HEALTH CARE FOR THE HOMELESS/FARMWORKER HEALTH PROGRAM (HCH/FH)
Co-Applicant Board Meeting
Puente de la Costa Sur, Pescadero
August 13, 2015, 9:30 A.M - 12:00 P.M.

AGENDA

A.	**CALL TO ORDER**	Robert Stebbins		**9:30 AM**
B.	**CLOSED SESSION**			
	1. No Closed Session this meeting			
C.	**PUBLIC COMMENT**			**9:32 AM**
	Persons wishing to address items on and off the agenda			
D.	**CONSENT AGENDA**			**9:35 AM**
	1. Meeting minutes from July 9, 2015		**TAB 1**	
	2. Program Calendar		**TAB 2**	
E.	**BOARD ORIENTATION**			
	1. No Board Orientation items this meeting.			
F.	**REGULAR AGENDA**			
	1. Ad Hoc Sub-Committee Reports	Committee Members		**9:40 AM**
	i. Transportation			
	ii. Health Navigation			
	iii. Board Composition			
	2. HCH/FH Program QI Committee Report	Frank Trinh	**TAB 3**	**9:45 AM**
	3. HCH/FH Program Director's Report	Jim Beaumont	**TAB 4**	**9:50 AM**
	4. HCH/FH Program Budget/Finance Report	Jim Beaumont	**TAB 5**	**10:00 AM**
	The documents for the following item will be available for review at the meeting. Time will be provided for review prior to consideration and action by the Board.			
	5. HCH/FH Program Clinical Guidelines	Jim Beaumont	**TAB 6**	**10:08 AM**
	iv. Action Item –Request to Approve Clinical Guidelines			
	6. HCH/FH Program RFP Discussion and Review	Jim/Linda	**TAB 7**	**10:15 AM**
	7. HCH/FH Program- SAC DRAFT Narrative Discussion	Jim Beaumont	**TAB 8**	**10:25 AM**
	8. Board review & approval of Program Services, Sites, Hours	Jim Beaumont	**TAB 9**	**10:35 AM**
	v. Action Item –Request to Approve Program Scope			
	9. HCH/FH Program – Dismantle former sub-committees	Jim Beaumont	**TAB 10**	**10:40 AM**
	vi. Action Item –Request to Approve dismantling of sub-committees			
	10. Contractors 2nd Quarter Report Updates	Linda Nguyen	**TAB 11**	**10:45 AM**
	11. UDS reports – Discussion on new population wide data	Linda Nguyen	**TAB 12**	**10:55 AM**
	12. HCH/FH Program – Discussion on clinic utilization	Jim Beaumont	**TAB 13**	**11:05 AM**
	13. Budget tool presentation ***Instructions given at meeting***	Jim Beaumont		**11:15 AM**
	14. Discussion with consultant	Pat Fairchild (by phone)		**11:20 AM**
	15. Consumer Input to Board	Linda and Others	**TAB 14**	**11:22 AM**
G.	**OTHER ITEMS**			
	1. Future meetings – every 2nd Thursday of the month (unless otherwise stated)			
	vii. Next Regular Meeting – September 10, 2015; 9:00 A.M. – 11:00 A.M. at Fair Oaks Clinic, Redwood City			
H.	**ADJOURNMENT**	Robert Stebbins		**11:30 AM**

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

TAB 1
Meeting Minutes
(Consent Agenda)

Healthcare for the Homeless/Farmworker Health Program
Co-Applicant Board Meeting Minutes
Thursday, July 9, 2015
Health System-2000 Alameda de las pulgas San Mateo

Co-Applicant Board Members Present	County Staff Present	Members of the Public
Robert Stebbins, Chair	Linda Nguyen, HCH/FH Program Coordinator	
Daniel Brown	Nirit Eriksson, County Counsel	
Brian Greenberg	Frank Trinh, HCH/FH Medical Director	
Paul Tunison	Gloria Gross, BHRS	
Kerry Lobel, Vice Chair	David McGrew, SMMC CFO	
Steve Carey		
Jim Beaumont, HCH/FH Program Director (Ex-Officio)		
Eric Brown		
Julia Wilson		

Absent: Kathryn Barrientos, Beth Falls, Tayischa Deldridge

ITEM	DISCUSSION/RECOMMENDATION	ACTION
Call To Order	Robert Stebbins called the meeting to order at 9A.M. Everyone present introduced themselves.	
Public Comment	No Public Comment at this meeting.	
Consent Agenda	All items on Consent Agenda (meeting minutes from and the Program Calendar) were approved. Please refer to TAB 1, 2	Consent Agenda was MOVED by Kerry SECONDED by, Paul Abstain- Dan and APPROVED by all Board members present.
Board Orientation:	No Board Orientation for this meeting.	
Regular Agenda: *Consumer Input*	Discussion on a patient experience from 2010-2011 with SMMC, regarding treatment of homeless patients and discharge from ER policies. If there is further interest in any of the workshop topics from 2015 NHCHC Conference please contact	

	Jim or Linda to prepare a presentation. Discussion on initial research of Health Care Literature that was provided from Health Plan of San Mateo. *Please refer to TAB 3 on the July 9 Board meeting packet.*	
Regular Agenda: Transportation *Sub-committee reports*	No report	
Patient Navigator Sub-committee reports	No report	
Board orientation Sub-committee reports	Conversation on current efforts to recruit Board members: Placed a call to recruit MSFW to a few organizations. Conversation on recruiting other municipality Board members. Jim suggested to the sub-committee members to come up with a policy of recruitment for future use as well.	Jim- to send out HRSA requirements on what sectors to recruit for Board membership to all Board Composition sub-committee members
Regular Agenda: HCH/FH Program *Director's Report*	Jim Beaumont (Dir) reported on program: Discussion on current grant conditions, as four conditions have not demonstrated compliance, and established new 60-day conditions for each of them. On June 29 a conference call was held with our HRSA Project Officer, Kathy Ruck, the HRSA Clinical Consultant, Dr. Mills, and program staff, the Board Chair and SMMC staff to address the four conditions and determine the specifics necessary to finish coming into compliance. Program staff will continue to work with SMMC staff and others to ensure that grant conditions are completed by deadline in August. The Management Analyst position has been posted on Tuesday and closing date is in 2 weeks. We hope to be able to hire by early August. Request to approve updated Program budget and discussion on Expanded Services is listed later in the agenda for approval and discussion. HRSA has confirmed Board TA for September 22-24, 2015 in regards to Governance (Board Authority) and Services (QI/QA Plan; Required and Additional Services; Staffing requirements) As 3 Board members will be unavailable for most or all of the days offered for TA because of a	

	religious holiday it was requested to inquire with HRSA alternative dates. Program staff has completed 2 Site visits thus far and hope to complete all by the summer. Program has continued moving forward in the efforts in strategic planning, potential service development reviews and automation tools for reporting/UDS/case management. *Please refer to TAB 4 on the July 9 Board meeting packet.*	Jim- to request HRSA alternative days for TA
Regular Agenda: HCH/FH Program *Budget & Financial Report*	A brief report was presented indicating: Currently underspending grant funds. *Documents available at Board meeting for review.*	
QI Committee Report ***Request to Approve HCH/FH Program QI Plan***	Dr. Frank Trinh, Medical Director for the HCH/FH Program gave an oral report on QI/QA Plan status: On June 29, 2015, the Program received a Technical Assistance Conference Call with our Project Officer and a HRSA clinical consultant. Based on that call, the feedback and comments from the recent Operational Site Visit and the recommendations of our consultants, the HCH/FH Program QI Plan has been redrafted. The plan is a required submission by August 16, 2015 on our 60-day implementation grant condition on Program Requirement #10 – Quality Improvement. Extensive discussion on the expanded plan to include multiple outcome measures for Medical Care and Enabling Services and full population data to be included in reports that will be analyzed by the QI Committee and reported back to the Board. Medicare Care outcome measures include: Tobacco cessation, Asthma, Coronary Artery Disease, Ischemic Vascular Disease, Diabetes (HgbA1c and perfect care), Hypertension, Mammogram, Pediatric Immunizations and Pediatric patients with Obesity. Enabling Service outcome includes new patients referred to Primary Care by Enabling Services that attend 2 or more Primary Care medical visits. Conversation on patient satisfaction survey timeline and suggestions to work with QI Committee to change the timeline and move up. **Action item: Request to Approve HCH/FH Program QI Plan** *Please refer to TAB 6, on the July 9 Board meeting packet.*	MOVED by Dan SECONDED by, Eric Abstain- Kerry and APPROVED by all Board members present.

Regular Agenda: *Discussion with SMMC CFO David McGrew*	SMMC CFO David McGrew gave a brief powerpoint presentation on what Boards should understand and information that they should be requesting to function effectively. Discussion on breaking down some of the costs to make it easier to understand the numbers that applies to HCH/FH program. David said that SMMC is working on a database that will later be able to break down the cost better. Request to provide financial documents that are prepared to the SMMC Board to the HCH/FH Board. Request to email powerpoint presentation to the Board.	Linda- email power point presentation to Board members.
Regular Agenda: *Request to Approve HCH/FH Program* – ***Request to Approved Updated Program Budget***	Based on the change in additional funding provided in NOA 14-12 as part of changing the extension of the Program's grant period to December 31. 2015, a new modified program budget is required to be submitted. The NOA placed a 30-day condition for submission of an updated Program Budget. That submission is due by July 11, 2015. *Please refer to TAB 7 on the Board meeting packet.* **Action Item- *Request to Approved Updated Program Budget***	MOVED by Kerry SECONDED by, Paul and APPROVED by remainder of Board members

Regular Agenda: *Board discussion- on available funds*	Discussion on the options for use in available funds include: Portal that is cloud based to be used for contractors for invoicing and possibly notes for case management. Options for Service Development include: Transportation, Health Navigator, Nutrition, Services for the street homeless with Companion Animals, Respite Care, Health Education and Street Services. Strategic Plan work will also be pursued with outside contractor to be completed by September. Staff is looking into Board training on topic of MSFW with outside contractors in East Bay. Kerry will forward some organizations she is familiar with that conducts training on MSFW such as Migrant Health Network. *Documents available at Board meeting for review.*	Board Members to give preference (4 out of 7) on Service Development options to Program staff. Kerry- email Jim on her contacts for training on MSFW.
Regular Agenda: *Board discussion- on available Expanded Services Grant funds*	Discussion on possible proposals include: 1. Nurse Practitioner to conduct street medicine along the coast in Pacifica to street homeless that are not currently seeking medical services and that have been identified by HOT (Homeless outreach team). 2. Nurse Practitioner to conduct street medicine along the coast in Puente to farmworkers that are not currently seeking medical services. 3. Expanding Vision Services along the Coast to Farmworkers, as that services is insufficient and in demand. Discussion on the general services that Mobile Van provides as not serving MSFW adequately. Other services that are lacking for MSFW include mental health and vision services. Some shelter staff utilizes the services of Costco to quickly obtain vision services/glasses for their homeless clients as it is an efficient process that can be completed in a few days. Majority of Board Members present favored the first two options to include in the Expanded Services Proposal for 2015. Proposal will be ready for review by the Board in a Special Meeting on July 17th to review and approve to submit for proposal for Expanded Services to HRSA by July 20th deadline.	Program staff will work with grant writer and others to complete proposal for Board review by July 17th approval.

	Please refer to TAB 8 on the Board meeting packet.	
Regular Agenda: Board discussion on *UDS reports*	*Tabled for next meeting* *Please refer to TAB 9 on the Board meeting packet.*	
Adjournment	Time 11:20 a.m.	Robert Stebbins

Healthcare for the Homeless/Farmworker Health Program (Program)
SPECIAL MEETING Co-Applicant Board Meeting Minutes
Thursday, July 17, 2015
SMMC

Co-Applicant Board Members Present
Robert Stebbins, Chair
Daniel Brown
Paul Tunison
Kerry Lobel, Vice Chair (conference call)
Jim Beaumont, HCH/FH Program Director (Ex-Officio)
Beth Falls
Tayischa Deldridge

County Staff Present
Linda Nguyen, HCH/FH Program Coordinator
Nirit Eriksson, County Counsel

Members of the Public

Absent: Kathryn Barrientos, Eric Brown, Steve Carey, Brian Greenberg, Julia Wilson

ITEM	DISCUSSION/RECOMMENDATION	ACTION
Call To Order	Robert Stebbins called the meeting to order at 9:09 A.M. Everyone present introduced themselves.	
Public Comment	No Public Comment at this meeting.	
Consent Agenda	No Consent agenda	
Board Orientation:	No Board Orientation for this meeting.	
Regular Agenda: **Request to Approve Expanded Services Grant Proposal**	Discussion of proposal: • Grant writer (Roger) worked with staff of Public Health Mobile Van (Anita and Frank) on details of the proposal. • Proposal comprises of a narrative and budget that includes a NP working with Homeless outreach teams (HOT) and Core Service Agencies (Pacific Resource Center and Puente de la Sur) to identify new homeless individuals and farmworkers that are currently not accessing SMMC services to perform Street/Field Medicine. • Anticipation of approval of ES proposal by September and start of contract by January 1, 2016 • Everyone is encouraged to attend the upcoming Street Medicine Symposium in San Jose to get familiar with Street Medicine in anticipation of the ES proposal.	Consent Agenda was MOVED by Dan Brown SECONDED by, Paul Tunison and APPROVED by all Board members present. Kerry Lobel approved via conference call.

	• Conversation regarding personnel costs. Questions raised : • Family NP to hire for proposal to see kids in the field as well as adults • What type of vehicle will be used in the field by NP • Funding to support staff (HOT and Puente) that will be supporting the outreach efforts of this ES proposal to recruit new homeless/farmworker patients. *Please see attached Proposal narrative and budget* **Request to Approve Expanded Services Grant Proposal** *Documents will be available at meeting for review before approval*	
Adjournment	Time __10:05 a.m._____	Robert Stebbins

TAB 2
Program Calendar
(Consent Agenda)

Health Care for the Homeless & Farmworker Health (HCH/FH) Program

2015 Calendar (*Revised August 2015*)

EVENT	DATE	NOTES
• Board Meeting (August 13, 2015 from 9:00 a.m. to 11:00 a.m.) • Board Review & Approval of Program Services, Sites and Hours • Board Approval of SAC submission • RFP distributed • Analysis of Needs Assessment	August	Board meeting at Puente- Pescadero PLEASE NOTE TIME CHANGE
• Board Meeting (September 10, 2015 from 9:00 a.m. to 11:00 a.m.) • Nominations for Chair & Vice-Chair • Review RFP proposals • TA with HRSA for Scope of Project (September 22 & 24)	September	Board meeting at Fair Oaks Clinic- RWC
• Board Meeting (October 8, 2015 from 9:00 a.m. to 11:00 a.m.) • Grant Year Budget Approval • Approval of RFP proposals • Election of Chair & Vice-Chair • International Street Medicine Symposium: Oct 14-17, San Jose	October	Board meeting at SMMC- San Mateo
• Board Meeting (November 12, 2015 from 9:00 a.m. to 11:00 a.m.) • Contracting , prepare for BOS	November	
• Board Meeting (December 10, 2015 from 9:00 a.m. to 11:00 a.m.) • Contracts needing approval for BOS submission	December	

Conference calendar	
2016 Western Forum for Migrant and Community Health	Feb 23-25, 2016; Portland,OR
National Health Care for the Homeless Council National Conference	May 31- June 3,2016; Portland. OR

TAB 3
QI Committee Report

DATE: August 13, 2015

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

SUBJECT: SAN MATEO COUNTY HCH/FH PROGRAM QI HGBA1C DIABETES OUTCOME MEASURES IN HOMELESS/FARMWORKER PATIENTS:REPORT OF INITIAL 2014 DATA

Demographic Data: Summary of Results

The 2014 HgbA1c Diabetes Outcome Measure data report included all homeless and farmworker patients diagnosed with Diabetes Mellitus who attended at least 2 visits within the San Mateo County Health System in 2014.

A total of 703 homeless and migrant seasonal farmworkers met these criteria (Appendix 1). Median age for the total population was 56 years, and 53.5% were female and 46.5% were male. Hispanic patients made up 45.8% of the total population, and the race breakdown was White 50.6%, Other/Over One Race 22.2%, Asian 13.8%, Black 7.1%, Pacific Islander 4.3%, and Native American 1.7%. Primary language for the total population was English 55.2%, Spanish 37.3%, and Other 7.5%.

Insurance and last clinic visit location data was also available for the total homeless and farmworker population (Appendix 2 and Appendix 3). The three most common insurance categories found in the total population were MediCal HPSM OP 39.3%, Ace County Fee Waiver 16.5%, MediCare Part B OP 12.4%. The top last clinic visit locations were Ron Robinson Senior Care Center 16.2%, Coastside Adult Clinic 11%, ICC Primary Care Clinic 9.1%, Fair Oaks South County Adult Clinic 7.1%, SSF Adult Clinic 4.7%, and Daly City Adult Clinic 4%.

Within the total population, 574 patients were homeless (Appendix 4). The further breakdown of homeless patients by living situation was Doubling Up 42.3%, Other 23.2%, Homeless Shelter 18.6%, Transitional 9.1%, and Street 6.8%. Homeless patients had a median age of 57 years with Female 51.9% and Male 48.1%. Homeless patients were 37.8% Hispanic and race breakdown was White 47.6%, Other/Over One Race 22%, Asian 15.3%, Black 8.4%, Pacific Islander 5.1%, and Native American 1.4%. Primary language for homeless patients was English 62.9%, Spanish 28.6%, and Other 8.5%.

Within the total population, 142 patients were migrant seasonal farmworkers (Appendix 5). Within this group, 14 patients were migrant farmworkers and 128 patients were seasonal farmworkers. Farmworker patients had a median age of 51 years with Female 61.3% and Male 38.7%. Farmworkers were 81% Hispanic and race breakdown was White 64.8%, Other/Over One Race 22.5%, Asian 7%, Native American 2.8%, Black 1.4%, and Pacific Islander 1.4%. Primary language for farmworkers was Spanish 76.1%, English 21.1%, and Other 2.8%.

Demographic Data: Analysis and Conclusions

The median age of the total homeless and farmworker population was 56 years, but differed between the two groups. The homeless patient group was older, with a median age of 57 years compared to 51 years for the

farmworker population. This result does support observations from HCH/FH Program-contracted homeless shelter staff and management that the homeless population is aging and older. In addition, the San Mateo County Primary Care Clinic with greatest representation in this database was the Ron Robinson Senior Care Center, which only serves patients >65 years.
The gender breakdown was approximately even for homeless patients, but was skewed towards more females in the farmworker population. The migrant seasonal farmworker population was comprised of 61.3% Female patients. One concern brought up by this result is whether farmworker Males are evenly engaged in care compared to farmworker Females. Farmworker family members, who are more likely to be female, may be accessing care at a higher rate than the farmworkers themselves, who are more likely to be male. Farmworker Males appear to be an important group to target with future expansion of HCH/FH Program services.
The other demographic data show expected differences between the homeless and farmworker groups. Compared to homeless patients, farmworker patients are more likely to be Hispanic and primarily Spanish-speaking. The farmworker group also has a higher predominance of White patients and fewer Black individuals.

HCH/FH Program HgbA1c Outcome Measure Data: SMMC Primary Care Comparator Data
The only comparator data for HgbA1c levels in the SMMC Primary Care System available to the HCH/FH QI Committee at this time comes from the Delivery System Reform Incentive Payment (DSRIP) Program. The 2014 DSRIP HgbA1c data only includes SMMC Primary Care patients with HgbA1c < 8%, which denotes adequate diabetic control. The rates of HgbA1c <8% among the various Primary Care Clinics range from 52% at Coastside Clinic to 64% at Ron Robinson Senior Care Center.

HCH/FH Program HgbA1c Outcome Measure Data: Results by Gender and Insurance Status
Among the total population of homeless and farmworker patients, Males had poorer diabetic control compared to Females (Appendix 6). A larger proportion of males had HgbA1c >9% (denoting poor diabetic control), 19.3% vs 13.8% in Females. Also, more males than females did not have a HgbA1c drawn in 2014, 21.7% vs 14.6%. The rates of good diabetic control, HgbA1c <8%, was lower in Males as well, 48.6% vs 63.6% in Females. Further analysis of the data will be needed to look for differences between homeless Males and Females and farmworker Males and Females. However, enough data exists pointing to homeless and farmworker Male diabetics being important target groups for the HCH/FH Program. Rates of adequate diabetic control (HgbA1c<8%) did not differ between the three most represented Insurance groups: MediCal HPSM OP (57.6%), Ace County Fee Waiver (58.6%), and Medicare Part B OP (62.1%) (Appendix 7).

HCH/FH Program HgbA1c Outcome Measure Data: Results in Homeless Patients
The homeless patient population was separated into the categories of Doubling Up, Homeless Shelter, Transitional, Street, and Other. The categories of Doubling Up, Homeless Shelter, and Street are self-explanatory. Transitional refers to transitional housing with wrap-around social services and Other refers to patients who left homelessness in 2014 or who were staying in Single Room Occupancies (SROs).
The data showed that as living situation became more unstable or closer to Street homelessness, diabetic control worsened (Appendix 8). Rates of HgbA1c<8% (adequate control) were highest in the Other (63.9%), Doubling Up (59.3%), and Homeless Shelter (50.5%) groups and were lowest in the Transitional (38.5%) and Street (35.9%) groups. In addition, the Street group had the highest rate of HgbA1c>9% (poor control) at 28.2% compared to the other four groups, which ranged from 14-17.8%. Finally, 19.5% of homeless diabetic patients did not have a HgbA1c drawn in 2014, with Transitional (36.5%), Street (28.2%), and Homeless Shelter (25.2%) making up the bulk of these patients. In comparison, far fewer Doubling Up and Other patients did not have a HgbA1c drawn in 2014, at 15.6% and 12.8%, respectively. The data point to the Street homeless especially as a target population for the HCH/FH Program given their high risk for significant morbidity and mortality from their Diabetes Mellitus. Homeless patients in the Transitional group also showed poor diabetic control. However, further characterization of what living situations comprise Transitional housing will be required before further analysis of this result can be done.

HCH/FH Program HgbA1c Outcome Measure Data: Results in Migrant Seasonal Farmworker Patients

The migrant seasonal farmworker population in the database was comprised mostly of seasonal farmworkers. Seasonal farmworkers made up 128 of the 142 total farmworkers.

Overall, the migrant seasonal farmworkers in the database had better diabetic control compared to the homeless population (Appendix 9). HgbA1c<8% (adequate control) was achieved in 71.4% of migrant and 60.9% of seasonal farmworkers. HgbA1c>9% (poor control) was found in 7.1% of migrant and 21.9% of seasonal farmworkers. Overall, 10.6% of migrant seasonal farmworkers did not have a HgbA1c drawn in 2014, which broke down to 21.4% of migrant and 9.4% of seasonal farmworkers. Further evaluation of the migrant seasonal farmworker population is needed to look for any differences in diabetic control in various subsets of farmworker patients, such as Male and Female patients.

Initial Target Diabetic Homeless and Farmworker Populations Identified and Current Expansion of HCH/FH Program Services

Several diabetic homeless and farmworker populations warrant further attention by the HCH/FH Program. The target groups are Male homeless, Male farmworker, and Street homeless diabetics. These groups of patients may not be accessing care enough, such as Male farmworkers, or are not receiving adequate care resulting in poor diabetic control, such as Male homeless/farmworker and Street homeless diabetics. Further assessment by the HCH/FH Program QI Committee will need to be done to identify barriers to adequate diabetic care for these target groups. In addition, further analysis of the HgbA1c database will be needed to identify other potential target populations for the program. The current proposed expansion of HCH/FH Program services involves development of a "Street and Field Medicine" Team that will deliver medical and enabling services care to Street homeless and farmworker individuals not accessing care. Working together with HCH/FH Program Enabling Services Agencies and the San Mateo County Health System, the "Street and Field Medicine" team will find these individuals and deliver care and services right where they are living (on the streets and in homes) and working (on the farms). The goal of this initiative is to increase outreach and care to the target populations identified in this report in order to improve their general health and well-being.

Attachments: Appendix1-8

Appendix 1. Demographic Data for Total Homeless and Farmworker Diabetic Population

Population =703	Range 17-74
median age	56
mean age (avg)	54.7

Race		
Black	50	7.1%
White	356	50.6%
Other/Over One Race	156	22.2%
Asian	97	13.8%
Unknown/Declined	1	0.1%
Pacific Islander	30	4.3%
Native American	12	1.7%
Hawaiian/Alaskan	1	0.1%

Hispanic		
Yes	322	45.8%
No	377	53.6%
Unknown	4	0.6%

Female	376	53.5%
Male	327	46.5%

Language		
ENG	388	55.2%
SPA	262	37.3%
other	53	7.5%

Appendix 2. Insurance Data for Total Homeless and Farmworker Diabetic Population

INSURANCE		
C20 - Medi-Cal Hpsm Op	276	39.3%
W22 - Ace County Fee Waiver	116	16.5%
M20 - Medicare Part B Op	87	12.4%
H20 - Hpsm Op Care Advantage	68	9.7%
C72 - Mcal Fqhc Full Scope	49	7.0%
W10 - Ace County	22	3.1%
E01 - Public Health Svs	20	2.8%
H24 - Hpsm Op Care Adv Cmc	14	2.0%
C74 - Mcal Hosp Pe	8	1.1%
G95 - Cdp	8	1.1%
E25 - Discounted Hlth	6	0.9%
F75 - Self Pay No Pt F/U	5	0.7%
C30 - Medi-Cal Hpsm Soc	3	0.4%
C80 - Medi-Cal Non Co W/Php	3	0.4%
C84 - Mcal Hpe/Fqhc	2	0.3%
O97 - Healthworx	2	0.3%
U15 - Referred To Medi-Cal	2	0.3%
W60 - Ace County Temporary	2	0.3%
C71 - Mcal Op Full Scope	1	0.1%
F19 - Self Pay	1	0.1%
G86 - Delta Dntl Kids/Fmly	1	0.1%
G90 - Pact	1	0.1%
H44 - Hpsm Ip Care Adv Cmc	1	0.1%
I50 - Blue Shield	1	0.1%
J10 - Sheriff-Medical Jail	1	0.1%
K05 - Worker'S Comp Non Co	1	0.1%
O00 - Ryan White	1	0.1%
Z60 - Ace	1	0.1%

Appendix 3. Last San Mateo County Health System Clinic Visit Data for Total Homeless/Farmworker Diabetic Pop.

