

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

Co-Applicant Board Meeting Agenda
 Fair Oaks Clinic | 2710 Middlefield Rd. (Great room) Redwood City
 December 12, 2019; 8:30 - 11:30am

AGENDA	SPEAKER(S)	TAB	TIME
A. CALL TO ORDER	Brian Greenberg		8:30am
B. CHANGES TO ORDER OF AGENDA			8:32am
C. PUBLIC COMMENT			8:33am
Persons wishing to address on matters NOT on the posted agenda may do so. Each speaker is limited to three minutes and the total time allocated to Public Comment is fifteen minutes. If there are more than five individuals wishing to speak during Public Comment, the Chairperson may choose to draw only five speaker cards from those submitted and defer the rest of the speakers to a second Public Comment at the end of the Board meeting. In response to comments on a non-agenda item, the Board may briefly respond to statements made or questions posed as allowed by the Brown Act (Government Code Section 54954.2) However, the Boards general policy is to refer items to staff for comprehensive action or report.			
D. CONSUMER INPUT			
a. Update on local policies and other advocacy items	Suzanne Moore		8:35am
E. CLOSED SESSION			8:40am
a. Director Evaluation			
F. CONSENT AGENDA			
1. Meeting minutes from November 14, 2019	Linda Nguyen	Tab 1	8:58am
G. BUSINESS AGENDA			
1. Travel request - National Alliance to end homelessness	Linda Nguyen	Tab 2	9:00am
a. Request to approve travel request			
2. Service Area Competition (SAC) Award	Jim Beaumont	Tab 3	9:05am
3. Board membership	Jim/Linda	Tab 4	9:10am
a. Request to approve board member			
H. REPORTING AGENDA			
1. QI report	Frank/Danielle	Tab 5	9:15am
2. Finance Report	Finance Subcommittee/Jim	Tab 6	9:20am
3. HCH/FH Program Director's Report	Jim Beaumont	Tab 7	9:25am
I. BOARD PRESENTATIONS AND DISCUSSIONS			
1. Discuss amending Board's Bylaws	Jim Beaumont	Tab 8	9:30am
2. Strategic Plan - Review outcomes of 8 sessions attended by Board Members and subject matter experts: 1) Street Field Medicine/Mobile Clinic, 2) Dental Health, 3) Collaboration with Law Enforcement, 4) Medical Respite/Medical Acuity in Shelters/ Housing, 5) Farmworker Education/Outreach, 6) SMMC clinics, 7) Nutrition/Food Access 8) Behavioral Health/Addiction Services	Irene Pasma		
3. Discuss Program Needs Assessment	Irene Pasma		

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>.

J. BOARD COMMUNICATIONS AND ANNOUNCEMENTS

Communications and Announcements are brief items from members of the Board regarding upcoming events in the community and correspondence that they have received. They are informational in nature and no action will be taken on these items at this meeting. A total of five minutes is allotted to this item. If there are additional communications and announcements, the Chairperson may choose to defer them to a second agenda item added at the end of the Board Meeting.

1. Future meetings – every 2nd Thursday of the month (unless otherwise stated)
 - a. Next Regular Meeting January 9, 2020; 9:00AM – 11:00AM at SMMC| San Mateo

K. ADJOURNMENT

11:30am

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TAB 1

Meeting Minutes

Request to Approve

**Healthcare for the Homeless/Farmworker Health Program (Program)
Co-Applicant Board Meeting Minutes (Nov 14, 2019)
Maple Street Shelter- RWC**

Co-Applicant Board Members Present

Brian Greenberg
Tayischa Deldridge
Suzanne Moore
Eric DeBode
Robert Anderson
Steven Kraft
Mother Champion
Jim Beaumont, HCH/FH Program Director (Ex-Officio)

County Staff Present

Frank Trinh, Program Medical Director
Linda Nguyen, Program Coordinator
Irene Pasma, Program Implementation Coordinator
Danielle Hull, Clinical Coordinator
Andrea Donahue, County Counsel's Office
Melissa Rombaoa, SMMC- PCMH Manager

Members of the Public

Shira Futornick, LifeMoves Intern

Absent: Christian Hansen , Victoria Sanchez De Alba, Shanna Hughes

ITEM	DISCUSSION/RECOMMENDATION	ACTION
Call To Order	Brian Greenberg called the meeting to order at _____A.M. Everyone present introduced themselves.	
Board Chair/Vice Chair nominations and elections	<p>Board Chair Nominations: Brian Greenberg; Robert Anderson</p> <p>Vice Chair Nominations: Robert Anderson; Eric Debode, Tayischa Deldridge</p> <p><u>ELECTIONS:</u> Board Chair votes: <u>Brian Greenberg</u>: received 5 votes from Tay, Suzanne, Eric, Steve K, Mother Champion <u>Robert Anderson</u>: received 1 vote from Brian Greenberg</p> <p>Board Vice Chair votes: <u>Robert Anderson</u>; received 1 vote by Tay <u>Eric Debode</u>: received 4 votes by Suzanne, Robert, Steve K, Brian <u>Tayischa Deldridge</u>: received 2 votes from Eric and Mother Champion</p>	<p>Positions Elected for January 1, 2020- December 31,2020</p> <p><u>Board Chair – Brian Green</u></p> <p><u>Vice Chair - Eric DeBode</u></p>
Regular Agenda Public Comment	No Public Comment at this meeting.	
<u>Consumer Input</u>		
CEO update	San Mateo Medical Center (SMMC) CEO, CJ Kunnappilly discussed Budget updates at SMMC that includes budget deficit. SMMC is experiencing a structural budget deficit because costs are not matching revenue streams. SMMC is looking at a radical re-design that includes using resources to be more effective. Also trying to bring additional 10,000 patients into care and looking at costs savings efforts.	
Local policies- Suzanne Moore	Local policy updates from Suzanne Moore: <u>Pacifica</u> : Outreach to Faith-based leaders on 10/25 to consider possible rotational shelters. Unhoused in Pacifica Task Force Forum on 11/20/19.	

	<p><u>Mountain View</u> is collecting signatures to protect homeless in motor homes.</p> <p><u>San Mateo County Safe Parking Working Group</u> had presentation last meeting by LifeMoves. Focus of group is Safe Parking as a regional issue.</p>	
No closed session-		
Regular Agenda Consent Agenda	<p>All items on Consent Agenda (meeting minutes from Oct 10, 2019) were approved.</p> <p>Please refer to TAB 1</p>	<p>Consent Agenda was <u>MOVED</u> by Steve K. <u>SECONDED</u> by Suzanne, and <u>APPROVED</u> by all Board members present.</p>
<p><u>Board Presentation/ Discussions</u></p> <p>Introduction to data</p> <p>Strategic Plan</p>	<p>Discussion about sources of clinical data the program receives and how we report on our annual Uniformed Data System (UDS) report to our funders Health Resource Service Administration (HRSA)</p> <p>Discussion on updates to the Strategic Plan included:</p> <ul style="list-style-type: none"> • Brainstorm Sessions Update • Next Steps in the Strategic Planning Process • Session De-brief or Values/Framework • Forming an ad-hoc Strategic Plan subcommittee • Having next December Board meeting extended to three hours (8:30-11:30am) 	
<p><u>Business Agenda:</u> Travel request:</p> <p>Request to Approve travel requests for Project WeHOPE and LifeMoves</p>	<p>HCH/FH staff received a travel request from (7) Non-Board members, staff of Project WeHOPE and LifeMoves, to attend the upcoming NAEH conf, Oakland (February 19-21, 2020)</p> <p>Project WeHOPE staff requests:</p> <ul style="list-style-type: none"> • Pastor Paul- President & Co-Founder • Cheryl Bains HR Director & Co-Founder • Alicia Garcia- Associate Director • Dina Bartello- Director of Development <p>LifeMoves staff requests:</p> <ul style="list-style-type: none"> • Brian Greenberg, VP Programs & Services • Donna Miller, Program Director, Maple Street • Jacob Stone, Director of Shelters and Services in San Mateo County <p>Request to Approve travel requests for Project WeHOPE and LifeMoves</p> <p>Please refer to TAB 2</p>	<p>Request to Approve travel requests for Project WeHOPE and LifeMoves staff <u>MOVED</u> by Tay <u>SECONDED</u> by Steve K., <u>Recused</u>-Brian <u>Abstain</u>- Mother Champion and <u>APPROVED</u> by all remaining Board members present.</p>
<p><u>Business Agenda:</u> Small funding update</p>	<p>Update to Small funding requests, efforts to spend down unexpended funds by end of the year. The progress to date to fund various projects to support organizations and departments working with our homeless and farmworker patients:</p>	

	<ul style="list-style-type: none"> • \$140,000 awarded to 14 projects • 6 community-based projects: \$80,500 • 8 SMC Health-based projects: \$59,500 • \$32,000 funded using SUD-MH grant funds <p>Please refer to TAB 3</p>	
<p><u>Business Agenda:</u></p> <p>Request to approve Budget line item to support SMMC SB1152 "Care Closet"</p> <p>SMMC Resource mgmt SB1152 request</p>	<p>As part of the Small Funding Request solicitation, the HCH/FH Program received a request from SMMC Discharge/Case Management Unit to support funding of their "Care Closet". Under California law (SB1152), certain services and items need to be provided to the homeless upon discharge from a hospital, including appropriate clothing. The "Care Closet" provides these items to the homeless discharged from SMMC. The request was to fund a single order at this time for approximately \$3,000.</p> <p>The HCH/FH Program is proposing to establish a permanent budget line item to support the SMMC "Care Closet" in the amount of \$10,000 per year. As the County entity tasked with Homeless Health and as a part of SMMC, this appears to us to be a specific effort that we should routinely be involved with. We often make these kinds of supportive efforts with our community partners, and this would position us to be doing so with our County partners.</p> <p>As the Board has approval authority for the Program budget, and as this would be establishing a permanent line item within the budget, we believe that the Board item should be acted on by the Board. This request is for the Board to approve the establishment of a permanent budget item for \$10,000 to support the SMMC "Care Closet" for clothing and other supplies for the homeless on discharge from SMMC. Approval of this item requires a majority vote of the Board members present.</p> <p>Request to approve Budget line item to support SMMC SB1152 "Care Closet"</p> <p>Please refer to TAB 4</p>	<p>Request to approve Budget line item to support SMMC SB1152 "Care Closet"</p> <p><u>MOVED</u> by Robert <u>SECONDED</u> by Steve K., and <u>APPROVED</u> by all Board members present.</p>
<p><u>Reporting Agenda:</u></p> <p>Sub-committee report</p>	<p>The Board Membership/Recruitment sub-committee brought up issue of membership. There was a discussion on recruitment efforts and the possible need of moving Board meetings to evening to encourage board membership and decrease barriers for consumers.</p>	
<p><u>Reporting Agenda:</u></p> <p>QI Committee Report</p>	<p>The San Mateo County HCH/FH Program QI Committee met on October 24th. The following was discussed:</p> <p>The QI/QA Committee reviewed and approved SMMC Credentialing and Privileging policies as part of HRSA requirement. Third Quarter Data Review: In a prior meeting, the QI Committee requested that clinical measures of focus be stratified by population type (homeless and farmworker), and by homeless status (doubling up, street, shelter, etc.). The committee reviewed and discussed areas for investigation and improvement.</p> <p>UDS Data Reporting: The committee reviewed all clinical quality measures and discussed optimization methods for 2019 and 2020. The clinical services coordinator will be working with Business Intelligence and other internal departments to improve reporting in the next year.</p> <p><u>Diabetes Action Plan:</u> The reporting period for the Diabetes Action Plan ended in October</p>	

	<p>2019. We will be continuing to work towards outreaching to patients due for A1c testing and referral to dental care as these two goals are integral to quality patient care. <u>Training for Contractors:</u> The Trauma Informed Care: Self-care Strategies Training for homeless service providers is November 15th. The next HCH/FH QI Committee meeting TBD in December 2019.</p> <p><i>Please refer to TAB 5 on the Board meeting packet.</i></p>	
<p><u>Reporting Agenda:</u></p> <p>HCH/FH Program Budget & Financial Report</p>	<p>Estimated grant expenditures to-date are \$2,341,654. In addition, we have an estimate \$110,798 in expenditures for items not claimable on the grant, for total Program estimated expenditures of \$2,452,452.</p> <p>Current projection for year-end is that total base grant expenditures will be \$2,645,207 by the end of the year, including expenditures for approved Small Funding Requests, which would create an <i>unexpended fund balance</i> of \$3,229. Including expenditures for the Expanded Services Awards (SUD-MH), the total Program grant expenditures would be \$2,905,607.</p> <p>Based on expenditures to date, we anticipate the overall expenditure rate on base grant contracts and MOUs to be around 84% for allocation during the current Grant Year (and at 90.0% overall).</p> <p>Next year's projection currently shows an estimated total expenditure of \$3,016,050 against all program grants (base, SUD-MH & IBHS) totaling \$3,017,193. This would leave an unexpended balance (for all grants) of \$1,143.</p> <p><i>Please refer to TAB 6 on the Board meeting packet.</i></p>	
<p><u>Reporting Agenda:</u></p> <p>HCH/FH Program Directors report</p>	<p>The Program has continued being focused on progress on the Strategic Planning effort, in addition to the usual routine engagements.</p> <p>There have been no significant updates from HRSA involving our grant award. We have been informed by our Project Officer that the proposed Technical Assistance (TA) covering contracting, scope and reporting (related to our agreements with Ravenswood Family Health Center) has again been approved. However, no dates have been discussed for the TA.</p> <p>Program did receive the summary report on the evaluation of our Oral Health Infrastructure competitive grant application.</p> <p>HRSA has indicated that if they receive sufficient funding in their full fiscal year appropriation, they may award additional New Access Point (NAP) grants (we did not apply) and/or Oral Health Infrastructure (OHI) grants. There has been no further update on finalization of HRSA appropriations for the Federal Fiscal Year.</p> <p>HRSA announced new policy on carrying over 25% of budget for next year, details to come.</p> <p><i>Please refer to TAB 7 on the Board meeting packet.</i></p>	
<p>Adjournment</p>	<p>Time <u>11:01am</u></p>	<p>Brian Greenberg</p>



Introduction to HCH/FH Data and Reporting



Where does the data come from?

San Mateo Medical Center and Clinics

Contracted Service Agencies

UDS Data Report

Working on getting aggregate data

Behavioral Health and Recovery Services Clinics and Data



Strict access; unable to get data



Types of Reports Received

From Contracted Service Agencies

- Monthly invoice data received
- Lists of patients served and number of visits

From SMMC, Clinics, Mobile Clinic, Street and Field Medicine

- Data from Electronic Health Record System (referred as “eCW”)
- Data from billing, such as ICD-10 codes (diagnostic codes) and CPT codes (service delivered codes)

*Outpatient: a patient who receives medical treatment without being admitted to a hospital.



- Publications
 - SMMC
 - HCH - HealthCare for the Homeless
 - UDS - Uniform Data System
 - UDS Archive

Type	Name ^	
	UDS - Finance Details	10/11/2019 6:07:18 PM
	UDS - Finance Summary	10/11/2019 6:09:26 PM
	UDS - Patient Master	10/11/2019 6:04:01 PM
	UDS - Patients By Zip Code	10/11/2019 2:50:27 PM
	UDS - Table3A - Patients By Age and Gender	10/11/2019 2:47:59 PM
	UDS - Table3B - Patients by Ethnicity Race SOGI	10/11/2019 6:09:27 PM
	UDS - Table3B - Patients By Hispanic or Latino	10/11/2019 2:47:59 PM
	UDS - Table4 - Homeless Status	10/11/2019 2:49:03 PM
	UDS - Table4 - Income As Percent of Poverty Level	10/11/2019 2:49:03 PM
	UDS - Table4 - Insurance Source Details	10/11/2019 2:49:25 PM
	UDS - Table4 - Insurance Source Summary	10/11/2019 2:49:18 PM
	UDS - Table4 - Migratory Seasonal Worker Status	10/11/2019 2:48:00 PM
	UDS - Table4 - Payors Insurance Summary	10/11/2019 2:50:21 PM
	UDS - Table4 - School Based Health Centers Patient	10/11/2019 2:48:26 PM
	UDS - Table4 - Veterans	10/11/2019 2:49:03 PM
	UDS - Table5 - Staff Utilization By UDS Service	10/11/2019 3:15:30 PM
	UDS - Table5 - Staff Utilization Provider Details	10/11/2019 2:58:30 PM
	UDS - Table5 - Staff Utilization Summary	10/11/2019 3:08:03 PM
	UDS - Table6A - Services Rendered Homeless	10/11/2019 2:37:56 PM
	UDS - Table6A - Services Rendered Merged	10/11/2019 2:45:36 PM
	UDS - Table6A - Services Rendered Merged Detail	10/11/2019 2:42:53 PM
	UDS - Table6A - Services Rendered MSFW	10/11/2019 2:47:58 PM
	UDS - Table6B SectionA - Prenatal Care Age Cat	10/11/2019 2:30:43 PM
	UDS - Table6B SectionB - Prenatal Care	10/11/2019 2:33:08 PM
	UDS - Table6B SectionC - Childhood Immunization	10/11/2019 2:35:19 PM
	UDS - Table6B SectionD - Pap Tests	10/11/2019 4:27:40 PM
	UDS - Table6B SectionE - Weight Assessment Child	10/11/2019 6:00:03 PM
	UDS - Table6B SectionF - Weight Assessment Adult	10/11/2019 5:03:12 PM
	UDS - Table6B SectionG - Tobacco Cessation	10/11/2019 5:08:27 PM
	UDS - Table6B SectionH - Asthma	10/11/2019 5:08:28 PM
	UDS - Table6B SectionI - Coronary Artery Disease	10/11/2019 5:12:33 PM
	UDS - Table6B SectionJ - Ischemic Disease	10/11/2019 5:14:56 PM
	UDS - Table6B SectionK - Colorectal Cancer	10/11/2019 5:39:44 PM
	UDS - Table6B SectionM - Depression Screening	10/11/2019 6:03:59 PM
	UDS - Table7 - Pregnant with HIV	10/11/2019 2:40:11 PM
	UDS - Table7 SectionA - Women with Deliveries	10/11/2019 2:38:24 PM
	UDS - Table7 SectionB - Hypertension Details	10/11/2019 3:22:34 PM
	UDS - Table7 SectionC - Diabetes Details	10/11/2019 3:31:10 PM
	UDS - Visit Master	10/11/2019 6:05:02 PM

What the data portal looks like for data we receive from SMMC and Outpatient Clinics

Clinical Reports

What “Counts”?

Visits

- Clinic Visits are documented face-to-face visits with a provider who exercises independent, professional judgement in the provision of services to the patient
- Count one visit per patient
- Per visit type per day
- Per provider per day
- Per provider type per day

Patients

- Patients are unduplicated, meaning they are only counted once per measurement.
- Unique patients can appear in multiple service categories
- Example:
- Patient A can receive both Medical AND Dental Services
- The sum of patients across categories is 2, but it's 1 unique patient

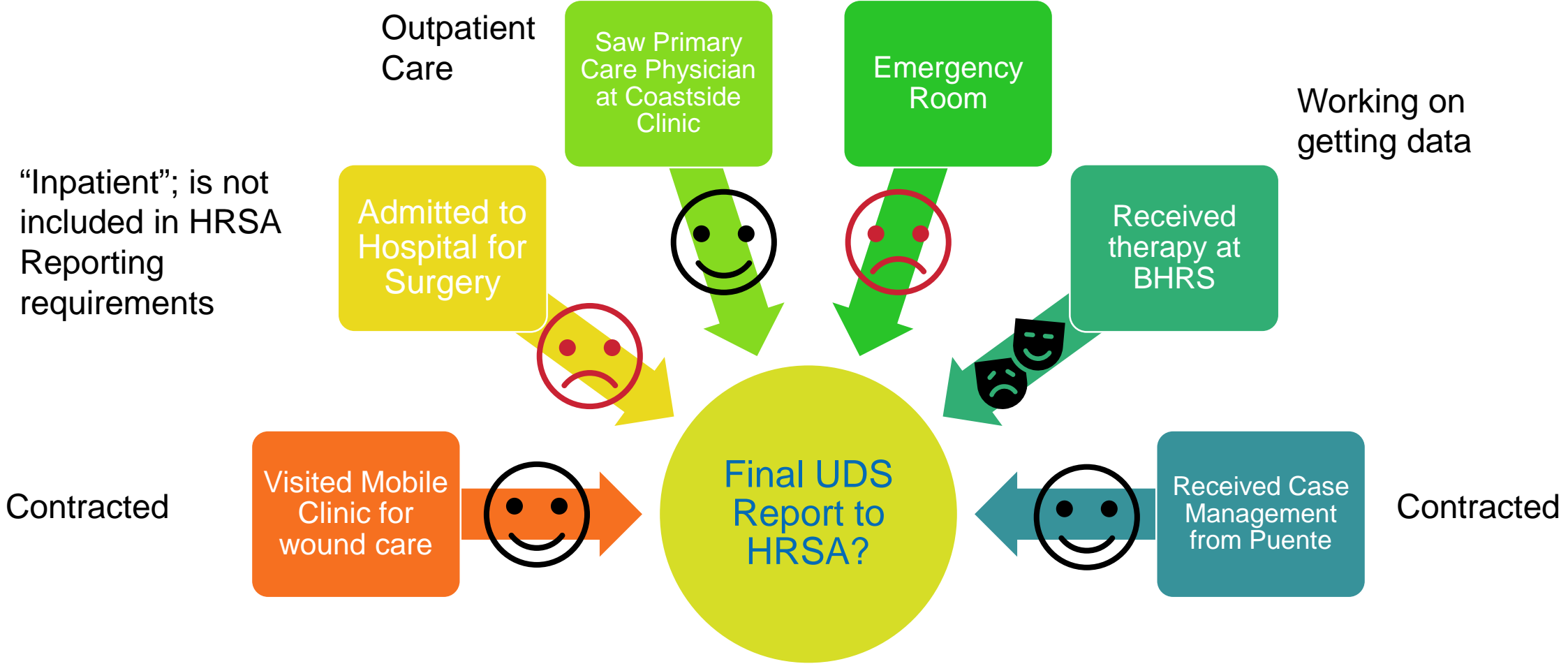
Only outpatient visits are counted; Emergency Room or Inpatient visits are not included in HRSA reporting requirements.

