Health & Human Services Agency
COUNTY OF TULARE
AGENDA ITEM

AGENDA DATE: November 19, 2019

Public Hearing Required	Yes ☐	N/A ☒
Scheduled Public Hearing w/Clerk	Yes ☐	N/A ☒
Published Notice Required	Yes ☐	N/A ☒
Advertised Published Notice	Yes ☐	N/A ☒
Meet & Confer Required	Yes ☐	N/A ☒
Electronic file(s) has been sent	Yes ☒	N/A ☐
Budget Transfer (Aud 308) attached	Yes ☐	N/A ☒
Personnel Resolution attached	Yes ☐	N/A ☒
Agreements are attached and signature line for Chairman is marked with tab(s)/flag(s)	Yes ☒	N/A ☐

CONTACT PERSON: Donna Ortiz PHONE: 624-8000

SUBJECT: Authorize the Health and Human Services Agency to apply for certification as a National Health Service Corps-approved site

REQUEST(S):

That the Board of Supervisors:

1. Authorize the Health and Human Services Agency, Mental Health Branch to apply for certification as a National Health Service Corps-approved site for the Visalia Adult Integrated Clinic and Porterville Mental Health Clinic for a period of three (3) years effective upon approval;

2. Authorize the Director of Mental Health to sign and submit the required Site Agreement;

3. Authorize the Director of Mental Health to sign and submit the required National Health Service Corps Comprehensive Behavioral Health Service Checklist and Site Data Table for Visalia Adult Integrated Clinic; and

4. Authorize the Director of Mental Health to sign and submit the required National Health Service Corps Comprehensive Behavioral Health Service Checklist and Site Data Table for Porterville Mental Health Clinic.

SUBJECT: Authorize the Health & Human Services Agency to apply for certification as a National Health Service Corps-approved site

DATE: November 19, 2019

SUMMARY:

The National Health Service Corps (NHSC) Loan Repayment Program (LRP) offers primary care medical, dental, and mental and behavioral health providers the opportunity to have their student loans repaid, while earning a competitive salary, in exchange for providing health care in urban, rural, or tribal communities with limited access to care. Providers are able to participate in the LRP as long as they are working in a NHSC-approved site.

The Health and Human Services Agency (HHSA), Mental Health Branch, is requesting approval to apply for certification as a NHSC-approved site for the Visalia Adult Integrated Clinic and the Porterville Mental Health Clinic. Tulare County has been recognized as having a shortage of licensed professionals in both the physical and behavioral health fields by the Health Resources and Services Administration. As part of the application process, HHSA is required to sign a Site Agreement, and each clinic is required to complete and sign a NHSC Comprehensive Behavioral Health Services Checklist for evaluation. The certification is effective upon approval and valid for three years.

Licensed professionals are considered hard-to-fill classifications and as a NHSC-approved site, the County enhances its recruitment process by incentivizing licensed providers to seek employment at either the Visalia Adult Integrated Clinic or the Porterville Mental Health Clinic. If certified as NHSC-approved sites, licensed providers may apply for loan repayment assistance through the NHSC LRP in exchange for at least two years of service at either clinic.

FISCAL IMPACT/FINANCING:

There are no fees associated with this certification; therefore, approval will have no impact to the County General Fund.

LINKAGE TO THE COUNTY OF TULARE STRATEGIC BUSINESS PLAN:

The County's five-year strategic plan includes the Quality of Life Initiative that encourages innovative provision of quality supportive services for at-risk adults, youth, and children in state and federally mandated programs. This agreement increases the ability to fulfill that obligation by providing an additional incentive for providers to seek employment providing mental health services at the Visalia Adult Integrated Clinic and the Porterville Mental Health Clinic.

ADMINISTRATIVE SIGN-OFF:

Donna Ortiz
Director of Mental Health

Cc: County Administrative Office

SUBJECT: Authorize the Health & Human Services Agency to apply for certification as a National Health Service Corps-approved site

DATE: November 19, 2019

Attachment(s) Site Agreement
NHSC Comprehensive Behavioral Health Checklist for Visalia Adult Integrated Clinic
Site Data Table for Visalia Adult Integrated Clinic
NHSC Comprehensive Behavioral Health Checklist for Porterville Mental Health Clinic
Site Data Table for Porterville Mental Health Clinic

BEFORE THE BOARD OF SUPERVISORS
COUNTY OF TULARE, STATE OF CALIFORNIA

IN THE MATTER OF AUTHORIZE THE HEALTH AND HUMAN SERVICES AGENCY TO APPLY FOR CERTIFICATION AS A NATIONAL HEALTH SERVICE CORPS-APPROVED SITE

Resolution No. _____
Agreement No. _____

UPON MOTION OF SUPERVISOR _____, SECONDED BY SUPERVISOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF SUPERVISORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST: JASON T. BRITT
COUNTY ADMINISTRATIVE OFFICER/
CLERK, BOARD OF SUPERVISORS

BY: _____
Deputy Clerk

* * * * * * * * * * * * * * * * * * *

1. Authorized the Health and Human Services Agency, Mental Health Branch to apply for certification as a National Health Service Corps-approved site for the Visalia Adult Integrated Clinic and Porterville Mental Health Clinic for a period of three (3) years effective upon approval;

2. Authorized the Director of Mental Health to sign and submit the required Site Agreement;

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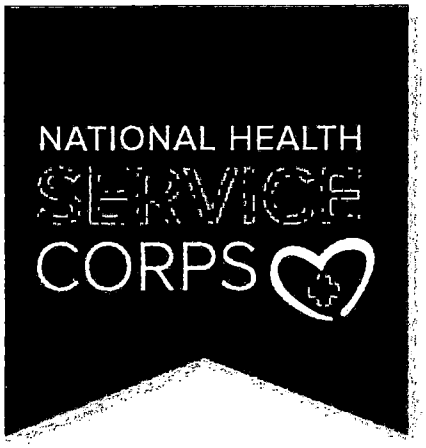
4. Authorized the Director of Mental Health to sign and submit the required National Health Service Corps Comprehensive Behavioral Health Service Checklist and Site Data Table for Porterville Mental Health Clinic.



National Health Service Corps
SITE AGREEMENT

National Health Service Corps (NHSC) approved sites must meet all requirements stated below at the time of application and must continue to meet the requirements in order to maintain status as an NHSC-approved site.

1. Is located in and treats patients from a federally designated Health Professional Shortage Area (HPSA).
2. Does not discriminate in the provision of services to an individual (i) because the individual is unable to pay; (ii) because payment for those services would be made under Medicare, Medicaid, or the Children's Health Insurance Program (CHIP); or (iii) based upon the individual's race, color, sex, national origin, disability, religion, age, or sexual orientation. *[May or may not be applicable to Indian Health Service Facilities, Tribally-Operated 638 Health Programs, and Urban Indian Health Programs (ITUs)].*
    a. Uses a schedule of fees or payments for services consistent with locally prevailing rates or charges and designed to cover the site's reasonable costs of operation. *(May or may not be applicable to ITUs, free clinics, or prisons.)*
    b. Uses a discounted/sliding fee schedule to ensure that no one who is unable to pay will be denied access to services. This system must provide a full discount to individuals and families with annual incomes at or below 100% of the Federal Poverty Guidelines (only nominal fees may be charged). Therefore, those with incomes between 100% and 200% of the Federal Poverty Guidelines must be charged in accordance with a sliding discount policy based on family size and income. *(May or may not be applicable to ITUs, free clinics, or prisons.)*
    c. Makes every reasonable effort to secure payment in accordance with the schedule of fees or schedule of discounts from the patient and/or any other third party. *(May or may not be applicable to ITUs, free clinics, or prisons.)*
    d. Accepts assignment for Medicare beneficiaries and has entered into an appropriate agreement with the applicable State agency for Medicaid and CHIP beneficiaries. *(May or may not be applicable to ITUs, free clinics, or prisons.)*
    e. Prominently displays a statement in common areas and on site's website (if one exists) that explicitly states that (i) no one will be denied access to services due to inability to pay; and (ii) there is a discounted/sliding fee schedule available. When applicable, this statement should be translated into the appropriate language/dialect. *(May or may not be applicable to ITUs, free clinics, or prisons.)*

