

Kedren Community Health Center, Inc.

**Community Health Needs Assessment
(CHNA) and Implementation Strategy**

2019 - 2021

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NEED

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 Guidelines (FPG).

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, and now serves over 4,000 unduplicated patients per year. Furthermore, Kedren currently has over 10,200 registered patients. The fact that Kedren's community care clinic has been able to acquire over 2,000 managed care enrollees during this relatively short time since becoming operational 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 considering that there are 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.

1) *Describe the proposed service area (consistent with Attachment 1: Service Area Map and Table)*

a) *The service area boundaries*

As illustrated in *Attachment 1: Service Area Map and Table*, Kedren's designated service area encompasses 19 zip codes within South Los Angeles, covering an area of 59.3 square miles. The service area zip codes are included in *Form 5B: Service Sites* with this application. 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.

b) ***If you are a competing continuation applicant: How you annually review and determine your service area based on where patients reside, as reported in the 2017 UDS and identified in the SAAT (e.g., service area zip codes listed on Form 5B represent those from which at least 75 percent of current patients reside)***

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 UDS Performance Report, confirming that the service area includes 82.1% of patient residences, which exceeds the 75% requirement. Additionally, this work facilitates the annual update of Kedren's Needs Assessment for both the current and proposed service populations, and was conducted prior to the submission of the Service Area Competition (SAC) application.

- 2) *Citing data sources and the frequency of assessments, describe the service area/target population and the current health care needs, specifically addressing items a-d below. This description must include the unique needs of each special population for which you are requesting funding*
- a) *Factors associated with access to care and health care utilization (e.g., geography, transportation, occupation, unemployment, income level, educational attainment, transient populations)*

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.¹ The urban cultural landscape reflects this distribution with retail products and services in many of the service area’s neighborhoods advertised only in Spanish.

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.

¹ U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates, Tables B05006 and B01003

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 (per patient feedback). 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 has 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, Kedren patients who have, or are experiencing, unstable housing may at times end up in the park as a temporary home. Thus, compassionate care, such as the programs and services provided at Kedren, is of the utmost 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, as indicated on *Form 4: Community Characteristics*. 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.

b) Most significant causes of morbidity and mortality (e.g., diabetes, cardiovascular disease, cancer, low birth weight, mental health and/or substance abuse)

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.

According to Kedren’s 2017 UDS Report, more than one-third (38.3%) of all visits were provided to patients who had a diagnosis of hypertension and/or diabetes. Many had multiple, conditions. Consequently, the providers we have at Kedren are those with an understanding of patients with co-morbidities and the social determinants of health that often accompany those conditions. Moreover, services to patients with the following chronic disease diagnosis included:

Kedren Patient Diagnosis	# Patients in 2017	# Patient Visits in 2017
Hypertension	864	2,700
Diabetes Mellitus	684	2,504
Asthma	192	344
Hepatitis C	111	312
Heart Disease	43	115
Chronic Bronchitis	54	92
HIV	19	58

Source: 2017 UDS Report – Table 6A: Selected Diagnoses and Services Rendered

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.

c) 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 who 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.

In 2017, services to patients with the following behavioral health diagnosis were provided.

Kedren Patient Diagnosis	# Patients in 2017	# Patient Visits in 2017
Tobacco Use Disorder	1,522	4,053
Depression/Mood Disorder	1,589	1,689
Anxiety Disorders	213	248
Other Mental Disorders	784	857
Alcohol Related Disorders	33	38
Other Substance Use Disorder	253	264

Source: 2017 UDS Report – Table 6A: Selected Diagnosis and Services Rendered

According to a special report created through Kedren’s Electronic Health Record (EHR) system, eClinicalWorks, a total of 788 patients received services at both Kedren’s primary care clinic (FQHC) and through its behavioral health program(s) in 2017. While Kedren continues to identify opportunities to integrate services across primary and behavioral health care, we anticipate this number to increase over the next few years.

- d) *Unique health care needs or characteristics that impact health, access to care, or health care utilization (e.g., social factors, environmental factors, occupational factors, cultural/ethnic factors, language needs, housing status)*

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. As noted on *Form 4: Community Characteristics*, 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.² The following table details the ethnic and racial composition of the service area population.

² U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates, Tables B05006 and B01003

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.

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.”³ 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.

³ 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.

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).⁴ 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.

⁴ <https://lasentinel.net/thousands-of-prison-inmates-are-being-released-into-local-communities.html>

Implementation Strategy

Service Delivery Sites

1) *Describe how you will ensure access to all required and additional services (consistent with Form 5A: Services Provided) and other activities, as applicable, (consistent with Form 5C: Other Activities/Locations) to meet the identified needs, including:*

a) *The method of provision of services (as indicated on Form 5A: Services Provided).*

Kedren's compassionate, culturally responsive service delivery model is designed to address the health problems and disparities of our target populations across their lifecycle. Kedren'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 a way that conveys to patients that staff are non-judgmental and are understanding of their healthcare needs. Providers are trained in both cultural competency and motivational interviewing in order to ensure cultural responsiveness. Furthermore, our providers are well-versed in the latest chronic disease care guidelines and one provider is also an obesity specialist, which is critical in that there are high rates of diabetes in our service area. 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 hypertension. These and other health issues in the service area are addressed by Kedren through the provision of family-oriented, evidence-based primary health care services.

As indicated in *Form 5A: Services Provided*, Kedren provides all of the *Required Services* either either directly or through referral, which together comprise a comprehensive primary health care system. *Diagnostic Laboratory* services are provided via contract with Quest Clinical Laboratory and Labcorp, Kedren staff collect specimens and send them to the laboratory for analysis. Pharmacy services are provided via contract with Prime Pharmacy Services, Inc., a licensed pharmacy on Kedren's campus. *Diagnostic Radiology* is provided through a contract with Broadway Radiology. Prenatal, and Obstetrical/Intrapartum Care are provided by California Hospital Medical Center (CHMC) hospitalists, as well as through a formal Memorandum of Understanding (MOU) with AllSafe Obstetrics and Gynecology. Finally, Kedren provides Preventive Dental Services via an arrangement with Los Angeles County Health Department, Dr. David Frederick, DDS, and Western Dental, all who provide sliding fee schedules.

Kedren refers patients to providers that treat and bill Medi-Cal (Medicaid) and offer a sliding fee discount schedule to those with incomes under the 200% FPG. Kedren has several written agreements with allied services providers that will accept referrals for specialty care services, such as those listed above, while Kedren's mental health program accepts referrals for behavioral health issues. Additional non-clinical services, such as benefits establishment, are provided by Kedren and several of its community-based partners. Furthermore, a significant percentage of the uninsured patient referrals made by Kedren providers are to County facilities. These Los Angeles County facilities do not enter into written affiliation and/or referral agreements with FQHCs. There are, however, written transfer agreements with key hospitals.

Kedren is organized as multi-specialty, as opposed to a family practice model for physician services, which affords the opportunity for Kedren to expand the range of services offered. This allows Kedren to provide a broader array of services and limits the number of referrals that are required. This method maximizes patient retention, and ensures that Kedren continues to address a broad array of patient care needs. Kedren's spectrum of services is comprehensive and includes primary and behavioral health care services that are most needed by the target population. Kedren offers a model of care that has primary medical services augmented with selected specialty care, and enabling services. Inpatient and outpatient behavioral health services are provided via Kedren's Acute Psychiatric Hospital and Mental Health Center, which is on the same campus as Kedren Community Health Center, Inc., affording patients the convenience of an exceptionally comprehensive service delivery site.

Kedren's Board of Directors also reviews the service delivery plan annually, taking into account the annual update of the health center's Needs Assessment, to determine which, if any, additional health services to offer in order to meet the health needs of the service area population.

b) How services provided through contractual agreements (Form 5A: Services Provided, Column II) will be documented in the patient's health center record and how the health center will pay for the services.

Kedren staff document patient visits by contracted providers by recording the visit in the patient's electronic health record, which becomes part of our annual UDS year-end report, as appropriate. Kedren is accountable for paying and/or billing for the direct care provided via a contractual agreement in place with third parties (*Column II*). All Kedren contracts/agreements shown in on *Form 5A: Services Provided, Column II* include language ensuring that patient fees are based on Kedren's sliding fee discount schedule. Moreover, the contracts state that all consult reports are required from all referral specialists and discharge information from referral hospitals. This information is required in order for Kedren to bill for the services. The contracts also outline that fees are paid to the contractor only when appropriate documentation and signatories are provided by the provider.

Moreover, a significant percentage of the uninsured patient referrals made by Kedren providers are to Los Angeles County (Health Department) facilities. These Los Angeles County facilities do not enter into written affiliation and/or referral agreements with FQHCs. There are, however, written transfer agreements with key hospitals (see *Collaboration Section*).

c) How services provided through referral arrangements (Form 5A: Services Provided, Column III) will be managed, and the process for tracking and referring patients back to the health center for appropriate follow-up care.

Services provided by a formal written referral arrangement (*Column III*) are rendered by the referring entity (the referral provider); however, Kedren maintains responsibility for the establishment of the referral arrangement(s) for Kedren patients and follow-up care subsequent to

the referral. Kedren ensures that there is a seamless communication process between the health center and the referral agency to ensure comprehensive, wrap-around services to Kedren patients. All Kedren Memoranda of Understandings (MOUs) include language that states all the referring entity is responsible for ensuring that the use a sliding fee discount schedule for all patients with incomes at or below 200% of the FPG. As illustrated above, the MOUs include language that states consult reports are required for all patients who were referred for specialty services, so Kedren staff can properly track the information in eCW and follow-up, as appropriate.

Furthermore, Kedren maintains four (4) agreements with Independent Practice Associations (IPAs), with which approximately 2,000 enrollees are assigned to Kedren. Each of these IPAs maintains a network of specialists and referral hospitals that can be accessed by this enrolled population most of who are Medicaid Managed Care enrollees. Kedren providers are familiar with these referral sources and regularly receive information on referred patients. This organized system of care works very well for a significant number of Kedren patients. The organized system of care includes excellent specialty referral resources and systems for tracking patients who are referred for specialty care. Consult forms are routinely received for referrals within these systems.

d) How you make arrangements and provide resources that address health care access and utilization barriers (e.g., transportation, transience, unemployment, income level, educational attainment) and other factors that impact health status (e.g., social factors, the physical environment, cultural/ethnic factors, housing status). Additionally, describe such services for any targeted special populations.

Kedren's service delivery model continues to be based on meeting the specific healthcare needs of South Los Angeles, which includes residents of disadvantaged communities with many barriers to accessing services. Kedren's 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.

Kedren routinely participates in collaborative outreach activities through a range of programs and services established by Kedren. The health center benefits from a comprehensive list of community-based collaborative and organizational activities, which further its reach into the community. Examples include the provision of health care services for low-income residents in supportive housing and a team approach to substance use services through co-location at the Amity Foundation, a residential and outpatient substance use provider. An extensive summary of collaborative relationships is in the *Collaboration Section* of this application. Furthermore, Kedren staff also maintain, and regularly update, a list of community agencies that can assist patients with housing, linguistic skills, and other enabling services with which Kedren patients can be referred,

Kedren 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 outreach coordinators who provide education and awareness workshops at the clinic for area residents. We anticipate expanding these services to include chronic disease clinics (focused on for example, diabetes) to help the patient identify ways to be more involved in their care. Furthermore, while Kedren sites are located near a bus stop, tokens for subsidized (free) transportation are offered to those in need.

e) If HCH funding is requested: Document how substance abuse services will be made available (consistent with Form 5A: Services Provided).

Not applicable.

Primary Care Services

2) Describe the proposed service delivery sites (consistent with Form 5B: Service Sites) and how the sites assure availability, prompt accessibility, and continuity of services (consistent with Forms 5A: Services Provided and 5C: Other Activities/Locations) within the proposed service area relative to where the target population lives and works (e.g., areas immediately accessible to public housing for health centers targeting public housing residents). Specifically address:

Kedren's main campus has a community garden, as well as ample visitor parking and three buildings (two of which are for the clinic). The largest building on campus consists of adult/children outpatient and inpatient mental health services, including a wellness department. These are services that Kedren provides ensuring continuity of care across services, and fully integrating primary care with behavioral health. The main primary care sites are two contiguous modular buildings on the eastern edge of Kedren's campus. The modular buildings are approximately 12-feet apart and have the same street address. These facilities described below as Suite A and Suite B essentially function as a single primary care site as all systems are identical and integrated. As illustrated previously, Kedren is located along major transit and bus routes, with bus stops located near all sites. Free transportation tokens are provided to patients in need in order to access services. We are also not far from other social service organizations, including Homeless Outreach Program Integration Care System and Hope Food Center. Furthermore, Kedren is located close to many providers with which we refer to, including as radiology, podiatry, and cardiology, so that patients have fewer barriers to accessing a continuity of care.

Kedren's care management model is accountable for meeting the 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 model that Kedren utilizes 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. Kedren coordinates care across all elements of the broader health care system including specialty care, hospitals, home health care, and community services and supports. The

health center 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 access. Kedren staff demonstrate 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.

a) Access barriers (i.e., barriers resulting from the area's physical characteristics, residential patterns, or economic and social groupings).

Transportation barriers include residents having adequate access to vehicles. According to the 2012-2016 American Community Survey 5-Year Estimates, 20% of service area residents do not own a vehicle. Moreover, more than one-quarter (30.8%) of total households have a vehicle shortage. While Kedren is located near major transit ways, there is heavy traffic congestion, and some patients are required to take two to three buses in order to access services at Kedren. Knowing this, Kedren provides free transportation tokens to those in need to ensure that all patients have access to services.