Example: Unduplication and Visits



- In UDS Reporting, when we say “unduplicated patient”, we mean that we have seen “X” number of unique patients across multiple service categories and delivery sites
- At the end of the year, the management analyst (Sofia) combines lists from contracted service agencies as well as the list we receive from the SMMC Business Intelligence Team

Example: Does it count?



Report Inclusion

Example: If we say we had a 90% Tobacco Screening and Cessation rate, it would include patients and visits from these three entities

Patients, Visits, Demographic, Payor, and Staff Utilization

AKA “UDS Tables 1-5”

Contractor data

SMMC & Outpatient Clinics

Clinical Reports

AKA “UDS Tables 6A, 6B, 7”

SMMC & Outpatient Clinics

Ravenswood (Contractor)

Mobile/Street/Field Medicine (Contractor)

Table 6A Overview:

Selected Diagnoses and Services Rendered



Provides an aggregate count
(numbers only)

Example: 506 patients
received service "X"



No specific patient information provided



Useful when looking at
mental/behavioral health data
which is under additional
federal protections

The data we are working on
getting from BHRS will be
aggregate



34 different diagnoses and services included in this
table

Categories of Data

Selected Infectious And Parasitic Diseases

- TB Testing, STI's, Hepatitis

Selected Diseases Of The Respiratory System

- Asthma, Chronic lower respiratory disease

Selected Other Medical Conditions

- Diabetes, Heart Disease, Hypertension, Dehydration, Overweight/Obesity, Abnormal breast findings, Abnormal cervical findings, etc.

Selected Childhood Conditions (Limited To Ages 0 Through 17)

- Perinatal medical conditions, lack of expected physiological development, etc.

Selected Mental Health And Substance Use Disorder Conditions

- Alcohol related disorders, Tobacco Use Disorder, Anxiety, Depression, Substance Use Disorder, etc.

Selected Diagnostic Tests/Screening/Preventive Services

- SBIRT, HIV, Hepatitis, Mammogram, Pap, Immunizations, etc.

Selected Dental Services

- Emergency services, Oral Exams, Sealants, Oral surgery, etc.

Strategic Plan Update

Prepared for November 2019
Co-Applicant HCHF Board
meeting



Agenda

- Brainstorm Sessions Update
- Next Steps in the Strategic Planning Process
- Choose your own adventure: Session De-brief or Values/Framework

Brainstorm Session Update

- Productive conversations; combination of discussing current state and new project ideas
- All 8 sessions completed (almost all HCHF staff were at each session):
 1. **Mental Health/Addiction Services**
 - BHRS
 2. **Street and Field Medicine**
 - PHPP, HOT, Board Member
 3. **Dental Services**
 - Oral Health Coalition
 4. **Collaboration with Law Enforcement**
 - Correctional Health Services, Sherriff's Office, Board Member
 5. **Medical Respite/Shelter Medical Capacity/Housing**
 - MHA, HSA, Hospital Consortium, SMMC, Maple Street, Board Member
 6. **Farmworker Outreach/Education**
 - Puente, Coastside Hope, BHRS, Board Member
 7. **Decrease wait time/collaborate with existing clinics/SMMC navigator**
 - SMMC, Board Member
 8. **Nutrition / Food Access**
 - Puente, Family Health Services, Board Members

THANK YOU to everyone who participated.

Next Steps

- **Goals:**
 - Complete Strategic Plan in March 2020
 - Release RFPs reflecting Strategic Plan May 2020
- **Remaining Work to Finalize Strategic Plan:**
 - **Now:** Form a sub-committee to meet ad-hoc
 - **Now:** Board provide input on brainstorming session outcomes
 - **December/January:** Identify which projects or collaboration efforts the Board wants to pursue – some projects can be short term and others more long term
 - **Now-January:** Define the Board's value framework, this will support the above bullet point
 - **January-March:** Share Draft Plan with Stakeholders, including consumers
 - **March:** Finalize the report and its operationalization

Note:

SMMC Transformation efforts may impact services currently provided to our population, and we need to be able to respond to any changes in the New Year

Brainstorming Session and Beyond

- **Option 1: All together**

- Brainstorming sessions are discussed at November and December Board Meetings
- *Impact:* potential additional meeting in January or February to ensure we finish on time

- **Option 2: Subcommittee**

- Brainstorming sessions are discussed at subcommittee early December,
- Subcommittee provides input to full Board at December meeting
- December Board meeting focuses on financial/contractor questions
- *Impact:* not all Board members will provide input to all potential ideas

In both scenarios:

- Request the December Co-Applicant Board Meeting be 3 hours
- Ad hoc meetings may be required if SMMC transformation has a large impact on our population

(Fun)committee Selection



Source: https://www.google.com/search?q=excited+to+participate+meme&rlz=1C1GCEB_enUS809US809&sxsrf=ACYBGNoDoPI-4TE9lKhcoLkvqq_jk_bAg:1573695001014&source=inms&tbm=isch&sa=X&ved=0ahUKewitpJTcxujAHWQuZ4KHc-bB-8Q_AUIEigB&biw=1596&bih=754#imgrc=xvheLnLXrvBMM

Option 1

HCH/FH Brainstorming Session Summaries

Behavioral Health and Addiction Services

Pernille Gutschick, Clinical Services Manager (BHRS), Matt Boyle, Medical Assisted Treatment, (BHRS), Clara Boyle, Deputy Director Alcohol and Other Drug, (BHRS), HCHF Staff: Jim Beaumont, Danielle Hull, Irene Pasma, Sofia Recalde

Homeless Individuals

- Residential Treatment Beds
 - survey clients previously homelessness who leave treatment early on why they left
 - work with inpatient and outpatient providers to create more welcoming environments for homeless clientele
 - incidental medical services at residential facilities throughout the county
- Detox
 - Designate beds at SMMC for Medical Detox
 - Co-locate SUD services with shelters or medical respite, like HealthRight360 at Maple Street
- “Honor Dorms” in shelters to incentivize compliance

Farmworkers

- **IMAT team could go out with Field Medicine**
- Tele-health
- Home visits
- There’s no SUD/AOD treatment facilities on the coast
 - i.e. AA meetings

*Orange indicates this item was cross referenced in other brainstorming sessions

Street/Field Medicine & Mobile Clinic

Robert Anderson, Board Member; Anita Booker, PHPP; Frank Trinh, PHPP; James O'Connell, PHPP; Hannah Blankenship, Lifemoves HOT; HCHF Staff: Jim Beaumont, Sofia Recalde, Danielle Hull, Linda Nguyen, Irene Seliverstov

Ideas

- Attach Care Navigator to Street/Field/Mobile Team
- **Attach IMAT to Field Medicine Team**
- PHPP to develop relationships with Farm owners / expand services to Mid & North Coast Farms
- **Boosting clinic spaces – Puente, Maple Street (need more information whether this is desired, licensure and revenue)**
- Women's Health – better connection with OBGYN, changing mode of administration of tests and screening, revamping clinic space

Additional Thoughts / Links with Other Sessions

- If patient doesn't have Medi-Cal or ACE, he/she cannot get specialty care
- How to keep someone connected to health care even after they're housed?
- **Slotting spaces in SMMC Clinics**
- Farmworkers are priced out of ACE, but can't afford insurance
- **Designating Mobile Clinic as a primary care site**
- Mobile Clinic is raising awareness about its services

Dental (Oral Health Coalition Meeting)

Presented at Oral Health Coalition Meeting, attended by ~20 people, Irene Pasma, Danielle Hull

- Co-locate “dental and primary care” services or “dental and BHRS” services – do a “warm hand off” between the clinicians; follow what SMMC is doing on this effort
 - From SMMC: historically, mobile clinic patients didn’t want mobile dental clinic services, they came to mobile clinic for a specific item
- Further explore ‘street/mobile’ dental services
 - Look at other counties models, i.e. Alameda, Santa Clara
 - Dental van does not go to the Coast
 - If there was a van or mobile dental, consider going to churches
- Denti-Cal Integration Implementation is January 2021
- Dental care at shelters – Family Health Services is interested in partnering
- Getting an oral health subject matter expert on the Board

Collaboration with Law Enforcement

Robert Anderson, Board Member; Correctional Health Services: Carlos Morales, Ashely Sokolov, Karina Sapag; Melissa Wagner, Sheriff's Office, HCHF Staff: Jim Beaumont, Danielle Hull, Linda Nguyen, Irene Pasma, Sofia Recalde

45% of inmates
are out of
county

- Correctional Health Services (CHS) desire to be able to 'text' "someone" when an individual is being released and ensure follow up
- Discharge is an opportunity to provide intervention – i.e. daily case management after someone is released from jail
- Data sharing is a large opportunity – desire to connect more with HOT in advance
- Problem providing services to released sex offenders due to local laws (i.e. limited housing opportunities)
- Someone who is homeless who goes into jail has no place to put all their belongings, when they are released, they start completely from scratch including documents
- More thought needs to go into multiple booking short stay individuals ("frequent jail fliers") because they are the least connected to services



Medical Respite/Medical Acuity in Shelter/Housing

Suzanne Moore, Board Member; Francine Serafin Dickson, Hospital Consortium; Judith Klain, Health Administration; Melissa Platte, MHA; Brian Eggers, HSA; James Schindler, SMMC Discharge Planner; Maple Street: Donna Miller, Kelly McGrath, Robert Moltzen, Jim Beaumont, Linda Nguyen, Irene Pasma

Shelter

- Increase medical staff at shelter
- **Better equip 'clinic-like' spaces at shelters and community based organizations**
 - CES questionnaire does not screen for health appropriate-ness
- Improved hand off between shelter and street homelessness (i.e. between shelter staff and HOT)

Medical Respite

- Was not significantly touched upon due to separate task force work

Housing: large focus on individuals exiting homelessness into subsidized housing

- Community space for previously homeless individuals
- Daily contact is needed with newly housed individuals
- Need to incentivize newly housed individuals to complete tasks, i.e. OT, doctor's visit, etc.
- Improve data flow during hand off between shelter and PSH/affordable housing unit to prevent crisis
- **SDOH: train clinicians to ask about housing, consider housing stability (link to SMMC efforts)**

Farmworker Education/Outreach

Victoria Sanchez de Alba Board Member, Vicente Lara, Puente; Judith Guerrero, Coastside Hope; Ziomara Ochoa, BHRS, HCHF Staff: Jim Beaumont, Danielle Hull, Linda Nguyen, Irene Pasma, Sofia Recalde

- **Adopt a Promotores community health model on the Coast (particularly Mid- and North-Coast)**
- “Attorney hours” at a clinic (Coastside, Rotacare, Puente) following CRLA’s partnership with Monterey Health
- HCH/FH to host forum for Farmworker Providers, analogous to CRLA/Monterey event
- In-depth training for clinicians on Public Charge / other legal issues
- There is no laundry mat in Pescadero, only one in Half Moon Bay
- Food security topics
- Establish relationships with Half Moon Bay growers

Patients at SMMC Clinics

Brian Greenberg Board Member, Vanessa Washington, SMMC New Patient Connection; Christine Zachos, SMMC Patient Navigator; Frank Trinh, HCHF Staff: Jim Beaumont, Danielle Hull, Linda Nguyen, Irene Pasma, Sofia Recalde

- **Changing how a patient can become established to simplify & expedite access, i.e. Mobile Clinic or Field/Street Medicine Team**
- **Create slots for homeless and farmworker patients at county clinics**
- Create Care Navigator position linked to new patient connection line and focus on non-WPC patient population
- Leverage patient portal

Nutrition / Food Access

Board Members: Victoria Sanchez de Alba, Eric Debode, Christian Hansen; Vicente Lara, Puente; Ankita Tandel, Family Health Services;
HCHF Staff: Jim Beaumont, Danielle Hull, Linda Nguyen, Irene Pasma

Ideas

- HCH/FH lead advocacy efforts on “healthy food” – thought leaders in San Mateo County
- Community gardens linked with clinics/shelters
- Industrial kitchen with cooking classes, food, etc.
- Partner with existing organizations to deliver food to our populations
- Partner with Blue Apron/Freshly to deliver discounted boxes to people who just moved into housing

Themes/Actions

- Define the differing needs between these two populations
- Set aspirational definition for “healthy food”, i.e. whole food/plant diet
- Learn which shelters currently have kitchens/pantries/community gardens
- Learn what education programs currently exist in San Mateo County
- **Work with SMMC for Social Determinants of Health to be incorporated in clinic screening**

Option 2

**What does it
mean to be
providing the
best possible
care to our
two
populations?
(draft)**

- Our patients feel welcome and safe
- Patients trust their providers
- Patients are able to get an appointment within a reasonable time frame
- Providers understand the unique challenges/stressors each population faces and is equipped to respond to them
- We provide integrated care, are flexible and innovative on how we provide it
- Focus on mental health
- Reduce health disparities / manage chronic disease
- Patients can access quality and specialty care
- We want our patients to live their best possible lives

Strategic Plan Framework Values

(draft)

- Partner/collaborate whenever possible/avoid duplication of efforts
- Build-in advocacy into whatever we are doing/funding
- 80% of funds/staff time for homeless individuals, 20% for farmworkers
- HCH/FH is an information and networking “hub” for providers
- Actively solicit input from the people we’re developing programming for
- Build-in flexibility as health needs and political/economic environments change
- Apply for new funding opportunities as they align with strategic goals
- Consider how to measure a project’s cost savings to the health system
- Partners are held to high standards, contracts are amended when needed / terminated if services are not being delivered as agreed
- Contract outcomes reflect what is important to the program
- High HRSA Compliance
- Good quality care

Existential Questions

- Should we be more client facing i.e. provide services directly?
How much do we want to contract?
- What if the Board chooses to prioritize projects which inherently mean the program will serve fewer unduplicated patients?

TAB 2
Travel request



DATE: December 12, 2019

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: TRAVEL REQUESTS FOR NAT'L ALLIANCE TO END HOMELESSNESS CONF.

HCH/FH Co-Applicant Board Policy on travel reimbursement for non-board/non-staff members (effective 3/10/2016) states that:

For national and regional events outside of California, the Board may choose to consider the equivalent of full travel reimbursement of up to one (1) individuals, and

If more individuals than noted above express interest for support and reimbursement, the Board shall consider the overall benefit to the program, consumer status, additional support being provided by non-program funds, other similar support having been previously provided to the individual or their employer, agency or others, availability of program funds and any other criteria the Board may deem as appropriate.

HCH/FH staff received a travel request from Board member, Mother Champion to attend the upcoming NAEH conf, Oakland (February 19-21, 2020) to support registration costs:

Requested amount for registration: \$625 per person



TAB 3

Service Area

Competition

Award

Jim Beaumont

From: Jim Beaumont
Sent: Tuesday, November 26, 2019 9:35 AM
To: Jim Beaumont
Cc: Sofia Recalde; Danielle Hull; Linda Nguyen; Irene Pasma; Frank Trinh; Andrea Donahue
Subject: SAC Application

DO NOT FORWARD THIS EMAIL

DO NOT DISCUSS THIS EMAIL OR THE NOTICE OF AWARD (NOA) WITH OTHER BOARD MEMBERS, IN PERSON, BY PHONE OR ELECTRONICALLY.

The HCH/FH Program is providing a courtesy update for the Co-Applicant Board on the Program's Service Area Competition (SAC) application.

We have received a Notice of Award from HRSA/BPHC providing the San Mateo County HCH/FH Program the 330 Program Grant for the next three (3) years. This represents our ongoing base grant funding for the program. Specifically, the award for 2020 is \$2,625,049.

Discussion of this would/might be considered Board business, which would make it covered by the Brown Act.

UNDER THE BROWN ACT, YOU MAY NOT DISCUSS THIS WITH OTHER BOARD MEMBERS OUTSIDE OF A BOARD MEETING.

If you have any questions, please contact me or the other HCH/FH Program staff (contact numbers below).

Jim Beaumont, Director
650-573-2459; jbeaumont@smcgov.org

Irene Pasma, Planning & Implementation Coordinator
650-573-4741; ipasma@smcgov.org

Linda Nguyen, Program Services Coordinator
650-573-2966; linguyen@smcgov.org

Danielle Hull, Clinical Services Coordinator
650-573-2640; dhull@smcgov.org

Sofia Recalde, Management Analyst
650-573-2569; srecalde@smcgov.org

Dr. Frank Trinh, Medical Director
650-573-2385; frinh@smcgov.org

**Jim Beaumont, Director
Health Care for the Homeless/
Farmworker Health Program
San Mateo Medical Center
San Mateo County
650-573-2459
jbeaumont@smcgov.org**

1. DATE ISSUED: 11/18/2019		2. PROGRAM CFDA: 93.224	
3. SUPERSEDES AWARD NOTICE dated: except that any additions or restrictions previously imposed remain in effect unless specifically rescinded.			
4a. AWARD NO.: 2 H80CS00051-19-00		4b. GRANT NO.: H80CS00051	5. FORMER GRANT NO.: H66CS00469
6. PROJECT PERIOD: FROM: 11/01/2001 THROUGH: 12/31/2022			
7. BUDGET PERIOD: FROM: 01/01/2020 THROUGH: 12/31/2020			



NOTICE OF AWARD
AUTHORIZATION (Legislation/Regulation)
 Public Health Service Act, Title III, Section 330
 Public Health Service Act, Section 330, 42 U.S.C. 254b
 Affordable Care Act, Section 10503
 Public Health Service Act, Section 330, 42 U.S.C. 254, as amended.
 Authority: Public Health Service Act, Section 330, 42 U.S.C. 254b, as amended
 Public Health Service Act, Section 330, 42 U.S.C. 254b, as amended
 Public Health Service Act, Section 330(e), 42 U.S.C. 254b
 Section 330 of the Public Health Service Act, as amended (42 U.S.C. 254b, as amended) and Section 10503 of The Patient Protection and Affordable Care Act (P.L. 111-148)
 Section 330 of the Public Health Service Act, as amended (42 U.S.C. 254b)
 Public Health Service Act, Section 330, as amended (42 U.S.C. 254b)
 Section 330 of the Public Health Service (PHS) Act, as amended (42 U.S.C. 254b, as amended)
 Section 330 of the Public Health Service Act, as amended (42 U.S.C. 254b, as amended)
 Public Health Service Act, Section 330(e), (g), (h), or (i),, as amended (42 U.S.C. 254b(e), (g), (h) and/or (i)))
 The Health Center Program is authorized by Section 330(e), (g), (h) and/or (i) of the Public Health Service Act, as amended (42 U.S.C. § 254b(e), (g), (h), and/or (i)). Specifically, IBHS supplemental funding will be awarded under section 330(e)

8. TITLE OF PROJECT (OR PROGRAM): Health Center Program

9. GRANTEE NAME AND ADDRESS:
 SAN MATEO COUNTY HEALTH SERVICES AGENCY
 222 W 39th Ave
 San Mateo, CA 94403-4364
DUNS NUMBER:
 625139170
 BHCNIS # 091140

10. DIRECTOR: (PROGRAM DIRECTOR/PRINCIPAL INVESTIGATOR)
 Jim Beaumont
 SAN MATEO COUNTY HEALTH SERVICES AGENCY
 222 W 39th Ave
 San Mateo, CA 94403-4364

11. APPROVED BUDGET:(Excludes Direct Assistance)
 Grant Funds Only
 Total project costs including grant funds and all other financial participation

a . Salaries and Wages :	\$5,422,787.00
b . Fringe Benefits :	\$2,442,965.00
c . Total Personnel Costs :	\$7,865,752.00
d . Consultant Costs :	\$0.00
e . Equipment :	\$0.00
f . Supplies :	\$2,525,045.00
g . Travel :	\$17,300.00
h . Construction/Alteration and Renovation :	\$0.00
i . Other :	\$5,805,840.00
j . Consortium/Contractual Costs :	\$1,757,865.00
k . Trainee Related Expenses :	\$0.00
l . Trainee Stipends :	\$0.00
m . Trainee Tuition and Fees :	\$0.00
n . Trainee Travel :	\$0.00
o . TOTAL DIRECT COSTS :	\$17,971,802.00
p . INDIRECT COSTS (Rate: % of S&W/TADC) :	\$0.00
q . TOTAL APPROVED BUDGET :	\$17,971,802.00
i. Less Non-Federal Share:	\$15,346,753.00
ii. Federal Share:	\$2,625,049.00

12. AWARD COMPUTATION FOR FINANCIAL ASSISTANCE:

a. Authorized Financial Assistance This Period	\$2,625,049.00
b. Less Unobligated Balance from Prior Budget Periods	
i. Additional Authority	\$0.00
ii. Offset	\$0.00
c. Unawarded Balance of Current Year's Funds	\$1,531,279.00
d. Less Cumulative Prior Awards(s) This Budget Period	\$0.00
e. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	\$1,093,770.00

13. RECOMMENDED FUTURE SUPPORT: (Subject to the availability of funds and satisfactory progress of project)

YEAR	TOTAL COSTS
20	\$2,711,882.00
21	\$2,711,882.00

14. APPROVED DIRECT ASSISTANCE BUDGET:(In lieu of cash)

a. Amount of Direct Assistance	\$0.00
b. Less Unawarded Balance of Current Year's Funds	\$0.00
c. Less Cumulative Prior Awards(s) This Budget Period	\$0.00
d. AMOUNT OF DIRECT ASSISTANCE THIS ACTION	\$0.00

A printer version document only. The document may contain some accessibility challenges for the screen reader users. To access same information, a fully 508 compliant accessible HTML version is available on the HRSA Electronic Handbooks. If you need more information, please contact HRSA contact center at 877-464-4772, 8 am to 8 pm ET, weekdays.