3. Provides culturally competent, comprehensive primary care services (medical, dental, and/or behavioral) which correspond to the designated HPSA type. For a detailed description of culturally and linguistically appropriate services in health, visit http://minorityhealth.hhs.gov/.
4. Uses a credentialing process which, at a minimum, includes reference review, licensure verification, and a query of the National Practitioner Data Bank (NPDB) of those clinicians for whom the NPDB maintains data.
5. Functions as part of a system of care that either offers or assures access to ancillary, inpatient, and specialty referrals.
6. Adheres to sound fiscal management policies and adopts clinician recruitment and retention policies to help the patient population, the site, and the community obtain maximum benefits.
7. Maintains a clinician recruitment and retention plan, keeps a current copy of the plan onsite for review, and adopts recruitment policies to maintain clinical staffing levels needed to appropriately serve the community.
8. Does not reduce the salary of NHSC clinicians because they receive or have received benefits under the NHSC Loan Repayment or Scholarship programs.
9. Requires NHSC clinicians to maintain a primary care clinical practice (full-time or half-time) as indicated in their contract with NHSC and described in part below. **The site administrator must review and know the clinician's specific NHSC service requirements.** Time spent on call will not count toward a clinician's NHSC work hours. Participants do not receive service credit hours worked over the required hours per week, and excess hours cannot be applied to any other work week. Clinicians must apply for a suspension if their absences per year are greater than those allowed by NHSC. If a suspension is requested and approved, the participant's service obligation end date will be extended accordingly. Please refer to the NHSC Loan Repayment Program Application and Program Guidance for definitions of NHSC service requirements.
10. Communicates to the NHSC any change in site or clinician employment status for full-time and half-time, including moving an NHSC clinician to a satellite site for any or all of their hour work week, termination, etc.
11. Supports clinicians with funding and arrangements, including clinical coverage, for their time away from the site to attend NHSC-sponsored meetings, webinars, and other continuing education programs.
12. Maintains and makes available for review by NHSC representatives all personnel and practice records associated with an NHSC clinician including documentation that contains such information that the Department may need to determine if the individual and/or site has complied with NHSC requirements.
13. Completes and submits NHSC Site Data Tables (requires 12 months of data) to NHSC at time of site application, recertification, and NHSC site visits.
14. Complies with requests for a site visit from NHSC or the State Primary Care Office with adherence to all NHSC requirements.

Site Official's Signature: _____ Date: _____

Site Official's Title: Director of Mental Health

Bureau of Health Workforce
U.S. Department of Health and Human Services
Health Resources and Services Administration

OMB No. 0915-0127
Form Approved
Exp. Date 02/29/2020

NHSC COMPREHENSIVE BEHAVIORAL HEALTH SERVICES CHECKLIST

Attach all signed affiliation agreements for any service elements not provided onsite.

****Only NHSC Site Administrators are permitted to submit certification documents****

Name of Site Visalia Adult Integrated Clinic

Address 520 East Tulare Avenue, Visalia, CA 93292

Section I. Core Comprehensive Behavioral Health Service Elements The following three sets of services *must* be provided onsite; these services cannot be offered through affiliation.	**Provided Onsite (Select One)** **Yes**	**No**
1. **Screening and Assessment:** *Screening* is the practice of determining the presence of risk factors, early behaviors, and biomarkers which enables early identification of behavioral health disorders (e.g., warning signs for suicide, substance abuse, depression) and early access to care. *Assessment* is a structured clinical examination that analyzes patient bio-psych-social information to evaluate a behavioral health complaint.	X	
2. **Treatment Plan:** A formalized, written document that details a patient's current clinical symptoms, diagnosis, and outlines the therapeutic strategies and goals that will assist the patient in reducing clinical symptoms and overcoming his or her behavioral health issues. The plan also identifies, where indicated, clinical care needs and treatment(s) to be provided by affiliated health and behavioral health care providers and settings.	X	
3. **Care Coordination:** *Care Coordination* is the practice of navigating and integrating the efforts primary care, specialty health care and social service providers to support a patient's health, wellness and independence.	X	

Section II. Additional Comprehensive Behavioral Health Service Elements The following four sets of services *may* be provided onsite or through formal affiliation. Signed affiliation agreements must be uploaded to the BHW Customer Service Portal for any services not provided onsite.	**Provided Onsite (Select One)** **Yes**	**No**
1. **Diagnosis:** The practice of determining a patient's emotional, socio-emotional, behavioral or mental symptoms as a diagnosable disorder in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM; most current edition) and International Classification of Disease (ICD; most current edition).	X	
2. **Therapeutic Services (including, but not limited to, psychiatric medication prescribing and management, chronic disease management, and Substance Use Disorder Treatment):** Broad range of evidence-based or promising behavioral health practice(s) with the primary goal of reducing or ameliorating behavioral health symptoms, improve functioning, and restore/maintain a patient's health (e.g., individual, family, and group psychotherapy/ counseling; psychopharmacology; and short/long-term hospitalization).	YES	

Section II. Additional Comprehensive Behavioral Health Service Elements The following four sets of services *may* be provided onsite or through formal affiliation. Signed affiliation agreements must be uploaded to the BHW Customer Service Portal for any services not provided onsite.	**Provided Onsite (Select One)** **Yes**	**No**
a. Psychiatric Medication Prescribing and Management	X	
b. Substance Use Disorder Treatment	X	
c. Short/long-term hospitalization	X	
d. Other (Please list) _____ Substance Use Disorder Residential Treatment and Co-Occuring Disorder Residential Affiliation	X	
e. Other (Please list) Rehabilitation skill building	X	
3. **Crisis/Emergency Services (including, but not limited to, 24-hour crisis call access):** The method(s) used to offer immediate, short-term help to individuals who experience an event that produces emotional, mental, physical, and behavioral distress or problems. In some instances, a crisis may constitute an imminent threat or danger to self, to others, or grave disability. *(Note: generic hotline, hospital emergency room referral, or 911 is not sufficient).*	X	
4. **Consultative Services:** The practice of collaborating with health care and other social service providers *(e.g., education, child welfare, and housing)* to identify the biological, psychological, medical and social causes of behavioral health distress, to determine treatment approach(s), and to improve patient functioning.	X	
5. **Case Management:** The practice of assisting and supporting patients in developing their skills to gain access to needed health care, housing, employment, social, educational and other services essential to meeting basic human needs and consistent with their health care treatment, symptom management, recovery and independent functioning.	X	

Section III. Affiliation Agreements for Off-Site Behavioral Health Services

For each of the services under Section II that are provided off-site, a formal affiliation agreement(s) must be uploaded to the BHW Customer Service Portal. Under this section, the NHSC-approved site must provide basic information for each entity with which a formal affiliation is in place.

Affiliated Entity: Keweah Delta Health Care District	**Affiliated Entity:** Kings View Corporation
Address: 400 West Mineal King Avenue, Visalia, CA 93291	**Address:** 7170 North Financial Drive, Suite 110, Fresno, CA 93720
Services Covered Under Affiliation: Short term inpatient services	**Services Covered Under Affiliation:** telepsych services, direct behavior health services
Date Affiliation Agreement Executed: 04/25/2017	**Date Affiliation Agreement Executed:** 07/01/2018
Services available under this agreement are offered to all without regard for the ability to pay? Yes ☒ No ☐	**Services available under this agreement are offered to all without regard for the ability to pay?** Yes ☒ No ☐
Affiliated Entity: Turning Point	**Affiliated Entity:** Bakersfield Behavioral HealthCare Hospital
Address: 615 Atwood Street, Visalia, CA, 93277	**Address:** 5201 White Lane, Bakersfiled, Ca 93309
Services Covered Under Affiliation: SMHS adults adn adolescents	**Services Covered Under Affiliation:** Short term inpatient services
Date Affiliation Agreement Executed: 07/01/2018	**Date Affiliation Agreement Executed:** 07/01/2017
Services available under this agreement are offered to all without regard for the ability to pay? Yes ☒ No ☐	**Services available under this agreement are offered to all without regard for the ability to pay?** Yes ☒ No ☐

Section IV. Certification of Compliance with Behavioral Health Clinical Practice Requirements Certify that the behavioral health site adheres to the clinical practice requirements for behavioral health providers under the NHSC and supports NHSC participants in meeting their obligation related to the clinical practice requirements.	**Site Meets Criteria (Select One)** Yes	No
Fulltime: The site offers employment opportunities that adhere to the NHSC definition of full-time clinical practice. Full-time clinical practice for behavioral health providers means a minimum of 40 hours/week, for a minimum of 45 weeks/service year. At least 32 hours/week are spent providing patient care at the approved service site(s). Of the minimum 32 hours spent providing patient care, no more than 8 hours/week may be spent in a teaching capacity. The remaining 8 hours/week are spent providing patient care at the approved site(s), providing patient care in alternative settings (e.g., hospitals, nursing homes, shelters) as directed by the approved site(s), and as an extension of care at the approved site, or performing clinical-related administrative activities.	☒	☐

Section IV. Certification of Compliance with Behavioral Health Clinical Practice Requirements Certify that the behavioral health site adheres to the clinical practice requirements for behavioral health providers under the NHSC and supports NHSC participants in meeting their obligation related to the clinical practice requirements.	**Site Meets Criteria (Select One)** Yes	No
Half-time: The site offers employment opportunities that adhere to the NHSC definition of half-time clinical practice. Half-time clinical practice for behavioral health providers means a minimum of 20 hours/week, for a minimum of 45 weeks/service year. At least 16 hours/week are spent providing patient care at the approved service site(s). Of the minimum 16 hours spent providing patient care, no more than 4 hours/week may be spent in a teaching capacity. The remaining 4 hours/week are spent providing patient care at the approved site(s), providing patient care in alternative settings (e.g., hospitals, nursing homes, shelters) as directed by the approved site(s), and as an extension of care at the approved site, or performing clinical-related administrative activities.	[X]	[ ]

we do provide part time internship opportunities for paid employees of other departments within HHSA as well as non-paid, part time internship opportunities for some individualls referred from schools of higher education seeking training opportunities.