In addition, as stated in the Needs Section of this application, a disproportionately high number of service area residents (38.4%) are not in the labor force. Moreover, nearly one in 10 (11.7%) service area residents are unemployed, which is greater than LA County (8.9%) and the State (8.7%). Nearly one-half (45.6%) of patients have income that falls below 138% of the FPG. These factors make a resident less likely to have a regular source of income and health insurance. Kedren addresses these barriers by providing services to all patients, regardless of their ability to pay. Further, we help enroll patients into Covered California or My Health LA. While this holds true, Kedren has the best possible sites to serve the intended target patient population.

b) Distance and duration for patients to travel to or between service sites to access the full range of services proposed (consistent with Form 5A: Services Provided).

Kedren's sites, Suite A, and B, are located next door to each other, and on the same campus as Kedren's Acute Psychiatric Hospital and Community Mental Health Center. The distance between Suite A and B, and the Amity site are 1.4 miles away (five-minute car ride, or 16 minutes by bus).

Should a service or patient wait time be less at one of Kedren's facilities, transportation vouchers are available for patients to access the other site for more timely services. Kedren strives to always have referrals for other services available within a reasonable distance of the health clinic so patients do not have to travel far to access specialty care services.

c) How the total number and type (e.g., fixed site, mobile van, school-based clinic), hours of operation, and location (e.g., proximity to public housing) of service delivery sites facilitate scheduling appointments and accessing services.

To meet the identified needs of our service area population, Kedren has three service delivery sites.

Kedren Community Care Clinic (Suite A) – 4211 Avalon Blvd, Suite A, Los Angeles, CA 90011. This is Kedren’s main site, located on the same campus as Kedren’s Acute Psychiatric Hospital and Community Mental Health Center.

Community Care Clinic (Suite B) – 4211 Avalon Blvd. Suite B, Los Angeles, CA 90011. This site is located adjacent to Kedren’s main site, and is on the same campus as Kedren’s Acute Psychiatric Hospital and Community Mental Health Center.

Kedren Community Health / Amity – 3745 S. Grand Avenue, Suite KA 102, Los Angeles, CA 90007. This site is through a partnership with Amity Foundation, a substance use disorder treatment program in Los Angeles. Kedren providers offer an array of general primary care services onsite via one (1) exam room and one (1) triage room. While many patients who access services at this location are receiving substance use disorder services at Amity, the site is open to the public.

All three sites are located in South Los Angeles, and are open to the public January through December. Each site is handicap accessible, and furthermore, in 2017, Kedren received a grant from LA Care Health Plan to purchase three (3) ADA-compliant, adjustable exam tables with integrated accessible scales for patients who are wheel-chair bound, as well as four (4) listening devices with ear covers for patients who are hard of hearing. This affords Kedren the ability to properly accommodate patients with physical limitations, and/or hearing or literacy limitations.

To best assure that services are available and accessible at times that meet the needs of the population, Kedren is open Monday through Friday, including evening hours. Our site hours are:

	4211 Avalon Blvd, Suite A	4211 Avalon Blvd, Suite B	3745 S. Grand Avenue, Suite KA 102
Monday	8:00 am to 5:00 pm	8:00 am to 5:00 pm	Closed
Tuesday	8:00 am to 8:00 pm	8:00 am to 5:00 pm	8:00 am to 5:00 pm
Wednesday	8:00 am to 5:00 pm	8:00 am to 5:00 pm	Closed
Thursday	8:00 am to 5:00 pm	8:00 am to 12:00 pm	Closed
Friday	8:00 am to 5:00 pm	Closed	Closed
Saturday	Closed	Closed	Closed
Sunday	Closed	Closed	Closed

Emergency Response

3) *Describe how you will promptly respond to patient medical emergencies during and after regularly scheduled hours, including:*

During the health center’s regularly scheduled hours, Kedren staff are properly trained to handle emergencies. Front office staff ensure that each provider has availability during the day to take same-day appointments and walk-in patients, should an urgency arise and a patient needs to be

seen during the same business day. Kedren also has a policy and procedure protocol approved by the board on an annual basis which outlines the steps for handling medical emergencies onsite during regular hours, which includes triaging the patient, a provider observing the patient and if necessary calling an ambulance and alerting the hospital that the patient is en-route. Staff are also trained on these operating procedures and life support skills.

When Kedren is closed, professional medical after-hours coverage is offered through on-call provider rotation. When a patient call comes in after hours, the call is answered by the 24-hour answering service and the on-call provider is contacted. The provider handles the call according to standard medical protocols and procedures and decides on the best response, and if necessary, refers to immediate emergency medical attention. This type of flexibility ensures that Kedren patients 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 provider 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.

- a) *How you ensure that at least one staff member certified in basic life support skills is present at each service delivery site (consistent with Form 5B: Service Sites) during regularly scheduled hours of operation.*

Kedren has on staff at all times a minimum of one staff member certified in basic life support skills at each service delivery site. Furthermore, every staff member is mandated to take CPR training every two years.

- b) *How you ensure after-hours coverage that:*
- *Is provided via telephone or face-to-face by an individual with the qualifications and training necessary to exercise professional judgment in assessing the need for emergency care.*
 - *Includes the ability to refer patients either to a licensed independent practitioner for further consultation or to locations, such as emergency rooms or urgent care facilities, for further assessment or immediate care, as needed.*

Kedren maintains 24-hour coverage and access for its patients. Access is organized around in-clinic availability and after-hours coverage (evenings, weekend, and holidays), through direct access to providers via the on-call provider panel. When patients call the clinic offices after hours, the answering service picks up the call and immediately notifies the provider on call. The provider on-call responds to the caller within 30 minutes and documents each call in the patient's medical record, including the chief complaint, instructions provided, whether or not a health center appointment was made, prescriptions ordered, and a follow-up plan. In the case of a life-threatening or other acute condition, patients are instructed to dial 911 or go to a nearby emergency room.

For those with Medi-Cal, Medicare, or private insurance, Kedren's primary care physicians currently maintain "refer and follow" privileges at California Hospital Medical Center (CHMC), which is 2.8 miles (11 minutes) away from Kedren's main site, and 2.2 miles (8 minutes) away from the Amity site. Patients are also referred to Los Angeles County's system of three public acute care hospitals: Los Angeles County + USC Healthcare Network, which is 6.5 (15 minutes) and 7.7 (14 minutes) miles away from Kedren's three sites; Harbor-UCLA Medical Center, 13.4 and 13.2 away from Kedren's clinics, and Olive View-UCLA Medical Center, 34.3 and 32.8 miles from the health center's clinics.

- c) *How patients are informed of after-hours coverage, including those with limited English proficiency (i.e., language(s), literacy levels, and formats of materials/messages).*

As patients are first established at Kedren, they are informed of the health center's after-hours procedures as described above, and provided with both the agency's and local hospital's telephone number on an information card, along with other helpful patient services information. In addition, a sign is posted at each health center's entrance for any patients that may arrive after hours, indicating the clinic phone number, directions to the nearest hospital, and instructions for dialing 911 in case of an emergency. We also have *Welcome Patient Packets* that are shared with new patients which provides the after-hours coverage information to patients. All posted signs, and informational handouts are provided in English and Spanish.

Furthermore, to better serve our Hispanic/Latino community, Spanish/English speaking staff members are actively recruited for each area of health center operations, and local residents are hired whenever possible. More than 75% of the clinic staff live within our service area. In addition, Kedren strives to assist its patients with practical arrangements for additional and supporting services in a linguistically appropriate manner, including transportation, translation, referrals for primary and specialty care, medication management, and assistance with understanding and adhering to provider-recommended care plans.

Continuity of Care

4) *Describe how you address the following related to continuity of care:*

- a) *Hospital admitting privileges, such as provider(s) with admitting privileges at one or more hospitals and/or formal arrangements with one or more hospitals or entities (e.g., hospitalists, obstetrics hospitalist practices).*

Kedren has adopted a primary care medical home model that fits the needs of its target population and establishes systems in place to ensure continuity of care. Kedren continues to maintain a transfer agreement with California Hospital Medical Center (CHMC), a full-service hospital that address all in-patient and ER needs. Kedren's family physicians, Dr. Gill, and Dr. Jones, have privileges at CHMC and hospitalists also treat our admitted patients. We receive discharge summaries from CHMC via a secure online portal, which are scanned into patients' electronic health record by Kedren's front office staff and sent to the primary care provider to review and

sign. We also receive a secure e-mail daily that lists the patients who were discharged from the hospital and the ED. Front office staff will call these patients within one (1) day post discharge to schedule follow-up appointments as per our clinical protocols within seven (7) business days. The provider ensures continuity of care and appropriate follow-up by working collaboratively with the hospitalist and discussing further management of the patient's condition, as needed.

For expecting mothers, Kedren staff work closely with OB hospitalists who handle the labor and delivery at California Hospital Medical Center (CHMC). Through this collaborative partnership, Kedren staff ensure patient discharge summaries are documented in the patient's medical record. Similarly, front office staff follow-up with the patient post-discharge, and schedule a follow-up appointment with their provider within seven (7) business days.

As referenced above, inpatient care for medically indigent patients is also 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). Some hospitals have transitioned to a hospitalist model, and referring Kedren providers work closely with the assigned hospitalist. Between the County hospitals, all inpatient and ER needs of uninsured patients can be met that cannot be addressed by CHMC.

Continuity of care is of utmost importance to Kedren. Planning for appropriate continuity of care allows Kedren and its network of specialty care providers to minimize resource and service duplication, while facilitating a seamless care among multiple providers and facilities. Through Kedren'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) Health center receipt and recording of medical information from non-health center providers/entities for patients who are hospitalized or visit a hospital's emergency department (e.g., hospital or emergency department discharge follow-up instructions; laboratory, radiology, or other results).*

Kedren staff closely follows the care of its hospitalized patients and maintains open communication with specialists and hospital staff. As demonstrated above, Kedren has designated referral staff that work directly with patients, clinicians, and specialists to ensure a seamless system of care when patients require services outside the range of our health center. Through the various consultation portals for specialty care, Kedren's staff can access consultation notes upon their completion. For example, laboratory results are electronically sent to Kedren providers and entered into eCW. Kedren's contracts and MOUs have language that states the referral provider agrees to cooperate with Kedren's patient tracking system; ensuring patient consult reports are provided back to the health center in a timely manner to ensure high quality of care.

- c) Health center staff follow-up, when appropriate, for patients who are hospitalized or visit a hospital's emergency department.*

Regarding discharge planning and patient tracking, inpatients are followed by a Kedren provider, who reports in the patient's medical record the anticipated discharge date, and anticipated aftercare needs. Kedren staff coordinate with the hospital discharge planner to arrange for the transition from discharge to resumption of timely and necessary ambulatory care. Patient discharge information is shared with Kedren and entered into the patient's medical record. As the patient service information is received and recorded, any necessary follow-up actions are identified and initiated.

With the new Chief Medical Officer (CMO) of Primary Care on board, Kedren is in the process of creating a weekly "Discharge Clinic" for any patients who have been recently discharged from the hospital in order to conduct medication reconciliation and confirm appropriate consultation appointments. Furthermore, this will include the opportunity for the provider to order necessary labs and provide diagnostic imaging, if needed.

Sliding Fee Discount Schedule Components

5) Describe the sliding fee discount program (consistent with Attachment 10: Sliding Fee Discount Schedule). Specifically address how:

a) Define income and family size.

A review of individual or family income is conducted once each year, and updated at each visit to determine eligibility for the sliding fee discount schedule. 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 dependents of the head of household or spouse.

b) Assess the eligibility of all patients for sliding fee discounts based only on income and family size.

Kedren's Board of Directors has established policies and procedures, which are reviewed annually, 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. The result is an organized system of eligibility determination for the sliding fee discount schedule with which all applicable staff are trained. Kedren is committed to ensuring that no patient is denied service based on an inability to pay.

c) Apply sliding fee discounts to all required and additional services (Form 5A: Services Provided).

To honor the mission of Kedren 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 (required and additional) listed on *Form 5A: Services Provided*. The Sliding Fee Discount Schedule (Attachment 10), provides discounts for persons with demonstrated incomes below 200% of current FPG, and available for a nominal fee (\$20) to patients with incomes below 100% of FPG. Persons with incomes above 200% of the current FPG are expected to pay full fees as determined by the Kedren's charge schedule, which is based on the cost of providing care. Prevailing rates and charges for care by other primary care providers in the service area are also used in the development and updates of the sliding fee discount schedule.

For those services that are not directly provided, Kedren will refer patients to providers who treat and bill Medi-Cal and/or offer a sliding fee scale to those with incomes under the 200% FPG. Kedren has several written agreements with allied services providers that will accept referrals for specialty healthcare services, while Kedren's mental health program accepts referrals for behavioral health issues. Additional non-clinical services, which are provided by Kedren and several of its community-based partners, have equally adopted a sliding fee schedule (see *Collaboration Section*).

d) Determine the number and income ranges of sliding fee discount pay classes.

As is congruent with the sliding fee schedule, Kedren 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 four pay classes: Class A is 100% or below, Class B is 101% to 133%, Class C is 134% to 166%, and Class D is 167% to 200%. No discounts are available for patients with incomes above 200% of the FPG. With a graduated fee schedule, every effort is made to ensure access to affordable health care for all residents of the service area.

e) Establish a nominal charge, if applicable, for patients at or below 100 percent of the Federal Poverty Guidelines (FPG), available at <https://aspe.hhs.gov/poverty-guidelines>.

