The County of Santa Cruz
Integrated Community Health Center Commission
MEETING AGENDA

August 6, 2025 @ 1:00pm - 2:00pm

MEETING LOCATION: In-Person – 150 Westridge, Suite 101, Watsonville, Ca 95076 and 1080 Emeline Ave., Bldg. D, Admin Conference Room, Santa Cruz, CA 95060, 40 Eileen Street, Watsonville CA 95076, will connect through Microsoft Teams Meeting or call in (audio only) +1 831-454-2222,191727602# United States, Salinas Phone Conference ID: **191 727 602#**

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

1. Welcome/Introductions
2. Oral Communications
3. July 2, 2025, Meeting Minutes – Action Required
4. Policy 300.24 - Coverage for Medical Emergencies During and After-Hours Operating Procedures – Action Required
5. Policy 300.31 - Continuity of Care and Hospital Admitting – Action Required
6. False Claims Act P & P Approval – Action Required
7. Report on Prop 35 Ramifications for FQHCs
8. Quality Management Update
9. Financial Update
10. CEO Update

Action Items from Previous Meetings: **Action Item**	**Person(s) Responsible**	**Date Completed**	**Comments**
Proposition 35 passed. Report back next couple of months what does that mean on revenues that will be coming into the clinic system.	Julian		

Next meeting: Wednesday, September 3, 2025, 1:00pm - 2:00pm **Meeting Location: In-Person -** 150 Westridge, Suite 101, Watsonville, Ca 95076 and 1080 Emeline Ave., Bldg. D, Admin Conference Room, Santa Cruz, CA 95060. Commission will connect through Microsoft Teams Meeting or call in (audio only) +1 831-454- 2222,191727602# United States, Salinas Phone Conference ID: **191 727 602#**

The County of Santa Cruz Integrated Community Health Center Commission

Minute Taker: Mary Olivares

Minutes of the meeting held August 6, 2025

TELECOMMUNICATION MEETING: Microsoft Teams Meeting - or call-in number +1 916-318-9542 -- PIN# 500021499#

Attendance	
Rahn Garcia	Member
Dinah Phillips	Member
Marco Martinez-Galarce	Member
Michelle Morton	Member
Nicole Pfeil	Member
Amy Peeler	County of Santa Cruz, Chief of Clinics
Jennifer Herrera	County of Santa Cruz, Health Services Agency Director
Raquel Ruiz	County of Santa Cruz, Senior Health Services Manager
Julian Wren	County of Santa Cruz, Admin Services Manager
Mary Olivares	County of Santa Cruz, Admin Aide
Meeting Commenced at 1:00 pm and concluded at 2:10 pm	

Excused/Absent:

Excused: Christina Berberich
Excused: Len Finocchio
Absent: Maximus Grisso

1. Welcome/Introductions

Juliette Rezzato, Chief Deputy Clerk of the Board was present virtually to swear in commission member Nicole Pfeil.

2. Oral Communications:

3. July 2, 2025, Meeting Minutes – Action Required

Review of July 2, 2025, Meeting Minutes – Recommended for approval. Dinah motioned to accept minutes as presented. Marco second, and the rest of the members present were all in favor.

4. Policy 300.24 - Coverage for Medical Emergencies During and After-Hours Operating Procedures – Action Required

Raquel presented Policy 300.24 - Coverage for Medical Emergencies During and After-Hours Operating Procedures.
Raquel reported that two polices where combined into one. There were a few questions from commissioners on calling 911 for patients. Raquel will come back at a future meeting with updated policy for review and approval.

5. Policy 300.31 - Continuity of Care and Hospital Admitting – Action Required

Raquel reported it had been three years since this policy was reviewed and there were no significant changes. The commissioners had a few questions regarding policy. Raquel will update policy with language suggested and bring back policy at a future meeting for review and approval.