Section V. Site Certification:

By signing below, the NHSC Site Administrator is affirming the truthfulness and accuracy of the information in this document.

I, Donna Ortiz, hereby certify that the information provided above, and all supporting information, is true and accurate. I understand that this information is subject to verification by the NHSC.

Signature Date

OFFICIAL NHSC USE ONLY		
Recommended By:	[ ] Certified	[ ] Not Certified
Comments:		

NATIONAL HEALTH SERVICE CORPS

Site Data Tables

Site Name: Visalia Adult Integrated Clinic

Site Address: 520 East Tulare Avenue, Visalia, CA 93292

Site Address:

Date Prepared: 09/11/2019

Prepared By: Diane Higginbotham

6-Month Reporting Period (from mm/yy to mm/yy): 01/19 - 08/19

Total Patients: 2,137

Total Patient Visits: 21951

TABLE 1: PATIENTS OR VISITS BY PRIMARY INSURANCE TYPE

Primary Insurance	Complete data for "Number of Patients" OR "Number of Patient Visits"			
	Number of Patients	Percentage (Patients)	Number of Patient Visits	Percentage (Visits)
1) Medicare	312	14.60	1,173	5.34
2) Medicaid	1,603	75.01	19,005	86.58
3) Other Public Insurance				
4) Private Insurance	26	1.22	207	0.94
5) Sliding Fee Schedule (SFS)	128	5.99	1,447	6.59
6) Self-Pay (No Insurance and not on SFS)	68	3.18	119	0.54
7) Total	2,137	100.00	21,951	100.00

Site Data Tables

TABLE 2: PATIENT SERVICE CHARGES, COLLECTIONS, AND SELF-PAY ADJUSTMENT

Payment Source	Full Charges (a)	Amount Collected (b)
1) Medicare	$ 240,050.00	$ 12,995.00
2) Medicaid	$ 3,195,036.00	$ 1,798,162.00
3) Other Public Insurance	$ 3,886.00	
4) Private Insurance	$ 35,140.00	$ 4,983.00
5) Self-Pay	$ 268,382.00	$ 350.00
6) Total (lines 1-5)	$ 3,742,494.00	$ 1,816,490.00

Self-Pay Adjustment Type	Adjustments (c)
7) Self-Pay Sliding Fee Adjustments	$ 234,881.91
8) Other Self-Pay Adjustments (e.g., Self-Pay Bad Debt)	$ 0.00
9) Total Self-Pay Adjustments (lines 7 and 8)	$ 234,881.91

TABLE 3: PATIENT APPLICATIONS FOR SLIDING FEE SCHEDULE (SFS)

Patient Applications for the Sliding Fee Schedule	Number of Applications
1) SFS Applications Approved	90
2) SFS Applications Not Approved	1,152
3) Total SFS Applications Received	1,242

Site Data Tables

TABLE 4: SERVICE SITE STAFFING

Personnel by Major Service Categories	FTEs
Medical Services	
1) Family Practitioners	
2) General Practitioners	
3) Internists	
4) Obstetrician/Gynecologists	
5) Pediatricians	
6) Psychiatrists	6.90
7) Other Physician Specialists	
8) Total Physicians (lines 1-7)	6.90
9) Nurse Practitioners/Physician Assistants	
10) Certified Nurse Midwives	
11) Nurses	4.00
12) Other Medical Support Personnel	2.00
13) Total Medical Services (lines 8-12)	12.90
Ancillary Services	
14) Laboratory Services Personnel	
15) X-Ray Services Personnel	
16) Pharmacy Personnel	
17) Total Ancillary Services (lines 14-16)	
Dental Services	
18) Dentists	
19) Dental Hygienists	
20) Dental Assistants, Aides, Technicians, and Support	
21) Total Dental Services (lines 18-20)	
Mental Health and Behavior	
22) Mental Health & Behavioral Health Specialists	14.60
23) Mental Health & Behavioral Health Support Personnel	51.00
24) Total MH & BH Services (lines 22-23)	65.60
25) TOTAL (lines 13, 17, 21, and 24)	78.50

NOTES: Sliding fee numbers are from a sampling of financials between 01/2019-08/2019. The specific months sampled were Jan/Apr. The final figures were an extrapolated calculation of what the data would look like for 8 months.

Site Data Tables

General Instructions

Reporting Period
The reporting period should include up-to-date data for the preceding six months. Please indicate the start and end dates of the six months for which the site is reporting.

Scope of Activity Reported
The NHSC Site Data Tables are site specific (one per physical address). Activity at other sites owned or operated by the applicant site is to be excluded.

All related activity of all providers at the site is to be reported, including activity of all NHSC and non-NHSC providers at the site. Related activity includes all primary care services and related supplemental services, which support the primary health care activity.

These services are an integral part of the primary care delivery system:
Under direction and control of the applicant site; and
Provided by the site's providers to the applicant site's patients.

The services are provided at the approved site location or by the site's providers to the applicant site's patients at approved off-site locations such as the patient's home, nursing home, emergency room or hospital.

Sites may elect to include or exclude all or some portion of referred care services paid by the applicant site which are rendered to the site's patients at off-site locations. This election may be based upon the ability or ease of reporting this information on a site specific basis. The same scope of off-site referred care should be used to complete the visit, patient, charge, and cost tables.

Institutional or large provider organizations may opt to limit the scope of reportable activity to the smallest set of common primary care services that can readily be reported at the site.

Who Submits Site Data Tables
The NHSC Site Data Tables are to be filed by those parties which enter into an agreement with the Secretary of the Department of Health and Human Services to participate as an NHSC member site and which are not currently receiving grant support from the Health Resources and Services Administration's Bureau of Primary Health Care (HRSA/BPHC). The NHSC Site Data Tables are to be completed prior to an NHSC Site Visit. Only one report per site is to be filed.

- The following eligible Auto-Approved NHSC Sites ARE NOT required to submit the NHSC Site Data Tables: 1) FQHCs, and 2) FQHC Look-Alikes. The standard HRSA/BPHC Uniform Data System (UDS) report will be reviewed in place of the data tables.
- The following eligible Auto-Approved NHSC sites must provide NHSC Site Data Tables upon request if HRSA needs to determine NHSC site eligibility: 1) ITUs, 2) Federal Prisons, 3) State Prisons, and 4) ICE Health Service Corps sites.

Site Data Tables

Detailed Table Instructions

Table 1: Patients or Visits by Primary Insurance Type

The number of patients or patient visits by primary insurance type may be actual or estimated. Estimates are to be based upon a sample. The minimum sample size is 200 records of randomly selected patients or visits. The total number of patients and the total number of visits should be based upon actual data.

A patient may have coverage under more than one insurance plan, different coverage for different services and this coverage may change over the course of a year. When medical services are provided, report the patient's ***primary health insurance covering primary medical care***, if any, ***as of the last visit during the reporting period***. If medical services are not provided, report the patient's primary insurance, if any, for the services offered. Report the patient's primary health insurance even though it may not have covered the services rendered during the patient's last visit.

Primary insurance is defined as the insurance plan or program that the site would ***bill first*** for services rendered.

Example: Report Medicare as the primary insurance if a patient has both Medicare and Medicaid because Medicare is billed before Medicaid. Report the employer plan as the primary insurance if a patient has both an employer plan and Medicare because the employer plan is billed first.

(Line 1) Medicare: patients whose primary insurance is a plan for Medicare beneficiaries including Rural Health Clinic (RHC), managed care, Federally Qualified Health Center (FQHC), and other reimbursement arrangements administered by Medicare or by a fiscal intermediary.

(Line 2) Medicaid: patients whose primary insurance is a plan for Medicaid beneficiaries including RHC, managed care, FQHC, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, Child Health Insurance Program (CHIP) and other reimbursement arrangements administered either directly by the state agency or by a fiscal intermediary

(Line 3) Other Public Insurance: patients whose primary insurance is provided by federal, state, or local governments that is not reported elsewhere such as, state indigent care programs, city welfare, and similar government plans. A CHIP operated independently from the Medicaid program is an example of other public insurance. Patients with health benefit plans offered to government employees, retirees and dependents such as TRICARE, the federal employees health benefit program, state employee health insurance benefit programs, teacher health insurance and similar plans are to be classified as private insurance patients. Private insurance is earned and other public insurance is unearned. ***Patients with no insurance but who have public categorical or other grant funds applied to their accounts for services received are to be classified as self-pay.*** The National Breast and Cervical Cancer Early Detection Program is an example of a categorical grant program, which is not insurance.

(Line 4) Private Insurance: patients whose primary insurance is a private insurance plan, managed care plan, or a contractual arrangement. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, and service contracts with employers and others. As noted above, patients with health benefit plans offered to government employees, retirees and dependents such as TRICARE, the federal employees' health benefit program, state employee health insurance benefit programs, teacher health insurance and similar plans are to be classified as private insurance patients.

