uses *eClinicWorks* as its patient data management system for documenting and evaluating clinical operations. It has the ability to track and measure key performance indicators, associate billings with clinical procedures and services, and provide patient population management. The Health Center also has systems in place to track diagnostic tests and other services, including prescribing, capturing charges, ordering labs and viewing results, providing patient education, and documenting clinical encounters and clinical services.

g) *Developing, updating, and obtaining board approval for such policies and procedures, including their implementation.*

The Board has full authority and responsibility to develop, update, and approve policies and procedures related to Quality Improvement/Quality Assurance and Risk Management Practices. These policies are adhered to and implemented by the Health Center's Quality Management Committee and team with Board approval to proceed with improvement projects.

h) *Communication to all project stakeholders and utilization of QI/QA results to improve performance.*

Kedren's Quality Improvement Committee provides ongoing operational leadership for continuous quality improvement activities at the Health Center. It meets at least monthly and consists of the Medical Director (Chairperson), Dr. Gill the Director of Quality Management, a parent advocate, a recipient of adult services, the Chief Medical Officer of Kedren Community Care Clinic, The Director of Nursing, environmental services, internist, dietician, pediatrician, compliance officer, Board Chairperson and licensed practitioner from pharmacy and social work.

The responsibilities of the Committee include (a) developing and improving the Quality Improvement Plan; (b) establishing measurable objectives based on priorities identified to the use of established HRSA criteria to improve the quality and safety of the Health Center's services; (c) developing indicators of quality on a priority basis; (d) periodically assessing information based on the indicators; (e) taking action as evidenced through the quality improvement initiatives to solve problems and pursue opportunities to improve quality; and (f) establishing supporting specific quality improvement initiatives.

i) *Accountability throughout the organization, specifically the role and responsibilities of the Clinical Director in providing oversight of the QI/QA program.*

The Medical Director is the chairperson of the Quality Improvement and Risk Management Committee and is responsible to provide leadership in measuring, assessing and improving medical care rendered in the hospital, including, but not limited to, oversight of ongoing

professional practice evaluation activities, and on its own behalf or in concert with other medical staff (or department) committees, oversight of focused professional practice evaluations to assess members' general competencies, medical assessment and treatment, use of medications, use of blood and blood components, operative and other procedures, and efficiency of clinical practice patterns. The Committee is also responsible for monitoring of significant departures from established clinical patterns, patients' and families' education, coordination of care with other practitioners and hospital personnel, and the accurate, timely, and legible completion of patients' medical records. Subcommittees that report to the Quality Improvement Committee may be appointed, using the procedure described in the Medical Staff Bylaws, when necessary to carry out these functions.

9) *Describe plans for assisting individuals in determining their eligibility for and enrollment in affordable health insurance options available through the Marketplace, Medicaid and CHIP, including:*

   a) *How potentially eligible individuals (both current patients and other individuals in the service area) will be identified and informed of the available options.*

Individuals who access care are screened by intake workers and billing staff for their eligibility to enroll in affordable health insurance options through the Marketplace, Medi-Cal, and CHIP. As affordable health care options have become income based, the same method used to determine eligibility in a sliding fee scale payment is used to identify eligible individuals, no less than once each year, and upon each visit. Available options for healthcare are presented to consumers by staff that are stationed in the reception area and are qualified to discuss enrollment options, having been trained by Covered California, the State's Health Exchange.

   b) *The type of assistance that will be provided for determining eligibility and completing the relevant enrollment process.*

The Health Center patients are able to check their eligibility and apply for coverage in a number of ways that include online, by mail, by phone, and in person, and clinic staff are committed to making these tasks as easy on the patient as possible. Full assistance in determining eligibility and completing the enrollment process is available as the Health Center has benefited from funding from Covered California to hire "assistors" to work with persons eligible for insurance coverage. The Health Center outreach, front desk and management personnel routinely attend trainings to become well-versed in ACA eligibility, enrollment policies and related procedures. The Health Center understands that patients need help deciding about the options available to them and how to navigate unfamiliar systems - even those touted as being a simplified enrollment process. In recognition of those needs, the Health Center conducts community outreach and provides onsite assistance to potential and current patients in languages that they are most comfortable speaking.

NEW AND COMPETING SUPPLEMENT APPLICANTS ONLY:

10) Upload a detailed implementation plan to Attachment 13: Implementation Plan (see Appendix C). The plan must include reasonable and time-framed activities that assure that, within 120 days receipt of the Notice of Award,11 all proposed sites (as noted on Form 5B: Service Sites) must have the necessary staff and providers in place to begin operating and delivering services to the proposed community and/or target population as described on Forms 5A: Services Provided, 5B: Service Sites, and 5C: Other Activities/Locations.

Not applicable.

11) Describe plans to ensure that the organization will:

a) Hire/contract with all providers (consistent with Form 2: Staffing Profile, Form 8: Health Center Agreements, and Attachment 7: Summary of Contracts and Agreements) and begin providing services at all sites for the targeted number of hours within one year of Notice of Award.

Not applicable.

b) Minimize potential or anticipated negative impacts for patients currently served (as noted on the SAAT) that may result from an award recipient transition.

Not applicable.

COLLABORATION

1) Describe both formal and informal collaboration and coordination of services with other community providers in the service area (consistent with in Attachment 1: Service Area Map and Table). Specifically describe collaboration and coordination with the following or explain if such community services are not available:

The vision of the Health Center is to improve the quality of life in the surrounding neighborhoods through the creation of a healthy community. Kedren has a long history of working in the community mental health centers' field providing section 330 services in the Watts/Willowbrook and other Central Los Angeles areas. Since Kedren's FQHC designation in 2013, the Health Center began to establish more formalized relationships with other FQHC's, substance abuse providers, the Los Angeles County Department of Public Health, the City of Los Angeles' Parks and Recreation Department, law enforcement, and other faith based organizations. In addition, relationships with the Los Angeles and Compton Unified School districts have been solidified through the recent establishment of Kedren's Health Neighborhood

Council and have brought more parents, transitional aged youth, businesses, and other community resources as involved partners in the process. Elected officials from the Second County Supervisorial District and City Council members for Districts 8 and 9 are also interested and supportive partners in the process (see Health Neighborhood below).

The Health Center also has a large number of community health providers who continue to work with Kedren care manager's to ensure that all needs and resources are available to aid Kedren with the realization of its vision (see Network diagram below).

The recent integrated care system by the County Board of Supervisors has created a clear pathway for the departments of Mental Health, Public Health, and Health Services to consolidate the public and private delivery system. This has provided the Health Center with opportunities to work with healthcare publications, law enforcement, County Parole and Probation Departments to better address the needs of the community that now comprises 40% of residents with mental health, substance abuse, and forensic problems. Kedren has been identified as the lead agency for the northern end of the service area, and is currently working on formalizing collaboration by developing a shared vision, strategic planning, assessment of the environment and collaborative member capacities, while also establishing well-formed goals and developing a plan of action to include, but is not limited to, conducting community focus groups, supporting parents in the collaborative efforts, and visiting other collaborative groups. The 21.98 square mile service area, which conforms to Health Center patient utilization patterns, is 84.4% a Medically Underserved Area (MUA).

a) Existing health centers (Health Center Program award recipients and look-alikes).

There are several section 330 community health centers and look-alikes in the Health Center service area (please see Attachment 1), all of which work collaboratively with the Health Center in connection with the Health Center's provision of specialized mental health and psychiatric services, and conversely, the Health Center refers its outpatients to these health centers for specialty care services that are not provided directing by the Health Center. The health centers currently in the Health Center's service area are:

Site	Address
South Central Valley Family Health Center	4425 S Central Ave, Los Angeles, CA 90011
JWCH Institute Inc. (Homeless Provider)	5132 S San Pedro St, Los Angeles, CA 90011
AltaMed Health Services (Huntington Park)	6330 Rugby Ave., Suite 200 Huntington Park, CA 90255
St. John's Well Child & Family Center (Magnalia)	1910 Magnolia Avenue, Suite 101 Los Angeles, CA 90007

Central Neighborhood Health	2707 So. Central Avenue Los Angeles, CA 90001
Eisner Pediatric and Family Medical Center	1530 So. Olive Street Los Angeles, CA 90015
Universal Community Health Center	1005 E. Washington Blvd. Los Angeles, CA 90021
Northeast Community Health Clinics	4129 Gage Ave. Bell, CA 90201
Central City Community Health Center	5970 South Central Ave. Los Angeles, CA 90001
University Muslim Medical Center	7821 S. Avalon Blvd. Los Angeles, CA 90003
Family Health Care Centers of Greater Los Angeles	4943 Slauson Ave. Maywood, CA 90270

b) State and local health departments.

The Health Center is a member of the Community Clinic Association of Los Angeles County (CCALAC), which facilitates communication with several FQHCs in and around the service area, and that also liaisons with the Los Angeles County Department of Health Services (DHS). The Health Center has for years worked with DHS's counterpart, the Los Angeles County Department of Mental Health (DMH). The Health Center's membership with CCALAC has supported development of new collaborative relationships, facilitating even greater reach throughout its largely medically underserved service area. The Health Center is also a member of the California Primary Care Association (CPCA). Affiliation with CPCA has provided the Health Center access to information and programs on a variety of timely topics, including state and federal regulatory compliance, leadership development, managed care, chronic disease management, financial management, operational efficiency, technology management, and quality improvement and assurance, including special events, such as the CPCA Tech Summit and CFO Conference.

c) Rural health clinics.

The Health Center is not located in a rural area and thus does not partner with rural health clinics.

d) Free clinics.

There are no free clinics in the Health Center's service area.

e) Critical access hospitals.

There are no critical access hospitals in the Los Angeles area, however, the Health Center does have relationships with Harbor-UCLA Medical Center, LA County-USC Medical Center, and Olive View-UCLA. The Health Center's primary care physicians maintain admitting privileges to Hollywood Presbyterian Hospital and California Hospital Medical Center

f) Other federally supported award recipients (e.g., Ryan White programs, Title V Maternal and Child Health programs).

In the broader service area there are grantees that receive federal funding, including Watts Health Care Center, which receives Ryan White program funds as well as JWCH Institute, which also has a Ryan White contract. The Health Center refers patients to these agencies for specialty care.

g) Private provider groups serving low income/uninsured patients.

There are several for-profit clinics in the service area, with many focusing on worker injury and urgent care services. The Health Center also partnered with two private nonprofit medical providers, including inviting their staff to see residential patients at its facility and referring outpatients to their nearby clinic offices.

The two private providers to which the Health Center refers are:

- The Vernbro Medical Center (231 W. Vernon Avenue, Los Angeles, CA 90037), which has worked collaboratively with KCHC since 2005. It provides medical services while referring challenging psychiatric patients to KCHC for treatment.
- DeVaughn Peace MD, Inc. (4326 S. Western Ave., Los Angeles, CA 90062) is a more than 30-year old medical practice providing primary and pediatric care services in the South Los Angeles community. A full range of primary care services are provided, though Dr. Peace reports that he is challenged to respond to Medi-Cal patients in that his service costs exceed his reimbursement

In addition to private providers, the following hospitals are available for low-income residents that are within a 10-mile radius of the Health Center's South Los Angeles facility: California Hospital Medical Center, 1401 South Grand Ave., which is a nonprofit hospital; Martin Luther King Jr. Medical Center, 12021 Wilmington Ave., which is a public hospital; and also the Los Angeles County + USC Medical Center, 1200 N. State Street, which too is a public hospital.

h) Evidence-based home visiting programs serving the same target population.

The Health Center does not currently partner with any evidence-based home visiting programs serving the same target population.

i) *Additional programs serving the same target population (e.g., social services; job training; Women, Infants, and Children (WIC); coalitions; community groups; school districts).*

Throughout South Los Angeles there are numerous community-based and faith-based health and human service organizations with which the Health Center has established collaborative working relationships. All totaled, there are more than 50 organizations and agencies with which the Health Center has partnerships, and together they comprise a network of services for low-income and marginalized residents of the service area. These include resources for common health and human service needs, including alcohol and drug services provided by BAART Community Healthcare and Amity Foundation. The Health Center also works with the Compton/Watts Interfaith Collaborative, which supports promotion of services to residents, many of whom are active with faith-based communities. Amity Foundation and BAART are especially important partners given the high prevalence of substance use in the community. Amity has more than 20 years' experience providing residential treatment services. A national organization with strong ties to Los Angeles, Amity operates a 187-bed residential treatment facility in South Los Angeles where residents receive a structured curriculum and aftercare services in the six month intensive program. The Health Center and Amity began working together in 2010. BAART offers substance abuse services that comprise a full service wrap around continuum of care, including opiate treatment; methadone maintenance; individualized counseling; psychosocial services; and HIV screening. The Health Center, and these and other allied service providers, has a history of working collaboratively together, and it is not uncommon for teams to be formed of representatives from organizations that jointly discuss patients in common and share information to produce a unified treatment plan based on HIPAA guidelines. Sometimes included are peer outreach staff, family members, as well as the patient in treatment planning.

j) *If applicable, organizations that provide services or support to the special population(s) for which funding is sought (e.g., Migrant Head Start, Public Housing Authority, homeless shelters).*

Although the Health Center does not receive funding for special populations, we serve homeless men and women, and works closely with several homeless services providers, many of which are not far from its South Los Angeles location. These include the Downtown Women's Center, Los Angeles Mission, Union Rescue Mission, Volunteers of America, Midnight Mission, the Weingart Center, and Veteran's Affairs.

k) *If applicable, neighborhood revitalization initiatives such as the Department of Housing and Urban Development's Choice Neighborhoods, the Department of Education's Promise Neighborhoods, and/or the Department of Justice's Byrne Criminal Justice Innovation Program.*

Note: *Formal collaborations (e.g., contracts, memoranda of understanding or agreement) should also be summarized in Attachment 7: Summary of Contracts and Agreements.*

A working group of public agencies and philanthropic organizations in Los Angeles called the LA Neighborhood Revitalization Workgroup was established in 2010 to support Promise Neighborhoods grantees and similar neighborhood-centered initiatives throughout the City. The federal Department of Education funded two Los Angeles nonprofits, the Youth Policy Institute and Proyecto Pastoral at Dolores Mission in 2010, with Promise Neighborhoods grants. The agencies are taking an important step towards revitalizing impoverished communities and invigorating local education and the Health Center has relationships with both programs.

2) *Document support for the proposed project through current dated letters of support that reference specific coordination or collaboration from all of the following in the service area (as defined in Attachment 1: Service Area Map and Table), or state if such organizations do not exist in the service area:*

   a) *Existing health centers (Health Center Program award recipients and look-alikes).*

The Health Center has included in this application letters of support from the following health center grantees and Look-Alikes: All-Inclusive Community Health Center and Central Neighborhood Health Foundation.

   b) *State and local health departments.*

The Los Angeles County Department of Health Services (DHS) does not provide letters of support as policy with rare exceptions. The Health Center works closely with DHS, and is presently a contractor for My Health LA, which is for low-income undocumented adults made possible by the Federal 1115 Waiver. Kedren additionally has contracts with the Los Angeles County Department of Mental Health, and is in fact, its largest contractor.

   c) *Rural health clinics.*

As our service area and geographic region resides completely within urban areas, there are not rural health clinics within or adjacent to our service area

   d) *Critical access hospitals.*

NOTE: *If such letters cannot be obtained from organizations in the service area, include documentation of efforts made to obtain the letters along with an explanation for why such letters could not be obtained.*

There are not any critical access hospitals in the service area.

3) *Provide current dated letters of support that reference specific coordination or collaboration from other community organizations in support of the proposed project beyond those required in Item 2 above (e.g., social service agencies, school districts, homeless shelters).*

Note: *Merge all letters of support from Items 2 and 3 into a single document and submit it as Attachment 9: Letters of Support.*

The Health Center has included in this application letters of support from community nonprofit organizations that include: A Community of Friends, Amnity Foundation, APAIT, BREATHE California of Los Angeles County, Chinatown Service Center, Clifford Beers Housing, LA Care, Los Angeles County Department of Mental Health, and Pacific Asian Counseling Services. Additionally enclosed are letters of support from patients currently receiving treatment at the Health Center.

EVALUATIVE MEASURES

1) *Within the Clinical Performance Measures form (see detailed instructions in Appendix B), outline time-framed and realistic goals that are responsive to the identified needs.*

Clinical Performance Measures (CPM) have been designed to address the community health needs identified in this competing application. The needs of the service area and target population are presented throughout the application narrative. Clinical performance measures are conducted to assess the stability of processes or outcomes to determine whether it is an undesirable degree of variation or a failure to perform at an expected level. The process also identifies problems and opportunities to improve the performance and assess the outcome of the care provided. The measuring and assessing of the performance of the Health Center is done through the collection and analysis of data, continuing quality improvement initiatives, and taking action where necessary including the design of new services and/or improvement of existing services. Once the performance of a select process has been measured, assessed and analyzed, the information gathered on the selected performance indicators is used to identify the continuous quality improvement initiative to be undertaken. Evaluations are done frequently and results communicated to the Board on a monthly basis.

The clinical measures are reported in the table format below. Most of the measures as we enter the next project period have baseline data included within this application with the exception of new measures for which data have not been compiled.

Clinical Performance Measure	Baseline	Target
Diabetes (HbA1c level) < = 9.0	55.71%	80%
Cardiovascular Disease < (140/90)	50.0%	65%
Cancer (Pap test)	35.79%	75%

Prenatal Care (1st trimester)	83.3%	85%
Perinatal (birth weight < 2500 grams)	8%	7.8%
Child Health (Immunizations)	91%	93%
Oral Heath (use of system) - New	0%	30%
Children's Weight Assessment and Counseling	46.81%	75%
Adult Weight Screening and Follow Up	95.09%	97%
Tobacco Use Screening and Cessation	75.08%	87%
Asthma – Pharmacological Therapy	56.76%	71%
Coronary Artery Disease – Lipid Therapy	100%	100%
Ischemic Vascular Disease – Aspirin Therapy	100%	100%
Colorectal Cancer Screening	39.91%	55%
HIV Linkage to Care	0%	100%
Depression Screening and Follow Up	61.75%	75%

2) *Within the Financial Performance Measures form (see detailed instructions in Appendix B), outline time-framed and realistic goals that are responsive to the organization's financial performance.*

The Financial Performance Measures (FPM) have been designed to address the key factors in the financial health of the organization identified for tracking and target setting to the project ending period addressed in this competing application. Of the three (3) FPMs, two measures are calculated based on financial classifications flowing from generally accepted accounting principles reported in the audited financial statements of the organization and on an interim basis in the unaudited monthly statements presented to management and the Board of Directors. Kedren has included monitoring of the new required financial indicator for Health Center Program Grant Cost per Patient

As for the annual Total Cost per Patient and Medical Cost per Patient Visit FPMs, Kedren will continue to provide these calculations in the monthly Board package and immediately following the annual UDS submission with prior three year comparison and project ending period targets with analysis and recommendations, if needed.

Where possible all measures will be compared to state and national calculations when provided through HRSA BPHC published sources.

The following table summarizes the baselines, and targets within each focus area of the Financial Performance Measures through to the end of the project period:

Financial Performance Measure	Baseline	Target
Total cost per patient	$1,099	$ 527.66

Medical cost per medical visit	$347.27	$ 161.71
Health Center Program Grant Cost per Patient	$0	$122.81

Kedren collects these data through agency-wide records and audited financial statements. Please see completed the **Financial Performance Measures** form included with this application, which in addition to the summary provided in the table above, includes numerators, denominators, data collection methodology, and other details, such as specific factors that may contribute or restrict progress toward achieving each of the five measures.

Kedren has in place a financial management team composed of administrators, clinic managers, and providers, which is responsible for reviewing budget variances. Total costs per patient and costs per visit have historically fallen below the average for health centers in California and across the nation. The management team diligently researches new potential sources of income to ensure that as revenue streams change, the organization's income has the diversity to withstand reduction in any single source.

3) *Describe the organization's ongoing process for assessment of the health care needs of the target population, including:*

   a) *The frequency and when the last assessment occurred.*

The Health Center's assessment is ongoing through patient interviews and satisfaction and needs surveys, with a formal and complete needs assessment of secondary sources being conducted at least every other year. This proposal represents the most current assessment of needs, which has included an extensive review of secondary data from the updated U.S. census, 2013 American Community Survey 5-year average (2009-2013), and California-based health surveys. It also represents knowledge gleaned from interviews with key informants about healthcare needs in the service area, including FQHCs.
The most recent patient satisfaction survey was completed in August/September 2015, which showed strong positive results. Nearly two-thirds (64%) reported that ease of getting care was "great," and 23% reported "good." Staff assessments were more than three-quarters (78%) as great and 14% "good" for a total of 96% satisfaction. Other response sets for the 90 respondents were as follows:

Staff Provider (Physician, Dentist, Physician Assistant, and Nurse Practioner):				
	Great	Good	OK/Fair	Poor
Listens to you	69	14	6	1
Takes enough time with you	71	11	7	1
Explains what you want to know	68	15	6	1
Gives you good advice and treatment	68	14	7	1

Respondents also reported that payments were acceptable with 69% "great" and 19% "good." Similarly, the facility was rated 82% "great" and 12% "good."

b) Community engagement.

Community outreach workers participate in health fairs and other community events at which they enroll community members in Medi-Cal or other public health plans and Covered California health plans, at which time they conduct informal interviews to determine community needs and report on their findings to their supervisor who includes the information in their reports to the executive team. Kedren also conducts periodic surveys to assess patient satisfaction as a measure of success of the healthcare treatment received and to discover any unmet needs in health care or cultural competence of the services delivered. Findings are shared with all staff members in line with the organization's ongoing commitment to continuous quality improvement.

c) Assessment tools/methods (e.g., written or verbal patient satisfaction surveys), and analysis, including cultural appropriateness.

The Health Center monitors and measures success of the healthcare needs of the target population through its internal quality assurance team, which utilizes tools such as patient satisfaction surveys and outcome measures derived from evidence-based practices employed system-wide. Ongoing evaluation tools are measured by tracking and trending relevant data derived from concurrent evaluation of clinical, administrative and related domains.