6. False Claims Act P & P Approval – Action Required

Julian reported this was a new policy he had brought to the commission a couple of months back and it was the commissions direction that Julian present this to County Counsel for review. Julian reported that County Counsel did not make any changes and approved the language as is. There was a motion from Marco to accept policy as presented. Michelle second, and the rest of the members present were all in favor.

7. Report on Prop 35 Ramifications for FQHCs

Julian reported on California Proposition (Prop) 35: Impact on Federally Qualified Health Centers (FQHCs). Julian reported on what is proposition 35 he reported Prop 35 makes the MCO tax permanent, requires federal approval each year, locks funds into Medi-Cal use only, protects Medi-Cal provider rate increases from being cut, and temporarily lifts state budget cap through 2027.
Julian reported on the Direct Financial Impacts of FQHCs. He stated it locks in 2023-24 Medi-Cal rate increases, prevents surprise cuts during budget downturns, and supports stable PPS wraparound and APM payments. Lastly Julian reported on final takeaways of prop 35 that there will be more stable funding for Medi-Cal, FQHCs benefit from steady reimbursement and planning confidence, and risk remains if CMS says no.

8. Quality Management Plan - Action Required

Raquel reported that the Watsonville Health Center reported on this month's quality improvement project on colorectal cancer screening. Raquel reported that the Community Health workers did a large outreach on getting colorectal screenings kits out to

patients. They created bilingual, easy to read instructions and as of June every physician numbers had climbed. Raquel also reported Ochin, who is the electronic health record vender had a grant from HRSA and they were in the top 20 performers of their grant. Lastly Raquel reported they had been awarded a healthcare technology grant in the amount of $50,000. With this grant they will purchase 2 exam tables, immunization refrigerator freezer combo, pharmaceutical refrigerator, ECG/EKG, vital signs monitors, and other miscellaneous supplies.
9. Financial Update
Julian reported at the end of last fiscal year 2024-2025 that the revenue was $46,894,756 and that was 91.37% of what they had budgeted for. He lastly reported that the deficit was $3,672,638.00.
10. CEO Update
Amy reported that it is National Health Centers Week, and the Board of Supervisors made a proclamation yesterday, and they will be holding a press conference this week. Amy also reported the new Director of the Health Services Agency will be starting in September. Lastly Amy reported they had been awarded the bronze award through HRSA and that only 5% of Health Centers nationwide receive this award. Raquel also reported they have a sustainability retreat scheduled later this month for the supervisors.

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☐ Minutes approved _____ ___/___/___

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

SUBJECT:	POLICY NO.:	
Coverage for Medical Emergencies During and After Hours Operating Procedures	**300.24**	COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY **Health Centers Division**
SERIES: 300 Patient Care and Treatment	**EFFECTIVE DATE:** March 2000	
APPROVED BY: Amy Peeler, Chief of Clinic Services	**REVISED:** November 2003 August 2017 March 2020 April 2024 August 2025	

GENERAL STATEMENT:

Primary care health centers are not equipped to provide sophisticated emergency medical care. The following during office hours procedures are to be used by staff in the instance when specific physician's orders are not immediately available, and while awaiting the 911 emergency medical response. The following after hours procedures are to be used in the instance that patients are seeking clinical advice over the phone outside of normal business hours.

POLICY STATEMENT: It is the policy of the County of Santa Cruz Health Services Agency (HSA) Health Centers Division to respond to an emergency need while awaiting a 911 emergency medical response.

It is the policy of HSA Health Centers Division that patients have timely access to interactive clinical advice to communicate over the telephone with a clinician outside of normal business hours in a manner that is culturally and linguistically appropriate. Clinical advice by telephone outside of normal business hours is communicated only to patients who are established with the HSA's Health Centers. Communication outside of normal business hours (and during business hours) by telephone is performed and documented in the patient's medical record in a manner that is consistent with medical and legal prudence.