Note: The nominal fee must be a flat charge considered nominal from the perspective of the patient. It cannot reflect the actual cost of the service provided.

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. While Kedren's nominal fee is \$20, no patient will be denied services based on their ability to pay.

f) Inform patients of the availability of sliding fee discounts (e.g., language and literacy-level appropriate materials, intake process, health center's website).

The availability of discounted services is posted in Kedren'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 and English, with basic and easy to read format. Receptionists are responsible for ensuring that all patients are aware of the discounts available and ensuring that signage remains visible, and that organizational brochures that include information about services and the fee structure are always available.

- g) Evaluate the sliding fee discount program to ensure its effectiveness in reducing 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 CFO and utilization of Electronic Health Record system dashboard updates. Kedren also considers feedback from patients on the effectiveness of the sliding fee schedule to reduce financial barriers to care. Payment questions are included on the distributed patient satisfaction survey. In its latest report (May 2018), 83.7% of patients who responded reported that what they pay is "good" to "great."

- 6) In Attachment 10: Sliding Fee Discount Schedule, document how the Sliding Fee Discount Schedule(s) (SFDS) is structured to provide:*

- a) A full discount for individuals and families with annual incomes at or below 100 percent of the current FPG, unless there is a nominal charge. If there is a nominal charge, it is a flat fee and less than the fee paid by a patient in the first sliding fee discount pay class above 100 percent of the FPG.*

As demonstrated above, and illustrated in *Attachment 10: Sliding Fee Discount Schedule*, the sliding fee scale for primary medical care incorporates a nominal fee of \$20 for patients who earn at or below 100% of the FPG. While Kedren's nominal fee is \$20, no patient will be denied services based on their ability to pay.

- b) Partial discounts for individuals and families with incomes above 100 percent of the FPG, and at or below 200 percent of the FPG, that adjusts in accordance with income using a minimum of three discount pay classes.*

For primary medical care, patients pay 25% of the cost for services if they earn between 101% and 133% of the FPG, 50% of the cost for services if they earn between 134% and 166% of the FPG, and 75% of the cost for services if they earn between 167% and 200% of the FPG. No discount is given to patients above 200% of the FPG. See *Attachment 10: Sliding Fee Discount Schedule*.

- c) *No discounts to individuals and families with annual incomes above 200 percent of the FPG.*

As illustrated in Attachment 10: Sliding Fee Discount Schedule, no discount is given to patients above 200% of the FPG.

- d) *Discounts based on the most current FPG.*

Kedren's Board of Directors evaluates and updates the policies and procedures supporting the sliding fee discount schedule annually following the Federal Register's release of the updated FPGs.

Unduplicated Patient Commitment

- 7) *Describe the unduplicated patient commitment (number of patients projected to be served in 2020 as documented on Form 1A: General Information Worksheet), including how it was determined and how it is achievable given any recent or anticipated changes in the local health care landscape, organizational structure, and/or workforce capacity.*

As shown on *Form 1A: General Information Worksheet*, Kedren projects to serve 4,700 unduplicated patients in the year ending on December 31, 2020. This is equal to the patient target number listed in the Service Area Announcement Table (SAAT).⁵ Kedren's visit-to-patient ratio is 3.06 (14,370 visits per 4,700 unique patients). Kedren continues to increase staffing in order to meet the needs of our target population, and we are on track to achieving our patient target. In addition, with the continued uncertainty of – and proposed changes to – the Affordable Care Act, Kedren anticipates the demand for low-cost/no-cost services to increase, and more patients to need quality health care services in our service area.

Only new and competing supplement applicants should address items 8 and 9 below.

- 8) *Upload a detailed operational plan to Attachment 12: Operational Plan (see Appendix C). The plan must include reasonable and time-framed activities which assure that, within 120 days of receipt of the NoA, all proposed sites noted on Form 5B: Service Sites will have the necessary staff and providers in place to begin operating and delivering services as described on Forms 5A: Services Provided and 5C: Other Activities/Locations.*

Not applicable.

⁵ HRSA. 2018. "FY 2019 SAC Service Area Announcement Table." Retrieved from <https://bphc.hrsa.gov/sac/default.aspx>.

9) *Describe plans to:*

- a) *Hire, contract, and/or establish formal written referral arrangements with all providers (consistent with Forms 2: Staffing Profile, 5A: Services Provided and 8: Health Center Agreements, and Attachment 7: Summary of Contracts and Agreements) and begin providing services at all sites for the stated number of hours (consistent with Form 5B: Service Sites) within 1 year of receipt the NoA.*

Not applicable.

- b) *Minimize potential disruption for patients served by the current award recipient (as noted in the SAAT) that may result from transition of the award to a new recipient.*

Not applicable.

COLLABORATION

Coordination and Collaboration

- 1) *Describe efforts to coordinate and integrate activities with other providers (consistent with Attachment 1: Service Area Map and Table) and programs in the service area, including those that serve targeted special populations, to support:*

Continuity of care across community providers.

Kedren has a long history of working with other community clinics and health centers, many of which are FQHCs, as well as other health and human services agencies in the service area. Several have come to rely on Kedren as a resource for mental health and substance abuse services for their patients. Moreover, Kedren is always seeking new partnerships within and adjacent to the service area. The 59.4 square mile service area is notably medically underserved, with 79.8% designated as a Medically Underserved Area (MUA). In total, there are more than 50 organizations and agencies with which Kedren has partnerships, and together they comprise a network of services for low-income and marginalized residents of the service area.

Kedren and allied service providers have a history of working collaboratively by forming inter-organizational teams to discuss patients in common and share information to produce a unified treatment plan based on HIPAA guidelines. Peer outreach staff, family members, and patients are often included in the treatment planning process as well. Kedren has identified a set of specialty referral providers and hospitals for its Medi-Cal managed care patients, which are immediately accessible to patients who qualify. For uninsured/underinsured patients, Kedren has formal and information partnerships with other section 330 grantees, Look-Alikes, Los Angeles County, hospitals, and other health and human service organizations. For all formal and informal

partnerships, Kedren staff consistently track referrals and enter results of those referrals and hospital visits in eClinicalWorks (eCW) for continuity of care across providers.

Since 2005, Kedren has worked collaboratively with Vernbro Medical Center, which is approximately half a mile away from Kedren's main campus, who provide specialty medical services not offered by Kedren. In turn, Vernbro refers patients to Kedren for mental health services that are beyond their scope. Furthermore, Vernbro offers urgent care, radiology, and other services which coupled with Kedren's ensures that we provide whole person care to our patients. In addition, through a long-standing formal partnership with the Los Angeles County Department of Health Services (DHS), Kedren patients are referred for oral health and preventive dental services based on a sliding fee schedule. Moreover, Kedren partners with DHS to provide patients with specialty care services such as endocrinology, urology, mammography, gynecology, nephrology, ear-nose-throat, cardiology, and nutrition services. For many years now, Kedren also has a close working relationship with DHS's counterpart, the Los Angeles County Department of Mental Health (DMH) for mental health and substance abuse services.

Kedren is in the process of becoming a member of the California Primary Care Association (CPCA). Affiliation with CPCA will provide Kedren with 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. It also offers participation in special events, such as the CPCA Tech Summit, CFO Conference, and UDS seminars.

Finally, Kedren 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 links health centers with DHS, as illustrated above. CCALAC serves as a County-wide community health planning council, and also services to facilitate collaboration with other service providers. Kedren's membership with CCALAC has supported development of new collaborative relationships, facilitating even greater reach throughout its largely medically underserved service area. Kedren participates in CCALAC- sponsored workgroups such as the Policy Advisory Group (PAG); the eCW workgroup, disaster preparedness workgroup, and now the Clinical Advisory Group (CAG) for sharing information and best practices.

Access to other health or community services not available through the health center that impact the patient population.

There are several other health and human services providers in, and adjacent to, the service area with which Kedren collaborates to meet the needs of our target population. Through these formal and informal partnerships, Kedren works collaboratively to ensure quality of health care services for community residents. For example, many health and human services delivery organizations have partnered with Kedren for the provision of specialized mental health and psychiatric services. In turn, Kedren refers its health center patients to these organizations for specialty care services not provided directly by Kedren. In 2017, Kedren had a total of 5,352 referrals for all services.

Approximately, 2,116 (39%) of these referrals were for behavioral health services, emphasizing the importance of our community partnerships as well as our integrated model of care.

Although Kedren does not receive funding for special populations, Kedren serves homeless men and women, and works closely with several homeless services providers. 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.

Additional formal and informal partnerships include:

Name	Summary
Amity Foundation	Kedren and Amity began working together in 2010. Amity operates a 200-bed residential alcohol and drug treatment facility in South Los Angeles where residents receive a structured curriculum and aftercare services in the six-month intensive program. In 2016, Kedren opened a satellite site at Amity Foundation.
BAART Community Healthcare	BAART offers substance abuse services that comprise a full-service wraparound continuum of care, including opiate treatment, methadone maintenance, individualized counseling, psychosocial services, and HIV screening.
Clifford Beers Housing	Provides supportive housing and case management services in Los Angeles County.
A Community of Friends	Provides supportive housing and case management services in Los Angeles County
Breathe California of Los Angeles	An advocacy organization providing environmental education and lung health awareness to the Los Angeles Area, including Kedren’s proposed service area.
Los Angeles Veterans Administration	Kedren works with the Los Angeles Veterans’ Administration primarily with regard to behavioral health services, though local residents that are veterans are also welcome to use its medical services as a convenience. These are also offered to homeless veterans through allied homeless services and substance use agencies, as well as with regard to supportive housing programs.
Urban League, Los Angeles Opportunities Center, and Employment Development Department	Provide employment services to Kedren patients.
Olive View – UCLA Medical Center	Provides substance use disorder and mental health treatment and counseling
Charles R. Drew University of Medicine and Science	Kedren works closely with the school on projects to enhance the health center. Most recently, students worked with Kedren to complete a state-of-the-art telemedicine room to help facility patient intake, as well as host treatment sessions.
All Safe Obstetrics and Gynecology	Provides OBGYN services to Kedren patients.
Nathan Javari, Doctor of Podiatric Medicine (DPM)	Provides podiatry services to Kedren patients.

- *A reduction in non-urgent use of hospital emergency departments.*

Kedren works closely with other health and human services agencies in order to reduce the number of community residents who may access a hospital emergency department for non-urgent care. With a focus on preventive care, we strive to treat/prevent health conditions and events before they become an emergency. We also work closely with partners who provide additional and specialty care services not currently offered at Kedren to ensure the patient receives the treatment they need. As outlined in our policies and procedures for referring patients for services, Kedren staff keep open lines of communication with our partners to track whether the patient has followed up with the referred entity, and should a consult report/treatment take place, that the information is shared with Kedren to ensure continuity of care.

Per our own Patient Centered Medical Home (PCMH) model, Kedren has a minimum of one walk-in slot per hour that the clinic is open and has readily available open appointment slots within three days of an appointment request in order to encourage patients to come to the health center for care before going to the emergency room. Furthermore, we also have same day appointments available. Additionally, when Kedren is closed, professional medical coverage is offered through an 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 provider is contacted. The provider handles the call according to standard medical protocols and procedures and makes a determination for its resolution, and only if necessary refers out to either immediate urgent care services at Vernbro Medical Center (immediately near the main campus) or emergency medical attention. Patients are educated on these services and how to access them after-hours. The on-call provider also has immediate access to the CMO, should she not be the one on call, for any needed further consultations with a supervisor.

- 2) *In Attachment 9: Collaboration Documentation, document collaboration with primary care and other providers serving similar patient populations in the service area (consistent with Attachment 1: Service Area Map and Table), including:*

Other Health Center Program award recipients and look-alikes.

As can be seen in *Attachment 1: Service Area Map and Table*, Section 330 grantees and FQHC Look-Alike clinics in Kedren’s service area include:

Sites	
AltaMed Health Services Corporation	Clinica Msr. Oscar A Romero
APLA Health & Wellness	University Community Health Center
Benevolence Industries Incorporated	University Muslim Medical Association, Inc.
Central City Community Health Center, Inc.	Watts Healthcare Corporation
Central Neighborhood Health Foundation	Wilmington Community Clinic
Eisner Pediatric & Family Medical Center	Queenscare Health Centers
JWCH Institute, Inc.	KHEIR Center
Los Angeles Christian Health Centers	Los Angeles LGBT Center
Northeast Valley Health Corporation	Westside Family Health Center
Northeast Community Clinic	Saban Community Clinic

South Central Family Health Center	Venice Family Clinic
St. Anthony Medical Centers	South Bay Family Health Center
T.H.E. Clinic, Inc.	

Kedren requested letters of support from these health centers as documentation of current and future collaboration efforts in the community. Letters of support have come from the following health centers (see *Attachment 9: Collaboration Documentation*): a) Central City Community Health Center, Inc.; b) Central Neighborhood Health Foundation; c) Eisner Pediatric & Family Medical Center; d) Mission City Community Network, Inc.; e) Los Angeles Christian Health Centers; f) Los Angeles LGBT Center; g) St John’s Well Child & Family Health Center; h) To Help Everyone T.H.E. Health and Wellness Center; i) UMMA Community Clinic; j) Watts Healthcare Corporation, and k) Wilmington Community Clinic. Requested letters are also documented in *Attachment 9*.

Health departments.

While DHS does not provide letters of support as policy with rare exceptions, Kedren works closely with DHS, having applied as a contractor for Healthy Way LA services, and also has worked with DHS and DMH for more than 30 years as its single largest vendor. As illustrated above, Kedren has an excellent working relationship with DHS and DMH and actively refers patients to them for selected referrals, including dental. We are also providers of care under the My Health LA program (MHLA) which is an LA County program that provides primary health care at no cost to eligible residents of the County. MHLA is a health care program for the uninsured (and un-insurable) residents.