LAST CLINIC VISIT		
SCC - Senior Care Center	114	16.2%
COA - Coastside Adult	77	11.0%
PCC - Primary Care Clinic	64	9.1%
SOA - South County Adult	50	7.1%
SSFA - Ssfa - Adult	33	4.7%
NCA - Daly City Clinic - Adult	28	4.0%
CAR - Cardiology	23	3.3%
EYE - Eye Clinic	21	3.0%
SCMH - South County Mh Pc	21	3.0%
PRC - Public Health Redwood City	20	2.8%
PSF - Public Health So SF	20	2.8%
SUR - Surgery	19	2.7%
SOPT - South County Optometry	16	2.3%
PSM - Public Health San Mateo	14	2.0%
GYN - Gynecology	12	1.7%
URO - Urology	11	1.6%
EDI - Edison Clinic	10	1.4%
COOB - Coastside Obstetrics	9	1.3%
MDC - Mobile Dental Clinic	9	1.3%
MPC - Main Campus Mp Pc	9	1.3%
SOD - South County Dental	8	1.1%
NEPH - Nephrology	7	1.0%
RHS - Rehab Services	7	1.0%

Appendix 4. Demographic Data for Homeless Diabetic Population

H- Homeless Shelter	107	18.6%
S- Street	39	6.8%
T- Transitional	52	9.1%
O- Other	133	23.2%
D- Doubling up	243	42.3%
subtotal	574	81.7%

Age (17-74)	
Median	57
Mean/avg	56.0

Gender		
Male	276	48.1%
Female	298	51.9%
	574	

Race		
Black	48	8.4%
White	273	47.6%
Other/Over One Race	126	22.0%
Asian	88	15.3%
Unknown/Declined	1	0.2%
Pacific Islander	29	5.1%
Native American	8	1.4%
Hawaiian/Alaskan	1	0.2%
	574	

Hispanic		
Yes	**217**	37.8%
No	**353**	61.5%
Unknown	**4**	0.7%
	574	

Language		
English	361	62.9%
Spanish	164	28.6%
other	49	8.5%
	574	

Appendix 5. Demographic Data for Migrant Seasonal Farmworker Diabetic Population

Age (20-72)	
Median	51
Mean/avg	49.2

Seasonal	128	90.1%
Migrant	14	9.9%
subtotal	142	20.2%

Race		
Black	2	1.4%
White	92	64.8%
Other/Over One Race	32	22.5%
Asian	10	7.0%
Unknown/Declined	0	0.0%
Pacific Islander	2	1.4%
Native American	4	2.8%
Hawaiian/Alaskan	0	0.0%
	142	

Gender		
Male	55	38.7%
Female	87	61.3%
	142	

Hispanic		
Yes	115	81.0%
No	27	19.0%
Unknown	0	0.0%
	142	

Language		
English	**30**	21.1%
Spanish	**108**	76.1%
other	**4**	2.8%
	142	

Appendix 6. HgbA1c Data for Total Homeless and Farmworker Diabetic Population by Gender

BY GENDER—POPULATION 703

	Total		No test		>9.0		Total No test & >9.0		Total <9.0		<8.0		>7.9<9.0	
Male	327 | 46.5%		71	21.7%	63	19.3%	134	41.0%	193	59.0%	159	48.6%	34	10.4%
Female	376 | 53/5%		55	14.6%	52	13.8%	107	28.5%	269	71.5%	239	63.6%	30	8.0%
	703		126	17.9%	115	16.4%	241	34.3%	462	65.7%	398	56.6%	64	9.1%

Overall-age	
median	56
mean/avg	54.7

Male- age	
median	55
mean/avg	54.4

Female- age	
median	57
mean/avg	55.0

Appendix 7. HgbA1c Data for Total Homeless and Farmworker Diabetic Population by Insurance

BY INSURANCE

INSURANCE TYPE	No Test		>9.0		Total No test & >9.0		total <9.0		<8.0		>7.9<9.0	
C20- Medi-Cal Hpsm Op	42	15.2%	51	18.5%	93	33.7%	183	66.3%	159	57.6%	24	8.7%
W22- Ace County Fee Waiver	11	9.5%	25	21.6%	36	31.0%	80	69.0%	68	58.6%	12	10.3%
M20- Medicare Part B Op	21	24.1%	7	8.0%	28	32.2%	59	67.8%	54	62.1%	5	5.7%

Appendix 8. HgbA1c Data for Total Homeless Diabetic Population

HOMELESS (POPULATION 574)

	Total	No test		>9.0		Total no test & >9.0		Total <9.0		<8.0		>7.9<9.0	
D- Doubling up	243	38	15.6%	34	14.0%	72	29.6%	171	70.4%	144	59.3%	27	11.1%
H- Homeless Shelter	107	27	25.2%	19	17.8%	46	43.0%	61	57.0%	54	50.5%	7	6.5%
O- Other	133	17	12.8%	19	14.3%	36	27.1%	97	72.9%	85	63.9%	12	9.0%
S- Street	39	11	28.2%	11	28.2%	22	56.4%	17	43.6%	14	35.9%	3	7.7%
T- Transitional	52	19	36.5%	8	15.4%	27	51.9%	25	48.1%	20	38.5%	5	9.6%
	574	112	19.5%	91	15.9%	203	35.4%	371	64.6%	317	55.2%	54	9.4%

Appendix 9. HgbA1c Data for Total Farmworker Diabetic Population

MIGRANT/SEASONAL FARMWORKERS (POPULATION 142)

	Total	No test		>9.0		Total No test & >9.0		Total <9.0		<8.0		>7.9<9.0	
Migrant	14	3	21.4%	1	7.1%	4	28.6%	10	71.4%	10	71.4%	0	0.0%
Seasonal	128	12	9.4%	28	21.9%	40	31.3%	88	68.8%	78	60.9%	10	7.8%
	142	15	10.6%	29	20.4%	44	31.0%	98	69.0%	88	62.0%	10	7.0%

TAB 4
Director's Report

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: August 13, 2015

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

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: DIRECTOR'S REPORT

Program activity update since the July 9, 2015 Co-Applicant Board meeting:

1. Grant Conditions

   On June 17th we received NOA 14-13 which identified the previous 120-day Implementation submissions on the four current outstanding grant conditions to not have demonstrated compliance, and established new 60-day conditions for each of them. The submission date for each is on August 16, 2015.

   An outline of where we stand with each condition will be provided as part of the Seven-Day Update.

2. NOA 14-04 Additional Funding from Grant Period Extension

   On August 6, 2015, we received NOA 14-14 date 08/05/15. This NOA provided additional funding as an adjustment to account fully for previous supplemental awards. The additional funds totaled $30,517.00 and bring our authorized funding level for Grant Year 2015 – through December 31, 2015 – to $2,404,112.00 .

3. Operational Site Visit (OSV)

   At this time we have not yet received the Report from the Program's March 10-12, 2015 OSV. We have not received any recent updates on the status of the report.

4. Management Analyst Position

The Management Analyst position was announced on Tuesday, July 7, 2015 as an Associate Management Analyst/Management Analyst – Limited Term recruitment. The recruitment closed on July 21, 2015. There were 16 applications received. The applications have been reviewed and seven candidates are in the process of being invited for an interview. We are on track to fill the position by/around the end of the month.

5. Expanded Services Award Opportunity

As approved by the Board at its July 17, 2015 Special meeting, on July 17, 2015 the program's Expanded Services funding request for $246,642 was submitted to HRSA. The award announcement is expected to be made in September.

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

HRSA has confirmed the Board TA for September 22-24, 2015. They have indicated two areas for the TA: Governance (Board Authority) and Services (QI/QA Plan; Required and Additional Services; Staffing Requirements). The consultants are scheduled to be Larry Peaco and Candace Chitty respectively.

As noted at the last Board meeting, some conflicts have been identified for the scheduled dates. On discussion with HRSA, when we receive the formal announcement of the TA it represents that a contract has been executed for the TA. There is no adjustment available short of cancelling the TA and beginning the process of identifying availability of consultants and dates again.

At the last Board meeting we requested the Board members identify those times/dates that were in conflict for the currently scheduled TA and what other availability they had. We received one response. Based on that response, we have left the TA as scheduled and will attempt to work around the identified conflicts.

We also have been contacted by our Project Officer on Board and staff availability for a pre-TA session from the Board Authority consultant. We received only two responses to our request for information on Board members' availability. However, our Project Officer is attempting to determine if the information intended for the pre-TA session can be recorded and reviewed when the Board is available.

7. Seven Day Update

TAB 5
Budget/Finance Report

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: August 13, 2015

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

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: DIRECTOR'S REPORT

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7. Seven Day Update

Details for budget estimates	Budget	To Date (07/31/15)	Projection for GY (+~22 wks)		Projected for GY 2016	
Salaries						
Director					134,000	
Program Coordinator					87,538	
Medical Director					53,944	
Management Analyst					91,118	
new position, misc. OT, other, etc.				new	90,687	If Added
	319,778	188,736	329,736		457,287	
Benefits						
Director					75,991	
Program Coordinator					49,643	
Medical Director					30,592	
Management Analyst					51,673	
new position, misc. OT, other, etc.				new	51,429	If Added
	190,426	90,359	166,350		259,327	
Travel						
National Conferences (1500*2*2)		3,167	5,000		6,000	
Regional Conferences (600*2)		0	1,200		1,200	
Local Travel		360	800		800	
Taxis		1,616	2,900		4,000	
Van		1,477	1,600			
	12,833	6,620	11,500		12,000	
Supplies						
Office Supplies, misc.	5,833	5,833	9,000		2,500	
	5,833	5,833	9,000		2,500	
Contractual						
Current SMMC Clinic commitment (to 06/30)	407,713	407,713	407,713		-	
Current 2015 contracts	823,083	499,164	785,000		705,500	
Est available (for 07/01 on or otherwise)	327,705					
	1,558,501	906,877	1,192,713		705,500	
Other						
Consultants/grant writer	44,500	22,142	145,000		50,000	
IT/Telcom	15,000	4,927	10,000		12,000	
Memberships	5,000	0	5,000		5,000	
Training	2,000	100	2,000		2,000	
	30,517					
	97,017	27,169	162,000		69,000	
TOTALS - Base Grant	2,184,388	1,225,594	1,871,299		1,505,614	
Expanded Servcies Grant	219,724	77,500	219,724		219,724	
					245,000	
HCH/FH PROGRAM TOTAL	2,404,112	1,303,094	2,091,023		1,970,338	
PROJECTED AVAILABLE BASE GRANT			313,089		555,053	

NOTE:
Former Full Annual SMMC Clinic Funding = $611,570

based on est. grant of $2,060,677

TAB 6
Request for Board to Approve Clinical Guidelines

Documents will be available at meeting for review prior to consideration.

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: August 13, 2015

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

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: REQUEST FOR THE BOARD TO TAKE ACTION TO APPROVE CLINICAL GUIDELINES, DIRECT ESTABLISHMENT OF A MINIMUM SET OF TWELVE (12) CONDITIONS CONSIDERED COMMON AND CHRONIC IN THE HCH/FH TARGET POPULATIONS, AND DIRECT THE HCH/FH MEDICAL DIRECTOR TO ENGAGE SMMC CLINICAL LEADERSHIP IN THE ESTABLISHMENT OF GUIDELINES FOR ANY CONDITIONS INCLUDED AMONG THE TWELVE FOR WHICH HCH/FH CLINICAL GUIDELINES DO NOT EXIST

As part of a Quality Improvement Program, it is necessary to have activity guidelines intended to provide quality performance and against which improvements can be targeted. These further provide the cornerstone for addressing health disparities in target populations.

As part of the Co-Applicant Board's responsibilities in establishing a Quality Improvement Program, the Board is responsible to establish the clinical guidelines for the care of the homeless and farmworker populations. In working with the clinical management staff from SMMC Ambulatory Services, they have developed a set of guidelines for numerous conditions, many commonly seen in our target populations. These guidelines will inform and guide the delivery of services to the homeless and farmworker populations for these conditions.

While not necessarily all-encompassing, these guidelines do provide an excellent starting point within the framework of the HCH/FH QI Program. It represents the beginning of the process in working with SMMC clinical leadership in ensuring the best possible care for our target populations. Program is strongly recommending the approval of these guidelines as the current HCH/FH Clinical Guidelines for the specified services for the HCH/FH target populations.

Further, to ensure that the HCH/FH target populations receive the requisite quality care for those conditions that are most common and chronic amongst the populations, this action directs the HCH/FH Medical Director to develop, through and with the HCH/FH Quality

Improvement Committee, a list of a minimum of twelve (12) conditions determined to be most common and chronic among the HCH/FH populations, and to engage the SMMC Clinical Leadership on establishing clinical guidelines for any of those conditions for which HCH/FH approved guidelines do not exist.

This request is for the Board to approve the attached clinical guidelines as the HCH/FH Clinical Guidelines for the conditions specified in the guidelines. It further directs the HCH/FH Medical Director to develop a list of at least twelve (12) common and chronic conditions for the HCH/FH target populations, and to engage the SMMC Clinical Leadership on the development of guidelines where there are no current HCH/FH approved guidelines. Approval of this item requires a majority vote of the Board members present.

Attachments:
SMMC Clinical Guidelines List

San Mateo Medical Center

Clinical Guidelines

As listed on the SMMC Intranet August 10, 2015.

CLINICAL GUIDELINES AND ALGORITHMS

Aminoglycoside Guidelines
Antibiogram 2014
Antibiotics Treatment Guidelines
Asthma Care NHLBI
Community Acquired Pneumonia Treatment Guidelines
Controlled Medication Prescribing Guidelines
Diabetes Basic Care Guidelines
Diabetes Medication Algorithm
Fracture Risk Assessment Tool
HTN JNC8 Medication Algorithm
Immunization Guidelines: Adults
Immunization Guidelines: Children and Adolescents
Primary Prevention Guidelines: Adult
Primary Prevention Pediatric Periodicity Guidelines
Smoking Cessation Guidelines
Specialty Referral Guidelines
Vancomycin Dosing Guidelines

In addition, the SMMC Intranet provides links to the following additional guidance and resources for topics for which there is not a single consensus organizational document.

ONLINE MEDICAL REFERENCES
Up To Date online
PsychiatryOnline
EBSCOhost
First Consult
DSM-V
JAMA
Medical Letter
New England Journal of Medicine
Pediatrics in Review (AAP)
Red Book

TAB 7
RFP Discussion and Review

REQUEST FOR PROPOSALS NO.

Primary Care, Dental Care, Behavioral Health/Mental Health/Substance Abuse Services, Health Enabling Services, and Coordinating/Program Support Services [Fixed Site, Mobile and/or Portable]

County of San Mateo, Health System

San Mateo Medical Center
Health Care for the Homeless/ Farmworker Health Program

Date: August 14, 2015

Responses Must be Received by 1:00 p.m. on September 25, 2015

REQUEST FOR PROPOSALS
FOR
Primary Care,
Dental Care,
Behavioral Health/Mental Health/Substance Abuse Services,
Health Enabling Services. and
Coordinating/Program Support Services
[Fixed Site, Mobile and/or Portable]

Proposals must be submitted to:

San Mateo Medical Center
Materials Management
Attn: Ron Keating
222 W. 39th Avenue
San Mateo, CA 94403

By 1:00 P.M. Pacific on

September 25, 2015

PROPOSALS WILL NOT BE ACCEPTED AFTER THIS DATE AND TIME

Note regarding the Public Records Act:

Government Code Sections 6550 *et seq.*, the California Public Record Act, defines a public record as any writing containing information relating to the conduct of the public business. The Public Record Act provides that public records shall be disclosed upon written request and that any citizen has a right to inspect any public record unless the document is exempted from disclosure.

Be advised that any contract that eventually arises from this Request For Proposals is a public record in its entirety. Also, all information submitted in response to this Request For Proposals is itself a public record **without exception**. Submission of any materials in response to this Request For Proposals constitutes a waiver by the submitting party of any claim that the information is protected from disclosure. By submitting materials, (1) you are consenting to release of such materials by the County if requested under the Public Records Act without further notice to you and (2) you agree to indemnify and hold harmless the County for release of such information.

(RFP template rev. 8/15)

TABLE OF CONTENTS

Enclosure 2. Standard County Agreement – Attachment I: Assurance of Compliance with Section 504 of the Rehabilitation Act of 1973, as Amended

Enclosure 3. Equal Benefits Program – Frequently Asked Questions

Enclosure 4. Exhibit E - Corporate Compliance Code of Conduct

Enclosure 5. Chapters 2.84 and 2.85 of the Ordinance Code of San Mateo County

Enclosure 6. HIPPA Requirements

SECTION I - GENERAL INFORMATION

STATEMENT OF INTENT

As outlined in more detail in Section IV, below, this Request for Proposals (RFP) seeks providers to deliver health and health related services to the homeless and farmworker populations of San Mateo County. The target commencement date for services under agreements fostered by this RFP is January 1, 2016, with a term of from one (1) to three (3) years, subject to negotiation and funding availability.

Services for which proposals will be accepted are:

- primary health care services
- dental health care services
- substance abuse/mental health/behavioral health services
- health enabling services (see Section IV.2.C for enabling services definitions)
- coordinating and program support services

All services may be proposed for fixed site, mobile or portable delivery.

San Mateo Medical Center

San Mateo Medical Center (SMMC) is a fully accredited **509**-bed acute and long term care facility which provides emergency, acute medical/surgical, psychiatric patient services and a full range of outpatient services to all San Mateo County residents.

SMMC manages and maintains:

- Outpatient clinics throughout San Mateo County
- Long Term Care unit on-site
- Relationships with approximately **175** physicians
- More than **1,200** employees

BACKGROUND

Overview of the Health Care for the Homeless/Farmworker Health Program

SMMC's Health Care for the Homeless/Farmworker Health Program (HCH/FH Program) has delivered and coordinated health care and support services for homeless individuals and families since 1991 and for farmworkers and their families since 2010. Funds provided by the U.S. Department of Health and Human Services, Health Services and Resources Administration, Bureau of Primary Health Care support a comprehensive range of primary and preventive medical care, dental care, substance abuse and mental health services, health education, outreach, eligibility, health navigation, care coordination/case management and other health enabling services for homeless and farmworker individuals and their families.

Under HRSA guidelines, a farmworker is an individual whose principal employment is in agriculture on a seasonal basis, or for whom such work was their principal source of income within the past 24 months, as well as their dependents.

Under HRSA guidelines, a homeless individual is defined as a person with no fixed address living on the street, in shelters, transitional housing, abandoned housing, a vehicle, or other non-permanent situation, including "doubling up" with a series of friends or extended family members.

(Please see Section IV.1.A, for more information on the definitions of the homeless and farmworkers.)

Although homeless and farmworker programs have much in common with services offered by other community-based health care providers serving underserved populations, the homeless and farmworker population is markedly different.

People who are homeless suffer from health care problems at more than double the rate of individuals with stable housing. This is exacerbated by the multiple barriers they experience in trying to access mainstream health care, including a lack of transportation and limited hours of service. When people who are homeless do attempt to access services, they often do not have the financial resources (health insurance, Medicaid, etc.) to pay for care. In addition, many have significant mental health and/or substance abuse problems, for which needed treatment services are unavailable from traditional providers. As a result, the homeless individual can become increasingly disenfranchised from mainstream services and become frequently distrustful of traditional health care and social service systems. **(Source: Bureau of Primary Health Care Center)**

Farmworkers may suffer more frequent injuries or other health problems due to the nature of their work (respiratory, eye, and skin disorders, urinary tract infections, dehydration, heat stroke), and may face cultural or language barriers in efforts to access care. According to the National Center for Farmworker Health Inc., there are many barriers that prevent farmworkers from obtaining health care such as cost, lack of medical facilities or transportation near their work site, being unaware of social service programs for which they may be eligible, disqualification from benefits because of documentation status, and loss of a day's wage (no sick leave in farm work). Depression is common among farmworker adults where it is often related to isolation, economic hardship, and weather conditions. In addition, poverty, stress, mobility, hard labor, substandard and overcrowded living conditions, physical discomfort and lack of recreation make farmworkers vulnerable to high risk behavior activities, such as substance abuse, which can lead to an increased risk for HIV and sexually transmitted diseases. The constant struggle to secure the basic necessities of life often causes farmworkers to forsake attention to their personal health. **(Source: National Center for Farmworker Health Inc.)**

HCH/FH funding is intended to improve health status and outcomes for homeless and farmworker individuals and their families by improving access to primary health care, dental health care, and behavioral health care services, and through the provision of health enabling services.

The main purpose of the HCH/FH Program is to outreach to individuals who are homeless and/or are farmworkers and then provide targeted, flexible and accessible services that are

designed to improve their overall health. Those programs that receive HCH/FH funding must seek ways to create new approaches to delivering comprehensive services, linking providers through collaboration, decreasing fragmentation of services, and advocating on behalf of the homeless and farmworker populations. The HCH/FH Program seeks to fund organizations that collaborate with other agencies that also provide services to homeless and farmworker individuals and their families that will result in a comprehensive and integrated system of care.

HCH/FH Program Mission, Vision, Values

Health Care for the Homeless/Farmworker Health Mission

The mission of the HCH/FH Program is to serve homeless and farmworker individuals and families by providing access to comprehensive health care, in particular, primary health care, dental health care, and behavior health services in a supportive, welcoming, and accessible environment.

Health Care for the Homeless/Farmworker Health Vision

- The HCH/FH Program provides services that are patient centered and utilize a harm reduction model that meets patients where they are in their progress towards their goals.
- The HCH/FH Program lessens the barriers that homeless and/or farmworker individuals and their families may encounter when they try to access care.
- The HCH/FH Program provides health services in consistent, accessible locations where the homeless and farmworkers can receive timely care and have their immediate needs addressed in a supportive, respectful environment
- Through its services, the HCH/FH Program reduces the health care disparities in the homeless and farmworker populations.

Health Care for the Homeless/Farmworker Health Values

1. ACCESS: Homeless and farmworker individuals and their families have full access to the continuum of health care and social services.
2. DIGNITY: The services provided by the HCH/FH Program are respectful, culturally competent and treat the whole person's physical health and behavioral health.
3. INTEGRITY: Homeless and farmworker individuals and their families are valued and considered a partner in making decision regarding their health care.
4. INNOVATION: Services provided by the HCH/FH Program will be targeted to respond to the needs of the homeless and farmworker individuals and their families with the outcome of making these individuals healthier and their lives more stable.

THE REQUEST FOR PROPOSALS PROCESS

This RFP seeks the submission of proposals to provide services from any and all interested and qualified proposers. The HCH/FH Program, which is a program of the County of San Mateo, seeks by way of this RFP to obtain the listed services in a manner that maximizes the quality of services while also maximizing value to the County and, by extension, the citizens of the County. Proposers must show that they are capable of performing the services

requested. Such evidence includes, but is not limited to, the respondent's demonstrated competency and experience in delivering services of a similar scope and type and local availability of the proposer's personnel and equipment resources.

Eligibility

The proposer must meet the following general program requirements:

A. Be a non-profit service provider, as determined by the U.S. Internal Revenue Service, and/or a public agency or program;
B. For those programs including the homeless in their services target population(s), at least 75% of the homeless population served through these contract funds should reside in a shelter program, a transitional housing program, and/or on the “streets” of San Mateo County;
C. The proposer and any proposed subcontractor must have a minimum of one-years’ experience providing the services to the homeless or to farmworkers and their families in the relevant program area(s), or otherwise demonstrate competence to perform the planned new services;
D. Provide comprehensive primary health care, and/or dental health care, and/or substance abuse/mental health /behavioral health care, and/or health enabling services either through the proposer’s own program and/or through formal collaborations with other programs that serve the specified population(s), or provide services benefiting the support and coordination of the above services;
E. Have the ability to provide accessible and flexible services that are targeted to meet the needs of homeless or farmworker individuals and their families; and
F. The proposer, proposer staff and/or any subcontractor proposing to provide primary medical care and/or dental care services and/or substance abuse/mental health/behavioral health care must be licensed as appropriate by the State of California or designated as the County Health Department.

SECTION II - RFP PROCEDURE

This section describes the general RFP procedure used by the Department, and the remaining sections of this RFP list detailed requirements.

A. TENTATIVE SCHEDULE OF EVENTS

EVENT	TARGET DATE
RFP Release	August 14, 2015
Deadline to submit Written Questions	September 4, 2015
RFP Response Workshop	September 4, 2015
Release of Response to Written Questions	September 11, 2015
Proposal Deadline – Proposals Must be RECEIVED by 1:00 p.m. on this date	**September 25, 2015**
Proposal Evaluation	September 29- October 2
Contract Negotiations	October 2015
Initiate Contract/MOU Approval Process	October 2015
Contracts to HCH/FH Co-Applicant Board for Approval	November 12, 2015
Contracts to San Mateo County Board of Supervisors for Approval (as necessary)	December 15, 2015
New Contracts Begin	January 1, 2016

B. SUBMISSION OF PROPOSALS

Response Workshop: Proposers are encouraged and advised to attend the Response Workshop on September 4, 2015 from 10:00 AM – 12:00 Noon in Education Classroom 1 at San Mateo Medical Center (Administration Wing), located at 222 W. 39th Ave., San Mateo, California. Questions regarding the RFP process will be answered and guidelines for preparing the proposals will be discussed. Questions regarding the RFP process will also be accepted in writing by close of business on Friday, October 4, 2013 and can be submitted by email to rkeating@smcgov.org. Written responses to all questions submitted in writing and discussed at the Response Workshop will be available/released by close of business September 11, 2015. Note that this is not a proposal writing workshop. The intent is to answer questions and provide clarification on this RFP, not to train on proposal writing.

Proposal: One (1) original in hardcopy format and one electronic copy (in PDF or Word/Excel format provided on CD or USB media) **must be received and date stamped by the Department no later than 1:00 p.m. on September 25, 2015** as listed in the TENTATIVE SCHEDULE OF EVENTS above. Proposals should be in the format required in Section V.A, below. There will be no public opening of proposals. All proposals shall be firm offers, and will so be considered by the County, although the County reserves the right to negotiate terms upon evaluation of the proposals. Proposals will be considered valid offers for a period of ninety (90) days following the close of the RFP.