REFERENCE: Health Centers Code Blue Protocol
HSA Health Center Protocol – After Hours Call Documentation

DURING OFFICE HOURS PROCEDURE:

1. The Health Centers Division maintains an emergency cart and ensures that all equipment used is accessible and in good working order. The equipment is inventoried monthly and tested according to recommendation of the vendor(s).

2. The first staff member on the scene currently trained in emergency response initiates cardiopulmonary resuscitation (CPR) or basic airway management as required.

SUBJECT: Coverage for Medical Emergencies During and After Hours Operating Procedures	POLICY NO.: **300.24**	

3. Any staff member who discovers a patient, visitor, or employee needing emergent care is responsible for activating the emergency medical system. This includes:
    a. Calling a "Code Blue"
    b. Getting appropriate assistance, including notifying an employee who is currently trained in CPR.
    c. Calling 911 or requesting another staff person call 911 and bring the AED.
    d. Notifying a clinician in the immediate vicinity of the location and type of emergency.

4. The first licensed clinician on the scene is responsible for managing the emergency situation until paramedics arrive. They should then assist as necessary. Until that time, the licensed clinician can delegate roles as they see fit for the effective performance of resuscitation.

5. A staff member is assigned to the entrance door to direct paramedics to the emergency location.

6. Thorough documentation of any patient involved in an emergency is required.

7. If the emergency involves a non-patient, a thorough incident report should be completed by the Health Center Manager or clinician on scene with input from staff present.

8. For any actual event requiring resuscitation, the Health Center Manager will be required to schedule a debrief within two working days with all involved staff members to debrief the event, provide support as needed, and review any suggestions for improvement.

AFTER HOURS PROCEDURE:

Patients can seek and receive clinical advice from an on call clinician employed by HSA by telephone when the office is closed in addition to when the office is open.

HSA establishes a monthly schedule for on call clinicians which can be found on the intranet site.

Patients are informed of the availability of outside of normal business hours coverage service when they establish care with an HSA Health Center, on the front door of the health centers, on the after visit summary, as well as on every appointment reminder card. The number is also stated on the outside of normal business hours message.

When patients call an HSA Health Center during usual operating hours they hear a recording that informs them:

SUBJECT: Coverage for Medical Emergencies During and After Hours Operating Procedures	POLICY NO.: **300.24**	

1. Of the Health Center's usual business hours.
2. To call 911 for a medical emergency.
3. Of the telephone number for the on call clinician.

Once the patient is connected to the answering service, the operator on duty at the answering service:

1. Obtains the caller's name, the patient's full name, the patient's date of birth, the primary clinician's name, and the reason for the call.
2. Identifies the correct clinician and contacts them.

The clinician contacts the patient within 30 minutes of receiving the call. The clinician provides the patient with advice related to his or her needs. All communications are documented in the patient's medical record in a manner that is consistent with medical and legal prudence.

If there is no response to the operator's call within 30 minutes from the on call clinician, the operator on duty at the answering service performs one or more of the following steps, listed in sequential order:

1. Calls the clinician on call.
2. Attempts to contact the on call clinician at his or her secondary contact number.
3. Calls the back up call clinician
4. Contacts the Medical Director on their secondary contact number.
5. If the back up call clinician and on call clinician is not reached the operator directs the patient to go to the Emergency Room.

The operator reports unsuccessful attempts to contact the on call clinician to the HSA Clinic Administration email or telephone call the next morning.

If applicable, the operator reports unsuccessful attempts to contact the on call clinician to the HSA Clinic Administration email or telephone call the next morning.

All communication is documented in the patient's record, including the content of the communication, the clinician, and date and time.

The HSA Health Centers strive to employ and make available clinicians who are able to speak in the language of its patients. In the event that a patient cannot be accommodated with a clinician fluent in the patient's language, the clinician is responsible for initiating a three-way conference call with the HSA's interpreter service. All calls will be handled in a manner that is culturally appropriate.

As with any form of patient communication and documentation, unprofessional remarks or comments in telephone communications are prohibited. Confidentiality of patient information is maintained at all times to protect the integrity of protected health information (PHI).

