

TAB 9A
Request to Approve
Remainder of
Draft SAC
application
submission

(Please note that FTE may not align with budget as this is a draft and we are still working on the final calculations.)

RESPONSE

1) Describe the proposed service delivery sites and how they are appropriate for the needs of the service area and target population. Specifically address:

The HCH/FH service delivery model is designed to create a “safety net for the safety net” through an integrated model of care that incorporates primary care, mental health, substance abuse, oral health, optometry, and enabling services. The HCH/FH network of front-line mobile and fixed-site services linked to the SMMC system of care engages and serves homeless people and farmworkers who cannot or will not use primary health services in conventional settings. Case management services based in homeless shelters and a community resource center serving farmworkers connect patients to comprehensive services, including care at SMMC Health Centers and Specialty Clinics. This model emphasizes accessibility, affordability and relationship building to counter the practical, cultural/linguistic and attitudinal barriers that impede access to healthcare for homeless people and farmworkers through:

- Services that reach homeless people and farmworkers “where they are;”
- Provision of all services without regard to ability to pay;
- Assignment of patients to primary care providers to assure patient-centered medical home access;
- Active assistance to get and stay enrolled in health coverage and other benefits programs;
- Recognition and respect for each patient’s strengths and autonomy; and
- Communication of compassion, dignity and hope in every patient encounter.

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

HCH/FH locates health care and enabling services at key sites throughout the service area to provide convenient access for homeless people and farmworkers through our network of County-operated and contracted services.

County-Operated

- **Public Health Mobile Clinics:** Mobile units make weekly visits to homeless shelters, the Fair Oaks Community Center, a reentry service center and street locations in Redwood City, San Mateo and San Bruno where homeless people congregate. A nurse practitioner provides twice weekly “black bag clinics” at a large shelter for single adults and a family shelter. Mobile services provide convenient, walk-in primary and preventive care, including illness and injury treatment, chronic disease screening, infectious disease testing, vaccinations, emergency contraception, and health education.
- **The Street and Field Medicine** is a new initiative (started in January 2016), that aims to provide high quality medical assessments and treatments, health screening and education, and appropriate Primary Care in the field where they live and work throughout San Mateo County.
- **SMMC Dental Mobile Unit:** Purchased with ACA Capital Investment Program funds, this mobile dental clinic with four dental chairs visits homeless shelter and service sites to provide comprehensive preventive, treatment and restorative oral health care. The Dental Van makes weekly visits to emergency and interim housing programs.
- **Behavioral Health Team:** This Behavioral Health and Recovery Services two-person case management team engages and assesses homeless consumers for mental health and substance abuse disorders, facilitates referrals to assure access to appropriate primary care and behavioral health (mental health and substance abuse) treatment, and follows up to promote ongoing participation in and compliance with treatment. The team is headquartered at the BHRS main office in San Mateo, but delivers services at shelter locations and places homeless people congregate throughout the County.

- San Mateo Medical Center Clinics: SMMC health centers located in low-income communities throughout the service area provide comprehensive primary care to homeless and farmworker patients. In March 2015, the Coastside Clinic initiated a pilot primary care clinic for farmworkers one evening weekly at the Puente de la Costa Sur community center in Pescadero. Staffed by a physician, nurse and medical assistant and funded through a special tax measure, the pilot will expand to more evenings as demand warrants. Specialty Clinics on the main SMMC campus deliver indicated diagnostic and treatment services for patients referred by their primary care providers.

Contractor Services

- Ravenswood Family Health Center (RFHC): Under a contract with HCH/FH, RFHC, a Section 330 community health center located in East Palo Alto, delivers comprehensive primary care, including integrated behavioral health treatment, oral health services, and care coordination services for homeless people. RFHC's Homeless Health Navigator assists patients to access all needed health care and support services.
- Legal Aid Society of San Mateo County: HCH/FH contracts with Legal Aid, a public interest law firm, to address the health needs of farmworkers in San Mateo County rural, coastal communities by: 1) performing a Needs Assessment and an Experience Study to identify the continuing barriers to health care for farmworkers and their families; 2) Provide outreach and education to farmworkers and training and technical assistance to health providers and outreach partners ; 3) Provide referrals, eligibility assistance, legal advice, and representation.
- LifeMoves: HCH/FH contracts with LifeMoves, the largest homeless service provider in the region, for care coordination services and eligibility assistance throughout the county to connect homeless people to health coverage and HCH/FH primary care, and to assist chronically homeless people to complete applications for SSI and SSDI benefits. They are also assisting the new Street Medicine initiative that Public Health Mobile Clinic is conducting, to act as liaison between homeless patients and health care organizations to offer support and care coordination services.
- Samaritan House: HCH/FH's contract with Samaritan House supports shelter-based care coordination services that actively assist homeless residents of the Safe Harbor emergency shelter located in north San Mateo County to access HCH/FH primary care.
- Puente de la Costa Sur: HCH/FH contracts with this community center located near farm operations on San Mateo County's south coast to provide case management care coordination that educates farmworkers and their families about available health services, assists with enrollment in health coverage, and helps overcome scheduling, transportation, cultural and other barriers to care.
- Sonrisas Community Dental Clinic: HCH/FH contracts with Sonrisas to provide oral health services to MSFW at Puente's community resource center, work sites, and housing locations in the South Coast region. The Sonrisas Registered Dental Hygienist in Alternative Practice (RDHAP) performs basic oral health observations and relays findings back to the Sonrisas Dental Director to determine the most appropriate treatment for the patient. The Field Hygienist provides cleaning, oral health maintenance information and supplies, and works with Puente case managers to coordinate referrals to the Sonrisas clinic in Half Moon Bay.

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

HCH/FH network of care includes eight fixed site clinics, two mobile medical units, and a dental mobile unit with locations at and near places that homeless people and farmworkers frequent. HCH/FH

will continue to provide comprehensive primary care during hours convenient for homeless people and farmworkers, as follows. Schedules are reviewed and adjusted based on utilization and feedback from patients and homeless service providers.