A letter of support was also requested from the California Department of Health Care Services, and documentation is included with *Attachment 9: Collaboration Documentation*.

Local hospitals

Kedren has a hospital transfer agreement with California Hospital Medical Center (CHMC), which is approximately 2.7 minutes (12-minute drive) from Kedren’s main site (Suite A and B), and 1.9 miles (10-minute drive) from the Amity clinic. Furthermore, two of Kedren’s providers, Dr. Gill and Dr. Jones, have hospital admitting privileges at CHMC. A letter of support from CHMC is included with *Attachment 9: Collaboration Documentation*.

Rural health clinics.

As Kedren’s service area and geographic region resides completely within urban areas, there are no rural health clinics within or adjacent to our service area.

Note: If documentation of collaboration with one or more of the entities above is not provided in Attachment 9: Collaboration Documentation, explain why it could not be obtained and provide documentation of the request.

EVALUATIVE MEASURES

1) *Describe how the health center's QI/QA program addresses:*

a) *Adherence to current clinical guidelines and standards of care in the provision of services.*

Kedren's Quality Improvement/Quality Assurance (QI/QA) program is composed of clinicians and managers, and is overseen by the health center's CMO, who also sits on Kedren's corporate QI Committee. The QI/QA program also receives oversight from the Quality and Compliance (QC) Committee of the Board. All QC Committee members have a skillset that includes clinical and programmatic evaluation as part of their education and training. The objectives of Kedren's QI/QA program ensure that the provision of healthcare services is consistent with our clinical and financial performance measures. Kedren's QI/QA program objectives also include adherence to the current standard of care in the community, while providing accessibility and timeliness of primary and sub-specialty services to the community.

Kedren's QI/QA program responsibilities include: (1) updating credentials of professional staff through medical staff membership activities; (2) ongoing peer reviews; (3) facility-specific site reviews including medical equipment safety, maintenance, emergency preparedness, and facility safety; (4) maintaining and updating—when necessary—guidelines for clinical performance; and (5) regulatory agency compliance (California Department of Health Care Services and California Department of Public Health licensing, health plans, etc.).

Moreover, the QI/QA program sets the standards for the overall coordination of all clinical quality management activities. Hence, the QI/QA plan establishes a multidimensional, planned, systematic and comprehensive approach to assess and improve the quality of care and services delivered by Kedren. In addition, continuing education and training, staff improvement and participation, and enhancement of employee recognition programs are strongly emphasized. Periodic chart reviews are used to monitor compliance with QI/QA standards.

The QC Committee's responsibilities relative to the QI/QA program include: (1) a form for reporting pertinent clinical aspects of patient care, safety, risk management, and QI/QA functions; (2) inform board of problems identified and progress on resolution; (3) provide a setting for creating, discussing, and recommending program ideas, and for identifying opportunities for improvements in the quality of care provided by the health center; and (4) monitor the health center's compliance with all applicable laws and regulations pertaining to the provision of health care services for patients.

b) *Identification and analysis of patient safety and adverse events, including implementation of follow-up actions, as necessary.*

Kedren is fully committed to the safety and satisfaction of our patients; as such, we have a well-developed and effective Risk Management Program, which is overseen by our CMO in collaboration with key managers and executives from throughout Kedren. Kedren's Risk Management Program utilizes proactive strategies to prevent adverse events and to properly mitigate adverse events when they do occur. These strategies include monthly Quality Assurance (QA) audits where health center staff complete a log and ensure that all health care equipment, supplies, and sample medicine are working properly, and not expired, etc. The lead for the QA audit shares the log with both the Chief Medical Officer (CMO) and Chief Operating Officer (COO) of Primary Care for review, and follows up on any action items. Risk management activities under the CMO also entail maintaining comprehensive medical records, credentialing and peer reviews.

Another Risk Management Program strategy includes regular collection and review of all incident reports, planning for sentinel events, infection control policies, and safety training and education programs for patients and staff. All applicable Kedren staff members are required to participate in risk management by reporting incidents, assisting in problem identification, and following policies, procedures and standards of care and conduct to prevent future incidents. If a sentinel event (e.g., 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 an incident report will be prepared which will be reviewed by the CMO, COO, and key management staff. For serious incidences, a response team will be formed comprising of senior clinic management, and other appropriate managers. The team will perform a detailed review of the event followed by immediate corrective measures to prevent recurrence. The effectiveness of the corrective measures will be assessed to determine whether the response was sufficient or whether additional action is required. This process will be performed on an ongoing basis until the issue underlying the event is resolved.

Essential elements of the incident reporting process include:

- Consistent and timely incident reporting in a fair and just culture;
- Evaluation of incidents and development of corrective action plans to prevent future/similar events from occurring again;
- Triage and communication of service errors for review,
- Investigation and appropriate follow-up action; and
- Monitoring, trending and assurance of compliance with all relevant standards.

Kedren's Board-approved policy and procedures for reporting of incidents are reviewed and updated as needed, at least annually. Analysis of incidents provides a mechanism to improve care by identifying opportunities to enhance internal processes and prevent future similar incidents. The QC Committee reviews significant incident reports and sentinel events requiring communication with staff, additional staff training, and/or policy revision or development. The QC Committee also works with QI/QA program staff to develop and document a corrective action plan, as well as follow each incident or sentinel event to closure.

Kedren recognizes that patient safety is also a top priority in the event of an emergency or natural disaster. As evidence of this core value, Kedren participates in Los Angeles County's emergency and disaster planning efforts, and as a member of the Community Clinic Association of Los Angeles County (CCALAC), Kedren participates in CCALAC's Disaster Preparedness Workgroup. In addition, Kedren has its own disaster plans in place, which includes detailed evacuation plans for the entire facility, policies and procedures for communication during an emergency, guidelines for staff to follow in an emergency, risk assessments, and implementing disaster drills. Further, Kedren has developed internal emergency plans and installed information and energy back-up systems in the event of a power failure or other act of nature. Kedren is compliant and up-to-date with all government mandates and other requirements for emergency response and disaster preparedness. In the event that a disaster should strike within our neighborhood, Kedren will be well-apprised and well-equipped to mitigate the disaster.

c) Assessment of patient satisfaction, including hearing and resolving patient grievances.

Not only does Kedren value patient safety, but we also prioritize patient satisfaction. Kedren is sincere in our desire to provide a positive patient experience to all who visit our facilities. To this end, Kedren ensures that all patients are aware of their rights, and aware of what they are entitled to as patients in our care. We encourage patients to participate actively in their care and to express dissatisfaction arising from problems with the care they received, and/or any perceived unfair treatment. Kedren follows written policies and procedures that establish a process for hearing and resolving patient grievances. These policies illustrate that the COO, with support from the key management team, is responsible for handling all patient complaints, grievances, and/or issues that arise. The key management team will meet, as needed, to identify solutions to resolving area issues. The QC Committee will also receive and monitor patient grievances, and consider policy changes which may be useful in reducing grievances.

Patient feedback is solicited from patients at the time services are provided, and is collected through patient satisfaction surveys, patient suggestions, and patient grievances. Kedren's first quarter patient satisfaction findings surveyed 115 patients that had been seen at the health center. The survey utilized a scale from one (1) to five (5) (1 = Poor; 2 = Fair; 3 = OK; 4 = Good; and 5 = Great), and assessed patient satisfaction in the following areas 1) ease of getting care; 2) wait times; 3) staff friendliness and professionalism; 4) payment processes; 5) the clinic itself (e.g., cleanliness, safety); and 6) confidentiality. The survey also queries patients about the likelihood of referring family and friends to the health center, and whether patients consider the clinic as their regular source of health care. First quarter key findings included the following:

Ease of Getting Care: The average response (i.e., the most frequently occurring response) for each statement was 5 (Great). Mean scores for each of the statements suggest that patients reported the ease of getting care at Kedren was good.

Wait Times: The average response for each statement was 5 (Great). Mean scores for each of the statements suggest patients reported that the wait times at Kedren are good.

Staff: The average response for each statement was 5 (Great). Mean scores for each of the statements suggest patients reported that the professionalism of providers as good.

Payment Processes: The modal response for each statement was 5 (Great). Mean scores for each of the statements suggest patients reported that the payment processes at Kedren were good to great.

Regular Source of Care: The vast majority of patients (93.0%) reported that they considered Kedren as their regular source of care.

d) Completion of quarterly (or more frequent) QI/QA assessments to inform modifications to the provision of services.

At Kedren, our QI/QA and risk management programs allow for continuous assessment, so that we can effectively and efficiently update clinical practices when needed, adjust policies and procedures when appropriate, and understand the experience of our patients. Accordingly, Kedren's QC Committee implements, monitors, revises, and sustains improvements in the delivery of health care to patients through the monitoring of clinical outcomes, including HRSA's required 16 clinical performance measures (e.g. IVD and aspirin use). Every month, QI/QA program meetings are held. The CMO and other key management staff are in attendance of these meetings, and any QI/QA activities, or recommended revisions to any aspect of the QI/QA or risk management plan, and other related policies are reported to the Board on a monthly basis. Moreover, the CMO meets regularly with other key management and clinical staff to ensure that the provision of health care services is consistent with Kedren's clinical and financial performance measures and meets the current needs of our service area population. Modifications to the provision of services are made as required, and are thoroughly communicated internally across all programs and departments.

Additionally, Kedren recognizes the importance of patient and community input to inform the QI/QA process. We intend to garner information from our patients and the community in order to provide programs that meet the needs of those in our service area. Suitably, we consider internal data on utilization, clinical and financial performance measures, and patient satisfaction through surveys. Bi-lingual (English and Spanish) surveys assess patients' experiences in a number of areas, including quality of service, availability of care, patient/provider communication, patient experience, and patient safety. To further inform the QC Committee and to assist the committee in meeting their objectives, we pull information and data from local Community Health Needs Assessments conducted by hospitals with overlapping service areas, the United States Census Bureau, and the UCLA California Health Interview Survey (CHIS) findings for Los Angeles County.

e) Production and sharing of QI/QA reports to support oversight of and decision-making regarding the provision of services by key management staff and the governing board.

The management team meets monthly to review a variety of QI/QA agenda items. At these meetings, QI/QA reports are used to support oversight of and decision making regarding the provision of services. These reports may include, but are not limited to: unusual occurrence/incident reports and trends; copies of patient complaints and trends; patient satisfaction

questionnaire/survey results or trends; reports on employee health and safety issues; clinic risk audit results; facility inspection reports; licensing and accreditation audit results; and random medical chart and electronic record audit results. The QI/QA program staff prepare this documentation for the monthly management team meetings to facilitate oversight and offer evidence for decision making regarding the provision of services.

In addition to the management team, Kedren's QI/QA team provides monthly reports to the QC Committee, so that appropriate measures can be 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 QI/QA program staff work with information technology (IT) staff, to prepare monthly dashboard reports, which are useful in tracking progress toward and compliance with the goals laid out in the clinical and financial performance measures. This information is also useful in framing issues for the QC Committee to consider, and as the committee identifies areas of concern, the embedded strategic planning process can be informed by the committee's observations.

2) *Describe the responsibilities of the individual designated to oversee the QI/QA program related to:*

a) *Implementation of the QI/QA program and related assessments.*

The CMO is involved extensively in the activities of the QI/QA program at Kedren. Specifically, the CMO provides clinical leadership for implementation of the QI/QA plan and is responsible for leadership of the QC Committee, oversight of chart reviews, supervision and review of assessments of progress toward clinical performance measure target goals, oversight of compliance with and participation in quality improvement and risk management plans and activities, and review of and response to any reported incidents.

Furthermore, the Board of Directors participates once a year in a one-day retreat to review strategic planning for the organization and to develop annual goals. During this retreat, the QC Committee chair or other key management staff provide a comprehensive report to the Board on the progress made to date, including the monitoring of QI/QA outcomes, and strategic areas that may need to be revisited as indicated by QI/QA documentation or reporting. The QC Committee chair used this opportunity to accept expertise and input from the Board to guide the QI/QA and risk management processes.

b) *Monitoring of associated QI/QA outcomes.*

The CMO regularly monitors outcomes which are critical in order to determine if interventions, strategies, and approaches are successful at improving performance and/or achieving desired objectives. One strategy to monitor QI/QA outcomes is to conduct a comprehensive review of health records for each patient, using Kedren's Electronic Health Record (EHR) system, eClinicalWorks. For this purpose, the CMO leads and supervises regular review of patient records in the EHR system conducted by licensed health professionals to assess the appropriateness of utilization of services and the quality of services. Review of appropriate utilization of services

includes review of data on: a) clinical performance measures related to preventive services; b) chronic disease patients to assess appropriateness and timeliness of visits, testing and medications, based on clinical guidelines; c) practice management system data on numbers and types of visits per patient; and d) quality of services focusing on clinical performance measures and compliance with clinical guidelines.

Additionally, the frequencies of patient incidents, complaints, and/or grievances are compared monthly, quarterly, or annually to determine if these issues are being handled successfully and if outcomes are trending favorably. Results from patient satisfaction surveys are reviewed each quarter and compared to previous quarters to determine if improvements are being made in those areas. Moreover, as mentioned previously, the QC Committee produces monthly dashboards that track our progress toward meeting clinical and financial performance measures. If QI/QA program activities are successful, these dashboards should reveal that progress is being made in achieving the performance measures.