As previously described, the Health Center's community outreach workers conduct periodic patient satisfaction surveys as another means of assessment. This is an invaluable tool for community engagement and to ensure the ongoing cultural appropriateness and competence of the services provided. Information gathered from these surveys is routinely reviewed by both staff and Board of Directors, who can make changes to address identified needs. The Health Center also utilizes its Electronic Health Record (EHR) and practice management system to track clinical outcomes by disease and to aggregate data by population group.

d) Dissemination of results to board members, health center staff, community stakeholders, project partners, and patients.

The Board of Directors conducts extensive systems reviews of the entire organization on an annual basis to ensure that the goals and objectives are being met relative to the needs of the population served. Each clinical department conducts meetings at least quarterly to consider the findings from the ongoing monitoring and evaluation of the quality of care and treatment provided to patients. The responsibilities of the clinical departments and medical staff members are specified in the Medical Staff Bylaws and include: (a) identifying and charting key processes addressing medical necessity; (b) ensuring that the quality of patient care provided within the services is monitored, evaluated and improved on an ongoing basis; (c) directing and being

accountable for all professional and administrative services provided by the department; (c) recommending criteria for the delineation of clinical privileges within the department; (d) recommending clinical privileges for each member of the department; and (e) continuing surveillance of the professional performance of all members of the department with clinical privileges.

Kedren's medical executive committee is given monthly reports by the Health Center's QM Committee and appropriate measures are taken by the staff and Board of Directors to ensure Kedren is fulfilling its stated mission of providing total quality care to its clients. Additionally, the QM Committee working with IT staff, will prepare monthly dashboard reports, as noted above, which are useful in tracking progress toward and compliance with the goals laid out in the clinical and financial performance measures. This information is useful in framing issues for the QM Committee to consider, and as the QM Committee identifies areas of concern, the embedded strategic planning process can be informed by the Committee's observations.

4) *Provide a brief description of any additional evaluation activities planned throughout the project period, including planned data collection tools.*

Kedren is in receipt of a SAMHSA integrated behavioral health grant and has engaged an evaluation firm that is assessing its progress toward integrated care involving primary care and mental health services.

RESOURCES/CAPABILITIES

1) *Describe how the organizational structure (including any subrecipients/contractors) is appropriate for the operational needs of the project (consistent with Attachments 2: Corporate Bylaws and 3: Project Organizational Chart, and, as applicable, Attachments 6: Co-Applicant Agreement and 7: Summary of Contracts and Agreements), including:*

    a) *How lines of authority are maintained from the governing board to the CEO.*

Kedren and the Health Center's lines of authority are clearly defined in its organizational chart, bylaws and personnel policies. The organization is governed by a Section 330-compliant Board of Directors with consumer and non-consumer members identified. The Board's composition is representative of the service area population in terms of race and ethnicity, and as required, has a majority of consumer members. The Kedren Board strives to improve its governance competency by having members attend trainings and evaluate their performance. Additionally, when FQHC Section 330-recognition is accomplished, the Board will ensure that it maintains compliance with Section 330 guidelines, while ensuring that the needs of the target population are at the forefront of its governance activities.

The Board delegates day-to-day oversight to the President and Chief Executive Officer (CEO) John H. Griffith, PhD. Dr. Griffith answers directly to the Board of Directors and maintains oversight for the management team that includes the Chief Financial Officer (CFO) Samuel W. Qiu. Mr. Qiu is responsible for the organization's financial activities, including the annual operating budget, which he submits to the Board for approval. He also compiles regular financial reports, which are also presented to the Board, to ensure that Kedren is effectively meeting financial goals, and that revenues and expenses are being received as anticipated. The CFO also oversees the financial and billing staff.

The Chief Medical Officer of Kedren (CMO) is Frank L. Williams, MD, who directs and coordinates healthcare services and supervises clinicians for Kedren. Dr. Williams is responsible for the quality review of the medical staff and also leads the clinic's quality management program, as well as overseeing the pharmacy staff. The Health Center's Chief Medical Director, Dr. Cadrin Gill is responsible for assuring quality primary care is delivered to the Center's clients. Dr. Gill also participates in the monthly quality management review meetings and provides reports on the Center's QI/QA monitoring activities and outcomes. The Chief Operating Officer (COO), Shenyell Morales, MSN, FNOP-C oversees the Health Center operations. All technology staff reports to the CIO, Dr. Earle Charles who oversees billing and IT concerns. Ms. Marilyn Campbell, RN is the Director of Quality Management. The executive team meets monthly with the CEO of Kedren to discuss ongoing concerns and mission fulfillment.

b) Whether the applicant organization is part of a parent, affiliate, or subsidiary organization (consistent with Form 8: Health Center Agreements).

The Health Center is not part of a parent, affiliate, or subsidiary organization.

2) Describe how the organization maintains appropriate oversight and authority over all proposed service sites, including contracted/sub-awarded sites, and services including (as applicable):

a) Current or proposed contracts and agreements summarized in Attachment 7: Summary of Contracts and Agreements.

Kedren has few contracted services among its core healthcare systems, and there are no sub-recipient or affiliation arrangements that could compromise the integrity and control of its operations or the care that it provides. Some members of the medical staff are employed by the organization and others function as independent contractors who will provide, among other services, general primary care, 24-hour coverage, and communicable disease testing and treatment. Where there are referral arrangements, such as to the allied health centers that provide specialty care services not available at the Health Center, care is provided at levels comparable to that available at Kedren based on annual quality assurance assessments. The Health Center

contracts for radiology and diagnostic laboratory services with RadNet/Beverly Tower Wilshire Advanced Imaging Center of Los Angeles and Laboratory Corporation of America, respectively. The latter provides daily pick-up of laboratory specimens and results-reporting.

b) Subrecipient arrangements, subawards, contracts, or parent/affiliate/subsidiary agreements uploaded in Form 8: Health Center Agreements.

Note: *Exclude contracts for the acquisition of supplies, material, equipment, or general support services (e.g., janitorial services, contracts with individual providers).*

Kedren or the Health Center does not have a sub-recipient arrangement in place with another entity.

3) Describe how the organization's management team (CEO, CMO, CFO, CIO, and COO, as applicable) is appropriate for the operational and oversight needs, scope, and complexity of the proposed project, including:

a) Defined roles (consistent with Attachment 4: Position Descriptions for Key Management Staff), in particular the CEO's responsibilities for day-to-day program management of health center activities.

Job descriptions are reviewed once each year by the Kedren Board of Directors to ensure that they are current in terms of presently assigned duties and responsibilities. The management staff is consulted with regard to this annual review to ensure that duties accurately reflect current functions. With regard to the management team, their job descriptions are reviewed as a suite of complementary competencies given the interdependence that the CEO, CMO, CFO and COO have with regard to one another. As part of this renewal process for continued FQHC designation, the management team's job descriptions were reviewed by a Board committee to ensure that they accurately portrayed duties and responsibilities necessary for the health center to successfully operate.

b) Skills and experience for the defined roles (consistent with Attachment 5: Biographical Sketches for Key Management Staff).

Kedren's senior management team has substantial experience working for large complex organizations and in providing health and mental health services to the proposed target population. As noted above, Kedren's CMO Frank L. Williams, MD, has been with Kedren since its inception and has dedicated his entire career to working with patients from the South Los Angeles community. Dr. Griffith, Kedren's President/CEO, has been working with the proposed target population for more than 30 years, initially as Kedren's Chief Operating Officer of Mental Health Services until he became President/CEO. Additionally, all of Kedren's senior management team have lived in or near the service area and have been active members of the surrounding community for decades. They are also committed to the goal of maintaining a

primary health care clinic to serve the residents of this underserved and economically challenged community, including current users of Kedren's services. Furthermore, Kedren senior management have substantial experience providing comprehensive programs and services for children, transitional aged youth, adults and older adults residing in Los Angeles County that are experiencing serious or persistent mental illness or emotional disturbances. The management team has ensured that the delivery of services has been holistic, collaborative, multidisciplinary and culturally competent, focusing on the individual and his or her needs.

c) *If applicable, shared key management positions (e.g., shared CFO/COO role) and time dedicated to health center activities (e.g., 0.5 FTE).*

There are not any shared positions.

d) *If applicable, changes in key management staff in the last year or significant changes in roles and responsibilities.*

There have not been any changes in key management staff.

4) *Describe the plan for recruiting and retaining key management staff and health care providers necessary for achieving the proposed staffing plan (consistent with Form 2: Staffing Profile).*

Kedren and the Health Center follow a disciplined approach in its hiring strategies, which has resulted in low-turnover rates and high employee loyalty, as exemplified by the average length of tenure by staff members. Recruitment is conducted internally, when possible, and multiple external strategies are utilized when not. External strategies include (a) advertising in leading local newspapers, professional career magazines, or other forms of media; (b) job postings on the Kedren web site (http://www.kedren.org); (c) job and college fairs, and the Internet (e.g., Career Builders); (d) Job lines including the Los Angeles County Human Resources Department and California Employment Development Department; (e) professional journals for physician recruitment and for specialists; (f) physician referral and placement services; and (g) as a HPSA designated site by virtue of being a FQHC, Kedren participates in loan forgiveness programs for providers that work for the Health Center. Retention of providers and other staff is a priority for Kedren and is facilitated by (a) compensation and continuing education that is competitive with similar organizations serving similar populations (compensation is reviewed once each year and adjusted based on market conditions); (b) competitive vacation benefits; (c) clearly defined job descriptions with annual performance reviews; (d) comfortable working environment with enthusiastic, unified staff; and (e) active participation of staff in strategic planning and quality improvement activities.

Like all employers, Kedren selects providers based on their clinical competencies along with their "mission-driven" commitment to careers in community health and to addressing the

healthcare needs of South Los Angeles residents. Before a new provider starts, the Medical Director will credential new hires. This process is applied uniformly to all new hires and includes licensure, education and training, references, liability and claims history including Office of Inspector General (OIG) clearance, disciplinary action history, ability to perform requested privileges, loss or limitation of clinical privileges, professional liability insurance history and current coverage.

5) Describe organizational experience in the following areas:

a) Working with the target population.

Kedren has been an enduring landmark and touchstone for the South Los Angeles community for more than 50 years. Historically, South Los Angeles was the center of African-American culture in Los Angeles, though in recent years, the dramatic increase in the Latino population has resulted in South Los Angeles being a truly multicultural community. Kedren has kept pace with these changing demographics to meet and address the complex and emergent needs of the community through active participation in community events, such as health fairs and holiday celebrations, and by hiring local residents whenever possible to work for Kedren.

b) Developing and implementing systems and services appropriate for addressing the target population's identified health care needs.

Dr. Gill, as Medical Director of KCHC, has overseen clinical services planning for the health center based on residents' healthcare needs. The clinical staffing plan is related to the level and mix of services that have been provided with Section 330 funding and the needs of residents. This includes physicians (1.0 FTE family physician, internist, and pediatrician), mid-level providers (physician's assistant or nurse practitioner), and licensed clinical social worker. Kedren is experienced in implementing systems of care, which is accomplished by continually monitoring clinical efficiencies that ensure that quality standards remain high, and that implementation has occurred according to expectations. For example, as part of service implementation, Kedren's budget and implementation plan assumes a pairing of physicians to medical support staff at a ratio of 3:1, as this level of support will allow providers to comfortably maintain productivity while tending to individual patient needs. The hiring of clinical support staff is thus based on the proportional engagement of providers, a ratio that has been provided to Kedren by allied health centers that have offered advice on services planning.

6) Describe the organization's ongoing strategic planning process, including:

a) The roles of the governing board and key management staff.

Kedren's Board of Directors is ultimately responsible for strategic planning. In fact, strategic planning has played a key role in the Board's decision to open a primary health care center.

Employing the help of consultants, Kedren studies national, regional, state, and local data and trends, as well as reviewing its own utilization patterns, in an effort to effectively tailor its strategic plan to the unmet needs of the target population. The goals and objectives of strategic planning are directly tied to the organization's mission. Performance trend data is a major resource in developing Strategic Plan strategies. The Board's Executive Committee functions as its strategic planning committee and meets periodically with management to review the current plan's progress and to make recommendations where necessary; bi-annual reports are provided to the full Board on the results of those reviews and the plan's progress.

Kedren's management team plays a pivotal role in the organization's strategic planning process. Though the Board is ultimately in charge of developing and implementing the strategic plan, the management team act as advisors on clinical and organizational operations, and conducts the research and otherwise frame the issues for the Board to consider with regard to planning. The management team also oversees the compilation of reports and data that is presented to the Board for review, in addition to providing its expertise as a resource to the Board. For example, Kedren's Medical Director, Dr. Frank L. Williams, leads the organization's QM Committee. Dr. Williams is experienced in the area of quality care and compliance, and quickly recognizes and reports issues that may arise concerning the quality of clinical care or trends that are emerging that require a retooling of how Kedren responds to client needs. Additionally, Kedren's CFO, Samuel Qiu, CPA keeps up-to-date financial records as well as records of operational performance, which are also used for day-to-day as well as strategic planning. These records are a useful reference tool in the development of a well-grounded strategic plan.

b) The frequency of strategic planning meetings.

Every five (5) years, Kedren's Board conducts an in-depth, formal strategic planning process and implements a strategic plan to guide the Organization.

c) Strategic planning products (e.g., strategic plan, operational plan).

Kedren's mission is to promote and sustain health and wellness through comprehensive integrated health services, community partnerships and advocacy for residents of the South Los Angeles.

The organization's vision is to develop and implement a research based treatment model, utilizing best clinical practices in targeted treatment intervention. Our strategic focus is on illness and disease prevention management; and early intervention using cost effective and efficient approaches. Our integrated healthcare collaborative, using these stated strategies, will continue to result in successful healthcare outcomes.

Kedren has revised its strategic plan to incorporate the FQHC, which represents a substantial expansion of its service capacity. The written strategic plan has been modified by addendum.

Additionally, Kedren has reviewed the implementation plan that was submitted with the initial New Access Point proposal, and has continued to build on it to extend operational planning more than two years after the initial designation.

Kedren's strategic goals over the next five years include:

1. To create a Customer-Friendly Environment that is reflective of service satisfaction, accessibility, sustainability, and cultural relevance.
2. To continuously train and develop professional staff in evidence-based practices, clinical documentation, outcome data and performance measures.
3. To fully upgrade and implement the Electronic Health Record System.

In order for the organization to continue to work toward achieving these goals, Kedren has developed and identified evaluative measurement tools that target outcomes and quality of service; Developed and implemented treatment to target instruments that capture the efficacy of clinical and treatment interventions; and lastly has developed an instrument that ensures the effectiveness of the EHR system. Based on an anticipated increase in referrals, along with grants and other contracts Kedren receives, the Organization anticipates a proportional increase in utilization patterns, necessitating an expansion of medical and other staff resources. Resulting outcome information will be reviewed by managing staff and expansion of services will then be approved by the Board of Directors.

d) Incorporation of needs assessment and program evaluation findings.

The needs of the Health Center's target population are the foundation for all strategic planning activities. Responses to needs assessments and patient satisfaction surveys are discussed during all strategic planning meetings. The organization's strategic plan is developed with the needs of the consumers as a top priority.

7) Describe current or planned acquisition and implementation of certified EHR systems.15 When describing EHR systems, include the number of sites and providers utilizing, or that will utilize, EHRs (e.g., number and types of providers that receive Medicare and Medicaid EHR Incentive Payments) for tracking patient and clinical data to achieve meaningful use.16

Currently, the Health Center uses a secure, web-based electronic medical system, *eClinicWorks,* that allows patients and medical providers easy and secure access to clinical records. This system is integrated throughout the entire organization with all providers currently using the system. It is crucial in providing timely, effective and efficient healthcare information to patients and providers alike. These systems are compliant with Meaningful Use standards, and are capable of interacting with outside systems to provide a depth and breadth of information for patients who interact with other health care providers. Implementation of *eClinicWorks* has helped the Health Center to cut costs and medical errors, thus ensuring a more efficient and

effective delivery system. The new system allows patient tracking for periodic preventive checks, tracking patient demographic information, patient scheduling, and billing functions. The new system also provides the Health Center with the ability to analyze and report on a variety of data for use in program evaluation, quality management, planning and development by the management team, and supports regular reporting to the Health Center and Kedren's many funding agencies.

8) *Describe any national quality recognition the organization has received or is in the process of achieving (e.g., Patient-Centered Medical Home, Accreditation Association for Ambulatory Health Care, Joint Commission, state-based or private payer initiatives).*

Kedren and the Health Center has not received specific recognitions as a new health center, though intends to apply for the future.

9) *Describe the current status or plans for participating in FQHC-related benefits (e.g., Federal Tort Claim Act (FTCA) coverage, FQHC Medicare/Medicaid/CHIP reimbursement, 340 Drug Pricing Program, National Health Service Corps Providers).*

The Health Center has applied for FTCA deeming, and has closely reviews FTCA requirements to ensure that we are compliant with changes or revisions to the regulations.

The Health Center also participates in the Section 340B Drug Pricing Program for in-clinic administered drugs, and has secured an agreement with a 340B Third Party Administrator to assist us with managing our 340B contract pharmacy program.

For the Vaccine for Children's (VFC) Program, the Health Center stays abreast on updated information by receiving e-mail alerts. We also have direct contact with the Los Angeles County Immunization Program, which manages the VFC Program in Los Angeles. We are involved in the Immunize LA Families Coalition, whereby we have an AFIX intervention regarding flu and pneumococcal vaccine. Finally, we receive ongoing provider updates from the Los Angeles County Department of Health Services related to vaccine-preventable diseases.

The Health Center also has been eligible and has been receiving FQHC Medicare/Medicaid/CHIP service reimbursements

10) Describe the billing and collections policies and procedures, including:

a) *How the established schedule of charges for health center services (consistent with Form 5A: Services Provided) is consistent with locally prevailing rates and is designed to cover the reasonable cost of service operation.*

The schedule of charges is reviewed annually by the Kedren Board of Directors to ensure that the schedule of charges is appropriate for the community, reflective of the actual costs of operation and consistent with locally prevailing rates. The Kedren CFO develops the schedule of charges that is reviewed by the Finance and Audit Committee and presented to the Board of Directors for adoption. Projections are based on actual experience and anticipated costs of operation over the subsequent year. The cost of services provided at the Health Center are covered by a mix of third-party payer reimbursement, private foundation funding, individual donations, and public funding, and the cost of services is calculated to allow the organization to stay whole and cover its expenses. Patients are charged for services based on their ability to pay for services at the time of their appointment (or walk-in) by front office staff. Bilingual, full-time certified application-assistants help identify publicly-funded insurance programs for uninsured patients and assists families in completing requisite paperwork.

b) *Efforts to collect appropriate reimbursement from Medicaid, Medicare, and other public and private insurance sources (e.g., CHIP, Marketplace qualified health plans) (consistent with Form 3: Income Analysis).17*

The Health Center maintains a system of individual patient accounts and payments to those accounts whether from sliding scale or third parties which are regularly reconciled. The only problems encountered in this area have been the lack of timely reimbursements from the state Medicaid (Medi-Cal in California) program.

Efforts are continuing towards obtaining and retaining Medi-Cal eligibility for our patients to assist them in covering health care costs and in maximizing the Health Center's reimbursements. Third party reimbursement will continue to be maximized by expanding assistance to Medi-Cal enrollees in the retention of their eligibility. The Health Center's full implementation of its practice management system has improved its ability to track patient billing information and patient account status.

c) *Efforts to secure payments owed by patients that do not create barriers to care.*

Kedren's Board-approved policy is to collect patient fees and co-pays up front in order to minimize payment on overdue accounts while minimizing bad debt/collection problems. Aging reports are generated at least monthly and patient billing statements are mailed each month. Non-payment of fees by the patient are subject to progressive, yet sensitive administrative actions designed to settle claims of financial hardship or dispute of account balance by the patient before other measures are taken. Public and private third-party insurance is billed after each eligible patient visit to the extent allowable by the insurance plan. Follow-up for unreimbursed services is conducted at least on a monthly basis.

Up front patient payments are collected at the front desk and will be delivered to the Finance Department on a daily basis. These payments are verified and included in the regular bank

deposits. Billing transactions are reviewed by the CFO on a daily basis and reconciled against the daily billing report. On a monthly basis, a detailed accounts receivable report is reconciled to the general ledger by the Finance Department. Differences are investigated and resolved, and the reconciliation is then reviewed by the CFO with a report prepared for the CEO and the Board. Patient, third-party and grant revenues are also reviewed on a monthly basis by the CFO.

d) Criteria for waiving charges and staff authorized to approve such waivers.

Waived charges are written-off and will be initiated by the CFO and must be approved by the CEO, depending on the amount of the write-off. When a patient returns for services, his or her bad debt will be reinstated if previously written off.

11) Describe how the financial accounting and control systems, as well as related policies and procedures:

a) Are appropriate for the size and complexity of the organization.

Financial management procedures and accounting and controls are in place and are overseen by the Chief Financial Officer. Kedren's annual operating budget is about $35 million, which includes its newer primary health care center, inpatient and outpatient mental health services, and its Head Start program. The addition of the health center to its operating budget, though significant with regard to its impact on the community, has not affected it capacity to financially manage and control revenues and expenses. The finance department is highly experienced in managing third-party billings to public and private sources, fee collection procedures, and fund accounting, and will maintain separate records and ledgers for the health center operations.

b) Reflect Generally Accepted Accounting Principles (GAAP).