Conditions Accepted by Proposers:

- The proposer agrees to provide to the HCH/FH Program any information requested to assist in the evaluation of the proposal.
- All proposals will remain the property of San Mateo County and will be maintained on file. The County may, at its discretion, use any idea presented in a proposal without liability or obligation to any of the proposers.
- The County, SMMC or the HCH/FH Program may reject all or part of any proposal and may reject all proposals if it deems that no suitable response has been submitted or that no suitable proposer has responded.
- The projected HCH/FH annual funding is conditional and subject to change depending on funding resources.
- The proposal(s) selected for funding will become part of a contract or Memorandum of Understanding which will be the basis for payment, monitoring performance and compliance.
- Proposals will be stored unopened in a secure location at the Medical Center until the due date, when they will be opened, reviewed for completeness and compliance and then distributed for evaluation.

By submitting a proposal, each proposer certifies that its submission is not the result of collusion or any other activity which would tend to directly or indirectly influence the selection process. The proposal will be used to determine the proposer's capability of rendering the services to be provided. The failure of a proposer to comply fully with the instructions in this RFP may eliminate its proposal from further evaluation as determined in the sole discretion of the County, SMMC or the HCH/FH Program. The County, SMMC and HCH/FH Program reserves the sole right to evaluate the contents of proposals submitted in response to this RFP and to select a contractor, if any.

Proposals received late will not be opened or given any consideration for the proposed services unless doing so is deemed to be in the best interest of the County, as determined in the sole discretion of the HCH/FH Program.

All proposals must be delivered as required by Section V., below, to:

San Mateo Medical Center
Materials Management
Attn: Ron Keating
222 W. 39th Avenue
San Mateo, CA 94403

Upon receipt by the Department, all proposals will be date/time stamped. All proposals received prior to the deadline for proposals will be kept in a secure place.

C. CONFIDENTIALITY OF PROPOSALS

California Government Code Sections 6250 *et seq*. (the “California Public Records Act” or the “Act”) defines a public record as any writing containing information relating to the conduct of the public business. The Act provides that public records shall be disclosed upon written request and that any citizen has a right to inspect any public record unless the document is

exempted from disclosure. The Department, which is part of the County of San Mateo, is subject to the California Public Records Act.

Be advised that any contract that eventually arises from this RFP is a public record in its entirety. Also, all information submitted in response to this RFP is itself a public record **without exception**. Submission of any materials in response to this RFP constitutes a waiver by the submitting party of any claim that the information is protected from disclosure. By submitting materials, (1) you are consenting to release of such materials by the County if requested under the Public Records Act without further notice to you and (2) you agree to indemnify and hold harmless the County for release of such information.

If the County/Department receives a request for any portion of a document submitted in response to this RFP, the County will not assert any privileges that may exist on behalf of the person or entity submitting the proposal, and the County reserves the right to disclose the requested materials without notice to the party who originally submitted the requested material. To the extent consistent with the Public Records Act and applicable case law interpreting those provisions, the County/Department and/or its officers, agents, and employees retain discretion to release or withhold any information submitted in response to this RFP.

Submission of a proposal constitutes a complete waiver of any claims whatsoever against the County and/or its officers, agents, or employees that the County has violated a proposer's right to privacy, disclosed trade secrets, or caused any damage by allowing the proposal to be inspected.

D. PROPOSAL EVALUATION

Evaluation teams based on service category, composed of at least three (3) individuals will review each of the given service category proposals independently. Evaluators will be required to sign an Absence of Conflict of Interest Statement. The evaluation team will consist of individuals from the HCH/FH Co-Applicant Board, HCH/FH Program staff, representatives of organizations serving the homeless and/or farmworker population(s), or individuals with specific service category knowledge/background.

The evaluators will review each of the proposals using the evaluation documents and proposal requirements given to them by HCH/FH Program staff. After independent review, the evaluators will meet with HCH/FH Program staff, discuss their evaluations of responses, and make a recommendation regarding selected submissions in the service category.

Each proposal will be checked for the presence of required material and information in conformance with the RFP.

Responses to this RFP should adhere to the format for proposals detailed in Part B, above. The criteria used as a guideline in the evaluation shall include, but not be limited to, the following:

1. Compliance with RFP requirements, including County Contracting Requirements

2. Relevant Agency/Proposer Experience

3. Quality and feasibility of proposed approach to meeting program requirements, including the quality of the proposals: Program Service Description; Program Service Delivery; Program Objectives; Program Community Collaboration; Program Management; Outcome Reporting; and Budget.

4. Client Service

5. Efficiency of Services Provided Against Amount of Funds (Cost Analysis)

6. References

If errors are found in a proposal, the proposal may be rejected. However, the HCH/FH Program may, in its sole discretion, correct arithmetic and/or transposition errors. The proposer will be informed of the errors and corrections.

The recommendations from the evaluation teams will be submitted to an RFP Selection Committee composed of representatives from each of the evaluation teams. During this process, the HCH/FH Program may require the presence of a proposer's representative for answering specific questions orally and/or in writing. The HCH/FH Program may also require a visit to the proposer's offices or other field visits or observations by the HCH/FH Program representatives. Once a finalist or group of finalists is selected, additional review may be required.

E. PROPOSAL RECOMMENDATION

The most qualified proposal(s), as best fit the program goals, objectives priorities and available funding, will be recommended by the RFP Selection Committee to the HCH/FH Program Co-Applicant Board, SMMC and County management based on the overall strength of each proposal, and selection is not restricted to considerations of single factors such as cost.

Ultimate acceptance or rejection of the recommended proposal(s) and execution of a contractual agreement thereto is the independent sole legal prerogative of San Mateo County, SMMC, and the HCH/FH Program Co-Applicant Board notwithstanding any recommendations made by the RFP Selection Committee. All responses to this RFP become the exclusive property of San Mateo County, SMMC and the HCH/FH Program. Any and all costs incurred by the RFP respondents in the preparation of proposals are entirely the responsibility of the respondent.

San Mateo County, SMMC, and the HCH/FH Program reserves the right to accept other than the lowest prices and to negotiate with proposer on a fair and equal basis when the best interests of the County, SMMC and the HCH/FH Program are served by doing so.

Not all proposals that meet the program's requirements may be allocated HCH/FH funding due to limited amounts of funding for each service category and the possibility that another selected proposal could be awarded the full amount budgeted for that service category. RFP Selection Committee members will make their recommendations based on the overall merit

of each proposal and in the best interests of the HCH/FH Program, SMMC, and San Mateo County.

The recommendations from the RFP Selection Committee will be presented to the HCH/FH Co-Applicant Board for review and approval, followed by submission to Administrators of the SMMC to ensure that the recommendations meet the requirements of the HCH/FH Program and are aligned with the 2013 HCH/FH Program Goals and Objectives. Depending on the funding amount and term of the recommended proposal(s), final recommendations may require presentation to the San Mateo County Board of Supervisors for final approval.

F. NOTICE TO PROPOSERS

While a target date for announcement of selected proposals is included in the RFP schedule, the HCH/FH Program is not required to give notice to proposers in any specific format or on any particular timeline. At some point prior to execution of a final agreement(s) for the requested services, the HCH/FH Program will notify those who submitted proposals of their non-selection. Proposers may be notified at different times depending on the needs of the Department.

G. PROTEST PROCESS

If an applicant desires to protest the selection decision, the applicant must submit by fax or email a written protest within five (5) business days after the delivery of the notice about applicants not selection. The written protest should be submitted to the Deputy Director for Ambulatory Services and the HCH/FH Program Director as outlined below. Protests received after the deadline will not be accepted. Protests must be in writing, must include the name and address of the Proposer, and must state the specific ground(s) for the protest. A protest that merely addresses a single aspect of the selected proposal, e.g., comparing the cost of the selected proposal in relation to the non-selected proposal, is not sufficient to support a protest. A successful protest will include sufficient evidence and analysis to support a conclusion that the selected proposal, taken as a whole, is an inferior proposal.

The Deputy Director for Ambulatory Services or a designee at SMMC, after consultation with the HCH/FH Program Staff and representative from SMMC Board of Directors, will respond to the protest in writing within fifteen (15) business days of receiving it. SMMC may, at its election, set up a meeting with the proposer to discuss the concerns raised by the protest. The Deputy Director or designee may determine that corrective action is appropriate, and, if necessary, implement such action.

The decision of the Deputy Director will be final. The protest letter shall be addressed to:

San Mateo Medical Center
Deputy Director for Ambulatory Services
rogden@smcgov.org
FAX: 650-573-2030

HCH/FH Program Director
jbeaumont@smcgov.org
FAX: 650-573-2030

SECTION III – GENERAL TERMS AND CONDITIONS

1. **Read all Instructions.** Proposers are advised to read the entire RFP and all enclosures before preparing your proposal.

2. **Proposal Includes the RFP.** This RFP constitutes part of each proposal and includes the explanation of the Department's needs, which must be met.

3. **Proposal Costs.** Costs for developing proposals are entirely the responsibility of the proposer and shall not be charged to the Department or otherwise reimbursed by the County.

4. **Proposal Becomes County Property.** The RFP and all materials submitted in response to this RFP will become the property of the County. Once submitted, changes and/or additions to the proposals, except for responses to inquiries as part of the proposal evaluation process, will not be accepted.

5. **Questions and Response Process.** Submit all questions relating to this RFP by one of three methods:

A.	Mailed to:	San Mateo Medical Center Attn: Ron Keating 222 W. 39th Avenue San Mateo, CA 94403
B.	E-mailed to:	rkeating@smcgov.org
C.	Faxed to:	650/573-2267 Attn: Ron Keating

All questions must be received no later than 1:00 p.m. on Friday, September 4, 2015.

All questions and answers will be posted on the Department website at www.sanmateomedicalcenter.org/content/rfp.htm

The Department may, at its option, email prospective proposers with the questions and answers in addition to posting them on the website listed above. If you wish to receive such notice, you may email Ron Keating at the email address above before you submit a proposal.

If changes to the RFP are warranted, they will be made in writing, clearly marked as addenda to the RFP, and posted to the website. It is the responsibility of each proposer to check the website listed above for changes and/or clarifications to the RFP prior to submitting a response, and a proposer's failure to do so will not provide a ground for protest.

6. **Alteration of Terms and Clarifications.** No alteration or variation of the terms of this RFP are valid unless made or confirmed in writing by the County. Likewise, oral understandings or agreements not incorporated into the final contract are not binding on the County.

   If a proposer discovers any ambiguity, conflict, discrepancy, omission, or other error in the RFP, the proposer must immediately notify the County of such error in writing and request modification or clarification of the document. If a proposer fails to notify the Department of an error in the RFP prior to the date fixed for submission, the proposer shall submit a response at his/her own risk, and if the proposer enters into a contract, the proposer shall not be entitled to additional compensation or time by reason of the error or its later correction.

   Modifications or clarifications to the RFP will be posted to the Department website as outlined in Section III.5, above, without divulging the source of the request for same. The Department may, at its discretion, also give electronic notice by email to all parties who have notified the Department of their electronic contact information in response to this RFP, but no party that fails to receive email notice has any basis for protest given that all clarifications will be available online. It is the obligation of all proposing parties to check the Department website for updates regarding the RFP if they wish to be kept advised of clarifications prior to submitting a proposal.

7. **Selection of Vendor(s).** The selection of a vendor will be memorialized in the form of a "County Agreement with Independent Contractor" (see the sample template at Section VI, Enclosures 2-4, below), authorized by a resolution of the County Board of Supervisors and signed by both parties. The County may use a "Memorandum of Understanding" for public entity agreements.

   The County reserves the right to reject any or all proposals without penalty. The County's waiver of an immaterial deviation in the proposal shall in no way modify the RFP documents or excuse the proposer from full compliance with the specifications if the proposer enters into a contract.

   Once a vendor is selected, the Agreement with that vendor must still be negotiated and submitted for required approvals (Departmental or to the San Mateo County Board of Supervisors), and <u>there is no contractual agreement between the selected vendor unless and until the agreement is approved and signed.</u> Selection of a proposal for negotiation of contract terms and eventual submission to County leadership by way of an Agreement does not constitute an offer, and proposers acknowledge by submission of a proposal that no agreement is final unless and until approved as required.

8. **Statement of Compliance with County Requirements.** The County's standard contract is attached hereto as "Attachment 1." Each proposal must include a statement of the applicant's commitment and ability to comply with the terms of the County's standard contract, or to otherwise accept similar terms in a MOU.

   Proposers must advise County in their proposals of any objections to any terms in the County's contract and provide an explanation for the inability to comply with the required term(s). If no objections are stated, County will assume the applicant is prepared to sign the County contract as is.

9. **Equal Benefits.** With respect to the provision on employee benefits, Contractor/vendor must comply with the County Ordinance prohibiting discrimination in the provision of employee benefits between a full-time employee with a registered domestic partner and one with a spouse. See Section VI, Enclosure 5.

10. **Jury Duty.** The contractor must comply with the County Ordinance requiring that the contractor have and adhere to a written policy the provides its full-time employees who live in San Mateo County with no fewer than five days of regular pay for actual jury service in San Mateo County. This policy may provide that employees deposit any fees received for such jury service with the contractor or that the contractor deduct the from the employee's regular pay the fees received for jury service. See Section VI, Enclosure 5. If the proposer has no employees that qualify for jury duty in San Mateo County, the proposer may satisfy this requirement by providing the County with written confirmation of the fact that (1) it has no such employees and (2) its policy is to comply with the jury duty pay ordinance with respect to any future qualifying employees.

11. **Insurance.** The County has certain insurance requirements that must be met. In most situations those requirements include the following: the contractor must carry $1,000,000 or more in comprehensive general liability insurance; the contractor must carry motor vehicle liability insurance, and if travel by car is a part of the services being requested, the amount of such coverage must be at least $1,000,000; if the contractor has two or more employees, the contractor must carry the statutory limit for workers' compensation insurance; if the contractor or its employees maintains a license to perform professional services (e.g., architectural, legal, medical, psychological, etc.), the contractor must carry professional liability insurance; and generally the contractor must name the County and its officers, agents, employees, and servants as additional insured on any such policies (except workers compensation). Depending on the nature of the work being performed, additional requirements may need to be met.

12. **Incomplete Proposals May be Rejected.** If a proposer fails to satisfy any of the requirements identified in this RFP, the proposer may be considered non-responsive and the proposal may be rejected at the sole discretion of the HCH/FH Program Director.

13. **Contact With County/Department Employees.** As of the issuance date of this RFP and continuing until the final date for submission of proposals, all proposers are specifically directed not to hold meetings, conferences, or technical discussions with any County employee for purposes of responding to this RFP except as otherwise permitted by this RFP. Any proposer found to be acting in any way contrary to this directive may be disqualified from entering into any contract that may result from this RFP.

    Proposers should submit questions or concerns about the process as outlined in Section III.5, above. The proposer should not otherwise ask any County/Department employees questions about the RFP or related issues, either orally or by written communication, unless invited to do so.

14. **Miscellaneous.** This RFP is not a commitment or contract of any kind. The County reserves the right to pursue any and/or all ideas generated by this RFP. The County

reserves the right to reject any and all proposals and/or terminate the RFP process if deemed in the best interest of the County. Further, while every effort has been made to ensure the information presented in this RFP is accurate and thorough, the County assumes no liability for any unintentional errors or omissions in this document. The County reserves the right to waive or modify any requirements of this RFP when it determines that doing so is in the best interest of the County.

SECTION IV – SCOPE OF WORK

Length of Agreement: Agreements resulting from this RFP may be for a period of between one (1) and three (3) years.

1. Service Requirements and Specifications

A. Service Requirements

Each proposal shall provide a detailed description of the health care services to be provided, and the service population for that service. This should include separate segments for each of the service components the proposal represents, as provided below.

Preferred solutions will include strategies targeting the farmworker population and/or the specific homeless categories of street, shelter and transitional, but not necessarily the doubling up category. The definitions for farmworkers and homeless are defined below:

FARMWORKER

Farmworkers are defined as those whose principal employment is in agriculture, aquaculture and animal production on a seasonal or migratory basis, or who has been so employed within the last 24 months. While HRSA does distinguish between *migrant* and *seasona*l farmworkers, there is no preference for either designation as part of this solicitation. The term "agriculture" means farming in all its branches, including cultivation and tillage of the soil; the production, cultivation, growing, and harvesting of any commodity (including nursery and greenhouse stock) grown on, in, or as an adjunct to or part of a commodity grown in or on, the land; and any practice (including preparation and processing for market and delivery to storage or to market or to carriers for transportation to market) performed by a farmer or on a farm incident to or in conjunction with an activity described above.

The farmworker population is further defined as including family/household members of a farmworker, and individuals who have previously been migratory or seasonal agricultural workers but who no longer meet the definition because of age or disability.

HOMELESS

Shelter: An individual staying in a homeless shelter or mission on a short-term basis, including emergency shelters, informal shelters established by community organizations, domestic violence shelters or any other supervised public or private facility providing temporary living accommodations.

Street: An individual staying outdoors, such as camping or sleeping on the street or in a park, an encampment or freeway underpass; an

individual staying in a car, van, bus, truck, RV or other vehicle; or an individual staying in an abandoned building or other structure generally not deemed safe or fit for human occupancy.

Transitional: An individual staying in a long-term shelter; a resident in transitional or supportive housing program; or an individual living in a Single Room Occupancy (SRO hotel) who does not have tenancy rights.

Doubling Up: An individual who is unable to maintain his/her housing situation and is forced to stay temporarily with friends and/or extended family members. The individual has been staying there for approximately six months or less and does not have tenancy rights. The individual typically pays a marginal amount (such as <$300 a month for rent).

Note: Ongoing living in overcrowded housing conditions does not meet the doubling up criteria.

While the HCH/FH definition of homeless status recognizes those individuals at high risk for becoming homeless as "doubling up", programs providing services for the homeless population should focus the majority of effort to serve individuals meeting the shelter, street, or transitional homeless definitions.

a. **Specifications**

Proposers shall describe their proposed services using the criteria laid out below for each service category and for each service population for which a proposal is made.

2. Program Funding Areas

A. Primary Health Care (Fixed Site and/or Mobile)

Eligibility Specifics

Comprehensive primary health care services should be provided to homeless and/or farmworker children, families, and adults. For the homeless service population, it is expected that 75% of unduplicated individuals served by programs receiving HCH funding will meet the shelter, street, or transitional homeless definition.

Primary health care is defined as medical services provided by a licensed provider including a physician, nurse practitioner, physician's assistant, certified nurse midwife, or nurse. Visits are defined as documented, face-to-face contacts between a patient and a provider who exercises independent professional judgment in the provision of services to the patient. To be included as a visit, services rendered must be documented in a chart or electronic health record maintained by the program. The visit will be documented and submitted to HCH/FH in the monthly report. The primary

diagnosis code (ICD-9, CPT) to indicate the type of service provided will be included for each visit.

Primary care visit criteria **are not** met in the following circumstances:

- When a provider participates in a community meeting or group session that is not designed to provide clinical services. Examples of such activities include information sessions for prospective patients, health presentations to community groups (high school classes, PTA, etc.), and information presentations about available health services at the center.
- When the only health service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair).
- When a provider is primarily conducting outreach and/or group education sessions, not providing direct services.
- When the only services provided are lab tests, x-rays, immunizations or other injections, TB tests or readings and/or prescription refills.
- Services performed under the auspices of a WIC program or a WIC contract.

Program Goal and Objectives

Goal: To provide an array of preventative and primary medical care services throughout San Mateo County, which are accessible and available to homeless individuals residing in shelters, on the streets, in transitional housing programs, and other locations where homeless individuals are located or who qualify as “doubling up”, and to farmworker individuals and their families who work, or recently worked (past 24 months), in the agricultural industry.

Program Services Description
The HRSA and BPHC require that the HCH/FH Program provide full and comprehensive primary health care. The HCH/FH Program is allocating funding to community and/or County organizations that can provide the following primary health care services to homeless and/or farmworker individuals:

Comprehensive Health Screenings: Conduct a medical history including mental health and substance abuse history. This can be accompanied with screenings for hypertension, diabetes, tuberculosis, sexually transmitted diseases and/or HIV; immunizations; and health education. The primary diagnosis should reflect the comprehensive health screening service. A registered nurse, mid-level practitioner and/or medical physician can complete the comprehensive health screening. Health education should be provided during the initial health screening and should include information on how the individual can provide self-care to address any of their health condition(s).

Primary Health Care Visit: Those homeless or farmworker individuals who are diagnosed with an acute health care issue(s), have ongoing chronic health issue(s), require prenatal health care, require specialty health care, and/or medication

management, or have completed a health screening and will receive care by a physician and/or mid-level practitioner with the goal of providing a medical home for the individual.

B. Dental Health Care (Fixed Site and/or Mobile)

Eligibility Specifics

Comprehensive dental health care services should be provided to homeless and/or farmworker adults, children, and families. These dental services may be provided from a fixed site location and/or through mobile services as specified. It is expected that 75% of unduplicated individuals served by programs, or portions of programs, whose service population is specified as homeless will meet the street, shelter or transitional homeless definition.

A dental health care visit is defined as a visit between a dentist or dental hygienist and a patient for the purpose of prevention, assessment, or treatment of a dental problem, including restoration. NOTE: A dental hygienist is credited with a visit only when s/he provides a service independently, not jointly with a dentist. Two visits may **not** be generated during a patient's visit to the dental clinic in one day, regardless of the number of clinicians who provide services or the volume of service (number of procedures) provided.

Dental health care visit criteria **are not** met in the following circumstances:

- When a provider participates in a community meeting or group session that is **not** designed to provide clinical services. Examples of such activities include information sessions for prospective patients, health presentations to community groups (high school classes, PTA, etc.), and information presentations about available health services at the center.
- When the only health service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair).
- When a provider is primarily conducting outreach and/or group education sessions, not providing direct services.
- When the **only** services provided are lab tests, x-rays, immunizations or other injections, TB tests or readings and/or prescription refills.
- Services performed under the auspices of a WIC program or a WIC contract.

Program Goal and Objectives

Goal: To provide preventive and restorative dental care to homeless and/or farmworker individuals. For the homeless service population, with an emphasis on serving shelters and transitional housing programs where ongoing care can be provided so that these individuals will improve their overall oral health.

Program Services Description

HRSA and the BPHC require that HCH/FH Programs provide preventive and restorative dental health care, including screenings and treatment plans. Dental health care is a very critical and needed service for individuals who are homeless as well as for farmworkers and their families. The majority of our target population has not received dental health care services for many years and may be dealing with multiple oral health issues.

The HCH/FH Program is allocating funding to community and/or County organizations that can provide the following dental health care services to homeless and farmworker individuals:

Dental Health Care Screenings: Provide a full dental exam on an individual, which includes x-rays, assessment, oral health education, and cleaning, which could include deep cleaning for individuals that have severe decay.

Dental Care Treatment Plans: Individuals who have received a full dental health screening and have oral health issues will be given a treatment plan which includes extraction(s), restorative care, and sealant (for children between 1 and 12 years of age) to be accomplished within six – nine months, with the result of having improved oral health.

Prosthetic Dental Devices: For a homeless individual to receive dentures, partials and other prosthetic dental devices as part of his/her dental treatment plan, the individual must be residing in a shelter and/or transitional housing program, engaging in social and/or behavioral services, and demonstrating efforts to move into stable, permanent housing.

C. Substance Abuse/Mental Health/Behavioral Health Services (Fixed Site and/or Mobile)

Eligibility Specifics

Substance abuse/mental health/behavioral health care services should be provided to the homeless and/or farmworker children, families, and adults. For the homeless service population, it is expected that 75% of unduplicated individuals served by programs receiving HCH funding will meet the shelter, street, or transitional homeless definition.

Behavioral Health/Mental Health Services refers to prevention, screening, intervention, assessment, diagnosis, treatment, and follow-up of common mental health disorders, such as depression, anxiety, and Attention Deficit Disorder with Hyperactivity (ADHD). Behavioral Health Services also include the treatment and follow-up of patients with severe mental illnesses (e.g., schizophrenia, bi-polar disorder, psychotic depression) who have been stabilized and are treatment compliant on psychiatric/psychotropic medications. Clinical and support services may include individual and group counseling/psychotherapy, cognitive-behavioral therapy or problem solving therapy, psychiatric/psychotropic medications, self-management groups, psycho-educational groups, and case management. A Behavioral Health/Mental Health visit is between a licensed mental health provider (psychiatrist, psychologist, LCSW, and certain other

masters prepared mental health providers licensed by specific States) or an unlicensed mental health provider credentialed by the center, and a patient, during which mental health services (i.e., services of a psychiatric, psychological, psychosocial, or crisis intervention nature) are provided. Visits are defined as documented, face-to-face contacts between a patient and a provider who exercises independent professional judgment in the provision of services to the patient. To be included as a visit, services rendered must be documented in a chart or electronic health record maintained by the program.

Substance Abuse Services include screening, assessment and diagnosis, treatment, and where possible, recovery services for substance use (alcohol, tobacco, prescription, and illicit drugs) disorders. Clinical and support services may include individual and group counseling, educational groups, 12-step and/or other mutual self-help groups, brief alcohol intervention and case management. A Substance Abuse visit is between a substance abuse provider (e.g., a mental health provider or a credentialed substance abuse counselor, rehabilitation therapist, psychologist, etc.) and a patient, during which alcohol, or drug abuse services (i.e., assessment and diagnosis, treatment, or aftercare) are provided. Programs which include the regular use of narcotic agonists or antagonists or other medications on a regular (daily, every three days, weekly, etc.) basis are to count the counseling services as visits but not the dispensing of the drugs, regardless of the level of oversight that occurs during that activity. Visits are defined as documented, face-to-face contacts between a patient and a provider who exercises independent professional judgment in the provision of services to the patient. To be included as a visit, services rendered must be documented in a chart or electronic health record maintained by the providing organization.

Substance abuse/mental health/behavioral health care visit criteria **ARE NOT** met in the following circumstances:

- When a provider participates in a community meeting or group session that is not designed to provide clinical services. Examples of such activities include information sessions for prospective patients, health presentations to community groups (high school classes, PTA, etc.), and information presentations about available services.
- When the only health service provided is part of a large-scale effort, such as a mass screening program, or community-wide service program (e.g., a health fair).
- When a provider is primarily conducting outreach and/or group education sessions, not providing direct services.
- When the only services provided are ancillary services such as prescription refills.

Program Goal and Objectives

Goal: To provide an array of behavioral health/mental health/substance abuse services throughout San Mateo County, which are accessible and available to homeless individuals residing in shelters, on the streets, in transitional housing programs, and other locations where homeless individuals are located or who qualify as “doubling up”, and to farmworker individuals and their families who work, or recently worked (past 24 months), in the agricultural industry.