15. PROGRAM INCOME SUBJECT TO 45 CFR 75.307 SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES:
A=Addition B=Deduction C=Cost Sharing or Matching D=Other **[D]**

Estimated Program Income: \$15,346,753.00

16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY HRSA, IS ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:

a. The grant program legislation cited above. b. The grant program regulation cited above. c. This award notice including terms and conditions, if any, noted below under REMARKS. d. 45 CFR Part 75 as applicable. In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS: (Other Terms and Conditions Attached Yes No)

This grant is included under Expanded Authority

Electronically signed by Elvera Messina , Grants Management Officer on : 11/18/2019

17. OBJ. CLASS: 41.51 **18. CRS-EIN:** 1946000532A1 **19. FUTURE RECOMMENDED FUNDING:** \$0.00

FY-CAN	CFDA	DOCUMENT NO.	AMT. FIN. ASST.	AMT. DIR. ASST.	SUB PROGRAM CODE	SUB ACCOUNT CODE
18 - 3980879	93.224	20H80CS00051	\$368,959.00	\$0.00	N/A	HEALTHCARECENTERS_20
20 - 398180J	93.527	20H80CS00051	\$230,173.00	\$0.00	MH	HEALTHCARECENTERS_20
20 - 398879J	93.527	20H80CS00051	\$494,638.00	\$0.00	HCH	HEALTHCARECENTERS_20

HRSA Electronic Handbooks (EHBs) Registration Requirements

The Project Director of the grant (listed on this NoA) and the Authorizing Official of the grantee organization are required to register (if not already registered) within HRSA's Electronic Handbooks (EHBs). Registration within HRSA EHBs is required only once for each user for each organization they represent. To complete the registration quickly and efficiently we recommend that you note the 10-digit grant number from box 4b of this NoA. After you have completed the initial registration steps (i.e., created an individual account and associated it with the correct grantee organization record), be sure to add this grant to your portfolio. This registration in HRSA EHBs is required for submission of noncompeting continuation applications. In addition, you can also use HRSA EHBs to perform other activities such as updating addresses, updating email addresses and submitting certain deliverables electronically. Visit <https://grants3.hrsa.gov/2010/WebEPSEExternal/Interface/common/accesscontrol/login.aspx> to use the system. Additional help is available online and/or from the HRSA Call Center at 877-Go4-HRSA/877-464-4772.

Terms and Conditions

Failure to comply with the remarks, terms, conditions, or reporting requirements may result in a draw down restriction being placed on your Payment Management System account or denial of future funding.

Grant Specific Term(s)

1. This action reflects a new document number. Please refer to this number when contacting the Payment Management System or submitting drawdown requests. Reporting on the FFR (Federal Financial Report) SF 425-Federal Cash Transaction Report (FCTR) should reflect this number for all disbursements related to this project period.
2. By accepting these grant funds, the health center acknowledges its commitment to providing service to the number of unduplicated patients projected to be served on Form 1A: General Information Worksheet by December 31, 2020, as well as any additional unduplicated patient projections associated with supplemental awards received that can be monitored by this date via the 2020 UDS submission. Failure to meet this total patient commitment may result in a reduction of total funding announced for the service area in the next Service Area Competition.
3. Based upon the review of your Service Area Competition application, your award is for a 3-year project period.
4. The funds for this award are sub-accounted in the Payment Management System (PMS) and will be in a P type (sub accounted) account. This type of account allows recipients to specifically identify the individual grant for which they are drawing funds and will assist HRSA in monitoring the award. If your organization previously received a grant under this program, it was in a G type (cash pooled) account designated by a PMS Account Number ending in G or G1. Now that this grant is sub accounted the PMS Account Number will be changed to reflect either P or P1. For example, if the prior year grant was in payee account number 2AAG it will now be in 2AAP. Similarly, if the prior year grant was in payee account 2AAG1, the grant will be in payee account 2AAP1. The P sub account number and the sub account code (provided on page 1 of this Notice of Award) are both needed when requesting grant funds.
You may use your existing PMS username and password to check your organizations P account access. If you do not have access, complete a PMS Access Form (PMS/FFR Form) found at: <https://pms.psc.gov/grant-recipients/access-newuser.html> and send it to the fax number indicated on the bottom of the form. If you have any questions about accessing PMS, contact the PMS Liaison Accountant as identified at: <https://pms.psc.gov/find-pms-liaison-accountant.html>.
5. This action approves the FY 2020 Service Area Competition application and awards 5-month prorated support based on your target FY 2020 funding under the Health Center Program. Prorated funding is provided in this award due to the status of the FY 2020 Health Center Program appropriation. The balance of grant support for the FY 2020 budget period will be provided consistent with subsequent Congressional action on the FY 2020 Health Center Program appropriation.
6. Based on the unduplicated patient projection provided on Form 1A: General Information Worksheet, your annual award amount for the upcoming project period has been reduced by 2.0% per the guidance provided in the notice of funding opportunity. For further information, visit <https://bphc.hrsa.gov/programopportunities/fundingopportunities/sac/patienttarget.pdf>.
7. This award includes pro-rated funding to support the increased access to integrated SUD and/or mental health services as part of the Fiscal Year 2018 Expanding Access to Quality Substance Use Disorder and Mental Health Services (SUD-MH).
8. This Notice of Award provides the offset of an unobligated balance in the amount of \$368,959 from the 01/01/2018-12/31/2018 budget period to the current budget period. Please be advised that if the final resolution of the audit determines that the unobligated balance of Federal Funds is incorrect, HRSA is not obligated to make additional Federal Funds available to cover the shortfall.

Program Specific Term(s)

1. If federal funds have been used toward the costs of acquiring a building, including the costs of amortizing the principal of, or paying interest on mortgages, you must notify the HRSA Grants Management Contact listed on this Notice of Award (NoA) for assistance regarding Federal Interest in the property within 60 days of the issuance date of this NoA.

2. The non-federal share of the project budget includes all anticipated program income sources such as fees, premiums, third party reimbursements, and payments that are generated from the delivery of services, and from "other revenue sources" such as state, local, or other federal grants or contracts; private support; or income generated from fundraising or contributions. In accordance with Section 330(e)(5)(D) of the PHS Act, health centers may use their non-grant funds, either "as permitted" under section 330 or "for such other purposes ... not specifically prohibited" under section 330 if such use "furthers the objectives of the project."
3. Consistent with Departmental guidance, health centers that purchase, are reimbursed, or provide reimbursement to other entities for outpatient prescription drugs are expected to secure the best prices available for such products to maximize results for the health center and its patients. Eligible health care organizations/covered entities that enroll in the 340B Program must comply with all 340B Program requirements and will be subject to audit regarding 340B Program compliance. 340B Program requirements, including eligibility, can be found at www.hrsa.gov/opa.
4. The Uniform Data System (UDS) annual performance report is due in accordance with specific instructions from the Program Office. Failure to submit a complete UDS report by the specified deadline may result in additional conditions and/or restrictions being placed on your award, including the requirement that all drawdowns of Health Center Program award funds from the Payment Management System (PMS) have prior approval from the HRSA Division of Grants Management Operations (DGMO) and/or limits on eligibility to receive future supplemental funding.
5. This grant is governed by the post-award requirements cited in Subpart D-Post Federal Award Requirements, standards for program and fiscal management of 45 CFR Part 75 except when the Notice of Award indicates in the "Remarks" section that the grant is included under "Expanded Authority." These recipients may take the following action without prior approval of the Grant Management Officer:
Section 75.308 (d)(3) Carry forward unobligated balances to subsequent periods of performance: Except for funds restricted on a Notice of Award, recipients are authorized to carry over unobligated grant funds remaining at the end of that budget period up to 25% of the amount awarded for that budget period.
In all cases, the recipient must notify HRSA when it has elected to carry over unobligated balances (UOB) under Expanded Authority and indicate the amount to be carried over. This notification must be provided by the recipient under item 12, "Remarks," on the initial submission of the Federal Financial Report (FFR). In this section of the FFR, the recipient must also provide details regarding the source of the UOB for each type of funding received and to be carried over (e.g., the specific supplemental award(s), base operational funding). If the recipient wishes to carry over UOB in excess of 25% of the total amount awarded, the recipient must submit a prior approval request for carryover in the HRSA Electronic Handbooks (EHBs). Contact your Grants Management Specialist with any questions.
6. You are required to submit an annual Budget Period Progress Report (BPR) non-competing continuation (NCC) to report on progress made from the beginning of your most recent budget period until the date of NCC submission; the expected progress for the remainder of the budget period; and any projected changes for the following budget period. HRSA approval of an NCC is required for the release of each subsequent year of funding, dependent on Congressional appropriation, program compliance, organizational capacity, and a determination that continued funding would be in the best interest of the federal government. Failure to submit the NCC by the established deadline or submission of an incomplete or non-responsive progress report may result in a delay or a lapse in funding.
7. Health centers are reminded that separate Medicare enrollment applications must be submitted for each permanent site at which they provide services. This includes units considered both "permanent sites" and "seasonal sites" under their HRSA scope of project (see <https://bphc.hrsa.gov/programrequirements/scope.html> for more information). Therefore, a single health center organization may consist of two or more FQHCs, each of which must be separately enrolled in Medicare and submit bills using its unique Medicare billing number. In order to enroll in Medicare, first obtain a National Provider Identifier (NPI) (<https://nppes.cms.hhs.gov/#/>). You may enroll in Medicare electronically via the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) available at <https://pecos.cms.hhs.gov>. PECOS automatically routes applications to the appropriate Medicare Administrative Contractor for review and approval. While HRSA encourages electronic application, you may alternatively choose to submit a paper application available at <http://www.cms.hhs.gov/cmsforms/downloads/cms855a.pdf>. To identify the address where the package should be mailed, refer to http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf. The appropriate Medicare contractor is listed next to "Fiscal Intermediary."
The Medicare enrollment process is not applicable to the Medicaid program. State Medicaid Agencies use their own enrollment process. Contact your State Medicaid office to determine the process and timeline for becoming eligible for payment as an FQHC under Medicaid.
8. Pursuant to existing law, and consistent with Executive Order 13535 (75 FR 15599), health centers are prohibited from using federal funds to provide abortion services (except in cases of rape or incest, or when the life of the woman would be endangered).
9. Prior approval by HRSA is required for any significant change in the scope of project (e.g., sites or services) or the nature of approved project activities. Requests to change the approved scope of project must be submitted for prior approval via the HRSA Electronic Handbooks (EHBs) Change in Scope Module prior to implementation. See <http://www.bphc.hrsa.gov/programrequirements/scope.html> for more information.
10. You must comply with all Health Center Program requirements. The Health Center Program Compliance Manual

(<https://bphc.hrsa.gov/programrequirements/compliancemanual/index.html>) provides consolidated guidance for demonstrating compliance with Health Center Program requirements. The Compliance Manual also serves as the foundation for HRSA's compliance determinations and for health centers when responding to any subsequent Progressive Action condition(s) placed on a Notice of Award (NoA) or Notice of Look-Alike Designation (NLD) due to an identified area(s) of non-compliance. For additional information on the Progressive Action process, see Chapter 2: Health Center Program Oversight of the Compliance Manual. If you elect to respond to a condition by demonstrating compliance in a manner alternative to that specified in the Compliance Manual, the response must include an explanation and documentation of how this alternative explicitly demonstrates compliance with applicable Health Center Program requirements. All responses to conditions are subject to review and approval by HRSA.

11. Your scope of project includes the approved service sites, services, providers, service area, and target population which are supported (wholly or in part) under your total approved health center budget. In addition, the scope of project serves as the basis for eligibility for associated programs such as Medicare and Medicaid Federally Qualified Health Center (FQHC) reimbursements, Federal Tort Claims Act coverage, and 340B Drug Pricing. Proper documentation and maintenance of an accurate scope of project is critical in the oversight and management of programs funded or designated under section 330 of the PHS Act. You are responsible for maintaining the accuracy of your Health Center Program scope of project, including updating or requesting prior approval for significant changes to the scope of project when applicable. Refer to the Scope of Project policy documents and resources available at <http://www.bphc.hrsa.gov/programrequirements/scope.html> for details pertaining to changes to sites, services, providers, service area zip codes, and target population(s).

Standard Term(s)

1. Recipients must comply with all terms and conditions outlined in their grant award, including grant policy terms and conditions outlined in applicable Department of Health and Human Services (HHS) Grants Policy Statements, and requirements imposed by program statutes and regulations and HHS grant administration regulations, as applicable; as well as any requirements or limitations in any applicable appropriations acts.
2. All discretionary awards issued by HRSA on or after October 1, 2006, are subject to the HHS Grants Policy Statement (HHS GPS) unless otherwise noted in the Notice of Award (NoA). Parts I through III of the HHS GPS are currently available at <http://www.hrsa.gov/grants/hhsgrantspolicy.pdf>. Please note that the Terms and Conditions explicitly noted in the award and the HHS GPS are in effect.
3. "This [project/publication/program/website] [is/was] supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$XX with xx percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government."
Recipients are required to use this language when issuing statements, press releases, requests for proposals, bid solicitations, and other HRSA-supported publications and forums describing projects or programs funded in whole or in part with HRSA funding. Examples of HRSA-supported publications include, but are not limited to, manuals, toolkits, resource guides, case studies and issues briefs.
4. Recipients and sub-recipients of Federal funds are subject to the strictures of the Medicare and Medicaid anti-kickback statute (42 U.S.C. 1320a - 7b(b) and should be cognizant of the risk of criminal and administrative liability under this statute, specifically under 42 U.S.C. 1320 7b(b) Illegal remunerations which states, in part, that whoever knowingly and willfully: (A) Solicits or receives (or offers or pays) any remuneration (including kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for referring (or to induce such person to refer) an individual to a person for the furnishing or arranging for the furnishing of any item or service, OR (B) In return for purchasing, leasing, ordering, or recommending purchasing, leasing, or ordering, or to purchase, lease, or order, any goods, facility, services, or itemFor which payment may be made in whole or in part under subchapter XIII of this chapter or a State health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.
5. Items that require prior approval from the awarding office as indicated in 45 CFR Part 75 [Note: 75 (d) HRSA has not waived cost-related or administrative prior approvals for recipients unless specifically stated on this Notice of Award] or 45 CFR Part 75 must be submitted as a Prior Approval action via Electronic Handbooks (EHBs). Only responses to prior approval requests signed by the GMO are considered valid. Grantees who take action on the basis of responses from other officials do so at their own risk. Such responses will not be considered binding by or upon the HRSA.
In addition to the prior approval requirements identified in Part 75, HRSA requires grantees to seek prior approval for significant rebudgeting of project costs. Significant rebudgeting occurs when, under a grant where the Federal share exceeds \$100,000, cumulative transfers among direct cost budget categories for the current budget period exceed 25 percent of the total approved budget (inclusive of direct and indirect costs and Federal funds and required matching or cost sharing) for that budget period or \$250,000, whichever is less. For example, under a grant in which the Federal share for a budget period is \$200,000, if the total approved budget is \$300,000, cumulative

changes within that budget period exceeding \$75,000 would require prior approval). For recipients subject to 45 CFR Part 75, this requirement is in lieu of that in 45 CFR 75 which permits an agency to require prior approval for specified cumulative transfers within a grantee's approved budget. [Note, even if a grantee's proposed rebudgeting of costs falls below the significant rebudgeting threshold identified above, grantees are still required to request prior approval, if some or all of the rebudgeting reflects either a change in scope, a proposed purchase of a unit of equipment exceeding \$25,000 (if not included in the approved application) or other prior approval action identified in Part 75 unless HRSA has specifically exempted the grantee from the requirement(s).]

6. Payments under this award will be made available through the DHHS Payment Management System (PMS). PMS is administered by the Division of Payment Management, Financial Management Services, Program Support Center, which will forward instructions for obtaining payments. Inquiries regarding payments should be directed to: ONE-DHHS Help Desk for PMS Support at 1-877-614-5533 or PMSSupport@psc.hhs.gov. For additional information please visit the Division of Payment Management Website at <https://pms.psc.gov/>.
7. The DHHS Inspector General maintains a toll-free hotline for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. Such reports are kept confidential and callers may decline to give their names if they choose to remain anonymous. Contact: Office of Inspector General, Department of Health and Human Services, Attention: HOTLINE, 330 Independence Avenue Southwest, Cohen Building, Room 5140, Washington, D. C. 20201, Email: Htips@os.dhhs.gov or Telephone: 1-800-447-8477 (1-800-HHS-TIPS).
8. Submit audits, if required, in accordance with 45 CFR Part 75, to: Federal Audit Clearinghouse Bureau of the Census 1201 East 10th Street Jefferson, IN 47132 PHONE: (310) 457-1551, (800) 253-0696 toll free <https://harvester.census.gov/facweb/default.aspx/>.
9. EO 13166, August 11, 2000, requires recipients receiving Federal financial assistance to take steps to ensure that people with limited English proficiency can meaningfully access health and social services. A program of language assistance should provide for effective communication between the service provider and the person with limited English proficiency to facilitate participation in, and meaningful access to, services. The obligations of recipients are explained on the OCR website at [HHS Limited English Proficiency \(LEP\)](#).
10. This award is subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to: <https://www.hrsa.gov/sites/default/files/hrsa/grants/manage/trafficking-in-persons.pdf>. If you are unable to access this link, please contact the Grants Management Specialist identified in this Notice of Award to obtain a copy of the Term.
11. The Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019, Division H, § 202, (P.L. 115-245), enacted September 28, 2018, limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements to the Federal Executive Pay Scale Level II rate set at \$192,300, effective January, 2019. This amount reflects an individual's base salary exclusive of fringe benefits. An individual's institutional base salary is the annual compensation that the recipient organization pays an individual and excludes any income an individual may be permitted to earn outside the applicant organization duties. HRSA funds may not be used to pay a salary in excess of this rate. This salary limitation also applies to sub-recipients under a HRSA grant or cooperative agreement. The salary limitation does not apply to payments made to consultants under this award although, as with all costs, those payments must meet the test of reasonableness and be consistent with recipient's institutional policy. None of the awarded funds may be used to pay an individual's salary at a rate in excess of the salary limitation. Note: an individual's base salary, per se, is NOT constrained by the legislative provision for a limitation of salary. The rate limitation simply limits the amount that may be awarded and charged to HRSA grants and cooperative agreements.
12. To serve persons most in need and to comply with Federal law, services must be widely accessible. Services must not discriminate on the basis of age, disability, sex, race, color, national origin or religion. The HHS Office for Civil Rights provides guidance to grant and cooperative agreement recipients on complying with civil rights laws that prohibit discrimination on these bases. Please see <http://www.hhs.gov/civil-rights/for-individuals/index.html>. HHS also provides specific guidance for recipients on meeting their legal obligation under Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color or national origin in programs and activities that receive Federal financial assistance (P. L. 88-352, as amended and 45 CFR Part 75). In some instances a recipient's failure to provide language assistance services may have the effect of discriminating against persons on the basis of their national origin. Please see <http://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html> to learn more about the Title VI requirement for grant and cooperative agreement recipients to take reasonable steps to provide meaningful access to their programs and activities by persons with limited English proficiency.
13. Important Notice: The Central Contractor registry (CCR) has been replaced. The General Services Administration has moved the CCR to the System for Award Management (SAM) on July 30, 2012. To learn more about SAM please visit <https://www.sam.gov/SAM/>. It is incumbent that you, as the recipient, maintain the accuracy/currency of your information in the SAM at all times during which your entity has an active award or an application or plan under consideration by HRSA, unless your entity is exempt from this requirement under 2 CFR 25.110. Additionally, this term requires your entity to review and update the information at least annually after the initial registration, and more frequently if required by changes in your information. This requirement flows down to subrecipients. Note: SAM information must be updated at least every 12 months to remain active (for both grantees and sub-recipients). Grants.gov will reject submissions from applicants with expired registrations. It is advisable that you do not wait until the last minute to register in SAM or update your information.

According to the SAM Quick Guide for Grantees (https://www.sam.gov/SAM/transcript/Quick_Guide_for_Grants_Registrations.pdf), an entity's registration will become active after 3-5 days. Therefore, check for active registration well before the application deadline.

14. In any grant-related activity in which family, marital, or household considerations are, by statute or regulation, relevant for purposes of determining beneficiary eligibility or participation, grantees must treat same-sex spouses, marriages, and households on the same terms as opposite-sex spouses, marriages, and households, respectively. By "same-sex spouses," HHS means individuals of the same sex who have entered into marriages that are valid in the jurisdiction where performed, including any of the 50 states, the District of Columbia, or a U.S. territory or in a foreign country, regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage. By "same-sex marriages," HHS means marriages between two individuals validly entered into in the jurisdiction where performed, including any of the 50 states, the District of Columbia, or a U.S. territory or in a foreign country, regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage. By "marriage," HHS does not mean registered domestic partnerships, civil unions or similar formal relationships recognized under the law of the jurisdiction of celebration as something other than a marriage. This term applies to all grant programs except block grants governed by 45 CFR part 96 or 45 CFR Part 98, or grant awards made under titles IV-A, XIX, and XXI of the Social Security Act; and grant programs with approved deviations.