The financial and accounting controls used for the health center are compliant with Generally Accepted Accounting Principles (GAAP) that includes:

- Maintaining financial records and conducting transactions according to GAAP;
- Adherence to written policies and procedures for internal controls of health center operations;
- Maintaining an efficient system for billing third party payors, as well as Medicaid (Medi-Cal in California);
- Maintaining an active accounts receivable and billing process, ensuring timely submission of third-party reimbursement requests and tracking and follow-up of monies due;
- Regular review of a financial procedures manual; and
- Tracking of overdue accounts and bad debt.

c) *Separate functions/duties, as appropriate for the organization's size, to safeguard assets and maintain financial stability.*

Kedren's financial systems support separation of duties and functions. Kedren uses integrated financial systems for its general ledger to develop and track budgets, to manage purchasing and acquisitions, and to provide detailed monthly financial reports to the Board of Directors, and to various funding agencies that require timely reporting. All purchasing and check writing functions are managed by the Finance Department and require review and approval by designated members of the program, department and senior management team, depending on the amount of purchase. All financial transactions are entered by accounting staff into its financial system, and reconciliation of bank statements and other accounts are performed by persons that have no responsibility for checking writing and purchasing. Through the annual audit and management letter, Kedren is assured that accounting functions and duties are appropriate to safeguard assets and maintain financial stability.

d) *Enable the collection and reporting of the organization's financial status, as well as tracking of key financial performance data (e.g., visits, revenue generation, aged accounts receivable by income source or payor type, aged accounts payable, lines of credit).*

On a monthly basis, the CFO along with members of the Finance Department meet with program managers and department directors to review their monthly results and to compare it with the Board approved budget and service projections. In addition, the CEO and CFO meet with the Finance Committee of the Board of Directors to similarly review revenues and expenditures to date relative to the Board-approved budget, and receivables and collections. An account aging report is also reviewed each month and late payments are discussed with strategies developed to accelerate monies due. At Board meetings, the full Board is provided with a monthly revenue and expenditure statement and balance sheet, as well as update on receivables, collections, and when lines of credit have been used. The CFO and the management team also monitor debt-to-equity ratio, net assets to expenses, and working capital to expenses, and though this has not been shared in the past with the Board of Directors, unless a problem was apparent, they will be shared now that these metrics are part of the financial performance measures. Along with clinical performance measures the Board will be apprised of the agency's movement toward goal attainment.

e) *Support management decision-making.*

Having timely information supports management decision-making, which includes historical information on payment histories by payor source, including client payments. Dashboards and timely entry of information helps the management team to track in real time receivables. An aging schedule also enables the management team to identify specific categories or payors that are behind.

12) Describe the organization's current financial status, including profitability (change in net income/total expenses), cash-on-hand (total unrestricted cash/daily expenses), and solvency (total liabilities/total net assets). Source documents (e.g., current income statement and balance sheet) may be uploaded to Attachment 14: Other Relevant Documents, as desired.

Kedren is in good financial health with net assets of $6,689.071 as of June 30, 2015. There has been profitability with a change in net income of $320,007 compared with total expenses of $35,369,028.

13) Describe the annual independent auditing process performed in accordance with federal audit requirements.18 Explain any adverse audit findings (e.g., questioned costs, reportable conditions, cited material weaknesses) and corrective actions that have been implemented to address such findings.

Kedren ensures that an independent audit is performed each year and that the audit is compliant with OMB Circular A-133. The audit for the FY ending June 30, 2014 had no adverse findings.

14) Describe the status of emergency preparedness planning and development of emergency management plan(s), including efforts to participate in state and local emergency planning. If applicable, explain negative responses on Form 10: Emergency Preparedness Report and plans for resolution.

The Health Center participates in the California Primary Care Association (CPCA), the Community Clinic Association of Los Angeles County (CCALAC), and the County of Los Angeles in CCALAC's sponsorship of the Disaster Recovery Center for community health centers and clinics in Los Angeles County. As a member of CCALAC, the Health Center is part of the Disaster Preparedness Workgroup, and participates in Los Angeles County's emergency and disaster planning efforts. CCALAC is assisting its members to meet Federal expectations for FQHCs concerning emergency preparedness. The Health Center has an emergency preparedness and management plan, and although Los Angeles County's emergency preparedness plan currently does not address deployment of health center staff, the Board and senior management are willing to do so once the agency becomes formally integrated into the countywide systems of care. Kedren is also interested in serving as a point of distribution for providing antibiotics and vaccines given that its pharmacy maintains and dispenses a substantial volume of medications in addition to serving as an emergency shelter.

GOVERNANCE

1) *Describe how Attachments 2: Corporate Bylaws, 6: Co-Applicant Agreement, and 8: Articles of Incorporation demonstrate that the organization has an independent governing board that retains (i.e., does not delegate) the following unrestricted authorities, functions, and responsibilities:*

The Kedren Board of Directors, as an independent governing body, has the full authority and responsibility to manage the business and affairs of the Corporation subject to the provisions of the California Nonprofit Corporation Law and is compliant with Section 330 of the Public Health Service Act. A complete list of the members of Kedren's Board of Directors, including Board office held, area of expertise, user status, residence and/or employment within the service area, years of continuous Board service and special population representation can be found in Form 6A. Kedren does not have a Co-Applicant Agreement with any organization.

a) *Meets at least once a month.*

Under Article Four, Section 4.1 of the bylaws, the Board of Directors are required to hold regular meetings "at a time and place to be determined."

b) *Determines board composition with patient majority (51 percent) required.*

Article Three, Section 3.3 of the bylaws states, "The number of directors shall be no less than nine and no more than 25, with an optimum range of 11-15."

Section 3.4 goes on to stipulate, "A majority of the board members (51%) shall be individuals who are, or will be, served by the Center and who, as a group, represent the individuals being served in terms of demographic factors, such as race, ethnicity, age, sex, and economic status. As a rule, user or patient board members should live and/or work in the service area. User members are individuals who are served by the health center and who utilize the Health Center as their principal source of primary care. It is essential that each user member uses the Health Center's services on a regular basis, with no lapse in utilization of services for more than two years while serving as board members. A legal guardian of a consumer who is a dependent child or adult, or a legal sponsor of an immigrant consumer, may be considered a consumer for purposes of Board representation."
."

c) *Determines executive committee function and composition.*

Under Article Six, Section 6.1, the Board of Directors may "The Board of Directors may, by a majority vote of Directors then in office, designate two (2) or more of its members (who may also be serving as officers of this Corporation) to constitute an Executive Committee and delegate to such Committee any of the powers and authority of the Board in the management of the business and affairs of the Corporation, except with respect to: (a) The

approval of any action, which under law or the provisions of these Bylaws, requires the approval of the Board of Directors or of a majority of all of the Board of Directors; (b) The filling of vacancies on the Board or on any committee which has the authority of the Board; (c) The fixing of compensation of the Directors for serving on the Board or on any committee: (d) The amendment or repeal of Bylaws or the adoption of new Bylaws; (e) The amendment or repeal of any resolution of the Board which by its express terms is not so amendable or repealable; (f) The appointment of committees of the Board; (g) The expenditure of corporate funds to support a nominee for Director after there are more people nominated for director than can be elected; and (h) The approval of any transaction to which this Corporation is a party and in which one or more of the Directors has a material financial interest, except as expressly provided in Section 5233(d)(3) of the California Nonprofit Public Benefit Corporation Law."

d) Ensures that minutes documenting the board's functioning are maintained.

Under Article Four, Section 4.9 of the bylaws, "Official minutes (after formal approval) of each meeting of the Board of Directors and its respective committees shall be signed and dated by the Secretary or Designee of the Board and/or committee and binder/notebook maintained in chronological order. Board Meeting minutes must appropriately document major discussions and formal approvals by directors."

In addition, Article V, Section 5.8 (a) of the bylaws states that, "The Secretary is responsible for ensuring maintenance of accurate and concise minutes of all Board proceedings. While actual recordings of the minutes may be delegated to a staff person, the Board Secretary maintains responsibility for reviewing the minutes to ensure they and other written records are accurate, complete, and appropriately maintained. Minutes shall include the time and place of holding, names of those attending, whether regular or special, and if special; how authorized. He/she shall perform other duties as may be delegated to him/her by the governing Board."

e) Selects the services to be provided.

Under Article Three, Section 3.1, of the bylaws, the Board of Directors has the duty to "conduct programmatic and financial planning," to conduct a "comprehensive health care needs assessment," and "engage in "long-term strategic planning to position health center for the future." These activities are designed to inform the section of services that are offered. Furthermore, "The BOD shall evaluate all Center activities. The Board is responsible for periodic evaluation of its performance as it relates to bylaw compliance and funding requirements; evaluation of Corporate activities including services utilization patterns, productivity, patient satisfaction, and a process for hearing and resolving patient grievances."

f) Determines the hours during which services will be provided.

As stated in Article Three, Section 3.1, of the bylaws, the Board of Directors will determine "hours of operations."

g) Measures and evaluates the organization's progress and develops a plan for the long-range viability of the organization through: strategic planning and periodic review of the organization's mission and bylaws; evaluating patient satisfaction; monitoring organizational performance; setting organizational priorities; and allocating assets and resources.

Article Three, Section 3.1 of the bylaws describes that the Board of Director's duties will be: "The BOD shall evaluate all Center activities. The Board is responsible for periodic evaluation of its performance as it relates to bylaw compliance and funding requirements; evaluation of Corporate activities including services utilization patterns, productivity, patient satisfaction, and a process for hearing and resolving patient grievances. Also in the same section, the Board will "monitor and evaluate center activities: service utilization patterns, productivity of the center, quality of care, patient satisfaction, achievement of project objectives . . . financial goals . . . and patient grievances."

h) Approves the health center's annual budget, grant applications, and selection/dismissal/performance appraisal of the organization's CEO.

Under Article Three, Section 3.1 of the bylaws it is the responsibility of the Board of Directors "approve annual budgets . . ." In the same section it also states that the Board monitors and evaluates center activities that include "financial goals including projected budget to actual expenditures."

Article Three, Section 3.1 also states that the Board is responsible for "Implementation of policy and day-to-day operations are delegated to the President/Chief Executive Officer who is hired, evaluated, and dismissed by the Board of Directors."

i) Establishes general policies for the organization.

Article Three, Section 3.1 of the bylaws states that "The Board shall have the power to . . . establish center priorities, develop policies, rules, regulations, and reporting systems to govern and monitor the affairs of the Corporation."

***Note:** An applicant requesting funding to serve the general community (CHC) AND special populations (MHC, HCH, and/or PHPC) must have appropriate board representation from these populations. At minimum, there must be at least one representative from/for each special population group for which funding is requested who can clearly communicate the target*

population's needs/concerns (e.g., advocate for migratory and seasonal agricultural workers, formerly homeless individual, current resident of public housing). Applicants targeting only special populations may request a waiver of the 51% patient majority board composition requirement on Form 6B: Request of Waiver of Board Member Requirements.

2) Describe how the governing board:

a) Operates, including the organization and responsibilities of board committees (e.g., Executive, Finance, QI/QA, Risk Management, Personnel, Planning).

The Kedren Board of Directors operates effectively by meeting monthly, as stipulated in the bylaws, and conducting business outlined in its agenda, including hearing reports by committees that may meet between monthly Board meetings to address specific Board issues such as governance, finance and quality/compliance.

Under Article Six, "The Board of Directors may, by resolution, adopt by a majority of the members constituted at the time and present at a duly called meeting of the Board, authorize and designate such committees and provide said committees with such powers and authority in the oversight of the Corporation as the Board deems necessary and desirable. Section 6.1 established the Executive Committee, Board Development/Governance Committee, Finance & Audit Committee, Quality & Compliance Committee, and other committees "as may be deemed necessary from time to time by resolution of the Board of Directors, and shall have such powers, and authority and duties as may be established by the Board of Directors."

b) Monitors and evaluates its performance, inclusive of identifying training needs.

The president of the Board is charged with overseeing the monitoring and evaluating of Board performance. This is accomplished through a process of annual confidential assessments by Board members of their contribution to the Board and the Board's overall accomplishments. The president meets once each year with each member, reviewing their commitment to the agency and discussing their interests and ways in which he and they can further the agency's mission. This is also an opportunity for Board members to decide as to whether they wish to continue given the commitment of time required and other commitments that they have. A report is made annually to the Board of Directors by the president, which outlines his or her findings and lays out a plan for the coming year, which often coincides with the agency's strategic plan, though may also include specific interests identified by the president and Board members.

Article Three, Section 3.1 stipulates that it shall be the duty of the Board "to meet educational and training needs including new board member orientation and training." Furthermore, the Board Development/Governance Committee is charged with recommending training for

members.

c) *Provides training, development, and orientation for new members to ensure that they have sufficient knowledge to make informed decisions regarding the strategic direction, general policies, and financial position of the organization.*

The Kedren Board Development/Governance Committee is charged with duties of recruiting, nominating, orienting and training members of the Board of Directors. Kedren routinely sends members to trainings for Board members sponsored by the National Association of Community Health Centers, and calls on local FQHCs and the Community Clinic Association of Los Angeles County for consultation on governance. This ensures that Board members are aware of FQHC program expectations for health centers, and their vital role on the Board.

Additionally, as new members are added to the Board, a one-on-one orientation is conducted to review issues presently concerning the Board, and for those that are not familiar with Board functioning and roles, a review of practices is also included. New members are matched with an experienced Board member who will sit beside them at meetings and provide additional context for the items being considered, and who is also available between meetings to answer questions concerning Board-related business.

3) *Applicants with a co-applicant or parent/affiliate/subsidiary (consistent with Form 8: Health Center Agreements): Describe how this organizational structure/relationship does not impact or restrict the applicant's governing board composition and/or authorities (reference Attachment 2: Corporate Bylaws and other attachments as needed), including:*

Not applicable.

a) *Selection of the board chairperson, a majority of board members (both patient and non-patient), and, if applicable, Executive Committee members.*

Not applicable.

b) *Selection or dismissal of the CEO/Executive Director, including arrangements that combine this position with other key management positions.*

Not applicable.

c) *Ensuring that no outside entity has the authority to override board approval (e.g., dual or super-majority voting, prior approval process, veto power, final approval).*

Not applicable.

Note: *Upon award, the applicant organization would be the legal entity held accountable for carrying out the approved Health Center Program scope of project.*

4) *Document that the health center's bylaws and/or other board-approved policy document(s) and procedures include specific provisions that prohibit real or apparent conflict of interest by board members, employees, consultants, and others in the procurement of supplies, property (real or expendable), equipment, and other services procured with federal funds. Describe how the health center's bylaws and governing board will be updated as changes occur in the target population and service area.*

The bylaws have specific provisions to prevent conflicts of interest within the organization as expressed in Article Seven, Section 7.1 which describes restrictions regarding interested persons. An interested person is someone who has a financial interest in a Board-related decision, and there is a duty to disclose the relationship. Furthermore, "A Financial Interest is not necessarily a conflict of interest. A person who has a Financial Interest may have a conflict of interest only if the appropriate Board or committee decides that a conflict of interest exists."

Article Twelve, Section 12.2 also states that "no member of the Board may be an employee of the Corporation. Directors are prohibited from contracting or otherwise benefitting from the Corporation in any way for at least one year after service on the Board of Directors has terminated, unless the Board determines that it is in the best interest of the organization to make an exception to this rule."

Under Article Seven, Section 7.5, Board members are required to sign a conflict of interest statement. There are also procedures that address conflict of interest that include "The Chairperson of the Board or committee shall, if appropriate, appoint a disinterested person or committee to investigate alternatives to the proposed transaction or arrangement." There is also a requirement that a record of proceedings concerning conflicts of interest (Article Seven, Section 7.4) must be maintained.

Article Three, Section 3.1 requires that "the bylaws shall be reviewed annually."

5) *INDIAN TRIBES OR TRIBAL, INDIAN, OR URBAN INDIAN GROUPS ONLY: Describe the applicant organization's governance structure and how it will assure adequate:*

Not applicable.

   a) *Input from the community/target population on health center priorities.*

Not applicable.

b) Fiscal and programmatic oversight of the proposed project.

Not applicable.

SUPPORT REQUESTED

1) Provide a complete, consistent, and detailed budget presentation through the submission of the following: SF-424A, Budget Justification Narrative, Form 2: Staffing Profile, and Form 3: Income Analysis.

Please see SF-424A, budget justification, Form 2, Form 3, and the Federal Object Class Categories form, as part of this Service Area Competition application.

2) Describe how the total budget is appropriate for the proposed project and the total number of unduplicated patients projected to be served (consistent with Form 1A: General Information Worksheet, Table 1: Funding Reduction by Patients Projected to Be Served, and the Summary Page).

The proposed budget is nearly identical to the budget for the current budget period with adjustments made for salary and benefit cost increases. The budget requests $761,417 from HRSA as indicated on the Service Area Announcement Table in the 330 grant guidance. The total budget for the next Budget Period is proposed at $2,957,671. Careful analysis has been done to assure that the projected revenues and expenses for the coming year are the best that can be produced. The staffing plan includes filing of vacant provider positions and is adequate to meet the projected clinical service level increases.

3) Describe how the proportion of federal grant funds requested in this application is appropriate given other sources of funding, including those specified in Form 3: Income Analysis (e.g., in-kind donations) and the Budget Justification Narrative.

The level of Federal grant funds requested by Kedren versus total budget for the 2016-17 year is appropriate as it represents only 29% of total operational funding.

The proportion of federal funds is small for a grantee of our size. Only 29% of the cost to provide patient and participant services is supported by the federal grant, while 71% is covered by the income generated by operations.

The core community health center program supported by federal grant funding provides an operational platform for the health care and prevention services, which in turn generates income from multiple sources to cover the balance of the budget. This is evidence of the reasonableness

of the level of federal grant funding that Kedren receives. Over the remaining project period, this percentage of non-federal funds is projected to become higher.

4) *Describe expected shifts in the payer mix (consistent with payer categories listed on Form 3: Income Analysis) and the potential impact on the overall budget, including plans to mitigate any expected adverse impacts.*

Third party reimbursement will continue to be maximized by expanding assistance to patients to obtain and/or retain their Medi-Cal eligibility. This is being pursued through the ongoing training of intake staff and aggressive following on diligent accounts. The recent reactivation of an out-stationed County eligibility worker has also assisted with increased Medi-Cal enrollment. The Billing Department has also refined it billing practice to improve our claims processing activities. Recent improvements in managed care encounter reporting are also yielding increased incentive payments associated with services to Medi-Cal managed care patients.

ATTACHMENT TWO

Community Health Needs Assessment (CHNA) Implementation Strategy

Community Health Needs Assessment

&

Implementation Strategy

Kedren Community Health Center, Inc.
Acute Psychiatric Hospital
Community Mental Health Center

2016 - 2018

Introduction

Kedren Community Care Clinic (Kedren) operates as a division of Kedren Community Health Center, Inc., Acute Psychiatric Hospital and Community Mental Health Center. Kedren was established to address core barriers to accessing health care in our service area, including a low provider to population ratio, a high rate of residents living in poverty, and a high percentage of medically uninsured residents, although many more have acquired insurance since Kedren was established, due to the Affordable Care Act. Even still, 75.2% of the patients Kedren served in 2017, live below the federal poverty level.

The need for primary care services in Kedren's service area was long recognized by the top managers, line staff and board of directors of Kedren. Kedren has served as the major resource for both outpatient and inpatient behavioral health services as a recipient of Los Angeles County funding for over 30 years and recently a recipient of Substance Abuse and Mental Health Services Administration (SAMHSA) funds for over four years. Kedren has maintained a 72-bed behavioral health inpatient hospital unit and an outpatient unit that serves over 4,500 patients per year. Kedren has been long recognized as the major behavioral health provider in most of South Los Angeles. Kedren's recognition of the need for primary care services both within its behavioral health service population and in the communities surrounding Kedren's campus with over 100,000 square feet of patient-services space motivated Kedren to apply for FQHC status and funding in 2013. The result has been that Kedren's sense of primary care needs had been historically underestimated as Kedren starting from zero now serves over 4,000 users per year and has over 9,445 registered patients. The fact that Kedren has been able to acquire over 2,000 managed care enrollees during this relatively short time also demonstrates that there was an unmet need for primary care providers in the service area as well.

Kedren is located in South Los Angeles, an area of densely populated Los Angeles County designated as Service Planning Area (SPA) 6, where a majority of our patients (81.7%) reside. SPA 6 spreads over 51.08 square miles and includes 25 neighborhoods within the city of Los Angeles and three unincorporated districts. It is home to an estimated 1,048,734 people and holds the distinction of having the greatest health disparities among the County's eight SPAs, as well as the highest poverty rate. There's also slight overlap (13.6%) with SPA 4, and slight overlap with SPA 8.

Major health disparities exist within SPA 6 as evidenced by the very high mortality rates from heart disease, cancer, stroke, diabetes, pneumonia, and hypertension, as well as liver and kidney disease. The age-adjusted death rate for all causes, at 810.6 per 100,000, is 26.4% higher than the county as a whole; 16.3% higher than California's rate; and 10.6% higher than the nationwide rate.

More than one-half million residents (596,487) of the service area struggle financially, with 31.9% living on incomes below the Federal Poverty Guideline (FPG), a rate that is more than double the state's or nation's rates. Almost two out of three individuals (62.3%) in the service area live at or below twice the FPG.

Knowing these health disparities exist, Kedren established its community care clinic to expand services and increase access to health care for this high-need area. Since receiving Federally Qualified Health Center (FQHC) designation in 2013, Kedren has provided high quality comprehensive health care across the age continuum to meaningfully address health disparities in

our service area. Using a Board-approved sliding fee schedule, Kedren ensures that no patient is denied services based on their ability to pay.

The table below provides a summary of some of the disparities experienced by service area residents. These disparities, which are discussed at length within this Community Health Needs Assessment, include unequal access to care, lower socio-economic status, and a higher prevalence of chronic health conditions.

	Service Area	Los Angeles County	California	U.S.A
Access to Care				
Percent Uninsured	23.5%	15.9%	12.6%	11.7%
Percent on with Medicaid as Primary Insurance	34.9%	20.1%	18.0%	14.2%
Percent of Households with no Vehicle Available	20.2%	9.5%	7.6%	9.0%
Socio-Economic Status				
Percent Below 200% FPG	62.3%	39.6%	35.2%	33.6%
Percent w/ No HS Education (Less than 9th Grade)	35.9%	21.2%	17.3%	13.1%
Percent with no HS Diploma or GED	15.5%	9.6%	8.5%	8.0%
Percent Non-White	75.0 %	58.6 %	62.1 %	38.5 %
Chronic Health Conditions				
Age-Adjusted Death from Heart Disease (rate per 100,000)	228.1	167.4	165.1	168.5
Age-Adjusted Death from Malignant Neoplasms (Cancer) (rate per 100,000)	175.4	151.9	160.9	158.5
Age-Adjusted Death from Accidents (rate per 100,000)	27.4	21.1	33.5	43.2
Percent of Overweight or Obese Adults	79.7%	78.2%	62.7%	N/A

Source: U.S. Census Bureau, 2017 American Community Survey 5-Year Estimates, and 2017 California Health Interview Survey, 3-year average. Some data may have been extrapolated by Gary Bess Associates.