Program Services Description

The HCH/FH Program has available potential funding for County entities that can provide the following behavioral health/mental health/substance abuse services to homeless and/or farmworker individuals:

Comprehensive Screenings: Conduct a mental health and substance abuse history. The primary diagnosis should reflect the comprehensive screening. Behavioral Health education should be provided during the initial screening and should include information on how the individual can provide self-care to address any of their behavioral health condition(s).

Behavioral Health/Mental Health/Substance Abuse Visit: Those homeless or farmworker individuals who are diagnosed with an acute behavioral health issue(s), have ongoing chronic behavioral health issue(s), or have completed a health screening and will receive care by an appropriate behavioral health professional, and/or medication management.

D. Enabling Services

Proposers shall describe their proposed services in each and any of the following areas, using the criteria laid out below for each service area included in the proposal:

Case Management - the provision of services to aid patients in the management of their health and social needs, including assessment of patient medical and/or social services needs, and maintenance of referral, tracking and follow-up systems. Case management may include eligibility assistance if performed in the context of other case management functions. Staff may include nurses, social workers and other professional staff who are specifically allocated to this task during assigned hours, but not when it is an integral part of their other function. Care/Referral Coordinators are considered Case Managers, as are Health Navigators. Health navigation and utilization assistance activities are included in this category.

- Health Case Manager
- Health Navigator

Patient and Community Education - the provision of services in health education, family planning information, HIV information, and other information about health conditions and guidance about appropriate use of health services that are not otherwise classified under outreach.

Outreach – the provision of services in conducting case finding, education or other services to identify potential clients and/or facilitate access/referral of clients to available services.

Transportation – the provision of services in assisting patients in accessing transportation to available primary medical, dental, mental health or substance abuse services.

Eligibility Assistance - the provision of assistance in securing access to available health, social service, pharmacy and other assistance programs, including Medi-Cal, Medicare, MCE, ACE, Healthy Kids, and related assistance programs related to the access of medical, dental, mental health or substance abuse services. Assistance is securing access to other available aid programs (WIC, TANF, etc.) may occur as part of the overall eligibility assistance.

Interpretation/Translation Services – the provision of *full time or dedicated time* services devoted to translation and/or interpretation services. ***DO NOT INCLUDE*** that portion of the time of a nurse, medical assistant or other support staff who provides interpretation or translation during the course of their other activities.

Other Enabling Service Activities - all other services that function as enabling services, not described above. You must define what the service is, what the staff is doing and in what way it enables the provision of medical, dental, mental health or substance abuse services to the patient.

Health care enabling services are defined above and are delivered by staff of an appropriate skill level. Visits are defined as documented, face-to-face contacts between a patient and the staff providing the service. To be included as a visit, services rendered must be documented in a file/chart or electronic case/health record maintained by the program. The visit will be documented and submitted to the HCH/FH Program in the monthly report.

Program Goal and Objectives

Goal: To support and enable the delivery of an array of preventative and primary medical care services throughout San Mateo County, which are accessible and available to homeless and farmworker individuals and families.

Program Services Description
The Bureau of Primary Health (BPHC) requires that the HCH/FH Program provide full and comprehensive primary health care. The HCH/FH Program is allocating funding to community and/or government organizations that can provide the following enabling services in support of the delivery of primary health care, dental health care, mental health care and substance abuse services to homeless and farmworker Individuals and families (see definitions above):

Case Management
Patient and Community Education
Outreach
Transportation
Eligibility Assistance
Interpretation/Translation Services
Other Enabling Service

E. Coordinating, Program Support or Other Services

It is recognized by the HCH/FH Program that there are appropriate and acceptable services that help improve the quality and quantity of the direct services described above to the HCH/FH target populations that do not involve providing direct services to those target populations. These types of coordinating and support services may be considered for funding.

Proposers should describe their proposed services in sufficient detail so as to provide a clear description of how the intended service/program would help support the intent and goals of the HCH/FH Program, and the access to and delivery of the medical and health care services described above to the homeless and farmworker populations.

PROPOSAL WORK PLAN

Please complete the work plan in narrative form following the order and the headings shown below:

1. Proposal Submitter Information (2 pages)

Provide an overview of your agency/organization/clinic/program including:

a) The services you currently provide
b) Target populations (for example: homeless children, farmworker families, etc.) and geographic areas of San Mateo County to be served by this proposal
c) Explain why HCH/FH services are needed in the area(s)/program(s)/ population(s) you serve
d) Describe the experience you have providing the proposed health services to homeless and/or farmworkers

2. Program Service Delivery (3 pages)

Describe the health services your agency is proposing to provide to the service populations.

Please respond to each of the following points:

a) What services will be provided (i.e., comprehensive health screenings and assessments, primary medical care, behavioral health services, dental screenings, dentures, case management, etc.)
b) Who will provide the services (i.e., physicians, nurse practitioners, psychologists, dentist, hygienist, case manager, eligibility worker, etc.)
c) Where the services will be provided. (i.e., shelters, transitional housing, stationary clinic, streets, parks, employer housing sites, mobile unit), specifying the geographic location(s) involved
d) How these services will be provided. (i.e., mobile teams, stationary clinic staff, etc.)
e) Hours of operation
f) Explain how you will ensure that the services provided will be flexible, accessible, and comprehensive so as to meet the needs of homeless and/or farmworker population(s). How will you ensure that these individuals gain access to the services?
g) How will your program ensure that the individual completes or complies with his/her treatment plan.
h) Explain how your agency will coordinate the proposed services with primary care, dental, behavioral health, enabling services and other necessary social services that homeless and/or farmworker individuals and their families may require so as to further efforts towards a comprehensive system of care.

3. Program Objectives (2 pages)

Please explain how you plan to accomplish the objectives below by identifying key action steps, explaining the expected outcomes, and describing how you will collect data to measure progress/success for each objective.

Objective 1**:** Provide access to the proposed services to the specified service population(s). Identify the number of unduplicated individuals you plan to serve and total number of visits you plan to deliver to patients during a 12-month period. Include specific efforts to target the needs the proposed services are intended to address for homeless or farmworker individuals or their families.

Objective 2**:** Provide comprehensive screenings (as appropriate to the service(s) proposed) to each homeless or farmworker individual. Identify the number of screenings and the process by which you will provide the screening, including details on how health education will be delivered, how treatment plans will be established, and how referrals (if necessary) will occur. Submit an example of the screening document/protocol and indicate how this screening will be documented.

Objective 3**:** For primary care proposals, provide on-going primary care services to the specified service population(s) members for those health conditions as specified for reporting conditions by HRSA such as high blood pressure, low birth weight, smoking cessation, depression screening, etc. Describe processes, baselines, targets, etc. Explain how this data will be collected.

For proposals of Enabling Services, please explain what objectives you plan to achieve in support of the delivery of Primary Health Care, Dental Health Care, Mental Health Care and Substance Abuse Services to the homeless and farmworker population. These objectives must be measurable and relate to how the services you are proposing to provide will improve the health care situation for the homeless and/or farmworker population you are targeting. You must have at least two (2) objectives, which may include some form of those listed above. Discuss how you plan to accomplish these objectives by identifying key action steps, explaining the expected outcomes, and describing how you will collect data to measure progress/success for each objective.

For proposals of Coordinating and Program Support Services, please explain what objectives you plan to achieve in support of the HCH/FH Program and the delivery of Primary Health Care, Dental Health Care, Mental Health Care and Substance Abuse Services and Enabling Services to the homeless and farmworker population. These objectives must be measurable and relate to how the services you are proposing to provide will improve the health care situation for the homeless and/or farmworker population you are targeting, or otherwise improve HCH/FH Program outcomes. You must have at least two (2) objectives, which may include some form of those listed above. Discuss how you plan to accomplish these objectives by identifying key action steps, explaining the expected outcomes, and describing how you will collect data to measure progress/success for each objective.

4. Program Community Collaboration (1 page)

If your program plans to collaborate, provide linkages to and/or refer patients into other programs that serve the homeless and farmworker population, explain the following:

a) Provide an overview of the collaboration/linkage with other agency(s).
b) Describe the role of the other agency(s) involved in the collaborative effort.

5. Program Management (2 pages)

a) Staffing: Detail your staffing plan, and include brief job descriptions for those positions which will be involved in providing the services for which you are requesting HCH/FH funding. Describe the responsibilities that these positions will have in providing services to the homeless and/or farmworker population.
b) Funding Management: Indicate the staff responsible for overseeing the HCH/FH funding including the following activities: data collection and reporting, monitoring and reporting on outcomes, participation in HCH/FH Provider Collaborative Meetings, and quality assurance activities.

6. Outcome Reporting and Data Collection (1 page)

Explain how you will track demographic and visit information. This data must be submitted in an electronic format with the monthly invoice. All demo graphic and visit information required for reporting by HRSA on the annual Universal Data System (UDS) Report will be required for reporting. All visit, patient and provider definitions are as defined by HRSA for the UDS Report. Information on HRSA UDS requirements can be found at http://bphc.hrsa.gov/healthcenterdatastatistics/reporting/2014udsmanual.pdf.

HRSA and BPHC require that HCH/FH Programs establish, track, and report on outcome measures for the homeless and/or farmworker population who are receiving health care services, including specifically those outcomes that are required reporting items on the UDS Report. The HCH/FH Program requires programs which receive funding to have outcome measures for each of the objectives (which are indicated on the Objectives Tables Section) proposed. Describe how your agency will track and report on each of the objective outcomes that are being proposed.

3. Budget Requirements

There are four parts to the budget to be completed for each service category proposed by the HCH/FH applicant. These include:

1. **Table 1**: List all the positions (including medical, dental, case management, administrative staff, etc.) that will be funded, even partially, through these HCH/FH

dollars, and include the FTE for each as allocated to the HCH/FH services being proposed.

2. **Table 2**: List all the expenses that will be involved with providing HCH/FH services as proposed. The HCH/FH Program limits allocation for administrative costs to 10% (this does not include cost for supplies, medication, or other direct patient costs) of allotted funds. This is the description of the total cost for delivery of the services specified in the proposal other than staff costs.

3. **Half Page Narrative**: Provide a budget narrative justifying expenses that are being requested for HCH/FH Funding to implement the services being proposed.

4. **Program Income & Matching Funds**: Applicants are required to provide estimates of any and all program income that may be generated in the provision of the services proposed. This includes Medi-Cal/Medicaid, Medicare, ACE, patient payments and other third party reimbursements. In addition to HCH/FH funding and program income, applicants are required to identify at least 10% matching funds for the HCH/FH dollars requested.

Budget Table 1:

FEDERAL HCH/FH FUNDED				
POSITION	Wage/Salary	Budget Fringe Benefits	HCH/FH FTE	Total Staff Costs for HCH/FH activities
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
TOTALS		0		$ -

Budget Table 2

– EXPENSES		TOTAL
Travel		
Client Travel	$ -	
Staff Travel	$ -	
Other Travel	$ -	
Total Travel		$ -
Equipment:		$ -
Supplies:		
Medical	$ -	
Dental	$ -	
Laboratory	$ -	
Radiology	$ -	
Pharmacy	$ -	
Hygiene/Health Maintenance	$ -	
Printed Materials	$ -	
Office	$ -	
Other	$ -	
Total Supplies		$ -
Contractual:		
Subcontractor	$ -	
Laboratory	$ -	
Radiology	$ -	
Pharmacy	$ -	
Consultant	$ -	
Other	$ -	
Total Contractual		$ -
Staff Training		$ -
Communications:		
Telephone	$ -	
Postage	$ -	
Internet	$ -	
Other	$ -	
Total Communications		$ -
Insurance		$ -
Facility:		
Rent	$ -	
Utilities	$ -	
Maintenance	$ -	
Total Facility		$ -
Other Expenses (detail)		$ -
TOTAL EXPENSES		**$**

Additional Requirements:

1. Data and Programmatic Reporting and Operational Requirements

   Report Requirement: All reporting will be done on forms as designated by the HCH/FH Program. Contractors must comply with the following data collection and reporting requirements:

   Electronic Data Collection: All programs receiving HCH/FH funding will submit data in an electronic format. Demographic information shall be collected at the time of initial encounter for each homeless or farmworker individual. Additionally, all subsequent visits will be electronically documented. This documentation will comply with Health Services and Resources Administration (HRSA), Bureau of Primary Health Care (BPHC) standard so that the HCH/FH Program can include the demographic information and these services in the Uniform Data System (UDS) annual report.

   Monthly Invoices and Reports: Programs that receive HCH/FH funding will submit monthly invoices detailing the number of unduplicated homeless or farmworker individuals served and the number of service visits on a monthly basis. Electronic reports will accompany the invoice to document the services provided. These reports will include all demographic information collected at the initial encounter and details to verify all visits provided by the program. The monthly invoice and report will be due no later than the 10th of every month following the month services are provided.

   Quarterly Reports: Programs that are contracted to provide HCH/FH services will be required to report on the progress of their HCH/FH objectives and outcome measures on a quarterly basis due by the 15th of the month following the end of the quarter (April, July, October, January). These quarterly reports will also include a short narrative on the strengths and challenges that the agency is experiencing in implementing the HCH/FH services.

   Operational Requirements: Contract awardees must comply with the following operational requirements:

   Planning & Quality Assurance: Programs that receive HCH/FH funding must participate in planning activities including but not limited to client needs' assessment, agency surveys, and planning meetings. Programs also must participate in quality assurance activities which include but are not limited to Quality Assurance/Quality Improvement Committee meetings, client satisfaction surveys, client chart reviews, administrative and fiscal reviews.

   HCH/FH Provider Collaborative Meeting: Agencies that receive HCH/FH funding will be required to send a representative to the bi-monthly HCH/FH Provider Collaborative Meetings. The purpose of the meeting is to receive updates on program activities from the HCH/FH Program Coordinator, discuss issues pertaining to implementing the HCH/FH services, and collaborate with other agencies that receive HCH/FH funding to assure services are being provided to homeless and farmworker individuals in an integrated and

comprehensive way. When deemed necessary, HCH/FH funded agencies will be required to attend additional meetings that pertain to the operation and/or planning of the HCH/FH Program.

Community Activities: The HCH/FH Program requires agencies that receive HCH/FH funding participate in community activities that address homeless or farmworker issue (i.e., Homeless One Day Count, Homeless Project Connect).

Corrective Action Plan: A Corrective Action Plan will be required by the HCH/FH Program when a contracted agency is not meeting the contract requirements (See Section V, Form 4, below).

Continuity of Services: Services must be provided during each of the months of the contract year unless the exception is described in detail in the Program Work Plan and approved by the HCH/FH Program staff and so noted in the contract/MOU. This includes the continuation of service delivery (and reporting) after full payment allowed for the contract year has been received.

Confidentiality: The confidentiality of all clients served with HCH/FH funding shall be protected. No client-related information shall be released by the program without the written consent of the client. All programs are required to be compliant with guidelines set forth in the Health Insurance Portability and Accountability Act (HIPPA) and all applicable regulations.

Cultural Relevance: In order to ensure accessibility and acceptability of services and programs to culturally diverse homeless and farmworker populations throughout the county, providers shall employ staff, recruit volunteers and/or coordinate with appropriate organizations that are knowledgeable about and able to communicate effectively with the communities to be served.

SECTION V – PROPOSAL SUBMISSION REQUIREMENTS & FORMS

1. Each service category (primary care, dental care, specific enabling service, etc.) and target population (homeless or farmworker) shall constitute a separate proposal. There are six components that must be included in every proposal for it to be considered complete, which are:

    a. Cover Sheet (see Form 1 below)
    b. Table of Contents
    c. Program Section(s)
    d. Budget Section(s)
    e. Required Forms (see Forms 2 through 4 below)
    f. References

2. Proposer must complete and attach a separate Cover Sheet (see Form 1 below) for each service category and target population for which funding is requested. Each cover sheet must contain the signature of an agency officer, member, representative, or employee indicating that officer's or employee's authorization to commit the proposer to the terms of the proposal. Obligations assumed by such signature must be fulfilled.

3. Proposals must be typed in a minimum of 12-point font, with the original three hold-punched and placed either in a folder or binder (unstapled). White paper with black print should be used. All pages must be numbered and the sections labeled. Proposers are encouraged to use recycled paper for their proposals. Proposal pages must be numbered with sections numerically referenced in the Table of Contents. The Table of Contents should appear as the first page after the Cover Sheet.

4. Proposers are advised to thoroughly read the program descriptions and standards for each of the program areas for which funding is being requested. A resource page is also included in the Appendix section to be a reference for proposers. Workplan instructions immediately follow each program area description.

5. The Budget Section (above) includes instructions for completing the budget forms and narrative. A separate budget needs to be submitted for each of the program areas and should follow the program workplan in the proposals.

6. **Statement of Compliance with County Contractual Requirements:**
   A sample of the County's standard contract (including Exhibits A and B) is attached to this RFP. Each proposal must include a statement of the proposer's commitment and ability to comply with each of the terms of the County's standard contract, including but not limited to the following:
   The County non-discrimination policy;
   The County equal employment opportunity requirements;
   County requirements regarding employee benefits;
   The County jury duty ordinance;
   The hold harmless provision;
   County insurance requirements;

The requirements of Exhibit E (if attached); and
All other provisions of the standard contract.

In addition, the proposer should include a statement that it will agree to have any disputes regarding any contract venued in San Mateo County or the Northern District of California.

Proposals must advise County of any objections to any terms in the County's contract template and provide an explanation for the inability to comply with the required term(s). If no objections are stated, County will assume the proposer is prepared to sign the County contract as-is.

PLEASE NOTE: The sample standard contract attached to this RFP is a template and does not constitute the final agreement to be prepared for the vendor that is selected. Please do not attempt to insert missing information and complete the attached sample. Once a vendor is selected, the Department will work with the selected vendor to draft a vendor-specific contract using the template. However, each proposal should address the general terms of the standard contract as outlined in this section.

Form 1

Health Care for the Homeless/Farmworker Health
Proposal Cover Sheet

Submit one for each Service Category and Population to be Served

This proposal is for services to the: _____ Homeless Population _____ Farmworker Population
(Check one)

This proposal service area is: _____ Primary Health Care _____ Dental Health Care
(Check one)

_____ Substance Abuse/Mental Health Care

_____ Enabling Services (specify)

_____ _____

_____ _____

_____ _____

This Funding Request: $ _____

Applicant Agency: _____

Address: _____

City: _____ Zip: _____ Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Agency Type (Check One) ____ Public / Government ____ Private / Non Profit

____ Other/ Specify

This proposal has been authorized for submission by the follow individual:

Name of Individual: _____ Title: _____

Signature: _____ Date: _____

Form 1 continued

Applicant Checklist: Please check off items enclosed

( ) Cover Sheet (submit one for each service category/target population)
( ) Program Proposal Section:
    ( ) Service Description
    ( ) Service Delivery, Objectives
    ( ) Community Collaboration
    ( ) Management
    ( ) Outcome Reporting
    ( ) Data Collection
( ) Budget Section:
    ( ) Table 1
    ( ) Table 2
    ( ) Budget Narrative
    ( ) Program Income & Matching Funds

Number of unduplicated individuals to be served with funds requested:

Target Population	**Unduplicated Individuals**
Street Homeless	
Homeless Shelter	
Transitional Housing	
Doubling Up	
Homeless Total	
Farmworkers	
TOTAL	

Proposals must include one original hardcopy set, and one electronic/soft copy (in PDF or Word/Excel format) of the original.

Supporting Documents: Submit one complete set per agency (can be a link to an online resource)

( ) Agency Organizational Chart
( ) Related Job Descriptions
( ) Board Member List and Ethnicity
( ) Sliding Fee Scale if there are charges for services
( ) List of Authorized Signature(s)
( ) Emergency Preparedness Plan*
( ) Article of Incorporations; By-Laws*
( ) Last Audited Financial Statement
( ) References (list 2-3)

* Not required if previously provided as part of a Proposal Solicitation and there have been no changes.

Form 2

Contract Requirement

Agency Name: _____
Contact Person: _____

As a program that receives HCH/FH Funding I agree (Name of Agency)_____ will fulfill the following contract requirements:

1. Submit **demographic information** for each new unduplicated individual **and details for each visit** by the 10th day of each month in an electronic format
2. Submit **monthly demographic and visit data with Payment Invoices** by the 10th day of each month
3. Submit **Quarterly Reports** regarding the progress on the HCH/FH contracted goals & objectives and outcome measures
4. Attend the **quarterly HCH/FH Provider Meetings** and other meetings required by the HCH/FH Program
5. Complete **Annual Chart Review**
6. Complete **Annual Administrative Review**
7. Attend the monthly **Quality Improvement Committee meetings**
8. Participate in **Community Activities** that address the needs of homeless and farmworker individuals.
9. Submit any other required documentation

Signature: _____

Date: _____

Form 3

SAN MATEO MEDICAL CENTER

HEALTH CARE FOR THE HOMELESS/FARMWORKER HEALTH PROGRAM

LIST OF AUTHORIZED SIGNATURES

_____

Name of Agency

List below the individuals who are authorized to sign on behalf of your agency for various aspects of contract business. Please print name and sign on same line. Add additional copies of this page as necessary.

Agreements/Contracts_____

Amendments to Agreements/Contracts _____

Budgets_____

Budget Revisions _____

Monthly Invoices _____

Other_____

Form completed by _____

Title_____

Organization _____

Date_____

Form 4

SAN MATEO MEDICAL CENTER
HEALTH CARE FOR THE HOMELESS/FARMWORKER HEALTH (HCH/FH) PROGRAM
CORRECTIVE ACTION POLICY

FOR

HEALTH CARE FOR THE HOMELESS/FARMWORKER HEALTH PROGRAM PROVIDERS

1. The provider will make every effort to take the corrective action immediately after a verbal or written request regarding program performance made by HCH/FH staff.

2. If corrective action is not taken within 30 days, a written request to comply will be made by the HCH/FH staff.

3. A written response outlining a corrective action plan will require within a timeline specified in the written request. Compliance will be required in a timeframe appropriate to the requested corrective action and specified by the HCH/FH staff.

4. If compliance does not occur within the specified timeline, payment for services may be withheld until corrective action is taken. In the event this occurs, a written warning will be sent to the provider specifying that payment will cease 30 days from the date the letter was sent by the HCH/FH staff.

5. Non-compliance with Corrective Action may result in termination of the contract.

I have read and understand the above policy on Corrective Action

Signature _____

Date _____

SECTION VI APPENDIX

Definitions

Farmworkers

Due to the similarity in the definitions and the lack of true distinction within our target population, we have programmatically chosen to refer to all of the target population as "Farmworkers". *The farmworker population is further defined as including family/household members of a farmworker, and individuals who have previously been migratory or seasonal agricultural workers but who no longer meet the definition because of age or disability.*

Farmworkers are defined as those whose principal employment is in agriculture, aquaculture and animal production on a seasonal or migratory basis, or who has been so employed within the last 24 months. The term "agriculture" means farming in all its branches, including cultivation and tillage of the soil; the production, cultivation, growing, and harvesting of any commodity (including nursery and greenhouse stock) grown on, in, or as an adjunct to or part of a commodity grown in or on, the land; and any practice (including preparation and processing for market and delivery to storage or to market or to carriers for transportation to market) performed by a farmer or on a farm incident to or in conjunction with an activity described above. The technical definitions below do apply.

Migratory Agricultural Workers – Defined by Section 330(g) of the Public Health Service Act, a migratory agricultural worker is an individual *whose principal employment is in agriculture on a seasonal basis* (as opposed to year-round employment) and who establishes a temporary home for the purposes of such employment. Migratory agricultural workers are usually hired laborers who are paid piecework, hourly or daily wages. The definition includes those individuals who have had such work as their principal source of income within 24 months of their last visit as well as their *dependent* family members who have also used the center. The dependent family members may or may not move with the worker or establish a temporary home. Note that agricultural workers who *leave* a community to work elsewhere are just as eligible to be classified as migratory workers in their home community as are those who migrate *to* a community to work there.

Seasonal Agricultural Workers – Seasonal agricultural workers are individuals *whose principal employment is in agriculture on a seasonal basis* (as opposed to year-round employment) and who do not establish a temporary home for purposes of employment, who are not also migratory. Seasonal agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. The definition includes those individuals who have been so employed within 24 months of their last visit and their dependent family members who have also used the center.

Homeless

The following are the definition for the homeless category set by the Bureau of Primary Health Care:

Street**:** An individual staying outdoors, such as camping or sleeping on the street or in a park, an encampment or freeway underpass; an individual staying in a car, van, bus, truck, RV or other vehicle; or an individual staying in an abandoned building or other structure generally not deemed safe or fit for human occupancy.

Homeless Shelter**:** An individual staying in a homeless shelter or mission on a short-term basis, including emergency shelters, informal shelters established by community organizations, domestic violence shelters or any other supervised public or private facility providing temporary living accommodations.

Transitional**:** An individual staying in a long-term shelter; a resident in transitional or supportive housing program; a resident of a treatment program providing living accommodations; a homeless individual currently living in a treatment program, half-

way house, or hospital; or an individual living in a Single Room Occupancy (SRO hotel) who does not have tenancy rights.

Doubling Up: An individual who is unable to maintain his/her housing situation and is forced to stay temporarily with friends and/or extended family members. The individual has been staying there for less than six months **and** does not have tenancy rights. The individual typically pays a marginal amount, such as < $300 a month for rent.
Note: Ongoing living in overcrowded housing conditions does not mean "Doubled Up."
Basic guidelines for helping you identify a doubled up situation are as follows:

- He or she is not making significant (greater than $300) rent payments nor is their partner
- He or she is not living with their parents or adult children**.**
- The individual has been staying there for approximately 6 months or less
- The individual anticipates needing to move out soon (he/she cannot stay in the housing indefinitely)

SECTION VII RESOURCE PAGE

The following are websites and documents that are on the internet that relate to providing services to the homeless population that could be used as you prepare the HCH/FH RFP Proposal:

The U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care (BPHC) http://bphc.hrsa.gov/

Information on the Uniform Data System:
http://bphc.hrsa.gov/healthcenterdatastatistics/index.html

The National Health Care for the Homeless Council (www.nhchc.org)
The National Health Care for the Homeless Council website provides many resources regarding providing primary health care, dental health care, and behavior health care and how to provide these services to homeless individuals.

National Association of Community Health Centers (http://nachc.com/)
Provides sponsorship for the National Farmworkers Health Conference (http://meetings.nachc.com/c-training/national-farmworkers-health-conference/).

National Center for Farmworker Health (http://www.ncfh.org/) is a private non-profit dedicated to improving the health status of farmworkers.

