

HEALTH CARE FOR THE HOMELESS/FARMWORKER HEALTH PROGRAM (HCH/FH)

Co-Applicant Board Meeting

Coastside Clinic – Half Moon Bay

November 12, 2015, 9:30 A.M - 11:30 A.M.

AGENDA

A. CALL TO ORDER	Robert Stebbins	9:30 AM
B. CLOSED SESSION		
1. No Closed Session this meeting		
C. PUBLIC COMMENT		9:32 AM
Persons wishing to address items on and off the agenda		
D. CONSENT AGENDA		9:35 AM
1. Meeting minutes from October 8, 2015	TAB 1	
2. Program Calendar	TAB 2	
E. BOARD ORIENTATION		
1. No Board Orientation items this meeting.		
F. REGULAR AGENDA		
1. Consumer Input to Board	Linda and Others	TAB 3 9:38 AM
2. Board Ad Hoc Committee Reports	Committee Members	9:42 AM
<i>i. Transportation</i>		
<i>ii. Health Navigation</i>		
<i>iii. Board Composition</i>		
3. HCH/FH Program QI Committee Oral Report	Frank Trinh	9:46 AM
4. HCH/FH Program Director's Report	Jim Beaumont	TAB 4 9:51 AM
5. HCH/FH Program Budget/Finance Report	Jim Beaumont	TAB 5 9:58 AM
6. HCH/FH Program - Contractors 3 rd Quarter Report Updates	Linda Nguyen	TAB 6 10:05 AM
7. HCH/FH Program- Request to Approve C&P Policy	Jim Beaumont	TAB 7 10:10 AM
<i>i. Action Item –Request to Approve Credentialing/Privileging Policy</i>		
8. Strategic Plan – Program Discussion	Jim/Rachel Metz/ Pat Fairchild	10:15 AM
9. Discussion/Review/Approval of RFP Proposals	Jim Beaumont	TAB 8 10:45 AM
<i>Any documents involved will be available at meeting. Time will be provided for review prior to consideration.</i>		
10. National Advisory Council on Migrant Health Nominations		TAB 9 11:15 AM
11. Discussion on attendance of Western Forum for Migrant & Community Health Conference (Feb 23-25)		
G. OTHER ITEMS		
1. Future meetings – every 2 nd Thursday of the month (unless otherwise stated)		
<i>iv. Next Regular Meeting – December 10, 2015; 9:00 A.M. – 11:00 A.M. at Human Service Agency Office- Belmont</i>		
H. ADJOURNMENT	Robert Stebbins	11:30 AM

Meetings are accessible to people with disabilities. Individuals who need special assistance or a disability-related modification or accommodation (including auxiliary aids or services) to participate in this meeting, or who have a disability and wish to request an alternate format for the agenda, meeting notice, or other documents that may be distributed at the meeting, should contact the HCH/FH Program Coordinator at least five working days before the meeting at (650) 573-2966 in order to make reasonable arrangements to ensure accessibility to this meeting and the materials related to it. The HCH/FH Co-Applicant Board regular meeting documents are posted at least 72 hours prior to the meeting and are accessible online at: <http://www.sanmateomedicalcenter.org/content/Co-ApplicantBoard.htm>.

TAB 1

Meeting Minutes

(Consent Agenda)

**Healthcare for the Homeless/Farmworker Health Program (Program)
Co-Applicant Board Meeting Minutes
Thursday, Oct 8, 2015
SMMC- San Mateo (classroom 2)**

Co-Applicant Board Members Present

Robert Stebbins, Chair
Daniel Brown
Brian Greenberg
Jim Beaumont, HCH/FH Program Director (Ex-Officio)
Tayischa Deldridge
Julia Wilson
Kathryn Barrientos
Molly Wolfes
Paul Tunison

County Staff Present

Linda Nguyen, HCH/FH Program Coordinator
Glenn Levy, County Counsel
Elli, Lo, HCH/FH Management Analyst
Jessica Silverberg, Human Services Agency- COH
Brian Eggers, Human Services Agency- COH

Members of the Public

Absent: Eric Brown, Steve Carey

ITEM	DISCUSSION/RECOMMENDATION	ACTION
Call To Order	Robert Stebbins called the meeting to order at 9:57_A.M. Everyone present introduced themselves.	
Public Comment	No Public Comment at this meeting.	
Consent Agenda	All items on Consent Agenda (meeting minutes from and the Program Calendar) were approved. Please refer to TAB 1, 2	Consent Agenda was MOVED by Dan SECONDED by, Kat and APPROVED by all Board members present.
Board Orientation:	No Board Orientation for this meeting.	
Board leadership nominations Motion to vote on nominees	In accordance with the Bylaws, the Board is to elect its Chair and Vice-Chair as the first order of business at either the October or November Board meeting. Further, as directed by the Bylaws, we have requested nominees for the positions to be presented to the Board. Nominations will also be taken from the floor. The following were nominated: For Chair: Robert Stebbins For Vice Chair: Paul Tunison and Brian Greenberg After recording nominations from the floor, it is requested that the Board vote to	

	<p>select their Chair and Vice Chair for 2016. The term of office for each commences on January 1, 2016.</p> <p>Action item: Motion to vote for nominees for Chair and Vice Chair</p> <p>There was a motion to vote for the following nominees: For Chair: Robert Stebbins For Vice Chair: Paul Tunison</p>	<p>Motion to vote for nominees MOVED by Dan SECONDED by, Julia</p> <p>and APPROVED by all Board members present.</p>
Consumer Input	<p>Discussion on Breast Cancer Awareness month and how misleading and ubiquitous marketing can be, as well as the lack of medical/scientific information involved in the marketing that can negatively impact females decisions on their health.</p> <p>Discussion on mammography education with our target populations.</p> <p>Announcement on one of our Board Members (Tay) acknowledged with a local heroes award for her great local work in the community.</p>	
Transportation <i>Sub-committee reports</i>	No report	
<i>Board orientation Sub-committee reports</i>	No report (Brian and Dan) Dan drafting a memo currently. Discussion on Spanish translation services that would be offered if required.	
<i>Patient Navigator Sub-committee reports</i>	No report (Tay and Kat)	
QI report	<p>Oral report by Frank Trinh, Medical Director:</p> <ul style="list-style-type: none"> · Currently working on data for Asthma report · QI Committee will review IVD and Hypertension data next month. 	

Regular Agenda:
HCH/FH Program
Director's Report

Oral Report by Jim Beaumont, Program Director:

Grant Conditions

On September 16th we received Notice of Action (NOA) 14-16 which lifted the QI/QA Program (Requirement #8) grant condition. During the Technical Assistance (TA) Site Visit September 22-24, we were informed by our Project Officer and her supervisor that the Data Reporting (#16) grant condition had been lifted and that we should receive the corresponding NOA in the near future.