15. **§75.113 Mandatory disclosures.**

Consistent with 45 CFR 75.113, applicants and non-federal entities must disclose, in a timely manner, in writing to the HHS awarding agency, with a copy to the HHS Office of Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Sub recipients must disclose, in a timely manner, in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to the awarding agency and to the HHS OIG at the following address:

Department of Health and Human Services
Health Resources and Services Administration
Office of Federal Assistance Management
Division of Grants Management Operations
5600 Fishers Lane, Mailstop 10SWH-03
Rockville, MD 20879

AND

U.S. Department of Health and Human Services
Office of Inspector General
Attn: Mandatory Grant Disclosures, Intake Coordinator
330 Independence Avenue, SW, Cohen Building
Room 5527
Washington, DC 20201

Fax: (202)205-0604 (Include: "mandatory Grant Disclosures" in subject line) or Email: MandatoryGranteeDisclosures@oig.hhs.gov

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371. Remedies for noncompliance, including suspension or debarment (See 2 CFR parts 180 & 376 and 31 U.S.C. 3321). The recipient must include this mandatory disclosure requirement in all sub-awards and contracts under this award.

Non-Federal entities that have received a Federal award including the term and condition outlined in Appendix XII are required to report certain civil, criminal, or administrative proceedings to www.sam.gov. Failure to make required disclosures can result in any of the remedies described in §75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. 3321).

Recipient integrity and performance matters. If the total Federal share of the Federal award is more than \$500,000 over the period of performance, [Appendix XII to CFR Part 200](#) is applicable to this award.

Reporting Requirement(s)

1. **Due Date: Annually (Calendar Year) Beginning: 01/01/2020 Ending: 12/31/2020, due 45 days after end of reporting period.**

The Uniform Data System (UDS) is a core set of information appropriate for reviewing the operation and performance of health centers. The data help to identify trends over time, enabling HRSA to establish or expand targeted programs and identify effective services and interventions to improve the health of underserved communities and vulnerable populations. UDS data also inform Health Center programs, partners, and communities about the patients served by health centers. Health centers must report annually in the first quarter of the year. The UDS submission deadline is February 15 every year. Contact the UDS Support Line at 1-866-837-4357 or udshelp330@bphcdata.net for additional instructions or for questions. Reporting technical assistance can be found at <https://bphc.hrsa.gov/datareporting/index.html>.

2. **Due Date: Annually (Budget Period) Beginning: Budget Start Date Ending: Budget End Date, due Quarter End Date after 90 days of reporting period.**

The grantee must submit an annual Federal Financial Report (FFR). The report should reflect cumulative reporting within the project period and must be submitted using the Electronic Handbooks (EHBs). The FFR due dates have been aligned with the Payment Management

System quarterly report due dates, and will be due 90, 120, or 150 days after the budget period end date. Please refer to the chart below for the specific due date for your FFR:

- Budget Period ends August – October: FFR due January 30
- Budget Period ends November – January: FFR due April 30
- Budget Period ends February – April: FFR due July 30
- Budget Period ends May – July: FFR due October 30

Failure to comply with these reporting requirements will result in deferral or additional restrictions of future funding decisions.

Contacts

NoA Email Address(es):

Name	Role	Email
Jim Beaumont	Program Director	jbeaumont@smcgov.org

Note: NoA emailed to these address(es)

Program Contact:

For assistance on programmatic issues, please contact Kimberly Range at:
90 7th St Fl 8th
San Francisco, CA, 94103-6701
Email: KRange@hrsa.gov
Phone: (415) 437-8150

Division of Grants Management Operations:

For assistance on grant administration issues, please contact Christie Walker at:
MailStop Code: 10SWH03
OFAM/DGMO/HCB
5600 Fishers Ln
Rockville, MD, 20852-1750
Email: cwalker@hrsa.gov
Phone: (301) 443-7742
Fax: (301) 443-9810

TAB 4

**Board
membership**



SAN MATEO COUNTY HEALTH

**SAN MATEO
MEDICAL CENTER**

San Mateo Medical Center
222 W 39th Avenue
San Mateo, CA 94403
650-573-2222 T
smchealth.org/smmc

DATE: December 12, 2019

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

FROM: Board Membership/Recruitment Committee
HCH/FH Program

SUBJECT: BOARD MEMBERSHIP FOR STEVE CAREY

Program received a formal resignation email on October 1, 2019 from Steve Carey. Staff announced at the last November Board meeting that Steve Carey resigned. Members from the Board Recruitment/Membership Committees spoke with Steve Carey and later reported back to staff that Steve Carey is interested in returning to the HCH/FH Board.

It is up to the Board on what actions to take regarding Steve Carey. The Board may reject his initial resignation, reinstate his Board membership or vote to approve his board membership if they are interested on Steve Carey returning to the Board as a member.



TAB 5
QI Memo



DATE: December 12th, 2019

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

FROM: Frank Trinh, Medical Director HCH/FH Program
 Danielle Hull, Clinical Services Coordinator

SUBJECT: QI COMMITTEE REPORT

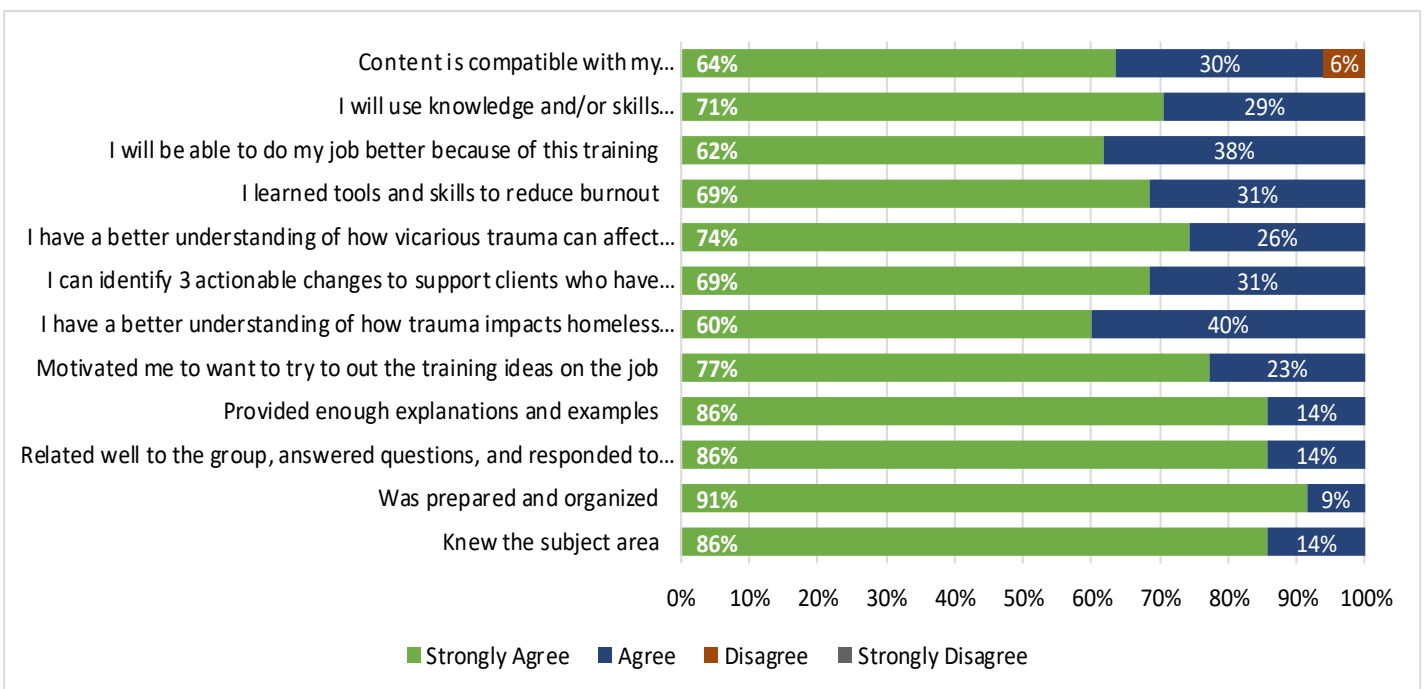
The San Mateo County HCH/FH Program QI Committee did not meet in November. Below are quality improvement updates:

SMMC QI Presentation:

- Frank Trinh provided quarterly update of the HCH/FH Program to the San Mateo Medical Center Quality Meeting, including an overview of homeless-specific cancer statistics

Training Updates

- Trauma Informed Care: Self-Care Training
 - Administered by Rebecca Levenson of Futures without Violence
 - First Training for Homeless Providers, November 15th, 2019
 - 42 total attendees, 35 evaluations completed
 - Below is the summary of responses:



- Many participants requested that management attend the training so that workers are not advocating for a themselves and a trauma informed workplace
- Second Training scheduled for December 18th
 - Currently 8 out of 40 spots registered
- Outreach Workshop for Special Populations: Homeless and Farmworker Clients
 - Administered by Health Outreach Partners
 - Scheduled for Friday, December 13th, 2019
 - Currently, 19 out of 30 spots registered

UDS Clinical Data Improvement

- Universal reporting (meaning no chart reviews were performed) are now required in order to receive a Quality Improvement Award for 2019 UDS Reporting
- Performing chart reviews on low performing measures to identify actions to improve data quality

TAB 6

**Budget &
Finance Report**



DATE: December 12, 2019

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

Estimated grant expenditures to-date are \$2,539,440. In addition, we have an estimate \$116,316 in expenditures for items not claimable on the grant, for total Program estimated expenditures of \$2,655,756.

Current projection for year-end is that total base grant expenditures will be \$2,655,407 by the end of the year, including expenditures for approved Small Funding Requests, which would create an over-expended budget amount of **(\$6,971)**. Including expenditures for the Expanded Services Awards, etc. (SUD-MH), the total Program grant expenditures would be \$2,953,686. That leaves approximately \$35,579 total in unexpended funding from all grants.

Program intends to carefully monitor actual expenditures and payment requests during December to keep the actual base grant budget expenditure inline with the actual available base grant funds. If expected expenditures fall short, there may be a resultant, small amount of unexpended funds. The overall target is to minimize any unexpended funds without exceeding the actual grant award.

Based on expenditures to date, we anticipate the overall expenditure rate on base grant contracts and MOUs to be around 85% for allocation during the current Grant Year (and at ~90.0% overall).

Next year's projection currently shows an estimated total expenditure of \$3,033,200 against all program grants (base, SUD-MH & IBHS) totaling \$2,942,049. This would create an over-expenditure of **(\$91,151)**. However, this would anticipate full expenditure of every contract/MOU, which is highly unlikely.

Attachment:

- GY 2019 Summary Grant Expenditure Report Through 11/30/19



GRANT YEAR 2019

ACTUALS UPDATE FOR Q3 DRAWDOWN *Nov \$*

Details for budget estimates	Budgeted [SF-424]		To Date (10/31/19)	Projection for GY (+~8 weeks) SUD-MH/QI		Projected for GY 2020
EXPENDITURES						
<u>Salaries</u>						
Director, Program Coordinator Management Analyst ,Medical Director new position, misc. OT, other, etc.	554,324	44,475	537,828	582,500		614,250
<u>Benefits</u>						
Director, Program Coordinator Management Analyst ,Medical Director new position, misc. OT, other, etc.	224,198	10,910	146,242	157,500		163,800
<u>Travel</u>						
National Conferences (2500*8)	20,000		21,566	27,000		25,000
Regional Conferences (1000*5)	5,000		3,721	5,000		5,000
Local Travel	1,000	175	1,390	1,600		1,500
Taxis	3,500	193	997	1,000		1,000
Van & vehicle usage	3,000		745	1,750		2,000
	32,500		28,419	36,350		34,500
					32,000	
<u>Supplies</u>						
Office Supplies, misc. Small Funding Requests	7,500		11,254	12,500		12,000
	7,500		11,254	142,500		12,000
					35,000	
<u>Contractual</u>						
2018 Contracts			67,867	67,967		105,245
2018 MOUs			23,540	23,540		46,655
Current 2019 MOUs	872,000		711,095	757,750		822,000
Current 2019 contracts	1,034,000		797,655	857,000		1,024,250
ES contracts (SUD-MH)	180,000		109,100	155,000		150,000
---unallocated---/other contracts			12,000	12,000		
	2,086,000	109,715	1,721,257	1,873,257		2,148,150
					155,000	
<u>Other</u>						
Consultants/grant writer IT/Telcom New Automation	30,000 12,000 4,000	1,800 1,858	73,137 12,973 2,300	95,000 15,000 0	32,000	30,000 15,000 -
Memberships Training Misc	10,000 750	5,770 8	5,945 85	4,500 10,000 500	7,700	5,000 10,000 500
	56,750		94,440	125,000		60,500
TOTAL	2,961,272	174,904	2,539,440	2,917,107	261,700	3,033,200
GRANT REVENUE						
Available Base Grant * Available Expanded Services Awards **	2,648,436 305,250			2,648,436 305,250		2,625,049 *2% reduction 167,000 IBHS 150,000 SUD-MH
HCH/FH PROGRAM TOTAL	2,953,686		2,539,440	2,953,686		2,942,049
BALANCE	(7,586)		PROJECTED AVAILABLE	36,579		(91,151)
			BASE GRANT PROJECTED AVAILABLE	(6,971)	2,655,407	based on est. grant of \$2,678,621 before reduction
* includes \$13,232 of QI targeted funding ** includes \$175,000 of one-time funding (SUD-MH) (\$125,250 unallocated)						
Total special allocation required	\$ 138,446					
<u>Non-Grant Expenditures</u>						
Salary Overage Health Coverage base grant prep food incentives/gift cards	13090 40000 15000 2500 1,000	953 3935 160	11,688 46,793 53,812 1,613 2,410	12,641 51,000 53,812 2,000 2,410		13,750 57,000 0 1,500 1,500
	71,590	5,048	116,316	121,863		73,750
TOTAL EXPENDITURES	3,032,862	179,952	2,655,756	3,038,970	NEXT YEAR	3,106,950
	BUDGETED	<i>This month</i>	TO DATE	PROJECTED		

TAB 7
Director's
Report



SAN MATEO COUNTY HEALTH

**SAN MATEO
MEDICAL CENTER**

San Mateo Medical Center
222 W 39th Avenue
San Mateo, CA 94403
650-573-2222 T
smchealth.org/smmc

DATE: December 12, 2019

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 CALENDAR

Program activity update since the November 14, 2019 Co-Applicant Board meeting:

Again this month, the Strategic Planning effort has been the major focus of the Program.

As noted in email to the Board and elsewhere on today's agenda, on November 18, 2019, HRSA issued Notice of Award (NOA) 19-00 to San Mateo County Health, awarding a new three (3) years (January 1, 2020 through December 31, 2022) project period for the HCH/FH grant. This action is the approval of our Service Area Competition (SAC) application. The first-year award amount is \$2,625,049, which represents the expected 2% reduction due to not being able to project to meet HRSA's target population service numbers. Actual final funding for Grant Year (GY) 2020 is expected to be higher after inclusion of any carry-over and any mid-year supplemental funding. I would like to thank the HCH/FH Program staff, especially Sofia Recalde, for all of their hard work and effort in preparation of the SAC application, along with the support of our contractor, Eileen Tremaine of Wipfli Consulting.

In addition, our NOA had no grant condition identified. This, along with our three-year project period means that we should not have another site visit until sometime early-mid 2021. We have been informed by our Project Officer that the proposed Technical Assistance (TA) covering contracting, scope and reporting (related to our agreements with Ravenswood Family Health Center) is still approved. However, no dates have been discussed for the TA.

I informed Dr. Kunnappilly (CJ) of the positive response from the Board to his visit and discussion at the last Board meeting. Along those lines, we are working to establish routine quarterly updates/discussions with San Mateo Medical Center (SMMC) leadership. The appearances at the Board meetings would likely rotate through the full set of SMMC executives (CEO, CFO, CMO, CNO, COO). We will keep the Board updated on this as we move forward and (hopefully) schedule the next visit.

San Mateo County Health is in the process of identifying and implementing a new Electronic Health Record System (HER 2.0) to replace the amalgamation of various current systems and provide a singular record of care for clients/patients across the entire SMC Health environment. As part of the Case Management Team, I reviewed the Case Management portions of the three (3) Proposals received. The overall review process continues, and two proposals will be invited to provide demonstrations in January.

Seven Day Update

ATTACHED:

- Program Calendar



Health Care for the Homeless & Farmworker Health (HCH/FH) Program
2019/2020 Calendar (Revised December 2019)

EVENT	DATE	NOTES
<ul style="list-style-type: none"> Board Meeting (December 12, 2019 from 9:00 a.m. to 11:00 a.m.) QI Meeting Outreach training- 12/13/19 at SMC Health Trauma informed care/self care training 12/18 at Fair Oaks Clinic 	December	@ Fair Oaks Clinic
<ul style="list-style-type: none"> Board Meeting (January 9, 2020 from 9:00 a.m. to 11:00 a.m.) Provider Collaborative meeting 	January	@SMMC
<ul style="list-style-type: none"> Board Meeting (February 13, 2020 from 9:00 a.m. to 11:00 a.m.) Initial UDS submission- 2/15/20 National Alliance to end Homelessness Conference- Oakland (Feb 19-21) Western Forum for Migrant & Community Health Conf -Sacramento (Feb 19-21) QI Meeting 	February	
<ul style="list-style-type: none"> Board Meeting (March 12, 2020 from 9:00 a.m. to 11:00 a.m.) Final UDS submission due (March 31, 2020) QI Meeting 	March	

BOARD ANNUAL CALENDAR	
Project	Deadline
UDS submission- Review	April
SMMC annual audit- approve	April/May
Forms 5A and 5B -Review	June/July
Strategic Plan/Tactical Plan-Review	June/July
Budget renewal-Approve	August/sept- Dec/Jan
Annual conflict of interest statement - members sign (also on appointment)	October
Annual QI Plan-Approve	Winter
Board Chair/Vice Chair Elections	Winter
Program Director annual review	Fall /Spring
Sliding Fee Scale (FPL)- review/approve	Spring

TAB 8

Board Presentations

**Discussion on
Board Bylaws
Strategic Plan
Needs Assessment**

Strategic Plan Update

Prepared for December 2019
Co-Applicant HCHF Board
meeting



HCH/FH Brainstorming Session Summaries

Behavioral Health and Addiction Services

Pernille Gutschick, Clinical Services Manager (BHRS), Matt Boyle, Medical Assisted Treatment, (BHRS), Clara Boyle, Deputy Director Alcohol and Other Drug, (BHRS), HCHF Staff: Jim Beaumont, Danielle Hull, Irene Pasma, Sofia Recalde

Homeless Individuals

- Residential Treatment Beds
 - survey clients previously homelessness who leave treatment early on why they left
 - work with inpatient and outpatient providers to create more welcoming environments for homeless clientele
 - incidental medical services at residential facilities throughout the county
- Detox
 - Designate beds at SMMC for Medical Detox
 - Co-locate SUD services with shelters or medical respite, like HealthRight360 at Maple Street
- “Honor Dorms” in shelters to incentivize compliance

Farmworkers

- **IMAT team could go out with Field Medicine**
- Tele-health
- Home visits
- There’s no SUD/AOD treatment facilities on the coast
 - i.e. AA meetings

*Orange indicates this item was cross referenced in other brainstorming sessions

Street/Field Medicine & Mobile Clinic

Robert Anderson, Board Member; Anita Booker, PHPP; Frank Trinh, PHPP; James O'Connell, PHPP; Hannah Blankenship, Lifemoves HOT; HCHF Staff: Jim Beaumont, Sofia Recalde, Danielle Hull, Linda Nguyen, Irene Seliverstov

Ideas

- Attach Care Navigator to Street/Field/Mobile Team
- **Attach IMAT to Field Medicine Team**
- PHPP to develop relationships with Farm owners / expand services to Mid & North Coast Farms
- **Boosting clinic spaces – Puente, Maple Street (need more information whether this is desired, licensure and revenue)**
- Women's Health – better connection with OBGYN, changing mode of administration of tests and screening, revamping clinic space

Additional Thoughts / Links with Other Sessions

- If patient doesn't have Medi-Cal or ACE, he/she cannot get specialty care
- How to keep someone connected to health care even after they're housed?
- **Slotting spaces in SMMC Clinics**
- Farmworkers are priced out of ACE, but can't afford insurance
- **Designating Mobile Clinic as a primary care site**
- Mobile Clinic is raising awareness about its services

Dental (Oral Health Coalition Meeting)

Presented at Oral Health Coalition Meeting, attended by ~20 people, Irene Pasma, Danielle Hull

- Co-locate “dental and primary care” services or “dental and BHRS” services – do a “warm hand off” between the clinicians; follow what SMMC is doing on this effort
 - From SMMC: historically, mobile clinic patients didn’t want mobile dental clinic services, they came to mobile clinic for a specific item
- Further explore ‘street/mobile’ dental services
 - Look at other counties models, i.e. Alameda, Santa Clara
 - Dental van does not go to the Coast
 - If there was a van or mobile dental, consider going to churches
- Denti-Cal Integration Implementation is January 2021
- Dental care at shelters – Family Health Services is interested in partnering
- Getting an oral health subject matter expert on the Board

Collaboration with Law Enforcement

Robert Anderson, Board Member; Correctional Health Services: Carlos Morales, Ashely Sokolov, Karina Sapag; Melissa Wagner, Sheriff's Office, HCHF Staff: Jim Beaumont, Danielle Hull, Linda Nguyen, Irene Pasma, Sofia Recalde

45% of inmates
are out of
county

- Correctional Health Services (CHS) desire to be able to 'text' "someone" when an individual is being released and ensure follow up
- Discharge is an opportunity to provide intervention – i.e. daily case management after someone is released from jail
- Data sharing is a large opportunity – desire to connect more with HOT in advance
- Problem providing services to released sex offenders due to local laws (i.e. limited housing opportunities)
- Someone who is homeless who goes into jail has no place to put all their belongings, when they are released, they start completely from scratch including documents
- More thought needs to go into multiple booking short stay individuals ("frequent jail fliers") because they are the least connected to services