Besides reviewing QC Committee outcomes, it is also important to evaluate the effectiveness of the committee, itself. Hence, a quarterly organizational assessment, conducted by the Board and the management team, is completed to evaluate the effectiveness of all QI/QA activities. This assessment facilitates the planning of the following year's QI/QA activities related to goal accomplishment, resource efficiency, team collaboration, utilization, and peer review activities.

- 3) *Describe how the health center's physicians or other licensed health care professionals conduct QI/QA assessments using data systematically collected from patient records, to ensure:*
 - a) *Provider adherence to current clinical guidelines, standards of care, and standards of practice.*

Kedren's QI/QA program is dynamic, in that participation across multiple disciplines within the clinic is required to be successful. Any physician or licensed healthcare professional who comes in contact with a patient will participate in the QI/QA process. As such, Kedren maintains an active, ongoing assessment and planning process that allows physicians and other licensed health care professionals to respond to the rapidly changing health care environment and the medical needs of the service area residents.

Under the Board's direction, both our COO and CMO and other clinical staff regularly review new and existing services, patient care delivery, work-flows, and support systems that maximize results and satisfaction for our patients and their families, as well as for our own staff. A systematic evaluation of patient records (e.g., chart reviews) are also performed by the CMO, or her clinical designee, to identify areas for improvement and to ensure that documentation of services are clearly provided and that standards of care and standards of practice are always followed.

- b) *The identification of patient safety and adverse events, and the implementation of related follow-up actions*

Kedren's QI/QA program utilizes a proactive approach to prevent and/or reduce adverse events, and to implement related follow-up actions, as needed. As mentioned previously, one of Kedren's primary proactive strategies is to properly train staff members. Staff trainings include: a) current evidence-based practices; b) providing culturally competent service; c) recognizing and reducing safety hazards; d) proper documentation in the EHR system; e) proper documentation of incidents, complaints, and grievances; f) assisting in problem identification; and g) following policies, procedures and standards of care and conduct to prevent adverse events.

If a serious event occurs, a response team comprised of senior clinic management, including Kedren's CEO, will be informed. The team will perform a detailed review of the event, followed by immediate corrective measures to prevent recurrence. The effectiveness of these corrective measures will then be assessed to determine whether the response was sufficient or whether additional action is required. The QC Committee will continue to follow-up until the incident and/or the underlying issue is resolved.

4) *Describe how the organization's health record system (e.g., electronic health record (EHR) system) will:*

a) *Optimize health information technology.*

Kedren uses eClinicalWorks (eCW) as its EHR and practice management system for tracking clinical outcomes by disease and to aggregate data by population group. The use of eCW is also fully integrated with claims billing systems. With Kedren's EHR system, patient care and communication is optimized and streamlined via the online patient-access portal. Through the portal, online appointments can be made, on-line check in is available, patients can access their own health records, and physicians can share secure messages with patients. The eCW system also allows patient tracking for periodic preventive checks, the tracking of patient demographic information, patient scheduling, and billing functions.

Besides improving individual patient care and patient record keeping, eCW also can be used as an evaluative tool for the clinic. For example, our EHR system provides Kedren with the ability to analyze and report on a variety of data for use in program evaluation, quality management, and planning and development by the management team. The system produces comprehensive detailed reports and analytics of required HRSA clinical performance measures as well as other established benchmarks. With eCW, physicians are afforded the opportunity to make prudent clinical judgments based on predictive analysis. Moreover, by using eCW, Kedren is able to determine if there is a provider issue, an operations issue, or an access issue with respect to the delivery of quality health care services. Kedren fully maximizes a Clinical Decision Support System (CDSS) tool that affords Kedren to share with its patients' timely alerts for preventive care, according to the latest clinical guidelines. As a result, we continue to provide efficient and timely quality of care to our patients.

Components of risk management and QI/QA programs are incorporated into our EHR system, which allow us to quickly determine the entirety of a clinical case, especially when there has been a complaint. Kedren also uses data accumulated through eCW and accounting software to evaluate the health center's financial performance, including specific financial measures required by HRSA. Patient care activity summaries are produced for each individual clinical provider to assess their respective clinical practice performance.

Ultimately, Kedren's EHR system helps to optimize health care delivery by cutting costs, reducing medical errors, empowering the patient to be involved in his/her care through the patient portal; streamlining data and reporting, and providing an automated evaluation tool. Suffice it to say, eCW plays a critical role in ensuring personal, efficient, and effective health care delivery to our patients.

b) Protect the confidentiality of patient information and safeguard it against loss, destruction, or unauthorized use, consistent with federal and state requirements.

The Health Information Portability and Accountability Act (HIPAA) is used in setting the standards for patient confidentiality and the protections that are to be provided to patients regarding the sharing of their medical information. Kedren's key management team is trained in HIPAA and assumes responsibility in ensuring that all staff members are trained in HIPAA confidentiality requirements, either before they begin working or within 30 days of hire. Kedren's patient records are maintained securely on the organization's servers to ensure the privacy, security, and confidentiality of its clients' personal health information and histories. In addition, Kedren staff have the ability to make confidential notations in its EHR system to alert their colleagues to issues related to clinical service delivery (e.g., an inappropriate pharmaceutical request), patient behavior or health care needs, or concerns identified by the risk management team. Documentation in eCW is secure and confidential, yet easily accessible by staff when interacting with our patients.

Medical records, information, and reports that are not located within Kedren's EHR system are also subject to strict HIPAA confidentiality protections. The COO is responsible for storage of all copies of minutes, reports, worksheets and other data in a manner ensuring strict confidentiality. A written confidentiality policy detailing procedure for maintenance and release of data and other QI/QA-related information governs the release of such information. This policy specifies the use of record numbers or other identifiers in place of patient names, and code numbers in place of physician or other provider and staff names. This policy also provides methods for restricting access solely to authorized individuals. In addition, all peer reviewed documents completed by medical staff, as defined in the California Statute, shall be considered protected information under the provisions of the California Evidence Code 1157.

c) Facilitate the collection and organization of data for the purpose of monitoring program performance.

As has been described previously, the eCW EHR system can also be used as an evaluative tool; in this manner the system supports the collection and reporting of UDS data. The software provides benchmarking, which makes it user-friendly to review, track, and print summaries on the 16 clinical performance measures, and other important data. In conjunction with the IT team,

Kedren's QC Committee staff is responsible for maintaining the EHR practice management system, including data extraction for annual UDS reporting. The eCW system has been programmed to provide daily and weekly operations reports which are used for monitoring program performance.

- 5) *On the Clinical Performance Measures form only (see detailed instructions in Appendix B), establish realistic goals that are responsive to clinical performance and associated needs. Goals should be measure-specific and informed by contributing and restricting factors affecting achievement:*

Kedren's Clinical Performance Measures have been designed to address the community health needs identified in *Need Section* of the narrative. The Clinical Performance Measures are reported in the Clinical Performance Measures form, including the proposed baseline and target statistics for the project period. The QC Committee is responsible for reporting and monitoring the stated HRSA Clinical Performance Measures and has determined that the goals for the designation period are responsive to the needs identified for the target population. For more detailed information, including contributing and restricting factors for each measure, as well as details on how each measure will be approached, please see *Clinical Performance Measures*, as submitted in the EHB.

- 6) *Describe how the health center will focus efforts on the following HRSA clinical priorities to achieve goals cited in the Clinical Performance Measures form and improve the health status of the patient population:*

Though there are 16 clinical performance measures, each of which are important factors in our patients' overall health, HRSA has identified four (4) of the measures to be clinical priorities. These clinical measures are: 1) Diabetes; 2) Depression Screening and Follow-up; 3) Child Weight Assessment Counseling; and 4) Body Mass Index. Accordingly, Kedren will place more emphasis on these measures using a care management process to improve the status of the patient population. The focus on these four (4) measures does not in any way diminish the importance of the other 12 clinical measures, their role in optimal health, nor our dedication to improving outcomes around these other 12 measures.

- a) *Diabetes.*

As illustrated in the *Need Section*, there are high rates of diabetes in Kedren's service area. Kedren patients are often seen for the first time with untreated diabetes, and conditions associated with the disease. In 2017, 684 Kedren patients received one or more visits associated with their diabetes (2,504 diabetes visits total).⁶ Knowing this, we continue to establish programs, and services that address patients with untreated diabetes. Furthermore, Kedren has a provider on staff who

⁶ Kedren's 2017 Uniform Data System (UDS) Report

specialists in obesity, and developing appropriate treatment plans to address this critical need. We anticipate expanding our services to include a diabetes clinic to help the patient identify ways to be more involved in their care

To establish a baseline for the Diabetes clinical performance measure, Kedren measures the percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c greater than 9.0% during the measurement period. Kedren providers are trained on how to document A1c levels for diabetic patients during their visit in the patient's electronic medical record. To increase control of hemoglobin A1c for patients with diabetes, Kedren will continue to provide diabetes education to patients. Education is given to patients during the visit, and also to community residents during health fairs and other health education events. Additionally, Kedren will encourage patients and their families to partake in healthy eating and exercise habits. Providers will discuss various strategies for addressing the need for acquiring healthy foods for patients and their families, including ideas on food preparation and where to shop for healthy food options. Additionally, Kedren empowers diabetic patients by assisting them in developing self-management goals so that they can learn to manage their own condition. Patient education is documented in their chart.

Kedren staff also hold monthly provider meetings wherein workflow strategies and patient education tactics are discussed. We are also in the process of identifying patient ambassadors, who have shown substantial improvements and who can attend health fairs, and other community events, as well as provide testimonials on a patient education video that is shared in the waiting room for all patients to see. Furthermore, our QC Committee will continue to monitor the performance measure around diabetes, and review patient records to ensure that providers are appropriately documenting hemoglobin A1c levels, and that the performance measure continues to improve during the project period.

b) Depression Screening and Follow-Up.

To establish a baseline for the Depression Screening and Follow-Up clinical performance measure, Kedren measures the percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool (e.g. the PHQ-9 and PHQ-2) and if positive, a follow-up plan is documented on the date of the positive screen. With Kedren Acute Psychiatric Hospital and Community Mental Health Center being around for more than 50 years, and specializing in mental health treatment, we are well versed in depression screening and proper follow-up. We are equipped to do a full integration of care between primary and behavioral health, and are in the process of recruiting a Licensed Clinical Social Worker (LCSW) on the FQHC side who can see patients with mild to moderate depression before being referred to Kedren's Acute Psychiatric Hospital and Community Mental Health Center for more intensive treatment.

Staff will also educate patients and their parents/guardians on the risks of untreated depression. The QI/QA program team will monitor patient charts to ensure that eligible patients are screened, to ensure that follow-up plans and appointments are made, that appropriate mental health referrals are made, and that patients are receiving the proper education for their condition. Furthermore,

Kedren has experienced bilingual, culturally competent staff, and materials printed in languages other than English. We will link a staff member with a patient, as needed, so they feel more comfortable receiving care.

c) Child Weight Assessment and Counseling.

To establish a baseline for the Child Weight Assessment and Counseling clinical performance measure, Kedren measures the percentage of patients aged 3 -17 years of age who have had evidence of Body Mass Index (BMI) percentile documentation and who have had documentation of counseling for nutrition AND who had documentation of counseling for physical activity during the measurement year. To achieve this goal, Kedren providers have been trained and workflows have been established to collect and track child/adolescent's BMI percentile at every visit. Additionally, patients (or their parents) will be offered nutrition and physical activity counseling. Further, there will be follow-up consultations for patients whose BMI is 30 and greater or 18.5 and lower. Kedren will also educate children and their families on the importance of healthy eating and exercise. Recommendations to Boys and Girls Club locations, and other safe places for exercise will be provided.

d) Body Mass Index.

To establish a baseline for the Body Mass Index clinical performance measure, Kedren measures the percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months and when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter. To achieve this objective, the BMI will be automatically calculated and documented in the patient's record after entering their height and weight. Medical assistants will arrange follow-up appointments for patients who are within the overweight or obese ranges. Documentation of overweight/obese patients will be documented in the patients' charts, as well as any identified treatment goals and plans and any education provided. Education on healthy eating and exercise will be given, and patient involvement in the identification of treatment goals/plans will be encouraged.

- 7) *On the Financial Performance Measures form only (see detailed instructions in Appendix B), establish realistic goals that are responsive to the organization's financial performance and associated needs. Goals should be measure-specific and informed by contributing and restricting factors affecting achievement.*

As part of Kedren's management team's responsibility, timely and accurate reporting contribute to financial viability of the organization. Compiled from Kedren's financial management system and accounting records, we have documented required baseline and targeted financial goals for the project period on the Financial Performance Measures form. For more details, including contributing and restricting factors, please see *Financial Performance Measures*, as submitted in the EHB.

RESOURCES AND CAPABILITIES

Organizational Structure

- 1) *Describe how the organizational structure (including any sub-recipients/contractors) is appropriate to implement the proposed project (consistent with Attachments 2: Bylaws and 3: Project Organizational Chart, and, as applicable, Attachments 6: Co-Applicant Agreement and 7: Summary of Contracts and Agreements), including whether your organization is part of a parent, affiliate, or subsidiary organization (consistent with Form 8: Health Center Agreements).*

As per Kedren's bylaws and the organizational chart, the structure is *appropriate to implement the proposed project*. Specifically, Kedren's Board of Directors is directly responsible for the employment and annual evaluation of the Chief Executive Officer (CEO). With policy and procedure guidance from the Board, the CEO provides clinical, operational, and fiduciary oversight of the organization. The Chief Operating Officer (COO) of Primary Care is responsible for the daily operation of the clinic, including the Medical Assistant, clinic schedules, and customer service workflows, and routinely reports to the CEO. Furthermore, the Chief Financial Officer (CFO) and Director of Human Resources report directly to the CEO. The lines of authority from the Board of Directors to the CEO to the management team are delineated in *Attachment 3: Organizational Chart*. Furthermore, the COO, CFO and CMO present on a monthly basis at the Board of Directors' meeting. This management structure ensures that the daily and long-term needs of the clinic can be addressed on both an immediate, timely manner as well on a long-term strategic basis that takes into account operational, clinical and financial goals.