(Line 5) Sliding Fee Schedule (SFS): patients participating in the site's sliding fee discount program who do not have other coverage. NHSC sites are expected to make services available through the use of a sliding fee discount schedule or other documented means of eliminating financial barriers for those at or below 200 percent of the federal poverty income guidelines. All Sliding Fee Discount Programs must include the following elements:

- Applicable to all individuals and families with annual incomes at or below 200 percent of the most current FPG; and
- Provide a full discount for individuals and families with annual incomes at or below 100 percent of the FPG, with allowance for a nominal charge only, consistent with site's policy; and
- Adjust fees (partial sliding fee discount) based on family size and income for individuals and families with incomes above 100 percent and at or below 200 percent of the FPG.

The most current poverty guidelines can be found at http://aspe.hhs.gov/poverty. The data reported here should be based upon the number of patients making use of the sliding fee discount policy as their primary source of coverage.

(Line 6) Self-Pay (no insurance and not on SFS): patients without any health insurance and not participating in the site's sliding discount fee schedule program. As noted above, patients with no insurance but who have categorical or other grant funds applied to their accounts for services received are to be classified as self-pay.

(Line 7) Total: the sum of lines 1-6.

Table 2: Patient Service Charges, Collections, and Self-Pay Adjustment
This table shows the patient service charges, receipts, and sliding fee discounts by payment source for all related activity of all providers at the site to which the NHSC provider is assigned. See the General Instructions for a definition of the scope of activity to be reported. Report in whole dollars.

Charges and collections are to be reported in ***five pay classes:*** Medicare, Medicaid, other public, private insurance, and self-pay. Charges and receipts are to be identified with the payer, which is the responsible party. For instance, Medicare receipts are attributable to Medicare even though the receipts were made by an intermediary such as Blue Shield. Similarly, charges and receipts for which a Medicare beneficiary is personally responsible such as deductibles and copayments are self-pay rather than Medicare charges and receipts.

Site Data Tables

(Column a) Full Charges: the gross charges as established by the site for the services rendered during the reporting period. Charges are reported at their full value for all services prior to any adjustments. Fee-for-service charges are uniformly reported at the full charge rate from the site's fee schedule. Site's with capitation contracts or who are reimbursed on a cost based flat fee, such as a RHC rate or FQHC rate are to report the normal full charge from the site's fee schedule rather than the negotiated visit, capitation, or contract rate.

Charges are to reflect the amount for which the payer is responsible. ***Deductibles, copayments, and uncovered services for which the patient is personally responsible should be reclassified and reported as self-pay. Similarly, any charges*** not payable by a third party payer that are due from the patient or another third party should be deducted from the payer's charges and added to the account of the secondary payer. The reclassification of charges to secondary and subsequent payers may be estimated based upon a sample.

Sites may elect to include or exclude all or some portion of paid referred care services rendered to the site's patients at off-site locations. This election may be based upon the ability or ease of reporting this information on a site-specific basis. The same scope of off- site referred care should be used to complete the visit, patient, charge, and cost tables.

(Column b) Amount Collected: the actual cash received during the period for services rendered, regardless of the date of service. This includes RHC and FQHC settlement receipts, case management fee receipts, incentive receipts from managed care plans, and other similar receipts.

Amounts collected are the amounts collected from the payer. If there is more than one payer involved in a given visit, the charges due from the primary payer and the amount collected from the primary payer are reported on the primary payer line. The charges due from the secondary payer are reported on the secondary payer line along with any amounts collected from the secondary payer. The reclassification of charges and collections to secondary and subsequent payers may be estimated based upon a sample of accounts.

(Column c) Adjustments: the difference between the full charges and the amount actually received or expected. The only adjustments to be reported here are self-pay adjustments.

(Line 1) Medicare (Title XVIII): charges and receipts related to services provided to Medicare beneficiaries that are payable by insurance plans operated under Title 18 of the Social Security Act including FQHC, RHC, or any other reimbursement arrangement excluding capitated managed care administered by Medicare or its fiscal intermediaries.

(Line 2) Medicaid (Title XIX): charges and receipts related to services provided to Medicaid beneficiaries and payable by insurance plans operated under Title 19 of the Social Security Act, including FQHC, RHC, case management, fee-for- service managed care, EPSDT Program, CHIP and any other reimbursement arrangement, excluding capitated managed care, administered either directly by the state agency or by its fiscal intermediaries.

(Line 3) Other Public: charges and receipts related to services provided to patients and payable by insurance plans operated by federal, state, or local governments that are not reported elsewhere such as separately administered CHIP, state or county indigent care programs, city welfare, and similar plans. This may also include that portion of charges and receipts from public categorical service grants, which are directly applied to a self-pay or insured patient's account. The National Breast and Cervical Cancer Early Detection Program is one example of a public categorical service grant program whose charges and receipts are classifiable as other public.

(Line 4) Private Insurance: charges and receipts related to services provided to patients and payable by insurance plans other than those reported above such as a private insurance plan, managed care plan, or a contractual arrangement. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, and service contracts with employers, schools, health departments, and others. Health benefit plans offered to government employees, retirees and dependents such as TRICARE, the federal employees health benefit program, state employee health insurance benefit programs, teacher health insurance and similar plans are to be classified as private insurance.

(Line 5) Self-Pay: charges and receipts related to services provided to patients without any principal health insurance or to patients with insurance but only that portion for which the patient is personally liable such as deductible, copayments, and uncovered charges. Charges not paid by a third party payer and due from the patient should be deducted from the full charges of the third party payer and added to the full charges for the self-pay patients.

(Line 6) Total: the sum of lines 1–5.

(Line 7) Self-Pay Sliding Fee Adjustments: the value of charge discounts granted to patients prior to service and based upon financial hardship. It does not include professional courtesy, staff, service incentive, or similar discounts. Also, it does not include bad debt adjustments related to patients who were initially charged full fee but unable to pay because of financial hardship or other reasons. If a hardship fund is used to pay for the referred lab, x-ray, pharmacy or other care for sliding fee patients, report the charge value of those services in column (a) and an offsetting sliding fee adjustment in column (c). Sliding fee discounts reflect the site's compliance with its assurance to the NHSC that there are no financial barriers to care for those at or below 200 percent of the current federal poverty income guideline.

(Line 8) Other Self-Pay Adjustments: the value of all self-pay adjustments other than sliding fee adjustments. This includes bad debt and charity adjustments taken or granted to self-pay patients who were initially charged a full, discounted, or partial fee but who subsequently were either unwilling or unable to pay the amounts charged. It does not include bad debt related to other pay sources, which may be caused by a failure to file timely claims, payer bankruptcy or similar reasons.

(Line 9) Total Self-Pay Adjustments: the sum of lines 7 and 8.
compliance with its assurance to the NHSC that there are no financial barriers to care for those at or below 200 percent of the current federal poverty income guideline.

Site Data Tables

Table 3: Patient Applications for the Sliding Fee Schedule
This table provides information on the number of unique sliding fee schedule applications submitted by patients/clients during the reporting period.

(Line 1) SFS Applications Approved: the number of patient applications for the sliding fee schedule received during the reporting period that were approved for discounted service.

(Line 2) SFS Applications Not Approved: the number of patient applications for the sliding fee schedule received during the reporting period that were not approved for discounted services for any reason (e.g., incomplete application, patient did not meet poverty guideline requirements, application not processed).

(Line 3) Total SFS Applications Received: the total number of patient applications for the sliding fee schedule received during the reporting period. This should be equal to the sum of lines 1-2.

Table 4: Service Site Staffing
This table profiles the personnel by major service category. The number of staff is reported in full time equivalents (FTEs).

Staff: salaried full-time or part-time employees of the applicant site who work on behalf of the site and non- salaried individuals paid by the applicant site who work ***for the site on a regular schedule that is controlled by the site*** under any of the following compensation arrangements: contract, NHSC assignment, retainer, capitation, block time, fee-for-service, and ***donated time.*** Provider staff work at the NHSC approved site. Support staff may work for the site at other locations. Regularly scheduled means a pre- assigned number of work hours devoted to the site's activities.

FTEs are reported for staff and are not reported for non-staff individuals. Some examples of staff and non-staff personnel are noted below:

- NHSC providers are considered staff.
- Providers working onsite under contract on a scheduled basis are considered staff.
- Referral providers who are paid by the applicant site are considered non-staff when working independently at unapproved off-site locations such as the referral provider's office.
- Contracted support staff working under a contract which replaces personnel the site would otherwise have hired, who work directly for the site, who may work either on or off-site, and ***who work for the site on a regularly scheduled basis*** are consider "staff" whose time or FTE value is to be reported. This might include personnel employed by a practice management company, a management services organization, billing service company, or similar contractor. If individuals under these arrangements work on an irregular, unscheduled or indirect basis, they are considered non-staff and their FTEs are not counted.
- Professionals working for the site under legal, audit, actuarial, management consulting, and similar contracts for services provided on a one-time, sporadic, or unscheduled basis are considered non-staff.
- Consulting pathologists, radiologists, and other consulting providers who provide services on an unscheduled or sporadic basis are considered non-staff.