Medical Respite/Medical Acuity in Shelter/Housing

Suzanne Moore, Board Member; Francine Serafin Dickson, Hospital Consortium; Judith Klain, Health Administration; Melissa Platte, MHA; Brian Eggers, HSA; James Schindler, SMMC Discharge Planner; Maple Street: Donna Miller, Kelly McGrath, Robert Moltzen, Jim Beaumont, Linda Nguyen, Irene Pasma

Shelter

- Increase medical staff at shelter
- **Better equip 'clinic-like' spaces at shelters and community based organizations**
 - CES questionnaire does not screen for health appropriate-ness
- Improved hand off between shelter and street homelessness (i.e. between shelter staff and HOT)

Medical Respite

- Was not significantly touched upon due to separate task force work

Housing: large focus on individuals exiting homelessness into subsidized housing

- Community space for previously homeless individuals
- Daily contact is needed with newly housed individuals
- Need to incentivize newly housed individuals to complete tasks, i.e. OT, doctor's visit, etc.
- Improve data flow during hand off between shelter and PSH/affordable housing unit to prevent crisis
- **SDOH: train clinicians to ask about housing, consider housing stability (link to SMMC efforts)**

Farmworker Education/Outreach

Victoria Sanchez de Alba Board Member, Vicente Lara, Puente; Judith Guerrero, Coastside Hope; Ziomara Ochoa, BHRS, HCHF Staff: Jim Beaumont, Danielle Hull, Linda Nguyen, Irene Pasma, Sofia Recalde

- **Adopt a Promotores community health model on the Coast (particularly Mid- and North-Coast)**
- “Attorney hours” at a clinic (Coastside, Rotacare, Puente) following CRLA’s partnership with Monterey Health
- HCH/FH to host forum for Farmworker Providers, analogous to CRLA/Monterey event
- In-depth training for clinicians on Public Charge / other legal issues
- There is no laundry mat in Pescadero, only one in Half Moon Bay
- Food security topics
- Establish relationships with Half Moon Bay growers

Patients at SMMC Clinics

Brian Greenberg Board Member, Vanessa Washington, SMMC New Patient Connection; Christine Zachos, SMMC Patient Navigator; Frank Trinh, HCHF Staff: Jim Beaumont, Danielle Hull, Linda Nguyen, Irene Pasma, Sofia Recalde

- **Changing how a patient can become established to simplify & expedite access, i.e. Mobile Clinic or Field/Street Medicine Team**
- **Create slots for homeless and farmworker patients at county clinics**
- Create Care Navigator position linked to new patient connection line and focus on non-WPC patient population
- Leverage patient portal

Nutrition / Food Access

Board Members: Victoria Sanchez de Alba, Eric Debode, Christian Hansen; Vicente Lara, Puente; Ankita Tandel, Family Health Services;
HCHF Staff: Jim Beaumont, Danielle Hull, Linda Nguyen, Irene Pasma

Ideas

- HCH/FH lead advocacy efforts on “healthy food” – thought leaders in San Mateo County
- Community gardens linked with clinics/shelters
- Industrial kitchen with cooking classes, food, etc.
- Partner with existing organizations to deliver food to our populations
- Partner with Blue Apron/Freshly to deliver discounted boxes to people who just moved into housing

Themes/Actions

- Define the differing needs between these two populations
- Set aspirational definition for “healthy food”, i.e. whole food/plant diet
- Learn which shelters currently have kitchens/pantries/community gardens
- Learn what education programs currently exist in San Mateo County
- **Work with SMMC for Social Determinants of Health to be incorporated in clinic screening**

INTRODUCTION AND METHODOLOGY

INTRODUCTION

San Mateo County's Health Care for the Homeless and Farmworker Health Program (HCH/FH) provides care for two of the county's most vulnerable and underserved populations.

As part of its effort to improve access to, delivery of, and quality of health care for these populations, HCH/FH conducts a needs assessment biennially. This includes administration of a health needs and health utilization survey among homeless and farmworker residents to gather information on how these populations access care and the kind of care and services they need. The 2019 needs assessment also includes a literature review to build on and integrate findings from previous research and assessments conducted in San Mateo County, and to provide additional context to survey findings. The development of this needs assessment was supported by John Snow, Inc. (JSI), and will be used to inform decisions on health care planning and delivery for HCH/FH for the coming years.

This document includes the methodology used in the needs assessment, and integrated literature review findings and survey results for the homeless and farmworker populations. The full surveys and complete data tables can be found in the Appendix.

METHODOLOGY

This needs assessment was conducted using a variety of data sources, including quantitative data from hospital medical records and UDS reporting, self-reported health data from surveys, and qualitative data from a literature review. The relevant information collected from these sources is integrated throughout this report. The methodology for identifying and collecting data from these sources is detailed below.

SURVEYS

Surveys were designed by HCH/FH staff and administered by partner organizations and/or trusted community members. Separate surveys were developed and administered for the homeless and farmworker populations. No personally identifiable information was collected, and individuals could decline to answer the survey or stop at any point.

HEALTH SURVEY FOR FARMWORKERS AND THEIR DEPENDENTS

Survey Design

HCH/FH designed a farmworker-specific health survey instead of using the same survey for homeless and farmworker individuals as was done in the past. The farmworker survey focused on workplace injuries, pesticide exposures, food and diet, and living conditions (see Appendix 1). Numerous resources and stakeholder were consulted to generate the survey:

- Resources Referenced:
 - Survey tool for the Sonoma County Farmworker Health Survey (FHS) 2013-14: Report on the health and well-being of Sonoma County farmworkers
 - Half Moon Bay Survey conducted in 2016 by Abundant Grace, a local nonprofit
 - 2-Item Hunger Vital Sign HM Screen
- Stakeholders consulted:
 - Puente de la Costa Sur

- Food System Alliance
- Medical Director, HCH/FH
- Field Medicine Team
- HCH/FH Board Members with Farmworker Background
- JSI
- HCH/FH QI/QA Committee

Survey Administration

Most of San Mateo County’s farms are located on the Coast. HCH/FH wanted to ensure both North Coast and South Coast were included in the Needs Assessment.

Half Moon Bay: HCH/FH partnered with Abundant Grace, a nonprofit located in Half Moon Bay, to distribute most of the surveys. The organization had previous experience administering a survey in February 2018 by working with trusted community members and paying administrators \$10 per survey administered. HCH/FH used this same model and also asked the administrator to give \$5 to the individual responding. By asking community members to administer the survey, HCH/FH hoped to get responses from people not connected to services to better understand their health needs.

Abundant Grace organized an evening meeting with refreshments for the individuals who would administer the surveys. This was a combination of older women who administered the survey previously and high school students who are part of an after-school achievement program. HCH/FH staff conducted the training, covering respondent eligibility requirements, importance of the survey, and the rationale behind potentially complex or sensitive questions. Each administrator was given 10 surveys, typically in Spanish, and some in English. Administrators were also given “Public Charge” fliers if anyone they were speaking to had questions about the Rule (see Appendix). This team administered about 150 surveys.

Pescadero: HCH/FH asked Puente de la costa Sur, a trusted community based organization which has a contract with HCH/FH to provide services, to administer surveys in the community. Puente has administered HCH/FH surveys in the past, and they provided edits to the survey as well as support ensuring the translated Spanish version as culturally appropriate. Puente administered about 40 surveys.

Respondent Characteristics

In total, 185 surveys were completed: 155 by farmworkers, and 30 by family members of farmworkers. Just over 40% of farmworkers (n=63) indicated how long they had been employed in agricultural labor. Among these respondents, the average length of employment was 16 years.

	Farmworker	Family of Farmworker
Males		
<18	0	0
18-25	5	5

26-35	13	1
36-45	15	1
46-55	21	2
56-65	13	0
>65	5	0
Unknown Age	2	0
Subtotal	74	9
<i>Females</i>		
<18	0	0
18-25	0	4
26-35	13	6
36-45	30	4
46-55	15	2
56-65	12	0
>65	4	1
Unknown Age	3	4
Subtotal	77	21
<i>Unknown Sex</i>		
<18	0	0
19-25	1	0
26-35	0	0
36-45	0	0
46-55	0	0
56-65	3	0
>65	0	0
Unknown Age	0	0
Subtotal	4	0
Total	155	30

Length of Employment (n=63)		
1-3 years	10	16%
4-10 years	13	21%
11-20 years	23	37%
21-30 years	11	17%
31-40 years	5	8%
>40 years	1	2%

HEALTH SURVEY FOR PEOPLE EXPERIENCING HOMELESSNESS

Survey Design

The survey for people experiencing homelessness was developed primarily to understand health needs of the aging homeless population and how they compare to the general aging population (see Appendix II). Numerous resources and stakeholders were consulted to generate the survey, including:

- Resources Referenced:
 - San Mateo County Senior Homeless Population Needs Assessment, Prepared for Mission Hospice by Peninsula Conflict Resolution Center, January 11, 2019
 - 2019 San Mateo County Medical Respite Data Collection & Analysis, Prepared by Irene Pasma, County of San Mateo Health Care for the Homeless/Farmworker Health Program and Francine Serafin-Dickson, Hospital Consortium of San Mateo County
 - San Mateo County Aging and Adult Services Needs Assessment
- Stakeholders Consulted:
 - HCH/FH Medical Director
 - JSI
 - HCH/FH Board members
 - LifeMoves Staff
 - HCH/FH QI/QA Committee

Survey Administration

Surveys were administered by HCH/FH contractors, typically by giving the survey to clients during the intake process. A kick-off call was held to walk administrators through the survey and answer any questions. If someone was not able to attend the call, a separate call was scheduled.

Surveys were administered by the following entities:

- **Safe Harbor Shelter** – an adult shelter in South San Francisco run by Samaritan House
- **Maple Street Shelter** - an adult shelter in Redwood City run by LifeMoves
- **LifeMoves HOT Team** – case managers who go to some of the hardest-to-reach homeless individuals typically living on the street/encampments
- **Ravenswood Family Health Care** – an FQHC in East Palo Alto; the clinic’s Street Team administered the surveys at some other EPA locations for example the shelter directly across the street
- **PHPP Mobile Van** – goes to various locations throughout San Mateo County
- **PHPP Street Team** – goes to various locations throughout San Mateo County
 - **HCH/FH Staff** – conducted a handful of surveys by joining PHPP Street Team

These organizations have contract agreements for data sharing with HCH/FH. An individual could decline to complete a survey or stop at any time while filling one out. Surveys were available in English, Spanish and Tongan. If an individual did complete a survey, he or she received a \$5 Safeway gift card.

Entity Administering Survey	Number of Surveys Administered	Percent of Total (n=274)
HOT Team	8	3%
Maple Street Shelter	62	23%
Mobile Clinic	42	15%
Ravenswood	80	29%
Safe Harbor Shelter	61	22%
Street Team	21	8%

Respondent Characteristics

A total of 274 surveys were administered and completed by individuals ranging from age 15 to 85. Roughly two-thirds of respondents were male, and the median length of homelessness was just under one year.

Age of Survey Respondents (n=274)		
Under 18	2	1%
18-29	30	11%
30-39	46	17%
40-49	43	16%
50-59	78	28%
60-69	48	18%
70-79	12	4%
80+	2	1%
Blank	13	5%

Gender Identity of Survey Respondents (n=274)		
Female	100	36%
Male	170	62%
Other	1	0%
Blank	3	1%

Length of Homelessness among Survey Respondents (n=274)		
Less than 1 month	28	10%
1 to 6 months	50	18%
>6 to 12 months	28	10%
>1 to 3 years	59	22%
>3 to 5 years	26	9%
>5 to 10 years	27	10%

>10 years	21	8%
Blank	35	13%

LITERATURE REVIEW

JSI reviewed roughly 70 documents provided by HCH/FH staff or identified based on conversations with them to support the needs assessment. These documents included prior needs assessments, patient satisfaction surveys, UDS data, census data, Point In Time Count reports, and prior research conducted by or on behalf of HCH/FH. These documents were reviewed for relevant data to provide additional detail or context to survey findings. When data were included for multiple years, the most recent information was included, or a comparison across years was made.

FINDINGS: FARMWORKERS

BACKGROUND

According to the USDA's most recent Census of Agriculture, almost 3.4 million people are employed as farmworkers on over 2 million farms in the United States.¹ For the purposes of this report, farmworkers are classified as persons who are engaged in growing crops, raising animals, or harvesting fish and other animals from a farm, ranch, or natural habitats.²

SAN MATEO COUNTY

In recent years, the number of farms in San Mateo County (SMC) has decreased by more than 25%, from 334 farms in 2012 to 241 farms in 2017.³ A range of agricultural firms are located in SMC, including floral/nursery crop operations and vegetable farms growing crops such as leeks, Brussels sprouts, pumpkins, peas, and fava beans.⁴ Farm businesses in the County also produce field crops (grain and hay), fruit crops (wine grapes and strawberries), and ranching (cattle and sheep).⁵ The enterprises that hire the most labor in SMC specialize in the production of flowers, Brussels sprouts, and leeks.⁶ Of 155 farmworkers who participated in the 2019 Needs Assessment Survey, 70% (n=108) responded that they worked in nursery operations, 20% (n=32) indicated they worked in produce, and 2% (n=4) listed other operations (e.g. ranching, field crops).

Estimates place the number of farmworkers in SMC between 1,300 and 1,600.⁷ The number of migrant farmworkers was estimated to be 123 in 2017, representing less than 10% of all farmworkers in the County.⁸ This aligns with the national trend, where more than 80% of hired crop farmworkers are not migrant workers, but work within 75 miles of their home.⁹ A recent study found that 95% of farmworkers do not work outside of SMC in a typical year.¹⁰ In this same study respondents had, on average, worked in SMC between 11 and 15 years and over 25% had worked in SMC agriculture for 21 years or more. The average age among these farmworkers was 58.6 years. The median household size was five persons per household for those living in non-group quarters settings, with a median household income for farmworkers of \$26,000.¹¹

Many farmworkers in San Mateo County are long term residents. A multiplier of 1.3 is used to estimate the family members of farmworkers living in SMC, putting the total number of persons who could receive services through HCH/FW between 2,990 and 3,680.ⁱ Geographically, farmworkers are evenly split between the Northern part of the County (Half Moon Bay, El Granada, and Moss Beach) and the Southern part of the County (Pescadero, Loma Mar, La Honda, and San Gregorio).¹² The 2019 Needs Assessment Survey found that 66% (n=102) of farmworkers surveyed both lived and worked in the northern part of the county, 21% (n=33) both lived and worked in the southern part of the county, and 13% (n=20) lived in one part of the county and worked in the other.

IMMIGRATION

ⁱ The USDA uses a multiplier of 1.2 to estimate the number of family members associated with farmworkers, but a higher estimate is used here to account for the fact that a high percentage of farmworkers in SMC are settled in the community.

In California, 90% of farmworkers are immigrants – the highest percentage of any state and nearly 20% higher than the national average.¹³ Furthermore, more than half of the immigrant farmworker population in California is undocumented.¹⁴ In SMC, 51% of farmworker respondents in a recent study reported that they were undocumented, aligning with the state trend.¹⁵ For this reason, many farmworkers in California – and in San Mateo County – are impacted by local, state, and federal immigration policies.

At the national level, the Trump administration is increasing its focus on federal immigration enforcement in the interior of the United States (in addition to its operations at the border).¹⁶ The administration has identified California as a target location for interior immigration enforcement, with the former director of ICE stating that California will “see a lot more special agents, a lot more deportation officers” and that ICE will “have no choice but to conduct at-large arrests in local neighborhoods and at worksites” in the state.¹⁷ In addition, the recently introduced “public charge” rule – which specifies that a person can be denied a green card if they use Medicaid, food stamps, housing vouchers, or other forms of public assistance – could negatively impact a large percentage of farmworkers in California.

In contrast to the federal government’s stance on immigration, California has the most progressive immigration policies of any state in the nation.¹⁸ Between 2013 and 2017, the California legislature considered and passed seven lawsⁱⁱ designed to protect workers in the state from the risk of retaliation and discrimination related to their immigration status.¹⁹

In San Mateo County, farmworkers have indicated that concerns about their immigration status impacts their ability to access healthcare.²⁰ Farmworkers who are undocumented may be afraid to come forward and seek treatment services.²¹ The 2019 Needs Assessment Survey found that 10% of all farmworkers who reported problems receiving necessary medical attention listed immigration concerns as a primary factor.

ⁱⁱ AB 263 (2013), SB 666 (2013), AB 524 (2013), AB 2751 (2014), AB 622 (2015), SB 1001 (2016), and AB 450 (2017)

HCH/FH PROGRAM

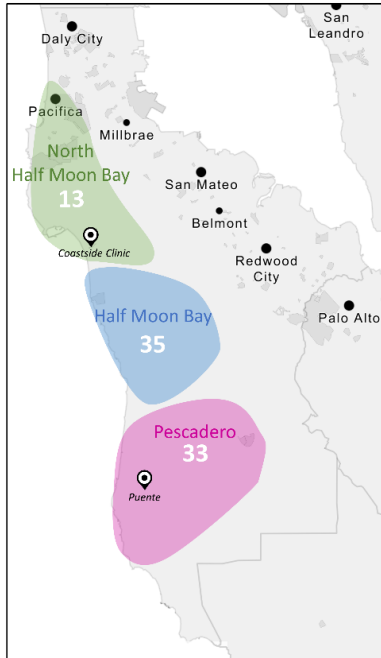


Figure 1: Distribution of Farms

Of the County's 241 farms, 81 fall within the purview of the HCH/FH program. These farms are distributed along the western, coastal side of SMC (see Figure 1) .

San Mateo County's unique geography physically separates portions of the population, as the Santa Cruz Mountains bisect the county and serve as a barrier to coastal areas. Consequently, farmworkers on the South Coast have to travel 18 miles to access the Coastside Health Center and 30 miles over mountain roads to access San Mateo Medical Center's main campus.²²

Utilization of HCH/FH services by farmworkers has decreased in recent years, down from 1,947 in 2015 to 1,180 in 2018.²³ This decrease may be the result of a combination of two factors: first, the political environment around immigration enforcement has created a "chilling effect," and has led people to avoid coming to clinics due to worries about their immigration status.²⁴ Second, there has been a decrease in the overall farmworker population in San Mateo County.

Of the 1,180 farmworkers and their family members who received services through HCH/FH in 2018, 34% (n=401) were under age 18, 61% (n=720) were 19-64, and 4% (n=59) were over age 65.^{iii,25} Well over half (56%) of farmworker clients of the HCH/FH program were best served in a language other than English.²⁶

FARMWORKER HEALTH

Recent studies in SMC have used self-reported health status as a proxy measure to understand the health of farmworkers in the county. Self-reported health status is regarded as a good indicator of a person's overall health. In a 2013 study of farmworkers in SMC, the majority rated their health status between "fair" and "good."²⁷ More recently, the 2019 Needs Assessment Survey found that the majority of farmworkers in the county (55%; n=85) rated their health as either "average" or "bad." Approximately 30% of farmworkers surveyed rated their health as "good," and less than 10% rated their health as "very good" or "excellent."

The California Agricultural Workers Health Survey indicated a high prevalence of risk factors and indicators of chronic diseases among farmworkers in the state, including obesity and diabetes, but low utilization of healthcare.²⁸ Individuals of Hispanic/Latino descent – as is the case for the majority of farmworkers in San

ⁱⁱⁱ Throughout the document, we refer to individuals who "received services through HCH/FH"; this means they identified as a farmworker, family member of a farmworker, or as experiencing homelessness, and received services either at SMMC or one of HCH/FH's contractors.

Mateo County – are at greater risk of food insecurity, obesity, and diabetes compared to the general population.²⁹

DIABETES, HYPERTENSION, HEART DISEASE, AND OBESITY

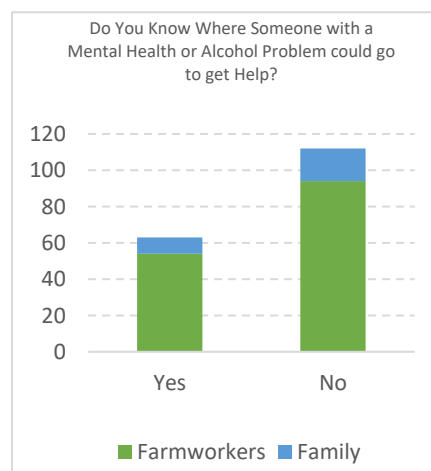
Farmworkers and their family members face barriers to care and have health needs related to chronic disease and environmental and occupational health problems.³⁰ A 2013 study of farmworkers in San Mateo County found that diabetes, heart disease, and hypertension were prevalent and were a major concern for many group participants.³¹ Among farmworker clients who received services through HCH/FH in 2018, 11% (n=84) were diagnosed with diabetes, 14% (n=106) were diagnosed with hypertension, and 25% (n=190) were diagnosed as overweight or obese.³² Type 2 diabetes mellitus without complications was the second most common diagnostic code used for outpatient farmworker visits to SMMC in 2018, and essential (primary) hypertension was the fifth most common.³³

This aligns with the 2019 Needs Assessment Survey, where 15% of all respondents (n=28) indicated that they had high blood pressure and 10% (n=19) reported that they had diabetes. Of the family members of farmworkers who took the survey, 13% (n=4) reported high blood pressure and 10% (n=3) reported diabetes. Respondents who reported diabetes were more likely to have visited the doctor in the last year as compared to those who did not have diabetes (68%/n=13 among those with diabetes versus 58%/n=87 among those without). Those who reported having high blood pressure were significantly more likely to have visited the doctor in the past year compared to those without high blood pressure (82%/n=23 among those with hypertension versus 58%/n=83 among those without).