SUBJECT: Continuity of Care and Hospital Admitting	POLICY NO.: **300.31** PAGE: 1 OF 1	COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY **Clinics and Ancillary Services**
SERIES: 300 Patient Care and Treatment	EFFECTIVE DATE: August 2022	
APPROVED BY: Amy Peeler, Chief of Clinic Services	REVISED: August 2025	

GENERAL STATEMENT:

This policy outlines the process of tracking hospital and emergency department (ED) visits for established primary care patients seen in the health center within the past 24 months. The Health Services Agency Health Centers Division will provide continuity of care visits post hospital and EDadmissions. Hospital admissions visits are staffed by a hospitalist group through a written agreement.

POLICY STATEMENT:

Tracking hospital and emergency visits as close as possible to when they happen can enhance follow-up, prevent readmission, and improve monitoring, which may prevent the condition from worsening. To accomplish this effectively, there is two-way communication with the health centers and hospital systems via the Santa Cruz Health Information Exchange (HIE). The clinician is notified through the HIE of an admission or ED visit. Health center staff will utilize the Central California Alliance for Health reporting portal to reach out to patients within 24-72 hours after a hospital admission or ED visit and will continue to follow up until contact is made, patient is seen or at least three attempts are completed. The goal of outreach will be to offer an appointment with the patient's primary clinician for continuity of care and follow up of any outstanding medical issues.

Clinical staff should also ask patients at the beginning of appropriate visits whether they have had a hospital admission or ED visit since their last health center appointment.

REFERENCE:

Health Resources & Services Administration (HRSA) Health Center Program Compliance Manual Chapter 8: Continuity of Care and Hospital Admitting

SUBJECT: False Claims Act Requirements	POLICY NO.: 100.10 PAGE: 1 OF 6	
SERIES: 100 Compliance	EFFECTIVE DATE: August 2025	COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY
APPROVED BY: Amy Peeler, Chief of Clinic Services	REVISED:	Clinics and Ancillary Services

GENERAL STATEMENT: To outline the procedures to be followed by providers in establishing, communicating, and maintaining compliance with federal and California False Claims Act requirements, including employee education, reporting mechanisms, and protections related to the prevention, detection, and reporting of fraud, waste, and abuse.

POLICY STATEMENT: The County of Santa Cruz Health Services Agency (HSA) Health Centers Division is committed to compliance with all federal and state laws regarding the prevention, detection, and reporting of fraud, waste, and abuse. In accordance with Section 1902(a)(68) of the Social Security Act, any provider receiving annual Medicare payments of at least five million dollars ($5,000,000) shall establish and maintain written policies and procedures for all employees, contractors, and agents. These policies must provide detailed information about the Federal False Claims Act, applicable California state laws regarding false claims and statements, whistleblower protections, and HSA's procedures for detecting and reporting fraud, waste, and abuse. This information will be included in the employee handbook and communicated to all staff.

DEFENITIONS:

1. **False Claims Act (FCA):** A Federal law (31 U.S.C. §§ 3729–3733) that imposes liability on individuals and organizations who knowingly submit, or cause to be submitted, false or fraudulent claims for payment to the federal government.

2. **California False Claims Act:** California Government Code Sections 12650–12656, which mirrors the Federal FCA and provides for civil penalties against individuals or entities that knowingly submit false claims to the State of California.

3. **Whistleblower:** An individual who reports suspected fraudulent, wasteful, or abusive practices. Whistleblowers are protected from retaliation under both federal and state laws.

4. **Fraud, Waste, and Abuse:** Fraud is an intentional deception or misrepresentation made to gain a benefit. Waste is the overuse or misuse of resources. Abuse refers to practices that are inconsistent with sound fiscal, business, or medical practices, resulting in unnecessary cost.