Service Area Boundaries

As illustrated in our service area, Kedren's designated service area encompasses 19 zip codes within South Los Angeles, covering an area of 59.3 square miles. The service area includes part of the City of Los Angeles, plus unincorporated neighborhoods of Florence-Graham, View Park-Windsor Hills, West Athens, Westmont, and Willowbrook. The boundaries of the service area are roughly South San Pedro and Alameda Streets to the east; El Segundo Boulevard and Rosecrans Avenue to the south; Van Ness Avenue, La Cienega Boulevard, and Fairfax Avenue to the west; and Olympic Boulevard, James M Wood Boulevard, and 9th Street to the north.

Timeframe

Every year, Kedren confirms that its service area zip codes include at least 75% of patient addresses; those who access services at the health center. Kedren employs a community analytics and development consultant, Gary Bess Associates, for this analysis. One of its ongoing services is to evaluate the service area to keep Kedren abreast of any notable changing trends in resident demographics and/or socioeconomic trends. Specifically, the consultant evaluated patient origin as reported in the 2017 Uniform Data System (UDS) Performance Report, confirming that the

service area includes 82.1% of patient residences, which exceeds the 75% requirement for the FQHC program. Additionally, this work facilitates the annual update of Kedren's Needs Assessment for both the current and proposed service populations.

Strategic Priorities

The strategic priority goals, responsibilities, and timelines are as followed based on a review of environmental and internal factors and trends.

Strategic Priority: Finance

Finance Goal #1: Create and track the FY 2019 – 2020 and FY 2021 - 2022 budgets against actual expenditures by month and year-to-date.

Action Items: Over the course of the strategic planning process, Kedren created and had approved by the Board the agency's FQHC operating budget. This budget is based on growth in patient visits and revenue.

Responsible Staff: CFO, CEO

Timing: December 31, 2021

Finance Goal #2: Maintain acceptable levels of profitability and cash reserves.

Action Items: Kedren will develop high-level projections for three years' financial performance as a planning tool for the management team and the Board's use.

Responsible Staff: CEO, CFO

Timing: Through December 31, 2021

Finance Goal #3: Explore efforts to obtain change in PPS rate for current sites.

Action Item: Kedren will continue to work with consultants and others to advocate for a higher rate.

Responsible Staff: CEO

Timing: President

Strategic Priority: Management, Organizational Structure & Human Resources & Facilities

Management Goal #1: Review and Update Management and Other Job Descriptions (as appropriate)

Action Items: There are several reasons to rewrite job descriptions: 1) a position is being upgraded to include more job responsibilities; 2) a position is being downgraded to remove some job responsibilities; 3) the current job description is insufficient and requires a higher level of detail; or 4) it is a newly created position. Kedren recognizes that its management, job descriptions are likely to change, which may include the expectation of the manager holding their staff accountable to different performance standards.

Responsible Staff: CFO, CMO, CEO and HR

Timing: December 31, 2021

Management Goal #2: Continue to provide training for the Board of Directors on its role and responsibilities, and on FQHC governance requirements, including preparation of the next Board for the Operational Site Visit.

Action Items: Identify topics for presentation with Board input and identify presenters for training.

Responsible Staff: CEO and CFO

Timing: December 31, 2021

Management Goal #3: Explore telemedicine and teleconferencing as strategy to extend Kedren's reach into the community and to add new resources.

Action Items: Establish committee to explore feasibility with recommendation made to Board of Directors, and assuming a positive response, develop budget and acquire quotes for equipment and timeline for implementation.

Responsible Staff: CEO and CFO

Timing: July 31, 2020

Management Goal #4: Conduct an assessment of no-show rates and develop a strategy to reduce current rate by at least 10%

Action Items: Review no-show rates for six-month period, profile those that miss appointments, and convene staff workgroup to develop strategies to address this problem.

Responsible Staff: CEO and CFO

Timing: December 31. 2020

Strategic Priority: Clinical Management and Quality

Clinical Goal #1: Refine quality improvement system[1]

Action Items: Kedren's current clinical quality improvement (CQI) efforts focus primarily on reporting, and have in place a strong process to improve performance. There are currently Plan-Do-Study-Act (PDSA) activities designed to improve quality, and the quality improvement process will continue as follows:

- Assign accountability for quality improvement to clinical staff. Activities include specific measures pertaining to mammograms, such as making sure that they are ordered, that the patient actually receives them, and/or that the provider checked to make sure that the patient was current on her mammogram. In addition, the CMO will be responsible for clinical quality improvement across sites either directly or through a designee. This will be a team-based approach, and clinical staff will also be assigned as the lead to specific clinical quality measures. Each clinic will work with the department directors on quality improvement interventions/programs. Given that quality improvement relies on day-to-day activities, decentralization improves the responsiveness of those providing services

Responsible Party: CMO, CMO Designee

Timing: December 31, 2021

Action Items: Continue CQI plan with whole population reporting; patient management at this level requires a fully implemented EHR, populated with sufficient data metrics.

Action Items: Ensure that data are accurately entered into the EHR and remain current.

Responsible Party: CMO and CEO

Timing: December 31, 2021

Clinical Goal #2: Continue review of paneling, provider productivity, provider capacity, team capacity, continuity/visits per patient per year, overall capacity, and third available appointment.

These measures are crucial for Kedren to understand how well it is serving its patient base, as well as its capacity to expand. Kedren will continue its comprehensive, focused effort to track measures, which are a core piece of training. Specific steps and timelines to achieve this goal include:

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[1] *The activities in this goal are consistent with and supportive of the requirements for certification as a PCMH by the National Council on Quality Assurance.*

- Continue to assign patients to an active provider.

Action Items: Kedren will continue its comprehensive, focused effort to track measures.

Responsible Party: CMO, CFO, Data Analyst

Timing: Ongoing

- Continue to identify and resolve underlying data issues.

Action Items: Self-explanatory

Responsible Party: CFO, Data Analyst

Timing: December 31, 2020

- Continue review of metrics that analyze success/appropriateness of paneling efforts, including provider productivity, patient acuity, visits per patient per year by provider, visit frequency distribution, new patients, continuity of care, and other measures.

Action Items: Self-explanatory

Responsible Party: CMO, CFO

Timing: Ongoing

Clinical Goal #3: Evaluate Programs/Services – Kedren offers a broad range of services. Many of these services are historically-based and may not be appropriate or relevant for current operating environment. The organization continually evaluates the scope of its offerings. Kedren's CMO will continue to assess and develop recommendations for the management team and Board in time for the development of each annual operating budget.

Action Items: Prepare report for management team and Board of Directors on service utilization with recommendations for continuation / expansion / reduction in range of services offered.

Responsible Party: CMO

Timing: December 31, 2020

Clinical Goal #4: Patient Centered Medical Home

- **Short term** – Continue process toward application to become a Patient Centered Medical Home

Action Items: Self-explanatory

Responsible Party: CMO

Timing: December 31, 2020

Clinical Goal #5: Continue Care Coordination -- Continue care coordination/case management for patients (ensuring that patients don't have barriers to care) with the goal of decreasing patient attrition; improved care delivered, and customer service.

Action Items: Ensure that environmental and other factors are considered with regard to patient health and well-being. Care coordination includes addressing social determinants of health that impact patients.

Responsible party: CMO

Clinical Goal #6: Service Expansion -- Explore expansion of services to one additional geographic location where there is high need for primary care.

Action Items: Work with consultants and realtors to locate facilities in communities with medically underserved needs, and make recommendation to Board of Directors.

Responsible Staff: CEO, CMO, and CFO

Timing: December 31, 2020

Clinical Goal #7: Opioid Training -- Provide opioid training for staff with different content conveyed for providers and others that interact with patients. Training for providers to include advice on prescribing and managing alternative medications, and for all staff, training on identifying persons that may be addicted.

Action Items: Identify vendor for training and finalize training curriculum before scheduling educational sessions.

Responsible Staff: CEO and CMO

Timing: December 31, 2020

Strategic Priority: Responding to Need

Need Response Goal #1: Kedren's service area has a 228.1/100,000 resident age-adjusted death rate for heart disease. This is significantly greater than Los Angeles County (167.4/100,000) and California (165.1/100,000).[2]

Action Item: Ensure screening and provide health education concerning proper nutrition, diet, and the importance of physical activity, and to address markers of heart disease such as obesity, smoking, and salt intake.

Staff: CEO, CMO, and Outreach & Enrollment Staff

Timing: Ongoing

Need Response Goal #2: The Kedren service area has a 39.3/100,000 resident age adjusted death rate for diabetes mellitus (diabetes). This is greater than Los Angeles County (24.7/100,000) and California (23.8/100,000).[3] The goal is to reduce rates to comparable levels found in the county or state populations.

Action Item: Proposed interventions are health education on diabetes control, compliance with provider recommendations chronic disease management, and support for families with a family member that has diabetes. Also include health education and education on food preparation and food content.

Staff: CEO, CMO, and Outreach & Enrollment Staff

Timing: Ongoing

Need Response Goal #3: The Kedren service area has a 175.4/100,000 resident age adjusted death rate for malignant neoplasms (cancer). This is greater than Los Angeles County (151.9/100,000) and California (160.9/100,000).[4] The goal is to reduce rates to comparable levels found in the county or state populations.

Action Item: Proposed interventions are health education on signs and symptoms of cancer, including regular screening and checkups based on age and gender. Also include health education, including lifestyle, such smoking and its relationship to cancer.

Staff: CEO, CMO, and Outreach & Enrollment Staff

Timing: Ongoing

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[2] *Source: Gary Bess Associates, using California Department of Public Health, Master Death Files, 2012 and U.S. Census Bureau, 2010 Census Summary File 1, Table P12*
[3] *Ibid*
[4] *Ibid*

Need Response Goal #4: Increase collaboration with allied organizations. Kedren to reach out to new and presently deemed health centers to secure a minimum of three new Memoranda of Agreements for patient coordination.

Action Item: Attempt to secure MOAs with other health centers and nonprofits in the Compton community.

Staff: CEO, CMO, and Outreach & Enrollment Staff

Timing: July 1, 2021

Need Response Goal #5: Develop new services that are responsive to unmet needs in the community such as high rates of STDs and teen pregnancy

Action Item: Service include STD screening and treatment, and pregnancy testing and family planning education.

Staff: CEO, CMO, and Outreach & Enrollment Staff

Timing: July 1, 2021

Factors Associated with Access to Care and Health Care Utilization

Geography: Kedren is located in South Los Angeles, which is a culturally rich and diverse area, but also an area with one of the largest concentrations of poverty in the United States—more than 300,000 service area residents are living below FPG, and at a rate that is more than twice both the state and national averages. The area is entirely urbanized and has been for many years—more than one-third of its development pre-dates World War II and almost two-thirds was established before 1960. The urban fabric is dense with a population density of 16,357 per square mile. The area is crossed by several of the most crowded, congested freeways in the nation—Interstates 10, 105, and 110, each with average annual daily traffic exceeding several hundred thousand vehicles that emit air pollution inhaled by local residents.

The service area is within one of the most culturally and ethnically diverse regions in the United States, with residents arriving here from all over the world. Almost two-thirds of the population (63.5%) is Hispanic or Latino, and more than one-quarter (26.7%) are African-American. Furthermore, more than one of three residents (37.3%) was born outside the United States, most from Latin American countries, including almost one in five (19.1%) of area residents being born in Mexico.[5] The urban cultural landscape reflects this distribution with retail products and services in many of the service area's neighborhoods advertised only in Spanish.

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[5] U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates, Tables B05006 and B01003

Transportation: Among the many impoverished and low-income residents of the service area, transportation presents a potential barrier to accessing services. Notably, according to the American Community Survey, 20.2% of households have no vehicle, and 30.8% have a vehicle shortage, where there are fewer vehicles than employed persons in the household. Families are then challenged, not only in traveling for employment, but also to get to medical appointments. In addition, family members who do not work are left without private transportation to get to medical appointments or to take children to appointments. The following table details the number and percentage of service area residents who report having no vehicle and those with a vehicle shortage, as well as the percentage of residents countywide, statewide, and nationwide without vehicles or with vehicle shortages. As demonstrated in the table, vehicle shortage is significantly higher in Kedren's service area than elsewhere in the county or nation.

Vehicles Available	Service Area Number	Service Area Percent	L.A. County	California	U.S.A.
No Vehicles Available	59,390	20.2%	9.5%	7.6%	9.0%
Fewer Vehicles than Workers in the Household	30,911	10.6%	6.9%	5.6%	4.7%
Households w/o Vehicle Shortage	199,954	69.2%	83.6%	86.8%	86.3%
Total Households	289,255	100%	100%	100%	100%
Total Households /w Vehicle Shortage	**89,301**	**30.8%**	16.4%	13.2%	13.7%

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates, Table B08203.

While public transportation is available in the service area, its complexity is difficult for some area residents to navigate, as well as challenging for families with small children or individuals with physical disabilities. From some parts of the service area, patients can take three or more buses to get to Kedren, and it can require a lot of coordination on behalf of the patient and their family/caregivers. The following table provides details and comparisons on the means of transportation used to travel to work.

Means of Transportation to Work	Service Area Number	Service Area Percent	L.A. County	California	U.S.A.
Drove alone	250,888	63.7%	73.3%	73.5%	76.4%
Carpool	42,314	10.7%	9.85	10.6%	9.3%
Public Transportation	**62,939**	**16.0%**	6.5%	5.2%	5.1%
Walked	13,276	3.4%	2.8%	2.7%	2.8%
Other means	10,273	2.6%	2.3%	2.6%	1.8%
Worked at home	14,320	3.6%	5.2%	5.4%	4.6%
Total Workers Age 16+	394,010	100.0%	100.0%	100.0%	100.0%

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates, Table B08101.

Transportation barriers are complicated by the distance that individuals in the service area must often travel to their employment each day. More than one-half (55.2%) have a travel time of one-half an hour or more, with almost one in four (24.6%) spending 45 minutes or more each way, and some traveling 90 minutes or more. The distance to work and time spent commuting, coupled with an overall shortage of transportation, may create a significant barrier to accessing health care services, especially during normal business hours. The following table provides details on travel time to work for residents of the service area, county, state, and nation.

Travel Time to Work	Service Area Number	Service Area Percent	L.A. County	California	U.S.A.
Worked at Home	14,320	3.6%	5.2%	5.4%	4.6%
Less than 5 minutes	3,239	0.8%	1.2%	1.8%	2.9%
5 to 14 minutes	40,132	10.2%	16.0%	19.8%	22.6%
15 to 29 minutes	118,687	30.1%	31.4%	33.6%	34.6%
30 to 44 minutes	**120,946**	**30.7%**	24.0%	20.6%	19.4%
45 to 59 minutes	**41,661**	**10.6%**	9.8%	8.1%	7.6%
60 to 89 minutes	**38,641**	**9.8%**	9.1%	7.3%	5.7%
90 or more minutes	**16,384**	**4.2%**	3.3%	3.4%	2.6%
Total Workers Age 16+	394,010	100%	100%	100%	100%
Commuting 30+ minutes to work	**217,632**	**55.2%**	46.2%	39.4%	35.3%

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates, Table B08101 and B08303.

While there are transportation limitations/barriers to care, Kedren's site is well located for meeting the needs of its service area residents. Kedren is located along major transit and bus routes, including the Metro Blue Line Subway, which provides a direct link throughout Los Angeles County SPA 6 to Downtown Los Angeles, as well as links to the Metrolink and Metro light rail and bus network. The public transit system operates seven days a week and has stops close to Kedren's main site and Amity. Free bus transportation tokens for are offered to those in need.

Occupation: The service area's high rates of individuals living in poverty or on low incomes has a root cause in the occupations of its workers and the low wages they earn, even those working full time. In Kedren's service area, as per the American Community Survey, many residents work in industrial or labor positions rather than in professional or management positions that have higher wages. Higher percentages of area workers hold jobs in areas such as construction, maintenance, grounds keeping, and food preparation than countywide, statewide, or nationwide, while lower percentages work in positions such as engineering, management, finance, education, legal services, or technical fields. The following table displays the percentages of service area residents within each employment category, compared with the percentages countywide, statewide, and nationwide.

Employment by General Occupational Category (Occupations Sorted by National Median Wage)	Service Area Number	Service Area Percent	L.A. County	Calif.	U.S.A.
Computer, Engineering, and Science	7,060	1.8 %	4.6 %	6.4 %	5.5 %
Management, Business, and Financial	29,163	7.2%	14.3%	15.3%	14.9%
Healthcare Practitioners and Technical	9,143	2.3%	4.7%	4.9%	5.8%
Protective Service	**10,938**	**2.7%**	1.9%	2.1%	2.2%
Education, Legal, Community Service, Arts, and Media	33,792	8.4%	12.5%	11.0%	10.8%
Natural Resources, Construction, and Maintenance	**41,417**	**10.3%**	7.7%	9.1%	8.9%
Production, Transportation, and Material Moving	**82,272**	**20.4%**	12.9%	11.1%	12.2%
Sales and Office	92,019	22.9%	24.4%	23.4%	23.8%
Healthcare Support	9,309	2.3%	1.9%	1.9%	2.4%
Building and Grounds Cleaning and Maintenance	**35,600**	**8.8%**	4.6%	4.3%	3.9%
Food Preparation and Serving Related	**29,179**	**7.2%**	5.7%	5.7%	5.8%
Personal Care and Service	**22,619**	**5.6%**	4.9%	4.7%	3.7%
Total Employed Population	402,516	100%	100%	100%	100%

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates, Table C24010.

Additionally impacting service area residents are the level of wages they earn, with the median annual wage being lower in almost all employment categories than they are elsewhere. For example, the median annual income for service area residents that work in the area of computers, engineering, and science is about 30% lower than the L.A. County average income. Similarly, those working in natural resources, construction, and maintenance earn about 75% of the average wage in those areas countywide. The following table shows these differences, with service area residents' annual wages matching those earned elsewhere in only two employment categories.

Median Annual Wage by General Occupational Category (Occupations Sorted by National Median Wage)	Service Area	L.A. County	California	U.S.A.
Computer, Engineering, and Science	**$ 51,817**	$ 74,331	$ 84,143	$ 72, 115
Management, Business, and Financial	**$ 49,346**	$ 62,809	$ 69,359	$ 62,641
Healthcare Practitioners and Technical	**$ 46,893**	$ 62,458	$ 68,329	$ 54,053
Protective Service	**$ 23,864**	$ 32,899	$ 50,982	$ 41,793
Education, Legal, Community Service, Arts, and Media	**$ 35,992**	$ 56,489	$ 45,410	$ 41,128
Natural Resources, Construction, and Maintenance	**$ 21,951**	$ 29,347	$ 30,866	$ 35,329
Production, Transportation, and Material Moving	**$ 19,621**	$ 24,249	$ 27,341	$ 30,488
Sales and Office	**$ 22,773**	$ 28,845	$ 30,360	$ 28,684
Healthcare Support	**$ 20,740**	$ 23,813	$ 25, 249	$ 22,660
Building and Grounds Cleaning and Maintenance	$ 16,851	$ 17,956	$ 16,099	$ 13,675
Food Preparation and Serving Related	$ 17,444	$ 17,061	$ 16,099	$ 13,765
Personal Care and Service	**$ 13,497**	$ 15,382	$ 15,357	$ 15,637

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates, Table B24011.

Unemployment: Over the five-year period of 2012-2016, Kedren's service area has experienced higher rates of unemployment than the county, state, or nation, with an overall unemployment rate of 7.2% for civilians in the service area, compared with 5.7% countywide, 5.5% statewide, and 4.7% nationwide. Another factor impacting income levels of service area residents is the high percentage of individuals who are not in the labor force for one reason or another, such as those living on Social Security or Disability, and those who have given up on finding employment. This rate, at 38.4%, is higher than the rate for the county as a whole, for the state, and for the nation. When considering that only 61.6% of adults ages 18 to 64 remain in the labor force, the unemployment rate among this population climbs to 11.7%, which is much higher than the county's rate of 8.9%, the state's rate of 8.7%, and the nation's rate of 7.4%. The following table provides data to compare these rates.

Employment Status	Service Area Number	Service Area Percent	L.A. County	California	U.S.A.
Civilian Employed	402,516	54.4%	58.6%	57.5%	58.4%
Civilian Unemployed	53,306	7.2%	5.7%	5.5%	4.7%
In Armed Forces	38	0.0%	0.0%	0.4%	0.4%
Age 18-64 Not in Labor force	**284,563**	**38.4%**	35.6%	36.6%	36.5%
Total Labor Availability	740,423	100%	100%	100%	100%
Labor Participation Rate		**61.6%**	64.4%	63.4%	63.5%
Civilian Unemployment Rate		**11.7%**	8.9%	8.7%	7.4%

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates, Table B23025.

Income: Partly due to the high unemployment rate in the neighborhoods served by Kedren, the percentage of impoverished and low-income residents has also been high, with 31.9% living on

incomes below the FPG - more than twice the state's rate of 15.8% and the nation's rate of 15.1%. Almost two of three individuals (62.3%) in Kedren's service area live at or below 200% of the FPG, nearly twice the State (39.6%), County (35.2%), and U.S. (33.6%). In essence, the majority of people living in the service area (596,487) are affected by low incomes and struggle financially. Large family size, including both children and elderly dependents, contributes to a significant number of working poor households in Kedren's service area. The following table includes data on the income status of residents of the service area, county, state, and nation.

Income as a Percent of Federal Poverty Guideline (FPG)	Service Area Number	Service Area Percent	L.A. County	Calif.	U.S.A.
Below 100% FPG	305,349	**31.9%**	17.8%	15.8%	15.1%
100% to 137% FPG	131,548	13.7%	8.9%	7.7%	7.2%
138% to 199% FPG	159,590	16.7%	12.9%	11.6%	11.3%
200% to 399% FPG	239,539	25.0%	27.6%	27.3%	29.9%
400% FPG and Above	121,489	12.7%	32.8%	37.5%	36.5%
Total Population for whom Poverty Status is Determined	956,513	100%	100%	100%	100%
Total Below 138% FPG	**436,897**	**45.6%**	26.7%	23.6%	22.3%
Total Below 200% FPG	**596,487**	**62.3%**	39.6%	35.2%	33.6%

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates, Table B17024 and C27016. Some data extrapolated by Gary Bess Associates.