Public Health Mobile Clinics

| Monday | Tuesday | Wednesday | Thursday | Friday |
|---|--|---|---|--|
| Service Connect Reentry Center 8:30am-4:30pm | Fair Oaks Community Ctr. 10:00am-2:00pm | Redwood City Street Location 12:00pm-7:00pm | San Mateo Street Location 9:30am-1:30pm | San Bruno Street Location 10:00am-2:00pm |
| S. San Francisco Street Location 11:00am-4:00pm | San Mateo Street Location 10:00am-2:00pm | S. San Francisco Street Location 10:00am-2:00pm | Service Connect Reentry Center 10:00am-2:00pm | First Step for Families 4:00pm-6:00pm |
| Maple Street Shelter 4:00pm-6:00pm | Maple Street Shelter 1:00pm-5:00pm | First Step for Families 4:00pm-6:00pm | Safe Harbor Shelter 5:00pm-7:00pm | |
| | Safe Harbor Shelter 5:00pm-7:00pm | | | |

Dental Mobile Unit

- Monday and Friday: SMMC Main Campus 8:30 am to 4 pm
- Tuesday: South San Francisco street location 8:30 am to 4 pm
- Wednesday: First Step for Families emergency shelter and transitional living program 8:30 am to 4 pm
- 1st and 3rd Thursdays: Maple Street Shelter 8:30 am to 4 pm
- 2nd and 4th Thursdays: Safe Harbor Shelter 8:30 am to 4 pm

SMMC Health Centers

- Coastside Clinic serving the county’s rural, agricultural area Monday-Saturday, 8 am to 5 pm and Thursday evening 5 pm to 8 pm
- Daly City Clinic in a working poor North County neighborhood, Monday-Friday 8 am to 5 pm and pediatric clinics Wednesday 5 pm to 9 pm and Saturday 9am to 1 pm
- Daly City Youth Clinic near high schools with concentrations of homeless students, Monday-Friday 9:30 am to 6 pm
- Fair Oaks Clinic in a working poor neighborhood where immigrant families double and triple up, Monday-Thursday 8:30 am to 7pm and Friday 8:30 am to 9 pm
- San Mateo Medical Center Outpatient Clinic, Specialty Clinics and Edison HIV and STD Clinic on bus lines from all county areas, Monday-Friday 8 am to 5 pm
- Sequoia Teen Wellness Center serving South County high schools, Monday-Friday 8:30 am to 4:30 pm
- South San Francisco Clinic in an immigrant neighborhood: Monday-Friday 8am to 5 pm and pediatric clinics Monday and Thursday 5 pm to 8:30 pm

Ravenswood Family Health Center (RFHC)

- RFHC’s main clinic is located in East Palo Alto, a community with a high concentration of unsheltered homeless people, and operates Monday, Wednesday and Thursday: 8 am to 7 pm; Tuesday 12:30 pm to 7:30 pm, Friday 8 am to 5 pm and Saturday 8 am to 12 pm.

Ravenswood Family Dentistry

- Monday, Wednesday and Friday 8 am to 5pm; Tuesday 1st and 4th 12:30 to 5pm 2nd and 3rd 9am to 5 pm; Thursday 10 am to 7 pm.

Street and Job Site Locations

HCH/FH is utilizing Expanded Services Supplemental funding to add weekly nurse practitioner visits to street locations with Homeless Outreach Teams, weekly nurse practitioner visits to farmworker job sites with Puente case managers, and weekly RN health assessments at a community center in the north coast region.

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

In calendar year 2015, SMMC provided services to 4,714 individuals through 39,915 visits. SMMC health centers have space and staffing to provide care for the projected number of patients through the projected number of visits. Mobile medical and dental units are configured and staffed to serve additional patients. As a community health center, SMMC is committed to seeing as many patients as our current space will allow, and as the demand for health care has evolved we have changed our services provided, the open hours, the size of the facility, and the number of providers and support staff to meet these needs.

d) Professional coverage for medical emergencies during hours when service sites are closed and provisions for follow-up by the health center for patients accessing after hours coverage. Specifically, discuss how these arrangements are appropriate for the services proposed and the projected number of patients (consistent with Form 1A: General Information Worksheet).

When clinics are closed, patients call any of the clinic phone numbers to be connected to an on-call provider. The on-call provider makes an assessment of the problem. For non-emergency problems, the provider gives advice as appropriate and advises the patient to visit the clinic on the next day it is open. In case of emergency, the physician advises the patient to go immediately to the SMMC emergency department or call 911, and contacts the emergency room to communicate pertinent facts to ER staff. When a HCH/FH patient is seen in the emergency department, the patient's primary care provider receives the ER note and clinical support staff reach out to the patient to schedule follow up. Bilingual coverage and/or translation services are available for after-hours calls to meet the needs of the target population.

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

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

PROVISION OF REQUIRED SERVICES

General Primary Medical Care

SMMC provides primary medical care directly. SMMC also has formal written agreements with Ravenswood Family Health Center, Samaritan House Free Clinics, Public Health-Mobile Health Van, and Public Health-Street Medicine.

Triage: Bilingual Medical Assistants and Nurses measure and record vital signs, interview patients to obtain information on symptoms and history, identify acuity level, and determine disposition (waiting area, exam room, and referral to hospital or other care). Training prepares staff to effectively interview culturally diverse patients with different understandings of health and health problems and to obtain needed information from patients who may be reluctant to disclose information or have communication problems.

Examination and testing: Primary care providers conduct health histories, physical exams, and testing for HCV, HIV, other STIs, TB, bacterial infections, anemia, pregnancy, and other conditions. Providers and Medical Assistants take care to explain the exam and testing procedures, answer questions, and make patients as comfortable as possible.

Evaluation/treatment: The clinics in HCH/FH's network of care provide diagnosis and treatment of acute illnesses, infectious diseases and minor injuries, including:

- Respiratory: colds, flu, ear infections, sore throat, bronchitis, etc.
- Eye: uncomplicated conjunctivitis and infections, etc.
- Gastrointestinal: vomiting, diarrhea, evaluation of abdominal pain, etc.
- Orthopedic: uncomplicated musculoskeletal injuries and casting
- Skin: rashes, infections, diseases, minor trauma, etc.
- Urologic: uncomplicated urinary tract infections
- Miscellaneous: headaches and other complaints

Pediatric care: All clinics in the network deliver CHDP care (described below) and assessment, diagnosis and treatment of acute and chronic illnesses and minor injuries for children ages birth to 17.