Operational Site Visit Report:

Based on the OSV Report received August 18th, we could have expected to receive 12 grant conditions. However, based on discussions during the TA Site Visit September 22- 24, since we have come into compliance for QI/QA Program (#8), there will not be a grant condition issued for that requirement. In addition, we have been allowed to submit the documentation for the Board's review and acceptance of the County Single Audit Report and it has been accepted. This will result in a grant condition for Board Authority (#17) not being issued.

Expanded Services Award Opportunity

On September 15, 2015, we received NOA 14-15 approving our Expanded Services application and providing \$264,942.00 in funding (application was for \$246,642). We are now engaged with Public Health Policy & Planning/Mobile Van to finalize the workplan for the project.

Base Grant Adjustment/Supplemental Funding

On September 21, 2015, we received NOA 14-17 providing awarding an ongoing base grant adjustment. This amount is now incorporated into our base grant going forward.

HRSA Technical Assistance (TA) for the Co-Applicant Board

As the Board is aware, HRSA provided an onsite TA Site Visit on September 22-24. In attendance were our Project Officer and her superior, and consultants for Governance and Clinical requirements. There was a positive exchange of information and ideas, and we do now better understand HRSA's specific issues, concepts and ideas.

Please refer to TAB 5 on the Board meeting packet.

<p>Regular Agenda: HCH/FH Program <i>Budget & Financial Report</i></p>	<p>Based on current projections, there remains a potential unexpended balance at the end of the GY (December 31, 2015). Given the known issues in appropriately and adequately addressing short term increases in expenditures, Program continues to work on a number of options that hold promise for utilizing one-time or short-term expenditures and providing longer-term or ongoing benefits.</p> <p>The GY Expenditures & Projections Report thru 083115 is attached.</p> <p><i>Please refer to TAB 6 on the Board meeting packet.</i></p>	
<p>Discussion on strategic planning study topics</p>	<p>Discussion on Strategic Plan work that includes working with Consultants from J. Snow to present initial work at November meeting. The service needs of homeless and farmworkers in San Mateo County will be discussed.</p>	
<p>Project funding</p>	<p>There was a long discussion on potential topics to research further to possibly pursue in the future that included:</p> <ul style="list-style-type: none"> · Smoking issues in shelters · Transportation, dental issues of farmworkers (procedures and severe issues), some farmworkers not qualifying for services because make more than 200% of FPL · Women's health- mammography, cervical cancer · Respite care and cost effective models, funding model , serving seniors too · Review weekly chronic patients, intensive Case management on health conditions and no shows · Medical Case Management, Patient Registry, Housing crisis 	
<p>Adjournment</p>	<p>Time __11:35a.m._____</p>	<p>Robert Stebbins</p>

TAB 2

**Program
calendar**

Health Care for the Homeless & Farmworker Health (HCH/FH) Program 2015 Calendar *(Revised November 2015)*

EVENT	DATE	NOTES
<ul style="list-style-type: none"> • Board Meeting (November 12, 2015 from 9:30 a.m. to 11:30 a.m.) • Annual Evaluation & Review of Program Director • Review/Approval of RFP proposals • Contracting , prepare for BOS (as required) 	November	Board meeting at Coastside Clinic-HMB
<ul style="list-style-type: none"> • Board Meeting (December 10, 2015 from 9:00 a.m. to 11:00 a.m.) • BOS approval of contracts (as required) • Grant Year Budget Approval 	December	Board meeting at HSA Office Belmont-
<ul style="list-style-type: none"> • Board Meeting (January 14, 2016 from 9:00 a.m. to 11:00 a.m.) • Contracts begin January 1, 2016 	January	Board meeting at SMMC
<ul style="list-style-type: none"> • Board Meeting (February 11, 2016 from 9:00 a.m. to 11:00 a.m.) • UDS report • Strategic Plan Draft • 2016 Western Forum for Migrant & Community Health Feb 23-25 Portland 	February	
<ul style="list-style-type: none"> • Board Meeting (March 10, 2016 from 9:00 a.m. to 11:00 a.m.) • 	March	

Conference calendar

National Health Care for the Homeless Council National Conference	May 31- June 3, 2016; Portland. OR
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TAB 3
Consumer Input

Should Gun Violence Be Treated Like Car Accidents?

Medical communities hail the “public health” designation as a solution to gun violence.

By [Kimberly Leonard](#) July 7, 2015 | 12:01 a.m. EDT + More

The gun-control debate in the aftermath of a mass shooting is a stark reminder of the deeply held beliefs in the U.S. about firearms and access to them. Some members of the medical community, however, have been trying for years to broaden those conversations to include, not just arguments about the Constitution or political ideologies, but a discussion about the toll gun violence takes on public health. Their goal: to work to reduce incidents of gun violence in the same way as campaigns that targeted polio, smoking-related cancer or car accidents.

It's a controversial approach. Opponents, among them the gun lobby and many Republicans, believe the move is a thinly veiled effort to further restrict gun ownership and to provide new grounds for seizing firearms. But supporters, including doctors and medical associations, say that designating gun violence – which they define to include homicides, suicides and injuries – as a public health issue will save lives. Doctors already counsel patients about a range of safety issues, including avoiding lead paint, wearing seatbelts, getting vaccinated and dealing with the dangers of backyard pools. If the designation were to change, they could more often ask patients about whether they keep a gun in the home and, if so, how it is secured.

"We're not debating the constitutionality of firearms – that exists," says Dr. Georges Benjamin, executive director for the American Public Health Association. "Firearms exist and people get hurt and die from firearms. There are ways for us in a nonpolitical manner to make people safer with their firearms in a society."

The CDC and the [World Health Organization](#) already [consider violence a public health threat](#), whether a firearm is involved or not. The American College of Physicians has been calling gun violence an epidemic [since 1995](#), and though homicide incidences have [decreased dramatically](#) since the early 1990s, the medical community still remains deeply concerned, as more than 478,000 fatal and nonfatal violent crimes were committed with a firearm in 2011, according to the [most recent data](#) from the Department of Justice.

In February, several leading health associations issued a [call to action](#) asking Congress to develop policies that would reduce the incidences of gun violence. Many of the recommendations look similar to those proposed by gun-control advocates – including limiting the availability of assault weapons and closing loopholes that exist in background checks for those who buy guns at gun shows or from dealers – and they are expected to gain little traction in the GOP-controlled Congress after also languishing under Democrats.

In fact, the proposed public health label has been so controversial that it [held up Dr. Vivek Murthy's nomination to be surgeon general](#) for more than 18 months after he tweeted about the issue. In a [January 2013 letter](#), he urged Congress to enact public health measures including improving background checks and collecting more government data on the prevalence of gun violence – the latter a proposal that would require federal funding.