Educational attainment: One root cause of the low incomes earned by service area residents is their low educational attainment. Fully one in five (20.4%) of individuals over 18 years of age has less than a ninth-grade education, and more than one in three (35.9%) lack a high school diploma or GED. These rates far exceed the rates for adults countywide, statewide, or nationwide. At the opposite end of the educational spectrum, far fewer service area adults have college degrees (even Associates Degrees), or post-graduate degrees. Only 12.8% of service area residents have a four-year college degree, compared with 28% of individuals in the county, 29% of California residents, and 27.7% of U.S. adults. These rates also illustrate how Kedren's patient health education services are so crucial. The following table illustrates the rates for educational attainment of residents of the service area, county, state, and nation.

Educational Attainment	Service Area Number	Service Area Percent	L.A. County	Calif.	U.S.A.
Less Than 9th Grade	**145,326**	**20.4%**	11.6%	8.8%	5.1%
9th-12th Grade, No Diploma	**110,136**	**15.5%**	9.6%	8.5%	8.0%
High School Graduate/GED	175,519	24.7%	21.5%	21.7%	27.8%
Some College, No Degree	156,520	22.0%	22.8%	24.6%	23.5%
Associate's Degree	32,089	4.5%	6.5%	7.4%	7.8%
Bachelor's Degree	64,275	9.0%	18.6%	18.6%	17.6%
Graduate or Professional Degree	27,019	3.8%	9.3%	10.4%	17.6%
Total Population 18+	710,884	100.0%	100.0%	100.0%	100.0%
Persons Who Have Not Graduated High School	**255,462**	**35.9%**	21.2%	17.3%	13.1%
Persons With a 4-Year College Degree	**91,294**	**12.8%**	28.0%	29.0%	27.7%

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates, Table B15001.

Transient populations: The Los Angeles Homeless Services Authority (LAHSA) conducted its biennial homeless count in January, 2018. Although the count indicated a drop of about 3% throughout Los Angeles County, there were still approximately 53,195 people experiencing homelessness. In SPA 6, there were a total of 8,317 homeless individuals, the highest among all eight SPAs. Of that number, 5,910 were unsheltered, which indicates they have been sleeping on the streets or in other public areas. A few may have owned a car that could provide some shelter. Among the SPA 6 homeless, 1,837 were considered chronically homeless, defined as someone who has been homeless continuously for a year or more or an individual who as had at least four episodes of homelessness in the last three years. Homeless encampments are not only readily visible on the sidewalks of several nearby streets and in the park directly adjacent to Kedren's main site, but Kedren patients experiencing unstable housing may at times end up in the park as a temporary home. Thus, compassionate care, such as that we provide at Kedren, is of the upmost importance, as well as a strong referral and partnerships network that we have established over five decades of providing mental health services in the community.

In Kedren's service area, which extends beyond SPA 6, there were an estimated 6,544 homeless individuals in 2017. This estimate comes from LAHSA's census tract analysis of its 2017 point-in-time survey, which is not yet available for their 2018 survey. Of these, 4,695 were sheltered and 8,421 were unsheltered.

Significant Causes of Morbidity and Mortality

As elsewhere in California and the U.S., the two leading causes of death in Kedren's service area are heart disease and cancer. However, the rates of death in the service area are much higher for both these causes. When adjusted for age, residents of the service area die at a rate that is 36.2% higher than the county as a whole, which has a rate that is very close to the state's and nation's rates. The age-adjusted rate per 100,000 people is 228.1 in the service area, compared with 167.4 per 100,000 in the county, 165.1 per 100,000 in California, and 168.5 per 100,000 in the U.S.A.

Cancer also causes death more frequently in Kedren's service area than elsewhere in the county, or in the state or nation. At 175.4 per 100,000, the service area rate is 15.5% higher than the countywide rate of 151.9 per 100,000; 9.0% higher than the statewide rate of 160.9 per 100,000; and 10.7% higher than the nationwide rate of 158.5 per 100,000.

Important health statistics show higher age-adjusted death rates per 100,000 persons for cerebrovascular disease (stroke), diabetes, influenza and pneumonia, kidney disease, liver diseases, and hypertension. Deaths for all causes topped 810.6 per 100,000 in the service area, far exceeding rates in the county, state, and nation. The following table provides details related to death rates.

Age-Adjusted Death Rate /100,000 Persons, 2015	Service Area Number	Service Area Rate	L.A. County	Calif.	U.S.A.
Heart Disease	**1,561**	**228.1**	167.4	165.1	168.5
Malignant Neoplasms (Cancer)	**1,249**	**175.4**	151.9	160.9	158.5
Accidents	236	27.4	21.1	33.5	43.2
Chronic Lower Respiratory Disease (CLRD)	214	31.6	31.1	36.8	41.6
Cerebrovascular Disease (Stroke)	**363**	**54.1**	38.3	40.6	37.6
Alzheimer's Disease	236	27.4	39.6	40.4	29.4
Diabetes Mellitus	**276**	**39.3**	24.7	23.8	21.3
Influenza and Pneumonia	**185**	**28.3**	22.2	16.6	15.2
Nephritic (Kidney) Diseases	**145**	**21.0**	12.8	9.6	13.4
Suicide	46	5.1	7.7	11.0	13.3
Liver Diseases (Cirrhosis)	**184**	**23.2**	15.6	14.7	10.9
Hypertension	**146**	**21.3**	13.8	13.8	8.5
Other Causes	927	128.2	94.5	130.5	171.7
All Causes	**5,768**	**810.6**	640.8	697.2	733.1

Source: Calculated by Gary Bess Associates using 2015 California Department of Public Health Master Death File and U.S. Census Bureau American Community Survey, 5-Year Average 2012-2016, Table B01001, and using the 2010 U.S. standard million.

Teen birth rates in the service area are high. On average, between 2009 and 2013, there were 2,057 teen births out of 16,348 total births, a rate of 125.8 per 1,000 live births. This rate is much higher than in Los Angeles County (78.3), California (77.5), or the U.S. (85.4). Furthermore, the teen birth rate of females ages 15 to 19 is 51.5 per 1,000 live births, far greater than the county, state, and national averages. Infant mortality is also higher than average, with 6.4 infants per 1,000 live births dying in their first year after birth. The low-birthweight rate is 87.6 per 1,000 live births which is higher than the national average, and the rate of births where the mother's first prenatal care was some time after the first trimester (or never), was 184.6 per 1,000 live births, higher than both the county and the state rates.

Prenatal/Neonatal Health Disparities (5-Year Average 2009-2013)	Service Area Number	Service Area Rate	L.A. County	Calif.	U.S.A.
Teen Births (Rate per 1,000 Live Births)	**2,057**	**125.8**	79.8	77.5	85.4
Teen Births (rate per 1,000 fem. age 15-19)	**2,057**	**51.5**	28.9	28.7	32.6
Infant Mortality (<1 yr., Rate per 1,000 Live Births)	**105**	**6.4**	4.6	4.7	6.1
Low Birth Weight (<2,500g, Rate per 1,000 Live Births)	1,432	87.6	90.1	96.1	80.8
Late Prenatal Care (After 1st Trimester, Rate per 1,000 Live Births)	3,018	184.6	139.3	162.3	203.1
Total Births	16,348				

Source: Calculated by Gary Bess Associates using California Department of Public Health Birth Profiles by Zip Code of Residence and U.S. Census Bureau American Community Survey, 5-Year Average 2009-2013, Table B01001.

Health Disparities

Residents of the service area exhibit high rates of diagnosis for diabetes, with a total of 12.2% of adults, or about 62,000 individuals, having been diagnosed with some type of diabetes, compared with 10.1% of all residents of SPA 6, where a majority of our patients reside, and 9.1% of all California residents. The following table illustrates these data.

Diabetes (Ages 18 and Older)	SPA 6 Low-Income Number	SPA 6 Low-Income Percent	SPA 6 All Persons Percent	Calif. Percent
Ever Diagnosed with Type I Diabetes	**49,000**	**9.6%**	8.3%	7.8%
Ever Diagnosed with Other or Unknown Type of Diabetes	13,000	2.6%	1.8%	1.3%
Total Ever Diagnosed with Diabetes (Excl. Pregnancy)	62,000	**12.2%**	10.1%	9.1%

Source: 2016 California Health Interview Survey. Some counties' data was extrapolated by Gary Bess Associates.

A factor contributing to the high rates of diabetes in the service area, and subsequently Kedren's own patient population, is the percentage of adults that are overweight or obese in SPA 6, South Los Angeles, especially among the low-income residents who are the target population for Kedren. Almost four of five (78.2%) adults in South Los Angeles are overweight or obese, compared to 62.7% of all California adults. In SPA 6, among low-income adults, 45.7% are obese, slightly more than the SPA 6 all-persons rate of 43.7%, but significantly more than the rate of 27.9% for all California adults. The following table illustrates these data.

Adult Overweight and Obese	SPA 6 Low-Income Number	SPA 6 Low-Income Percent	SPA 6 All Persons Percent	Calif. Percent
Overweight or Obese (Ages 18 and Older)	403,000	79.7%	78.2%	62.7%
Obese (Ages 18 and Older)	**231,000**	**45.7%**	43.7%	27.9%

Source: 2016 California Health Interview Survey. Some counties' data was extrapolated by Gary Bess Associates.

The need for mental health and substance abuse services for low-income residents of Kedren's service area is evidenced by the number of South Los Angeles residents who reported having mental health challenges and/or have sought mental health care, and/or treatment for alcohol or drug use. According to the 2016 California Health Interview Survey, about 31,000 low-income adults in SPA 6 used prescription medications to address emotional or mental health distress; 18,000 seriously considered suicide; and an estimated 38,000 low-income residents 12 years and older self-reported having had serious psychological distress in the year before being surveyed. While the percentages of residents reporting these situations are similar to the percentages statewide, they total a large number of people and represent a need for services for low-income residents. A greater percentage of low-income SPA 6 adults sought out treatment from a medical professional for a mental health issue compared with all SPA 6 residents or all California residents. The following table provides these data.

Mental Health Disparities, Ages 18 and Older Unless Otherwise Noted	SPA 6 Low-Income Number	SPA 6 Low-Income Percent	SPA 6 All Persons Percent	Calif. Percent
Likely Has Serious Psychological Distress in the Past Year (Ages 12 and Older)	38,000	6.7%	6.4%	7.9%
Moderate to Severe Social Life Impairment Past 12 Months	66,000	13.1%	13.9%	13.9%
Moderate to Severe Family Life Impairment Past 12 Months	59,000	11.7%	12.9%	13.6%
Moderate to Severe Household Chore Impairment Past 12 Months	54,000	10.6%	12.4%	12.9%
Has Taken Prescription Medicine for Emotional/Mental Health Issue At Least 2 Weeks in Past Year	31,000	6.2%	6.3%	11.1%
Sought Treatment from Physician or Mental Health Professional for a Mental-Emotional Problem	**72,000**	**14.2%**	12.4%	13.1%
Ever Seriously Thought About Committing Suicide	18,000	3.6%	4.8%	9.3%
Binge Drank in Past Year (2015)	138,000	28.8%	30.1%	34.7%
Sought Treatment from Physician or Mental Health Professional for Alcohol or Drug Issue	1,000	0.3%	0.2%	1.0%

Source: 2016 California Health Interview Survey. Some counties' data was extrapolated by Gary Bess Associates.

According to the County Health Rankings & Roadmaps (2014 – 2016) report, the number of drug poisoning deaths per 100,000 population was 2,288. Moreover, 400 deaths per year from 2006 to 2012 were associated with a positive screening for prescription drugs (LA County Public Health Department) demonstrating the need for substance use disorder services. Co-occurring mental health and substance use disorders are also becoming more prevalent. In 2014, 7.9 million people experienced a co-occurring disorder. Kedren's approach to care addresses patients with primary and specialty care needs, such as patients with co-occurring conditions.

Characteristics that Impact Health, Access to Care, and Health Care Utilization

Kedren's service area includes four (4) low-income population Health Professional Shortage Areas (HPSAs). The ratio per low-income HPSA is 13,663 low-income residents to one (1) primary care physician who accepts Medi-Cal or has a sliding fee schedule; 21.775 Full Time Equivalent (FTE) physicians serving 297,232 low-income residents. Furthermore, there are six

(6) high-need population HPSAs. The ratio for these HPSAs is 8,890 residents to one (1) primary care physician; 67.39 FTE physicians serving 599,068 residents.

Social Factors: Residents of Kedren's service area are younger, on average, than elsewhere, with higher percentages of children and young adults. More than one-quarter (26.7%) of the population are children under age 18, totaling more than one-quarter million individuals, (compared with 22.8% of the county's population, 23.6% of the state's, and 23.1% of the nation's). Furthermore, 39% of residents are under age 25, exceeding the percentages in the county, state, and nation, and only 9.1% are 65 years or older, a percentage much lower than elsewhere. These demographics present specific needs and challenges, i.e. the need for family planning and pediatric care. These young families are primarily low-income or impoverished, with many children living in poverty. The following table represents these details.

Age Distribution	Service Area Number	Service Area Percent	L.A. County	California	U.S.A.
Ages 0-4	**74,543**	**7.7%**	6.3%	6.5%	6.2%
Ages 5-17	**184,034**	**19.0%**	16.5%	17.2%	16.9%
Ages 18-24	118,931	**12.3%**	10.4%	10.2%	9.8%
Ages 25-44	286,261	29.5%	29.5%	28.1%	26.4%
Ages 45-64	217,530	22.4%	25.0%	25.1%	26.2%
Ages 65-84	77,200	8.0%	10.5%	11.1%	12.6%
Ages 85+	10,962	1.1%	1.7%	1.8%	1.9%
Total Population	969,461	100.0%	100.0%	100.0%	100.0%
All Children Age 0-17	**258,577**	**26.7%**	22.8%	23.6%	23.1%
Children and Young Adults Age 0-24	**377,508**	**39.0%**	33.2%	33.9%	32.9%
All Seniors Age 65+	**88,162**	9.1%	12.2%	12.9%	14.5%

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates, Table B01001

Occupational factors: As described previously, service area residents are often employed in unskilled and manual labor positions such as construction, maintenance, grounds keeping, and food preparation, and less often in professional jobs that require advanced educations or training. In addition to being physically challenging and having higher accident risk, these unskilled, physical jobs are often without healthcare benefits and often are not full-time or permanent. These factors affect residents' incomes and health, and their access to healthcare services. Nearly one-quarter (27%) of the target population are medically uninsured. As detailed in the following table, more than one in three (34.9%) of service area residents depend on Medicaid for their healthcare coverage, compared with 20.1% countywide, 18% statewide, and 14.2% nationwide.

Primary Health Insurance	Service Area Number	Service Area Percent	L.A. County	California	U.S.A.
Medicaid (excl. Medi-Medi)	**337,576**	**34.9%**	20.1%	18.0%	14.2%
Medicare (excl. dually covered by employer-provided insurance)	**74,075**	**7.7%**	9.2%	9.2%	9.9%
Veteran's Administration or TRICARE	10,201	1.1%	1.1%	2.2%	3.3%
Private Insurance (incl. purchase through state insurance exchange)	315,918	32.7%	53.7%	58.0%	60.9%
None/Uninsured	**227,599**	**23.5%**	15.9%	12.6%	11.7%
Total Noninstitutionalized Population	965,364	100.0%	100.0%	100.0%	100.0%

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates, Tables B27002, B27003, B27010, C27004 through C27009, and C27016. Some values extrapolated by Gary Bess Associates.

Cultural/Ethnic Factors and Language Needs: An overwhelming majority (95.4%) of residents in Kedren's service area belong to ethnic and/or racial minorities. Almost two-thirds (63.5%) of service area residents self-identify as Hispanic/Latino and more than one-quarter (26.7%) as Black or African-American. Only 4.1% of residents are non-Hispanic Whites. In addition, more than one of three residents (37.3%) was born outside the United States, most from Latin American countries, including almost one in five (19.1%) of area residents being born in Mexico.[6] The following table details the ethnic and racial composition of the service area population.

Race/Ethnicity	Service Area Number	Service Area Percent	L.A. County	Calif.	U.S.A.
American Indian or Alaska Native	7,204	0.7%	0.6%	0.7%	0.8%
Asian (South or East) or Asian Indian	44,652	4.6%	14.2%	13.9%	5.2%
Black or African American	**258,600**	**26.7%**	8.3%	5.9%	12.6%
Native Hawaiian or Pacific Islander	1,113	0.1%	0.3%	0.4%	0.2%
White, Non-Hispanic (incl. North African and West/Central Asian)	39,310	4.1%	26.7%	38.4%	62.0%
Other/Multiple (non-Hispanic)	15,203	1.6%	2.5%	3.1%	2.5%
Hispanic or Latino	**615,546**	**63.5%**	48.3%	38.6%	17.3%
Total	969,461	100.0%	100.0%	100.0%	100.0%

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates, Table B03002.

[6] U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates, Tables B05006 and B01003

Nearly two-thirds (65.4%) of service area residents speak a language other than English in their homes, compared with 56.8% in L.A. County, 43.9% in California, and 21% in the U.S.A. The predominant home language in the service area is Spanish, with 60.1% of service area residents speaking Spanish at home. Among all residents who reported speaking a non-English language in their homes, half of them (51.3%) reported that they do not speak English "very well."[7] The following table shows the number and percentages of people speaking the five most common languages in the service area, compared with percentages in the county, state, and nation.

Primary Language Spoken at Home, Top 5 Languages	Service Area Number	Service Area Percent	L.A. County	Calif.	U.S.A.
Spanish or Spanish Creole	532,293	**60.1%**	39.4%	28.8%	13.0%
English	306,488	34.6%	43.2%	56.1%	79.0%
Korean	19,963	2.3%	2.0%	1.0%	0.4%
Chinese	6,575	0.7%	3.9%	3.1%	1.0%
African languages	3,818	0.4%	0.2%	0.2%	0.3%
All Other Languages	17,261	1.9%	11.3%	10.8%	6.2%
Total Population Age 5+	886,398	100.0%	100.0%	100.0%	100.0%
Total who Speak a Language Other than English at Home	**579,910**	**65.4%**	56.8%	43.9%	21.0%

Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates, Table B16001.

Housing/Environmental: Home ownership and affordability in the service area demonstrates a challenge related to residents' low-income status. Housing costs sometimes consume so much of a household's income, residents are forced to choose between paying the rent and other necessities, such as food, transportation, or medical expenses. The total number of owner-occupied housing units in the service area is only 88,404, compared with 200,851 renter-occupied units. Even among the residents that own their own homes, or are purchasing them, many are challenged by the high cost of home ownership, paying more than 30% of their incomes on housing. More than one-half (58.8%) of home-owners with mortgages and 16.1% of homeowners without mortgages are in this situation. Among residents who rent their housing, the percentage of households that spend more than 30% of their household incomes on rent is even higher, at 65.6%. The total of service area households in housing that is considered unaffordable is 60.6%, compared with 48% countywide, 42.8% statewide, and 32.9% nationwide. The following table illustrates these data.

[7] U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates, Table B16001.

Housing Affordability (Number and Percent of Households Paying 30% of More of Income on Housing)	Service Area Housing Units	Service Area Unaffordable Units	Service Area Percent	L.A. County	Calif	U.S.A.
Owner-Occupied Units w/Mortgage	68,268	40,153	58.8%	46.0%	41.0%	30.6%
Owner-Occupied Units w/o Mortgage	20,136	3,234	16.1%	15.6%	14.8%	14.0%
Renter Occupied Units	**200,851**	**131,834**	**65.6%**	56.5%	53.6%	47.3%
All Housing Units	**289,255**	**175,221**	**60.6%**	48.0%	42.8%	32.9%

U.S. Census, 2012-2016 American Community Survey 5-Year Estimates Table B25091

According to the Board of State and Community Corrections, the average daily population in the Los Angeles County Jail as of March 2018 was 16,667. As a result of the California Public Safety Realignment Act (AB 109), and related laws, approximately 35,000 inmates are being shifted to local county jails, including Los Angeles County Jail. And with felonies being reduced to misdemeanors, more inmates are being released into the community – 162,000 prisoners were released back into the community in 2013; 96,000 in 2014; and 72,000 in 2016 after the passage of Proposition 57 (statewide).[8] Los Angeles County, more specifically, houses one-quarter of California's jail population. Moreover, due to significant overcrowding, jails are not equipped to handle medical and mental health care of long-term inmates. Thus, with these large shifts in the jail population, there are more and more individuals in the communities with need for healthcare.

[8] https://lasentinel.net/thousands-of-prison-inmates-are-being-released-into-local-communities.html

UNIFORM PATIENT FEE SCHEDULE
COMMUNITY MENTAL HEALTH SERVICES
Effective October 1, 1989

MONTHLY ADJUSTED GROSS INCOME*	PERSONS DEPENDENT ON INCOME ANNUAL DEDUCTIBLES				
	1	2	3	4	5 or more
	MEDI-CAL ELIGIBLE AREA**				
0- 569	37	33	30	27	24
570- 599	40	36	32	29	26
600- 649	45	40	36	32	29
650- 699	50	45	41	37	33
700- 749	56	50	45	41	37
750- 799	63	57	51	46	41
800- 849	71	64	58	52	47
850- 899	79	71	64	58	52
900- 949	89	80	72	65	59
950- 999	99	90	80	72	65
1000-1049	111	100	90	81	73
1050-1099	125	112	101	91	82
1100-1149	140	126	113	102	92
1150-1199	156	140	126	113	102
1200-1249	177	159	143	129	116
1250-1299	200	180	162	146	131
1300-1349	226	203	183	165	149
1350-1399	255	230	207	186	167
1400-1449	288	259	233	210	189
1450-1499	326	293	264	238	214
1500-1549	368	331	298	268	241
1550-1599	416	374	337	303	273
1600-1649	470	423	381	343	309
1650-1699	531	478	430	387	348
1700-1749	600	540	486	437	393
1750-1799	678	610	549	494	445
1800-1849	752	677	609	548	493
1850-1899	835	752	677	609	548
1900-1949	927	834	751	676	608
1950-1999	1029	926	833	750	675
2000-2049	1142	1028	925	833	750
2050-2099	1268	1141	1027	924	832
2100-2149	1407	1266	1139	1025	923
2150-2199	1562	1406	1265	1139	1025
2200-2249	1734	1561	1405	1265	1139
2250-2299	1925	1733	1560	1404	1264
2300-2349	2136	1922	1730	1557	1401
2350-2399	2371	2134	1921	1729	1556
2400-2449	2632	2369	2132	1919	1727
2450-2499	2922	2630	2367	2130	1917
2500-2599	3275	2948	2653	2388	2149
2600-2699	3482	3134	2821	2359	2285
2700-2799	3695	3326	2993	2694	2425
2800-2899	3915	3524	3172	2855	2570
2900-2999	4139	3725	3353	3018	2716
3000-3099	4370	3933	3540	3186	2867
3100-3199	4607	4146	3731	3358	3022
3200-3299	4850	4365	3929	3536	3182
3300-3399	5099	4589	4130	3717	3345
3400-3499	5458	4912	4421	3979	3581
3500-3599	5830	5247	4722	4250	3825
3600-3699	6214	5593	5036	4532	4079
3700-3799	6610	5949	5354	4819	4337
3800-3899	7018	6316	5684	5116	4604
3900-3999	7438	6694	6025	5423	4881
4000-4099	7870	7083	6375	5738	5164
4100-4199	8314	7483	6735	6062	5456

Above $4200 Add $400 for each $100 additional income.