PROCEDURE:

1. **Distribution of Information**
   A. HSA will include a summary of the False Claims Act, relevant California laws, whistleblower protections, and internal reporting procedures in the employee electronic intranet handbook.
   B. New employees will be notified about where the policy is located.

2. **Reporting Suspected Violations**

   A. **Whistleblower Hotline**
   The Whistleblower Hotline provides Santa Cruz County employees and citizens with a way to report alleged fraudulent activity by Santa Cruz County government employees, misuse of County resources by vendors, contractors or County employees, and significant violations of County policy. Allegations reported over the Hotline are evaluated and investigated.

   B. **Online Report:**
   https://www.santacruzcountyca.gov/Government/WhistleblowerHotline.aspx

   C. **Mail:**
   Whistleblower Hotline
   701 Ocean Street, Suite 100
   Santa Cruz, CA 95060

   D. **Phone:**
   831-454-3333
   (You may leave a message in English or Spanish.)

   Report suspected Medi-Cal fraud, waste, or abuse incidents to County Counsel, Health Center Division Director and DHCS Medi-Cal Fraud: (800) 822-6222 or Fraud@dhcs.ca.gov

3. **Confidentiality**
   The Whistleblower Hotline is a confidential resource to report any wrongdoing. However, if your report results in criminal prosecution, you may be called upon to testify and confidentiality may not be maintained.

4. **Report Fraud, Waste, and Abuse**

   A. Examples of reportable offenses include:

      1. Illegal acts: theft, fraud, bribery, and kickbacks
      2. Conflict of interest
      3. Misuse, waste, or abuse of property or time
      4. Misappropriation of resources Internal Reporting
      5. Employees who suspect fraud, waste, or abuse may also report their concerns to their supervisor, the Compliance Officer, or through HSA's anonymous reporting

hotline.

6. Reports will be investigated promptly and thoroughly, with confidentiality maintained to the extent possible.

5. **Whistleblower Protections**

   A. HSA strictly prohibits retaliation against any employee who, in good faith, reports suspected violations or participates in an investigation.

   B. Retaliation may result in disciplinary action, up to and including termination.

6. **Management/Supervisor Responsibilities**

   A. Ensure employees have completed the required Compliance training upon hire and as needed, saving the received copy of employee's signed Code of Conduct certification.

   B. Create an environment of honesty and ethics within each manager/supervisor's area of control.
      1. Provide employees with clear directions about work expectations and internal controls.
      2. Actively discourage manipulation of clients, vendors or others for advantage.

   C. Reduce opportunities for fraud, waste, and abuse by implementing strong internal controls that detect and deter dishonest behavior.

   D. Ensure that employees are aware of the options available for reporting fraud, waste and abuse and other compliance issues.

   E. Establish an environment free from intimidation and retaliation to encourage open communication.
      1. Ensure that employees, contractors, or others who report issues are not subject to intimidation, harassment, or other forms of retaliation for reporting issues in good faith.
      2. Immediately address all forms of retaliation by co-workers.
      3. Actively discourage conduct that could be perceived as retaliatory.

7. **Employee Responsibilities**

   A. Review policy upon hire and as requested by management.

   B. Perform duties in a way that promotes the public trust and ensures proper expenditures and use of County assets and property.

   C. Employees, contractors, volunteers, and other designated individuals have a duty to report actual or suspected violations of law, regulations or policy including fraud, waste, and abuse to appropriate authorities. (See Section 2 above)

8. **Investigation and Corrective Action**

   A. All reports of suspected fraud, waste, or abuse will be investigated in accordance with HSA's policies and procedures.

   B. If violations are confirmed, appropriate corrective and disciplinary actions will be taken, and, if necessary, reported to the appropriate authorities.