For a time, CDC was banned from conducting such studies. After its [last study in 1996](#), wording was inserted into the agency's appropriations bill that stated, "None of the funds made available for injury prevention and control at the [CDC] may be used to advocate or promote gun control."

Through executive order, Obama lifted the ban two years ago, but the funding still has not been made available. Last month, the House Appropriations Committee rejected an amendment that would allow the CDC to study the causes of gun violence.

Rather than explore the broader implications of guns on public health, some Republicans in recent years have focused on the idea of limiting the availability of weapons to people who have a mental illness.

After mass shootings in Newtown, Connecticut; Aurora, Colorado; and at Virginia Tech University in Blacksburg, Virginia, questions about the gunmen's mental health surfaced almost immediately. It was mentioned in conjunction with last month's killing of nine black church members in Charleston, South Carolina, as well, though authorities found evidence that the attack was racially motivated and the alleged shooter, Dylann Roof, had purchased the gun legally in spite of previous arrests and a charge of felony possession.

Benjamin says focusing only on [mental health in relation to gun violence](#) is a mistake. "Most people with mental illness aren't violent, and while it's an important issue – particularly around suicides – doing it through that lens is the wrong way."

He points out that tackling the mental health issue won't prevent a child from coming across an unsecured gun at home, and won't make a difference in incidents like bar fights, in which someone shoots another person in anger.

"Even if we solved all the issues around [mental illness](#), the problem of gun violence doesn't go away," he says. Andrew Arulanandam, spokesman for the National Rifle Association, says gun violence should be viewed as a crime, not a public health issue.

The NRA has said that it is not making a statement on the Charleston case until all the facts come in, but Arulanandam spoke about gun violence in general.

"Trying to frame it as a public health issue diminishes the seriousness of a crime that has been committed," he says. "It provides criminals with a cover, and that's wrong. ... There seems to be an unwillingness by gun control activists to try to rightfully place the blame on the criminal. They are trying to find all of these excuses and issues to blame rather than on the criminal."

In an earlier interview with U.S. News, Arulanandam was critical of a giving doctors a greater role in the gun debate.

"Given that they are neither gun safety nor firearm storage experts, doctors ought to focus the limited time they spend with their patients focusing on their health and well-being instead of nosing around on private matters that do not concern them or engaging in political debate of a fundamental constitutional right," he said.

The Brady Campaign to Prevent Gun Violence, however, says it favors a more-comprehensive look at gun violence.

"We look to enact policy changes that would make it more difficult for guns to get into the wrong hands," says Rebecca Adeskavitz, the group's senior program manager.

Some doctors say the question about gun ownership can be important not only in homes where children are present, but also in cases where the patient [may be depressed](#). More than 21,000 people kill themselves with a gun each year – a number that represents more than half of all suicide deaths.

"Many people before they make a suicide attempt have visited a health care professional, and that's a real point of intervention – for people to talk about the risks not only about guns in the home with adolescents but also to talk to middle-aged and older adults, where suicides are high," Adeskavitz says.

But some medical providers say doctors should stay out of the debate. Dr. Paul Hsieh, co-founder of Freedom and Individual Rights in Medicine, says he views gun crime and violence as predominantly about criminal justice and individual rights.

"I remain deeply skeptical of any attempts to frame important public policy debates as also 'public health' issues, especially when it concerns a long-running political controversy," says Hsieh, who writes on health care policy from a free-market perspective for Forbes.com. "Pretty much any public policy issue will ultimately have some sort of effects on the lives and well-being of Americans – but that doesn't mean they should all be considered topics of 'public health.'"

People are concerned that sharing information about gun ownership with doctors may not remain private, [he wrote in a Forbes piece](#). "In short, I believe this undermines the critical doctor-patient trust necessary for the good practice of medicine," he says.

But public health advocates insist that they could make gun safety as successful as other public safety campaigns.

"You follow the evidence," Benjamin says. "[We did it for car accidents](#). We made cars safer, we made people safer driving their cars and we made the environment safer."

<http://www.usnews.com/news/articles/2015/07/07/the-rise-of-gun-violence-as-a-public-health-issue>

Death and guns in the USA: The story in six graphs

By Ray Sanchez, CNN Updated 9:01 PM ET, Sat October 3, 2015 | Video Source: [CNN](#)

(CNN)The shooting rampage at an Oregon community college occurred in the most heavily armed nation in the world, a society with a firearm for nearly 90% of its 321 million citizens.

The gunman who shot and killed nine people and injured nine others at Umpqua Community College in Roseburg on Thursday had 14 firearms, according to the Bureau of Alcohol, Tobacco, Firearms and Explosives. They were all purchased legally by the shooter or a member of his family in the past three years, officials said.

Five pistols and a rifle were found at the college, where the shooter died after a firefight with police. It's unclear whether police shot the gunman or he turned a weapon on himself. In the killer's apartment, authorities found other weapons, including three pistols, four rifles and a shotgun.

After the massacre, a visibly shaken President Barack Obama told the nation, "There is a gun for roughly every man, woman and child in America. So how can you, with a straight face, make the argument that more guns will make us safer?"

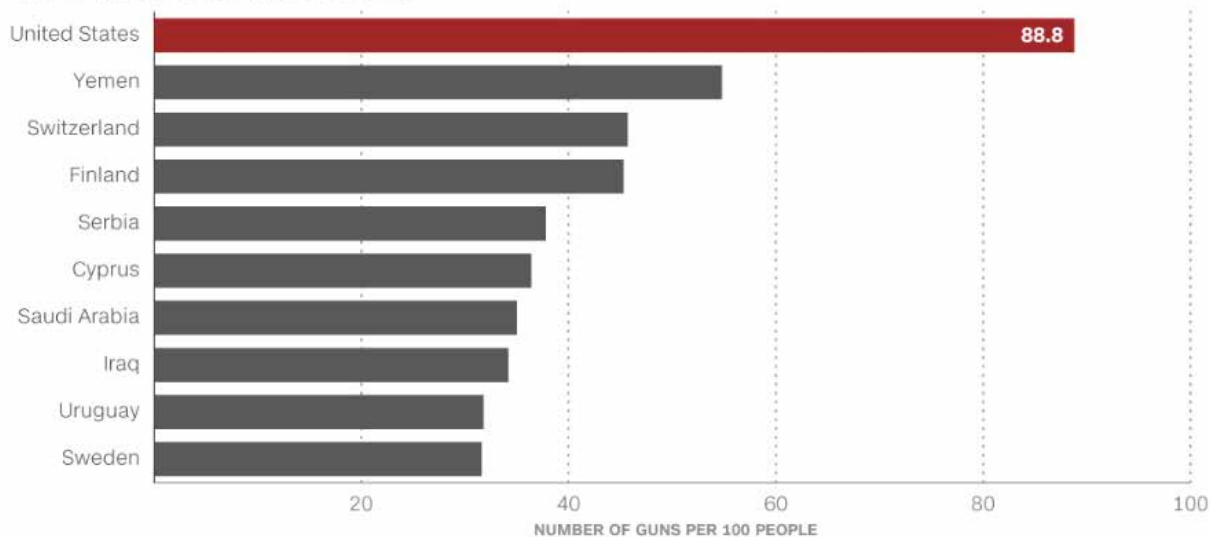
As the nation mourns the victims of another mass shooting, the raw numbers of gun violence paint a chilling picture of America's intimate relationship with firearms.