SECTION VIII - ENCLOSURES

Enclosure 1. Standard County Agreement with Independent Contractor

Enclosure 2. Standard County Agreement – Attachment I: Assurance of Compliance with Section 504 of the Rehabilitation Act of 1973, as Amended

Enclosure 3. Equal Benefits Program – Frequently Asked Questions

Enclosure 4. Exhibit E - Corporate Compliance Code of Conduct

Enclosure 5. Chapters 2.84 and 2.85 of the Ordinance Code of San Mateo County

Enclosure 6. HIPPA Requirements

TAB 8
Request to Approve SAC Draft

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: August 13, 2015

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

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: REQUEST FOR THE BOARD TO TAKE ACTION TO APPROVE THE DRAFT APPLICATION OF THE SERVICE AREA COMPETITION (SAC) GRANT

In accordance with the Board's Bylaws, Article 3, Section L, the Board has the responsibility to approve grant applications.

As the HCH/FH program's current grant period is coming to an end and the Health Resources and Services Administration has announced the opening of the SAC for the San Mateo County service area, homeless and farmworker target populations, the Board's approval of the grant application is required. The draft SAC application is attached.

This request is for the Board to approve the draft of the SAC application reflecting the content and the concept of the final submission due September 1, 2015. A majority vote of the Board members present is required to approve the grant application.

ATTACHED: DRAFT SAC APPLICATION

PROGRAM NARRATIVE

NEED

1) Describe the characteristics of the target population within the proposed service area:

The San Mateo Medical Center Health Care for the Homeless/Farmworker Health (HCH/FH) Program's target population is the estimated 5,555 to 7,151 people who experience homelessness in San Mateo County annually (2015 and 2013 San Mateo County Homeless Census) and the 2,100 migratory and seasonal farmworkers (California Employment Development Department, 2014) employed in farming and nursery operations in the rural Coastside region of San Mateo County and their estimated 2,520 family members (2,100 X1.2 (multiplier based on USDA estimates).

While each of these populations has unique characteristics and needs, both struggle to survive economically in an area with among the highest housing and other living costs in the United States. Located between San Francisco and Santa Clara County and bordered by San Francisco Bay to the east and the Pacific Ocean on the west, the HCH/FH service area is in the center of Silicon Valley. However, homeless people and farmworkers are economically, culturally and psychologically isolated from their affluent neighbors. They are concentrated in pockets of poverty that have become more crowded and less livable as gentrification forces more low income households to the brink of and into homelessness.

At the same time, the ever-increasing cost of housing is worsening existing socio-economic disparities in the service area. Rental costs for one and two bedroom apartments in San Mateo County are consistently ranked in the ten most expensive rental markets in the U.S. (Source: HUD Fair Market Rate Database). In June 2015, the market rent was $2,516/month for a one-bedroom apartment and $2,815/month for a two-bedroom apartment. Approximately 7,500 families are on closed waiting lists for public housing and rental assistance (Source: San Mateo County Housing Authority). Between June 2014 and 2015, the median cost of single family home in the county rose by 19.8%, from $1.085 million to $1.300 million (Source: County of San Mateo, Dept. of Housing).

As more high-tech firms locate in the service area, e.g. a large Facebook campus near a low income neighborhood, rental units are being torn down and/or upgraded to make way for higher density, mixed use development designed to attract high income renters. In coastal agricultural areas, demand for housing near the scenic shoreline has driven up rents and forced farmworkers into crowded, sometimes substandard housing. The San Mateo County Board of Supervisors recently waived many permitting and development fees for construction of farmworker housing. However, housing remains in short supply.

People experiencing homelessness: Table 1 shows trends in the overall service area homeless population and the sheltered and unsheltered homeless populations based on point-in time counts and the annualized homeless projections during HCH/FH's current project period. Between 2013 and 2015, the number of people experiencing at least one homeless episode annually decreased by 18% from 7,151 to 5,555 (Source: San Mateo Homeless Census, Corporation for Supportive

Housing projections). In the 2013 San Mateo County Community Health Needs Assessment, at least 1.4% of respondents who are currently housed or 8,042 adults (0.014 x 574,444 adults) reported having had to live on the streets, in a car, or in a shelter at some time in the past two years.

Table 1: Homeless Population Trends – 2009 to 2015

Point-in-Time Count	**2009**	**2011**	**2013**	**2015**	**% Change 2011-2015**
Total homeless	1,796	2,149	2,281	1,772	-18%
Unsheltered	803	1,162	1,299	775	-43%
Sheltered	993	987	982	997	+1%
Annual Homeless Estimate	NA	6,737	7,151	5,555	6%

Source: 2009, 2011, 2013 and 2015 San Mateo County Homeless Census, Point-in-Time Count; and Annual estimate from Corporation from Supportive Housing projections

The 2015 Homeless Count is still preliminary and data on the demographics of the homeless population is not available yet. In the 2013 Homeless Census Point-in-Time Count, the 2,281 homeless people identified were 60% White, 19% Latino, 13% African-American and 8% other/multiple races. The fact that African-Americans account for 13% of the homeless population but only 3% of the total service area population shows that African-Americans experience homelessness disproportionately. During 2013, 10% of the homeless people counted were adults with children. Extrapolating from the 2013 Homeless Survey, 71.5% were male, 28% were female and 0.5% were transgender.

The 2015 Homeless Census found homeless people living in almost every community in the service area. The highest per capita homeless populations, both sheltered and unsheltered, were concentrated in Redwood City (n=537) where many basic needs services are located, City of San Mateo (n=268), East Palo Alto (n=178), the poorest city in the service area, and Menlo Park (n=173). The largest unsheltered homeless populations were in Redwood City (n=223), Half Moon Bay/Coastside (n=116) and East Palo Alto (n=95). There are no shelter beds in Half Moon Bay or smaller Coastside communities where the MSFW population is concentrated.

Migrant and seasonal farmworkers (MSFW): Agricultural production and therefore farm employment dropped during HCH/FH's current project period. With shifts in crops and the ongoing effects of the recession on nursery operations, more agricultural jobs now provide only temporary employment for migrant and seasonal farmworkers. Farmworkers in San Mateo County work in the production of floral and nursery crops (potted plants, cut flowers, and bedding plants); vegetable crops (leeks, Brussels sprouts, pumpkins, peas, and fava beans); field crops (grain and hay); and fruit crops (wine grapes and strawberries); and in cattle and sheep ranching. The largest agricultural employers grow flowers, Brussels sprouts and leeks (San Mateo County Crop Report, 2012). Agricultural employment is highest during the second and fourth quarters of each year. Although the value of agricultural crops increased between 2010 and 2012, the number of acres in production dropped, resulting in a related decline in farmworkers' hours and wages.

From the second quarter of 2010 to the second quarter of 2013, average weekly pay for agricultural workers decreased from $561 to $520 (CA Employment Development Department, 2014) as rents and other costs rose. High housing costs force many farmworkers into near homelessness. Two, three or more farmworker families often share cramped single family dwellings. Some single farmworkers live in "agricultural housing," consisting of crowded, shared rooms with the only toilet and running water access in bathhouses in other buildings.

The following factors impact access to and utilization of health care by homeless people and farmworkers as well as other low income residents of San Mateo County.

a) Geographical/transportation barriers: Occupying 531 square miles, San Mateo County is characterized by its geographic contrasts. Four sub-regions define the service area: North County, South County and Mid-County typify the dense urbanization/suburbanization of the Bay Area Corridor linking Silicon Valley to San Francisco. The rural Coastside features agriculture, mountains and open space.

Homeless people experience financial and other practical barriers to accessing public transportation to attend health care appointments. Public transit fares have increased during the project period and service on intra-county routes has decreased as SamTrans, the local transit authority, focuses resources on routes serving high-tech job centers. Moreover, stress associated with homelessness strains people's planning and coping skills, making it difficult for many homeless people to identify bus routes and schedule travel time to health facilities. In a 2013 HCH/FH survey of 341 homeless people, a quarter of respondents cited lack of transportation as a barrier to health care. Transportation was most often an obstacle for shelter residents and people experiencing homelessness on the Coastside.

Distance and time create major geographic and transportation barriers for farmworkers employed by farm operations along San Mateo County's 54-mile rugged coastline which is separated from urban/suburban parts of the service area by the coastal mountain range. Farmworkers on the South Coast where larger agricultural employers are located must travel 18 miles of secondary roads to the Coastside Health Center and 30 miles over mountain roads to SMMC's main campus. HCH/FH and our partners have worked with the local transit agency to increase service to and from isolated Coastside agricultural communities. However, access to transportation is still limited and only available during weekdays when farmworkers are working. During planting and harvest seasons, they work extremely long hours and either end their work days after clinics close or are too exhausted to travel the long distances required.

In HCH/FH's 2013 focus group with farmworkers, participants reported delaying care due to transportation problems and then visiting emergency rooms when symptoms became severe. Women whose husbands drove the family vehicle to work said they often could not get to medical appointments for themselves and their children.

b. Uninsured: The U.S. Census Bureau's 2013 American Community Survey estimated that an estimated 70,106 persons county-wide were uninsured in 2013. Of the 147,450 residents below 200% FPL, 20.3% or an estimated 29,930 were uninsured, including 20,554 below 138% FPL

and 9,376 between 138-200% FPL. The County's uninsured population (above/below 200% FPL) has the following characteristics: 57.1% were male, 87.8% were ages 18-64, 49.7% were Latino, and 36.6% had part-time jobs. Most of the uninsured "working poor" were in households with one or more family members employed by small service businesses that have limited or no coverage for employees. During 2014, 36.4% (n=2,807) of HCH/FH's 7,707 patients were uninsured, including 41.7% of adult patients (2,387/5,720).

c) Unemployment and educational attainment:

- **Unemployment:** Although San Mateo County's overall unemployment rate is low, unemployment is persistent in the communities with large homeless populations and among low-skilled workers. In June 2015, for example, unemployment rates in East Palo Alto and North Fair Oaks (unincorporated area next to Redwood City), two communities with high concentrations of homeless residents, were 5.3% and 5.0% respectively, 60% higher than the countywide rate of 3.3%. Labor market analysis shows that rapid growth in professional and business service jobs in high-tech and finance have driven increases in employment while job growth in industries requiring lower skill levels has lagged. (CA Employment Development Department, 2014). In the 2013 Homeless Survey, respondents most often sited unemployment and high housing costs as the reasons they were homeless. Between 2013 and 2014, farm employment during the second quarter, the time of year when farm employment is highest, dropped from 2,200 to 2,100 jobs or by 4.5% (CA Employment Development Department, 2014).

- **Educational Attainment:** The 2013 American Community Survey (ACS) estimated that 25.4% of 55,095 County residents 25 years or older without a high school diploma had no health coverage versus 4.9% with a bachelor's degree or higher. In the 2013 San Mateo County Community Health Assessment Survey, 45.5% of the respondents with a high school education or less had incomes below 200% FPL, compared to 13.7% of those with education beyond high school.

d. Poverty and Income Level

- **Poverty:** In 2013, 147,450 service area residents or 19.9% of the service area population were in households with incomes below 200% FPL (Source: ACS, 2013). This is 19.2% higher than the 143,645 people below 200% FPL from the ACS 2008-2012 estimate used for the UDS Mapper.

- **Income level:** There are similar disparities in income levels in the service area. While overall household income continues to rise, wages for Latinos and African-Americans have dropped, down 18% for African-Americans and 5% for Latinos between 2009 and 2011 (Source: Joint Venture Silicon Valley, 2013). As noted above, average weekly pay for farmworkers decreased between the 2013 and 2014 growing seasons.

e) Health Disparities: San Mateo County's population experiences significant racial/ethnic and socio-economic health disparities. According to the 2013 American Community Survey, 58.1%

of the 742,989 service area residents were non-Caucasian, including 26.5% Asian/Pacific Islander, 25.3% Latino (any race), 2.5% African-American and 3.8% Other/Multiple Races. Low income service area residents that include the homeless and farmworkers experience disproportionately high rates of preventable health problems. Many health indicators exceed or equal the national benchmarks and/or county-wide averages used to measure disparities and access to care. The data below from the 2013 San Mateo County Community Health Assessment Health and Quality of Life Survey (HQL), UCLA's 2011-12 Community Health Interview Survey (CHIS) for San Mateo County, Centers for Disease Control & Prevention and other sources highlight the significant health disparities affecting San Mateo County.

- **Adult Obesity:** 32.3% of adults below 200% (vs. 27.6% national benchmark) are obese (BMI 30 or higher) and 32% are overweight and at-risk for obesity. Latinos (31.4%) and African-Americans (30.2%) have the highest rates for adult obesity (Source: 2013 HQL Survey).

- **Diabetes:** 17.9% of the adults below 200% FPL (vs. 8.1% national benchmark) were diagnosed with diabetes. From 1998 to 2013, the diabetes rate for all Latino adults regardless of income has increased from 5.0% to 10.8% (Source: 1998 and 2013 HQL Survey).

- **Hypertension:** 32.7% of the adults below 200% FPL (vs. 28.7% national benchmark) reported high blood pressure. African-Americans had the highest (38.9%) incidence of hypertension (Source: 2013 HQL Survey).

- **Asthma:** 21.3% of adults below 200% (vs. 9.0% national benchmark) have been diagnosed with asthma (Source: 2013 HQL Survey).

- **Cardiovascular:** 94.8% of the adults below 200% FPL (vs. 85.4% county-wide) exhibit at least one risk cardiovascular risk factor (e.g., obese, smoke, hypertension, etc.). From 2006 to 2010, African-Americans had the highest rate (191.2/100,000) for heart disease mortality (HP 2020 Goal = 100.8/100,000) (Source: 2013 HQL Survey).

- **All Cancers:** The four most prevalent cancers in San Mateo County were female breast, prostate, lung, and colon/rectum. Breast cancer was the most prevalent and had the highest age-adjusted mortality rate at 24.4/100,000 women from 2008-2010 (vs. 22.1% national benchmark). 13% of adults below 200% FPL (vs. 10.1% county-wide) are current smokers. African-Americans have the highest smoking rate (17.2%) (Source: 2013 HQL Survey).

- **Child Health:** In 2009, 93.4% of children six years old or younger in San Mateo County were not tested for elevated blood lead levels (vs. 84.1% national benchmark) (Source: CDC, Blood Lead Surveillance Report). Additionally, 26.3% of the low-income children ages 5-19 enrolled in the County's Child Health and Disability Program were obese (Source: California Pediatric Nutrition Surveillance System, 2010), and 34.9% (n=33,071) of the students enrolled during the 2013-14 school year were eligible for free or reduced price meals (Source: CA Dept. of Education, 2012).

- **Geriatric Health:** The county-wide percentage of older adults (65+) who had not had flu shots in the past year was 38.0% (vs. 32.6% national benchmark) (Source: CHIS, 2011-12). Among those 65 years or older, the county-wide rates for "ever diagnosed with hypertension or diabetes" were 58.7% and 23.1% respectively (Source: HQL Survey).

Other findings further highlight the access barriers to primary care affecting homeless people, farmworkers and other low income residents. The 2013 HQL Survey concluded "limitations in access have a discernible impact on the health status of county residents and in the way that health care is delivered in the community," based on survey findings that 28.2%, including 30.4% of Latinos, did not have a regular source of medical care; 26% perceived local access to health care as fair/poor; 22.7% cited the cost of medications; 19.1% cited overall costs; and 16.9% had difficulty getting appointments. In addition, 50.4% of uninsured respondents rated access to local health care services as "fair" or "poor" versus 8.5% and 27.0% of privately and publicly insured residents.

Adults without health insurance coverage also reported notably lower utilization of preventive health services when compared to privately insured individuals, including:

- 54.5% of uninsured had their blood pressure checked in the past year (vs. 85.3% of privately insured).
- 44.1% had a routine medical check-up in the past year (vs. 70.9% of privately insured).
- 25.3% had a flu shot in the past year (vs. 25.9% of privately insured).
- 13.9% had pneumonia shot ever (vs. 23.6% of privately insured).

Inadequate or limited access to preventive care also results in the under or late diagnosis of chronic conditions among the uninsured. Uninsured adults below 200% FPL, for example, were less likely to be diagnosed (16.9%) with asthma than insured adults (25.0%) below 200% FPL (Source: 2013 HQL Survey). Respondents living below the 200% poverty threshold more often report "fair" or "poor" health status than do those at higher income levels.

- 30.7% of those below 200% FPL self-reported "fair/poor" health (vs. 12.7% county-wide).

Reports of "fair/poor" health status were more frequent among Latinos and African-Americans (23% each) compared to Whites (11.0%) and Asian/Pacific Islanders (7.7%).

f) Unique Health Care Needs:

Homeless: Data from the 2013 Homeless Survey and HCH/FH's recent needs assessment points to significant health needs in the underserved homeless population. In the 2013 Homeless Survey 80% of respondents reported one or more health problems, including the following.

- 47.1% of respondents reported chronic medical problems.
- 72.5% said they had alcohol and/or other drug problems.
- 37.6% had mental health disorders, and

- 2.2% were living with HIV/AIDS.

Only 30.2% of homeless survey respondents said they were currently using medical care services and just 13% reported utilizing mental health services. Of the homeless people who reported using medical care, 35.9% identified hospital emergency rooms as their usual source of care.

Respondents to HCH/FH's 2013 needs assessment survey (n= 341) identified their top health care need as primary medical care (76%), dental care (55%), and mental health treatment (42%). Data on diagnoses of homeless patients served HCH/FH (Source: 2014 UDS Report) point to specific health care needs and disparities in the homeless population. Of the 5,596 homeless patients served in 2014:

- 1,333 or 23.8% were diagnosed with mental health disorders.
- 930 or 16.6% had substance abuse disorders.
- 706 or 12.6% were diagnosed with diabetes.
- 915 or 16.3% were diagnosed as overweight or obese.
- 367 or 6.6% were diagnosed with heart disease.
- 360 or 37.8% of the 951 homeless children served were diagnosed with lack of expected physiological development.

Farmworkers: As the number of farmworkers utilizing HCH/FH grew to 2,265 in 2014, the most unique and pronounced health care needs (Source: 2013 UDS Report) in this patient population included the following.

- **Mental health problems:** In 2014, higher numbers of farmworker patients were diagnosed with depression (n=69), anxiety (n=38) and other mental health disorders (n=100). The National Migrant Clinicians Network notes and HCH/FH providers have observed that "perpetual mourning" that is often associated with the experience of immigration (National Migrant Clinicians Network, 2012). Loss, grief, isolation, discrimination, confusion and uncertainty add to stressors of poverty, disease and biological predispositions. For some, the pre-migration experiences included violence and upheaval. The migration journey itself, particularly for the poor or undocumented, was often fraught with violence and risk. At HCH/FH's 2013 farmworker focus group, 90% of attendees said they did not know where to access mental health services.

- **Child health problems:** In 2014, HCH/FH delivered care for 1,204 children of farmworkers, of whom 214 or 17.7% were diagnosed with lack of expected physiological development. The National Migrant Clinician Network has identified common problems of farmworker families that contribute to lack of expected development, including parental poverty, frequent moves, low health expectations, interrupted schooling, overcrowded living conditions, and poor sanitation facilities. These children are at increased risk for respiratory and ear infections, bacterial and viral gastroenteritis, intestinal parasites, skin infections, scabies and head lice. Focus group participants reported delaying care for sick children due to inability to pay and transportation problems and then visiting emergency rooms when symptoms worsened.

- **Occupational injuries:** HCH/FH's experience reflects the findings of the 2010 National Farmworker Health Report on risks for a prevalence of injuries among farmworkers. Factors such as lack of training, poor safety precautions, over representation in dangerous industries, language barriers, piece-rate pay, undocumented worker status, and geographical and cultural isolation put these workers at increased risk for work related injuries and illnesses.

Cultural and Ethnic Factors: Of the 7,707 total patients who utilized HCH/FH services in 2014, 5,822 or 75.5% were people of color. Of the 5,596 homeless patients, 2,194 (39%) were Latino, 650 (12%) were African-American and 583 (10%) were Asian/Pacific Islander. Of the 2,265 MSFW patients, 1,954 or 86% were Latino. Cultural factors act as barriers to care for Latino, African-American, and Asian/Pacific Islander homeless people and MSFW, as follows.

- **Latino:** Latino attitudes regarding health and health care, especially among newly arrived immigrants, are often rooted in fatalistic beliefs about life and death, use of folk remedies, language and cost barriers and discrimination. Health services need to be planned and delivered in a culturally competent manner that uses the strong extended family, community and spiritual supports found in Latino cultures. In the HCH/FH survey, 38% of the 94 Latinos responding and 49% of the 49 Spanish only-speaking respondents reported experiencing disrespect from health care providers.
- **African-American:** Based on previous experiences, many African-Americans distrust health care providers and fear experiencing discrimination when they seek health care. Some believe, often as a result of their experiences, that health care providers will reject and ridicule home remedies and health beliefs based in African-American culture. Faith and religious institutions can play a pivotal role in increasing access in African-American communities.
- **Asian/Pacific Islander:** In San Mateo County's large immigrant Filipino community, cultural transitions make families particularly vulnerable to risk factors underlying health disparities. Immigrant parents working multiple jobs also do not have the time to seek healthcare for themselves or their children unless they have severe symptoms. Family and church-based programs have proven effective in improving health practices and healthcare utilization among Filipinos.

2. Other Health Care Access Indicators for the Target Population

a) Other Primary Care Services: As detailed in Attachment 1, Health Center Program (HCP) grantees only served 24,872 patients or 17.31% of the estimated 2008-2012 ACS low income population (n=143,645) below 200% FPL (UDS Mapper does not use 2014 UDS data). Of these patients, 19,133 were served by the HCH/FH Program and the South County Health Center (dba: Ravenswood Family Health Center), the only two San Mateo County-based FQHC programs.

RFHC, whose South San Mateo County service area includes the County's only MUA, served 11,617 patients, including 531 homeless patients through a HCH/FH contract for primary care and dental services. Most of the remaining 5,739 HCP patients were served by either the Gardner Family Health Network (GFHN) or North East Medical Services (NEMS), two community health centers whose main service areas are Santa Clara County and the City/County of San

Francisco respectively. GFHN recently opened a pediatric clinic on the border of Atherton and Redwood City in South San Mateo County and NEMS has a clinic in the North County city of Daly City. Neither clinic serves homeless or farmworker patients.

Although the San Mateo Medical Center (SMMC) clinics listed in Attachment 1 are an integral part of the HCH/FH network, the UDS Mapper Report does not report the non-HCP low income patients from the general community utilizing these clinics because the SMMC is not a Section 330(e) community health center. During 2013, approximately 50,000 low-income non-HCH/FH patients utilized the SMMC clinic system. Samaritan House, the small free clinic located in Redwood City only served 1,082 patients in 2013. Adding these 51,082 low-income patients to the 19,367 HCP patients means that 75,954 residents or just 52.8% (75,954/143,645) of the low-income population utilized the County's "safety-net" system of care during 2013.

The estimated county-wide number of residents below 200% FPL grew by almost 8,000 people between 2012 and 2013. As the low income population continues to grow, the demand for accessible care has become even more pronounced, particularly for homeless people and farmworkers. This demand or need is reflected in the 33% increase (from 5,799 to 7,707) in the number of HCH/FH patients between 2012 and 2014. The number of homeless utilizing the HCH/FH Program increased by 16.5% from 4,803 patients in 2012 to 5,596 in 2014 and the number of farmworker and family members increased by 120% from 1,031 patients in 2012 to 2,265 in 2014.

Based on the continued increase in the County's low income population along with the socio-economic factors that contribute to homelessness (e.g., high cost of housing and continued immigration of unskilled residents), the number of residents who are homeless in any one year is likely to average between 5,500 to 7,000 homeless people or more during the SAC project period. Many or most will be first time homeless residents newly eligible for HCH/FH services. The farmworker population may decrease slightly because of the gradual contraction of the farm and nursery industry on the Coastside, but the number of MSFW and related family members will still exceed 4,000 or more during the SAC project period.

Since the HCH/FH is the only healthcare service provider delivering comprehensive primary care designed specifically for homeless people and MSFW, the continuation of the HCH/FH Program is critical to meeting the on-going and increasing demand for accessible care by these two special populations.

b) Population to Physician Ratio: The county-wide population to physician rate is 1,413:1. The County's only geographic Health Professional Shortage Area (HPSA) covers East Redwood City, East Palo Alto and East Menlo Park, the areas with the highest concentration of homeless in the County.

3. Health Care Environment

a) Changes in insurance coverage: To implement the ACA, California expanded eligibility for the state's Medicaid program, Medi-Cal. Expansions of Medi-Cal eligibility include income eligibility up to 138% of FPL, determination of eligibility based on income without consideration

of assets, and eligibility for childless adults. State funds will support Medi-Cal coverage for legal immigrants excluded from federal funding. Medi-Cal coverage includes medical, dental, mental health and substance abuse services. The California Department of Health Services has also made changes in eligibility determination and enrollment procedures intended to simplify and streamline processes for getting and staying enrolled in Medi-Cal.

The recently passed 2015-2016 state budget expands eligibility for Medi-Cal for some immigrants who entered the U.S. illegally, including Deferred Action for Parental Accountability (DAPA) and the expanded category of Deferred Action for Childhood Arrivals (DACA) individuals earning up to 138% of FPL. The budget allocated funds for costs of coverage and for enrollment assistance.

Covered California, the state's health benefit exchange, began enrolling individuals, families and small businesses in coverage plans on October 1, 2013. Individuals and families in households with incomes from 138% to 400% of FPL who are citizens or legal residents are eligible for subsidies/premium assistance based on a sliding scale through Covered California. The exchange standardizes benefits plans provided by private insurers at four levels: bronze, silver, gold and platinum. Premiums, copayments, deductibles, coinsurance costs and/or maximum annual out-of-pocket expenses increase at each level.

The recently passed 2015-2016 state budget expands eligibility for Medi-Cal for some immigrants who entered the U.S. illegally, including Deferred Action for Parental Accountability (DAPA) and the expanded category of Deferred Action for Childhood Arrivals (DACA) individuals earning up to 138% of FPL. The budget allocated funds for costs of coverage and for enrollment assistance.