Kedren maintains open lines of communication with each of its salaried and contracted clinical staff, and our CMO of Primary Care guides, sets, and reviews the services provided to Kedren's patients. When we do engage provider-contractors outside of our agency, such as for specialty care, we receive consult reports electronically from these providers for each patient referred for services. The Kedren provider who made the referral signs off on these reports, or in the case of his or her absence, an assigned substitute provider fulfills this responsibility under the review of the CMO. Adhering strictly to HIPAA regulations, we also confer directly with contracted providers by telephone when there is an immediate need for authorization or when more extensive testing is recommended.

Kedren also complies with the *Health Center Program Compliance Manual*, and any updates to the *Compliance Manual* are reviewed by the key management team to ensure compliance, and any adjustments to operations in order to stay compliant are shared with the Board of Directors for review, and approval. Kedren is in the process of reviewing the revised *Compliance Manual* that was released August 2018 to ensure compliance to all program requirements.

Kedren is not part of a parent, affiliate, or subsidiary organization.

Staffing

2) Describe the following related to the staffing plan (consistent with Form 2: Staffing Profile):

a) How it ensures that clinical and related support staff, contracts, or formal referral arrangements with other providers/provider organizations, will be in place to provide all required and additional services (consistent with Form 5A: Services Provided).

Kedren has successfully demonstrated that clinical and related support staff, including contracts and formal referral arrangements with other providers/provider organizations, are in place to provide required and additional services, consistent with Form 5A: Services. We accomplish this by performing ongoing assessments, including patient satisfaction surveys, of patient needs and health center capacity to ensure that we have sufficient providers and other staff in place to support the continued growing demand for services. We also strive to ensure a good work environment in the clinic, and through our partners, in order to proactively address staff burnout and thus decrease staff turnover as continuity of care and ongoing patient-provider as well as patient-support staff communication is key to patient adherence and access to care.

As described in Form 2: Staffing Profile, our direct hire clinical staff for year one of the next project period include:

Position	Direct Hire Full Time Equivalent (FTE)
Chief Medical Officer	0.30 FTE
Family Practice Physician	0.20 FTE
Nurse Practitioners	2.00 FTE
Medical Assistants	5.00 FTE
Phlebotomy Technician	1.00 FTE
Licensed Clinical Social Worker	1.00 FTE
Case Managers	1.00 FTE
Outreach Workers	1.00 FTE
Eligibility Assistance Workers	1.00 FTE
Total Direct Hire FTE	12.50 FTE

Furthermore, Kedren also has contracts with general practitioners, and nurses who help Kedren carry out its scope of work. Finally, through our formal contracts with Medi-Cal Managed Care, Kedren has access to specialty referrals and associate hospitalization affiliations which covers a large portion of Kedren's service population.

b) How the size, demographics, and health care needs of the service area/patient population were considered in determining the number and mix of clinical support staff.

Kedren pays close attention to local health assessment data, economic trends, population movement, and shifts in insurance coverage/payer mix. We continue to expand and diversify our provider types based on the evolving needs of our target population. For example, we have a set of patients who are monolingual Spanish speakers. As a result, we have a salaried Nurse Practitioner who is bilingual in Spanish and English. Further, all our front desk support staff are bilingual as are 75% of our back office Medical Assistants.

Kedren's proposed mix of clinical providers and support staff is appropriate to maintain our existing scope and availability of services at our health center locations. Per our projections, we anticipate serving 4,700 unique patients in 14,370 visits during year one of the project period.

- c) *How credentialing and privileging are implemented for all health center employees, individual contractors, and volunteers who provide clinical services, including:*
- *Clinical staff members (licensed independent practitioners (LIPs), addressing provider categories separately (e.g., physicians, dentists, physician assistants, nurse practitioners).*
 - *Other licensed or certified practitioners (OLCPs), addressing provider categories separately (e.g., registered nurses, licensed practical nurses, registered dietitians, certified medical assistants).*
 - *Other clinical staff providing services on behalf of the health center, addressing provider categories separately (e.g., medical assistants, community health workers).*

***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 health care services will be secured via contract, include the contract/agreement as an attachment to Form 8: Health Center Agreements.*

Kedren's credentialing and privileging process is clearly documented in the Policies and Procedures manual, which contains the minimum standards and requirements for certifying and the recertifying of all medical providers, including contracted providers. Kedren's credentialing team, led by the CMO and COO, gathers and verifies all required information. The team assembles a packet that is then presented to the board for approval. Kedren's leadership has entrusted the medical staff with the responsibility for assuring that all patients admitted or treated in any of the referral hospitals receive uniform standard of quality patient care, treatment, efficiency, and the level of professional performance consistent with generally accepted standards attainable within Kedren's means and circumstances.

To ensure that all practitioners, including contracted, are qualified to deliver quality health care, regular verification of their credentials and definition of their privileges are required at Kedren in order to increase patient safety and reduction of medical errors. With the goal of improving quality health care, Kedren utilizes the Joint Commission on Accreditation of Health Care Organization (JACHO) standards, and the National Practitioner Data Bank (NPDB) to search for high-quality employees with valid credentials. During a pre-employment investigation, Kedren staff research

NPDB to determine if there are items of concern pertaining to the prospective hire. During the initial hiring and credentialing phase of employment, Kedren uses a government-issued picture identification for verification of credentials, including a Drug Enforcement Administration (DEA) registration (as applicable), hospital admitting privileges (as applicable), immunization status, and documentation of current Basic Life Support skills (as applicable). Credentialing of providers also requires primary source verification of current licensure including relevant education, training, or experience, and health fitness, including physical and mental health status. Each position is regularly reviewed for clinical competence and training and education are recommended, based on the outcome of the review. Information pertaining to each person's credentialing and privileging is kept in a folder in a secure location.

Kedren's credentialing/privileging team also keeps a tracking sheet which lists all Licensed Independent Practitioners (LIPs) – Medical Doctors - and Other Licensed Independent Practitioners (OLIP) – Nurse Practitioners, Medical Assistants - along with their a) hire date; b) initial credentialing data; c) most recent credentialing date; d) most recent privileging date; e) who on staff reviewed their credentialing and privileging; and f) the date the provider is due for another review. This tracking sheet, which was provided by Kedren's Project Officer, is actively monitored to ensure that an ILP and/or OLIP credentialing/privileges do not lapse. Moreover, Kedren requires that a privileging delineation form be completed for all referral providers listed on *Form 5A: Services Provided, Column III*. This form includes the providers requested privileges, initial criteria, renewal criteria, and proctor requirements. The form is signed by the referring providers, and vetted by key management and the QC Committee prior to becoming final.

Management Team

- 3) *Describe the management team (e.g., project director (PD), clinical director (CD), chief executive officer (CEO), chief financial officer (CFO), chief information officer (CIO), chief operating officer (COO), including:*

Kedren's senior management team includes. Dr. John H. Griffith, President/CEO; Dr. Miriam Vega, COO of Primary Care; Dr. Kelly Jones, CMO; and Ms. Regina Tercero, CFO. With the exception of Dr. Griffith, who has been with Kedren for more than 30 years, the senior management team is new as of 2018. Dr. Vega joined Kedren as the health center's COO of Primary Care in April 2018. Dr. Jones has been with the health center since August 2018, and Regina Tercero has been with the health center since July 2018. While the senior management team is new to Kedren, they bring an array of experience (over 55 years accumulated experience) and education that will benefit Kedren long-term.

- a) *How it supports the operation and oversight of the proposed project, consistent with scope and complexity.*

Kedren's senior management team is appropriate given the organization's current size and scope of services, and the Board of Directors regularly reviews each position and is prepared to adjust, as needed, to ensure that oversight capacity keeps pace with organizational growth. During our last operational site visit from HRSA in July 2017, and through our own analysis, it was determined

that a reorganization of the senior management staff at Kedren would improve management and accountability of the primary and behavioral health programs. In a reorganization plan that was submitted to HRSA, we outlined steps that have since taken place in order to ensure that the key management team was appropriate for health center operations. These changes included:

Chief Operating Officer – Primary Care. Kedren added a new position, COO of Primary Care. In her role as COO for Primary Care, Dr. Vega supervises, guides, and implements everyday operations for targeted outcomes in the clinic. Additionally, she facilitates and leads adherence to successful business operational standards and enforces accountability for the meeting of those standards within the departments. Dr. Vega reports directly to the CEO.

Chief Financial Officer – Ms. Maria Dia is retiring and the CFO role is now filled by Ms. Regina Tercero. Ms. Dia is still working a few days a week in order to make the transition seamless. Ms. Tercero is responsible for directing and overseeing all the financial activities of the corporation including preparation of current financial reports as well as summaries and forecasts for future business growth and general economic outlook. She provides reports, and updates to the Board of Directors on a monthly, or as needed, basis.

Chief Medical Officer – Primary Care – Kedren most recently recruited a full-time Medical Director (CMO). Dr. Jones is responsible for overseeing and managing all clinical functions of Kedren. She promotes organizational goals and objectives, and assures that high quality health care services are delivered at all times.

Chief Information Officer – Dr. Earle Charles, who has been the Chief Information Officer (CIO) for Kedren’s Acute Psychiatric Hospital and Community Mental Health Center since 2005, recently joined the FQHC team to support the health center’s capacity to effectively use information technology, business intelligence, customer service, as well as provide data security/HIPAA management. Dr. Charles has been an incredible asset to the health center, and we anticipate his involvement will continue assist us in bridging the gap between its primary and behavioral health care programs and services.

Assistant Medical Director -- Ms. Shenyell Morales, who previously served in a clinic management capacity continues to split her time between direct patient care services and program management in the position of Assistant Medical Director. Ms. Morales serves as the supervisor of the team of Medical Assistants who are key to patient flow in the clinic and provides assistance to both the COO for Primary Care and the CMO. Ms. Morales reports directly to the COO for Primary Care for her management responsibilities.

These updates have been shared with Kedren’s Project Officer, Sara Stepahin, and are reflected in the organizational chart, attached to this application. These staff additions have greatly improved Kedren’s ability to provide appropriate management staff for the operation and oversight of the proposed project.

The senior management team has substantial experience working for large complex organizations and in providing health and mental health services. Dr. Griffith, President/CEO, has been a strong catalyst of expansion of existing programs and services, demonstrating a strong commitment to patients’ needs, as well as dedication to the current scope and complexity of the services provided

to patients. 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. They are also committed to the goal of maintaining a primary health care clinic to serve residents of the underserved and economically challenged community. Furthermore, Kedren's senior management have substantial experience providing comprehensive programs and services for patients residing in Los Angeles County that are experiencing serious and persistent mental illness and emotional disturbances.

- b) *Training, experience, skills, and qualifications necessary to execute each defined role (demonstrated in Attachment 4: Position Descriptions for Key Management Staff), as well as the amount of time that each will dedicate to Health Center Program activities (consistent with Form 2: Staffing Profile).*

Kedren's senior management team has the training, experience, skills, and qualifications necessary to execute their defined roles as outlined in *Attachment 4: Position Descriptions for Key Management Staff*. Each staff member brings an array of experience from working with complex systems to their role at Kedren. One of Kedren's focus areas is the integration of primary and behavioral health care services, and the senior management team has the skills and experience necessary to continue along this path of integration. Furthermore, as outlined in *Attachment 4*, we provide more detail on each position's description of duties and responsibilities; position qualifications; supervisory relationships; skills, knowledge, and experience requirements; and work hours.

Kedren's key management team continues to identify conferences and trainings that will benefit clinic staff in providing services to patients. When an opportunity arises, Kedren will identify a few staff to attend trainings and/or will bring consultants to Kedren to educate staff on various important topics. Moreover, when possible, we use supplemental award opportunities (e.g., Delivery System Health Information Investment, Patient Centered Medical Home, Expanding Access to Quality Substance Use Disorder and Mental Health Services) to identify opportunities to expand our current scope of services, including enhanced staff training, experience, skills, and qualifications in order to enhance and expand services currently offered at Kedren.

- c) *Identification of individuals who will serve in the defined roles (demonstrated in Attachment 5: Biographical Sketches for Key Management Staff). If applicable, identify individuals that will fill more than one key management position, including the positions they will fill (e.g., CFO and COO combined role), and describe any changes in key management staff in the last year or significant changes in their roles.*

Kedren's senior management team comprises individuals who are skilled in their outlined roles and well-equipped to guide an organization the size and scope of the health center. Brief biographical background on Kedren's senior management team can be found below and additional information is included in *Attachment 5: Biographical Sketches for Key Management Staff*.

President/Chief Executive Officer, John H. Griffith, Ph.D. – A recognized medical care leader, Dr. Griffith is credited with more than 30 years' experience with Kedren's Acute Psychiatric Hospital & Community Mental Health Program, rising through the position of

Chief Operating Officer of Mental Health Services, and serving in the capacity of President/CEO for more than ten years. Dr. Griffith was the founder of Kedren Community Health Center, and continues to provide direct oversight of the clinic in his role. Dr. Griffith has a Bachelor of Arts in Psychology from the University of Sheffield, England, and a Ph.D. from the Institute of Psychiatry, University of London, England.