U.S. leads world in guns per capita

Civilians in the United States own about 270 million guns, according to a 2007 report by the Switzerland-based Small Arms Survey. That's almost the population of Indonesia, the world's fourth most-populated country. America ranks number one in firearms per capita.

COUNTRIES WITH MOST GUNS PER CAPITA

There are more guns owned by civilians in the United States than in any other country. Shown below are the ten countries with the highest rates of gun ownership.



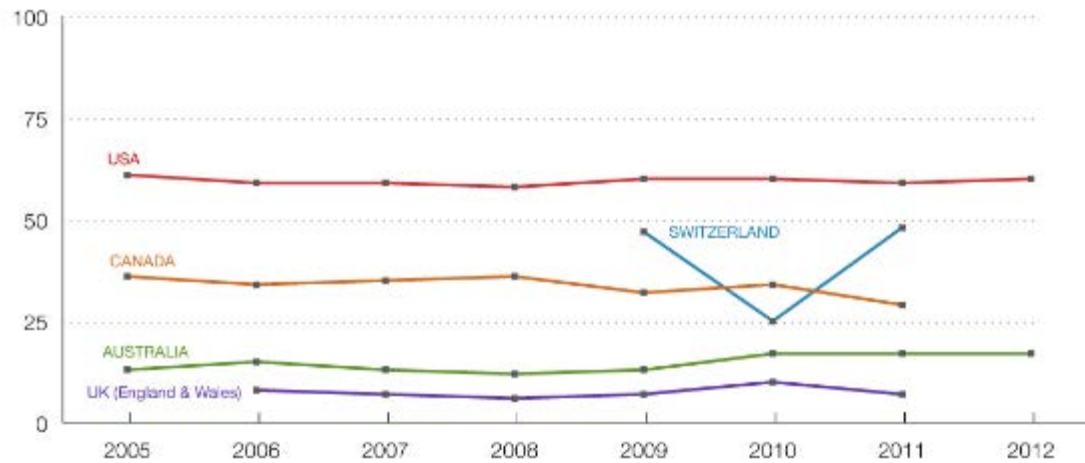
In the U.S., guns are used in homicides more often than in many other countries

Obama has delivered statements on gun violence 15 times during his presidency. After the latest shooting, he said the nation had become numb to the carnage.

"We know that other countries, in response to one mass shooting, have been able to craft laws that almost eliminate mass shootings," he said. "Friends of ours, allies of ours -- Great Britain, Australia, countries like ours. So we know there are ways to prevent it."

PERCENTAGE OF HOMICIDES INVOLVING FIREARMS

Firearms were used in over half of the homicides committed in the United States between 2005 and 2012. See how that compares with four other countries in the chart below. Data from Switzerland covered only three years – 2009, 2010 and 2011.

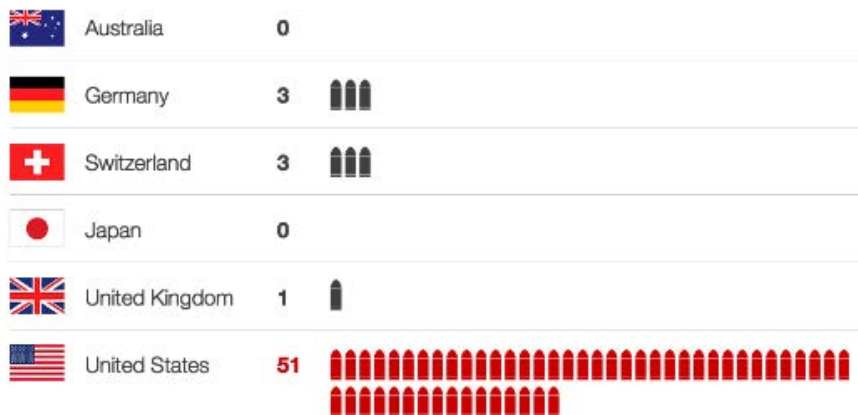


This happens year after year

The latest tragedy occurred on the picturesque campus of a community college in Oregon. Mass shootings seem to have become part of life in the United States. The numbers continue to grow.

MASS SHOOTINGS SINCE 1997

In which at least four people were killed



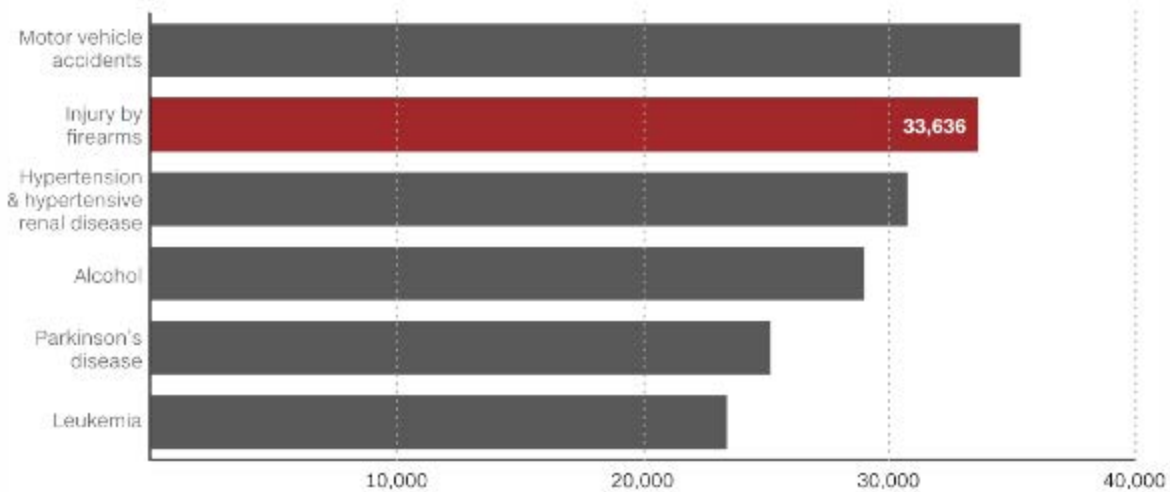
Source: MotherJones.com, US Mass Shootings Investigation, New York Daily News, Slate, The Washington Post, CNN, Bloomberg.com

Firearm deaths among leading causes of death

Gun deaths -- 33,636 -- pale in comparison to the nation's leading killer, heart disease, which claimed 611,105 lives in 2013, according to the Centers for Disease Control and Prevention. But, as the graph shows, guns took more lives than other top causes of death, such as hypertension (30,770) and Parkinson's disease (25,196).