Specialty care: HCH/FH is integrated with other components of the SMMC to assure that homeless and MSFW patients have access to consistent, comprehensive and coordinated care, including specialty care delivered through the Specialty Clinics on the main SMMC campus. Procedures and communication systems are in place to facilitate specialty care referrals and follow-up. EHR has functions to expedite referrals to specialty care and to facilitate communication between primary care providers and specialty providers. In addition to podiatry, Approved SMMC specialty clinics include cardiology, dermatology, ENT, GI, Hepatology, Orthopedics and Pain Management.

Chronic Disease Management: SMMC clinics and Ravenswood Family Health Center provide comprehensive chronic disease management services using the Chronic Care Model. Each chronic disease patient is assigned to a provider-led patient care team. The patient's team provides care, education and support, including self-care education, prescription management, social service referrals/ support, wellness care, and connections to clinic- and community-based chronic disease support and education groups.

Preventive Services: HCH/FH's approach to primary care emphasizes providing education on prevention of health problems and easy access to recommended preventive care for all life cycles for the large number of underserved patients in the target populations who have accessed health care only sporadically for acute symptoms, or not at all.

- Children's wellness care: Clinics provide Child Health and Disability Prevention services for patients ages birth through 17 based on CHDP periodicity schedules. Services, include: immunizations; developmental, oral health, nutritional, and psychosocial/behavioral assessments; physical exams; BMI measurement and related nutrition and physical activity counseling; vision and hearing screening; blood lead, TB and other indicated tests; and culturally and linguistically competent education for parents/caregivers and teens on healthy development, health risks, and the importance of regular preventive health care.
- Women's wellness care: Patient care teams educate women about the importance of and provide preventive services, including: pelvic and breast exams, mammograms, pap tests, HPV testing and vaccinations, voluntary family planning services, pregnancy testing, counseling on the prevention of and screening for sexually-transmitted infections, screening for and counseling on domestic violence, blood pressure and cholesterol checks, colon cancer screenings for women over 50, and appropriate immunizations.
- Men's wellness care: In addition to physical exams, blood pressure and cholesterol checks, immunizations, and colon cancer screening for men over 50, HCH/FH clinics provide STI screening and education and prostate screening, as appropriate.
- Well-senior health care: Preventive care for seniors includes annual physical exams; review of medications; cancer, depression, functional, and cognitive screenings; and vaccines for flu, pneumonia, and shingles. Wellness exams identify senior patients needing more intensive care

coordination and case management especially in the growing population of homeless seniors utilizing the HCH/FH mobile clinic and Ron Robinson Senior Care Center.

MSFW Specific Health Services: HCH/FH works with agricultural employers and Puente de la Sur to provide easy access to Tdap vaccines for farmworkers at risk for infections from occupational injuries. Most of the providers and clinical support staff at the SMMC Coastside Clinic which is the main source of care for farmworkers are bilingual (English/Spanish). Translation services are always available for patients with limited English proficiency.

MSFW Specific Health Services: HCH/FH works with agricultural employers and Puente de la Sur to provide easy access to Tdap vaccines for farmworkers at risk for infections from occupational injuries. Most of the providers and clinical support staff at the SMMC Coastside Clinic which is the main source of care for farmworkers are bilingual (English/Spanish). Translation services are always available for patients with limited English proficiency.

Diagnostic Laboratory

- SMMC provides some diagnostic laboratory services directly. SMMC also has formal written agreements with South County Community Health Center (dba: Ravenswood Family Health Ctr.)

Fixed site clinics in the HCH/FH network provide basic lab and pharmacy services and facilitate referrals the SMMC main campus facilities for diagnostic lab studies, pharmacy and x-ray services.

Diagnostic Radiology

- SMMC provides diagnostic radiology services directly. SMMC also has formal written agreements with South County Community Health Center (dba: Ravenswood Family Health Ctr.)

Fixed site clinics in the HCH/FH network provide basic lab and pharmacy services and facilitate referrals the SMMC main campus facilities for diagnostic lab studies, pharmacy and x-ray services.

Screenings

SMMC provides screening services directly. SMMC also has formal written agreements with Ravenswood Family Health Center, Samaritan House Free Clinics, Public Health-Mobile Health Van, and Public Health-Street Medicine.

Coverage for Emergencies During and After Hours

SMMC provides emergency medical services directly. SMMC also has formal written agreements with Ravenswood Family Health Center, and Samaritan House Free Clinics.

Voluntary Family Planning

SMMC provides voluntary family planning directly. SMMC also has formal written agreements with Ravenswood Family Health Center, Samaritan House Free Clinics, Public Health-Mobile Health Van, and Public Health-Street Medicine.

Immunizations

SMMC provides primary immunizations directly. SMMC also has formal written agreements with Ravenswood Family Health Center, Samaritan House Free Clinics, Public Health-Mobile Health Van, and Public Health-Street Medicine.

Well Child Services

SMMC provides well child services directly. SMMC also has formal written agreements with Ravenswood Family Health Center, Samaritan House Free Clinics, Public Health-Mobile Health Van, and Public Health-Street Medicine.

Gynecological Care

SMMC provides gynecological care directly. SMMC also has formal written agreements with Ravenswood Family Health Center, Samaritan House Free Clinics, Public Health-Mobile Health Van, and Public Health-Street Medicine.

Obstetrical Care

Prenatal Care, Intrapartum Care (Labor & Delivery), and Postpartum Care: SMMC provides prenatal care directly. SMMC also has formal written agreements with Ravenswood Family Health Center, Samaritan House Free Clinics, Public Health-Mobile Health Van, and Public Health-Street Medicine.

SMMC Health Centers, Ravenswood Family Health Center, and the SMMC Pregnancy & Birthing Center of Excellence provide comprehensive perinatal health care and education and labor and delivery services for HCH/FH patients. The Comprehensive Perinatal Services Program provides prenatal care, health education, nutrition services, and psychosocial support during pregnancy and up to 60 days after delivery of their infants.

Preventive Dental

SMMC provides preventive dental services directly. SMMC also has formal written agreements in place with Sonrisas Community Dental Center, Samaritan House Free Clinics, and Ravenswood Family Health Center.

HCH/FH provides comprehensive oral health services to homeless people through HCH/FH Dental Van visits to homeless shelters and service sites, SMMC fixed site dental clinics, and Ravenswood Family Dentistry contracted services. Farmworkers access dental care at the Coastside Clinic dental clinic and through contracted Sonrisas services. Oral health services include comprehensive oral health exams, treatment planning, dental hygiene education, diagnostic and preventive care, restorative care, and oral surgery.