BEHAVIORAL HEALTH

Comprehensive county-specific quantitative data on substance use and unmet substance use treatment needs are not available for the farmworker population, but a 2018 study reported a high rate of alcohol use among farmworkers in San Mateo County, with 11% of farmworker interviewees reporting that one or more people in their household had a substance use problem.³⁴ The study also noted reports of increasing opioid use in the southern portion of the county.

More recently, the 2019 Needs Assessment Survey found that 58% of all respondents (n=107) considered alcohol or drug use to be a problem in their community. Over 40% (n=75) of all respondents felt there were mental health problems in their community.



Eighteen people (representing just under 10% of all survey respondents) indicated that they had engaged in binge drinking behavior^{iv} at least once in the past month. Among these respondents, almost 80% (n=14)

^{iv} Binge drinking is defined as four or more drinks in one sitting for women and five or more drinks in one sitting for men

were male, nearly 90% (n=16) both lived and worked in the Northern part of SMC, and 72% (n=13) said that they did not know where someone could receive help with an alcohol or mental health problem. The binge drinking question had a low response level: almost 40% of survey takers (n=72) did not answer the question or selected “prefer not to respond.”

Among all respondents, 61% (n=113) indicated that they did not know where they could go to get help with substance abuse or mental health problems (see Figure 2). This aligns with an earlier study that found that “virtually none” of the farmworkers interviewed knew where to find help for alcohol and substance use problems.³⁵ The 2018 Substance Use Needs Assessment notes that there are limited services available in San Mateo County, particularly for farmworkers located on the south coast.

There is a need for trauma-informed care for the farmworker community, as past traumatic experiences may play a role in farmworker’s substance use, as well as in their mental health.³⁶ HCH/FH providers and experts have observed that the experience of immigration – which the majority of farmworkers in San Mateo County have had – is associated with “perpetual mourning.”³⁷ Pre-migration experiences may have included violence and upheaval, and the journey itself is often fraught with violence and risk.³⁸ Loss, grief, isolation, discrimination, confusion, and uncertainty face immigrants – all of which can negatively impact mental and behavioral health outcomes.³⁹

WOMEN’S AND CHILDREN’S HEALTH

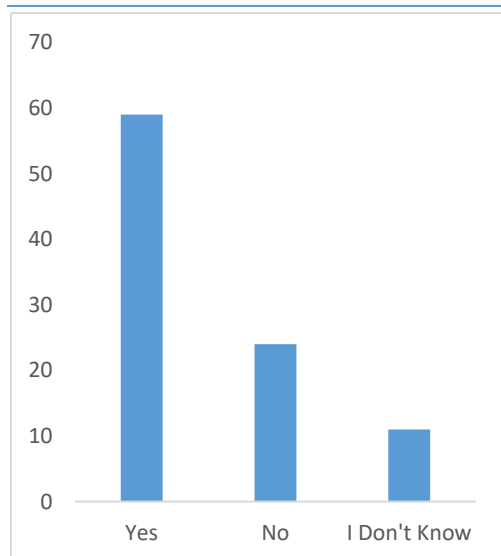


Figure 3: Number of women responding to the survey question, “in the past year, have you consulted a doctor or nurse for women’s health?”

In 2018, over half (n=606) of farmworker patients who received services through HCH/FH were female.⁴⁰ Of these, 62% (n=377) were over the age of 18.⁴¹ Approximately 81% (n=192) of female patients who received services through HCH/FH (23-64 years old) received a cervical cancer screening (pap smear) in 2018.⁴² The diagnostic code of “encounter for supervision of normal pregnancy, unspecified, third trimester” (n=167) was the fourth most commonly used code, indicating that pregnant women are utilizing services at SMMC for prenatal care.⁴³ The lack of first and second trimester visits potentially indicates that women are not connecting to care earlier in pregnancy.

The 2019 Needs Assessment Survey asked several questions related to women’s health. Approximately 58% (n=57) of women surveyed reported that they had consulted a doctor or a nurse for women’s health in the past year (see Figure 3). Of those reporting that they had seen someone for women’s health, over 60% indicated that they had been to Coastside Clinic for services. Pescadero had the next highest number, at just under 20%.

The top outpatient diagnostic code used for farmworkers seen at SMMC was “encounter for routine child health examination with abnormal findings,” (n=325) which indicates that children of farmworkers are regularly seen at SMMC.⁴⁴ Of the 1,180 farmworkers and their family members who received services

through HCH/FH in 2018, 34% (n=406) were under age 18.⁴⁵ Among children of farmworkers who received care from HCH/FH in 2018, 22% were diagnosed with a lack of expected physiological development.⁴⁶ This represents a decrease since 2015, when 28% of children were diagnosed with lack of expected physiological development.⁴⁷ A number of factors contribute to a lack of expected developmental outcomes for children of farmworkers, including parental poverty, frequent moves, low health expectations, interrupted schooling, overcrowded living conditions, and poor sanitation facilities.⁴⁸

FACTORS IMPACTING FARMWORKER HEALTH

A number of factors influence whether and how farmworkers access care in SMC. Insurance status, social and cultural beliefs about health and health services, geographic isolation, work requirements, and other aspects make the population difficult to reach and engage.⁴⁹ In a 2013 study, farmworkers in SMC indicated a desire for more health education, better provision of care, and increased access to care.⁵⁰ A 2012 report from the county found that there was a need for health education and promotion activities around: diabetes, environmental and occupational health, chronic disease management, pain management, eye health, respiratory infections, effects of drugs and alcohol, the availability of community and health services.⁵¹

HEALTH INSURANCE

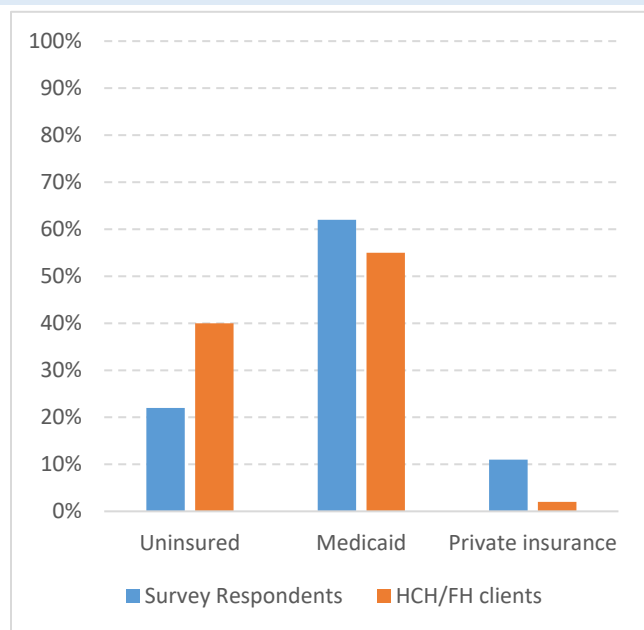


Figure 4: Insurance Status of 2019 survey respondents and 2018 HCH/FH clients. Bars represent the percent of persons in each category.

In the United States, health insurance status is an important determinant of a person’s health because it affects their ability to access and receive medical care.⁵² Within San Mateo County, some forms of private insurance (e.g. Kaiser) are tied to care that may be inconvenient and/or inaccessible due to the location of facilities (xx). ACE insurance, MediCal, and other sliding-fee scale insurance providers may be a good option for undocumented persons, but many farmworkers are ineligible for these as their income exceeds 250% of the federal poverty line (xx). For these reasons, some persons are only able to access acute and urgent care facilities through providers such as Rotacare (xx).

In San Mateo County, 32% of uninsured adults regard their access to local healthcare services as “fair” or “poor.”⁵³ This rate is four times higher than it is among insured adults in San Mateo County, of whom only 8% report “fair” or “poor” access to healthcare services in the County.⁵⁴ A 2013 interview of farmworkers found that many farmworkers were confused about health insurance, did not know where they could obtain reliable information about health insurance, and were unsure how to resolve health insurance-related problems they were having.⁵⁵

OCCUPATIONAL CONDITIONS AND HAZARDS

Migrant and seasonal farmworkers are one of the most underserved and understudied populations in the United States.⁵⁶ The nature of farming-related labor directly impacts the health and wellness of farmworker's health and wellness, as a wide variety risks and hazards are inherent to the work.⁵⁷ Physical exertion and exposure to toxins are associated with farmworker jobs.⁵⁸

The 2019 Needs Assessment Survey asked respondents about several aspects of their jobs, including hours worked, access to water, access to shade for breaks, and whether or not they had a break for food. Approximately 60% of farmworkers surveyed (n= 92) responded that they worked eight hours or less per day. Over 85% (n=133) of farmworkers said that they had access to shade for breaks. Almost 88% (n=136) indicated that they were given a break during the day to eat. The majority of farmworkers – 85% (n=132) – indicated that during their lunch break they ate food prepared at home.

During the planting and harvest seasons, farmworkers work long hours, meaning that they may not get off work until after clinics have closed.⁵⁹ Even if they do get off before clinic closing times, they may be too physically exhausted to travel for needed health services.⁶⁰ In the 2019 Needs Assessment Survey, almost half (44%, n=49) of those who expressed a preference for when to receive medical attention listed Saturday as a preferred day. Sunday was the least popular day of the week for clinic appointments.

INJURIES

Among farmworkers who completed the 2019 Needs Assessment Survey, 16% (n=25) reported suffering an injury at work. Males and females were equally likely to report having suffered a job-related injury. Among those respondents who reported injuries, less than a third (n=8) reported that their health was “good” or better. By comparison, among farmworker respondents who did not report suffering an injury at work, almost 50% (n=46) said reported that their health was “good” or better. More than half of the injuries reported were cuts or falls.

PESTICIDE EXPOSURE

Pesticide exposure is one of the most common risk factors associated with farm labor. Farmworkers can suffer serious short- and long-term health outcomes as a result of pesticide exposure.⁶¹ If a farmworker comes into direct contact with a pesticide, short-term acute effects may include stinging eyes, rashes, blisters, blindness, nausea, dizziness, and headaches.⁶² Extended low-level exposure to pesticides over the long-term can have chronic health effects such as cancer, infertility, birth defects, endocrine disruption, and neurological disorders.⁶³ Studies have also found that children exposed to pesticides are at a higher risk for asthma, cancer, and neurodevelopmental problems.⁶⁴ For these reasons, pesticides are tightly regulated.

In California, every county has an agricultural commissioner's office that is tasked with pesticide use enforcement and serves as the local branch of the Department of Pesticide Regulation (a division of CalEPA).⁶⁵ Growers are required to report all pesticide use to this office on a monthly basis and follow rules and regulations regarding buffer zones and drift. Local officials have the authority to inspect any

grower facility at any time where pesticide activity is occurring, and can level agricultural civil penalties of up to \$5,000 per incident.⁶⁶

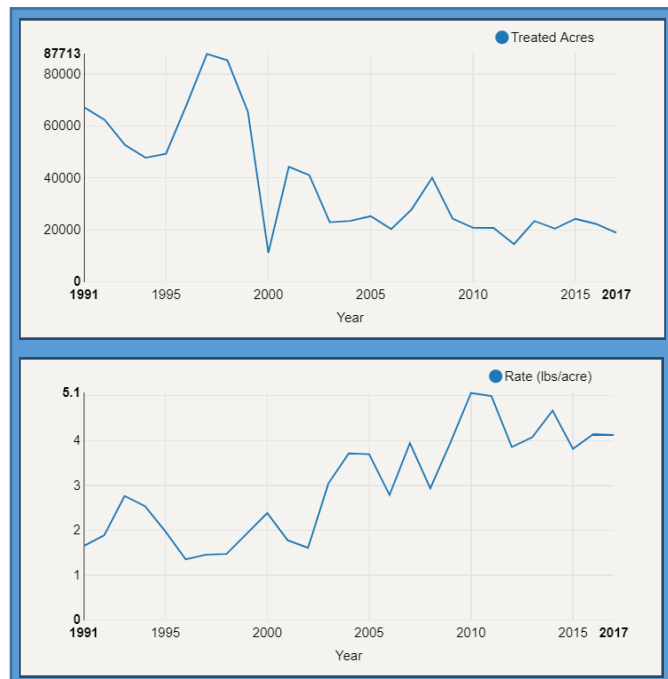


Figure 5: Trends in pesticide application in San Mateo County. The top chart shows the number of treated acres, and the bottom chart shows the rate of application (pounds per acre).

Furthermore, state law in California requires annual training on pesticides for fieldworkers.⁶⁷ The training covers 20 required topics and must be presented in a language that the employee understands.⁶⁸ The hazard communication requirement states that safety information and information on what was applied to the fields within the last 30 days must be posted where the employees begin their day.⁶⁹ Additionally, California requires that employers report pesticide exposure incidents into a centralized system within 24 hours of an occurrence.⁷⁰

Most counties in California report significantly higher levels of pesticide use than San Mateo County, which consistently ranks in the bottom third of all counties in the state (40th out of 58 counties).⁷¹ Between 2014 and 2017, the top three pesticides applied in San Mateo County

were potassium n-methyldithiocarbamate, 1,3-Dichloropropene, and pentachloronitrobenzene, respectively.⁷²

Potassium n-methyldithiocarbamate, also called metam potassium, is a non-selective soil fumigant that acts as a fungicide, nematicide, insecticide, and herbicide. It is harmful if swallowed, inhaled, or absorbed through the skin.⁷³ Additionally, metam potassium causes severe burns and eye damage. Like metam potassium, 1,3-Dichloropropene (also called 1,3-D) is a soil fumigant. It is toxic if swallowed or absorbed through the skin. 1,3-D can cause serious eye irritation, is harmful if inhaled, and may cause respiratory irritation.⁷⁴ Pentachloronitrobenzene, also called PCNB, is a fungicide. It is harmful if swallowed, inhaled, or absorbed through the skin.⁷⁵ All three of these pesticides are considered highly toxic, but it is unlikely that a farmworker would be directly exposed to them because they are strictly regulated (see above).

Almost 60% (n=92) of farmworker respondents to the 2019 Needs Assessment Survey reported having been exposed to pesticides at work, and just under 10% (n=15) reported that they were unsure whether or not they had been exposed. Females reported exposure to pesticides at work at a higher rate than did males (70% versus 60%). Of farmworker respondents who reported having been exposed to pesticides, 99% (n=91) indicated that they wore at least one form of protection while at work.

Types of Protection Worn by Pesticide-Exposed Farmworkers (n=92) <i>respondents could select multiple answers</i>	
Respirator	35
Gloves	84
Boots	54
Overalls	43
Face Protection	24
Solar Protection	44
No Protection	1

Among all farmworker respondents – regardless of whether they reported pesticide exposure– those who engaged in harvesting activities were the most likely to report wearing at least one form of protection (n=57, 37%). Among all individuals who listed harvesting, nearly 70% (n=44) reported pesticide exposure. Over 13% (n=18) of farmworker respondents who reported wearing some form of protection listed weeding as an activity. Among respondents who listed weeding, 75% (n=23) reported pesticide exposure.

Self-reported health among those who reported exposure to pesticides at work was slightly worse than among farmworkers who did not report pesticide exposure. Among those who reported pesticide exposure, 41% said their health was “good,” “very good,” or “excellent;” eight percentage points lower than among those who were not exposed to pesticides (see Figure 6).

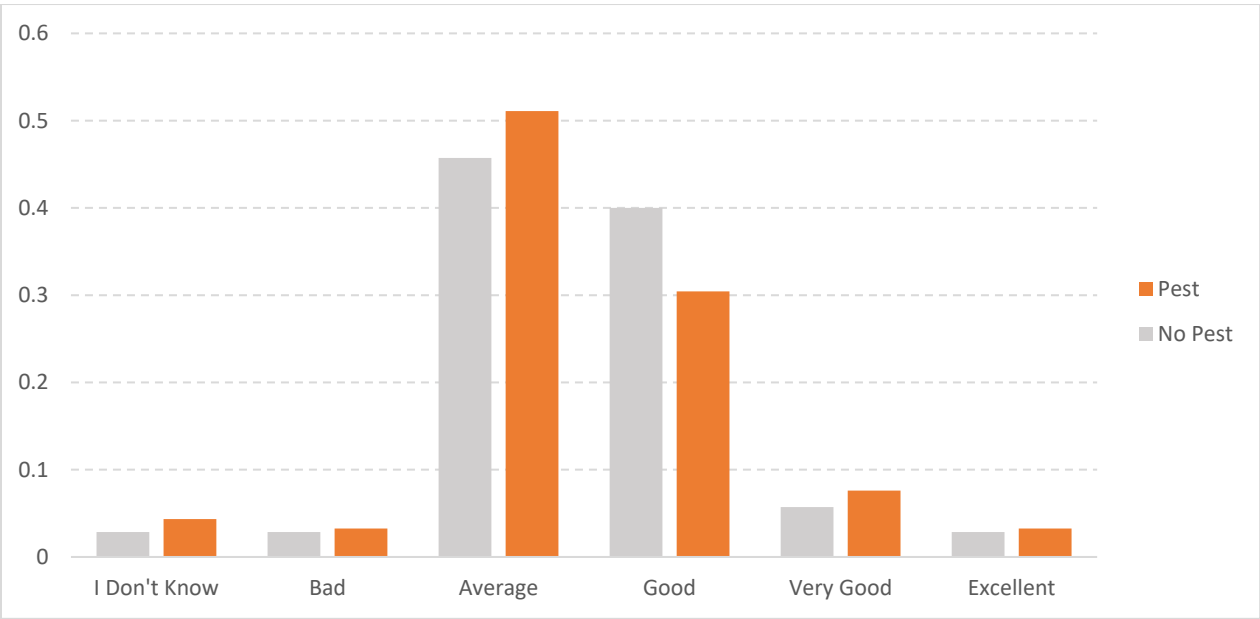


Figure 6: Percentage of Farmworkers Reporting on their health by pesticide exposure.

SOCIAL DETERMINANTS OF HEALTH

FOOD SECURITY

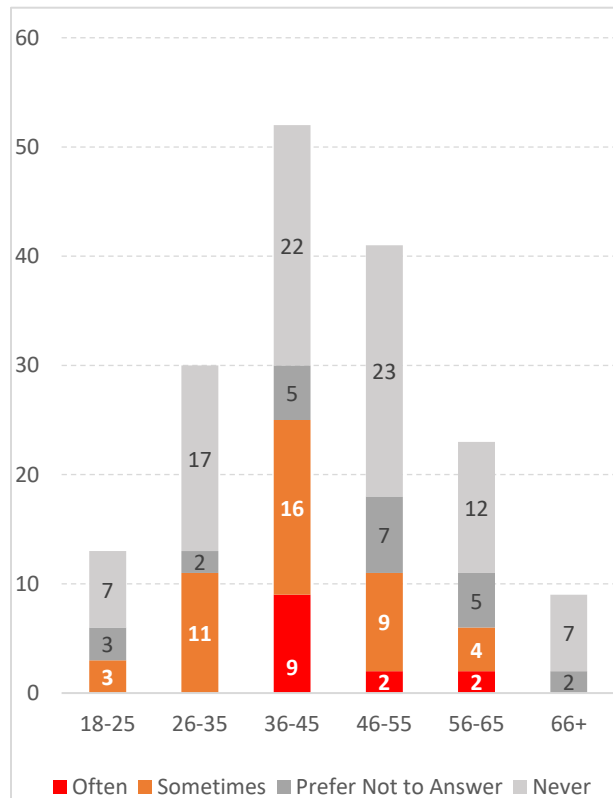


Figure 7: Count of responses to the question “In the last 12 months, how often did you worry about running out of food before you had money to buy more,” disaggregated by age.

People between the ages of 36 and 45 were the most food insecure age cohort. This is also the largest cohort, accounting for almost a third of all respondents (52 out of 168 persons that responded to this question). More than half of all male respondents between the ages of 36 and 45 reported being “often” or “sometimes” worried about running and being unable to afford food (see Figures 7 and 8).

As of 2012, a third of low-income households in San Mateo County were food insecure.⁷⁶ San Mateo has one of the lowest CalFresh participation rates in the state among those who are income-eligible.⁷⁷ It is possible that this participation rate will drop even lower – particularly among the farmworker population – given the Trump administration’s policy regarding public assistance, called the Public Charge (see “Immigration” section on page xx of this report).

Farmworkers’ food access and eating patterns are influenced by work schedules, transportation, income fluctuations, and cultural preferences.⁷⁸ The 2019 Needs Assessment Survey aimed to capture the relative food security of respondents, as well as gather some information about their eating habits using the two-item Hunger Vital Sign HM Screen. A positive response to either of these two items indicates a high likelihood that the person is food insecure.⁷⁹

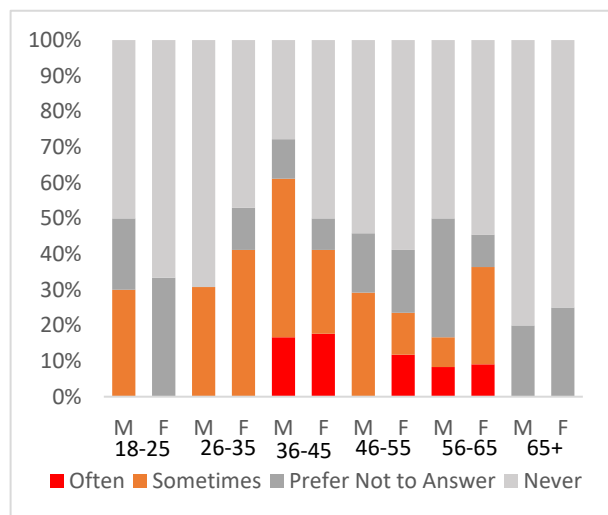
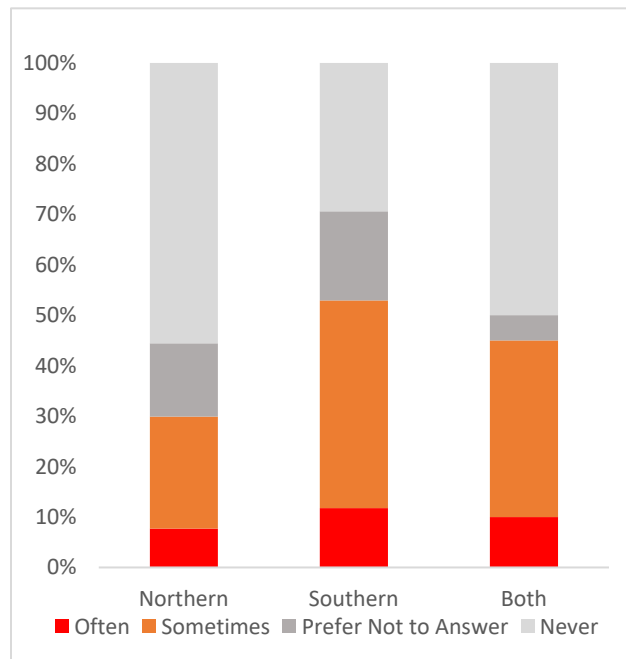


Figure 8: Percent of responses – disaggregated by sex and age – to the question, “In the last 12 months, how often did you worry about running out of food before you had money to buy more?”