LEADING CAUSES OF DEATH IN THE U.S.

Firearms claimed more lives than many other causes, such as hypertension and Parkinson's disease, according to 2013 CDC figures.



<http://www.cnn.com/2015/10/03/us/gun-deaths-united-states/index.html?sr=fb10315gundeathsunitedstates330pVODtopLink>

TAB 4
Program Director
Report



SAN MATEO COUNTY HEALTH SYSTEM

DATE: November 12, 2015

TO: Co-Applicant Board, San Mateo County Health Care for the Homeless/Farmworker Health (HCH/FH) Program

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: DIRECTOR'S REPORT

Program activity update since the October 08, 2015 Co-Applicant Board meeting:

1. Grant Conditions

On October 21, 2015, we were informed by our Project Officer, Kathy Ruck, that the HRSA review of our October 8th submission for the Appropriate Staffing grant condition (Credentialing & Privileging - #3) had been found to be unacceptable. We exchanged information with her on the issue to determine what was still needed, and we were requested to provide a timeline be submitted establishing when we would be able to complete the process.

Prior to the deadline for submission of the timeline, on October 26, 2015, we were notified by our Project Officer that HRSA intended to end the two current 60-day grant conditions and progress them to 30-day grant conditions (Appropriate Staffing (Credentialing & Privileging - #3) and the Key Management Staff (#9)). We had been methodically working through a series of requests from HRSA for additional information on each condition prior to this information.

Since that time we have worked with SMMC and our County Counsels to be able to fully address the remaining HRSA issues. On November 5, 2015, we had a conference call with our Project Officer and the HRSA senior Clinical Advisor, Dr. Mills, where we were able to receive specific feedback on the draft SMMC policies and HCH/FH policies that had been developed. We were very pleased to come away from that phone conversation with what we verified to be the final modifications to the drafts that would be necessary to have the grant condition lifted. The effort to make those final modifications in the SMMC policies and have them approved is ongoing, and the approval of the HCH/FH Policy is on today's agenda.



The other grant condition – Key Management Staff (#9) – involves the completion of the reclassification of the HCH/FH Director’s position within the county personnel system. While we had been advised specifically that the Salary Ordinance to do this would be on the Board of Supervisor’s October 20th agenda, the Salary Ordinance approved by the Board that day did not include the HCH/FH Director’s position reclassification. We have not received an explanation for the delay. However, the Human Resources Department has stated that the reclassification is included in the Salary Ordinance for Board of Supervisor’s approval at their November 17th meeting.

As the morning of November 6, 2015, the 30-day grant conditions have not yet been issued by HRSA.

We have also not received any grant conditions yet from the March 2015 Operational Site Visit (OSV).

2. Expanded Services Award Opportunity

The planning for the implementation of the HCH/FH Street/Field Medicine initiative funded by our Expanded Services award is ongoing. The week of November 2nd we hosted Candace Kugel who has been working with us on our clinical grant conditions. Candace has extensive experience working with Migrant Farmworker programs and her visit allowed us to get guidance from her in that area and well as other input on implementing the program. Candace also continue to be available to us as we continue forward.

3. International Street medicine Symposium

On October 14 through 16, 2015, The International Street Medicine Symposium was held in San Jose. We had over two dozen attendees at the Symposium who are involved with our HCH/FH Program. The Symposium was an outstanding event and provided a wealth of useful information, insights and contacts.

4. Strategic Plan

We have established a contract with Rachel Metz to support our strategic Planning effort. Over the next 3-5 months we expect to work through a ton of ideas, possibilities and thoughts, and come out with a robust, thoughtful strategic plan to submit for Board approval. Board members can expect to be involved in the process and they will be contacted by Rachel for discussion on issues and input during the process.

5. Management Analyst

On October 19, 2015, Elli Lo formally joined the HCH/FH Program as our Management Analyst. With her previous experience in a 330 program, she has been able to get up

to speed on many of our HRSA items quickly. We welcome her aboard and look forward to many great things.

6. Request for Proposals

On October 19, 2015, the HCH/FH Program released its Request for Proposals to use the program's available resources to generate services for the homeless and farmworker communities. The RFP was significantly streamlined in an effort to make the proposal process much simpler and easier to navigate. While the final submission deadline is currently set at November 30, 2015, we introduced a rolling evaluation process where proposals will be addressed as they are received. This was designed to allow current contractors – for whom the process of submitting a proposal is not new and for whom the current set of services is known and well understood – to possibly submit early in the process (we requested they try to submit by October 30th) so they could get reviewed, evaluated, negotiated and approved by the Board in sufficient time to get to the Board of Supervisor's agenda in time to ensure no break in services.

On October 26, we held a Proposal Workshop to gather questions and provide answers to potential submitters. It was nicely attended and between the workshop and the online process, a fair number of questions have been received and answered.

To date we have received four (4) proposals, all from current contractors. He are working determinedly to review and evaluate the proposals and initiate negotiations with the submitters. If we can get through that process successfully in time, there will be recommended contracts later on the agenda.

7. Seven Day Update

TAB 5
**Program Budget/
Finance Report**



SAN MATEO COUNTY HEALTH SYSTEM

DATE: November 12, 2015

TO: Co-Applicant Board, San Mateo County Health Care for the Homeless/Farmworker Health (HCH/FH) Program

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: HCH/FH PROGRAM BUDGET and FINANCIAL REPORT

Based on the information available, the program has expended \$1,513,729 through October 31, 2015. This represents about 70% of the base grant budget expended through 85% of the grant period.

The Expanded Services funding is more on track. The funding was intended to cover approximately 20 months of effort, and through 10 months (50%) the Mobile Van's contract is 55% expended. We are still waiting to begin receiving invoices from Sonrisas.

Based on current projections, there remains a potential unexpended balance of around \$325,000 at the end of the GY (December 31, 2015). Given the known issues in appropriately and adequately addressing short term increases in expenditures, Program continues to work on a number of options that hold promise for utilizing one-time or short-term expenditures and providing longer-term or ongoing benefits.

The GY Expenditures & Projections Report thru 10/31/15 is attached.