Pharmaceutical Services

- SMMC provides pharmaceutical services directly. SMMC also has formal written agreements for 340B discount pharmacy services with South County Community Health Center (dba: Ravenswood Family Health Ctr.).

Fixed site clinics in the HCH/FH network provide basic lab and pharmacy services and facilitate referrals the SMMC main campus facilities for diagnostic lab studies, pharmacy and x-ray services.

HCH Required Substance Abuse Services

SMMC provides substance abuse services directly. SMMC has a formal written agreement and a formal written referral arrangement with LifeMoves, Samaritan House, and the County Behavioral Health and Recovery Services.

BHRS case managers connect homeless people to appropriate substance abuse treatment programs in the BHRS network, using formal written referral procedures. The network consists of 16 community-based treatment programs operating outpatient, residential and transitional housing programs. It includes addiction medicine services, perinatal treatment, and gender- and culturally-specific treatment programs located throughout San Mateo County.

Substance Abuse Services For Homeless People: BHRS case managers connect homeless people to appropriate substance abuse treatment programs in the BHRS network, using formal written referral procedures. The network consists of 16 community-based treatment programs operating outpatient, residential and transitional housing programs. It includes addiction medicine services, perinatal treatment, and gender- and culturally-specific treatment programs located throughout San Mateo County.

Case Management (Care Coordination)

SMMC provides case management/care coordination services directly. SMMC also has formal written agreements in place with Behavioral Health and Recovery Services, LifeMoves, Puente de la Costa Sur, Samaritan House, and Ravenswood Family Health Center.

HCH/FH contracts with key community partners to provide care coordination services that provide the practical support and motivation farmworkers and homeless people need to connect to medical homes, including information about available services, assistance in making appointments, appointment reminders, assistance arranging transportation, and encouragement to attend appointments and follow treatment and self-care plans. Puente de la Sur provides care coordination for farmworkers and their families, including communication and advocacy with farm operators to reduce environmental and occupational health hazards and make farmworker health a priority, e.g. coordinating tetanus and other immunizations for farmworkers provided by Coastside Clinic staff at work sites. LifeMoves and Samaritan House provide care coordination for homeless individuals and families, including linkages to substance abuse treatment programs. A County Behavioral Health and Recovery Services team delivers intensive street-and shelter-based case management to assist chronically homeless people with mental health and substance abuse disorders to access primary care coordinated with behavioral health treatment.

Eligibility Assistance

SMMC provides eligibility assistance services directly. SMMC also has formal written agreements with LifeMoves, and Puente de la Costa Sur.

HCH/FH works in partnership with the SMMC Health Coverage Unit to streamline procedures for screening homeless and farmworker patients for eligibility for health coverage and assist them with applications and maintaining enrollment. The Health Coverage Unit has designated specially trained staff to assist HCH/FH patients with enrollment procedures and assigned these staff to work at HCH/FH and core services agency locations. The Health Coverage Unit has also waived the enrollment fee for the San Mateo County Access and Care for Everyone coverage program for homeless people and farmworkers. Please see Response #9 below for more detail.

Outreach

SMMC provides outreach services directly. SMMC also has formal written agreements with LifeMoves, and Puente de la Costa Sur.

HCH/FH conducts outreach through mobile unit visits to places homeless people frequent and partnerships with organizations that have established trust relationships with people experiencing homelessness and farmworkers. This approach reaches and engages underserved people where they are, literally, and in terms of the motivation, information, and assistance they need to access care. Key outreach partnerships include working relationships homeless shelters and transitional housing programs, and the eight community organizations service sites that served as core service centers, providing emergency and basic needs assistance for homeless people, farmworkers and their families, and other low income and working poor County residents: Coastside Hope, Puente de la Sur and Legal Aid Society of San Mateo which serve farmworkers, and Daly City Community Service Center, El Concilio Emergency Services Partnership in East Palo Alto, Fair Oaks Community Center, YMCA Community Resource Center, Samaritan House and Pacifica Resource Center.

Transportation

SMMC does not provide transportation services directly. SMMC also has formal written agreements with SamTrans Redi-Wheels, and MV Transportation.

HCH/FH sites and mobile unit visit locations are situated in neighborhood locations that make it possible for most homeless patients to walk or take bus lines to clinic appointments. SamTrans Redi-

Wheels paratransit provides transportation for patients with disabilities and those needing special assistance. HCH/FH provides taxi vouchers that case managers distribute to patients who need to visit a clinic immediately, are not able to arrange Redi-Wheels transit on short notice, and are too ill to take regular public transit. Puente de la Sur works with MV Transportation to coordinate transportation for farmworkers.

Translation

SMMC provides translation services directly. SMMC also has formal written agreements with Health Care Interpreter Network (HCIN).

PROVISION OF ADDITIONAL CLINICAL SERVICES

Additional Dental Services

SMMC provides pediatric restorative dental services directly. SMMC also has formal written agreements in place with Sonrisas Community Dental Center, Samaritan House Free Clinics, and Ravenswood Family Health Center.

HCH/FH provides comprehensive oral health services to homeless people through HCH/FH Dental Van visits to homeless shelters and service sites, SMMC fixed site dental clinics, and Ravenswood Family Dentistry contracted services. Farmworkers access dental care at the Coastside Clinic dental clinic and through contracted Sonrisas services. Oral health services include comprehensive oral health exams, treatment planning, dental hygiene education, diagnostic and preventive care, restorative care, and oral surgery. In 2015, 1,108 HCH/FH patients utilized dental care through 3,597 visits.

Behavioral Health Services

Mental Health Services: SMMC provides mental health directly. SMMC also has a formal written agreement with Ravenswood Family Health Center.

To provide linkages to behavioral health care for homeless people, a BHRS Behavioral Health Team provides case management care coordination services. The team contacts homeless people with mental illnesses and addictions on the street and at homeless service centers to conduct screening, assessment, treatment planning, facilitation of treatment linkages and follow-up. Case managers maintain contact with homeless patients participating in treatment to promote compliance, solve problems and connect them with support services. SMMC also provides psychological and psychiatric services directly to homeless patients through the Medical Psychiatry Department. HCH/FH provides access to behavioral health services for farmworkers through the BHRS clinic located at the Coastside Clinic.

Substance Abuse Services: SMMC provides substance abuse services directly. SMMC has a formal written agreement and a formal written referral arrangement with LifeMoves, Samaritan House, and the County Behavioral Health and Recovery Services.