HCH/FH is an active participant in San Mateo County's efforts to enroll all eligible, uninsured residents in health coverage programs, including Medi-Cal and the local Access and Care for Everyone (ACE) low cost coverage program for low income residents ineligible for Medi-Cal and/or Covered California options and subsidies. Our outreach and enrollment activities are reducing the numbers of uninsured homeless people and MSFW. To date, HCH/FH has enrolled 373 previously uninsured homeless people and MSFW in Medi-Cal and/or Covered California.

b) Changes in uncompensated care programs: Changes in state funding have reduced local healthcare funding, especially funds to cover costs of care for undocumented immigrants. Reasoning that many more residents will have coverage through the ACA, the state budget linked Medi-Cal expansion to a major realignment of fiscal and programmatic responsibilities for human services programs, shifting them from the state to the counties. The budget diverted funds from county public hospitals to CalWORKs (California's TANF program). Based on the county-by-county formula for reductions in funding, San Mateo County lost $15 million in health realignment revenue in 2014-2015. However, we do not anticipate any effect on HCH/FH.

c) Economic or Demographic Shifts: As described above, extremely high and constantly rising housing costs contribute to homelessness and to economic hardship experienced by MSFW. The need to spend most income on housing puts even low and subsidized health coverage premiums,

co-pays and deductibles out of reach for many homeless people striving to transition to stable housing and MSFW struggling to maintain housing.

Two local, private hospitals operated by Daughters of Charity, Seton Medical Center in Daly City and Seton Coastside Medical Center in Moss Beach, are struggling financially, facing bankruptcy and threatening to close after a potential buyer backed out of a deal to purchase all six Daughters of Charity hospitals in California. Seton, the largest employer in Daly City, and Seton Coastside are reducing workforces and taking other cost-saving measures to attract a new buyer. Need for costly seismic upgrades, labor union disputes and the California Attorney General's requirement that any new buyer commit to operating the hospitals for ten years will complicate any potential sale.

d) Natural Disasters or Emergencies: Does not apply

e) Changes affecting specific populations: HCH/FH and the San Mateo County Health System Health Coverage Unit are working together to enroll hard-to-reach homeless and MSFW sub-populations in Medi-Cal. HCH Public Health Mobile Van visits to a reentry service center include services to assist homeless ex-offenders to enroll in Medi-Cal as soon as they are released from local jails and state prisons. Enrollment services based at Puente de la Costa Sur provide the specialized assistance and follow up farmworker families whose members have different immigration statuses need to enroll in health coverage.

RESPONSE

1. Appropriate and Responsive Service Delivery Models

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

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

2. Proposed Service Delivery Sites Appropriate for the Service Delivery Model

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

County-Operated

- **Public Health Mobile Clinics:** Mobile units make weekly visits to homeless shelters, the Fair Oaks Community Center, a reentry service center and street locations in Redwood City, San Mateo and San Bruno where homeless people congregate, A nurse practitioner provides twice weekly "black bag clinics" at a large shelter for single adults and a family shelter. Mobile services provide convenient, walk-in primary and preventive care, including illness and injury treatment, chronic disease screening, infectious disease testing, vaccinations for all lifecycles, emergency contraception, and health education.
- **SMMC Dental Mobile Unit:** Purchased with ACA Capital Investment Program funds, this mobile dental clinic with four dental chairs visits homeless shelter and service sites to provide comprehensive preventive, treatment and restorative oral health care. The Dental Van makes weekly visits to emergency and interim housing programs.
- **Behavioral Health Team:** This Behavioral Health and Recovery Services two-person case management team engages and assesses homeless consumers for mental health and substance abuse disorders, facilitates referrals to assure access to appropriate primary care and behavioral health (mental health and substance abuse) treatment, and follows up to promote ongoing participation in and compliance with treatment. The team is headquartered at the BHRS main office in San Mateo, but delivers services at shelter locations and places homeless people congregate throughout the County.
- **San Mateo Medical Center Clinics:** SMMC health centers located in low income communities throughout the service area provide comprehensive primary care to homeless and farmworker patients. In March 2015, the Coastside Clinic initiated a pilot primary care clinic for farmworkers one evening weekly at the Puente de la Costa Sur community center in Pescadero. Staffed by a physician, nurse and medical assistant and funded through a special tax measure, the pilot will expand to more evenings as demand warrants. Specialty Clinics on the main SMMC campus deliver indicated diagnostic and treatment services for patients referred by their primary care providers.

Contractor Services

- **Ravenswood Family Health Center (RFHC):** Under a contract with HCH/FH, RFHC, a Section 330 community health center located in East Palo Alto, delivers comprehensive primary care, including integrated behavioral health treatment, and oral health services for homeless people. RFHC's Homeless Health Navigator assists patients to access all needed health care and support services.
- **InnVision Shelter Network:** HCH/FH contracts with InnVision Shelter Network, the largest homeless service provider in the region, for case management services and

eligibility assistance throughout the county to connect homeless people to health coverage and HCH/FH primary care, and to assist chronically homeless people to complete applications for SSI and SSDI benefits.

- **Samaritan House:** HCH/FH's contract with Samaritan House supports shelter-based case management services that actively assist homeless residents of the Safe Harbor emergency shelter located in north San Mateo County to access HCH/FH primary care.
- **Puente de la Costa Sur:** HCH/FH contracts with this community center located near farm operations on San Mateo County's south coast to provide case management that educates farmworkers and their families about available health services, assists with enrollment in health coverage, and helps overcome scheduling, transportation, cultural and other barriers to care.
- **Sonrisas Community Dental Clinic:** HCH/FH contracts with Sonrisas to provide oral health services to MSFW at Puente's community resource center, work sites, and housing locations in the South Coast region. The Sonrisas Registered Dental Hygienist in Alternative Practice (RDHAP) performs basic oral health observations and relays findings back to the Sonrisas Dental Director to determine the most appropriate treatment for the patient. The Field Hygienist provides cleaning, oral health maintenance information and supplies, and works with Puente case managers to coordinate referrals to the Sonrisas clinic in Half Moon Bay.

b) How the type and location of each proposed service delivery site assures that services are, or will be, accessible and available at times that meet the needs of the target population: The HCH/FH network of care includes eight fixed site clinics, two mobile medical units, and a dental mobile unit with locations at and near places that homeless people and farmworkers frequent. HCH/FH will continue to provide comprehensive primary care during hours convenient for homeless people and farmworkers, as follows. Schedules are reviewed and adjusted based on utilization and feedback from patients and homeless service providers.

- **Public Health Mobile Clinics:**

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

HCH/FH has proposed using Expanded Services Supplemental funding to add weekly nurse practitioner visits to street locations with Homeless Outreach Teams, weekly

nurse practitioner visits to farmworker job sites with Puente case managers, and weekly RN health assessments at a community center in the north coast region.

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

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

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

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

c) Capacity of service sites to achieve the projected number of patients and visits: SMMC health centers have space and staffing to provide care for the projected number of patients through the projected number of visits. Mobile medical and dental units are configured and staffed to serve additional patients. In May 2015, RFHC opened a new, 38,300 square foot clinic in East Palo Alto that will double the health center's capacity during the proposed project period.

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

follow up. Bilingual coverage and/or translation services are available for after hours calls to meet the needs of the target population.

3. Describe How the Proposed Primary Health Care Services (Consistent with Form 5A) And Other Activities (Consistent with Form 5C) Are Appropriate for the Needs of the Target Population.

a) Required and Additional Clinical and Non-Clinical Services: HCH/FH's approach to delivering primary health care takes into account our target populations' daily struggles with homelessness, arduous farm employment, economic hardship and inter-related health and psychosocial problems. Primary health services delivered directly and through HCH/FH's agreement with RFHC without regard to ability to pay include the following.

PRIMARY CARE

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

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

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

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

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

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

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

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

CHRONIC DISEASE MANAGEMENT

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

PREVENTIVE SERVICES

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

- **Children's wellness care:** Clinics provide Child Health and Disability Prevention services for patients ages birth through 17 based on CHDP periodicity schedules. Services, include: immunizations; developmental, oral health, nutritional, and psychosocial/behavioral assessments; physical exams; BMI measurement and related nutrition and physical activity counseling; vision and hearing screening; blood lead, TB and other indicated tests; and culturally and linguistically competent education for parents/caregivers and teens on healthy development, health risks, and the importance of regular preventive health care.

- **Women's wellness care:** Patient care teams educate women about the importance of and provide preventive services, including: pelvic and breast exams, mammograms, pap tests, HPV testing and vaccinations, voluntary family planning services, pregnancy testing, counseling on the prevention of and screening for sexually-transmitted infections,

screening for and counseling on domestic violence, blood pressure and cholesterol checks, colon cancer screenings for women over 50, and appropriate immunizations.

- **Men's wellness care:** In addition to physical exams, blood pressure and cholesterol checks, immunizations, and colon cancer screening for men over 50, HCH/FH clinics provide STI screening and education and prostate screening, as appropriate.

- **Well-senior health care:** Preventive care for seniors includes annual physical exams; review of medications; cancer, depression, functional, and cognitive screenings; and vaccines for flu, pneumonia, and shingles. Wellness exams identify senior patients needing more intensive care coordination and case management especially in the growing population of homeless seniors utilizing the HCH/FH mobile clinic and Ron Robinson Senior Care Center.

BEHAVIORAL HEALTH SERVICES

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

ORAL HEALTH CARE

HCH/FH provides comprehensive oral health services to homeless people through HCH/FH Dental Van visits to homeless shelters and service sites, SMMC fixed site dental clinics, and Ravenswood Family Dentistry contracted services. Farmworkers access dental care at the Coastside Clinic dental clinic. Oral health services include comprehensive oral health exams, treatment planning, dental hygiene education, diagnostic and preventive care, restorative care, and oral surgery. In 2014, 1,318 HCH/FH patients utilized dental care through 3,783 visits.

SUBSTANCE ABUSE SERVICES FOR HOMELESS PEOPLE

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

MSFW SPECIFIC HEALTH SERVICES

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

ENABLING SERVICES

The following enabling services are specifically designed and delivered to eliminate barriers to accessing care and to assist homeless and farmworker patients to utilize comprehensive, consistent care.

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

- **Transportation:** HCH/FH sites and mobile unit visit locations are situated in neighborhood locations that make it possible for most homeless patients to walk or take bus lines to clinic appointments. SamTrans Redi-Wheels paratransit provides transportation for patients with disabilities and those needing special assistance. HCH/FH provides taxi vouchers that case managers distribute to patients who need to visit a clinic immediately, are not able to arrange Red-Wheels transit on short notice, and are too ill to take regular public transit. Puente de la Sur works with SamCoast to coordinate transportation for farmworkers.

- **Case management:** HCH/FH contracts with key community partners to provide case management services that provide the practical support and motivation farmworkers and homeless people need to connect to medical homes, including information about available services, assistance in making appointments, appointment reminders, assistance arranging transportation, and encouragement to attend appointments and follow treatment and self-care plans. Puente de la Sur provides case management for farmworkers and their families, including communication and advocacy with farm operators to reduce environmental and occupational health hazards and make farmworker health a priority, e.g. coordinating tetanus and other immunizations for farmworkers provided by Coastside

Clinic staff at work sites. InnVision Shelter Network and Samaritan House provide case management for homeless individuals and families, including linkages to substance abuse treatment programs. A County Behavioral Health and Recovery Services team delivers intensive street-and shelter-based case management to assist chronically homeless people with mental health and substance abuse disorders to access primary care coordinated with behavioral health treatment.

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

b) Method by which enabling services such as case management, outreach, and transportation are integrated into the primary health care delivery system: Community-and shelter-based case managers and RFHC's Homeless Health Navigator provide a range of services based on each patient's needs to support patients to access primary care and follow treatment plans, including transportation assistance, motivational interventions, and linkages to community services and supports. The HCH/FH Providers Collaborative offers a forum for case managers and healthcare providers to communicate about strategies to meet the needs of individual patients and to plan system-wide communication and access improvements.

4. Proposed Clinical Team Plan

a) Provider types and support staff necessary for projected number of patients: The HCH/FH clinical staffing pattern provides adequate staffing to deliver care for the projected number of patients, including the large number of complex patients and patients who have lacked access to care for long periods. As detailed on Form 2, the medical clinical team includes: **TO BE INSERTED WHEN BUDGET IS FINAL.**

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

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

c) Appropriate mix for providing required services: The clinical staffing mix has been designed to deliver comprehensive care targeting the health needs of patients who have lacked access to care and patients with multiple chronic conditions, and to achieve efficient productivity levels for services to HCH/FH high-need target populations.

5. Continuity of Care and Access to Continuum of Care.

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

b) How these arrangements ensure a continuum of care, including discharge planning, post-hospitalization tracking, and patient tracking (e.g., shared electronic health records): The SMMC EHR and e-messaging system facilitate communication between out-patient physicians and hospitalists, track hospitalizations, and track patient utilization across systems. RFHC participates in the e-messaging system and receives messages on hospitalizations and discharge planning.

6. Sliding Fee Discount Schedule

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

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

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

registration for appointments. Reassessments of eligibility for sliding fee discounts are conducted at least annually.

d) Language and literacy level-appropriate methods to make patients aware of sliding fee discounts: Multi-lingual signs posted in clinic reception and waiting areas inform patients in simple English, Spanish, Chinese and Tagalog language terms about the availability of discounts and clearly state that HCH/FH provides health care regardless of ability to pay. HCH/FH also provides information about discounts and that services are available regardless of ability to pay in all registration and outreach materials. Bilingual outreach and front office staff verbally inform patients of the availability of sliding fee discounts.

e) How sliding fee discounts are applied to both required and additional services within the scope of project: Sliding fee discounts are applied to all HCH/FH services.

f) Method and frequency of evaluating the sliding fee discount program from the perspective of reducing patient financial barriers to care: Patient surveys and focus groups inform annual review of the sliding fee discount program by the Co-Applicant Board.

7. Description of the Sliding Fee Discount Schedule

a) Annual updates to reflect the most recent Federal Poverty Guidelines (FPG): The Co-Applicant Board reviews and approves updates to the SDFS proposed by staff to reflect the most recent FPG. The SFDS was most recently updated and approved by the Co-Applicant Board on October 20, 2014.

b) Adjustment of fees for individuals and families with incomes above 100 percent of FPG, and at or below 200 percent of the FPG, using at least three (3) discount pay classes: The SDFS in Attachment 10 uses four discount pay classes based on income thresholds by family size: 0-100% FPG no charge, 101-138% FPG 98% discount, 139-170% FPG 95% discount, 171-200% FPG 80% discount.

c) Provision of a full discount (or nominal charge) for individuals and families with annual incomes at or below 100 percent of the FPG: As shown in Attachment 10, the HCH/FH SFDS provides for a full discount for individuals and families with annual incomes at or below 100% FPG.

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

8. Quality improvement/quality assurance (QI/QA) and risk management plan(s) for systematically assuring and improving health care quality, including policies, procedures, and parties responsible for:

a) Addressing patient grievances: Patient/client grievances and complaints are treated with the highest importance. Complaints and concerns should be resolved at the program level whenever possible. When an issue cannot be resolved, procedures are followed as described in the policy in

the SMMC Rights and Responsibilities of the Patient chapter in WorkSite titled RI.01.07.01-B Patient Grievance Procedure. Complaints and grievances, which relate to quality of care issues, are referred to the appropriate department or committee for review and action. The HCH/FH Medical Director and Executive Director share responsibility for ensuring grievances/complaints are addressed.

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

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

d) Periodic assessment of appropriateness of service utilization, quality of services delivered, and patient outcomes that are conducted by physicians or other licensed health professionals under the supervision of physician: Based on SMMC policies and procedures, the HCH/FH Medical Director establishes procedures for and supervises reviews of electronic health records and/or representative samples of SMMC clinic patient charts to measure progress toward selected clinical performance measures and other quality indicators. The QI Plan developed annually by the QI Committee and approved by the Co-Applicant Board identifies clinical performance measures and other indicators. Reviews of patient records are conducted quarterly by licensed health professionals.

e) Process and parties responsible for ensuring providers (e.g., employed, contracted, volunteers, locum tenens) are appropriately licensed, credentialed, and privileged to perform proposed services at proposed sites/locations: SMMC primary care providers delivering care for homeless and farmworker patients are subject to SMMC credentialing and privileging policies and procedures. SMMC follows Board-approved policy and procedures to assess and verify the credentials of all licensed and certified health care practitioners it employs and to grant such individuals specific clinical privileges in full compliance with the HRSA requirements. The SMMC Board votes to approve the credentialing of providers whom the QI committee has put forward as having complete credentialing. The credentialing process documents current licensure and verifies appropriate education, training, certification and work history, and includes checks of criminal records, National Practitioner Database, and professional liability claims, as well as signed statements attesting to fitness to work and accuracy of documentation provided. At the

time of appointment, providers are privileged based on their skills to perform specific types of care in an ambulatory care setting by the CMO and privileges are reviewed by the QI Committee, signed by the CMO and approved by the Board. Privileges are renewed based on re-credentialing every two years. Re-credentialing includes peer review of patient records for compliance with clinical guidelines and QI target goals. The HCH/FH Executive Director assures that RFHC uses similar policies and procedures to ensure that providers delivering care for homeless patients under contract with HCH/FH are appropriately licensed, credentialed and privileged.

f) Utilization of appropriate information systems measures (e.g., electronic health records, payment management systems) for tracking, analyzing, and reporting key performance data, including data necessary for 1) required clinical and financial performance measures and 2) tracking of diagnostic tests and other services provided to health center patients to ensure appropriate follow up and documentation in the patient records: SMMC has implemented the eClinical Works (eCW) EHR. During the proposed project period, eCW will track and generate reports on HCH/FH performance measures and patient services. eCW sends orders for lab and radiology tests and incorporates findings in patients' EHRs, including alerts when results are out of range. EHRs also include reminders when patients are due for preventive services. eCW also has payment management features.

g) Developing, updating, and obtaining board approval for such policies and procedures, including their implementation: The QI Committee develops and annually updates QI policies and procedures for Co-Applicant Board approval. The Co-Applicant Board most recently approved implementation of updated policies and procedures on May 14, 2015.

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

i) Accountability throughout the organization, specifically the role and responsibilities of the Clinical Director in providing oversight of the QI/QA program: The Co-Applicant Board approves QI policies and procedures and annual QI plans; regularly reviews reports on QI findings; and delegates implementation of QI activities to the QI Committee led by the Medical Director. The Medical Director provides clinical leadership for implementation of the QI Plan and is responsible for leadership of the QI Committee, oversight of chart reviews, supervision and review of assessments of progress toward clinical performance measure target goals, oversight of compliance with and participation in quality improvement and risk management plans and activities, and review of and response to any reported incidents. At the recommendation of the HRSA site visit team, HCH/FH has increased Medical Director time from 0.10 FTE to 0.25 FTE to provide more time to carry out QI responsibilities and provide clinical leadership for the program.

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

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

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

COLLABORATION

1. Collaboration and Coordination of Services with Other Providers

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

a) Existing health centers: HCH/FH contracts with the Ravenswood Family Health Center, the only Section 330 Community Health Center in San Mateo County to provide primary care and oral health services for homeless residents of East Palo Alto. We also have cross-referral agreements with Gardner Family Health Network, a CHC/HCH program based in neighboring Santa Clara County, which recently opened a pediatric clinic in South San Mateo County. (Please see letters of support from RFHC and GFHN in Attachment 9.)

b) State and local health departments: HCH/FH is a component of the San Mateo Health System, which encompasses the local public health department and San Mateo Medical Center. We work closely with the Health Coverage Unit on enrollment of homeless people and MSFW in health coverage and with the SMMC Resources Management Department which is involved in

discharge planning for SMMC hospital patients. Resource Management staff now attend HCH/FH Providers Collaborative meetings to establish relationships with HCH/FH case management programs.

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

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

c) Rural health and free clinics: There are no rural health clinics in the service area.

d) Free clinics: Samaritan House's volunteer-based clinics in Redwood City and San Mateo, and the volunteer-based Rota-Care clinic in the Coastside region of San Mateo County provide urgent care and refer homeless and farmworker patients to HCH/FH for comprehensive primary care.

e) Critical access hospitals: There are no critical access hospitals in San Mateo County.

f) Other federally supported programs: Ryan White funds help support HIV care and support services at the SMMC Edison Clinic, an HCH/FH site which provides health care and support services for homeless people and farmworkers living with HIV/AIDS. HCH/FH facilitates referrals for services for children with special needs to the county's Title V-funded California Children's Services (CCS) program and coordinates primary care with CCS.

g) Private provider groups serving low income/uninsured patients: No private provider groups in the service area serve low income/uninsured patients.

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

i) Programs serving the same target population: HCH/FH and WIC programs countywide have cross-referral agreements. School district homeless and migrant education programs refer families for services.

j) Organizations that provide services and supports to homeless people and MSFW:

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

Homeless Service Providers

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

- InnVision Shelter Network provides case management to link homeless shelter residents to primary care through a contract with HCH/FH; provides space and coordinates referrals for HCH/FH medical and dental mobile unit visits to the Maple Street Shelter; refers participants in transitional living, supportive housing, rapid re-housing and support service programs to HCH/FH; and provides services for homeless patients referred by HCH/FH.

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

- Core service centers operated by Daly City Community Service Center, El Concilio Emergency Services Partnership in East Palo Alto, Fair Oaks Community Center and Pacifica Resource Center, which provide food assistance, housing referrals, and linkages to other community services, refer clients to HCH/FH and provide services for homeless patients referred by HCH/FH.

Organizations Serving Farmworkers

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

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

- Coastside Health Committee participation gives HCH/FH staff and contractors opportunities to network with various medical, dental and nutrition programs in the area where MSFW live and work.

k) Neighborhood revitalization efforts: There are no federally funded neighborhood revitalization programs in the service area.

2. Letters of Support from Health Care Providers

Attachment 9 includes letters of support from: San Mateo County Public Health and Behavioral Health and Recovery Services, RFHC and GFHN. Please note that there are no state health programs, rural health clinics, critical access hospitals, or private provider group serving the target populations in San Mateo County.

3. Letters of Support from Community Organizations

Attachment 9 includes letters of support from some of the many community organizations with which HCH/FH collaborates. Due to space constraints, additional letters are on file.

EVALUATIVE MEASURES

1. Clinical Performance Measures

The attached Clinical Performance Measures Form provides required information for all measures.

The Clinical Performance Measures Form identifies key contributing and restricting factors and key planned actions for each measure. Several overarching factors are relevant to all measures. In general, key restricting factors emphasize the high level of needs among HCH/FH's large population of patients with complex chronic conditions that have been un/under-treated due to

lack of access to care and, in many cases, exacerbated by co-occurring behavioral health disorders. Key contributing factors include HCH/FH's network of care in which frontline primary care and enabling services are delivered where homeless people and farmworkers are and linked to comprehensive primary care, oral health services and behavioral health treatment at fixed site clinics throughout the service area.

2. Financial Performance Measures

The Financial Performance Measures Form contains all required information on goals, measures and contributing and restricting factors.

The Financial Performance Measures Form also details contributing and restricting factors and describes major planned actions for each of the two performance measures. The following summarizes overarching contributing and restricting factors and key planned actions. Similar to the clinical performance measures, key contributing factors to meeting and exceeding our financial performance goals include the full implementation of an emphasis on patient-centered medical homes care to contain costs, increase productivity, manage/increase utilization, and enhance revenue. The major restricting factors are that the need and demand for affordable care among homeless people and MSFW in San Mateo County will outpace our capacity to provide accessible care and that the large percentage of uninsured homeless and MSFW adults ineligible for ACA health coverage programs increase the number and cost of uncompensated visits. Renewal of our Section 330/FQHC designation, ongoing outreach and enrollment activities, and continuing efforts to maximize productivity and efficiency will ensure that the HCH/FH continues to achieve our target goals during the upcoming SAC project period.

3. Ongoing process for assessment of the health care needs of the target population.

a) Frequency and when the last assessment occurred: HCH/FH conducts assessments every two years and updates annually. We most recently completed an assessment of target population health needs in 2013 and are currently completing a new assessment.

b) Community engagement: We engage and gather assessment information from shelter residents, farmworkers, patients, and healthcare and service providers through surveys and focus groups conducted with our community partners.

c) Assessment tools, methods and analysis: HCH/FH uses internal data on utilization, diagnoses, clinical and financial performance measures, and patient satisfaction; external data from the San Mateo County Community Health Assessment and Health & Quality of Life Survey, the San Mateo County Homeless Census and Survey, County Center on Homelessness reports, a recent South Coast Community Health Assessment conducted by Stanford University, and the UCLA California Health Interview Survey's (CHIS) findings for San Mateo County.

HCH/FH has developed a program-specific patient satisfaction survey and will begin administering the survey in October in English and Spanish. Survey questions cover access, quality of care and communications, and cultural competence of services. Analysis of survey

findings by program staff for review by the QI Committee and Co-Applicant Board will include disaggregation by race/ethnicity and language to assess cultural appropriateness of services.

d) Dissemination of results: HCH/FH disseminates evaluation findings through written reports and presentations at Co-Applicant Board meetings open to the public and Providers Collaborative meetings.

4) Additional evaluation activities.

The QI Committee is planning in depth analysis of clinical performance measures that did not meet expectations in 2014. This analysis will include disaggregation of data by race/ethnicity, homeless/ MSFW status, health care service site(s), and other variables

RESOURCES/CAPABILITIES

1. Organizational Structure.

HCH/FH is a program of the San Mateo Medical Center, a component of the San Mateo County Health System. A Co-Applicant Board governs the program in conjunction with the San Mateo County Board of Supervisors and San Mateo Medical Center Board of Directors (please see the Co-Applicant Board agreement in Attachment 6). The Co-Applicant Board exercises all programmatic and policy-setting authority for the program, except that the Board of Supervisors and SMMC Board of Directors, as appropriate, maintain the sole authority to set general policy on fiscal and personnel matters pertaining to all County facilities and programs.

a) How lines of authority are maintained from the governing board to the executive director: As depicted in the organizational chart in Attachment 3, the Co-Applicant Board sets policies and establishes priorities for HCH/FH and delegates responsibility to manage program implementation to the Executive Director. The Co-Applicant Board makes decisions regarding the selection and continued leadership of the Executive Director; however the Co-Applicant Board does not have authority to hire or fire any County employee and County employment must still meet all County requirements. The Co-Applicant Board annually evaluates and provides feedback to the Executive Director on his/her performance related to HCH/FH. San Mateo County annually evaluates and provides feedback on performance related to County criteria and standards. Both evaluations become part of the Executive Director's personnel file.

b) Whether the organization is part of a parent, affiliate or subsidiary organization: As noted above, HCH/FH is a component of the San Mateo Medical Center. It is not part of an affiliate or subsidiary organization.