Attachments:

GY Expenditures & Projections Report thru 10/31/15



Board of Supervisors: Carole Groom • Don Horsley • Dave Pine • Warren Slocum • Adrienne Tissier
Health System Chief: Jean S. Fraser • **San Mateo Medical Center CEO:** Susan Ehrlich, MD, MPP
222 W. 39th Avenue • San Mateo, CA 94403 • PHONE 650.573.2222 • CA RELAY 711 • FAX 650.573.2030
www.sanmateomedicalcenter.org

Details for budget estimates	Budget	To Date (10/31/15)	Projection for GY (+~9 wks)	Projected for GY 2016
<u>Salaries</u>				
Director				134,000
Program Coordinator				87,538
Medical Director				53,944
Management Analyst				91,118
new position, misc. OT, other, etc.				new 90,687 If Added
	319,778	241,500	329,736	457,287
<u>Benefits</u>				
Director				75,991
Program Coordinator				49,643
Medical Director				30,592
Management Analyst				51,673
new position, misc. OT, other, etc.				new 51,429 If Added
	190,426	119,787	166,350	259,327
<u>Travel</u>				
National Conferences (1500*2*2)		3,167	5,000	6,000
Regional Conferences (600*2)		1,443	6,900	1,200
Local Travel		517	800	800
Taxis		2,286	2,900	4,000
Van		1,477	1,600	
	12,833	8,890	17,200	12,000
<u>Supplies</u>				
Office Supplies, misc.	5,833	8,927	12,500	2,500
	5,833	8,927	12,500	2,500
<u>Contractual</u>				
Current SMMC Clinic commitment (to 06/30)	407,713	407,713	407,713	-
Current 2015 contracts	823,083	688,179	785,000	705,500
Est available (for 07/01 on or otherwise)	327,705			
	1,558,501	1,095,892	1,192,713	705,500
<u>Other</u>				
Consultants/grant writer	44,500	32,042	125,000	50,000
IT/Telcom	15,000	6,591	10,000	12,000
Memberships	5,000	0	5,000	5,000
Training	2,000	100	2,000	2,000
	30,517			
	97,017	38,733	142,000	69,000
TOTALS - Base Grant	2,184,388	1,513,729	1,860,499	1,505,614
Expanded Services Grant	219,724	98,650	113,000	219,724
				245,000
HCH/FH PROGRAM TOTAL	2,404,112	1,612,379	1,973,499	1,970,338
PROJECTED AVAILABLE BASE GRANT			323,889	810,053
NOTE: Former Full Annual SMMC Clinic Funding = \$611,570				based on est. grant of \$2,315,677

AS APPROVED 2015 GRANT YEAR BUDGET

Object Class Categories	Grant Program, Function or Activity			Total
	ES Grant - HCH	ES Grant - FH	Base Grant	
a. Personnel	120,334.00		319,778.00	440,112.00
b. Fringe Benefits	48,775.00		190,426.00	239,201.00
c. Travel	1,200.00		12,833.00	14,033.00
d. Equipment				-
e. Supplies	7,848.00		5,833.00	13,681.00
f. Contractual		32,557.00	1,558,501.00	1,591,058.00
g. Construction				-
h. Other	17.00	8,993.00	66,500.00	75,510.00
i. Total Direct Charges (sum of 6a-6h)	178,174.00	41,550.00	2,153,871.00	2,373,595.00
j. Indirect Charges				-
k. Totals (sum of 6i-6j)	178,174.00	41,550.00	2,153,871.00	2,373,595.00

To Date - Base Grant	To Date - ES Grant	Total
241,500.00		241,500.00
119,787.00		119,787.00
8,890.00		8,890.00
		-
8,927.00		8,927.00
1,095,892.00	98,650.00	1,194,542.00
		-
38,733.00		38,733.00
1,513,729.00	98,650.00	1,612,379.00
		-
1,513,729.00	98,650.00	1,612,379.00

Clincs contribution included on Contractual line

Expanded Services (ES) Contracts began 01/01/15 - intended to cover thru at least 08/31/16

TAB 6
Contractors 3rd
Quarter Report
Updates



SAN MATEO COUNTY HEALTH SYSTEM

DATE: November 12, 2015

TO: Co-Applicant Board, San Mateo County Health Care for the Homeless/Farmworker Health (HCH/FH) Program

FROM: Linda Nguyen, HCH/FH Program Coordinator

SUBJECT: Quarter 3 Report (July 1, 2015 through September 31, 2015)

Program Performance

The Health Care for the Homeless/Farmworker Health (HCH/FH) Program has contracts with four community-based providers, plus two County-based programs for the 2015 grant year. Contracts are for primary care services (Ravenswood Family Health Center and Public Health Mobile Clinic), dental care services (Ravenswood Family Health Center), and enabling services such as case management and eligibility assistance (InnVision Shelter Network, Behavioral Health & Recovery Services, Puente de la Costa Sur, and Samaritan House).

The following data table includes performance for the 3rd quarter (75%):

HCH/FH Performance 07/01/2015 – 09/31/2015	Yearly Target # Undup Pts	Actual # YTD Undup Pts	% YTD	Yearly Target # Visits	Actual YTD Visits	% YTD	HCH/FH Funding
Behavioral Health & Recovery Svs	300	174	58%	900	959	107%	\$90,000
InnVision Shelter Network (case mgmt & eligibility)	550	403	73%	1,250	704	56%	\$145,000
IVSN (O/E)	50	18	36%				
Public Health Mobile Van	1,250	1057	855%	2,500	1591	64%	\$240,000
Public Health- Expanded Services	626	285	46%	782	307	39%	\$178,500
Puente de la Costa Sur (CM & Intensive CM)	150	96	64%	350	594	170%	\$60,500
Puente (O/E)	100	147	147%				
Ravenswood (Primary Care)	500			1,895			\$65,000
Ravenswood (Dental)	133			600			\$50,000
Samaritan House	175	146	83%	300	279	93%	\$55,000
Total HCH/FH Contracts	3,834	2,152	186%	8,577	4,434	88%	\$884,000

O/E= Outreach & Enrollment



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HCH/FH- Selected Outcome Measure Review (Contracts); Third Quarter (July – September 2015)