BHRS case managers connect homeless people to appropriate substance abuse treatment programs in the BHRS network, using formal written referral procedures. The network consists of 16 community-based treatment programs operating outpatient, residential and transitional housing programs. It includes addiction medicine services, perinatal treatment, and gender- and culturally-specific treatment programs located throughout San Mateo County.

Optometry

SMMC provides comprehensive eye exams and vision services directly.

Environmental Health Services

SMMC does not provide environmental health services directly. SMMC has a formal written agreement with the County of San Mateo Health System.

Occupational Therapy

SMMC provides occupational therapy directly.

Physical Therapy

SMMC provides physical therapy services directly.

Nutrition

SMMC provides nutritional services directly. SMMC also has a formal written referral arrangement with Ravenswood Family Health Center.

Additional Enabling/Support Services

SMMC does not provide additional enabling and support services directly. SMMC has a formal written referral arrangement with LifeMoves, Puente de la Costa Sur, and the Legal Aid Society of San Mateo County. The Legal Aid Society provides health related legal services designed to identify barriers to healthcare for farmworkers; outreach and education to farmworkers of legal rights, training and technical assistance to health providers and outreach partners, health access referrals, eligibility assistance, legal advice and representation.

b) How enabling services (e.g., case management, outreach and enrollment activities, transportation) are integrated into primary care. Describe any enabling services designed to increase access for targeted special populations or populations with identified unique health care needs such as translation services for populations with limited English proficiency and accommodations to facilitate veterans' access to care.

Note:

- ***Applicants requesting HCH funding must document how substance abuse services will be made available either directly, through formal written contracts/agreements, and/or via a formal written referral arrangement.***
- ***Applicants requesting MHC funding must document how they will address any specific needs of this population (e.g., provide additional services such as environmental health).***
- ***Applicants requesting PHPC funding must document that the service delivery plan was developed in consultation with residents of the targeted public housing and describe how residents of public housing will be involved in administration of the proposed project.***

Community- and shelter-based case managers and RFHC's Homeless Health Navigator provide a range of services based on each patient's needs to support patients to access primary care and follow treatment plans, including transportation assistance, motivational interventions, and linkages to community services and supports. The HCH/FH Providers Collaborative offers a forum for case managers and healthcare providers to communicate about strategies to meet the needs of individual patients and to plan system-wide communication and access improvements.

3) Describe plans to ensure continuity of care for health center patients, including:

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

SMMC Health Center physicians are San Mateo Health System employees with SMMC admitting privileges. Formal agreements are in place for admitting privileges for RFHC physicians.

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

SMMC EHR and e-messaging system facilitate communication between out-patient physicians and hospitalists, track hospitalizations, and track patient utilization across systems. RFHC participates in the e-messaging system and receives messages on hospitalizations and discharge planning.

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

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

The HCH/FH clinical staffing pattern provides adequate staffing to deliver care for the projected number of patients, including the large number of complex patients and patients who have lacked access to care for long periods. As detailed on Form 2, our system-wide medical team includes 9.69 FTE providers that are split between physicians (6.69 FTE) and mid-level practitioners (3.0 FTE). Other medical staff consist of 4.0 FTE RNs and 6.0 FTE Clinical Support Staff who support provider panels of physicians and mid-levels. An Optometrist (0.20 FTE), Ophthalmologist (0.10 FTE) also provide vision services to HCH/FH patients.

HCH/FH productivity levels improved over the past year. Average visits per 1.0 FTE mid-level provider increased from 1,600 to 2,997. Physician productivity levels (3,054 visits) remained close to the range for the average Section 330 national benchmarks for medical (3,200-3,500 encounters). Although HCH/FH patients are spread across various provider panels, efforts are being made to assign them to the same PCMH team to provide for care coordination that includes health education and referrals to specialty care, behavioral health treatment, and oral health services. Other clinical staff include 1.0 FTE Dentist and 0.70 FTE behavioral health providers who will deliver services at various HCH/FH fixed and mobile clinic sites.

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

Hiring of staff who speak the languages and reflect the cultures of our culturally and linguistically diverse patients is a priority for SMMC which provides a pay differential for bilingual providers and clinical support staff. SMMC requires and provides regular training on cultural competence and use of interpretation services.

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

The range and depth of services provided by SMMC includes all required primary, preventive, enabling health services, and additional health services as determined necessary by the San Mateo County Board of Supervisors and the Co-Applicant Board through its assessment of unmet community needs in San Mateo County. SMMC maintains a staff sufficient to carry out required services that range from on-site primary care, dental and mental health care, to enabling supportive services and referrals within San Mateo County. All required services are provided directly by SMMC. In addition, SMMC has secured formal written contracts and formal written referral agreements in an effort to meet the identified need of the target population.

As required of all community health centers, SMMC physicians must hold current licensure by the Medical Board of California. Under the guidance of the Medical Director, providers follow national standards set forth for the treatment of chronic illnesses and preventive guidelines set by national regulatory and standards organizations. Mid-level practitioners consult with their preceptor when the scope of services required is beyond their specific training. Specific written policies, procedures and protocols are in place for nurse practitioners and physician's assistants.

When patients are referred for specialty medical and diagnostic consultation/services outside the scope of what SMMC provides, clinical protocols are followed. This includes protocols for referrals whereby the referral coordinator connects patients with needed care and works with the outside providers to ensure patients receive the needed services.

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

a) Definitions of income and family size.

HCH/FH's sliding fee discount program policies and procedures define income as modified adjusted gross income (MAGI) which includes adjusted gross income plus any tax-exempt Social Security, interest, or foreign income. The definition of family size is based on Federal Poverty guidelines. Family members include head of household, spouses, legal guardians, domestic partners and children under age 19. HCH/FH procedures recognize and account for the likelihood that some homeless and MSFW family members may temporarily find shelter apart from other family members.

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

Patient registration procedures at all HCH/FH fixed and mobile sites include assessment and reassessment of all patients for eligibility for discounts based only on income and family size. Multi-lingual staff screen patients to determine their eligibility for health coverage programs and sliding fee scale discounts at every visit. All uninsured patients are referred to Certified Enrollment Counselors to determine eligibility and assist with applications for health coverage.

c) Process for determining patient eligibility for sliding fee discounts, including frequency of re-evaluation of patient eligibility.