2. How the Organization Maintains Appropriate Oversight and Authority Over All Proposed Service Sites, Including Contracted/Sub-Awarded Sites, and Services.

a) Current contracts and agreements: As summarized in Attachment 7, HCH/FH has memoranda of understanding agreements with San Mateo Public Health for the delivery of mobile primary care and San Mateo County Behavioral Health and Recovery Services for

provision of shelter-based behavioral health assessments and case management. HCH/FH contracts with Ravenswood Family Health Center to deliver primary care and oral health services for homeless residents of East Palo Alto at RFHC's clinic there, with InnVision Shelter Network and Samaritan House for shelter-based case management and health coverage enrollment assistance for homeless people, with Puente Costa de la Sur for case management and health coverage enrollment assistance for farmworkers and their families, and with Sonrisas Community Dental Center for oral health care for farmworkers.. Based on policy and procedures approved by the Co-Applicant Board implements monitoring and evaluation processes for all executed contracts. These include, at a minimum:

- On a quarterly basis staff reports to the Board on contractor utilization, cost and quality;
- As indicated by invoices and/or reported data, staff confers/negotiates with contractors to achieve performance goals and insure data accuracy and integrity;
- On at least an annual basis, staff conducts an on-site visit to each contractor to determine compliance with contract terms and validate invoice and data reporting. Staff confirms compliance with Section 330 (g & h) requirements.
- Results of site visits are reported to the Co-Applicant Board. If the Board determines additional action is required, the Board shall direct program staff to take such action.

b) Subrecipient arrangements, subawards, contracts, or parent/affiliate/subsidiary agreements: Does not apply.

3. Management Team.

HCH/FH's management staffing pattern effectively supports our current operations while maximizing use of resources for the delivery of patient care. The management team currently consists of 1.0 FTE Executive Director, 0.25 FTE Medical Director, and 1.0 FTE Program Coordinator. The SMMC Executive Management Team provides executive oversight and leadership and assures that adequate resources are available for the program.

a) Defined roles: Position descriptions in Attachment 4 detail the responsibilities of the Executive Director for overall program leadership and management, the Medical Director's responsibilities in providing clinical leadership and managing quality improvement activities, and the Program Coordinator's duties relating to day-to-day management.

b) Skills and experience: The biographical sketches in Attachment 5 provide detailed information on the qualifications of management team members which are summarized below.

- **Executive Director Jim Beaumont:** Mr. Beaumont has led HCH/FH for five years. He has over 30 years of highly progressive experience in social service program management and administration including program operations, fiscal management, automation, program reviews, budget development, and program development and coordination. Mr. Beaumont served as an Administrative Services Manager in the San Mateo County Department of Child Support Services for 15 years before his appointment as HCH/FH Program Director. Mr. Beaumont has a Bachelor of Arts degree in Psychology from

Huron College in South Dakota and has completed course work toward a Masters in Public Administration at California State University-Hayward.

- **Medical Director Frank Trinh, MD:** Dr. Trinh has 13 years experience delivering and supervising primary health care for vulnerable populations and special expertise in infectious diseases that disproportionately affect homeless people and farmworkers. A board-certified internal medicine physician, Dr. Trinh is a graduate of the University of Maryland School of Medicine and completed clinical training in infectious diseases at the Stanford University School of Medicine. In addition to serving as HCH/FH Medical Director, he delivers primary care to homeless people through the HCH/FH Public Health Medical Mobile Unit and leads the San Mateo County Hepatitis B Free Steering Committee.

- **Program Coordinator Linda Nguyen, MPA:** Ms. Nguyen joined HCH/FH in 2014. She previously worked as a Human Services Analyst II for the San Mateo County Center on Homelessness. She brings strong relationships with homeless service providers and excellent contract management and data analysis skills to the program. Ms. Nguyen has eight years of experience in management and administration. She holds a Master of Public Administration and a Bachelor of Arts in political science from San Jose State University. Ms. Nguyen is bilingual (English/Vietnamese).

c) Shared key management positions: Does not apply.

d) Changes in key management staff in the past year: San Mateo County recently reclassified the former Program Director position to an Executive Director position, reflecting the complexity of HCH/FH management responsibilities. HCH/FH increased Medical Director time from 0.10 FTE to 0.25 FTE to provide sufficient time for QI leadership activities. Linda Nguyen was appointed Program Coordinator (see above) upon the resignation of Naida Pare-Alanda who moved to another state.

4. Plan for Recruiting and Retaining Key Management Staff and Providers

There are no vacant positions at this time. SMMC recruits key management staff through internal promotions, web site postings and professional association web sites and events. SMMC recruits providers for HCH/FH through the National Health Service Corps, postings on our website, in professional journals, and on California Primary Care Association, National Association of Community Health Centers and other websites. Because of the high cost of housing and living in the San Francisco Bay Area, a competitive above-average wage structure has also been established to attract/retain managers and providers.

5. Expertise in the Following Areas

a) Working with the target population: The HCH component of HCH/FH was first funded through a $150,000 award received in 1991. Over the past 24 years, the program has provided uninterrupted, comprehensive health care services to the homeless population through a multi-disciplinary network centered on primary health care, oral health services and behavioral health

treatment. In 2010, HCH/FH established our farmworker or migrant health component in response to the unmet needs of agricultural workers and their families in the rural Coastside region in San Mateo County.

HCH/FH providers and staff are experienced with, sensitive to, and respectful of our patients and their concerns, fears, and barriers. Providers and staff are fluent in the languages and norms of the target populations, and receive ongoing training on issues affecting the health and access to care of homeless people and farmworkers. Providers and staff possess the training, skills and compassion needed to engage hard-to-reach homeless people and farmworkers in comprehensive services, as well as provider expertise in health conditions that homeless persons and farmworkers experience disproportionately. To engage individuals and families who have lacked access to care, providers and staff convey respect and compassion in all interactions, avoid judgment, make patients' self-determined needs priorities, and are appropriately flexible. HCH/FH works in partnership with organizations that provide services needed and valued by our clientele, which serves to enhance trust and credibility.

b) Developing systems and services appropriate for addressing the target population's health needs: Throughout the program's history, HCH/FH has developed, adapted, and expanded services and systems to meet the needs of our target populations, including the development of farmworker health services. The development of a structured Provider Network with has strengthened linkages among health care and enabling services providers to more effectively engage homeless and farmworker patients in patient-centered medical homes. To address gaps in access identified by the Provider Network, HCH/FH will use Expanded Services Supplemental funds to provide more and more intensive mobile health services for underserved unsheltered, chronically homeless people and field-based primary care for farmworkers at job sites.

6. Ongoing Strategic Planning Approach.

a) Role of governing board, key management staff, and other relevant individuals: The Co-Applicant Board leads the ongoing strategic planning process and approves all strategic plans and updates/changes to strategic plans. The HCH/FH Executive Director oversees the collection and analysis of data to inform strategic planning, ensure that quality improvement findings guide strategic planning, manage implementation of strategic plan action steps, and regularly report to the Co-Applicant Board on progress. People in the target populations, patients, healthcare providers, and other service providers inform strategic planning through participation in surveys and focus groups. The current strategic plan was approved by the Co-Applicant Board at the July 2014 Board meeting.

b) Frequency of strategic planning meetings: These meetings are held at least annually.

c) Strategic planning products: HCH/FH developed a strategic plan in 2014 and is currently working on an update and an annual tactical plan. The strategic plan's program analysis identified major strengths and weaknesses, as follows.

- **Strengths:** Dedicated and passionate staff and other service providers, patient-centered care focus, active engagement of Co-Applicant Board and staff members in identifying

and developing solutions to problems, commitment to ongoing improvement and community engagement, emerging QI process, and representation of formerly homeless individuals on the Co-Applicant Board.
- **Weaknesses:** Independent functioning of teams and agencies, lack of resources to address increasing demand, and need for farmworker representation on the Co-Applicant Board.

Based on the analysis, the plan established the following strategic goals for HCH/FH.

- Improve access to care and care coordination.
- Ensure insurance enrollment to encourage patient visits for care and to improve finances.
- Employ the QI process to enhance care quality and identify care problems.
- Expand community engagement by creating an informative website and recruiting Co-Applicant Board members with skills such as public advocacy.
- Improve access, coordination and utilization of SMMC infrastructure services to benefit program operations.
- Pursue upcoming funding opportunities.

d) How the target population's health needs have been or will be incorporated into strategic plans: The strategic plan was the basis for determining program priorities for each target population.

- **Homeless:** Medical case management, health navigation, eligibility assistance, psychosocial case management, staff/provider training, and transportation.
- **Farmworkers:** Eligibility assistance, health navigation, medical case management, support for community organizations serving farmworkers, health education, and transportation.

The update to the strategic plan will set out goals, objectives and strategies to address target population health needs identified through ongoing assessment, including but not limited to:

- Respite care for homeless people discharged from in-patient care,
- Expansion of shelter-based services for homeless patients with complex chronic conditions,
- Targeting of services for the growing population of homeless formerly incarcerated people,
- Mobile health services to reach farmworkers and their families at work and housing sites,
- Access to medications in appropriate community locations for farmworkers and their families, and
- Enhanced integration of primary care and behavioral health treatment.

7. Implementation of EHR.

SMMC has implemented the eClinical Works EHR at all 11 health center sites in the HCH/FH scope. Mobile clinics have also implemented the EHR. All SMMC physicians assigned to HCH/FH now receive or are currently completing attestation to receive meaningful use

payments.

Accreditation Association for Ambulatory Health Care, Joint Commission, State-Based or Private Payer Initiatives) and Acquisition/Development and Implementation of Certified EHR Systems to Achieve Meaningful Use.

SMMC is fully accredited by the Joint Commission and has applied for Level 2 PCMH designation status.

9. Describe the current status or plans for participating in FQHC-related benefits (e.g., Federal Torts Claim Act (FTCA) coverage, FQHC Medicare/ Medicaid /CHIP reimbursement, 340 Drug Pricing Program, Vaccine for Children's Program, National Health Service Corps Providers).

SMMC participates in FQHC reimbursement, 340B Drug Pricing Program, FTCA and National Health Service Corps programs.

10. Billing and Collections Policies and Procedures.

a) Established schedule of charges: The Board-approved schedule of charges is based on consultation with the Health Plan of San Mateo, the County-organized single managed care entity responsible for administering federal, state and local public health insurance and health coverage programs in San Mateo County, to assure consistency with local prevailing rates and reasonableness.

b) Efforts to collect reimbursement from Medicaid, Medicare and other public and private insurance sources: SMMC has in place written procedures for billing public and private insurance programs for reimbursement for services. We continuously review and improve coding and charge capture practices to reduce administrative and clinical denials of billings due to inadequate documentation and non-compliance with payor rules. Written policies and procedures for billing are monitored for compliance, and updated to reflect changes in regulations and requirements as well as systems improvements.

c) Efforts to secure payments from patients that do not create barriers to care: SMMC has in place written procedures for collecting sliding scale payments from patients. To avoid creation of barriers to care, policies and procedures include options for payment plans and waiver of charges.

d) Criteria for waiving charges and staff authorized to approve such waivers: Changes in patients' eligibility for full discounts based on sliding fee scale policies make them eligible for waivers. Waivers in emergency situations as determined on a case-by-case basis. Billing managers are authorized to approve waivers.

11. Financial Accounting and Control Systems.

a) Appropriate for the size and complexity of the organization: HCH/FH is organizationally part of the San Mateo County Health System, a financially viable government agency with an annual budget exceeding $500 million. The Health System uses a fully integrated accounting system that is maintained by the County of San Mateo. Accounting processes for the SMMC are centralized and account detail is maintained by program, fund and object code. An independent auditing firm conducts annual audits.

In accordance with County guidelines, HCH/FH prepares an annual budget of revenue and expenditures reviewed and approved by the Co-Applicant Board. HCH/FH has a segregated budget unit or cost center that facilitates accrual of HCH/FH-related revenue and expenditures for HRSA fiscal and other reports. The program's County budget reflects the budget approved by HRSA during the annual grant renewal process. All expenditures charged to HCH/FH must be pre-approved by the Executive Director.

b) Reflect Generally Accepted Accounting Principles: Policies and procedures for accounting, fiscal controls, and financial reporting reflect GAAP.

c) Separate functions/duties appropriate to the organization's size to safeguard assets and maintain financial stability: The San Mateo County Health System has sound control policies and procedures in place that protect the health center's assets from loss, theft, or misuse. This includes policies, procedures and position descriptions that ensure separation of functions/duties.

d) Collection of information on financial status and performance measures: The Executive Director prepares regular reports on all HRSA-required measures for review, approval, and action planning to resolve any problems by the management team and Co-Applicant Board.

e) Support for management decisions: The management team and Co-Applicant Board review finance reports and use findings to inform financial decisions such as budgeting for service contracts.

12. Organization's Current Financial Status.

The most recent audit submitted through the EHB for FY 2013-2014 confirms the sound financial status of the San Mateo Health System and SMMC.

12. Current financial status and Annual Independent Audit Process.

MGO Public Accounting conducts the annual audit and reports its findings to the County Board of Supervisors. The SMMC Chief Financial Officer has primary responsibility for managing the audit process for the SMMC and HCH/FH Program.

13. Emergency Preparedness.

SMMC has in place emergency preparedness policies and procedures compliant with HRSA requirements (See Form 10 – Annual Emergency Preparedness and Management (EMP) Report.)

All HCH/FH sites participate in emergency preparedness training and drills and assign staff to attend emergency preparedness planning meetings convened.

GOVERNANCE

1. Independent Governing Board That Retains the Following Responsibilities, Functions and Authorities

a) Meets at least once a month: The Co-Applicant Board (CAB) holds regular monthly meetings and special sessions for strategic planning and other purposes. *(Bylaws Article 12 Section A page 7)*

b) Determines membership with patient majority (51%) required: Bylaws require that a majority of CAB members be patients unless this requirement is waived by HRSA. *(Bylaws Article 5 Sections 1 a and c page 4)* The HCH/FH Program is requesting a waiver for the 51% consumer majority requirement (Please see Form 6B).

c) Determines executive committee function and composition: The CAB establishes committees and determines their composition and functions. *(Bylaws Article 14 Page 10).* The CAB elects a chair and vice chair for two-year terms. *(Bylaws Article 13 Section A page 9)*

d) Ensures that minutes documenting the board's function are maintained: The Executive Director who serves as the CAB Secretary records and the program maintains minutes of all CAB meetings. *Article 12 Section A page 7and Article 13 Section D page 10)*

e) Selects the services to be provided: The CAB selects the services. (*Bylaws Article 3 Section E page 2)*

f) Determines the hours of services: The CAB sets schedules annually and approves any changes in schedules. (*Bylaws Article 3 Section E page 2)*

g) Measures and evaluates the organization's progress in meeting its annual and long-term programmatic and financial goals, and develops a plan for the long-range viability of the organization: The CAB evaluates effectiveness of care, services, and financial management. The CAB either as a whole or through committees:

- Reviews, and accepts or rejects periodic reports on the findings, actions, and results of QI activities;
- Assesses organizational structures and systems to improve program and financial performance;
- Reviews bylaws and makes needed revisions; and
- Reviews the findings of patient satisfaction surveys and conducts community meetings to obtain feedback and recommendations for improvements the target populations.

At strategic planning meetings, the CAB sets priorities and defines overall strategies which are assigned to CAB committees and HCH/FH staff for further development and implementation.

Board members monitor progress at regular monthly meetings. *(Bylaws Article 3 Sections A-P pages 2-3)*

h) Approves the organization's annual budget, grant applications, and selection/ dismissal/ performance appraisal of the chief executive officer: The CAB approves the annual budget and all grant applications *(Bylaws Article 3- page 3).* Because SMMC is a county government entity, the CAB conducts the Executive Director's performance appraisal. However, the County retains authority for all personnel actions. *(Bylaws Article 3 Page 3, Article 4 page 3 and Co-Applicant Agreement)*

i) Establishes general policies for the organization: The CAB adopts and reviews general policies and procedures for HCH/FH operations. *(Bylaws Article 3 Section G page 2)*

2. How the Governing Board Operates.

a) Committees: The CAB currently functions as a committee of the whole and establishes ad hoc committees as needed. I May 2015, the CAB established an Ad Hoc Committee on Member Recruitment and Selection.. Members will develop a committee structure in upcoming months.

b) Monitors and evaluates its performance: On an ongoing basis, the CAB monitors participation in Board activities, diligent performance of required duties, and Board composition. Annually, members conduct self-evaluation of the Board's performance.

c) Provides training, orientation and development for new members: CAB officers and the management team plan and conduct orientation for new members, including training in responsibilities and requirements of Section 330 grantees. New members receive orientation packets with information on the program, CAB responsibilities, and Section 330 requirements.

3. How the Co-Applicant Structure Does Not Impact Governing Board Composition and/or Authorities.

a) Selection of Board chairperson and majority of members: Under the Co-Applicant Agreement and Bylaws, the CAB elects the chairperson and selects all members. *(Bylaws Article 6 page 5)*

b) Selection or dismissal of the Executive Director: Under the HRSA-approved Co-Applicant Agreement, the CAB recommends selection or dismissal of the Executive Director who is a County employee; therefore, the County retains authority to appoint and dismiss the Executive Director.

c) Ensuring that no outside entity has the authority to override Board approval: The Co-Applicant agreement specifically makes this assurance.

4. Documentation that the Health Center's Bylaws and/or Other Board-Approved Policy Document(s) Include Specific Provisions that Prohibit Real or Apparent Conflict of Interest by Board Members, Employees, Consultants, and Others in the Procurement of Supplies,

Property (Real or Expendable), Equipment, and Other Services Procured With Federal Funds.

Voting members of the CAB are subject to the same conflict of interest rules and reporting requirements which are applicable to San Mateo County boards, commissions, and advisory committees. A conflict of interest is a transaction with the County of San Mateo Health System, any part of the Health System, or with any other entity in relation to which a Board member has a direct or indirect economic or financial interest.

A conflict of interest or the appearance of conflict of interest by Board members, employees, consultants, and those who furnish goods or services to the County of San Mateo Health System must be declared. Board members are required to declare any potential conflicts of interest by completing a conflict of interest declaration form. In situations when conflict of interest exists for a member, the member shall declare and explain the conflict of interest. No member of the Board shall vote in a situation where a personal conflict of interest exists for that member; however, a member of the Board who has a conflict of interest may still provide input regarding the matter that created the conflict. Any member may challenge any other member(s) as having conflict of interest. By roll call vote, properly recorded, the status of the challenged member(s) shall be determined prior to further consideration of the proposed project or issue. *(Bylaws Article 10 page 7)*

SUPPORT REQUESTED

TO BE WRITTEN WHEN THE BUDGET IS FINALIZED.

TAB 9
Request to Approve Program Scope

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: August 13, 2015

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

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: REQUEST FOR THE BOARD TO TAKE ACTION TO APPROVE HCH/FH PROGRAM SERVICES, SITES & HOURS

Under the Bylaws Article 3.E, the Board has the authority and responsibility to set the scope and availability of services to be delivered by and the location and hours of operation of the Program. This responsibility is also represented by HRSA Program Requirements #2 – Required and Additional Services, and #4 – Accessible Hours of Operation/Location. Further, at the Board meeting of December 11, 2014, the Board established Program Policy for the Board to review and approve, annually, to coincide with submission of the program's Service Area Competition (SAC) application or the Budget Period Progress Report (BPR) submission. It is further established in the policy that the Board can undertake this review at additional other times as the Boards deems appropriate.

With the SAC submission in preparation and due by September 1, 2015, the program calendar has established the August Board meeting as the time for Board review and approval of the Program's Scope (aka Services, Sites and Hours).

Attached to this request is the current Forms 5A and 5B representing the current Services and Sites for the program. At this time there is no recommendation to make any changes to the documents.

This request is for the Board to vote to approve the attached Forms 5A & 5B. Approval of this item requires a majority vote of the Board members present.

Attachments:
HCH/FH Form 5A
HCH/FH Form 5B

Self Updates: Services details

H80CS00051: SAN MATEO COUNTY HEALTH SERVICES AGENCY, San Mateo, CA

Grant Number: H80CS00051 **BHCMIS ID:** 091140 **Project Period:** 11/1/2001 - 12/31/2015

Budget Period: 11/1/2014 - 12/31/2015

Required Services

Service Type	Service Delivery Methods		
	Column I. Direct (Health Center Pays)	Column II. Formal Written Contract/Agreement (Health Center Pays)	Column III. Formal Written Referral Arrangement (Health Center DOES NOT pay)
General Primary Medical Care	X	X	
Diagnostic Laboratory	X	X	
Diagnostic Radiology	X	X	
Screenings	X	X	
Coverage for Emergencies During and After Hours	X	X	
Voluntary Family Planning	X	X	
Immunizations	X	X	
Well Child Services	X	X	
Gynecological Care	X	X	
Obstetrical Care			
Prenatal Care	X	X	
Intrapartum Care (Labor & Delivery)	X	X	
Postpartum Care	X	X	
Preventive Dental	X	X	
Pharmaceutical Services	X	X	
HCH Required Substance Abuse Services	X	X	X
Case Management	X	X	X
Eligibility Assistance	X	X	
Health Education	X	X	
Outreach	X	X	
Transportation	X	X	
Translation	X	X	

Additional Services

Service Type	Service Delivery Methods		
	Column I. Direct (Health Center Pays)	Column II. Formal Written Contract/Agreement (Health Center Pays)	Column III. Formal Written Referral Arrangement (Health Center DOES NOT pay)
Additional Dental Services	X	X	
Behavioral Health Services			
Mental Health Services	X	X	
Optometry	X		
Environmental Health Services		X	
Occupational Therapy	X		
Physical Therapy	X		
Nutrition	X		X
Additional Enabling/Supportive Services			X

Speciality Services

Service Type	Service Delivery Methods		
	Column I. Direct (Health Center Pays)	Column II. Formal Written Contract/Agreement (Health Center Pays)	Column III. Formal Written Referral Arrangement (Health Center DOES NOT pay)
Podiatry	X		
Psychiatry	X		
Ophthalmology	X		
Cardiology	X	X	
Dermatology	X	X	
Gastroenterology	X		
Other - Orthopedics	X		
Other - Hepatology	X		
Other - Neurology	X		

Close Window

Self Updates: Site details

H80CS00051: SAN MATEO COUNTY HEALTH SERVICES AGENCY, San Mateo, CA

Grant Number: H80CS00051 **BHCMIS ID:** 091140 **Project Period:** 11/1/2001 - 10/31/2015

Budget Period: 11/1/2014 - 10/31/2015

Site Id: BPS-H80-000552

Site Information

Site Name	COASTSIDE MENTAL HEALTH CENTER	**Physical Site Address**	225 Cabrillo Hwy S, Half Moon Bay, CA 94019-8200
Site Type	Service Delivery Site	**Site Phone Number**	(650) 726-6369
Web URL			
Location Type	Permanent	**Site Setting**	All Other Clinic Types
Date Site was Added to Scope	05/01/1998	**Site Operational Date**	05/01/1998
FQHC Site Medicare Billing Number Status	Application for this site has not yet been submitted to CMS	**Medicare Billing Number** (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field.)	
FQHC Site National Provider Identification (NPI) Number (Optional field)		**Total Hours of Operation** (when Patients will be Served per Week)	40
Saved Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		**Number of Intermittent Sites** (Required only for 'Intermittent' Site Type)	
Site Operated by	Grantee		

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By' field)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN
No Subrecipient or Contractor information to be displayed		

Service Area Zip Code (Include only those from which the majority of the patient population will come)

Saved Service Area Zip Code(s)	94019

Site Id: BPS-H80-000785

Site Information

Site Name	CENTRAL COUNTY MENTAL HEALTH CTR	**Physical Site Address**	1950 Alameda de las Pulgas, San Mateo, CA 94403
Site Type	Service Delivery Site	**Site Phone Number**	(650) 573-3571
Web URL			
Location Type	Permanent	**Site Setting**	All Other Clinic Types
Date Site was Added to Scope	07/31/2004	**Site Operational Date**	07/31/2004
FQHC Site Medicare Billing Number Status	Application for this site has not yet been submitted to CMS	**Medicare Billing Number** (Required if "This site has	

		a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field.)	
FQHC Site National Provider Identification (NPI) Number (Optional field)		**Total Hours of Operation** (when Patients will be Served per Week)	40
Saved Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		**Number of Intermittent Sites** (Required only for 'Intermittent' Site Type)	
Site Operated by	Grantee		

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By' field)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN
No Subrecipient or Contractor information to be displayed		

Service Area Zip Code (Include only those from which the majority of the patient population will come)

Saved Service Area Zip Code(s)	94403, 94402, 94401

Site Id: BPS-H80-003782

Site Information

Site Name	MOBILE HEALTH CLINIC	**Physical Site Address**	225 37th Ave, San Mateo, CA 94403-4324
Site Type	Service Delivery Site	**Site Phone Number**	(650) 573-2786
Web URL	www.co.sanmateo.ca.us		
Location Type	Permanent	**Site Setting**	All Other Clinic Types
Date Site was Added to Scope	01/05/1996	**Site Operational Date**	07/01/1994
FQHC Site Medicare Billing Number Status	Application for this site has not yet been submitted to CMS	**Medicare Billing Number** (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field.)	
FQHC Site National Provider Identification (NPI) Number (Optional field)		**Total Hours of Operation** (when Patients will be Served per Week)	40
Saved Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		**Number of Intermittent Sites** (Required only for 'Intermittent' Site Type)	
Site Operated by	Grantee		

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By' field)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN
No Subrecipient or Contractor information to be displayed		

Service Area Zip Code (Include only those from which the majority of the patient population will come)

Saved Service Area Zip Code(s)	94061, 94098, 94065, 94019, 94401, 94063, 94066, 94060, 94096, 94064, 94067, 94402, 94403, 94083

Site Id: BPS-H80-008946

Site Information

Site Name	HCH Mobile Dental Clinic	**Physical Site Address**	795 Willow Rd, Menlo Park, CA 94025-2539
Site Type	Service Delivery Site	**Site Phone Number**	(650) 573-2651
Web URL	www.co.sanmateo.ca.us		
Location Type	Mobile Van	**Site Setting**	All Other Clinic Types
Date Site was Added to Scope	06/29/2009	**Site Operational Date**	07/01/2010
FQHC Site Medicare Billing Number Status	Application for this site has not yet been submitted to CMS	**Medicare Billing Number** (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field.)	
FQHC Site National Provider Identification (NPI) Number (Optional field)		**Total Hours of Operation** (when Patients will be Served per Week)	16
Saved Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		**Number of Intermittent Sites** (Required only for 'Intermittent' Site Type)	
Site Operated by	Grantee		

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By' field)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN
No Subrecipient or Contractor information to be displayed		

Service Area Zip Code (Include only those from which the majority of the patient population will come)

Saved Service Area Zip Code(s)	94025

Site Id: BPS-H80-011967

Site Information

Site Name	HCH Mobile Dental Van	**Physical Site Address**	222 W 39th Ave, San Mateo, CA 94403-4364
Site Type	Service Delivery Site	**Site Phone Number**	(650) 573-2561
Web URL			
Location Type	Mobile Van	**Site Setting**	All Other Clinic Types
Date Site was Added to Scope	08/15/2012	**Site Operational Date**	08/15/2012
FQHC Site Medicare Billing Number Status	Application for this site has not yet been submitted to CMS	**Medicare Billing Number** (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field.)	