RELEVANT LEGAL AUTHORITIES

1. **Federal False Claims Regulations**

   A. **Civil False Claims**

      1. 31 U.S.C. Section 3729(a) prohibits any individual/entity from knowingly submitting or causing the submission of a false or fraudulent claim for payment to the US government. The civil penalty for a false claim is not less than $5,000 and not more than $10,000, plus, three times the amount of damages.
      2. 31 U.S.C. Section 3729(b) defines "knowingly" as having actual knowledge of the information, acting in deliberate ignorance of the truth or falsity of the information, or acting in reckless disregard of the truth or falsity of the information. The government does not have to prove that the person intended to defraud the government.
      3. 31 U.S.C. Section 3730 includes "Qui Tam" provisions that allow private citizens to sue violators on behalf of the government. The government can take over the prosecution or allow the individual to handle the case.
         a. If the government takes over the case and wins, the qui tam individual is eligible for 15-25% share of the recovery.
         b. If the Qui Tam individual handles the case and wins, the individual is eligible for 25-30% share of the amount recovered.
         c. If the action is initiated by an individual who planned and initiated the violation, then the court may reduce the share of the proceeds. If the individual bringing the action is convicted of criminal conduct arising from the violation of the False Claims Act, then they shall not receive any proceeds from the action.
         d. If the defendant prevails and the court finds that the qui tam individual was clearly frivolous, or acted for the purposes of harassment, then the court may award to the defendant reasonable attorney's fees and expenses.

   B. **Criminal False Claims**

      1. False Statements relating to Health Care Matters - 18 U.S.C. Section 1035 criminalizes any false or fictitious statements "in any manner involving a health care benefit program." The penalty is up to 5 years in prison and a fine.

      2. Federal Criminal False Statements - 18 U.S.C. Section 1001 specifies that

whoever knowingly and willfully - (1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; (2) makes any materially false, fictitious, or fraudulent statement or representation; or (3) makes or uses any false writing or document to contain any materially false, fictitious, or fraudulent statement or entry; shall be fined or imprisoned not more than 8 years, or both.

3. Federal Criminal False Claims Act- 18 U.S.C. Section 287 states, "Whoever makes or presents... any claim upon or against the United States, or any department or agency thereof, knowing such claim to be false, fictitious, or fraudulent, shall be imprisoned not more than five years and shall be subject to a fine."

C. **Federal Whistleblower Protections**

1. 31 U.S.C. Section 3730(h) protects employees against discharge, demotion, suspension, threats, harassment, or discrimination by the employer because of lawful acts performed by the employee in cooperating with the False Claims Act, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section.

2. **California False Claims Act Provisions**

A. **California Government Code Section 12650 definitions include:**

1. "Claim" includes any request or demand for money, property, or services made to any employee, officer, or agent of the state or of any political subdivision ... whether under contract or not, if any portion of the money ... was provided by, the state (hereinafter "state funds") or by any political subdivision thereof (hereinafter "political subdivision funds").

2. 'Knowing" and "knowingly" mean that a person, with respect to information, does any of the following:
   a. Has actual knowledge of the information.
   b. Acts in deliberate ignorance of the truth or falsity of the information.
   c. Acts in reckless disregard of the truth or falsity of the information.
   Proof of specific intent to defraud is not required.

3. "Political subdivision" includes any city, city and county, county, tax or assessment district, or other legally authorized local governmental entity with jurisdictional boundaries

4. "Person" includes any individual person, corporation, firm, association, organization, partnership, limited liability company, business, or trust.

B. **California Government Code Section 12651(a) states:**

A person can be liable for three times the amount of damages and also be liable to the state or to the political subdivision for the costs of a civil action brought to recover any of those penalties or damages, and may be liable for a civil penalty of up to ten thousand dollars ($10,000) for each false claim if the person;

1. Knowingly presents or causes to be presented to... the state or of any political subdivision thereof, a false claim for payment or approval.
2. Knowingly makes, uses, or causes to be made or used a false record or statement to get a false claim paid or approved by the state or by any political subdivision.
3. Conspires to defraud the state or any political subdivision by getting a false claim allowed or paid by the state or by any political subdivision.
4. Knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay ... the state or to any political subdivision.
5. Is a beneficiary of an inadvertent submission of a false claim to the state or a political subdivision, subsequently discovers the falsity of the claim, and fails to disclose the false claim to the state or the political subdivision within a reasonable time after discovery of the false claim.