Under HCH/FH's sliding fee discount policy and procedures, acceptable income verification includes: recent income tax returns; IRS forms W2 or 990; recent check stubs; recent bank statements; Unemployment, Social Security, Veterans, TANF, SNAP and retirement/pension benefits letters and statements; and court documents. To remove barriers for homeless and MSFW patients who often do not have documents or reasonable options for obtaining documents verifying income, HCH/FH accepts signed self-declarations of income and statements of why patients are unable to obtain documents verifying income. Patients are queried about changes in income and family size during registration for appointments. Reassessments of eligibility for sliding fee discounts are conducted at least annually.

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

Multi-lingual signs posted in clinic reception and waiting areas inform patients in simple English, Spanish, Chinese and Tagalog language terms about the availability of discounts and clearly state that HCH/FH provides health care regardless of ability to pay. HCH/FH also provides information about

discounts and that services are available regardless of ability to pay in all registration and outreach materials. Bilingual outreach and front office staff verbally inform patients of the availability of sliding fee discounts.

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

Sliding fee discounts are applied to all HCH/FH services.

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

Patient surveys and focus groups inform the annual review of the sliding fee discount program by the Co-Applicant Board.

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

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

The Co-Applicant Board reviews and approves updates to the SFDS proposed by staff to reflect the most recent FPG. The SFDS was most recently updated and approved by the Co-Applicant Board on June 9, 2016.

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

The SFDS in Attachment 10 uses four discount pay classes based on income thresholds by family size: 0-100% FPG no charge, 101-138% FPG 98% discount, 139-170% FPG 95% discount, 171-200% FPG 80% discount.

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

As shown in Attachment 10, the HCH/FH SFDS provides for a full discount for individuals and families with annual incomes at or below 100% FPG.

d) If a nominal charge is applied for individuals and families with annual incomes at or below 100 percent of the FPG, how the charge is:

- Determined to be nominal from the perspective of the patient (e.g., input from patient focus groups, patient surveys).***
- A fixed fee (not a percentage of the actual charge/cost) that does not reflect the true cost of the service(s) being provided.***
- Not more than the fee paid by a patient in the first SFDS pay class above 100 percent of the FPG.***

HCH/FH does not apply a nominal charge for services to ensure services are accessible to low income people experiencing homelessness and MSFW.

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

a) Addressing patient grievances.

Patient/client grievances and complaints are treated with the highest importance. Complaints and concerns should be resolved at the program level whenever possible. When an issue cannot be resolved, procedures are followed as described in the policy in the SMMC Rights and Responsibilities of the Patient chapter in WorkSite titled RI.01.07.01-B Patient Grievance Procedure. Complaints and grievances, which relate to quality of care issues, are referred to the appropriate department or committee for review and action. The HCH/FH Medical Director and Executive Director share responsibility for ensuring grievances/complaints are addressed.

b) Incident reporting and management.

HCH/FH complies with the SMMC Integrated Patient Safety Plan (in Work Site titled PI.03.01.01-A Integrated Patient Safety Program). In compliance with the Integrated Patient Safety Plan, sentinel events and other significant untoward events, or the risk of such events, will be included in the HCH/FH QI Plan through special reporting. Such events are further defined in the Integrated Patient Safety Plan. These events may also be reportable pursuant to the County's sentinel event reporting ordinance. Actions taken as a result of root causes analyses and focus reviews will be included in the quality improvement program and reported to the HCH/FH Co-Applicant Board, SMMC Board, and SMMC QI Committee. Primary care contractors have in place and comply with their individual risk management plans and all related policies and procedures.

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

All SMMC employees must participate in training and demonstrate proficiency on HIPAA requirements. All paper records are maintained in cabinets that are locked at the close of each business day. All computer workstations are password and firewall-protected and computer monitor screens are positioned to reduce the likelihood that an unauthorized person would have visual access. Fax machines that transmit and receive medical information are kept in protected employee-only areas.

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

Based on SMMC policies and procedures, the HCH/FH Medical Director establishes procedures for and supervises reviews of electronic health records and/or representative samples of SMMC clinic patient charts to measure progress toward selected clinical performance measures and other quality indicators. The QI Plan developed annually by the QI Committee and approved by the Co-Applicant Board identifies clinical performance measures and other indicators. Licensed health professionals conduct reviews of patient records quarterly.

e) Ensuring providers (e.g., employed, contracted, volunteers, locum tenens) are appropriately licensed, credentialed, and privileged to perform proposed health center services.

SMMC primary care providers delivering care for homeless and farmworker patients are subject to SMMC credentialing and privileging policies and procedures. SMMC follows Board-approved policy and procedures to assess and verify the credentials of all licensed and certified health care practitioners it employs and to grant such individuals specific clinical privileges in full compliance with the HRSA

requirements. The SMMC Board votes to approve the credentialing of providers whom the QI committee has put forward as having complete credentialing. The credentialing process documents current licensure and verifies appropriate education, training, certification and work history, and includes checks of criminal records, National Practitioner Database, and professional liability claims, as well as signed statements attesting to fitness to work and accuracy of documentation provided. At the time of appointment, providers are privileged based on their skills to perform specific types of care in an ambulatory care setting by the CMO and privileges are reviewed by the QI Committee, signed by the CMO and approved by the Board. Privileges are renewed based on re-credentialing every two years. Re-credentialing includes peer review of patient records for compliance with clinical guidelines and QI target goals. The HCH/FH Executive Director assures that RFHC uses similar policies and procedures to ensure that providers delivering care for homeless patients under contract with HCH/FH are appropriately licensed, credentialed and privileged.

f) Utilization of appropriate information systems (e.g., EHRs, practice management systems) for tracking, analyzing, and reporting key performance data, including 1) reporting required clinical and financial performance measures and 2) tracking diagnostic tests and other services provided to ensure appropriate patient record documentation and follow-up.

SMMC has implemented the eClinical Works (eCW) EHR. During the proposed project period, eCW will track and generate reports on HCH/FH performance measures and patient services. eCW sends orders for lab and radiology tests and incorporates findings in patients' EHRs, including alerts when results are out of range. EHRs also include reminders when patients are due for preventive services. eCW also has payment management features.

g) Developing, updating, and implementing such policies and procedures.

The QI Committee develops and annually updates QI policies and procedures for Co-Applicant Board approval. The Co-Applicant Board most recently approved implementation of updated policies and procedures on May 14, 2015.