Site Data Tables

FTEs: full time equivalents for ***all staff***. Full time equivalents are computed on an individual basis by dividing the total number of hours in the reporting period for which a person was compensated by the total number of hours in the year considered by the site to be full-time. The total number of hours for which an individual was compensated includes the number of hours a person was present for work and paid for their time, as well as paid leave time including vacation, sick leave, continuing education trips, etc. An annual hours pay base of 2,080 (40 hours/week x 52 weeks/year) is typical but the base may vary by organization and by class of employee. Employees who work less than the annual hour's base are normally considered part time. An individual staff member is not to be reported as more than 1.00 full time equivalents regardless of any overtime hours worked or compensation paid. Round FTEs to the second decimal place.

Salaried provider staff FTEs are to be calculated based upon the number of paid hours, not the number of scheduled hours. A provider who schedules 32 hours per week to see patients but who is paid for a 40-hour week is considered full time or 1.00 FTE.

Contract provider and support staff FTEs are to be calculated by dividing the hours the staff worked by the hours a full time employee of that type would be expected to work. The time worked in the numerator is to be taken from contracts, invoices, schedules or similar sources. The denominator or base of hours considered full-time for these arrangements should not include leave time unless leave is directly charged or the time salaried clinicians of that type are ordinarily not scheduled to see patients. For example, if full time salaried providers are expected to schedule 32 hours of patient care per week, a contract provider who was paid for 16 hours of scheduled patient care per week would be considered half time or 0.50 FTE. The annual scheduled hour's base considered full-time for contract providers is likely to vary by clinical specialty.

Time for personnel performing more than one function should be allocated as appropriate among the major personnel service categories. For example, the time of a physician who is also a medical director should be allocated between medical care services and administration. Time for nurses who also provide case management services should be allocated between medical care and case management.

Personnel by Major Service Category: FTEs are classified into four service categories. The categories are: medical care services; ancillary services, dental services; and mental health and behavioral health services.

(Lines 1 through 6) Physicians: (M.D. or D.O.): separate FTE totals for family practitioners, general practitioners, internists, obstetrician/gynecologists, pediatricians, psychiatrists, and all other specialists. Use board certification to classify physicians by specialty. Classify physicians with more than one board certification in the specialty representing the service the physician provides most, or allocate based upon time spent.

(Lines 1 through 6) Physicians: (M.D. or D.O.): separate FTE totals for family practitioners, general practitioners, internists, obstetrician/gynecologists, pediatricians, psychiatrists, and all other specialists. Use board certification to classify physicians by specialty. Classify physicians with more than one board certification in the specialty representing the service the physician provides most, or allocate based upon time spent.

(Line 7) Total Physicians: FTE total for medical services, lines 1-6.

(Line 8) Nurse Practitioners: FTE total for nurse practitioner staff performing medical services. Nurse practitioners include psychiatric nurse practitioners.

(Line 9) Physician Assistants: FTE total for physician assistant staff performing medical services.

(Line 10) Certified Nurse Midwives: FTE total for nurse midwives performing medical service.

(Line 11) Nurses: FTE total for nurses that are involved in provision of medical services, including registered nurses, licensed practical nurses, home health and visiting nurses,
clinical nurse specialists, and public health nurses. If an individual's time is divided between medical and nonmedical services, allocate the FTEs to reflect this division of time. For example, nurses who provide case management or education/counseling services in addition to medical care should be allocated between medical services and other services.

(Line 12) Other Medical Support Personnel: FTE total for medical assistants, nurse aides, and all other personnel providing services together with or in direct support of services provided by a physician, nurse practitioner, physician assistant, certified nurse midwife, or nurse. ***FTEs for registration, reception, appointments, transcription, patient records, and other support personnel are not reported.***

(Line 13) Total Medical Services: FTE total for medical services, lines 1-12.

(Line 14) Laboratory Services Personnel: FTE total for pathologists, medical technologists, laboratory technicians and assistants, phlebotomists. This ***refers exclusively to medical personnel not dental personnel.*** Dental personnel performing laboratory services are reported on lines 18-20. Lab visits are not reported.

(Line 15) X-ray Personnel: FTE total for radiologists, X-ray technologists, X-ray technicians and ultrasound technicians. ***Only report medical personnel not dental personnel.*** Dental personnel performing x-ray services are reported on lines 18-20. X-ray visits are not reported.

(Line 16) Pharmacy Personnel: FTE total for pharmacists and pharmacist assistants.

(Line 17) Total Ancillary Services: FTE total for ancillary services, lines 14 through 16.

(Line 18) Dentists: FTE total for general practitioners and specialists including oral surgeons, periodontists, and pedodontists.

(Line 19) Dental Hygienists: FTE total for dental hygienists.

(Line 20) Dental Assistants, Aides & Technicians: FTE total for other dental

personnel including dental assistants, aides, and technicians.

(Line 21) Total Dental Services: FTE total for dental services, lines 18-20.

(Line 22) Mental Health and Behavioral Health Specialists: FTE total for individuals providing counseling or treatment services related to mental health or behavioral health including clinical psychologists, clinical social workers, psychiatric social workers, psychiatric nurses, mental health nurses, and family therapists. ***Report psychiatrists on line 6 under physicians and psychiatric nurse practitioners on line 9 under nurse practitioners, not in this category.***

(Line 23) Mental Health and Behavioral Health Support Personnel: FTE total for assistants, aides, and all other personnel providing services in conjunction with or in direct support of services provided by mental health and behavioral health specialists.

(Line 24) Total Mental Health and Behavioral Health Services: FTE total for mental health and behavioral health services, lines 22 and 23.

(Line 25) Total: FTE grand total.

Bureau of Health Workforce
U.S. Department of Health and Human Services
Health Resources and Services Administration

OMB No. 0915-0127
Form Approved
Exp. Date 02/29/2020

NHSC COMPREHENSIVE BEHAVIORAL HEALTH SERVICES CHECKLIST

Attach all signed affiliation agreements for any service elements not provided onsite.

****Only NHSC Site Administrators are permitted to submit certification documents****

Name of Site Porterville Mental Health Clinic

Address 1055 West Henderson Avenue, Porterville, Ca 93257

Section I. Core Comprehensive Behavioral Health Service Elements The following three sets of services *must* be provided onsite; these services cannot be offered through affiliation.	**Provided Onsite (Select One)** **Yes**	**No**
1. **Screening and Assessment:** *Screening* is the practice of determining the presence of risk factors, early behaviors, and biomarkers which enables early identification of behavioral health disorders (e.g., warning signs for suicide, substance abuse, depression) and early access to care. *Assessment* is a structured clinical examination that analyzes patient bio-psych-social information to evaluate a behavioral health complaint.	X	
2. **Treatment Plan:** A formalized, written document that details a patient's current clinical symptoms, diagnosis, and outlines the therapeutic strategies and goals that will assist the patient in reducing clinical symptoms and overcoming his or her behavioral health issues. The plan also identifies, where indicated, clinical care needs and treatment(s) to be provided by affiliated health and behavioral health care providers and settings.	X	
3. **Care Coordination:** *Care Coordination* is the practice of navigating and integrating the efforts primary care, specialty health care and social service providers to support a patient's health, wellness and independence.	X	

Section II. Additional Comprehensive Behavioral Health Service Elements The following four sets of services *may* be provided onsite or through formal affiliation. Signed affiliation agreements must be uploaded to the BHW Customer Service Portal for any services not provided onsite.	**Provided Onsite (Select One)** **Yes**	**No**
1. **Diagnosis:** The practice of determining a patient's emotional, socio-emotional, behavioral or mental symptoms as a diagnosable disorder in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM; most current edition) and International Classification of Disease (ICD; most current edition).	X	
2. **Therapeutic Services (including, but not limited to, psychiatric medication prescribing and management, chronic disease management, and Substance Use Disorder Treatment):** Broad range of evidence-based or promising behavioral health practice(s) with the primary goal of reducing or ameliorating behavioral health symptoms, improve functioning, and restore/maintain a patient's health (e.g., individual, family, and group psychotherapy/ counseling; psychopharmacology; and short/long-term hospitalization).	YES	

Section II. Additional Comprehensive Behavioral Health Service Elements The following four sets of services *may* be provided onsite or through formal affiliation. Signed affiliation agreements must be uploaded to the BHW Customer Service Portal for any services not provided onsite.	**Provided Onsite (Select One)** **Yes**	**No**
a. Psychiatric Medication Prescribing and Management	X	
b. Substance Use Disorder Treatment	X	
c. Short/long-term hospitalization	X	
d. Other (Please list) _____ Substance Use Disorder Residential Treatment and Co-Occuring Disorder Residential Affiliation	X	
e. Other (Please list) Rehabilitation	X	
3. **Crisis/Emergency Services (including, but not limited to, 24-hour crisis call access):** The method(s) used to offer immediate, short-term help to individuals who experience an event that produces emotional, mental, physical, and behavioral distress or problems. In some instances, a crisis may constitute an imminent threat or danger to self, to others, or grave disability. *(Note: generic hotline, hospital emergency room referral, or 911 is not sufficient).*	X	
4. **Consultative Services:** The practice of collaborating with health care and other social service providers *(e.g., education, child welfare, and housing)* to identify the biological, psychological, medical and social causes of behavioral health distress, to determine treatment approach(s), and to improve patient functioning.	X	
5. **Case Management:** The practice of assisting and supporting patients in developing their skills to gain access to needed health care, housing, employment, social, educational and other services essential to meeting basic human needs and consistent with their health care treatment, symptom management, recovery and independent functioning.	X	

Section III. Affiliation Agreements for Off-Site Behavioral Health Services

For each of the services under Section II that are provided off-site, a formal affiliation agreement(s) must be uploaded to the BHW Customer Service Portal. Under this section, the NHSC-approved site must provide basic information for each entity with which a formal affiliation is in place.