*Monthly Gross Income after adjustment for allowable expenses and asset determination from computation made on the financial intake form.

**Medi-Cal eligible. The shaded Medi-Cal eligible area identifies income levels presumed eligible if client meets Medi-Cal eligibility requirements. (See back page).

Prepared and published by the California Department of Mental Health in accordance with Sections 5717 and 5718 of the Welfare and Institutions Code.

10/20/89

ATTACHMENT THREE

Board Minutes and items adopted by the Board of Directors on

July 29, 2016

Corporate

Corporate Action Items

1. Community Needs Assessment Implementation Strategy

2. Revised Discount/Sliding Fee and Family Assistance Plan Application

3. Financial Assistance Policy

4. Sliding Fee Scale Policy

	FINDINGS/DISCUSSION	CONCLUSIONS/RECOMMENDATIONS/ ACTION
	authority and responsibility to act in its behalf and within the best interest of the corporation; names of Authorized Account Signers include: Renee Woodruff, Carlita Hester, Kathy Gibbons, Robert Lawson, and John H. Griffith. Resolution signed by the current Board Secretary (Kathy Gibbons) and the Board Chairperson (Renee Woodruff, LCSW) on 7/29/2016. (2) **Request for Clinical Privileges**—the 4 physicians listed below applied for clinical privileges at Kedren. The Credentials Committee has reviewed their credentials and the physicians are being recommended to the Board of Directors by the Medical Executive Staff for consideration of appointment for the period of one 2-year term (July 29, 2016 to July 29, 2018). • Richard Casey, M.D. (Optometrist)—module building • Hiruy H. Gessesse, M.D. (AIP) • Maria R. Guevara, M.D. (CCC) • Juden C. Valdez, M.D. (weekend physician coverage) (3) Sliding Fee Policy The Board approved the Discount Policy and Procedures for Kedren Community Care Clinic and Kedren Acute Psychiatric Hospital and Community Mental Health Center (CMHC).	**Resolution of Authority granting President/CEO full authority was signed by the current authorized Board Officers of corporation at the full Board Meeting held on July 29, 2016. Current Board Secretary (Kathy Gibbons) and Board Chairperson (Renee Woodruff, LCSW)** **Request for Clinical Privileges—Approved by the Board on July 29, 2016 (Motion by Mr. Johnson; 2nd by Mr. Reyes; motion carried.)** **Sliding Fee Policy—Board approved Discount Policy & Procedures for Kedren CCC and Kedren Acute Psychiatric Hospital and CMHC (Motion by Mr. Johnson; 2nd by Ms. Garcia; motion carried.**
	Distribution – Board Notebooks Dr. Griffith distributed (to each Board Member) a notebook comprised of: • Board Manual: Guidelines for Board Members • Orientation Manual • By-Laws (Articles I-X)—Approved by Kedren's Board	**To be discussed at the next Board meeting.**

KEDREN COMMUNITY HEALTH CENTER, INC.

KEDREN COMMUNITY CARE CLINIC

The enclosed revised **Sliding Fee Policy** has been approved by the Board of Directors and the Chief Medical Officer:

Kathy Sibbons/for
Linda Renee Woodruff, LCSW
Chairperson

7/28/17
Date

Vera Patterson
Vera Patterson, MS
Secretary

7-31-17
Date

Cadrin Gill
Cadrin Gill, M.D.
Chief Medical Officer

7-28-17
Date

John H. Griffith
John H. Griffith, Ph.D.
President & CEO

7-28-17
Date

ATTACHMENT FOUR

KEDREN COMMUNITY HEALTH CENTER, INC.

Federal Assistance Policy (FAP)

KEDREN COMMUNITY HEALTH CENTER, INC.

1. **Provide Written FAP that was in place during tax year ended June 30, 2017.**

   Written FAP during the tax year ended June 30, 2017 is included herewith under Attachment Four.

FINANCIAL ASSISTANCE POLICY	**Policies** **Title:** Financial Assistance **Revised 1/1/2018** **Distribution:** Billing Offices Hospital Corporate Finance

POLICY

Kedren Community Health Center (KCHC), Inc., shall provide financial assistance to patients who either do not have health insurance or are underinsured, and may not be able to pay in full for their care based on their income, assets and needs. Uninsured or underinsured patients will be treated fairly and with respect during and after their treatment. Patients with high medical costs may also be eligible for a discounted rate if they meet the eligibility requirements. KCHC will provide financial counseling to all patents requiring financial assistance. This will include help in understanding and applying for local, state and federal healthcare programs such as Medicaid. All patients requiring financial assistance will be offered discounted pricing for the services provided at rates comparable to Medicare. All patients will be offered reasonable payments plans and, subject to their acceptance of the offer, will be billed at discounted rates. Whenever possible, this will occur before the services are provided or patients leave the hospital, as part of the financial counseling process. KCHC will not pursue legal action for non-payment of bills against any patient who is unemployed and without other significant income or assets.

PURPOSE

The purpose of this policy is to define the eligibility criteria for Charity Care services and to provide administrative and accounting guidelines for the identification, classification and reporting of patient accounts as Charity Care.

Self-Pay Patients: A self-pay patient means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare or Medicaid and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance or other insurance as determined and documented by the hospital. Self-pay patients may include Charity Care patients.

Charity Care for Self-Pay Patients: A self-pay patient is eligible for Charity Care (free care) or a discount payment plan based upon meeting the eligibility criteria established by the hospital. Financial eligibility criteria is derived from the most recently published US Department of Health and Human Services Annual Update of the HHS Poverty Guidelines, also referred to as the Federal Poverty Level (FPL).

Discount Payment Plan for Patients with High Medical Costs: An insured patient is eligible for a discount plan based on meeting the income eligibility criteria and has high medical costs. The income eligibility criterion is defined as the patient's family income that is at or below 350% of the FPL. High medical costs are defined as out-of-pocket medical expenses in the prior twelve (12) months that exceed 10% of the family's income, and does not otherwise receive a discount as a consequence of a third party coverage.

Patient's Family: (1) For persons 18 years of age or older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not. (2) For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

PROCEDURE

Eligibility Criteria:

1. Charity Care and Discount Payment Plans Application (See Attachment A)
   a. A low income self-pay patient or a low income insured patient with high medical costs who indicates the financial inability to pay a bill for a medically necessary service shall be evaluated for financial assistance.
   b. The Financial Assistance Application (Attachment A) will be used to document each patient's overall financial situation.
      i. Last three (3) months pay stubs are required for the purpose of documenting income and the tax return from the previous year.
      ii. Income and monetary assets are taken into consideration however, monetary assets shall not include retirement or deferred compensation plans qualified under the Internal Revenue Code, or non-qualified deferred-compensation plans. Additionally, the first $10,000 of a patient's monetary assets shall not be counted in determining financial eligibility, nor shall 50% of the patient's monetary assets over the first $10,000 be counted in determining eligibility.
      iii. The patient will need to apply for Medicaid eligibility and must be turned down for reasons other than not following through with the application process.
   c. Once a determination has been made, a notification form will be sent to each applicant advising them of the facility's decision and the reason for the denial if denied.
   d. A patient may request an appeal of a denial of eligibility. These requests are directed to the CFO of the hospital. The CFO will review the information submitted and/or request additional allowable documents to be submitted by the patient. A written decision regarding the appeal is provided by the CFO to the patient within 72 hours of the receipt of the request.
   e. A patient's employment status may be taken into consideration when evaluating Charity Care status as well as potential payments from pending litigation, and third party liens related to the incident of care.
   f. Interest free extended payment plans are also offered by the hospital to assist patients with payment and are subject to negotiation with the patient.
   g. A deposit may be required from self-pay patients prior to determination that a patient qualifies for Charity Care or discounted payment. The hospital will refund to the patient any amount collected from a financially qualified patient in excess of the amount due under the hospital's Charity Care or discounted payment policy.
   h. If the hospital bills a patient who has not provided proof of third party coverage, the hospital shall provide the patient with a notice of the following:
      1. A statement of charges
      2. A request to inform the hospital of coverage
      3. Notice of eligibility requirements for Medicaid etc.
      4. Instructions on how to obtain applications for Medicaid, and other governmental programs; and will be given copies of above mentioned applications
      5. A copy of the Patient Financial Assessment Application (Attachment A), the Sliding Scale Discount chart (Attachment B), and the Review Process and Eligibility notice.

Policy#: 900	Policies & Procedures	Approved By: BOD 07/24/15, 6/30/17, 7/28/17
Policy Title: Sliding Fee Policies and Procedures	**KEDREN Community Care Clinic**	Effective Date: 02/01/14
		Date Revised: 07/14/15
Distribution: All Staff		Manual: Administrative/Medical Office

Policy:

To make available discount services to all individuals and families with annual income at or below 200 percent of the Federal Poverty Guidelines (FPG). It is the policy of Kedren Community Care Clinic (KCCC) to assure that no patient will be denied health care services due to an individual's inability to pay for such services. To accomplish this goal, KCCC has developed a Sliding Fee Program (SFP) in accordance with the guidelines and requirements of HRSA Policy Information Notice (PIN) 2014-02.

Sliding Fee Program:

KCCC will offer to patients without insurance including those patients under Medicare or any insurance with or without a deductible a sliding fee discount. The sliding fee discount will be based on income and family size and no other factor. The definition of income and family size will be based on the established current Federal Poverty Guidelines (FPG). The Federal Poverty Guidelines are a version of the income thresholds used by the U.S. Census Bureau to estimate the number of people living in poverty. Individuals and families with annual income above two hundred percent (200%) of the FPG are not eligible for the sliding fee discount program.

The Federal Poverty Guidelines, http://aspe.hhs.gov/poverty, are used in creating and annually updating the sliding fee schedule (SFS) to determine eligibility (see attachment).

Sliding Fee Discount Schedule (SFDS):

The FPG will be updated annually (typically published in January or early February in the Federal Register) and approved at the next month's Board of Director's meeting with an effective date of the subsequent month in order to allow time to train staff and update systems. See attached current year's sliding fee scale.

Sliding Fee Discount Notification:

KCCC will notify patients of the Sliding Fee Discount Program by all of these means:

1) Notices/signage in waiting room and/or reception and/or service areas;
2) Staff discussions/notification;

3) KCCC published patient brochures in the waiting area/or reception, and/or services areas;
4) Health fair promotional materials; and
5) As part of the patients registration process (assessment for income) unless the patient declines/refuses to be assessed)

The communication to patients will be provided in the appropriate language and literacy levels for KCCC's patient population (at a minimum English and Spanish).

Completion of Application:

The patient/responsible party must complete the Sliding Fee Application and the inability to pay form, in its entirety. Staff will assist as necessary. By signing the Sliding Fee Application, patients authorize KCCC to confirm income as disclosed on the application form. Providing false information on a Sliding Fee Application will result in all Sliding Fee Discount Program discounts being revoked and the full balance of the account(s) restored and immediately payable.

KCCC patients will also complete a Family Assistance Plan Application that is an income eligibility document declaring their family size and income in order to participate in the Sliding Fee Discount Program. Family size is based on total members in the household.

If an application is unable to be processed due to the need for additional information, the applicant has two weeks from the date of notification to supply the necessary information without having the date on the application adjusted. If a patient does not provide the requested information within the two week time period, the application will be re-dated to the date on which requested information is supplied. If patients do not pay at the time of service after three attempts to collect, the amount due will be written off, though upon the patient's return to KCCC, the debt will be reinstated. If patients do not pay at the time of service, after three attempts to collect, the amount due will be written off.

Based on family size and income the patient will be notified of the eligibility and sliding fee discount classification (pay category). Proof is valid for one (1) year. The eligibility determination process will be conducted in an efficient, respectful and culturally appropriate manner to assure that the administrative operating procedures for determination do not present a barrier to care.

Proof of identification:

The following items can be used as proof:

- Drivers License
- ID card
- Passport
- Any other form of acceptable proof of identification

Eligibility:

Discounts will be based on income and family size only. KCCC uses the Census Bureau definitions of each.

1) **Family** is defined as a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.
2) **Income** includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. *Noncash benefits (such as food stamps and housing subsidies)* ***do not*** *count.*

Income verification:

Applicants must provide one of the following: (a) prior year W-2; (b) most recent pay stubs; (c) social security income postcard; (d) letter from employer; or (e) Form 4506-T (if W-2 not filed). Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program. **Self-declaration of Income** may only be used in special circumstances. Specific examples include patients who are homeless. Patients who are unable to provide written verification during the initial visit must provide a signed statement of income, and why (s)he is unable to provide independent verification. However, proof of income is required for subsequent visits.

Elderly patients that are dependent on their children for support and are claimed as a dependent on the family's income taxes will be placed on a sliding fee level based on the income of their child(ren).

Timeframe for Submission of Proof of Income:

The patient will be required to provide one of the required documents listed above at the earlier of thirty (30) days from the date of the first visit, or if a second visit occurs, before the thirty (30) days at such date. If documentation is not provided within the thirty (30) days of date of service, the patient will be considered to be 100% self-pay. No exceptions will be made to this without the written approval of the CEO or CFO, and will be based on a case by case basis if the circumstances of the patient did not allow them to comply with the requirement.

Some patients may choose not to provide information that the health center requires for assessing income and family size, even after being informed that they may qualify for sliding fee discount. These patients are considered by KCCC as declining to be assessed for eligibility for sliding fee discounts. As long as KCCC has followed its policies and procedures and the patient declines to be considered for the SFDS, KCCC may consider the patient ineligible for such discounts.

Eligibility Period:

The patient's eligibility will be valid for one (1) year. The eligibility period is also automatically programmed into KCCC's computer system once eligibility is confirmed. Proof of income and the application is scanned and maintained directly in the eClinicalWorks system. This will allow management to perform Quality Insurance (QI) reviews for compliance and evaluate the effectiveness of the sliding fee program.

Services Covered:

The sliding fee discount will apply to all services within the KCCC approved scope of project, whether required or additional for all of KCCC locations. KCCC does have multiple SFDS based on services/mode of delivery (see below).

Schedule of Fees:

KCCC maintains one schedule of fees (charge master) for all patients and this fee schedule is designed to cover reasonable costs of providing services in the approved scope of project using a Relative Value Unit (RVU's) and adjusting as needed for consistency with locally prevailing rates (which is 150% of the Medicare rates published). This fee schedule is approved by the Board of Directors and evaluated annually to ensure it is consistent with locally prevailing rates and KCCC's cost structure. See also Fee schedule/charge master formula in the billing and collections policy for more details.

Structure of Sliding Fee Discount Schedule (SFDS):

The Sliding Fee Discount Schedule is designed by KCCC in a manner that adjusts based on ability to pay. To accomplish this, KCCC has designed four discount pay classes above 100% and at or below 200% of the FPG. Only a nominal charge will be charged for individuals and families with annual income at or below 100% of the FPG. This nominal fee is a fixed amount, and does not reflect the true value or cover costs of the services, but is rather applied in order for patients to invest in their care and to minimize the potential for inappropriate utilization of services. This nominal charge is also less than the fee paid by a patient in the first "sliding fee discount pay class" beginning above 100% of the FPG.

Medical Services -----Class----	A	B	C	D
Income Threshold for sliding fee	<= 100% FPG	101%-133% FPG	134%-166% FPG	167%-200% FPG
Nominal Payment	$20.00			
% of Charges Paid		25%	50%	75%
% of Discount		75%	50%	25%
Example $ paid for Office Visit (99213)	$20.00	$30.38	$60.75	$91.13

Medical services includes: evaluation and management codes, injections (see exceptions), minor office procedures, Pap smears and breast exams, and some CLIA waived lab tests performed in-house by KCCC.

CLIA –waived Lab Tests and Prescription Drug Costs- Not Included in Medical Office Visit Charge:

KCCC contracts for lab services not performed in-house (under its CLIA waiver) with third party laboratory companies. These tests are contracted at low cost/preferred pricing for patients that qualify for sliding fee under KCCC's sliding fee program. The patients that qualify under KCCC's sliding fee program will be charged the direct cost of these lab tests.

The above SFSD applies to all services KCCC provides for which there are established charges**, regardless of service type (required or additional), or the mode of delivery (directly or through contract for which KCCC is financially liable (Form 5A, Columns I & II). For services that are not provided directly, but that KCCC has a formal written referral arrangement (as specified in our Form 5A, Column III), it is the policy to ensure the formal agreement includes language that entity/provider being referred to offers our patients a sliding fee discount that is outlined in the criteria requirements outlined in PIN 2014-02 on page 12. All formal agreements will be amended to include such language and all new referral agreements will automatically include the language to ensure compliance. The organization will also monitor this through a combination of patient inquiries as referrals are made and / or through annual certification by the referral provider. See sample amendment and annual certification –Appendix A and B, respectively.

Other Considerations

** The following supplies/injectables, and equipment are excluded and charged at KCCC's costs since they may be considered elective or considered related to, but not included in, the service itself as part of prevailing standards of care: any services performed at the hospital (excludes diagnostic radiology), any injectables outside the standard of care, prescription drugs.

Patients will be notified of separate charges prior to delivery of such items and the total amount of out of pocket costs for these supplies or equipment, and payment plans that are available through KCCC or other third party.

Evaluating the Sliding Fee Schedule:

This sliding fee discount schedule is evaluated annually to ensure it is not a barrier to care from the patient's prospective. This is accomplished by KCCC using one or more of these methods:

1) Meeting with a user group of the Board of Directors, and discussing from the consumers prospective the amounts being charged.
2) Evaluating the amount of paid debt that KCCC has in comparison to the established baseline, and if the amount has increased significantly doing further analysis to determine if this factor is causing barrier to care due to the patients inability to pay.
3) Obtaining feedback from the staff on their observations of KCCC's effectiveness in addressing financial barriers to care for the patients.
4) Performing a patient satisfaction survey at least once each year.
5) Input from patient focused groups.
6) Reviewing patient complaints.
7) Number of nursing visits***
8) Performing blind or random tests of referring providers' sliding fee program to ensure compliance and determine if barrier to care for KCCC patients.

The method(s) used to evaluate the effectiveness of KCCC's sliding fee program from the perspective of reducing patient financial barriers to care will be shared with the Board of Directors in order to assist them in determining appropriately of KCCC's sliding fee policy. This will occur annually in conjunction with the update of the FPG.

***There is no charge or a nominal charge for nurse visits in order to ensure finances are not barriers to care. .

Patients with Third party Coverage who are Eligible for SFDS:

KCCC sliding fee policy is based on income and family size only, so there may be patients with third party insurance that do not cover, or only partially covers, fees for certain health center services that may be eligible for KCCC's sliding fee program. In such cases, subject only to potentially legal and contractual limitations, the charge for each SFDS pay class is the maximum amount an eligible patient in that pay class is required to pay for a certain service, regardless of insurance status.

Waiving of Charges:

In certain situations, patients may not be able to pay the nominal or discount fee. Waiving of charges may only be used in special circumstances and must be approved by KCCC's CEO, CFO, or their designee. Any waiving of charges should be documented in the patient's file along with an explanation (e.g., ability to pay, good will, health promotion event).

Applying the Policy and Training Staff:

These policies and procedures will be uniformly applied across all KCCC patient population and staff will be trained to assist with the uniform implementation of the process and systems will be updated as the policy is updated to assist with compliance, and at a minimum, staff trained when hired and each time the policy is updated.

Kedren Community Care Clinic

Sliding Fee Scale
2017

Refer to Federal Register 1/31/2017*

Effective: 9/1/2017

	A		B		C		D		No Discount	
Persons in Family/ Household	<=100% FPG		101%-133%	FPG	134%-166%	FPG	167%-200%	FPG	201%>	FPG
1	$ -	$ 1,005	$ 1,006	$1,337	$1,338	$1,668	$1,669	$2,010	$2,011	+
2	$ -	$ 1,353	$ 1,354	$1,800	$1,801	$2,247	$2,248	$2,707	$2,708	+
3	$ -	$ 1,702	$ 1,703	$2,263	$2,264	$2,825	$2,826	$3,403	$3,404	+
4	$ -	$ 2,050	$ 2,051	$2,727	$2,728	$3,403	$3,404	$4,100	$4,101	+
5	$ -	$ 2,398	$ 2,399	$3,190	$3,191	$3,981	$3,982	$4,797	$4,798	+
6	$ -	$ 2,747	$ 2,748	$3,653	$3,654	$4,559	$4,560	$5,493	$5,494	+
7	$ -	$ 3,095	$ 3,096	$4,116	$4,117	$5,138	$5,139	$6,190	$6,191	+
8	$ -	$ 3,443	$ 3,444	$4,580	$4,581	$5,716	$5,717	$6,887	$6,888	+
Payment:										
Medical	$20.00		25%		50%		75%		100%	
	Nominal Charge		*Fee Schedule*		*Fee Schedule*		*Fee Schedule*		*Fee Schedule*	

For families/households with more than 8 persons, add $4,180 for each additional person.