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

HCH/FH communicates QI/QA findings to stakeholders through open Co-Applicant Board meetings and postings on the Board web page. Based on QI findings, the QI Committee identifies areas for improvement; establishes baseline data; conducts root cause analysis; develops a process improvement plan that specifies tasks, responsibilities, and time lines; revisits the issue through analysis of updated data; and evaluates the results of the redesigned process, using the rapid cycle improvement process (Plan-Do-Study-Act).

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

The Co-Applicant Board approves QI policies and procedures and annual QI plans; regularly reviews reports on QI findings; and delegates implementation of QI activities to the QI Committee led by the Medical Director. The Medical Director provides clinical leadership for implementation of the QI Plan and is responsible for leadership of the QI Committee, oversight of chart reviews, supervision and review of assessments of progress toward clinical performance measure target goals, oversight of compliance with and participation in quality improvement and risk management plans and activities, and review of and response to any reported incidents.

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

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

Appointment registration procedures include identification of uninsured patients, provision of information to them about potential eligibility for coverage programs, and referral to a Certified Enrollment Counselor for assessment of eligibility and assistance completing applications. To reach other individuals, we use a collaborative approach involving Homeless Outreach Teams, community organizations serving farmworkers, clinics, outreach and enrollment specialists, and Certified Enrollment Counselors to identify potentially eligible individuals and provide the high level of encouragement and assistance that many homeless people and farmworkers need to navigate and complete the process of enrollment in health coverage.

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

Certified Enrollment Counselors provide hands-on assistance to homeless people and farmworkers and their families with eligibility determination and enrollment applications through a regular weekly schedule of visits to clinics, shelters, community service sites, and schools, and periodic events at churches and community events. The Health Coverage Unit provides Certified Enrollment Counselor training for HCH/FH Provider Network members. Working with outreach workers and case managers at other agencies allows us to reach and stay in contact through the application process with hard-to-reach, uninsured homeless and MSFW individuals and families.

Note: If you are a new and competing supplement applicant, you must:

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

Not applicable.

10) Describe plans to ensure that you will:

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

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

Not applicable.

COLLABORATION

1) Describe both formal and informal collaboration and coordination of services with the following community providers in the service area (consistent with Attachment 1: Service Area Map and Table for items a through e below), or explain if such community services are not available:16

HCH/FH actively collaborates with other health care and community service providers to meet the needs of patients and make the most of federal and local resources. The HCH/FH Providers Collaborative facilitates communication among health care providers and community organizations serving homeless people and farmworkers to coordinate services and to identify and solve systems problems.

Information/updates on participation in any new collaborative initiatives with homeless programs/providers and/or MSFW programs.

The program continues to work closely with our Providers of homeless and farmworker services by holding quarterly meetings through our Providers' Collaborative meetings to network and trouble shoot challenges that the providers encounter.

Program staff attends San Mateo County's Continuum of Care meetings that are hosted by SMC's Center on Homelessness. The attendees are a network of organizations that provide services to homeless individuals/families throughout San Mateo County.

Program staff has also started forming relationships and conversing with staff from SMMC's Resources Management Department, involved in Discharge Planning of SMMC clients. Staff from the Resources Management Department have been in attendance of our Providers' Collaborative meetings to establish relationships with our contractors that provide case management services to our clients.

Information on participation in any new collaborative initiatives with other Health Agency/SMMC and/or community health programs (e.g., Pescadero Clinic).

The San Mateo County HCH/FH Program continues to work closely with various Health Agencies/collaborations to provide seamless services to our population as well as establishing new relationships.

We continue to work closely with our Health Coverage Unit Department, which assists with enrolling clients in health insurance/coverage. The close relationship ensures that the HCH/FH Program is kept abreast of health coverage information updates, as well as ensuring that our clients are receiving adequate health insurance services.

The program continues to work with the San Mateo County's Center on Homelessness and Department of Housing/Housing Authority, starting to meet at least quarterly to discuss efforts to collaborate and work together for our target populations.

The Oral Health Coalition, a San Mateo County Collaborative for Dental Education and Access is a group that program staff also works closely with to be kept aware of updates, assisting in planning and to keep others informed of our program.

The Program has also started forming a relationship with staff from the Health Plan of San Mateo (HPSM). We have been communicating with staff from their CareAdvantage program, a Coordinated Care Plan. As HPSM staff has been working with some of our clients that are high utilizers of the Emergency Room, we are encouraging our contractors that provide enabling services (Case Management) to our clients to connect with the CareAdvantage staff to ensure seamless services.

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

HCH/FH contracts with the Ravenswood Family Health Center, the only Section 330 Community Health Center in San Mateo County, to provide primary care and oral health services for homeless residents of East Palo Alto. We also have cross-referral agreements with Gardner Family Health Network, a CHC/HCH program based in neighboring Santa Clara County, which recently opened a pediatric clinic in South San Mateo County.

b) State and local health departments.

HCH/FH is a component of the San Mateo Health System, which encompasses the local public health department and San Mateo Medical Center. We work closely with the Health Coverage Unit on enrollment of homeless people and MSFW in health coverage and with the SMMC Resources Management Department, which is involved in discharge planning for SMMC hospital patients. Resource Management staff now attend HCH/FH Providers Collaborative meetings to establish relationships with HCH/FH case management programs.

During the current project period, HCH/FH enhanced our working relationship with the Health Plan of San Mateo (HPSM), the county-organized, local non-profit health care plan that offers health coverage and a provider network to San Mateo County's underserved population and is responsible for administration of Medi-Cal. We are communicating with staff from HPSM's CareAdvantage program, which coordinates care for Medi-Cal/Medicare beneficiaries, including homeless people with disabilities, to facilitate seamless services.

The San Mateo Health System works with the California Department of Health Services on efforts to improve access to care and the health status of homeless people, farmworkers and other low income residents, including outreach and enrollment of uninsured residents in Covered California health coverage options under the Affordable Care, the state immunization registry, and surveillance of maternal and child health and infectious diseases.

c) Rural health clinics.

There are no rural health clinics in the service area.

d) Critical access hospitals.

There are no critical access hospitals in San Mateo County.

e) Free clinics.

HCH/FH's contract with Samaritan House supports shelter-based care coordination services that actively assist homeless residents of the Safe Harbor emergency shelter located in north San Mateo County to access HCH/FH primary care.