C. **The California False Claims Act also includes provisions that allow a private citizen to bring a civil action for a violation of this article as a "qui tam plaintiff"**

1. If the Attorney General or local prosecuting authority takes over the case and prevails, the qui tam plaintiff may receive between 15% and 33% of the proceeds as determined by the court.
2. If the Attorney General or local prosecuting authority does not proceed and the qui tam plaintiff prevails, the qui tam plaintiff may receive between 25% and 50% of the proceeds as determined by the court.
3. There is no guaranteed minimum recovery for actions initiated by
   a. Present or former employees of the State or political subdivision (this includes County employees).
   b. Present or former employees who actively participated in the fraudulent activity.
4. If the defendant prevails and the court finds that the qui tam plaintiff was clearly frivolous, or acted for the purposes of harassment, then the court may award to the defendant reasonable attorney's fees and expenses.

D. **California Whistleblower Protections**

1. California Government Code Section 12653 provides protection for employees by preventing employers from making, adopting, enforcing any rule, regulation or policy that would prevent an employee from disclosing information to a government or law enforcement agency or from acting in furtherance of a false claims action.
2. California Government Code 12653 also requires that no employer shall discharge, demote, suspend, threaten, harass deny promotion to, or in any other manner discriminate against an employee because of lawful acts

performed by the employee on behalf of the employer or others in disclosing information to a government or law enforcement agency or in furthering, a false claims action, including investigation for, initiation of, testimony, for, or assistance in, an action filed or to be filed under the California False Claims Act.

LEGAL AUTHORITY

- Federal False Claims Act (31 U.S.C. §§ 3729–3733)
- Section 1902(a)(68) of the Social Security Act
- California False Claims Act (California Government Code §§ 12650–12656)
- California Labor Code §§ 1102.5, 98.6 (Whistleblower Protections)

REFERENCES

- Clinics Policy & Procedures intranet site: http://hsa.co.santa-cruz.ca.us/Home/Clinics/Policies-Procedures

Health Centers Division

Integrated Community Health Center Commission Fiscal Report

8-6-25

Fiscal Year 2024-2025 Year-End

Division	HEALTH CENTERS
JL Key & Title	(All)
FiscalMonth	(All)
Object	(Multiple Items)
GLKey	(Multiple Items)

Row Labels	Adopted Budget	Adjusted Budget	Actual	
⊟REVENUE	(50,835,554)	(51,321,383)	(46,894,756)	
⊞05-LICENSES, PERMITS AND FRANCHIS	0	0	0	
⊞15-INTERGOVERNMENTAL REVENUES	(6,815,851)	(7,265,680)	(4,901,826)	
⊞19-CHARGES FOR SERVICES	(43,445,117)	(43,445,117)	(41,260,835)	
⊞23-MISC. REVENUES	(574,586)	(610,586)	(732,095)	
⊟EXPENDITURE	50,858,280	51,754,897	50,567,394	
⊞50-SALARIES AND EMPLOYEE BENEF	36,922,899	36,952,899	37,765,437	
⊞60-SERVICES AND SUPPLIES	7,007,056	7,462,885	6,910,049	
⊞61-SERVICES AND SUPPLIES-ISF	1,307,806	1,558,562	1,376,115	
⊞70-OTHER CHARGES	48,404	48,404	53,243	
⊞80-FIXED ASSETS	1,111,100	1,223,429	873,406	
⊞95-INTRAFUND TRANSFERS	4,461,015	4,461,015	3,589,145	
⊞98-APPROP FOR CONTINGENCIES	0	47,703	0	
Grand Total	22,726	433,514	3,672,638	Deficit
			($832,877)	Budgeted NCC
			$4,485,042	IGT used to cover deficit

Questions?

Thank You