Agency	Outcome Measure	Progress- Q3
Behavioral Health & Recovery Services	At least 75% (225) screened will have a behavioral health screening. At least 55% (165) will receive case management services.	Year to date: •174 clients (58%) had a behavioral health screening •174 received case management services
InnVision Shelter Network	Minimum of 50% (250) will establish a medical home. At least 30% (150) of homeless individuals served have chronic health conditions.	Year to date: •41% (203) established a medical home • 32 % of individuals served have a chronic health condition.
Public Health Mobile Van	At least 20% (250) of patient encounters will be related to a chronic disease. At least 75% of clients: • seen at foot clinic will be referred to Mobile Clinic for a medical visit • contacted at Service Connect will be seen at Mobile Clinic for medical visit	Year to date: 13% (159) of encounters were related to chronic health. 100% of patients: • with foot patients referred to PH Mobile Clinic for medical visit • contacted at Service Connect will be seen at Mobile Clinic for medical visit
PH- Mobile Van- Expanded Services	At least 75% (470) of individuals will receive comprehensive health screening. Provide intensive primary care services to minimum of 100 residents with chronic health issues.	Year to date: • 145 patients received a comprehensive health screening • 105 patients with chronic health issues
Puente de la Costa Sur	At least 85 farmworkers served will receive case management services. At least 100 served will be provided transportation and translation services. At least 70% (105) will participate in at least 1 health education class/ workshop.	Year to date: • 96 received case management services • 46 client was provided transportation and translation services. • 15 % participated in Health education workshop.
RFHC – Primary Health Care	At least 60% will receive a comprehensive health screening. At least 250 (50%) will receive a behavioral health screening. At least 50 will be provided Case Mgmt.	Year to date: • 122% (611) received comprehensive health screening. • 37 received behavioral health screening. • 694 received case management services.
RFHC – Dental Care	At least 30% (39) will complete their treatment plans. At least 85% will attend their scheduled treatment plan appointments. At least 40% will complete their denture treatment plan.	Year to date: • 11% (15) completed dental treatment plan. • 339% (451) attended their scheduled treatment plan • 11% completed denture treatment plan.
Samaritan House-Safe Harbor	All 100% (175) will receive a healthcare assessment. At least 95% (166) will receive ongoing case management & create health care plan. At least 70% (122) will schedule primary care appointments and attend at least one.	Year to date: • 149 (85%) received a healthcare assessment. • 149 received case management services. • 73% attended at least one primary care appointment.

Contractor successes & emerging trends:

- **BHRS** states that Same Day Assessments at the Regional Mental Health Clinics are helpful in getting clients seen for mental health screenings in a timely fashion.
 - Housing continues to be less available in the Bay Area for homeless people as more landlords refuse to rent to them because of competition with growing tech industry worker population.
- According to **IVSN** they were able to re-strengthen some existing relationships as well as develop new ones, allowing for greater awareness of their program services and to connect more with individuals to services they could utilize.
 - Clients are waiting several days to receive their BIC cards in the mail, long wait times for primary care and noticing few are in need of insurance enrollment as they are already enrolled.
- **Public Health Mobile Clinic** has found success in the coordination and referral of clients between community partners and Service Connect, being on-site makes access for clients easier.
 - Staff has seen an increase in the age of clients and the severity of their health problems and diagnoses associated with aging such as heart conditions, vascular disease, arthritis and weakened immune systems. Due to increase rents, many elderly have been made homeless because of the unaffordable rent increases.
- **Puente** has had staff stay 2 late evenings each week to assist participants as farmworkers tend to work later hours at the end of summer. They also hired 4 Community Health Workers.
 - Clients having issues with receiving Kaiser documents, as well as not being able to enroll in Cover California because of their legal status.
- **Ravenswood Primary Care** has been able to reserve 4 primary care appointment slots weekly for homeless patients, as well as designate every Wednesday as a full access day- where homeless individuals can register to become patients, complete the health coverage enrollment process etc. Homeless Manager continues to work with Stanford ER and started establishing working relationship with New Directions (innovative hospital and community base case management program for complex medical and psychosocial needs).
 - They have experienced a critical need for Podiatry among their diabetic homeless patients. Continue to work toward making Podiatry services available at their health center in the next 6 months. Medical transfers of Medi-Cal from outside County continue to be long process of 45 days.
- **Ravenswood Dental Care** experiences success through their "Access Dentist" model, providing same day dental services to our unscheduled patients. Also successful is providing quadrant dentistry services, which refers to a treatment approach used on individuals who require extensive dental work to be carried out in a quadrant during a single appointment.
 - New homeless Patients voice frustration with their dental treatment plan possibly taking months to complete, so their Treatment Coordinator continues to spend additional time to explain the process.
- **Samaritan House/Safe Harbor** states the great relationship with the Public Health Van, a service much in demand and that clients love the staff and trust them.
 - Follow through is one of their biggest barriers, as they find more time is used to follow clients with everything to assist and remind them.

TAB 7
Request to
Approve
Credentialing/
Privileging Policy



SAN MATEO COUNTY HEALTH SYSTEM

DATE: November 12, 2015

TO: Co-Applicant Board, San Mateo County Health Care for the Homeless/Farmworker Health (HCH/FH) Program

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: REQUEST TO APPROVE CREDENTIALING AND PRIVILEGING POLICY

Based on continuing discussions with HRSA representatives, it has been noted that the Co-Applicant *must* approve credentialing and privileging of providers that serve the program's target populations. The Board's current Credentialing & privileging Policy approved May 14, 2015, uses the term 'endorse' for the Board's actions with regard to the credentialing and privileging actions of the San Mateo Medical Center's Board of Directors.

The Credentialing & Privileging Policy here presented for Board approval changes the references of 'endorse' to 'approve'

This request is for the Board to approve the HCH/FH Credentialing and Privileging Policy as presented. Approval of this item requires a majority vote of the Board members present.

Attachments:

HCH/FH Credentialing and Privileging Policy dated 11/12/15



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SAN MATEO COUNTY

HEALTHCARE FOR THE HOMELESS/FARMWORKER HEALTH PROGRAM

Program Policy

Policy Area: Program Services Staffing	Effective Date: 11/12/2015
Subject: Credentialing & Privileging	Revision Date: 11/12/2015
Title of Policy: HCH/FH Program Credentialing & Privileging Policy & Procedure	Approved by: Co-Applicant Board

1. Rationale or background to policy:

The San Mateo County Health Care for the Homeless/Farmworker Health (HCH/FH) Program supports that regular verification of the credentials of health care practitioners and delineation of their privileges are required for increased patient safety, reduction of medical errors and the provision of high quality health care services. As part of the responsibility to provide all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals, all services provided to HCH/FH patients must be provided by staff who are properly licensed, credentialed and privileged, as appropriate.

2. Policy Statement:

The HCH/FH Co-Applicant Board shall review and **approve** the credentialing and privileging actions taken by the San Mateo Medical Center (SMMC) Board of Directors (BOD).

In support of these actions, the HCH/FH Co-Applicant Board shall verify annually, or as needed, that SMMC's Credentialing & Privileging policies and processes are in full compliance with the Health Services and Resources Administration's (HRSA) requirements as referenced in Policy Information Notices (PIN) 2002-22 and 2001-16 and as ever updated by HRSA. Upon review of the SMMC Credentialing and Privileging policies and processes, the HCH/FH Co-Applicant Board shall affirm their compliance with HRSA requirements.