The Samaritan House operates two highly respected free clinics, the San Mateo Free Clinic and the Redwood City Free Clinic, that provide primary and specialty medical, dental and vision care to low income and uninsured individuals. This enables them to access the health care they need without compiling the disabling debt often attributed to medical expenses. Services includes dental, internal medicine, gynecology, breast care, dermatology, diabetic care, endocrinology, neurology, orthopedics, ophthalmology and optometry, podiatry, nutritional counseling, and pulmonary.

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

Ryan White funds help support HIV care and support services at the SMMC Edison Clinic, an HCH/FH site which provides health care and support services for homeless people and farmworkers living with HIV/AIDS. HCH/FH facilitates referrals for services for children with special needs to the

county's Title V-funded California Children's Services (CCS) program and coordinates primary care with CCS.

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

No private provider groups in the service area serve low income/uninsured patients.

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

HCH/FH coordinates referrals of pregnant women to San Mateo County's Pre to Three home visitation program designed to facilitate early identification and treatment of potential health and developmental problems, improve access to the health care system, and build parenting skills and confidence. The Pre-to-Three multi-disciplinary team provides in-home health screenings, education on healthy growth and development and facilitated referrals to community services and supports. A specialized Perinatal Addiction Outreach Team provides a comprehensive range of case management services; education on child development, parenting, and chemical dependency; developmental screenings; advocacy; and supportive counseling to pregnant and/or parenting women identified as being at risk for substance use.

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

HCH/FH and WIC programs countywide have cross-referral agreements. School district homeless and migrant education programs refer families for services.

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

HCH/FH has strong working relationships with all the homeless service providers and community organizations serving farmworkers in the service area, including the following.

Homeless Service Providers

San Mateo County Human Services Agency Center on Homelessness, the entity responsible for coordinating homeless services throughout San Mateo County, directs individuals and families to HCH/FH, provides data to inform HCH/FH planning, and is HCH/FH's forum for participating in implementation of the Housing Our People Effectively (HOPE) plan to address the core causes of homelessness in San Mateo County. HCH/FH provides health services for chronically homeless people identified by Homeless Outreach Teams (HOTs), a collaboration between the Center on Homelessness, homeless service providers, and local law enforcement agencies, to reach out to the chronically homeless people who are the target of the most merchant and residential complaints to police and most frequently visit hospital emergency rooms. HCH/FH has proposed to use Expanded Services Supplemental funds to assign a Nurse Practitioner to work directly with HOTs providing "street medicine" health care services. HCH/FH staff participate in Continuum of Care meetings for homeless service providers hosted by the Center on Homelessness.

LifeMoves, formerly known as InnVision Shelter Network, provides care coordination to link homeless shelter residents to primary care through a contract with HCH/FH; provides space and coordinates referrals for HCH/FH medical and dental mobile unit visits to the Maple Street Shelter; refers

participants in transitional living, supportive housing, rapid re-housing and support service programs to HCH/FH; and provides services for homeless patients referred by HCH/FH.

Samaritan House provides care coordination to link shelter residents to primary care through a contract with HCH/FH; provides space and coordinates referrals for HCH/FH mobile unit visits to the Safe Harbor Shelter; refers homeless participants in food assistance and volunteer-based free clinics, as well as homelessness prevention assistance, financial education, a temporary labor program to HCH/FH; and provides services for homeless patients referred by HCH/FH.

Core service centers operated by Coastside Hope, Puente de la Sur, Daly City Community Service Center, El Concilio Emergency Services Partnership in East Palo Alto, Fair Oaks Community Center, YMCA Community Resource Center in South San Francisco, Samaritan House and Pacifica Resource Center, which provide food assistance, housing referrals, and linkages to other community services, refer clients to HCH/FH and provide services for homeless patients referred by HCH/FH.

Organizations Serving Farmworkers

Puente de la Costa Sur, the community resource center serving farmworkers and their families in the isolated South Coast region of San Mateo County, provides care coordination to link farmworkers and their families to primary care through a contract with HCH/FH, including assistance to farmworkers to enroll in health coverage programs and coordination of MY Transportation, an on-demand service that provides low-cost public transportation to health care appointments; refers farmworker participants in youth development, parent education, and employment programs to HCH/FH; and provides services for farmworkers and their family members referred by HCH/FH.

Coastside Hope, the core service center serving farmworker families, informs farmworkers about HCH/FH services and refers farmworker participants in crisis intervention and case management services, emergency and supplemental food assistance, rental and utility assistance, and citizenship classes to HCH/FH.

Legal Aid Society of San Mateo County, a public interest law firm, provides free civil legal services to low-income San Mateo County residents. Under a contract with HCH/FH, Legal Aid addresses the health needs of farmworkers in San Mateo County rural, coastal communities by conducting a Needs Assessment to identify the continuing barriers to health care for farmworkers and their families, providing outreach and education to farmworkers and training and technical assistance to health providers and outreach partners, and providing referrals, eligibility assistance, legal advice, and representation.

k) If applicable, veterans service organizations, U.S. Department of Veterans Affairs (VA), Veteran's Health Administration community based outpatient clinics, VA medical centers, and other local veteran-serving organizations.

HCH/FH works with the San Mateo County Veterans Services Office (CVSO) to assist homeless veterans with needed health care services.

CVSO is responsible for providing benefit entitlement determinations, claim development, claim filing, advocacy, and case management services to the veteran population of San Mateo County. CVSO is also responsible for administering the College Fee Waiver Program for Veterans' Dependents. The CVSO and SMMC share an agreement to collaborate on services for veterans and have established protocols for information sharing between the offices.

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

There are no federally funded neighborhood revitalization programs in the service area.

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

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

- South County Community Health Center (dba: Ravenswood Family Health Ctr.)
- Gardner Family Health Network

b) State and local health departments.

- San Mateo County Public Health Dept.
- San Mateo County Behavioral Health & Recovery Services
- San Mateo County Center on Homelessness (on-file)

c) Rural health clinics.

There are no rural health clinics in the service area.

d) Critical access hospitals.

There are no critical access hospitals in San Mateo County.

3) If you are proposing to serve special populations, you must provide current dated letters of support that reference specific coordination or collaboration with community organizations that also serve the targeted special population(s) (e.g., Migrant Head Start, Public Housing Authority, homeless shelters).

- Puente de la Costa Sur
- LifeMoves
- Coastside Hope
- Samaritan House