*This is updated annually with the most current federal poverty guidelines published in the Federal Register and will be approved by the Board of Directors prior to being implemented. Typically the effective date will be approximately 30 days after board approval or earlier if board/management elects in order to allow time for proper implementation and staff training. Typically the policy will be effective at the 1st day of a new month.

Appendix A

SAMPLE

Amendment to formal written referral arrangement (i.e., Form 5A: Services Provided, Column III within the federally approved scope of project),

The agreement dated 00/00/0000 between the XXXXXXX (Referral Provider) and Kedren Community Care Clinic, (FQHC health center), is hereby amended to ensure compliance with Policy Information Notice (PIN) 2014-02 issued by the Bureau of Primary Health Care (BPHC) and credentialing and patient tracking.

Sliding fee

XXXXXXX (Referral Provider) is responsible for ensuring that the referral provider's discounts for health center patients meet the criteria below:

Sliding Fee Discount Scale (SFDS) must meet all of the following criteria:

- It must conform to the specific structural requirements outlined in this PIN 2014-02 (copy provided and hereby attached as part of this amendment).
- In cases where the health center has elected to establish a nominal charge for patients at or below 100 percent of the FPG, this charge meets the criteria for a nominal charge. (See Section VII.C, Establishing and Collecting Nominal Charges.)
- Patient access and uniform implementation have been taken into consideration in developing each SFDS.
- The FQHC health center and Referral Provider has a plan for routinely evaluating each SFDS and presenting this information to the board to ensure that it does not create a barrier to care.

XXXXXXX(Referral Provider) agrees to comply with the criteria and will certify to Kedren Community Care Center (FQHC health center) annually that the sliding fee program offered is compliant with PIN2014-02 and will provide a copy to the FQHC health center each time it is updated/changed and upon request by Kedren Community Care Center (FQHC health center). See Appendix A attached.

The Referral Provider SFDS will ensure that

- All FQHC health center patients at or below 200 percent of the FPG receive a receive a discount for these services; and
- Patients at or below 100 percent of the FPG receive no charge or only a nominal charge that (see Section VII.C, Establishing and Collecting Nominal Charges) for these services.

Kedren Community Care Clinic (FQHC health center) has the right to audit the Referral Provider and to request proof of compliance at any time. This is required in order for the FQHC health center to ensure compliance with the BPHC's program requirements and the PIN 2014-02.

By signing below XXXXXXX (Referral Provider) acknowledges they have received a copy of Kedren Community Care Clinic (FQHC health center) SFDS and PIN 2014-02. Kedren Community Care Clinic (FQHC health center) and they will comply with BPHC's requirement. They understand the credentialing requirements and have received a copy of Kedren Community Care Clinic (FQHC health center)'s patient tracking policy.

Kedren Community Care Clinic (FQHC health center) will provide XXXXXXX (Referral Provider) and updated copy of their SFDS each time it changes (which should be at a minimum annually when the FPG are updated) and XXXXXXX (Referral Provider) will also update their SFDS accordingly.

Both parties agree to allow routine evaluation of each SFDS and presenting this information to the board Kedren Community Care Clinic (FQHC health center) in order to ensure that it does not create a barrier to care. This evaluation can be performed by either party or both and can take a number of different forms. For example, patient survey or focused group evaluation, evaluating bad debt, evaluating collection percent for these patients, etc.

Credentialing:

The referral provider certify he/she (or licensed providers working of the referral provider) is properly credentialed to perform the agreed upon services and the referral provider will notify the FQHC health center) immediately upon any event that would impact such credentials. The referral provider also agrees to provide upon written request, proof of proper credentials, to the FQHC health center.

Patient Tracking

The referral provider also agrees to cooperate with the FQHC health center's patient tracking system (Policies and Procedures) to ensure that patient's information is provided back to the FQHC health center timely in order to ensure high quality care.

Referral Provider

Signature: _____
Title: _____
Date: _____

FQHC health center

Signature: _____
Title: _____
Date: _____

Appendix B

Sample

ANNUAL COMPLIANCE CERTIFICATION

XXXXXXX (Referral Provider) herby certifies that we are compliance with PIN 2014-02 requirements and that no patient referred to by Kedren Community Care Clinic (FQHC health center) has been denied services due to their ability to pay and the SFDS has been uniformly implementation to all referred patients.

XXXXXXX (Referral Provider) hereby also provide a copy of our most current SFDS as of the date below and certifies that no changes had been made to the SFDS since the last certification or original amendment date.

XXXXXXX (Referral Provider) herby certifies that they are properly credentialed to perform the contracted services Kedren Community Care Clinic (FQHC health center)'s patients.

XXXXXXX (Referral Provider) herby certifies that they have referred patients back to Kedren Community Care Clinic (FQHC health center) and have complied with the FQHC health center's referral tracking system- policy and procedure.

Signature below certifies compliance.

Referral Provider

Signature: _____

Title: _____

Date: _____

2017 Updated Federal Poverty Guidelines

Persons in Family Household	Poverty Guideline	MAGI* Medi-Cal <138% Federal Poverty Level (FPL)	MAGI Household Income ≤500% FPL
1	$12,490	$17,236	$62,450
2	$16,910	$23,336	$84,550
3	$21,330	$29,435	$106,650
4	$25,750	$35,535	$128,750
5	$30,170	$41,635	$150,850
6	$34,590	$47,734	$172,950
7	$39,010	$53,834	$195,050
8	$43,430	$59,933	$217,150

For families/households with more than 8 persons, add $4,420 for each additional person.

*Modified Adjusted Gross Income

	Limited	Expanded	Detailed	Extended	Campre.
New Patients	$70.00	$140.00	$172.00	$262.00	$325.00
Returning	$34.00	$130.00	$135.00	$171.00	$229.00

Sliding Fee Calculator by CPT4 Codes

Family Unit Size	Minimum PAY	25% PAY	50% PAY	75% PAY	100% PAY
Poverty	100%	133%	166%	200%	200% >
New Patients					
99201	$ 20.00	$ 20.00	$ 35.00	$ 52.50	$ 70.00
99202	$ 20.00	$ 35.00	$ 70.00	$ 105.00	$ 140.00
99203	$ 20.00	$ 43.00	$ 86.00	$ 129.00	$ 172.00
99204	$ 20.00	$ 65.50	$ 131.00	$ 196.50	$ 262.00
99205	$ 20.00	$ 81.25	$ 162.50	$ 243.75	$ 325.00
99211	$ 20.00	$ 20.00	$ 20.00	$ 25.50	$ 34.00
99212	$ 20.00	$ 32.50	$ 65.00	$ 97.50	$ 130.00
99213	$ 20.00	$ 33.75	$ 67.50	$ 101.25	$ 135.00
99214	$ 20.00	$ 42.75	$ 85.50	$ 128.25	$ 171.00
99215	$ 20.00	$ 57.25	$ 114.50	$ 171.75	$ 229.00

Nominal Fee: $20

2. **Sample application and instructions for applying for financial assistance.**

i. **A sample application and instructions for applying for financial assistance.**

Kedren Health
4211 Avalon Blvd., Building A
Los Angeles, CA 90011

Kedren Community Health Center, Inc.
Phone: 323.234.0616 Fax: 323.515.7017
Toll Free: 1.855.808.4580 Web: Kedren.org

DISCOUNTED/ SLIDING FEE AND FAMILY ASSISTANCE PLAN APPLICATION

It is Kedren Community Healther Center Inc's policy to provide essential services regardless of the patient's ability to pay. Discounts are offered depending upon family income and size. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at the center but not those services which are purchased from outside, such as reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and similar services. In the hope that your economic health improves, discounts apply onlty to current, not future services. This form must be completed for each visit. Please inquire at the front desk if you have questions.

*Number of related persons living in your household: ☐

NAME OF HEAD OF HOUSEHOLD:		
LAST	FIRST	MIDDLE
HEALTH INSURANCE PLAN:		SS#:
ADDRESS:	CITY:	ZIP:
HOME PHONE:	CELL PHONE:	WORK PHONE:
EMPLOYER:	OCCUPATION:	

PLEASE LIST SELF, SPOUSE, AND DEPENDENTS UNDER THE AGE OF 18.

NAME		Date of Birth	NAME		Date of Birth
SELF			DEPENDENT #3		
SPOUSE			DEPENDENT #4		
DEPENDENT #1			DEPENDENT #5		
DEPENDENT #2			DEPENDENT #6		

SOURCE	SELF	SPOUSE	OTHER	TOTAL
Gross wages, salaries, tips, etc.				
Social Security, Pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business, self employment, and dependents				
Rent, interest, dividend, and other income				
TOTAL INCOME				

Note: Include income from all related persons in household and income from all sources including gross wages, tips, social security, disability, pensions, annuities, Veteran's payments, net business or self employment, alimony, child support, military, unemployment, public aid, and other.

VERIFICATION CHECKLIST (Attach copies)	YES	NO
Identification/Address: Driver's License, Birth Certificate, Employment ID, Social Security Card, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance card(s)		
Medicaid: Application made or evidence of rejection		

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (Print): _____ Signature/Date: _____

OFFICE USE ONLY

Patient Name: _____ Discount: _____
Date of Service: _____ Approved by: _____

Patient Registration Form

Patient Income Form

Kedren Community Health Center is a federally qualified health center and is required to collect income information on all patients to report annually to the federal government. **This information will not be reported to anyone on an individual patient level basis; only in the sum total.**

If your income is at or below 200% of the federal poverty level ($24,276 annually or $2,023 per month) and you are uninsured or under-insured, you are eligible for our sliding fee discount program.

In addition, if your income is at or below 500% of the federal poverty level ($60,690 annually or $5,057.50 per month) you may be eligible for financial assistance with your premiums, copays, coinsurance, deductible and out-of-pocket maximum.

Your Enrollment Specialist will assist you with any additional paperwork required to apply for the above financial assistance programs.

	Please enter monthly income amount from all sources
Example	$1,050
If the income is under $2,023 per month, **enter amount in the box to the right**	
If monthly income is between $2,024 per month and $5,057.50, **enter amount in the box to the right**	
If monthly income exceeds $5,057.50, **do not enter an income amount but please check box to the right**	

Number of family members in the household_____

_____ _____

Signature of Patient/Legal Representative Date

HIPAA PATIENT CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain a patients' consent to disclosure health information about the patient to carry out treatment, payment, or health care operations.

As a patient Kedren Community Care Clinic, we want you to know that we respect the privacy of your personal health information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary-information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. This includes instances where you are a threat to yourself (suicide or homicide ideations) or instances of child or elder abuse. As part of this plan, we have implemented a Compliance Program that oversees the prevention of any inappropriate use of Personal Health Information. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), to request restrictions and revoke consent in writing.

Patient print name	Signature	Date

NOTICE PRIOR TO COMMENCING COLLECTION ACTIVITIES

Every initial statement of charges mailed to patients will include the following plain language summary of the patient's rights pursuant to AB 744, the Rosenthal Fair Debt Collection Practices Act and the federal Fair Debt Collection Practices Act (FDCPA): "State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgement." For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1(877) FTC-HELP (382-4357).

ii. **Describe how you widely publicize the FAP.**

Financial Assistance Policy (FAP)

ii. Describe how you widely publicized the FAP.

The report was made widely available to the public through the AB774 Charity and Care and Discount Payment and Policy which was posted on the OSHPD Website. It is also published through the Los Angeles County Department of Mental Health (LACDMH) through, Uniform Method of Determining Ability to Pay (UMDAP) and in the Integrated Behavioral Health Information System (IBHIS) as these Information elements are all required by LACDMH for health Care providers who are contracted with them for Health and Behavioral Health Care Services

This matter has been addressed and as of- will appear on the Organization's Website Kedren.org.

As stated earlier the content of Kedren Website was not finalized at the time and the currently revised Charity and Discount Payment Policy will appear on the organization Website as soon as there approved by the governing body.

All patients referred to Kedren Acute Inpatient Hospital are all indigent and receive treatment for various psychiatric disorders. As part of the L.A. County Department of Mental Health Safety Net Providers, The hospital is reimbursed by the LACDPH for all services provided to patients referred.

The Community Mental Health Center not only providers outpatient mental health Services to indigent referrals from the indigenous population, but also persons who are undocumented, clients who are on Medicaid, Medicare and commercial insurance.

Kedren has placed notices about the Discount Payment and Policy and Procedures in all areas accessible to patient, their families and members of the public.

3. Website where FAP was posted FAP was posted on the OSHPD Website under Charity Care and Discount Payment Policies. The Website has been used since 2016

4. Translated FAP documents including the FAP and the application Form

5. Notice Prior To Commencing Collection Activities

iii Describe how widely publicized the FAP.

Kedren provides patients with written notices containing information about availability of the hospitals Charity Care and Discount Payment Policy. Notices are clearly and conspicuously posted in locations that are visible to the public, such as the building and admissions office and other outpatient settings. Notices are provided in English and Spanish in a service area that has 43% Latino and 37% African American.

Website:https://syfphr.oshpd.ca.gov/searchdata.aspx&aid=8687&subtype=41&data=1
Kedren has been using this website since 2010.

iv. Plan language summary of the FAP. Also, describe the methodology used to ensure that any limited English proficiency (LEP) populations served by Kedren have access to these translated documents.

Kedren Community Health Center, Inc.

Health and Behavioral Health Care • Early Child Education • Housing • Employment

NOTICE TO PATIENTS

This practice serves all patients regardless of inability to pay. Discounts for essential services are offered depending upon family size and income.

You may apply for a discount at the front desk.

Thank you.

AVISO PARA PACIENTES

Los centros de salud ofrecen servicios de atención médica primaria y preventiva, sin considerar la capacidad de los pacientes para pagar. Los cargos generados por servicios de salud son calculados de acuerdo al nivel de ingreso del paciente.

Pacientes pueden aplicar para servicios médicos con la recepcionista en la clínica.

Gracias

For more information about our services, visit: www.kedren.org

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TARIFA DESCUENTADA / DESLIZANTE Y APLICACIÓN DEL PLAN DE ASISTENCIA FAMILIAR

La póliza de Kedren Community Health Center Inc es proporcionar servicios esenciales independientemente de la capacidad de pago del paciente. Se ofrecen descuentos dependiendo del ingreso y el tamaño de la familia. Complete la siguiente información y regrese a la recepción para determinar si usted o los miembros de su familia son elegibles para un descuento.

El descuento se aplicará a todos los servicios recibidos en el centro, pero no a los servicios que se compran desde el exterior, como pruebas de laboratorio de referencia, medicamentos, interpretación de rayos X por un radiólogo consultor y servicios similares. Con la esperanza de que su salud económica mejore, los descuentos se aplican solo a los servicios actuales, no futuros. Este formulario debe completarse para cada visita. Por favor, pregunte en la recepción si tiene preguntas.

* Número de personas relacionadas que viven en su hogar: ☐

NOMBRE DEL JEFE DEL HOGAR:			
APELLIDO	*NOMBRE*	*INICIAL*	
PLAN DE SEGURO DE SALUD:		SS#:	
DOMICILIO:	CITY:	ZIP:	
TELÉFONO DE CASA:	TELÉFONO MÓVIL:	TELÉFONO DEL TRABAJO	
EMPLEADOR:	OCUPACIÓN:		

LISTE POR FAVOR, EL ESPOSO Y LOS DEPENDIENTES MENORES DE 18 AÑOS.

NOMBRE		Fecha de Nacimiento	NOMBRE		Fecha de Nacimiento
YO			DEPENDIENTE #3		
ESPOSO/A			DEPENDIENTE #4		
DEPENDIENTE #1			DEPENDIENTE #5		
DEPENDIENTE #2			DEPENDIENTE #6		

FUENTE	YO	ESPOSO/A	OTRO	TOTAL
Ingresoss, salarios, propinas, etc.				
Seguro social, pensión, anualidad y beneficios para veteranos:				
Pensión alimenticia, manutención infantil, asignaciones familiares militares:				
Ingresos de negocios, trabajo por cuenta propia y dependientes:				
Renta, intereses, dividendos y otros ingresos				
INGRESO TOTAL				

Nota: Incluya los ingresos de todas las personas relacionadas en el hogar y los ingresos de todas las fuentes, incluidos los salarios brutos, propinas, seguridad social, discapacidad, pensiones, anualidades, pagos de veteranos, negocios netos o trabajo por cuenta propia, pensión alimenticia, manutención infantil, militar, desempleo, ayuda pública , y otra.

LISTA DE VERIFICACIÓN DE VERIFICACIÓN (Adjunte copias)	SI	NO
Identificación / dirección: licencia de conducir, certificado de nacimiento, identificación de empleo, tarjeta de seguro social u otro		
Ingresos: declaración de impuestos del año anterior, tres recibos de pago más recientes u otro		
Seguro: tarjeta (s) de seguro		
Medicaid: solicitud hecha o evidencia de rechazo		

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Certifico que el tamaño de la familia y la información de ingresos que se muestra arriba es correcta. Es posible que se requieran copias de las declaraciones de impuestos, recibos de pago y otra información que verifique los ingresos antes de aprobar un descuento.

Nombre (letra de imprenta):_____ Firma/Fecha: _____

USO DE OFICINA SOLAMENTEPatient

Nombre: _____ Descuento: _____
Fecha de Servicio: _____ Aprobado por: _____

Formulario de Registro de Pacientes

Formulario de Ingreso del Paciente

El Centro de Salud Comunitario Kedren es un centro de salud calificado a nivel federal y está obligado a recopilar información de ingresos sobre todos los pacientes para informar anualmente al gobierno federal. **Esta información no será reportada a nadie a nivel individual del paciente; sólo en la suma total.**

Si sus ingresos están en o por debajo del 200% del nivel federal de pobreza ($24,276 anuales o $2,023 por mes) y usted no está asegurado o está subasegurado, usted es elegible para nuestro programa de tarifa de descuento del pentagrama.

Además, si sus ingresos están en o por debajo del 500% del nivel federal de pobreza ($60,690 anuales o $5,057.50 por mes) usted puede ser elegible para asistencia financiera con sus primas, copagos, coseguro, deducible y máximo de su bolsillo.

Su especialista de inscripciones le ayudará con los trámites requeridos para solicitar los anteriores programas de asistencia financiera.

	Ingrese el monto de los ingresos mensuales de todas las fuentes
Ejemplo	$1,050
Si los ingresos son inferiores a $2,023 por mes, **ingrese el monto en la casilla a la derecha**	
Si el ingreso mensual está entre $2,024 por mes y $5,057.50, **ingrese el monto en la casilla a la derecha**	
Si los ingresos mensuales exceden los $5,057.50, no ingrese un monto de ingresos, **pero marque la casilla a la derecha**	

Número de miembros de la familia en el hogar _____

_____ _____

Firma de Paciente/ Representante Legal Fecha

AVISO ANTES DE COMENZAR LAS ACTIVIDADES DE COLECCIÓN

Cada declaración inicial de cargos enviada por correo a los pacientes incluirá el siguiente resumen en lenguaje sencillo de los derechos del paciente de conformidad con AB 744, la Ley de prácticas justas de cobro de deudas de Rosenthal y la Ley federal de prácticas justas de cobro de deudas (FDCPA): "Las leyes estatales y federales requieren deudas recaudadores para tratarlo de manera justa y prohibir a los recaudadores de deudas hacer declaraciones falsas o amenazas de violencia, usar lenguaje obsceno o profano, y hacer comunicaciones inadecuadas con terceros, incluido su empleador. Excepto en circunstancias inusuales, los cobradores de deudas no pueden contactarlo antes de las 8:00 a.m. o después de las 9:00 p.m. En general, un cobrador de deudas no puede brindar información sobre su deuda a otra persona, que no sea su abogado o cónyuge. Un cobrador de deudas puede contactar a otra persona para confirmar su ubicación o hacer cumplir un juicio." Para obtener más información sobre las actividades de cobro de deudas, puede comunicarse con la Comisión Federal de Comercio por teléfono al 1 (877) FTC-HELP (382-4357).

Policy#: 900	Policies & Procedures	Approved By: BOD 07/24/15, 6/30/17
Policy Title: Sliding Fee Policies and Procedures	**KEDREN Community Care Clinic**	Effective Date: 02/01/14
		Date Revised: 07/14/15
Distribution: All Staff		Manual: Administrative/Medical Office

Póliza:

Poner a disposición servicios de descuento para todas las personas y familias con ingresos anuales iguales o inferiores al 200 por ciento de las Pautas Federales de Pobreza (FPG). La política de Kedren Community Care Clinic (KCCC) es garantizar que a ningún paciente se le denegarán los servicios de atención médica debido a la incapacidad de un individuo para pagar dichos servicios. Para lograr este objetivo, KCCC ha desarrollado un Programa de tarifa variable (SFP, por sus siglas en inglés) de acuerdo con las pautas y requisitos del Aviso de información de políticas (PIN) de HRSA 2014-02.

Programa de tarifa variable:

KCCC ofrecerá a los pacientes sin seguro, incluidos aquellos pacientes con Medicare o cualquier seguro con o sin deducible un descuento de tarifa variable. El descuento de la tarifa variable se basará en los ingresos y el tamaño de la familia y no en otro factor. La definición de ingresos y tamaño de la familia se basará en las Directrices federales de pobreza (FPG) vigentes. Las Pautas Federales de Pobreza son una versión de los umbrales de ingresos utilizados por la Oficina del Censo de los EE. UU. Para estimar la cantidad de personas que viven en la pobreza. Las personas y familias con ingresos anuales superiores al doscientos por ciento (200%) del FPG no son elegibles para el programa de descuento de tarifa variable.

Federales de Pobreza, http://aspe.hhs.gov/poverty, se utilizan para crear y actualizar anualmente el programa de tarifas móviles (SFS) para determinar la elegibilidad (ver anexo).

Programa de descuento de tarifa variable (SFDS):

El FPG se actualizará anualmente (generalmente publicado en enero o principios de febrero en el Registro Federal) y se aprobará en la reunión de la Junta Directiva del próximo mes con una fecha de vigencia del mes posterior para dar tiempo a capacitar al personal y actualizar los sistemas. Consulte la escala de tarifas móviles adjunta del año en curso.