3. Procedures:

The HCH/FH Quality Improvement Committee (QIC) shall review SMMC Credentialing and Privileging policies, procedures and processes annually to determine continuing compliance with HRSA requirements. The QIC will report on their findings and determination at the Co-Applicant Board's regular January meeting each year. The HCH/FH Co-Applicant Board shall review the QIC's determination and take action to affirm SMMC compliance with HRSA requirements.

Should the HCH/FH Co-Applicant Board find during an annual verification, or at any other time, that the SMMC credentialing & privileging policies, procedures and processes are no longer fully in compliance with HRSA requirements, the HCH/FH Co-Applicant Board shall immediately initiate a resolution process as specified in the Co-Applicant Agreement to remediate the situation.

If the QIC determines that there is any material non-compliance with HRSA requirements, they shall immediately notify the HCH/FH Director, SMMC and the Medical Staff Office of SMMC of their finding and of the timing of their report to the HCH/FH Co-Applicant Board. On concurrence with the determination by the HCH/FH Co-Applicant Board, a resolution process as called for in the Co-Applicant Agreement shall be initiated to address the issue. The HCH/FH QIC shall track the progress on the issue and provide monthly reports to the HCH/FH Co-Applicant Board until the issue is resolved. Once resolved, the HCH/FH Co-Applicant Board will review and endorse the final resolution and the current status of the SMMC Credentialing and Privileging policies, procedures and processes.

As long as the SMMC Credentialing and Privileging policies, procedures and processes have been determined to be in compliance with HRSA requirements, all credentialing and privileging actions taken by the SMMC BOD shall be added to the HCH/FH Co-Applicant Board's next regular meeting agenda for review and approval.

The HCH/FH Co-Applicant Board will verify bi-annually, or as needed, that SMMC and primary care contractors have credentialing and privileging policies and procedures verifying that all licensed and certified healthcare practitioners delivering care for homeless and farm worker patients and families are in full compliance with the Bureau of Primary Health Care Policy Information Notices 2001-16 and 2002-22.

Approved _____

Board Chair

Program Director

TAB 8

Discussion/ Review RFPs

Documents will be available at meeting
with sufficient time to review

TAB 9
National
Advisory Council
on Migrant
Health
Nominations

NATIONAL ADVISORY COUNCIL ON MIGRANT HEALTH

Call for Nominations: The Secretary of the United States Department of Health and Human Services, Sylvia M. Burwell, requests nominations for qualified candidates to be considered for appointment to the **National Advisory Council on Migrant Health (NACMH)**.

NACMH Management and Support: The Health Resources and Services Administration (HRSA) is charged with the provision of management and support services for the Advisory Council and oversees the membership nomination process.

Who is Eligible?

Members of 330(g) Migrant Health Center governing boards or of other entities assisted under section 254(b) of the Public Health Service Act.

NACMH Charter: The National Advisory Council on Migrant Health (NACMH) was established to advise, consult with, and make recommendations to the Secretary and the Administrator, Health Resources and Services Administration, concerning the organization, operation, selection, and funding of migrant health centers.

- The recommendations center on the nationwide impact of health issues affecting migratory and seasonal agricultural workers and their families, and improving access to and the provision of high quality health care.
- Recommendations are based on: 1) knowledge the members have of issues that may impact the agricultural population; 2) testimonies and/or presentations that are received from migratory and seasonal agricultural workers, their families, providers, other interest groups, etc.; 3) and by national reports or published data.

NACMH Member Roles/Responsibilities:

- Commit to serving a 4-year term appointment.
- Attend and actively participate in bi-annual NACMH meetings (2-3 days per meeting commitment – travel is often required).
- Work collaboratively with co-council members to develop and write recommendations (in the form of a letter) to the Secretary.

NACMH Composition: The Council consists of 15 members who are appointed by the HHS Secretary, including chair and vice-chair.

A minimum of 12 members shall:

- Be members of the governing board of 330(g) Migrant Health Center, or of other entity assisted under section 254(b) of the Public Health Service Act.

9 out of the 12 members shall:

- Be individuals served by a 330(g) Migrant Health Center, or of other entity assisted under section 254(b) of the Public Health Service Act and who are familiar with the delivery of health care to migratory and seasonal agricultural workers.

3 out of the 12 members shall:

- Be individuals qualified by training and experience in the medical sciences or in the administration of health programs.

NACMH Compensation: Members are paid at the rate of \$200 per day including travel time, plus per diem and travel expenses in accordance with Standard Government Travel Regulations. Council members receive a full refund of 100% of approved travel expenses after the voucher and receipts are processed. Travel expenses include air/ground transportation, meals, lodging, and incidental expenses (i.e., allowable tip percentage, luggage fees, etc.).

NACMH Nomination:

Specifically, nominations will be accepted for the following appointments:

- **Board Member/Patient:**

A nominee **must be a member** or member-elect of a governing board of a 330(g) Migrant Health Center, or of other entity assisted under section 254(b) of the Public Health Service Act. A board member nominee **must also be a patient** of the entity that he/she represents. Additionally, a board member nominee **must** be familiar with the delivery of primary health care to migratory agricultural workers and seasonal agricultural workers and their families.

- **Administrator/Provider Representative:**

A nominee **must** be qualified by training and experience in the medical sciences or in the administration of health programs.

A complete nomination package should include the following information for each nominee:

- NACMH Nomination form;
- Three reference letters (professional or personal); and
- A biographical sketch of the nominee or his/her resume.

Interested in Nominating a Qualified Candidate? If so, complete the checklist below:

- ü Identify a qualified candidate and communicate your desire to nominate them for appointment to the NACMH.
- ü Provide the candidate with the nomination notice/package or the link (<http://bphc.hrsa.gov/qualityimprovement/supportnetworks/nacmh/index.html>) to the HRSA webpage that includes the nomination package and specific details about the commitment and the rules and responsibilities of NACMH members.
- ü Review with the candidate the items required for a complete nomination package, they are:
 - NACMH Nomination form;
 - Three reference letters (professional or personal); and
 - A biographical sketch of the nominee or his/her resume.
- ü Ask that the candidate check-in with you once the package has been submitted to HRSA for consideration.

If there are questions about NACMH or the nomination process please don't hesitate to reach out to HRSA for guidance. **For additional information please contact:** CDR Jacqueline Rodrigue, MSW Designated Federal Officer, NACMH, at (301) 443-1127 or email JRodrigue@hrsa.gov or Gladys Cate at GCate@hrsa.gov