More than half of all respondents in the Southern part of San Mateo County reported that they were “often” or “sometimes” worried about running out of food before they would have enough money to buy more (see Figure 9). Food insecurity was similarly high among those farmworkers who live and work in different parts of the county. Food insecurity was lowest in the northern part of the county, where only



30% of respondents reported being food insecure. Among the 19 respondents who reported that they had diabetes, 47% (n=9) screened positive for food insecurity and 21% (n=4) indicated that they did not want to answer.

LANGUAGE BARRIERS

Language barriers are associated with the farmworker population, as many farmworkers speak Spanish and have limited literacy.⁸⁰ For this reason, bilingual services need to be made available. Additionally, health services should be planned and delivered in a culturally competent manner that uses strong extended family, community, and spiritual supports found in Latino cultures.⁸¹

Figure 9: Food Insecurity among farmworkers by Location. Percent of responses disaggregated by where respondent lives and works.

HOUSING

Housing is an ongoing issue that faces many Californians, including residents of San Mateo County.⁸² At present, an additional 24,628 affordable rental homes are needed to meet demand.⁸³ When just considering the farmworker population, an estimated 1,020 to 1,140 more units are needed.⁸⁴ If one includes housing costs when calculating the poverty rate, San Mateo’s poverty rate more than doubles (from 7% to 17%).⁸⁵ Collectively, it is estimated that renter households in San Mateo County need to collectively earn \$65.29/hour to afford the median monthly asking rent of \$3,395. It is estimated that only 28% of farmworkers in San Mateo County have adequate housing.⁸⁶

Approximately 36% of Coastside homeowners and 50% of renters (where the majority of farmworkers in San Mateo County live) were housing-cost burdened between 2010-2014.⁸⁷ The 2016 Agricultural Workforce Housing Report found that about 30% of farmworkers were excessively housing-cost burdened, and almost 10% faced extreme cost burdens related to their housing.

Farmworkers usually live in barrack-style buildings that do not meet housing standards or regulations.⁸⁸ Families often share trailers, and entire families sometimes live in one room.⁸⁹ Persons who are currently unsheltered in the part of the County where most farmworkers are concentrated (Half Moon Bay and smaller Coastside communities) face particular difficulty, as there are no shelter beds in that region.⁹⁰

Of respondents to the 2019 Needs Assessment Survey, 51% (n=95) lived in an apartment, 39% (n=71) reported that they lived in a house, and 7% (n=13) said they had some other type of housing, such as a garage, a dorm, a trailer, or that they camp. Of those who lived in a dorm, 67% (n=4) rated the quality of their housing as either “bad” or “very bad.” Of those who rated their housing quality as “bad” or “very bad,” 17% (n=3) rated their health as “bad” and 22% (n=4) said their health as “good” or “very good.” Nearly a third of respondents (n=12) who reported that they lived in a barracks-style setting said that their housing was “too crowded.”

Over 96% (n=155) of respondents to the 2019 Needs Assessment Survey said that they had access to a kitchen in their place of residence. Of the six persons who responded either “no” or “I don’t know,” three people said they lived in an apartment, two people said they lived in a house, and one person did not indicate their type of housing.

Building adequate housing for the agricultural workforce is an ongoing concern in San Mateo County. Producers and farmworkers say that a key reason for the County’s shrinking farm labor pool is the lack of available housing.⁹¹ The strict and complicated regulatory environment in San Mateo County makes it difficult to build new farm housing in the area.⁹² To try and address the issue of inadequate housing for farmworkers, two tax-raising measures were introduced and approved by voters to fund the Agricultural Workforce Housing Pilot Program, but the results of this program are not yet public.⁹³

JOB SECURITY

Overall unemployment in San Mateo County is low, but unemployment is persistent among low-skilled laborers such as farmworkers.⁹⁴ In addition, seasonal unemployment is an issue for farmworkers, as the demand for farm labor shifts throughout the year. The highest demand for farm labor in San Mateo County occurs during the second and fourth quarters of the year, at harvest time.⁹⁵

Employment rates in San Mateo’s agricultural sector have been trending down year-round since 2005, amplifying seasonal trends and the likelihood that farmworkers in the county will face unemployment or underemployment at some point.⁹⁶ Wages for farmworkers in San Mateo County have increased over this same period, from \$9.07/hour to \$13.97/hour, an increase which has kept pace with inflation.⁹⁷

Maintaining employment is particularly critical for farmworkers as these jobs are often directly tied to housing. In SMC, places like Moonridge require persons to have an agricultural job in order to be eligible, so the loss of a job can put farmworkers and their families at risk of losing housing (xx).

The recent closure of Bay City Flower Company – which resulted in over 200 employee layoffs in September 2019– had a large impact on the farmworker community in SMC.⁹⁸ It is possible that a marijuana or hemp enterprise will open in place of Bay City Flower, which would result in a net loss of employment opportunities, as federal regulations bar undocumented workers from participating in the production of cannabis.⁹⁹ The HCH/FH program should continue monitoring the crop mixture in SMC and keep an awareness of changing needs within the community.

TRANSPORTATION

In a national needs assessment, lack of safe transportation was identified the number one barrier to healthcare access by farmworkers and migrant health professionals.¹⁰⁰ Residents' ability to access resources in San Mateo County often depends on their means of transport due to the geographic distribution of resources throughout the county. In San Mateo County, Hispanic residents and those with lower income or education levels – both characteristics of the majority of the farmworker population – were more likely to experience transportation as a barrier to accessing healthcare.¹⁰¹ In a 2012 report, transportation was cited as the biggest barrier faced by farmworkers in the Coastside region, as most relied on bicycling or carpooling to get to their job sites.¹⁰²

In the 2019 Needs Assessment Survey, cars were by far the most common form of transportation, with 87% of farmworkers listing that they either got to work in a “car” (55%) or by “carpooling” (32%). 100% of respondents who live and work in different parts of the county listed that they either carpooled or rode to work in a car. Car reliance was next highest in the South, where 87% said they either carpooled or arrived at their job in a car. Alternative forms of transportation were highest in the North, where 18% of respondents said they either walked, biked, or rode the bus to work.

Transportation was listed as a barrier to accessing necessary medical services by 18% of respondents (n=8). Of these, 75% (n=6) said that they traveled to work by car or carpool. Over 42% (n=78) of all respondents listed public transportation as way to improve life in San Mateo County.

FARMWORKER SURVEY LIMITATIONS

Limitations to the 2019 Needs Assessment Survey data collection and analysis process are outlined below; the findings described above should be considered with these limitations in mind.

- A high number of survey administrators (~15) introduced large variability in survey distribution, despite the training event.
- We do not have data on the distribution of farmworkers across the County (e.g., how many farmworkers in the full population of SMC work and live in the North versus the South). This makes it difficult to know how representative the survey population is of the actual farmworker population.
- Some data may be underreported in the survey in cases where respondents may have felt uncomfortable disclosing (accidents at work, for example).
- Data around pesticide exposure should be interpreted with caution; the survey did not include a clear definition of what was meant by “exposure” to pesticides, or ask respondents to identify the type of exposure that was experienced.
- We do not have information on the extent to which survey respondents overlap with the population of people accessing services through HCH/FH or SMMC (and who are thus represented in UDS and claims data). This makes it difficult to draw conclusions from comparisons across the two data sources.

FINDINGS:
PEOPLE EXPERIENCING HOMELESSNESS

HOMELESSNESS AND HEALTH

The experience of being homeless has detrimental impacts on an individual’s physical and mental health.¹⁰³ Adults experiencing homelessness suffer from a disproportionate share of chronic health conditions and are three-to-four times more likely to die prematurely than non-homeless persons.^{104, 105} The National Coalition for the Homeless estimates that up to a quarter of people experiencing homelessness also have severe mental health conditions.¹⁰⁶

Experiencing homelessness also increases utilization of high-cost care.¹⁰⁷ Hospital stays among people experiencing homelessness in the United States are nearly twice as long as the average stay, and cost over \$2,500 more on average. These stays were four times as likely to take place within a week of a prior emergency department visit or hospital stay, and readmission risk is much higher when patients are discharged to the street or a shelter where treatment and recovery are disrupted. In San Francisco, people experiencing homelessness account for 30% of emergency psychiatric service episodes.¹⁰⁸

HOMELESSNESS IN SAN MATEO COUNTY

San Mateo County and much of California is facing an affordable housing crisis. California has 13 of the 14 least affordable metropolitan areas in the country, and a shortfall of 1.5 million affordable homes.¹⁰⁹ Approximately 7,500 families in SMC are on closed waiting lists for public housing and rental assistance, and eight in 10 residents rate the availability of affordable housing in the community as “fair” or “poor”.¹¹⁰ ¹¹¹The high cost of living and low supply of affordable housing are driving a growing and increasingly urgent homelessness crisis in SMC and across the state, which has direct impacts on health outcomes for individuals.^{112,113}

DEMOGRAPHICS

The 2019 Point In Time (PIT) Count conducted in San Mateo County (SMC) identified 1,512 people experiencing homeless on a single night, and an estimated 4,638 to 6,798 people experience homelessness in the County annually.^{114 115} The single-night total was 21% higher than the PIT Count conducted in 2017, though less than the 2011 and 2013 Counts.¹¹⁶ Table 1 below describes the race/ethnicity of people experiencing homeless in SMC in 2018, as well as the race/ethnicity of those people experiencing homelessness who received services through HCH/FH.

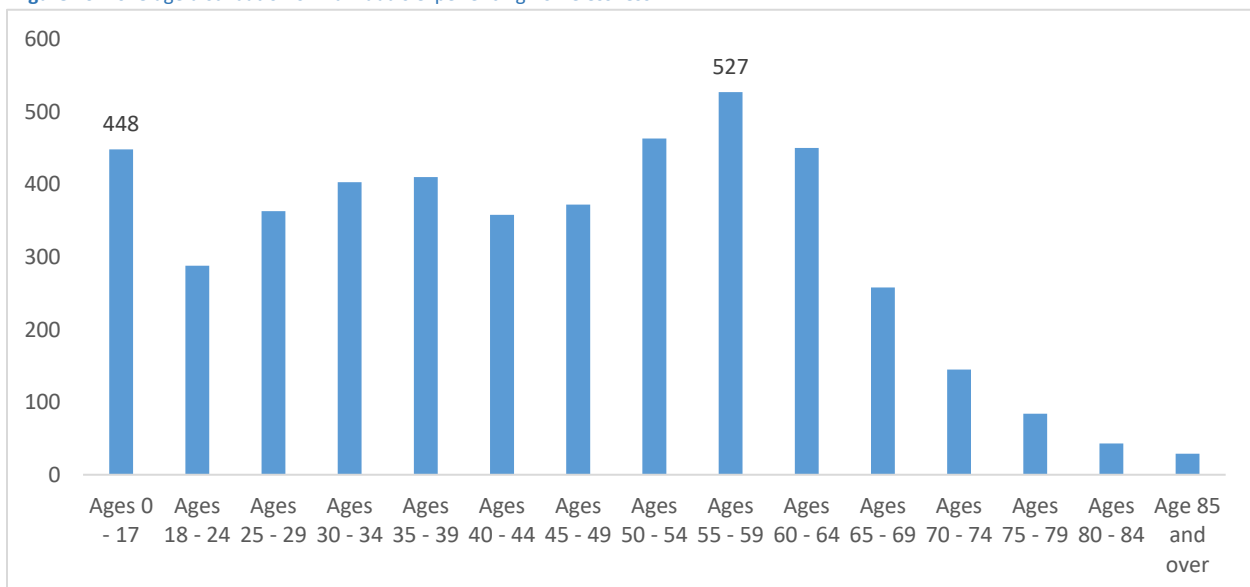
Table 1: Race/Ethnicity of People Experiencing Homelessness in SMC

	2019 PIT Count (N=1,512) ¹¹⁷	Received services through HCH/FH in 2018 (n=4641) ¹¹⁸	General Population of SMC ¹¹⁹
White	66.6%	51%	39.9%
Black/African American	13.3%	11%	2.9%
Asian	2.5%	7%	28.3%
American Indian / Alaska Native	6.2%	0.5%	0.8%
Native Hawaiian / Pacific Islander	3.6%	4%	1.6%

Multiple races	7.8%	10%	4.5%
Hispanic/LatinX	38.1%	32%	25.1%
Unreported		17%	

Individuals experiencing homelessness in SMC are predominantly male (66.9% vs. 32.9% female), with a small number identifying as transgender (0.3%).¹²⁰ These figures were similar for 2019 Needs Assessment Survey respondents, 37% of whom identified as female, 63% of whom identified as male, and one of whom responded “other”. The median age of patients experiencing homelessness who were seen at San Mateo Medical Center (SMMC) in 2018 was 47, and the median age of 2019 Needs Assessment Survey respondents was 50.¹²¹ Figure 10 below depicts the age distribution of people experiencing homelessness who received services through HCH/FH in 2018; previous needs assessments suggest that the number of seniors experiencing homelessness is increasing in the County.¹²²

Figure 10: 2018 age distribution of individuals experiencing homelessness



In 2019, 21.2% of people experiencing homelessness in SMC were chronically homeless, a slight increase from 2017.^{v 123} Among 2019 Needs Assessment Survey respondents, the median length of homelessness was just under one year (11.97 months), with the shortest time being less than one month and the longest being nearly 30 years. Half of respondents reported being homeless before (50%).

^v Chronic homelessness is defined by the Department of Housing and Urban Development as “someone who has experienced homelessness for a year or longer, or who has experienced at least four episodes of homelessness in the last three years, and also has a condition that prevents them from maintaining work or housing” (Point-in-Time, 2017).

WHERE AND HOW PEOPLE ARE SHELTERED

Of the 1,512 individuals experiencing homelessness identified in the 2019 PIT Count, 60% (901) were unsheltered (living on streets, in cars, in recreational vehicles, or in tents), and 40% (611) were sheltered (in emergency shelters and transitional housing programs).¹²⁴ The highest per capita homeless populations are concentrated in the southern part of the County, in Redwood City and East Palo Alto, the poorest city in the service area, and in the northern coastal community of Pacifica. The County's largest unsheltered homeless populations were also located in Redwood City, East Palo Alto, and Pacifica.¹²⁵ Figure 11 below highlights the areas in the County with the largest populations of unsheltered individuals, and their location with respect to health care services and shelters.

There was an overall increase in homelessness in SMC from 2017 to 2019. The PIT Count revealed that this increase was driven primarily by a significant increase (127%) in the number of people living in recreational vehicles.¹²⁶ This is a trend that has been seen in other counties in the Bay Area, and is likely related to the high cost of living leading to individuals with jobs being unable to afford homes or rent. A separate recent study found that 50% of people living in vehicles in San Mateo County were not connected to health care, suggesting a gap in services for this growing population.¹²⁷ The 2019 PIT also found a 24% increase in the number of people sleeping on the street, and a 7% decrease in the number of people sleeping in cars.¹²⁸

Among 2019 Needs Assessment Survey respondents, 65% were sheltered at the time of the survey, and 35% were unsheltered. The median ages of the two groups were similar (51 and 50 respectively).

HEALTH OF PEOPLE EXPERIENCING HOMELESSNESS IN SMC

The 2019 PIT Count found that up to 31% of sheltered and 23% of unsheltered individuals reported severe mental illness, and up to 21% of sheltered and 12% of unsheltered individuals reported alcohol and/or drug use.¹²⁹ Similarly, of the patients experiencing homelessness who received services through HCH/FH in 2018, 25.9% (1,201) were diagnosed with mental health disorders and 17.1% (793) were diagnosed with substance use disorders.¹³⁰ For those patients experiencing homelessness who had emergency

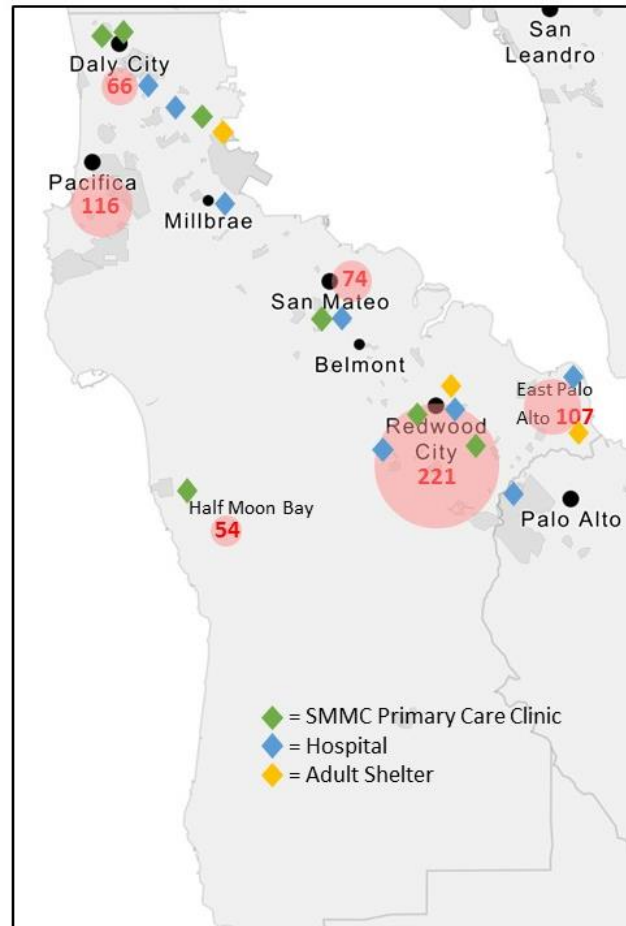


Figure 11: Top 6 locations for unsheltered people experiencing homelessness (2019 PIT Count)

encounters at SMMC in 2018, eight of the top ten and 12 of the top 20 diagnoses were mental health or substance use related.¹³¹

Outpatient encounters at SMMC in 2018 for patients experiencing homelessness were dominated by physical health diagnoses, with diabetes mellitus, chronic pain, and hypertension being the three most common.¹³² Breast cancer is also a common diagnosis among this population, with 71 patients diagnosed with breast cancer in 2018 (the 11th most common diagnosis for outpatient encounters at SMMC), despite the fact that breast cancer screening is lower among the population of people experiencing homelessness than among the general SMMC population. (CITE)¹³³ Of all patients experiencing homelessness who received services through HCH/FH in 2018, 12.9% (600) were diagnosed with diabetes mellitus, 22.2% (1,034) were diagnosed as overweight or obese, 10.6% (492) were diagnosed with heart disease, and 22.3% (1,036) were diagnosed with hypertension.¹³⁴

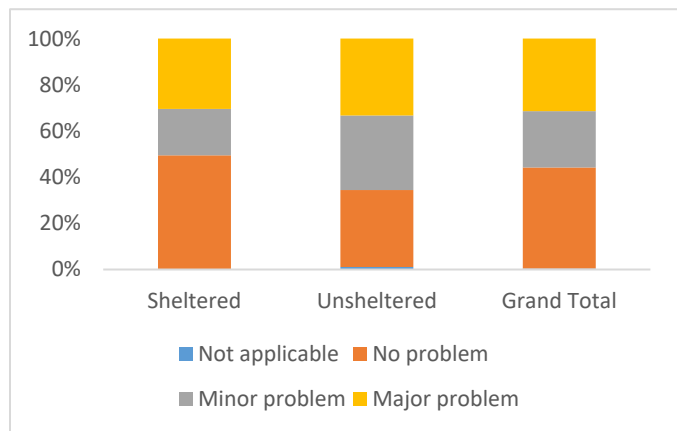


Figure 12: Reports of dental pain and other problems as a problem in the last 12 months, by shelter status

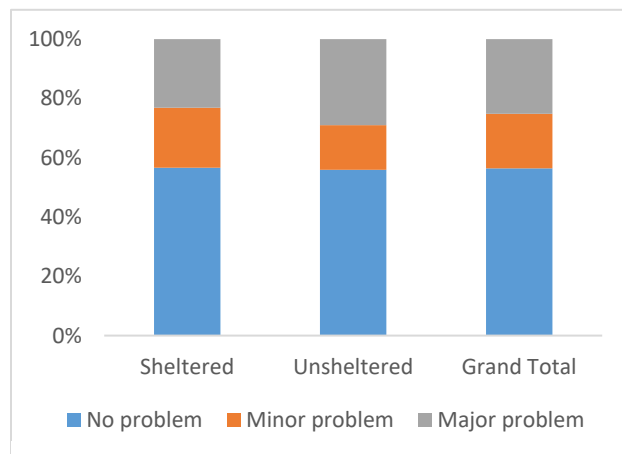


Figure 13: Reports of chronic pain as a problem in the last 12 months, by shelter status

Among 2019 Needs Assessment Survey respondents, 62% described their general health as “good”, “very good”, or “excellent”. This figure was the same regardless of whether an individual was sheltered or unsheltered at the time of the survey. The top six problems respondents reported facing over the last 12 months were: 1. stress or anxiety; 2. dental pain and other problems; 3. feeling depressed; 4. feeling lonely, sad, or isolated; 5. chronic pain; and 6. weight management/healthy eating. Figures 12 and 13 show that some of these conditions vary by shelter status; for both dental pain/problems and chronic pain, unsheltered individuals were slightly more likely to report them as a “major problem” than sheltered individuals.