Affiliated Entity: Keweah Delta Health Care District **Address:** 400 West Mineal King Avenue, Visalia, CA 93291 **Services Covered Under Affiliation:** Short term inpatient services **Date Affiliation Agreement Executed:** 04/25/2017 **Services available under this agreement are offered to all without regard for the ability to pay?** Yes ☒ No ☐	**Affiliated Entity:** Kings View Corporation **Address:** 7170 North Financial Drive, Suite 110, Fresno, CA 93720 **Services Covered Under Affiliation:** telepsych services, direct behavior health services **Date Affiliation Agreement Executed:** 07/01/2018 **Services available under this agreement are offered to all without regard for the ability to pay?** Yes ☒ No ☐
Affiliated Entity: Turning Point **Address:** 615 Atwood Street, Visalia, CA, 93277 **Services Covered Under Affiliation:** SMHS adults adn adolescents **Date Affiliation Agreement Executed:** 07/01/2018 **Services available under this agreement are offered to all without regard for the ability to pay?** Yes ☒ No ☐	**Affiliated Entity:** Bakersfield Behavioral HealthCare Hospital **Address:** 5201 White Lane, Bakersfiled, Ca 93309 **Services Covered Under Affiliation:** Short term inpatient services **Date Affiliation Agreement Executed:** 07/01/2017 **Services available under this agreement are offered to all without regard for the ability to pay?** Yes ☒ No ☐

Section IV. Certification of Compliance with Behavioral Health Clinical Practice Requirements Certify that the behavioral health site adheres to the clinical practice requirements for behavioral health providers under the NHSC and supports NHSC participants in meeting their obligation related to the clinical practice requirements.	**Site Meets Criteria (Select One)** Yes	No
Fulltime: The site offers employment opportunities that adhere to the NHSC definition of full-time clinical practice. Full-time clinical practice for behavioral health providers means a minimum of 40 hours/week, for a minimum of 45 weeks/service year. At least 32 hours/week are spent providing patient care at the approved service site(s). Of the minimum 32 hours spent providing patient care, no more than 8 hours/week may be spent in a teaching capacity. The remaining 8 hours/week are spent providing patient care at the approved site(s), providing patient care in alternative settings (e.g., hospitals, nursing homes, shelters) as directed by the approved site(s), and as an extension of care at the approved site, or performing clinical-related administrative activities.	X	

Section IV. Certification of Compliance with Behavioral Health Clinical Practice Requirements Certify that the behavioral health site adheres to the clinical practice requirements for behavioral health providers under the NHSC and supports NHSC participants in meeting their obligation related to the clinical practice requirements.	**Site Meets Criteria (Select One)** Yes	No
Half-time: The site offers employment opportunities that adhere to the NHSC definition of half-time clinical practice. Half-time clinical practice for behavioral health providers means a minimum of 20 hours/week, for a minimum of 45 weeks/service year. At least 16 hours/week are spent providing patient care at the approved service site(s). Of the minimum 16 hours spent providing patient care, no more than 4 hours/week may be spent in a teaching capacity. The remaining 4 hours/week are spent providing patient care at the approved site(s), providing patient care in alternative settings (e.g., hospitals, nursing homes, shelters) as directed by the approved site(s), and as an extension of care at the approved site, or performing clinical-related administrative activities.	[x]	[ ]

we do provide part time internship opportunities for paid employees of other departments within HHSA as well as non-paid, part time internship opportunities for some individualls referred from schools of higher education seeking training opportunities.

Section V. Site Certification:

By signing below, the NHSC Site Administrator is affirming the truthfulness and accuracy of the information in this document.

I, Donna Ortiz, hereby certify that the information provided above, and all supporting information, is true and accurate. I understand that this information is subject to verification by the NHSC.

Signature Date

OFFICIAL NHSC USE ONLY		
Recommended By:	[ ] Certified	[ ] Not Certified
Comments:		

NATIONAL HEALTH SERVICE CORPS

Site Data Tables

Site Name: Porterville Mental Health Clinic

Site Address: 1055 West Henderson Ste. 2, Porterville, Ca 93257

Site Address:

Date Prepared: 09/11/2019

Prepared By: Diane Higginbotham

6-Month Reporting Period (from mm/yy to mm/yy): 01/19 - 08/19

Total Patients: 1,238

Total Patient Visits: 9066

TABLE 1: PATIENTS OR VISITS BY PRIMARY INSURANCE TYPE

Primary Insurance	Complete data for "Number of Patients" OR "Number of Patient Visits"			
	Number of Patients	Percentage (Patients)	Number of Patient Visits	Percentage (Visits)
1) Medicare	91	7.35	245	2.70
2) Medicaid	1,072	86.59	8,453	93.24
3) Other Public Insurance				
4) Private Insurance	28	2.26	184	2.03
5) Sliding Fee Schedule (SFS)	26	2.10	147	1.62
6) Self-Pay (No Insurance and not on SFS)	21	1.70	37	0.41
7) Total	1,238	100.00	9,066	100.00

Site Data Tables

TABLE 2: PATIENT SERVICE CHARGES, COLLECTIONS, AND SELF-PAY ADJUSTMENT

Payment Source	Full Charges (a)	Amount Collected (b)
1) Medicare	$ 40,537.00	$ 325.00
2) Medicaid	$ 1,454,748.00	$ 639,938.00
3) Other Public Insurance		
4) Private Insurance	$ 34,440.00	$ 5,754.00
5) Self-Pay	$ 37,887.00	$ 323.00
6) Total (lines 1-5)	$ 1,567,612.00	$ 646,340.00

Self-Pay Adjustment Type	Adjustments (c)
7) Self-Pay Sliding Fee Adjustments	$ 27,279.00
8) Other Self-Pay Adjustments (e.g., Self-Pay Bad Debt)	
9) Total Self-Pay Adjustments (lines 7 and 8)	$ 27,279.00

TABLE 3: PATIENT APPLICATIONS FOR SLIDING FEE SCHEDULE (SFS)

Patient Applications for the Sliding Fee Schedule	Number of Applications
1) SFS Applications Approved	36
2) SFS Applications Not Approved	828
3) Total SFS Applications Received	864

Site Data Tables

TABLE 4: SERVICE SITE STAFFING

Personnel by Major Service Categories	FTEs
Medical Services	
1) Family Practitioners	
2) General Practitioners	
3) Internists	
4) Obstetrician/Gynecologists	
5) Pediatricians	
6) Psychiatrists	1.20
7) Other Physician Specialists	
8) Total Physicians (lines 1-7)	1.20
9) Nurse Practitioners/Physician Assistants	
10) Certified Nurse Midwives	
11) Nurses	
12) Other Medical Support Personnel	2.00
13) Total Medical Services (lines 8-12)	3.20
Ancillary Services	
14) Laboratory Services Personnel	
15) X-Ray Services Personnel	
16) Pharmacy Personnel	
17) Total Ancillary Services (lines 14-16)	
Dental Services	
18) Dentists	
19) Dental Hygienists	
20) Dental Assistants, Aides, Technicians, and Support	
21) Total Dental Services (lines 18-20)	
Mental Health and Behavior	
22) Mental Health & Behavioral Health Specialists	12.00
23) Mental Health & Behavioral Health Support Personnel	4.00
24) Total MH & BH Services (lines 22-23)	16.00
25) TOTAL (lines 13, 17, 21, and 24)	19.20

NOTES:

Sliding fee numbers are from a sampling of financials between 01/2019-08/2019. The specific months sampled were Jan/Apr. The final figures were an extrapolated calculation of what the data would look like for 8 months.

Site Data Tables

General Instructions

Reporting Period
The reporting period should include up-to-date data for the preceding six months. Please indicate the start and end dates of the six months for which the site is reporting.

Scope of Activity Reported
The NHSC Site Data Tables are site specific (one per physical address). Activity at other sites owned or operated by the applicant site is to be excluded.

All related activity of all providers at the site is to be reported, including activity of all NHSC and non-NHSC providers at the site. Related activity includes all primary care services and related supplemental services, which support the primary health care activity.

These services are an integral part of the primary care delivery system:
Under direction and control of the applicant site; and
Provided by the site's providers to the applicant site's patients.

The services are provided at the approved site location or by the site's providers to the applicant site's patients at approved off-site locations such as the patient's home, nursing home, emergency room or hospital.

Sites may elect to include or exclude all or some portion of referred care services paid by the applicant site which are rendered to the site's patients at off-site locations. This election may be based upon the ability or ease of reporting this information on a site specific basis. The same scope of off-site referred care should be used to complete the visit, patient, charge, and cost tables.

Institutional or large provider organizations may opt to limit the scope of reportable activity to the smallest set of common primary care services that can readily be reported at the site.