Chief Operating Officer – Primary Care, Miriam Y. Vega, Ph.D. - Dr. Miriam Vega joined Kedren in 2018 as COO for Primary Care. She brings to her position a distinguished career in preventive and primary care programs. She most recently served as the CEO of the UMMA Community Clinic, an FQHC in Los Angeles where she grew it to a 13% operating margin and helped integrate behavioral health and primary care services. Previously, she was Executive Director of AIDS Project of the East Bay where she grew programs to address the social determinants of health. As such, Dr. Vega is an experienced executive of nonprofits who has a Ph.D. in Social Psychology from the University of California, Berkeley, and a Bachelor of Arts from in Psychology from Vassar College in New York. Her experience and expertise have already been demonstrated since her start with Kedren in April 2018.

Chief Financial Officer, Regina Flores Tercero - Regina Tercero joined Kedren in July 2018 as CFO. Ms. Tercero received her Bachelors of Arts in Economics from the University of the Philippines, and a Masters in Business Administration from Pepperdine University in Malibu, California. Ms. Tercero is currently finishing her doctorate in Organizational Leadership from Pepperdine University. Prior to joining Kedren, Ms. Tercero was the Deputy City Controller for the City of Compton in Los Angeles County. She has also held roles as a Grants Accountant/Management Analyst for the City of Pasadena's Public Health Department; Finance Manager for the City of Maywood; Director of Finance & Administration for Parents Television Council, Inc.; and the Director of Finance & Accounting for the Institute for Healthcare Advancement, all in Los Angeles County. Ms. Tercero is replacing Maria Dia as CFO. The transition has been seamless with Ms. Dia working a few days a week in the interim as Regina settles into her new role.

Chief Medical Officer- Primary Care, Kelly Jones, M.D. - Dr. Kelly Jones joined Kedren in August 2018 as CMO. Dr. Jones earned her Medical Degree from the University of Kansas Medical Center in Kansas City, Kansas, in 1994. She did her residency in family medicine at Georgetown University / Providence Hospital in Washington, D.C. Dr. Jones participated in a fellowship in Maternity and Family Health at University of Southern California's (USC) Family Medicine Residency Program from 2001 to 2002, and a faculty development fellowship with the Keck School of Medicine at USC from 2010 to 2011. Dr. Jones is Board Certified and passed the American Board of Family Medicine for California (A76087). She also had a certification CEO DATA 200 Waiver to prescribe buprenorphine. She has been providing culturally competent and linguistically appropriate services for Kedren's diverse patient population, and has provided additional guidance/expertise in its Quality Improvement program.

d) Employment arrangement of the CEO (consistent with Form 2: Staffing Profile).

Dr. Griffith, Kedren's President/CEO is on payroll. While he currently provides 0.07 FTE to his role as President/CEO of the health center, he works closely with Dr. Vega, who is 1.0 FTE, and provides direct day-to-day oversight of all Kedren health center activities. None of the key management staff are employed through a contract.

- e) *Responsibilities of the CEO for and reporting to the governing board and overseeing other key management staff in carrying out the day-to-day activities of the proposed project.*

Kedren's line of authority runs from the Board of Directors to the CEO to senior management to mid-level staff. An organization chart (*Attachment 3: Organizational Chart*) illustrates Kedren's structure. The Board delegates oversight of day-to-day operations of the organization to the CEO. The CEO delegates day-to-day management responsibility of the HRSA project to the COO for Primary Care. The COO of Primary Care, CFO, and CMO report directly to the CEO. The CMO is responsible for all medical matters and directly oversees all medical staff. The CFO is responsible for the overseeing the fiscal and billing staff of Kedren, and the COO of Primary Care is responsible for overseeing all other health center staff not currently supervised under the CFO and CMO. The CEO's specific duties *are detailed in Attachment 4: Position Descriptions for Key Management Staff.*

Contracts and Sub-awards

- 4) *If applicable, describe how you will maintain appropriate oversight and authority over all contracts for substantive programmatic work and all sub-awards services and sites (consistent with Forms 5A: Services Provided, 5B: Service Sites, and 8: Health Center Agreements, and Attachment 7: Summary of Contracts and Agreements), including:*
 - a) *The structure of the agreement (i.e., contract or sub-award).*

While Kedren does not have a sub-recipient or affiliation arrangement that could compromise the integrity of operations or care provided, Kedren maintains agreements with contracted providers and our CMO exercises full authority over the services provided to Kedren patients. When we engage provider-contractors outside of our agency, such as for specialty care, we electronically receive consult reports from these providers for each patient referred for services. This is consistent with *Form 5A: Services; Form 5B: Sites; Form 8: Health Center Agreements, and Attachment 7: Summary of Contracts and Agreements.*

Adhering strictly to HIPAA regulations, Kedren confers directly with contracted providers by telephone when there is an immediate need for authorization or when more extensive testing is recommended. Kedren includes in its service contracts and MOUs that the services are provided on a sliding fee to Kedren patients, and that no patient will be denied services based on their ability to pay. Kedren also ensures that there are formal written processes to ensure that the consult report will be shared with Kedren providers for follow-up with the patient Kedren reviews the operation history of these service contracts on an annual basis using a set of evaluative standards.

Please see *Attachment 7: Summary of Contracts/Agreements* for a summary of our active contracts.

- b) Ensuring the contractor/sub-recipient performs in accordance, with all applicable award terms, conditions, and requirements, including those found in section 330 of the PHS Act, implementing program regulations, and grants regulations in 45 CFR Part 75.*

All contracts through referral have within them specific expectations. These include seeing patients with limited means on a sliding fee schedule, follow-up with Kedren as their medical home, etc. The senior management team is assigned to monitor and approve services rendered by contracts. The record retention and all other Section 330 and 45 CFR Part 75 requirements are conveyed to all recipients if any contract funds from Kedren are paid to outside providers.

- c) Mechanisms to monitor contractor or sub-recipient performance.*

While Kedren does not have a sub-recipient or affiliation arrangement, contracts and MOUs for services are reviewed by the senior management team on an annual, or as needed, basis. New contracts and MOUs are brought to the Board of Directors for review and approved before signed.

- d) Requirements for the contractor or sub-recipient to provide data necessary for you to meet applicable federal financial and programmatic reporting requirements, as well as provisions addressing record retention and access, audit, and property management.*

As illustrated above, while Kedren does not have sub-recipient or affiliation relationship, all grants, contracts, and agreements are on file and incorporate data reporting requirements. The senior management team is responsible for assuring that all contractors provide the necessary data to meet both federal requirement and internal management requirements in addition to information related to accounting, expenditure, and other external reporting requirements.

Note: Upon award, your organization will be the legal entity held accountable for carrying out the approved Health Center Program scope of project, including the portion of these activities that may be carried out by contractors or sub-recipients.

Financial Accounting and Controls

5) *Describe how your financial accounting and internal control systems will:*

- a) Have the capacity to account for all federal award(s) in order to identify the source (receipt) and application (expenditure) of funds for federally-funded activities in whole or in part, including maintaining related source documentation pertaining to authorizations, obligations, unobligated balances, assets, expenditures, income, and interest under the federal award(s).*

The CFO, Regina Tercero, is supervised directly by the CEO, and is responsible for the financial operations of the corporation, and also reports to the Board of Directors. Ms. Tercero, with support from her qualified financial staff, is responsible for the financial condition of the Health Center Program Award and other Federal Awards and follows the policies and procedures regarding internal control systems and segregation of financial duties to ensure transparency and accurate accounting. The CFO provides monthly reports to the senior management team on the senior management team. As part of the duties, the Finance Department maintains related source documentation pertaining to authorizations, obligations, unobligated balances, assets, expenditures, income, and interest under the federal awards. The CFO is very efficient and organized in the execution of these required duties.

b) Assure that expenditures of the federal award funds will be allowable in accordance with the terms and conditions of the Federal Award and Federal Cost Principles.

Ms. Tercero, CFO, conducts regular in-depth analyses of the financial results of each Federal Award and reports to the senior management team, and Board of Directors monthly. She reviews all budget expenditures to assure that they are both allowable and can be allocated to the grant. Kedren has established policies and procedures which utilize a financial management and internal control system that is based on GAAP principles, safeguards assets and tracks financial performance of the health center. In addition, Kedren has written procedures for utilization of the Federal Payment Management System requirements. Systems are in place with all applicable accounting staff to assure that all grant funds in the scope of project are both allowable and allocable.

6) Describe how you conduct billing and collections, including:

a) Requesting applicable payments from patients, while ensuring that no patient is denied service based on inability to pay.

Sliding fee discounts are developed based on policies that take into account patient responsibility, preferences, and need. A \$20 nominal fee is charged for patients at 100% of the Federal Poverty Guidelines (FPG) and below. Patients scheduled for service are informed about fees and given the opportunity to apply for the sliding fee scale, if eligible. 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.

In addition, providers will discuss costs with patients before ordering recommended, but not medically necessary, lab tests or procedures. Patients are asked to pay their sliding scale fees at the time the services are received, however no patient is denied services based on his or her ability

to pay. Kedren front office staff are trained every six months on handling billing, and are re-trained every year on the sliding fee schedule.

b) Educating patients on insurance and, if applicable, third-party coverage options available to them.

Comprehensive primary and preventive health care services are provided to all patients across their lifecycles, either directly or through contract or referral to collaborative partners and agencies, regardless of the patient's insurance coverage or ability to pay. Our billing staff is in constant communication with patients who have private insurance to assist them with a payment plan for co-pays and co-insurance fees, as well as educating them on third-party coverage, when appropriate. Patients scheduled for service are informed about fees and given the opportunity to apply for the sliding fee scale, if eligible, by completing a hardship form. In addition, providers will discuss costs with patients before ordering recommended, but not medically necessary, lab tests or procedures.

Furthermore, the availability of discounted services is posted in Kedren patient areas, including the waiting room and intake window. 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.

c) Billing Medicare, Medicaid, Children's Health Insurance Program (CHIP), and other public and private assistance programs or insurance in a timely manner, as applicable.

Kedren has a high collection rate from Medi-Cal and Medicare. A patient's eligibility for a given program is determined at the time of the initial visit and re-confirmed semi-annually thereafter or as required by our specific contracts and grants. Kedren's billing staff, with support from MedCor, Kedren's contracted billing company, reviews third-party payment denials weekly and ensures that issues are addressed immediately. Furthermore, the CFO and COO review all standard reports from MedCor on a monthly basis, and have standing meetings with MedCor to review billing activity. The Board of Directors also reviews third-party collection rates on a quarterly basis.

Through the combined efforts of Kedren billing staff, the COO, and the assigned MedCor billing staff, Kedren has established systems to assure that every reasonable effort is made to both accurately bill and collect appropriate reimbursement from Medi-Cal, Medicare, CHIO, patients and other service reimbursement sources.

Should an uninsured patient not meet the criteria for any public assistance programs, he or she is categorized as a self-pay patient. As such, payment for Kedren's services rendered is based on a sliding fee schedule. The extent of the discount is determined by the patient's household income and number of dependents relative to the FPG. Payment is requested at the time of each visit and upon receipt of a monthly statement of account. The billing process is conducted in accordance

with Kedren's financial policies and procedures. Kedren also has an enrollment specialist who on a weekly basis helps enroll patients into appropriate insurance plans, including My Health LA.

Telehealth

7) *Describe how you use or plan to use telehealth for the following, as applicable:*

a) Facilitating access to required primary and additional (including specialty) services.

In collaboration with Charles R. Drew University of Medicine and Science, Kedren just completed a telemedicine room located at the health center. The room includes state of the art equipment to help facilitate patient intake, as well as host treatment session. While the process is still being finalized, we anticipate providing behavioral health services at our health clinic through the use of our telehealth equipment. However, we are taking into account that many Kedren patients do not have their own homes, or even cell phones, thus providing telehealth services could be difficult. Knowing this, we anticipate conducting a needs assessment, as well as feasibility study, to determine the best use of this innovative service.

Using a care management, and patient centered medical home model, we anticipate using telehealth to confer with other providers and provider organizations with which Kedren has referred patients.

b) Providing long-distance primary and additional health services to health center patients.

Based on the needs assessment and feasibility study which will be conducted over the next year, we will have a better sense of how best to implement this innovative service.

c) Providing health education to health center patients.

As illustrated previously, we anticipate having a better sense of how to use health information technology following a needs assessment and feasibility study, which could potential include health education to patients via a telehealth platform.

d) Facilitating professional education.

Plans for using the telehealth equipment for professional education is under development.

e) Promoting public health.

Population health improvement uses of the new telehealth capability is being planned.

National Quality Recognition

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

Kedren is in the process of obtaining Patient Centered Medical Home (PCMH) recognition for its main service delivery site, which will be completed by September 2018.

Federal Benefits Participation

- 9) *Describe your current status or plans for participating in related federal benefits (e.g., Federal Tort Claim Act (FTCA) coverage, FQHC Medicare/FQHC Medicaid/CHIP reimbursement, 340 Drug Pricing Program, National Health Service Corps providers). If you do not have plans to seek FTCA coverage, describe plans for maintaining or obtaining private malpractice insurance. Refer to Section VIII for details.*

As an FQHC, Kedren takes advantage of related federal benefits, including a state license to operate as a community clinic, and participation in the PPS reimbursement program. Kedren also participates in Medicare and Medi-Cal reimbursement, and medications dispensed at our health center sites are purchased through the 340B Drug Pricing Program. Children vaccines are obtained through the Vaccine for Children's Program, with Kedren following all required guidelines. We are also registered with the National Health Service Corps in that our FQHC designation establishes us as a Health Professional Shortage Area. Today, we currently have two clinical staff participating in the program. In 2019, we anticipate applying for FTCA coverage having developed a solid quality assurance program.