Unsheltered individuals were slightly more likely to report them as a “major problem” than sheltered individuals.

Numerous reported health challenges among 2019 Needs Assessment Survey respondents varied by shelter status, as described in Figures 14-17 below. Unsheltered individuals were more likely to identify incontinence, kidney issues/failure, and accidental falls causing injury as a problem they faced in the last year. It may be that individuals with these health conditions are more likely to be turned away by shelters, and thus end up unsheltered, because shelters are not equipped to care for individuals with

complex needs. Interestingly, cancer was much more likely to be reported as a problem for sheltered individuals.

Figure 14: Reports of bladder or bowel incontinence/toileting as a problem in the last 12 months, by shelter status

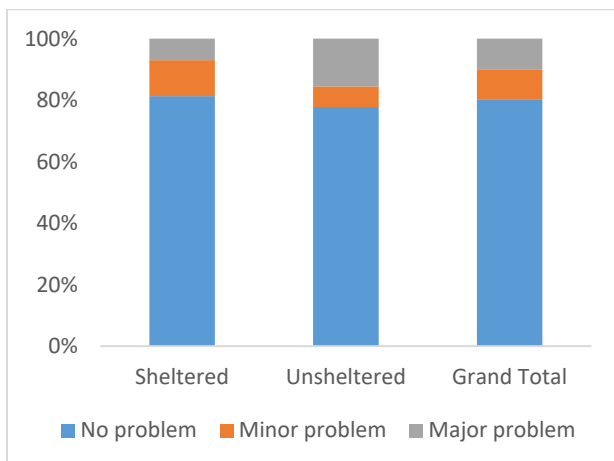


Figure 15: Reports of issues with kidneys/kidney failure as a problem in the last 12 months, by shelter status

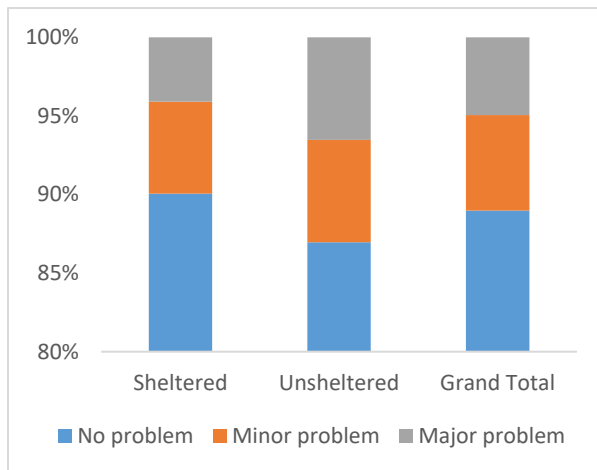


Figure 16: Reports of accidental falls causing injury as a problem in the last 12 months, by shelter status

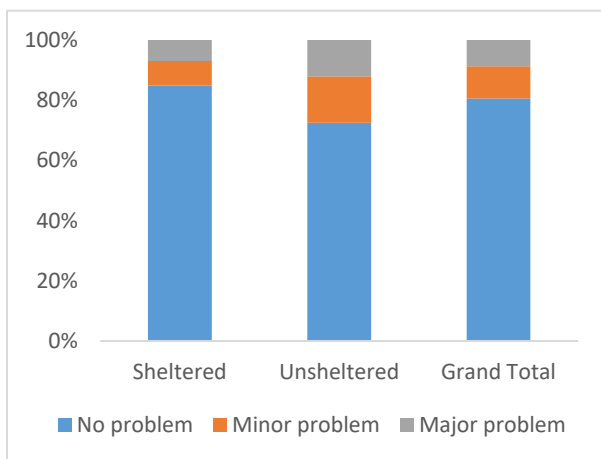
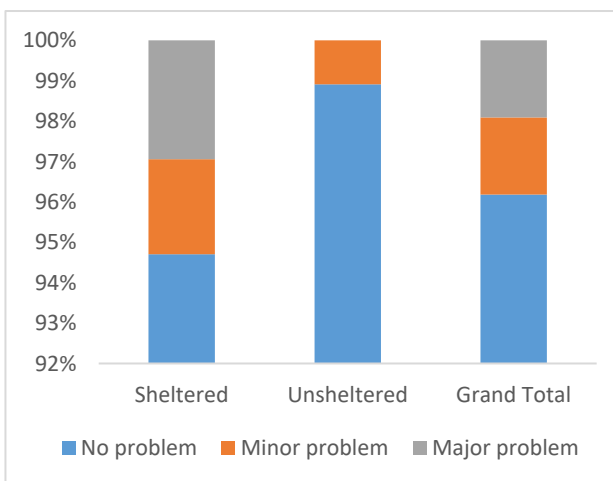


Figure 17: Reports of cancer as a problem in the last 12 months, by shelter status



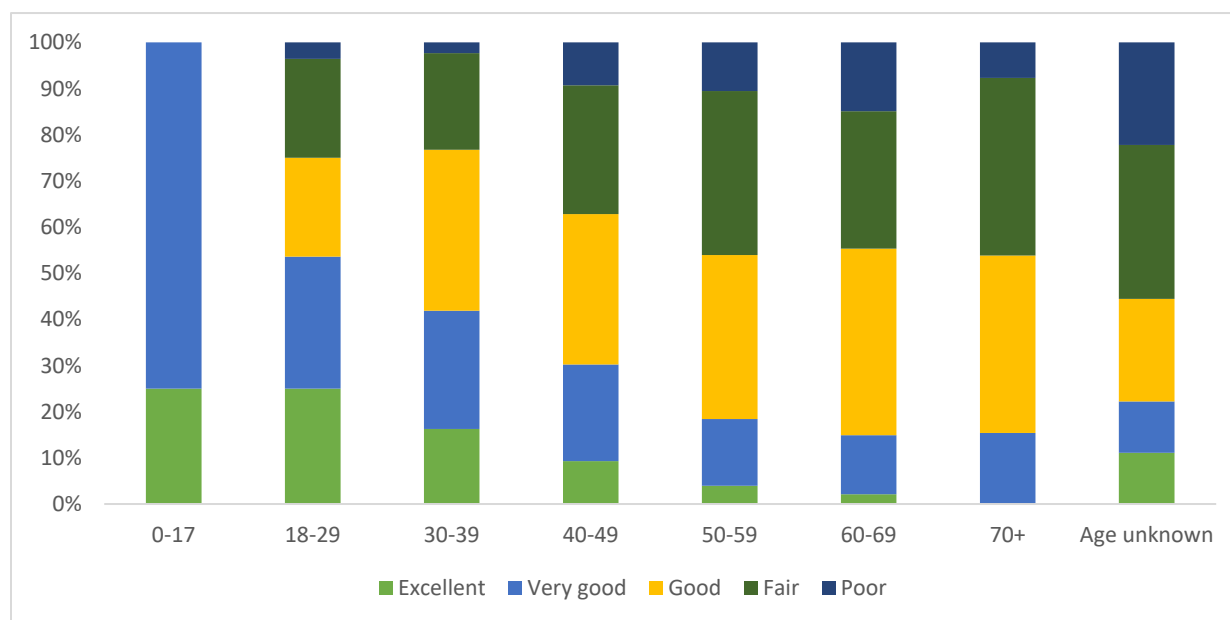
SOCIAL ISOLATION

Social isolation and loneliness have been linked to increased risk for numerous physical and mental health conditions, including heart disease, obesity, anxiety and depression, and cognitive decline.¹³⁵ Roughly a quarter (24.7%) of 2019 Needs Assessment Survey respondents identified feeling lonely, sad, or isolated as a major problem they faced in the last year. This number was highest among respondents under 30 (29.4%) and age 70 and above (28.6%). However, 70% of respondents “agreed” or “strongly agreed” that there are people they can reach out to if they need help, and 65% “agreed” or “strongly agreed” that they feel welcome in their community. Younger respondents (0-29) were much more likely to feel welcome (82% “agreed” or “strongly agreed”) than older adults, many of whom responded neutrally.

AGING AND HOMELESS

Physical and mental health conditions associated with aging, including incontinence, ability to manage activities of daily living, and dementia, can require a level of care and service that many shelters are not equipped to provide.¹³⁶ For the general population, these types of conditions and symptoms typically emerge when an individual is in their 70s and 80s.¹³⁷ The combination of an aging homeless population and the fact that people experiencing homelessness may experience these conditions at an earlier age than the general population means there may be a rapidly growing population whose needs cannot currently be met in shelters.¹³⁸ 15% of 2019 Needs Assessment Survey respondents reported having trouble getting or keeping a shelter bed due to health reasons; the median age for this group was slightly higher than those who did not report trouble getting or keeping a shelter bed (55.5 years vs. 50 years).

Figure 18: Self-reported general health among survey respondents, by age



Recent patient encounter data from SMMC does not reveal a difference in the median age of onset for dementia or incontinence between the general population and individuals experiencing homelessness.¹³⁹ However, 2019 Needs Assessment Survey data reveals that respondents aged 50-59 report facing similar aging-related conditions and challenges as older respondents. Figures 19-24 show that there is an increase in reports of incontinence, vision loss, problems with moving around (walking or changing clothes), chronic pain, accidental falls causing physical injury, and getting in and out of bed as minor or major problems among respondents aged 50-59.

Figure 19: Reports of bladder or bowel incontinence/toileting as a problem in the last 12 months, by age

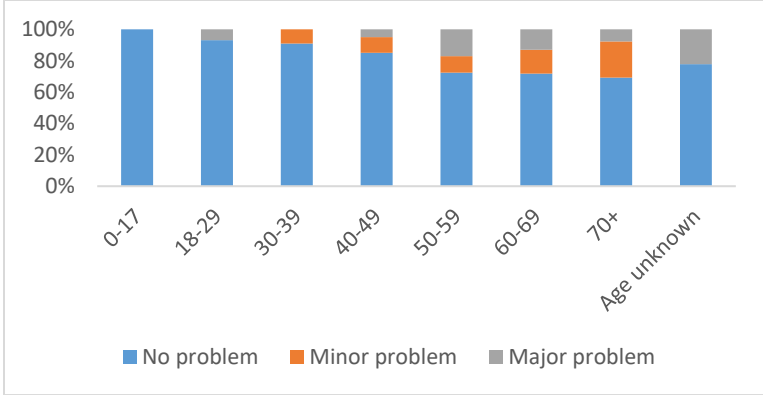


Figure 20: Reports of vision loss as a problem in the last 12 months, by age

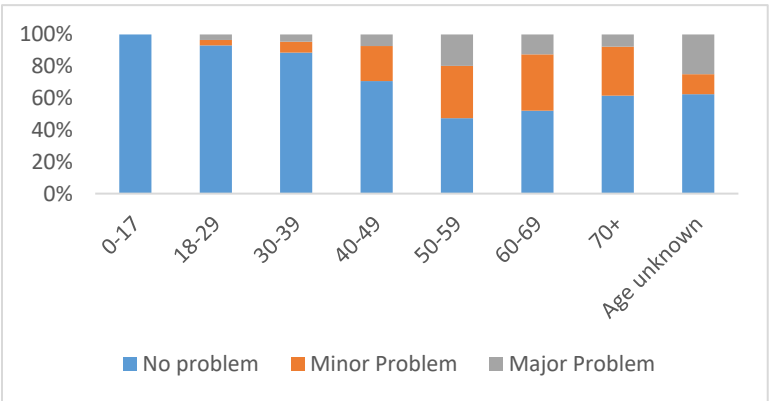


Figure 21: Reports of problems with moving around (like walking or changing clothes) in the last 12 months, by age

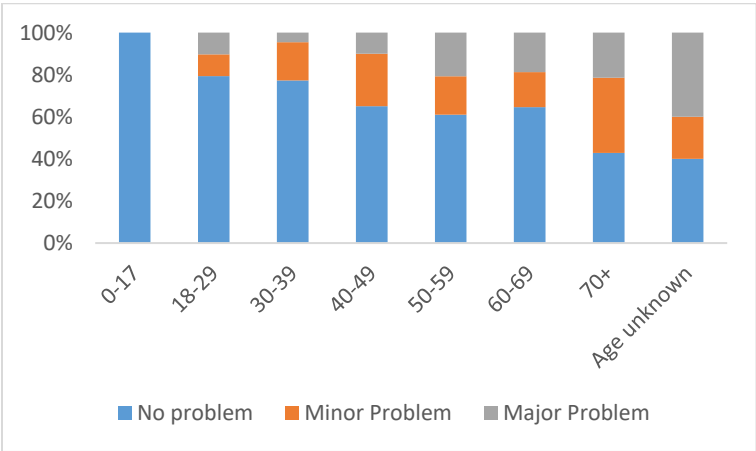


Figure 22: Reports of chronic pain as a problem in the last 12 months, by age

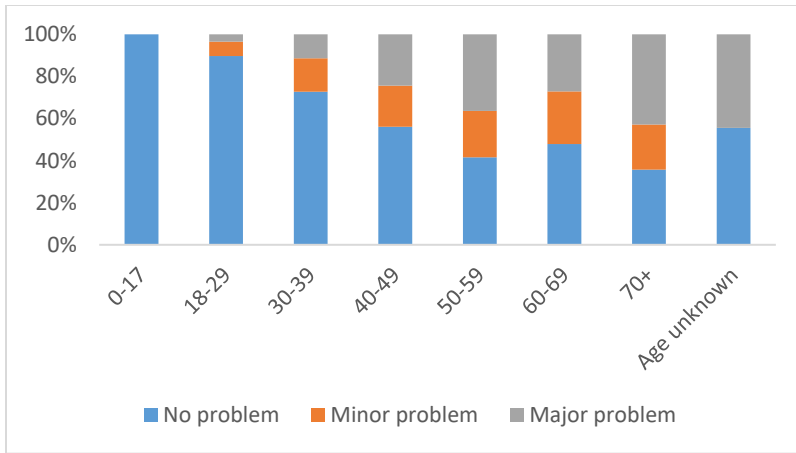


Figure 23: Reports of accidental falls causing injury as a problem in the last 12 months, by age

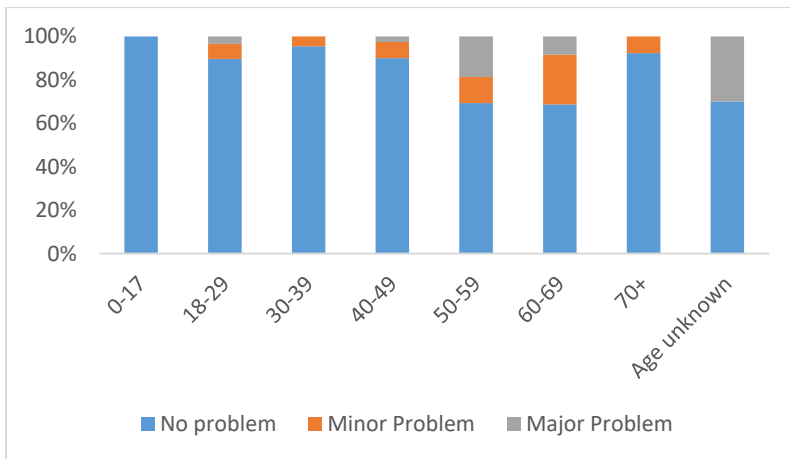
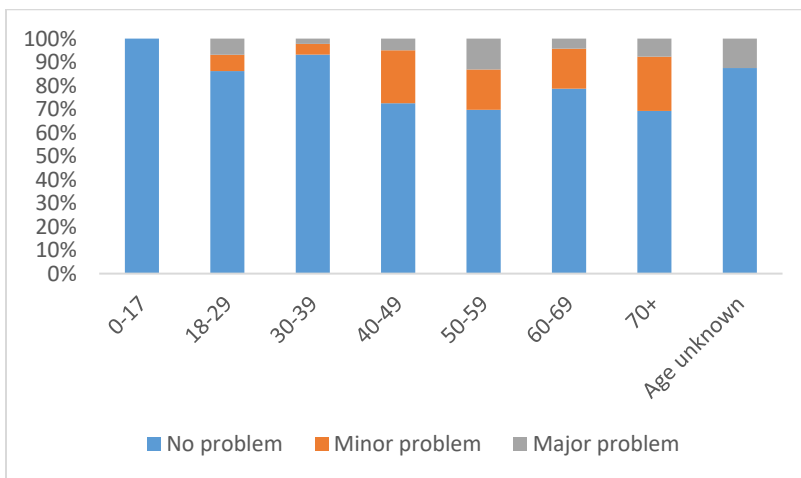


Figure 24: Reports of problems getting in and out of bed in the last 12 months, by age



Desired Discharge Location	Percentage of total homeless discharges
Medical Respite	14%
Short term SNF	14%
Long term placement (B&C/Assisted Living, Long term SNF)	46%
Mental Health/Substance Abuse	14%
Other (shelter, hospice)	13%

ACCESS TO CARE AND SERVICES

Unsheltered individuals experiencing homelessness tend to be frequent users of emergency services and often face significant barriers to receiving appropriate health care.¹⁴⁰ Among all 2019 Needs Assessment Survey respondents, 62% reported visiting the emergency room in the last year and 38% reported staying at a hospital for longer than one night in the last year. 65% also reported seeing a doctor or nurse for an outpatient visit in the last year, 38% reported going to therapy or counseling, and 28% reported seeing a dentist in the last year.

BARRIERS TO CARE

The 2017 HCH/FH Program Needs Assessment identified length of time to get an appointment, inability to afford healthcare bills, and a lack of insurance as significant barriers to care for people experiencing homelessness. In 2018, 27% (1,267) of HCH/FH patients experiencing homelessness were uninsured, and an additional 14% had an unknown insurance status. 2019 Needs Assessment Survey respondents had higher levels of insurance, with only 9% reporting having no insurance. However, among those respondents who provided a reason for not receiving outpatient care, 14% cited a lack of insurance. Additionally, a quarter (26%) of respondents who provided a reason for not receiving dental care named a lack of insurance or inability to afford the cost.

FOOD INSECURITY

As noted above, food security is a challenge for populations across SMC. A 2016 study in SMC found that 79% of people experiencing homelessness reported currently accessing free meals, and 59% used a food pantry.¹⁴¹ Among individuals surveyed in the 2019 PIT Count, 55% had accessed free meals and 41% were recipients of CalFresh.¹⁴² Among 2019 Needs Assessment Survey respondents, 9% reported feelings of hunger as a major problem in the last 12 months, and 20% named weight management/eating health as a major problem. As Figure 25 shows, feelings of hunger were a more significant problem for individuals who were unsheltered at the time of the survey.

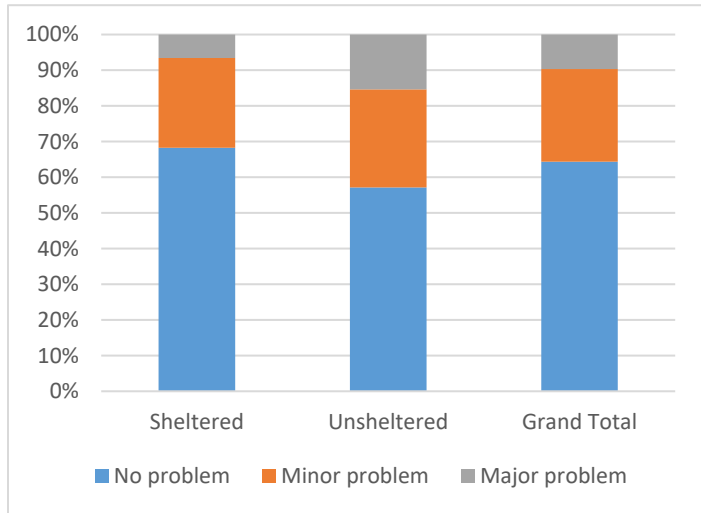


Figure 25: Reports of feelings of hunger as a problem in the last 12 months, by shelter status

HOMELESS SURVEY LIMITATIONS

Limitations to the 2019 Needs Assessment Survey homelessness data collection and analysis process are outlined below; the findings described above should be considered with these limitations in mind.

HOMELESS SURVEY LIMITATIONS

- Clients often filled out the survey themselves, which could mean they did not understand a question or did not answer all the questions. When someone else administered the survey to the client, Question 4 – which asks clients to rate about 15 health issues – was extremely tedious; HCH/FH staff were later told and witnessed themselves when administering surveys that the question led to administrator and client burn out.
- The survey is administered at places where individuals are already connected to some type of services, which may lead to bias in the responses. This was acceptable to the team because the purpose of the survey was to better understand homelessness and aging and to a lesser extend barriers to care. Still, this excludes homeless individuals who are likely the most difficult to connect to services.
- Survey administrators have been homeless providers for a long time and as much as possible ensured an individual only filled out one survey, but it is possible an individual filled out more than one survey, particularly if they moved between shelters during the time of survey administration.
- When breaking down survey data by age group and response categories, the sample sizes for analysis became small; they may not reflect the trends or breakdowns of a larger population.

- We do not have information on the extent to which survey respondents overlap with the population of people accessing services through HCH/FH or SMMC (and who are thus represented in UDS and claims data). This makes it difficult to draw conclusions from comparisons across the two data sources.

Conclusion Section

APPENDICES

- Homeless survey
- Farmworker survey
- Complete data tables

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To be finalized and formatted when content is finalized

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