Who Submits Site Data Tables
The NHSC Site Data Tables are to be filed by those parties which enter into an agreement with the Secretary of the Department of Health and Human Services to participate as an NHSC member site and which are not currently receiving grant support from the Health Resources and Services Administration's Bureau of Primary Health Care (HRSA/BPHC). The NHSC Site Data Tables are to be completed prior to an NHSC Site Visit. Only one report per site is to be filed.

- The following eligible Auto-Approved NHSC Sites ARE NOT required to submit the NHSC Site Data Tables: 1) FQHCs, and 2) FQHC Look-Alikes. The standard HRSA/BPHC Uniform Data System (UDS) report will be reviewed in place of the data tables.
- The following eligible Auto-Approved NHSC sites must provide NHSC Site Data Tables upon request if HRSA needs to determine NHSC site eligibility: 1) ITUs, 2) Federal Prisons, 3) State Prisons, and 4) ICE Health Service Corps sites.

Site Data Tables

Detailed Table Instructions

Table 1: Patients or Visits by Primary Insurance Type

The number of patients or patient visits by primary insurance type may be actual or estimated. Estimates are to be based upon a sample. The minimum sample size is 200 records of randomly selected patients or visits. The total number of patients and the total number of visits should be based upon actual data.

A patient may have coverage under more than one insurance plan, different coverage for different services and this coverage may change over the course of a year. When medical services are provided, report the patient's ***primary health insurance covering primary medical care***, if any, ***as of the last visit during the reporting period***. If medical services are not provided, report the patient's primary insurance, if any, for the services offered. Report the patient's primary health insurance even though it may not have covered the services rendered during the patient's last visit.

Primary insurance is defined as the insurance plan or program that the site would ***bill first*** for services rendered.

Example: Report Medicare as the primary insurance if a patient has both Medicare and Medicaid because Medicare is billed before Medicaid. Report the employer plan as the primary insurance if a patient has both an employer plan and Medicare because the employer plan is billed first.

(Line 1) Medicare: patients whose primary insurance is a plan for Medicare beneficiaries including Rural Health Clinic (RHC), managed care, Federally Qualified Health Center (FQHC), and other reimbursement arrangements administered by Medicare or by a fiscal intermediary.

(Line 2) Medicaid: patients whose primary insurance is a plan for Medicaid beneficiaries including RHC, managed care, FQHC, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, Child Health Insurance Program (CHIP) and other reimbursement arrangements administered either directly by the state agency or by a fiscal intermediary

(Line 3) Other Public Insurance: patients whose primary insurance is provided by federal, state, or local governments that is not reported elsewhere such as, state indigent care programs, city welfare, and similar government plans. A CHIP operated independently from the Medicaid program is an example of other public insurance. Patients with health benefit plans offered to government employees, retirees and dependents such as TRICARE, the federal employees health benefit program, state employee health insurance benefit programs, teacher health insurance and similar plans are to be classified as private insurance patients. Private insurance is earned and other public insurance is unearned. ***Patients with no insurance but who have public categorical or other grant funds applied to their accounts for services received are to be classified as self-pay.*** The National Breast and Cervical Cancer Early Detection Program is an example of a categorical grant program, which is not insurance.

(Line 4) Private Insurance: patients whose primary insurance is a private insurance plan, managed care plan, or a contractual arrangement. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, and service contracts with employers and others. As noted above, patients with health benefit plans offered to government employees, retirees and dependents such as TRICARE, the federal employees' health benefit program, state employee health insurance benefit programs, teacher health insurance and similar plans are to be classified as private insurance patients.

(Line 5) Sliding Fee Schedule (SFS): patients participating in the site's sliding fee discount program who do not have other coverage. NHSC sites are expected to make services available through the use of a sliding fee discount schedule or other documented means of eliminating financial barriers for those at or below 200 percent of the federal poverty income guidelines. All Sliding Fee Discount Programs must include the following elements:

- Applicable to all individuals and families with annual incomes at or below 200 percent of the most current FPG; and
- Provide a full discount for individuals and families with annual incomes at or below 100 percent of the FPG, with allowance for a nominal charge only, consistent with site's policy; and
- Adjust fees (partial sliding fee discount) based on family size and income for individuals and families with incomes above 100 percent and at or below 200 percent of the FPG.

The most current poverty guidelines can be found at http://aspe.hhs.gov/poverty. The data reported here should be based upon the number of patients making use of the sliding fee discount policy as their primary source of coverage.

(Line 6) Self-Pay (no insurance and not on SFS): patients without any health insurance and not participating in the site's sliding discount fee schedule program. As noted above, patients with no insurance but who have categorical or other grant funds applied to their accounts for services received are to be classified as self-pay.

(Line 7) Total: the sum of lines 1-6.

Table 2: Patient Service Charges, Collections, and Self-Pay Adjustment
This table shows the patient service charges, receipts, and sliding fee discounts by payment source for all related activity of all providers at the site to which the NHSC provider is assigned. See the General Instructions for a definition of the scope of activity to be reported. Report in whole dollars.

Charges and collections are to be reported in ***five pay classes:*** Medicare, Medicaid, other public, private insurance, and self-pay. Charges and receipts are to be identified with the payer, which is the responsible party. For instance, Medicare receipts are attributable to Medicare even though the receipts were made by an intermediary such as Blue Shield. Similarly, charges and receipts for which a Medicare beneficiary is personally responsible such as deductibles and copayments are self-pay rather than Medicare charges and receipts.

Site Data Tables

(Column a) Full Charges: the gross charges as established by the site for the services rendered during the reporting period. Charges are reported at their full value for all services prior to any adjustments. Fee-for-service charges are uniformly reported at the full charge rate from the site's fee schedule. Site's with capitation contracts or who are reimbursed on a cost based flat fee, such as a RHC rate or FQHC rate are to report the normal full charge from the site's fee schedule rather than the negotiated visit, capitation, or contract rate.

Charges are to reflect the amount for which the payer is responsible. ***Deductibles, copayments, and uncovered services for which the patient is personally responsible should be reclassified and reported as self-pay. Similarly, any charges*** not payable by a third party payer that are due from the patient or another third party should be deducted from the payer's charges and added to the account of the secondary payer. The reclassification of charges to secondary and subsequent payers may be estimated based upon a sample.

Sites may elect to include or exclude all or some portion of paid referred care services rendered to the site's patients at off-site locations. This election may be based upon the ability or ease of reporting this information on a site-specific basis. The same scope of off- site referred care should be used to complete the visit, patient, charge, and cost tables.

(Column b) Amount Collected: the actual cash received during the period for services rendered, regardless of the date of service. This includes RHC and FQHC settlement receipts, case management fee receipts, incentive receipts from managed care plans, and other similar receipts.

Amounts collected are the amounts collected from the payer. If there is more than one payer involved in a given visit, the charges due from the primary payer and the amount collected from the primary payer are reported on the primary payer line. The charges due from the secondary payer are reported on the secondary payer line along with any amounts collected from the secondary payer. The reclassification of charges and collections to secondary and subsequent payers may be estimated based upon a sample of accounts.

(Column c) Adjustments: the difference between the full charges and the amount actually received or expected. The only adjustments to be reported here are self-pay adjustments.

(Line 1) Medicare (Title XVIII): charges and receipts related to services provided to Medicare beneficiaries that are payable by insurance plans operated under Title 18 of the Social Security Act including FQHC, RHC, or any other reimbursement arrangement excluding capitated managed care administered by Medicare or its fiscal intermediaries.

(Line 2) Medicaid (Title XIX): charges and receipts related to services provided to Medicaid beneficiaries and payable by insurance plans operated under Title 19 of the Social Security Act, including FQHC, RHC, case management, fee-for- service managed care, EPSDT Program, CHIP and any other reimbursement arrangement, excluding capitated managed care, administered either directly by the state agency or by its fiscal intermediaries.

(Line 3) Other Public: charges and receipts related to services provided to patients and payable by insurance plans operated by federal, state, or local governments that are not reported elsewhere such as separately administered CHIP, state or county indigent care programs, city welfare, and similar plans. This may also include that portion of charges and receipts from public categorical service grants, which are directly applied to a self-pay or insured patient's account. The National Breast and Cervical Cancer Early Detection Program is one example of a public categorical service grant program whose charges and receipts are classifiable as other public.

(Line 4) Private Insurance: charges and receipts related to services provided to patients and payable by insurance plans other than those reported above such as a private insurance plan, managed care plan, or a contractual arrangement. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, and service contracts with employers, schools, health departments, and others. Health benefit plans offered to government employees, retirees and dependents such as TRICARE, the federal employees health benefit program, state employee health insurance benefit programs, teacher health insurance and similar plans are to be classified as private insurance.

(Line 5) Self-Pay: charges and receipts related to services provided to patients without any principal health insurance or to patients with insurance but only that portion for which the patient is personally liable such as deductible, copayments, and uncovered charges. Charges not paid by a third party payer and due from the patient should be deducted from the full charges of the third party payer and added to the full charges for the self-pay patients.

(Line 6) Total: the sum of lines 1–5.