Notificación de descuento de tarifa variable:

KCCC notificará a los pacientes sobre el Programa de descuento de tarifa variable por todos estos medios:

1) Avisos / señalización en sala de espera y / o recepción y / o áreas de servicio;
2) Discusiones / notificaciones del personal;
3) KCCC publicó folletos para pacientes en el área de espera / recepción y / o áreas de servicios;
4) Materiales promocionales de la feria de salud; y
5) Como parte del proceso de registro de pacientes (evaluación de ingresos) a menos que el paciente rechace / se niegue a ser evaluado)

La comunicación a los pacientes se proporcionará en los niveles apropiados de lenguaje y alfabetización para la población de pacientes de KCCC (como mínimo en inglés y español).

Finalización de la solicitud:

El paciente / parte responsable debe completar la Solicitud de tarifa móvil y el formulario de incapacidad de pago, en su totalidad. El personal asistirá según sea necesario. Al firmar la Solicitud de tarifa variable, los pacientes autorizan a KCCC a confirmar los ingresos tal como se revela en el formulario de solicitud. Proporcionar información falsa en una Solicitud de tarifa variable dará como resultado la revocación de todos los descuentos del Programa de descuentos de tarifa variable y el saldo total de la (s) cuenta (s) restaurada y pagadera de inmediato.

Los pacientes de KCCC también completarán una Solicitud del Plan de Asistencia Familiar que es un documento de elegibilidad de ingresos que declara el tamaño y los ingresos de su familia para poder participar en el Programa de Descuento de Tarifa Deslizante. El tamaño de la familia se basa en el total de miembros del hogar.

Si una solicitud no se puede procesar debido a la necesidad de información adicional, el solicitante tiene dos semanas a partir de la fecha de notificación para proporcionar la información necesaria sin ajustar la fecha de la solicitud. Si un paciente no proporciona la información solicitada dentro del período de dos semanas, la solicitud se actualizará a la fecha en que se suministre la información solicitada. Si los pacientes no pagan en el momento del servicio después de tres intentos de cobro, el monto adeudado se cancelará, aunque cuando el paciente regrese a KCCC, la deuda se restablecerá. Si los pacientes no pagan al momento del servicio, después de tres intentos de cobrar, el monto adeudado se cancelará.

Según el tamaño de la familia y los ingresos, se notificará al paciente sobre la elegibilidad y la clasificación de descuento de tarifa variable (categoría de pago). La prueba es válida por un (1) año. El proceso de determinación de elegibilidad se llevará a cabo de manera eficiente, respetuosa y culturalmente apropiada para garantizar que los procedimientos administrativos de operación para la determinación no presenten una barrera para la atención.

Prueba de identificación:

Los siguientes elementos se pueden usar como prueba:

- Licencia de conducir
- Tarjeta de identificación
- pasaporte
- Cualquier otra forma de prueba de identificación aceptable

Elegibilidad:

Los descuentos se basarán únicamente en los ingresos y el tamaño de la familia. KCCC utiliza las definiciones de la Oficina del Censo de cada uno.

1) **Familia** se define como un grupo de dos personas o más (una de las cuales es la cabeza de familia) relacionadas por nacimiento, matrimonio o adopción y que residen juntas; Todas esas personas (incluidos los miembros de la subfamilia relacionados) se consideran miembros de una familia.

2) Los **ingresos** incluyen ganancias, compensación por desempleo, compensación de trabajadores, Seguridad Social, Seguridad de Ingreso Suplementario, asistencia pública, pagos de veteranos, beneficios de sobrevivientes, ingresos por pensión o jubilación, intereses, dividendos, alquileres, regalías, ingresos de propiedades, fideicomisos, educación asistencia, pensión alimenticia, manutención infantil, asistencia externa al hogar y otras fuentes misceláneas. Los beneficios no monetarios (como cupones de alimentos y subsidios de vivienda) **no cuentan**.

Verificación de ingresos:

Los solicitantes deben proporcionar uno de los siguientes: (a) año anterior W-2; (b) recibos de pago más recientes; (c) tarjeta postal de ingresos de la seguridad social; (d) carta del empleador; o (e) Formulario 4506-T (si no se presentó W-2). Los trabajadores independientes deberán presentar detalles de los últimos tres meses de ingresos y gastos para el negocio. La información adecuada debe estar disponible para determinar la elegibilidad para el programa. La **autodeclaración de ingresos** solo se puede utilizar en circunstancias especiales. Ejemplos específicos incluyen pacientes sin hogar. Los pacientes que no pueden proporcionar una verificación por escrito durante la visita inicial deben presentar una declaración de ingresos firmada y por qué no pueden proporcionar una verificación independiente. Sin embargo, se requiere comprobante de ingresos para visitas posteriores.

Los pacientes de la tercera edad que dependen de sus hijos para el mantenimiento y que son reclamados como dependientes de los impuestos sobre la renta de la familia serán colocados en un nivel de tarifa variable en función de los ingresos de sus hijos.

Plazo para la presentación de la prueba de ingresos:

Se requerirá que el paciente proporcione uno de los documentos requeridos enumerados anteriormente a más tardar treinta (30) días a partir de la fecha de la primera visita, o si ocurre una segunda visita, antes de los treinta (30) días a esa fecha. Si la documentación no se proporciona dentro de los treinta (30) días de la fecha de servicio, se considerará que el paciente es 100% auto-pago. No se harán excepciones a esto sin la aprobación por escrito del CEO o CFO, y se basarán caso por caso si las circunstancias del paciente no les permitieran cumplir con el requisito.

Algunos pacientes pueden optar por no proporcionar la información que el centro de salud requiere para evaluar los ingresos y el tamaño de la familia, incluso después de haber sido informados de que pueden calificar para un descuento de tarifa variable. KCCC considera que estos pacientes declinan la evaluación de elegibilidad para descuentos de tarifas móviles. Mientras KCCC haya seguido sus políticas y procedimientos y el paciente decida ser considerado para el SFDS, KCCC puede considerar que el paciente no es elegible para dichos descuentos.

Período de elegibilidad:

La elegibilidad del paciente será válida por un (1) año. El período de elegibilidad también se programa automáticamente en el sistema informático de KCCC una vez que se confirma la elegibilidad. El comprobante de ingresos y la aplicación se escanean y mantienen directamente en el sistema eClinicalWorks. Esto permitirá a la gerencia realizar revisiones de Seguro de Calidad (QI) para el cumplimiento y evaluar la efectividad del programa de tarifas móviles.

Servicios cubiertos:

El descuento de tarifa variable se aplicará a todos los servicios dentro del alcance del proyecto aprobado por KCCC, ya sea requerido o adicional para todas las ubicaciones de KCCC. KCCC tiene múltiples SFDS basados en servicios / modo de entrega (ver más abajo).

Horario de tarifas:

KCCC mantiene un programa de tarifas (maestro de cargos) para todos los pacientes y este programa de tarifas está diseñado para cubrir los costos razonables de proporcionar servicios en el alcance aprobado del proyecto utilizando una Unidad de Valor Relativo (RVU) y ajustando según sea necesario para mantener la coherencia con las tarifas locales vigentes (que es el 150% de las tarifas de Medicare publicadas). Esta tabla de tarifas es aprobada por la Junta Directiva y evaluada anualmente para garantizar que sea coherente con las tarifas vigentes localmente y la estructura de costos de KCCC. Consulte también la fórmula maestra del programa de tarifas / cargos en la política de facturación y cobros para obtener más detalles.

Estructura del programa de descuentos de tarifas variables (SFDS):

El Programa de descuentos de tarifas móviles está diseñado por KCCC de manera que se ajuste según la capacidad de pago. Para lograr esto, KCCC ha diseñado cuatro clases de pago de descuento por encima del 100% y por debajo del 200% del FPG. Solo se cobrará un cargo nominal a las personas y familias con ingresos anuales iguales o inferiores al 100% del FPG. Esta tarifa nominal es una cantidad fija y no refleja el valor real ni cubre los costos de los servicios, sino que se aplica para que los pacientes inviertan en su atención y para minimizar la posibilidad de una utilización inadecuada de los servicios. Este cargo nominal también es menor que la tarifa pagada por un paciente en la primera "clase de pago de descuento de tarifa variable" que comienza por encima del 100% del FPG.

Servicios médicos -----Clase----	A	B	C	D
Umbral de ingresos por tarifa móvil	<= 100% FPG	101%-133% FPG	134%-166% FPG	167%-200% FPG
Pago Nominal	$20.00			
% Cargos Pagados		25%	50%	75%
% Descuentos		75%	50%	25%
Ejemplo $ pagado por Visita (99213)	$20.00	$30.38	$60.75	$91.13

Los servicios médicos incluyen: códigos de evaluación y gestión, inyecciones (ver excepciones), procedimientos menores de oficina, pruebas de Papanicolaou y exámenes de senos, y algunas pruebas de laboratorio de CLIA exentas realizadas internamente por KCCC.

CLIA - Pruebas de laboratorio exentas y costos de medicamentos recetados - No incluidos en el cargo de visita al consultorio médico:

KCCC contrata servicios de laboratorio que no se realizan internamente (bajo su exención CLIA) con compañías de laboratorio de terceros. Estas pruebas se contratan a bajo costo / precio preferencial para los pacientes que califican para la tarifa móvil según el programa de tarifas móviles de KCCC. A los pacientes que califican bajo el programa de tarifas móviles de KCCC se les cobrará el costo directo de estas pruebas de laboratorio.

El SFSD anterior se aplica a todos los servicios que KCCC proporciona para los cuales hay cargos establecidos **, independientemente del tipo de servicio (requerido o adicional), o el modo de entrega (directamente o mediante contrato por el cual KCCC es financieramente responsable (Formulario 5A, Columnas I) & II). Para los servicios que no se brindan directamente, pero que KCCC tiene un acuerdo formal de referencia

por escrito (como se especifica en nuestro Formulario 5A, Columna III), es la política para garantizar que el acuerdo formal incluya el lenguaje de la entidad / proveedor que se deriva ofrece a nuestros pacientes un descuento de tarifa variable que se describe en los requisitos de criterios descritos en PIN 2014-02 en la página 12. Todos los acuerdos formales se modificarán para incluir dicho lenguaje y todos los nuevos acuerdos de referencia incluirán automáticamente el idioma para garantizar el cumplimiento. la organización también supervisará esto mediante una combinación de consultas de pacientes a medida que se realicen referencias y / o mediante una certificación anual por parte del proveedor de referencias. certificación –Apéndice A y B, respectivamente.

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Otras Consideraciones

** Los siguientes suministros / inyectables y equipos están excluidos y cobrados a los costos de KCCC ya que pueden considerarse optativos o relacionados con, pero no incluidos en el servicio en sí, como parte de los estándares de atención vigentes: cualquier servicio realizado en el hospital (excluye radiología de diagnóstico), cualquier inyectable fuera del estándar de atención, medicamentos recetados.

Los pacientes serán notificados de los cargos por separado antes de la entrega de dichos artículos y el monto total de los costos de bolsillo para estos suministros o equipos, y los planes de pago que están disponibles a través de KCCC u otro tercero.

Evaluación de la lista de tarifas móviles:

Este programa de descuento de tarifa variable se evalúa anualmente para garantizar que no sea una barrera para la atención del posible paciente. KCCC logra esto utilizando uno o más de estos métodos:

1) Reunirse con un grupo de usuarios de la Junta Directiva y discutir con los consumidores prospectivos los montos cobrados.
2) Evaluar el monto de la deuda pagada que KCCC tiene en comparación con la línea de base establecida, y si el monto ha aumentado significativamente, hacer un análisis adicional para determinar si este factor está causando una barrera para la atención debido a la incapacidad de pago de los pacientes.
3) Obtener comentarios del personal sobre sus observaciones sobre la efectividad de KCCC para abordar las barreras financieras para atender a los pacientes.
4) Realizar una encuesta de satisfacción del paciente al menos una vez al año.
5) Aportaciones de grupos enfocados en pacientes.
6) Revisión de quejas de pacientes.
7) Número de visitas de enfermería ***
8) Realizar pruebas ciegas o aleatorias del programa de tarifas móviles de los proveedores de referencia para garantizar el cumplimiento y determinar si existe una barrera para la atención de los pacientes de KCCC.

El (los) método (s) utilizado (s) para evaluar la efectividad del programa de tarifas móviles de KCCC desde la perspectiva de reducir las barreras financieras para el cuidado de los pacientes se compartirá con la Junta de Directores para ayudarlos a determinar adecuadamente la política de tarifas móviles de KCCC. Esto ocurrirá anualmente junto con la actualización del FPG.

*** No hay ningún cargo o un cargo nominal por visitas a enfermeras para garantizar que las finanzas no sean barreras para la atención.

Pacientes con cobertura de terceros que son elegibles para SFDS:

La póliza de tarifas móviles de KCCC se basa únicamente en los ingresos y el tamaño de la familia, por lo que puede haber pacientes con un seguro de terceros que no cubren, o solo cubren parcialmente, las tarifas de ciertos servicios de centros de salud que pueden ser elegibles para el programa de tarifas móviles de KCCC. En tales casos, sujeto a limitaciones potencialmente legales y contractuales, el cargo por cada clase de pago de SFDS es la cantidad máxima que un paciente elegible en esa clase de pago debe pagar por un determinado servicio, independientemente del estado del seguro.

Renuncia de cargos:

En ciertas situaciones, es posible que los pacientes no puedan pagar la tarifa nominal o de descuento. La exención de cargos solo se puede usar en circunstancias especiales y debe ser aprobada por el CEO, CFO de KCCC o su designado. Cualquier renuncia a los cargos debe documentarse en el archivo del paciente junto con una explicación (por ejemplo, capacidad de pago, buena voluntad, evento de promoción de la salud).

Aplicación de la póliza y capacitación del personal:

Estas pólizas y procedimientos se aplicarán de manera uniforme en toda la población de pacientes de KCCC y se capacitará al personal para ayudar con la implementación uniforme del proceso y los sistemas se actualizarán a medida que se actualice la política para ayudar con el cumplimiento y, como mínimo, el personal capacitado cuando contratado y cada vez que se actualiza la póliza.

Kedren Community Care Clinic

Escala de tarifa variable
2017

Consulte el Registro Federal 1/31/2017 *

Efectivoe: 9/1/2017

	A		B		C		D		Sin Descuento	
Personas en Familia/Hogar	<=100% FPG		101%-133%	FPG	134%-166%	FPG	167%-200%	FPG	201%>	FPG
1	$ -	$ 1,005	$ 1,006	$1,337	$1,338	$1,668	$1,669	$2,010	$2,011	+
2	$ -	$ 1,353	$ 1,354	$1,800	$1,801	$2,247	$2,248	$2,707	$2,708	+
3	$ -	$ 1,702	$ 1,703	$2,263	$2,264	$2,825	$2,826	$3,403	$3,404	+
4	$ -	$ 2,050	$ 2,051	$2,727	$2,728	$3,403	$3,404	$4,100	$4,101	+
5	$ -	$ 2,398	$ 2,399	$3,190	$3,191	$3,981	$3,982	$4,797	$4,798	+
6	$ -	$ 2,747	$ 2,748	$3,653	$3,654	$4,559	$4,560	$5,493	$5,494	+
7	$ -	$ 3,095	$ 3,096	$4,116	$4,117	$5,138	$5,139	$6,190	$6,191	+
8	$ -	$ 3,443	$ 3,444	$4,580	$4,581	$5,716	$5,717	$6,887	$6,888	+
Pago:										
Medical	$20.00		25%		50%		75%		100%	
	Carga Nominal		Programa de tarifas		Programa de tarifas		Programa de tarifas		Programa de tarifas	

Para familias / hogares con más de 8 personas, agregue $ 4,180 por cada persona adicional.

* Esto se actualiza anualmente con las pautas federales de pobreza más recientes publicadas en el Registro Federal y será aprobado por la Junta de Directores antes de su implementación. Por lo general, la fecha de entrada en vigencia será aproximadamente 30 días después de la aprobación de la junta o antes si la junta / administración elige para dar tiempo a la implementación adecuada y la capacitación del personal. Por lo general, la política entrará en vigencia el primer día de un nuevo mes.

Apéndice A

MUESTRA

Enmienda al acuerdo formal de referencia por escrito (es decir, Formulario 5A: Servicios prestados, Columna III dentro del alcance del proyecto aprobado por el gobierno federal)

El acuerdo con fecha 00/00/0000 entre XXXXXXX (Proveedor de referencia) y Kedren Community Care Clinic, (centro de salud FQHC), se modifica por la presente para garantizar el cumplimiento del Aviso de información de política (PIN) 2014-02 emitido por la Oficina de Salud Primaria Atención (BPHC) y acreditación y seguimiento de pacientes.

Tarifa Móvil

XXXXXXX (proveedor de referencia) es responsable de garantizar que los descuentos del proveedor de referencia para pacientes del centro de salud cumplan con los siguientes criterios:

La escala de descuento de tarifa variable (SFDS) debe cumplir con todos los criterios siguientes:

- Debe cumplir con los requisitos estructurales específicos descritos en este PIN 2014-02 (copia provista y adjunta como parte de esta enmienda).
- En los casos en que el centro de salud ha elegido establecer un cargo nominal para pacientes en o por debajo del 100 por ciento del FPG, este cargo cumple con los criterios para un cargo nominal. (Consulte la Sección VII.C, Establecimiento y cobro de cargos nominales).
- El acceso del paciente y la implementación uniforme se han tenido en cuenta al desarrollar cada SFDS.

El centro de salud FQHC y el proveedor de referencias tienen un plan para evaluar de manera rutinaria cada SFDS y presentar esta información a la junta para asegurarse de que no cree una barrera para la atención.

XXXXXXX (Proveedor de referencia) acuerda cumplir con los criterios y certificará anualmente al Centro de Atención Comunitaria de Kedren (centro de salud FQHC) que el programa de tarifa móvil que se ofrece cumple con PIN2014-02 y proporcionará una copia al centro de salud FQHC cada vez que se actualiza / cambia y, a pedido, Kedren Community Care Center (centro de salud FQHC). Ver Apéndice A adjunto.

El proveedor de referencias SFDS se asegurará de que

- Todos los pacientes de los centros de salud de FQHC en el 200 por ciento o menos del FPG reciben un descuento por estos servicios; y
- Los pacientes con o por debajo del 100 por ciento de la FPG no reciben ningún cargo o solo un cargo nominal que (consulte la Sección VII.C, Establecimiento y cobro de cargos nominales) por estos servicios.

Kedren Community Care Clinic (centro de salud FQHC) tiene el derecho de auditar al Proveedor de referencias y solicitar pruebas de cumplimiento en cualquier momento. Esto es necesario para que el centro de salud FQHC garantice el cumplimiento de los requisitos del programa BPHC y el PIN 2014-02.

Al firmar a continuación, XXXXXXX (Proveedor de referencias) reconoce que ha recibido una copia de SFDS y PIN 2014-02 de Kedren Community Care Clinic (centro de salud FQHC). Kedren Community Care Clinic (centro de salud FQHC) y cumplirán con el requisito de BPHC. Entienden los requisitos de acreditación y han recibido una copia de la política de seguimiento de pacientes de Kedren Community Care Clinic (centro de salud FQHC).

Kedren Community Care Clinic (centro de salud FQHC) proporcionará XXXXXXX (proveedor de referencia) y una copia actualizada de su SFDS cada vez que cambie (que debe ser como mínimo anualmente cuando se actualicen los FPG) y XXXXXXX (proveedor de referencia) también actualizará su SFDS en consecuencia.

Ambas partes acuerdan permitir la evaluación de rutina de cada SFDS y presentar esta información a la junta de Kedren Community Care Clinic (centro de salud FQHC) para garantizar que no cree una barrera para la atención. Esta evaluación puede ser realizada por cualquiera de las partes o por ambas y puede tomar varias formas diferentes. Por ejemplo, encuesta de pacientes o evaluación de grupo focalizado, evaluación de deudas incobrables, evaluación del porcentaje de cobro para estos pacientes, etc.

Credencialización

El proveedor de referencia certifica que él / ella (o los proveedores con licencia que trabajan del proveedor de referencia) están debidamente acreditados para realizar los servicios acordados y el proveedor de referencia notificará al centro de salud de FQHC) inmediatamente ante cualquier evento que afecte dichas credenciales. El proveedor de referencia también acepta proporcionar, previa solicitud por escrito, prueba de las credenciales adecuadas, al centro de salud FQHC.

Seguimiento de pacientes

El proveedor de referencia también acepta cooperar con el sistema de seguimiento de pacientes del Centro de salud FQHC (Políticas y procedimientos) para garantizar que la información del paciente se envíe al centro de salud FQHC a tiempo para garantizar una atención de alta calidad.

Proveedor de referencias

Firma: _____
Titulo: _____
Fecha: _____

FQHC health center

Signature: _____
Title: _____
Date: _____

Apéndice B

Muestra

CUMPLIMIENTO ANUAL
PROCESO DE DAR UN TÍTULO

XXXXXXX (Proveedor de referencias) por este medio certifica que cumplimos con los requisitos del PIN 2014-02 y que a ningún paciente al que Kedren Community Care Clinic (centro de salud FQHC) le haya denegado los servicios debido a su capacidad de pago y el SFDS se ha implementado de manera uniforme a todos los pacientes referidos

XXXXXXX (Proveedor de referencias) por la presente también proporciona una copia de nuestro SFDS más actual a la fecha a continuación y certifica que no se han realizado cambios en el SFDS desde la última certificación o fecha de modificación original.

XXXXXXX (proveedor de referencia) herby certifica que están debidamente acreditados para realizar los servicios contratados por los pacientes de la Clínica de Atención Comunitaria Kedren (centro de salud FQHC).

XXXXXXX (Proveedor de referencias) por este medio certifica que han remitido a los pacientes a la Clínica de Atención Comunitaria Kedren (centro de salud FQHC) y que han cumplido con la política y el procedimiento del sistema de seguimiento de referencias del centro de salud FQHC.

La firma a continuación certifica el cumplimiento.

Proveedor de referencias

Firma: _____
Titulo: _____
Fecha: _____

v. Plan language summary of the FAP. Also, describe the methodology used to ensure that any limited English proficiency (LEP) populations served by Kedren have access to these translated documents.

v. Describe the methodology used to ensure that any limited English proficiency populations served by Kedren have access to these translated documents.

As a safety net provider of the Los Angeles County Department of Mental Health (DMH), Kedren Acute Psychiatric Hospital and Community Mental Health Center has access to forms in various languages and use these forms from DMH to assist us with clients who are limited to English proficiency.