GOVERNANCE

- 1) *Describe where in Attachment 2: Bylaws and other components of this application you document meeting the Health Center Program board composition and authority requirements, as follows:*
 - a) *Board size is at least 9 and no more than 25 members, with either a specific number or range of board members prescribed (compliance demonstrated on Form 6A: Board Member Characteristics).*

Kedren's bylaws are reviewed annually; the most recent version of Kedren's bylaws were adopted at a Board meeting held on June 30, 2017. Regarding board size, Article Three, Section 3.3 of Kedren's bylaws states: "The number of directors shall be no less than nine and no more than 25, with an optimum range of 11-15." As indicated on Form 6A, there presently are 11 members serving on Kedren's Board.

- b) *At least 51 percent of board members are patients served by the health center (compliance demonstrated on Form 6A: Board Member Characteristics).*

Consistent with Form 6A, Article Three, Section 3.4 of Kedren’s bylaws stipulates that “A majority of the board members (51%) shall be individuals who are, or will be, served by the Center.” Additionally, the Article states that, “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) *Patient members of the board, as a group, reasonably represent the patient population in terms of demographic factors (e.g., gender, race, and ethnicity) (compliance demonstrated on Form 6A: Board Member Characteristics, consistent with Form 4: Community Characteristics).*

Article Three, Section 3.4 additionally stipulates that board members shall, “as a group, represent the individuals being served in terms of demographic factors, such as race, ethnicity, age, sex, and economic status.” The Kedren Board of Directors’ demographic makeup is illustrated in the table below and is compared to Kedren’s patient distribution. The information presented is congruent with *Form 6A: Board Member Characteristics*, and *Form 4: Community Characteristics*.

Characteristic	Kedren Board of Directors	Kedren Patient Distribution
Gender		
Male	18%	17%
Female	82%	83%
Ethnicity		
Hispanic or Latino	27%	50%
Non-Hispanic or Latino	73%	50%
Race		
White	0%	0%
Latino/Hispanic	27%	50%
Native Hawaiian/ Pacific Islander	0%	0%
Black/African-American	73%	50%
American Indian/Alaska Native	0%	0%
Asian	0%	0%

- d) *Non-patient members are representative of the community in which the health center is located, either by living or working in the community or by having a demonstrable connection to the community.*

As indicated in the bylaws, all board members are expected to live and/or work within Kedren's service area, regardless of whether they are patients or community representatives. Article Three, Section 3.4 stipulates that, "As a rule, user or patient board members should live and/or work in the service area." Regarding non-patient members, Article Three, Section 3.4 also states, "The "non-user" board members will be representative of the community in which the Health Center is located and should live or work in the service area." Additionally, Article Three of Section 3.2, of the bylaws states that, "There shall be representation from each community where Kedren has established a satellite."

- e) *Non-patient members provide relevant expertise and skills (e.g., community affairs, local government, finance and banking, legal affairs, trade unions and other commercial and industrial concerns, social services) (compliance demonstrated on Form 6A: Board Member Characteristics).*

Article Three, Section 3.4 states, "the remaining members of the Board (49%) shall be selected for their expertise in local government, finance and banking, legal affairs, business, education, clinical services, marketing, or any other expertise needed by the Corporation to fulfill its mission and meet its goals and objectives of serving the communities it represents." At present, Board members represent the following professions: Social Work, Psychology, Business/Administration, Finance, Accounting, Health Care, Nursing, Construction, and Foster Care.

- f) *No more than one-half of non-patient board members may earn more than 10 percent of their annual income from the health care industry (compliance demonstrated on Form 6A: Board Member Characteristics).*

Consistent with Form 6A, and as indicated in Article Three, Section 3.4, "No more than one half of the remaining members of the Board may be individuals who derive more than ten (10) percent of their income from the health care industry." At present, less than one-half of board members are from the health care industry.

- g) *Health center employees, contractors, and immediate family members of employees may not be health center board members.*

Article Three, Section 3.4 of Kedren's bylaws states, "No member of the Board shall be an employee of the Center, or spouse, or child, parent, brother or sister, aunt, uncle, grandparent, first cousin by blood or marriage of such an employee." Furthermore, the "CEO may be a non-voting ex-officio member of the Board." Kedren strictly adheres to this policy.

- h) *Board meetings occur monthly.*

According to Article Three, Section 3.1 in the Bylaws, as part of Board Functions and Responsibilities, the Board of Directors shall "hold regularly scheduled meetings, at least once each month." Additionally, as stated in Article Four, Section 4.1 of the Bylaws, the Board "shall hold regular monthly meetings at a time and place to be determined." The Kedren Board currently

holds monthly meetings on the last Friday of each month at Kedren Community Health Center, Inc., 4211 S. Avalon Blvd., Los Angeles, CA 90011 (Executive Board Room, 2nd Floor).

i) Approving the selection and dismissal or termination of the project director/CEO.

Article Three, Section 3.1 indicates that one of the board's "General Powers" is "to select, evaluate, and dismiss the Chief Executive Officer..." Additionally, as described in the same Section, under the Board Functions and Responsibilities, the bylaws state that one of the Board's primary functions is to, "approve the selection and dismissal of the Chief Executive Officer and evaluate his/her performance on an annual basis." This power is further discussed in Section 3.1 with the following statement. "Implementation of the 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."

j) Approving applications related to the health center project, including approving the annual budget, which outlines the proposed uses of both federal Health Center Program award and non-federal resources, including revenue.

Article Three, Section 3.1 of the bylaws state primary functions of the Board of Directors, which include "to approve annual budgets and ensure the conduction of annual independent audits." This duty includes ensuring the budget outlines the proposed uses of revenue, and both federal and non-federal resources. The Section also states that the Board monitors and evaluates center activities that include "financial goals including projected budget to actual expenditures." At each Board meeting, members received a revenue and expenditure report that is compared with budget projections. Variances between budgeted and actual revenue and expenses are discussed.

Article Three, Section 3.1 also addresses the Board's function to approve applications related to the health center. Under the Board Function and Responsibilities, the Board shall, "participate actively in grant activities including approving scope of service...provide input to grant applications, obtain board approval of all grants prior to submission, review Notice of Grant Award upon receipt including all terms and conditions... and due dates by which grant conditions must be met."

k) Approving proposed sites, hours of operation, and services.

As stated in Article Three, Section 3.1, of the bylaws, the Board of Directors will determine "...location and hours of operations..." Hours of operation are reviewed at least once each year based on input from patients and consumer Board members with consideration given the days and hours that maximize patient access to care.

l) Evaluating the performance of the health center.

According to Article Three, Section 3.1 in the Bylaws, as part of Board Functions and Responsibilities, the Board of Directors shall "monitor and evaluate center activities." Monthly

reports to the board include but are not limited to the following: service utilization patterns, productivity of the center, quality of care, patient satisfaction, achievement of project objectives (annual and long-range strategic plans), financial goals including projected budget to actual expenditures, and patient grievances. The Board also reviews its clinical performance measures monthly to ensure that each metric is approaching goal attainment.

m) Establishing or adopting policy related to the operations of the health center.

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.” Furthermore, the Section also states that one of the Board’s primary functions is to “establish policies and assure the center is operating in accordance with its established policies and procedures.” Benefiting from an active Board of Directors, which understands its role as a policy and oversight body, members work closely with the CEO to address policy concerns that are within its purview. In addition, The Board of Directors reviews its overall operating plan for Kedren annually, and approves the annual operating budget.

n) Assuring the health center operates in compliance with applicable federal, state, and local laws and regulations.

According to Article Three, Section 3.1 in the Bylaws, as part of Board Functions and Responsibilities, the Board of Directors shall “assure the center is operating in compliance with all applicable federal, state and local laws and regulations.” Further, in this same Section, the bylaws state, “The Board has the responsibility to assure the center is operating in compliance with federal, state, and local laws, including but not limited to, compliance with Federal Procurement standards and grant requirements including conflict of interest policies.”

Moreover, following the directive in the *HRSA Compliance Manual, Chapter 13: Conflict of Interest*, Kedren maintains written standards of conduct that inform employees, officers, and board members of conflict of interest, including organizational conflicts of interest, and for governing its actions with respect to the selection, award, and administration of contracts. In cases where a conflict of interest was identified, Kedren’s procurement records document adherence to its standards of conduct, and disciplinary actions take place for those who violate the standards of conduct.

o) If you are requesting funding to target any special populations, you have at least one representative on the board from/for each special population who can clearly communicate the special population’s needs/concerns (e.g., migratory and seasonal agricultural workers advocate, former or current homeless individual, current resident of public housing).

Not applicable.

- 2) *Describe how your governing board (consistent with Attachment 3: Project Organizational Chart) maintains authority and oversight over the proposed project, as outlined in Attachments 2: Bylaws, 6: Co-Applicant Agreement, and 8: Articles of Incorporation. Specifically affirm that:*

Kedren's Board of Directors have taken steps to assure that the Section 330 funded primary care program receives sufficient time and attention as part of the governance of the overall organization. To achieve this goal, Kedren's corporate Board divides its monthly Board meetings into two parts with the first part focused exclusively on Kedren Community Health Center. In this first segment of the meeting, a minimum of the first two hours is dedicated exclusively to the health center, with the COO and CMO of Primary Care not only in attendance but providing monthly reports on progress made towards operational and clinical goals. During which all board members participate in review, discussion and action-plan setting, when needed. This Board meeting agenda management is one of several steps taken to assure compliance with the HRSA requirements that the Board maintains authority and oversight over the proposed project.

- a) *No individual, entity, or committee (including, but not limited to, an executive committee authorized by the board) reserves or has approval/veto power over the board with regard to the required authorities and functions.*

In accordance to Kedren policies, and consistent with Attachment 3, Attachment 2, Attachment 6, and Attachment 8, Kedren's Board of Directors maintains authority and oversight over the proposed project. As indicated by Board resolution approved July 27, 2018, Kedren explicitly ensures that no individual, no committee, and no entity of any kind reserves the power over the board to veto/approve any decisions, with regard to the required authorities and functions of the board.

- b) *Collaboration or agreements with other entities do not restrict or infringe upon the board's required authorities and functions.*

As indicated by board resolution approved July 27, 2018, Kedren explicitly provides assurance that any collaborations or agreements with other entities do not restrict or infringe upon the board's required authorities and/or functions.

- c) *New public agency applicants with a co-applicant board: Attachment 6: Co-Applicant Agreement delegates the required authorities and functions to the co-applicant board and delineates the respective roles and responsibilities of the public agency and the co-applicant in carrying out the project.*

Not applicable.

- d) *Applicants requesting PHPC funding: 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.*

Not applicable.

3) *INDIAN TRIBES OR TRIBAL, INDIAN, OR URBAN INDIAN GROUPS ONLY: Describe your organization's governance structure, operation, and process for assuring adequate:*

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 Narrative, and Form 2: Staffing Profile, and Form 3: Income Analysis that reflects projected costs and revenues necessary to support the proposed project (see Form 3: Income Analysis for details regarding revenue sources).*

Kedren is requesting \$929,507 per year in Federal section 330(e) funds, which matches the proposed allocation on HRSA's Service Area Announcement Table (SAAT). The federal funding represents 28.4% of the total projected budget of \$3,264,810 in Year 1, 28.2% of the total budget of \$3,288,163 in Year 2, and 26.3% of the total budget of \$3,524,029 in Year 3. Kedren maximizes operational use of federal support through effective financial management and economies of scale. The requested funding is appropriate to Kedren's proposed service delivery plan, detailed in this narrative, which will serve 4,700 unduplicated patients via 14,370 patient visits in the year ending December 31, 2020. This budget is aligned and consistent with the proposed service delivery plan and projected new patients to be served. The Board of Directors has approved this budget.

2) *Describe how you have considered and planned for mitigating the adverse impacts of financial or workforce-related challenges (e.g., payer mix changes, workforce recruitment or retention challenges).*

With the continued evolution of and uncertainty of federal and state healthcare policy changes as they relate to the Affordable Care Act, value-based health care versus a per-procedure reimbursement model, and progress toward a single-payer healthcare system, Kedren expects the demand for low-cost/no-cost care to continue to increase in the service area. These changes include the potential elimination of Medicaid expansion and a growth in the uninsured population due to high premium costs driven by private insurers. Though Kedren is committed to keeping costs down, it will continue to respond to the increasing demand for low-cost healthcare.

Kedren will continue to pursue and strengthen collaborations with community partners to leverage resources, maximize third-party payers, practice appropriate billing and collections procedures, and pursue private foundation support in order to optimize financial support, in-kind contributions, and any other assistance for its operations. The amounts of federal grant funds being requested in this application will be supplemented by these other sources of support.

Finally, Kedren intends to pursue funding more aggressively from individuals, foundations, state, and local government sources to ensure a strong financial foundation in light of the above-mentioned uncertainties.

In light of workforce recruitment challenges, Kedren participates in the National Health Services Corp (NHSC) where clinicians working at an approved site, like Kedren, receive funding for their initial two-year commitment and may be eligible for additional years of support to help pay their student loans. With the addition of students who are completing their residencies at Kedren, we anticipate some of them joining Kedren full-time and also benefitting from the NHSC program. We also provide a competitive benefits package, and are developing a provider incentive program based on QI/QA activities (e.g. quality, patient satisfaction, productivity).