(Line 7) Self-Pay Sliding Fee Adjustments: the value of charge discounts granted to patients prior to service and based upon financial hardship. It does not include professional courtesy, staff, service incentive, or similar discounts. Also, it does not include bad debt adjustments related to patients who were initially charged full fee but unable to pay because of financial hardship or other reasons. If a hardship fund is used to pay for the referred lab, x-ray, pharmacy or other care for sliding fee patients, report the charge value of those services in column (a) and an offsetting sliding fee adjustment in column (c). Sliding fee discounts reflect the site's compliance with its assurance to the NHSC that there are no financial barriers to care for those at or below 200 percent of the current federal poverty income guideline.

(Line 8) Other Self-Pay Adjustments: the value of all self-pay adjustments other than sliding fee adjustments. This includes bad debt and charity adjustments taken or granted to self-pay patients who were initially charged a full, discounted, or partial fee but who subsequently were either unwilling or unable to pay the amounts charged. It does not include bad debt related to other pay sources, which may be caused by a failure to file timely claims, payer bankruptcy or similar reasons.

(Line 9) Total Self-Pay Adjustments: the sum of lines 7 and 8.
compliance with its assurance to the NHSC that there are no financial barriers to care for those at or below 200 percent of the current federal poverty income guideline.

Site Data Tables

Table 3: Patient Applications for the Sliding Fee Schedule
This table provides information on the number of unique sliding fee schedule applications submitted by patients/clients during the reporting period.

(Line 1) SFS Applications Approved: the number of patient applications for the sliding fee schedule received during the reporting period that were approved for discounted service.

(Line 2) SFS Applications Not Approved: the number of patient applications for the sliding fee schedule received during the reporting period that were not approved for discounted services for any reason (e.g., incomplete application, patient did not meet poverty guideline requirements, application not processed).

(Line 3) Total SFS Applications Received: the total number of patient applications for the sliding fee schedule received during the reporting period. This should be equal to the sum of lines 1-2.

Table 4: Service Site Staffing
This table profiles the personnel by major service category. The number of staff is reported in full time equivalents (FTEs).

Staff: salaried full-time or part-time employees of the applicant site who work on behalf of the site and non- salaried individuals paid by the applicant site who work ***for the site on a regular schedule that is controlled by the site*** under any of the following compensation arrangements: contract, NHSC assignment, retainer, capitation, block time, fee-for-service, and ***donated time.*** Provider staff work at the NHSC approved site. Support staff may work for the site at other locations. Regularly scheduled means a pre- assigned number of work hours devoted to the site's activities.

FTEs are reported for staff and are not reported for non-staff individuals. Some examples of staff and non-staff personnel are noted below:

- NHSC providers are considered staff.
- Providers working onsite under contract on a scheduled basis are considered staff.
- Referral providers who are paid by the applicant site are considered non-staff when working independently at unapproved off-site locations such as the referral provider's office.
- Contracted support staff working under a contract which replaces personnel the site would otherwise have hired, who work directly for the site, who may work either on or off-site, and ***who work for the site on a regularly scheduled basis*** are consider "staff" whose time or FTE value is to be reported. This might include personnel employed by a practice management company, a management services organization, billing service company, or similar contractor. If individuals under these arrangements work on an irregular, unscheduled or indirect basis, they are considered non-staff and their FTEs are not counted.
- Professionals working for the site under legal, audit, actuarial, management consulting, and similar contracts for services provided on a one-time, sporadic, or unscheduled basis are considered non-staff.
- Consulting pathologists, radiologists, and other consulting providers who provide services on an unscheduled or sporadic basis are considered non-staff.

Site Data Tables

FTEs: full time equivalents for ***all staff***. Full time equivalents are computed on an individual basis by dividing the total number of hours in the reporting period for which a person was compensated by the total number of hours in the year considered by the site to be full-time. The total number of hours for which an individual was compensated includes the number of hours a person was present for work and paid for their time, as well as paid leave time including vacation, sick leave, continuing education trips, etc. An annual hours pay base of 2,080 (40 hours/week x 52 weeks/year) is typical but the base may vary by organization and by class of employee. Employees who work less than the annual hour's base are normally considered part time. An individual staff member is not to be reported as more than 1.00 full time equivalents regardless of any overtime hours worked or compensation paid. Round FTEs to the second decimal place.

Salaried provider staff FTEs are to be calculated based upon the number of paid hours, not the number of scheduled hours. A provider who schedules 32 hours per week to see patients but who is paid for a 40-hour week is considered full time or 1.00 FTE.

Contract provider and support staff FTEs are to be calculated by dividing the hours the staff worked by the hours a full time employee of that type would be expected to work. The time worked in the numerator is to be taken from contracts, invoices, schedules or similar sources. The denominator or base of hours considered full-time for these arrangements should not include leave time unless leave is directly charged or the time salaried clinicians of that type are ordinarily not scheduled to see patients. For example, if full time salaried providers are expected to schedule 32 hours of patient care per week, a contract provider who was paid for 16 hours of scheduled patient care per week would be considered half time or 0.50 FTE. The annual scheduled hour's base considered full-time for contract providers is likely to vary by clinical specialty.

Time for personnel performing more than one function should be allocated as appropriate among the major personnel service categories. For example, the time of a physician who is also a medical director should be allocated between medical care services and administration. Time for nurses who also provide case management services should be allocated between medical care and case management.

Personnel by Major Service Category: FTEs are classified into four service categories. The categories are: medical care services; ancillary services, dental services; and mental health and behavioral health services.

(Lines 1 through 6) Physicians: (M.D. or D.O.): separate FTE totals for family practitioners, general practitioners, internists, obstetrician/gynecologists, pediatricians, psychiatrists, and all other specialists. Use board certification to classify physicians by specialty. Classify physicians with more than one board certification in the specialty representing the service the physician provides most, or allocate based upon time spent.

(Lines 1 through 6) Physicians: (M.D. or D.O.): separate FTE totals for family practitioners, general practitioners, internists, obstetrician/gynecologists, pediatricians, psychiatrists, and all other specialists. Use board certification to classify physicians by specialty. Classify physicians with more than one board certification in the specialty representing the service the physician provides most, or allocate based upon time spent.

(Line 7) Total Physicians: FTE total for medical services, lines 1-6.

(Line 8) Nurse Practitioners: FTE total for nurse practitioner staff performing medical services. Nurse practitioners include psychiatric nurse practitioners.

(Line 9) Physician Assistants: FTE total for physician assistant staff performing medical services.

(Line 10) Certified Nurse Midwives: FTE total for nurse midwives performing medical service.

(Line 11) Nurses: FTE total for nurses that are involved in provision of medical services, including registered nurses, licensed practical nurses, home health and visiting nurses,
clinical nurse specialists, and public health nurses. If an individual's time is divided between medical and nonmedical services, allocate the FTEs to reflect this division of time. For example, nurses who provide case management or education/counseling services in addition to medical care should be allocated between medical services and other services.

(Line 12) Other Medical Support Personnel: FTE total for medical assistants, nurse aides, and all other personnel providing services together with or in direct support of services provided by a physician, nurse practitioner, physician assistant, certified nurse midwife, or nurse. ***FTEs for registration, reception, appointments, transcription, patient records, and other support personnel are not reported.***

(Line 13) Total Medical Services: FTE total for medical services, lines 1-12.

(Line 14) Laboratory Services Personnel: FTE total for pathologists, medical technologists, laboratory technicians and assistants, phlebotomists. This ***refers exclusively to medical personnel not dental personnel.*** Dental personnel performing laboratory services are reported on lines 18-20. Lab visits are not reported.

(Line 15) X-ray Personnel: FTE total for radiologists, X-ray technologists, X-ray technicians and ultrasound technicians. ***Only report medical personnel not dental personnel.*** Dental personnel performing x-ray services are reported on lines 18-20. X-ray visits are not reported.

(Line 16) Pharmacy Personnel: FTE total for pharmacists and pharmacist assistants.

(Line 17) Total Ancillary Services: FTE total for ancillary services, lines 14 through 16.

(Line 18) Dentists: FTE total for general practitioners and specialists including oral surgeons, periodontists, and pedodontists.

(Line 19) Dental Hygienists: FTE total for dental hygienists.

(Line 20) Dental Assistants, Aides & Technicians: FTE total for other dental

personnel including dental assistants, aides, and technicians.

(Line 21) Total Dental Services: FTE total for dental services, lines 18-20.

(Line 22) Mental Health and Behavioral Health Specialists: FTE total for individuals providing counseling or treatment services related to mental health or behavioral health including clinical psychologists, clinical social workers, psychiatric social workers, psychiatric nurses, mental health nurses, and family therapists. ***Report psychiatrists on line 6 under physicians and psychiatric nurse practitioners on line 9 under nurse practitioners, not in this category.***

(Line 23) Mental Health and Behavioral Health Support Personnel: FTE total for assistants, aides, and all other personnel providing services in conjunction with or in direct support of services provided by mental health and behavioral health specialists.

(Line 24) Total Mental Health and Behavioral Health Services: FTE total for mental health and behavioral health services, lines 22 and 23.

(Line 25) Total: FTE grand total.