FQHC Site National Provider Identification (NPI) Number (Optional field)		**Total Hours of Operation** (when Patients will be Served per Week)	20
Saved Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		**Number of Intermittent Sites** (Required only for 'Intermittent' Site Type)	
Site Operated by	Grantee		

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By' field)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN
No Subrecipient or Contractor information to be displayed		

Service Area Zip Code (Include only those from which the majority of the patient population will come)

Saved Service Area Zip Code(s)	94061, 94080, 94063, 94401, 94019, 94403

Site Id: BPS-H80-004798

Site Information

Site Name	EDISON CLINIC	**Physical Site Address**	222 W 39th Ave, San Mateo, CA 94403-4364
Site Type	Service Delivery Site	**Site Phone Number**	(650) 573-2358
Web URL	www.co.sanmateo.ca.us		
Location Type	Permanent	**Site Setting**	All Other Clinic Types
Date Site was Added to Scope	01/01/1987	**Site Operational Date**	01/01/1987
FQHC Site Medicare Billing Number Status	Application for this site has not yet been submitted to CMS	**Medicare Billing Number** (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field.)	
FQHC Site National Provider Identification (NPI) Number (Optional field)		**Total Hours of Operation** (when Patients will be Served per Week)	40
Saved Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		**Number of Intermittent Sites** (Required only for 'Intermittent' Site Type)	
Site Operated by	Grantee		

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By' field)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN
No Subrecipient or Contractor information to be displayed		

Service Area Zip Code (Include only those from which the majority of the patient population will come)

Saved Service Area Zip Code(s)	94403

Site Id: BPS-H80-005603

Site Information

Site Name	South County Community Health Center (Dba; Ravenswood Family Health Center)	**Physical Site Address**	1798 BAY RD, EAST PALO ALTO, CA 94303-1611
Site Type	Service Delivery Site	**Site Phone Number**	(650) 330-7400
Web URL	www.ravenswoodfhc.org		
Location Type	Permanent	**Site Setting**	All Other Clinic Types
Date Site was Added to Scope	12/01/2003	**Site Operational Date**	12/01/2003
FQHC Site Medicare Billing Number Status	This site has a Medicare billing number	**Medicare Billing Number** (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field.)	551946
FQHC Site National Provider Identification (NPI) Number (Optional field)		**Total Hours of Operation** (when Patients will be Served per Week)	62
Saved Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		**Number of Intermittent Sites** (Required only for 'Intermittent' Site Type)	
Site Operated by	Contractor		

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By' field)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN
South County Community Health Center (Dba; Ravensw	1798 Bay Rd, Palo Alto, CA 94303-1611	94-3372130

Service Area Zip Code (Include only those from which the majority of the patient population will come)

Saved Service Area Zip Code(s)	94303, 94025

Site Id: BPS-H80-006870

Site Information

Site Name	Coastside Health Center	**Physical Site Address**	225 Cabrillo Hwy, HALF MOON BAY, 94019
Site Type	Service Delivery Site	**Site Phone Number**	(650) 573-3941
Web URL	www.sanmateo.ca.us		
Location Type	Permanent	**Site Setting**	All Other Clinic Types
Date Site was Added to Scope	01/05/1998	**Site Operational Date**	01/05/1998
FQHC Site Medicare Billing Number Status	Application for this site has not yet been submitted to CMS	**Medicare Billing Number** (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field.)	
FQHC Site National Provider Identification (NPI) Number (Optional field)		**Total Hours of Operation** (when Patients will be Served per Week)	40

Saved Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		**Number of Intermittent Sites** (Required only for 'Intermittent' Site Type)	
Site Operated by	Grantee		

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By' field)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN
No Subrecipient or Contractor information to be displayed		

Service Area Zip Code (Include only those from which the majority of the patient population will come)

Saved Service Area Zip Code(s)	94019

Site Id: BPS-H80-001373

Site Information

Site Name	SOUTH SAN FRANCISCO CLINIC	**Physical Site Address**	306 SPRUCE STREET, SOUTH SAN FRANCISCO, CA 94080-2741
Site Type	Service Delivery Site	**Site Phone Number**	(650) 877-7070
Web URL	www.co.sanmateo.ca.us		
Location Type	Permanent	**Site Setting**	All Other Clinic Types
Date Site was Added to Scope	11/01/1999	**Site Operational Date**	01/10/1999
FQHC Site Medicare Billing Number Status	Application for this site has not yet been submitted to CMS	**Medicare Billing Number** (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field.)	
FQHC Site National Provider Identification (NPI) Number (Optional field)		**Total Hours of Operation** (when Patients will be Served per Week)	40
Saved Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		**Number of Intermittent Sites** (Required only for 'Intermittent' Site Type)	
Site Operated by	Grantee		

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By' field)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN
No Subrecipient or Contractor information to be displayed		

Service Area Zip Code (Include only those from which the majority of the patient population will come)

Saved Service Area Zip Code(s)	94080

Site Id: BPS-H80-004460

Site Information

Site Name	DALY CITY YOUTH HEALTH CENTER	**Physical Site Address**	2780 Junipero Serra Blvd, Daly City, CA 94015-1634

Site Type	Service Delivery Site	**Site Phone Number**	(650) 991-2240
Web URL	www.co.sanmateo.ca.us		
Location Type	Permanent	**Site Setting**	All Other Clinic Types
Date Site was Added to Scope	01/01/1992	**Site Operational Date**	01/01/1990
FQHC Site Medicare Billing Number Status	Application for this site has not yet been submitted to CMS	**Medicare Billing Number** (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field.)	
FQHC Site National Provider Identification (NPI) Number (Optional field)		**Total Hours of Operation** (when Patients will be Served per Week)	40
Saved Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		**Number of Intermittent Sites** (Required only for 'Intermittent' Site Type)	
Site Operated by	Grantee		

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By' field)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN
No Subrecipient or Contractor information to be displayed		

Service Area Zip Code (Include only those from which the majority of the patient population will come)

Saved Service Area Zip Code(s)	94015

Site Id: BPS-H80-001005

Site Information

Site Name	HEALTH SERVICES AGENCY MENTAL HEALTH DIVISION	**Physical Site Address**	225 37th Ave, San Mateo, CA 94403-4324
Site Type	Administrative	**Site Phone Number**	(650) 573-2541
Web URL	www.co.sanmateo.ca.us		
Location Type	Permanent	**Site Setting**	All Other Clinic Types
Date Site was Added to Scope	01/03/2001	**Site Operational Date**	01/03/2001
FQHC Site Medicare Billing Number Status	Health center does not/will not bill under the FQHC Medicare system at this site	**Medicare Billing Number** (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field.)	
FQHC Site National Provider Identification (NPI) Number (Optional field)		**Total Hours of Operation** (when Patients will be Served per Week)	40
Saved Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		**Number of Intermittent Sites** (Required only for 'Intermittent' Site Type)	

Site Operated by	Grantee

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By' field)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN
No Subrecipient or Contractor information to be displayed		

Service Area Zip Code (Include only those from which the majority of the patient population will come)

Saved Service Area Zip Code(s)	94403

Site Id: BPS-H80-005448

Site Information

Site Name	Fair Oaks Health Center	Physical Site Address	2710 Middlefield Rd, Redwood City, CA 94063-3404
Site Type	Service Delivery Site	Site Phone Number	(650) 363-4602
Web URL	www.sanmateo.ca.us		
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was Added to Scope	01/01/1988	Site Operational Date	01/01/1998
FQHC Site Medicare Billing Number Status	Application for this site has not yet been submitted to CMS	Medicare Billing Number (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field.)	
FQHC Site National Provider Identification (NPI) Number (Optional field)		Total Hours of Operation (when Patients will be Served per Week)	40
Saved Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		Number of Intermittent Sites (Required only for 'Intermittent' Site Type)	
Site Operated by	Grantee		

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By' field)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN
No Subrecipient or Contractor information to be displayed		

Service Area Zip Code (Include only those from which the majority of the patient population will come)

Saved Service Area Zip Code(s)	94063

Site Id: BPS-H80-005524

Site Information

Site Name	DALY CITY CLINIC	Physical Site Address	380 90th St, Daly City, CA 94015-1807
Site Type	Service Delivery Site	Site Phone Number	(650) 301-8600
Web URL	www.co.sanmateo.ca.us		
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was Added to Scope	01/05/1996	Site Operational Date	01/05/1996

FQHC Site Medicare Billing Number Status	Application for this site has not yet been submitted to CMS	**Medicare Billing Number** (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field.)	
FQHC Site National Provider Identification (NPI) Number (Optional field)		**Total Hours of Operation** (when Patients will be Served per Week)	40
Saved Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		**Number of Intermittent Sites** (Required only for 'Intermittent' Site Type)	
Site Operated by	Grantee		

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By' field)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN
No Subrecipient or Contractor information to be displayed		

Service Area Zip Code (Include only those from which the majority of the patient population will come)

Saved Service Area Zip Code(s)	94015

Site Id: BPS-H80-000595

Site Information

Site Name	39th Avenue Campus - Outpatient Clinics	**Physical Site Address**	222 W 39th Ave, San Mateo, CA 94403-4364
Site Type	Service Delivery Site	**Site Phone Number**	(650) 573-2222
Web URL	www.co.sanmateo.ca.us		
Location Type	Permanent	**Site Setting**	All Other Clinic Types
Date Site was Added to Scope	01/01/1994	**Site Operational Date**	01/01/1970
FQHC Site Medicare Billing Number Status	Application for this site has not yet been submitted to CMS	**Medicare Billing Number** (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field.)	
FQHC Site National Provider Identification (NPI) Number (Optional field)		**Total Hours of Operation** (when Patients will be Served per Week)	40
Saved Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		**Number of Intermittent Sites** (Required only for 'Intermittent' Site Type)	
Site Operated by	Grantee		

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By' field)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN
No Subrecipient or Contractor information to be displayed		

Service Area Zip Code (Include only those from which the majority of the patient population will come)	
Saved Service Area Zip Code(s)	94403

Site Id: BPS-H80-002922

Site Information

Site Name	MAPLE STREET SHELTER	Physical Site Address	1580 A MAPLE STREET, REDWOOD CITY, CA 94603-4364
Site Type	Service Delivery Site	Site Phone Number	(650) 364-4664
Web URL	www.shelternetwork.com		
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was Added to Scope	01/07/2006	Site Operational Date	01/07/2006
FQHC Site Medicare Billing Number Status	Application for this site has not yet been submitted to CMS	Medicare Billing Number (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field.)	
FQHC Site National Provider Identification (NPI) Number (Optional field)		Total Hours of Operation (when Patients will be Served per Week)	40
Saved Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		Number of Intermittent Sites (Required only for 'Intermittent' Site Type)	
Site Operated by	Contractor		

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By' field)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN
Shelter Network of San Mateo County	1450 Chapin Ave, Burlingame, CA 94010-4044	77-0160469

Service Area Zip Code (Include only those from which the majority of the patient population will come)	
Saved Service Area Zip Code(s)	94063

Site Id: BPS-H80-003064

Site Information

Site Name	RON ROBINSON SENIOR CARE CENTER	Physical Site Address	222 W. 39TH AVE, SAN MATEO, CA 94403-4364
Site Type	Service Delivery Site	Site Phone Number	(650) 573-2426
Web URL	www.co.sanmateo.ca.us		
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was Added to Scope	01/03/2004	Site Operational Date	01/03/2004
FQHC Site Medicare Billing Number Status	Application for this site has not yet been submitted to CMS	Medicare Billing Number (Required if "This site has a Medicare billing number"	

		is selected in 'FQHC Site Medicare Billing Number Status' field.)	
FQHC Site National Provider Identification (NPI) Number (Optional field)		**Total Hours of Operation** (when Patients will be Served per Week)	40
Saved Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		**Number of Intermittent Sites** (Required only for 'Intermittent' Site Type)	
Site Operated by	Grantee		

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By' field)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN
No Subrecipient or Contractor information to be displayed		

Service Area Zip Code (Include only those from which the majority of the patient population will come)

Saved Service Area Zip Code(s)	94403

Site Id: BPS-H80-005388

Site Information

Site Name	SOUTH COUNTY MENTAL HEALTH	**Physical Site Address**	802 BREWSTER AVE, REDWOOD CITY, CA 94063-1510
Site Type	Service Delivery Site	**Site Phone Number**	(650) 363-4111
Web URL			
Location Type	Permanent	**Site Setting**	All Other Clinic Types
Date Site was Added to Scope	01/01/1992	**Site Operational Date**	01/01/1992
FQHC Site Medicare Billing Number Status	Application for this site has not yet been submitted to CMS	**Medicare Billing Number** (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field.)	
FQHC Site National Provider Identification (NPI) Number (Optional field)		**Total Hours of Operation** (when Patients will be Served per Week)	40
Saved Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		**Number of Intermittent Sites** (Required only for 'Intermittent' Site Type)	
Site Operated by	Grantee		

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By' field)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN
No Subrecipient or Contractor information to be displayed		

Service Area Zip Code (Include only those from which the majority of the patient population will come)

Saved Service Area Zip Code(s)	

	94063, 94061

Site Id: BPS-H80-009159

Site Information

Site Name	sequoia teen wellness center	**Physical Site Address**	200 JAMES AVE, REDWOOD CITY, CA 94062-5123
Site Type	Service Delivery Site	**Site Phone Number**	(650) 261-3710
Web URL	www.sanmateo.ca.us		
Location Type	Permanent	**Site Setting**	School
Date Site was Added to Scope	11/05/2009	**Site Operational Date**	04/01/2009
FQHC Site Medicare Billing Number Status	Application for this site has not yet been submitted to CMS	**Medicare Billing Number** (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field.)	
FQHC Site National Provider Identification (NPI) Number (Optional field)		**Total Hours of Operation** (when Patients will be Served per Week)	40
Saved Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		**Number of Intermittent Sites** (Required only for 'Intermittent' Site Type)	
Site Operated by	Grantee		

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By' field)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN
No Subrecipient or Contractor information to be displayed		

Service Area Zip Code (Include only those from which the majority of the patient population will come)

Saved Service Area Zip Code(s)	94062

Site Id: BPS-H80-005206

Site Information

Site Name	NORTH COUNTY MENTAL HEALTH	**Physical Site Address**	375 89th St, Daly City, CA 94015-1802
Site Type	Service Delivery Site	**Site Phone Number**	(650) 301-8650
Web URL			
Location Type	Permanent	**Site Setting**	All Other Clinic Types
Date Site was Added to Scope	07/31/2004	**Site Operational Date**	07/31/2004
FQHC Site Medicare Billing Number Status	Application for this site has not yet been submitted to CMS	**Medicare Billing Number** (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field.)	
		Total Hours of Operation	40

FQHC Site National Provider Identification (NPI) Number (Optional field)		(when Patients will be Served per Week)	
Saved Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		**Number of Intermittent Sites** (Required only for 'Intermittent' Site Type)	
Site Operated by	Grantee		

Subrecipient or Contractor Information (Required only if 'Subrecipient or Contractor' is selected in 'Site Operated By' field)

Subrecipient/Contractor Organization Name	Subrecipient/Contractor Organization Physical Site Address	Subrecipient/Contractor EIN
No Subrecipient or Contractor information to be displayed		

Service Area Zip Code (Include only those from which the majority of the patient population will come)

Saved Service Area Zip Code(s)	94015

Close Window

TAB 10
Request to dismantle former sub-committees

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: August 13, 2015

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

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: REQUEST FOR THE BOARD TO DISBAND OUTDATED AD HOC COMMITTEES

As part of conducting Board business, it is necessary on occasion for the Board to establish Ad Hoc Committees for the purpose of effective and efficient Board operation. By definition, such Ad Hoc Committees are limited to the subject and directives as established in their creation, and are limited in duration.

In the establishment of many previous Ad Hoc Committees, the establishing Board Action did not designate a termination date for the committees' efforts. As such, there are presently numerous committees that have been created by Board action and have completed the business for which they were formed, but are still on record as being in existence.

Program is recommending that the Board take action to disband all of these committees. All have been in existence over 8 months and have completed their efforts, filed final reports or otherwise have had the reason for their creation completed. These committees and their creation dates are:

2013 RFP Evaluation Committee	est. October 2013
Funding Protocol and Policy Committee	est. February 2014
Hospital Accountability for Patient Discharge Committee	est. February 2014
Respite Care in San Mateo County Committee	est. March 2014
SMMC Clinic Funding Committee	est. June 2014
Director Evaluation Committee	est. October 2014

This request is for the Board to disband the listed committees and thank the committee members for the efforts. Approval of this action requires a majority vote of the Board members present.

TAB 11
Second Quarter Report Updates

DATE: August 13, 2015

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

FROM: Linda Nguyen, HCH/FH Program Coordinator

SUBJECT: Quarter 2 Report (April 1, 2015 through June 31, 2015)

Program Performance

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

The following data table includes performance for the 2nd quarter (50%):

HCH/FH Performance *04/01/2015 – 06/31/2015*	Yearly Target # Undup Pts	Actual # YTD Undup Pts	% YTD	Yearly Target # Visits	Actual YTD Visits	% YTD	HCH/FH Funding
Behavioral Health & Recovery Svs	300	130	43%	900	627	70%	$90,000
InnVision Shelter Network (case mgmt & eligibility)	550	292	53%	1,250	444	36%	$145,000
IVSN (O/E)	50	11	22%				
Public Health Mobile Van	1,250	668	53%	2,500	1071	43%	$240,000
Public Health- Expanded Services	626	224	36%	782	243	31%	$178,500
Puente de la Costa Sur (CM & Intensive CM)	150	71	47%	350	386	110%	$60,500
Puente (O/E)	100	107	107%				
Ravenswood (Primary Care)	500	318	64%	1,895	692	37%	$65,000
Ravenswood (Dental)	133	126	95%	600	294	49%	$50,000
Samaritan House	175	97	55%	300	211	70%	$55,000
Total HCH/FH Contracts	3,834	1,914	59%	8,577	3,968	56%	$884,000

O/E= Outreach & Enrollment

HCH/FH- Selected Outcome Measure Review (Contracts); Second Quarter (April - June 2015)

Agency	Outcome Measure	Progress- Q2
Behavioral Health & Recovery Services	At least 75% (225) screened will have a behavioral health screening. At least 55% (165) will receive case management services.	During the first quarter: •130 clients (57%) had a behavioral health screening •123 received case management services
InnVision Shelter Network	Minimum of 50% (250) will establish a medical home. At least 30% (150) of homeless individuals served have chronic health conditions.	During the first quarter: •27 % (133) established a medical home • 20 % of individuals served have a chronic health condition.
Public Health Mobile Van	At least 20% (250) of patient encounters will be related to a chronic disease. At least 75% of clients: • seen at foot clinic will be referred to Mobile Clinic for a medical visit • contacted at Service Connect will be seen at Mobile Clinic for medical visit	During the first quarter: 5% (55) of encounters were related to chronic health. 100% of patients: • with foot patients referred to PH Mobile Clinic for medical visit • contacted at Service Connect will be seen at Mobile Clinic for medical visit
PH- Mobile Van- Expanded Services	At least 75% (470) of individuals will receive comprehensive health screening. Provide intensive primary care services to minimum of 100 residents with chronic health issues.	During the first quarter: • 82 patients received a comprehensive health screening • 69 patients with chronic health issues
Puente de la Costa Sur	At least 85 farmworkers served will receive case management services. At least 100 served will be provided transportation and translation services. At least 70% (105) will participate in at least 1 health education class/ workshop.	During the first quarter: • 71 received case management services • 28 client was provided transportation and translation services. • 13 % participated in Health education workshop.
RFHC – Primary Health Care	At least 60% will receive a comprehensive health screening. At least 250 (50%) will receive a behavioral health screening. At least 50 will be provided Case Mgmt.	During the first quarter: • 83% (416) received comprehensive health screening. • 27 received behavioral health screening. • 318 received case management services.
RFHC – Dental Care	At least 30% (39) will complete their treatment plans. At least 85% will attend their scheduled treatment plan appointments. At least 40% will complete their denture treatment plan.	During the first quarter: • 8% (11) completed dental treatment plan. • 94% (126) attended their scheduled treatment plan • 56% completed denture treatment plan.
Samaritan House- Safe Harbor	All 100% (175) will receive a healthcare assessment. At least 95% (166) will receive ongoing case management & create health care plan. At least 70% (122) will schedule primary care appointments and attend at least one.	During the first quarter: • 97 (55%) received a healthcare assessment. • 97 received case management services. • 70% attended at least one primary care appointment.

Contractor successes & emerging trends:

- **BHRS** states that it continues to be easier and quicker to get clients into BHRS services.
    - Staff also reports that it is difficult to get appointments for clients from the New Patient Appointment Line.

- According to **IVSN** their HCH team has been effective in engaging clients by responding quickly to meet clients immediately where they are in an effort to make it convenient for clients and build trust.
    - Staff continues to experience a Medi-Cal backlog and obtaining an accurate timeline/status of approval, as well as long wait times for primary care.

- **Public Health Mobile Clinic** has found success in the coordination and referral of clients between community partners and Service Connect, being on-site makes access for clients easier.
    - Staff has seen an increase in the age of clients and the severity of their health problems. Also more veterans suffering from PTSD, depression, anxiety and drug and alcohol related problems.

- **Puente** works closely with an HSA Benefits Analyst assigned to their office, making workflow more streamlined for clients. Trying to be one stop service where families with mixed status are able to get services in one day versus multiple visits. Their onsite Thursday clinic is also providing more opportunities for clients.
    - Farmworkers are being sent the enrollment fee bill when they are should be waived.

- **Ravenswood Primary Care**'s working relationships with Stanford has worked exceptionally well, to enhance communication efforts between their HCH manager, Tayischa and Stanford's ER to ensure their clinic is informed of homeless patients visiting the ER to ensure adequate follow up care.
    - They have experienced a dramatic increase in the number of diabetic patients in critical need of Podiatry (foot care) care. The referral process for San Mateo County Health System's is long, as the wait time for appointments is usually over two weeks. Their new health center due to provide services by January 2016, which should help.

- **Ravenswood Dental Care** experiences success through their quadrant dentistry services, which refers to a treatment approach used on individuals who require extensive dental work to be carried out in a quadrant during a single appointment.
    - Patients voice frustration with their dental treatment plan possibly taking months to complete.

- **Samaritan House/Safe Harbor** states the great relationship with the Public Health Van, a service much in demand and that clients love the staff and trust them.
    - Follow through is one of their biggest barriers, as they find more time is used to follow clients with everything to assist and remind them.

TAB 12
Discussion on Population-wide Data

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: August 13, 2015

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

FROM: Linda Nguyen, Program Coordinator
HCH/FH Program

SUBJECT: UDS report – discussion on new population wide data

The program received a request from HRSA to produce universal data for our entire homeless and farmworker population for annual UDS report submission, rather than the 70 chart reviews that the program has submitted in the past. We have been working with our Business Intelligence team to produce reports for 10 of the outcome measures to be ready for review by July 1, 2015.

Attached you will find a document that includes a summary of the results from the reports, as well as the header to the reports which displays the logic that is used to run the reports for our entire population of homeless and farmworkers.

Attached: UDS Outcome Measure Reports

UDS Outcome Measure Reports- new population wide data

	2014 UDS chart review (70)	All HCH/FH patient data
Hypertension	64%	60.30%
Diabetes	49%	67%
Tobacco Cessation	77%	91%
Ischemic Vascular Disease	98%	77%
Coronary Artery Disease	90%	57%
Asthma Treatment Plan	100%	58%
Colorectal Cancer Screening	34%	51%
Child Weight Assessment	80%	66%
Pap Test	57%	43%
Adult Weight Assessment	44%	25%

7/1/2015

UDS - Table 7 Section B - Hypertension Details
UDS Reporting Year: 2014

Report Criteria:
All Unduplicated Patients
Born between 1930 and 1996 (Age 18 and 85 at the end of Reporting Year)
Had 2 or more Medical visits during the Reporting Year
Diagnosed with Hypertension (ICD9 Code - 401.xx - 405.xx) during the first half of the Reporting Year and previous 2 calender years
with flags for patients whose hypertension is under control (Systolic < 140 and Diastolic <90)
Exclusions: Patients diagnosed with Prenatal (ICD9 code - V22.1,V23.9,V24.9)
Or with End State Renal Disease (ESRD) (ICD9 Code - 585.6) during the Reporting Year

Total Number of Hypertensive patients (Denominator)	1,366
Total Number of Hypertensive patients with Controlled BP(Numerator)	824

MRN	Last Name	First Name	Gender	Birth Date	Race Cd	Hispanic Ind	Lang Cd	Homeless Status	MSFW Status	Last Visit Clinic	Last Visit Insurance	Last Visit Date	Last BP Collected Date	Systolic BP	Diasystolic BP	BP Under Control

7/1/2015

UDS - Table 7 Section C - Diabetes Details
UDS Reporting Year: 2014

Report Criteria:
All Unduplicated Patients
Born between 1940 and 1996 (Age 18 and 75 at the end of Reporting Year)
Had 2 or more Medical visits during the Reporting Year
Diagnosed with Diabetes Melitus (ICD9 Code - 250.xx, 648.00,648.01,648.02,648.03,648.04,775.10) during the last 3 years
Had a latest HbA1C value recorded in the reporting year
Exclusions: Patients diagnosed with Polycystic Ovaries(ICD9 Code - 256.4),Gestational Diabetes (ICD9-648.8)
and Steroid-Induced Diabetes (ICD9-962.0 or 251.8) during the Reporting Year

Total Number of Patients (Denominator)	707
Total Number of Patients Where HgBA1C <=9.0 (Numerator)	472
Total Number of Patients Where HgBA1C <8.0	399
Total Number Patients Where HgBA1C >=8.0 and <=9.0	73
Total Number of Patients Where HgBA1C > 9.0 or Not Recorded	235

MRN	Last Name	First Name	Gender	Birth Date	Race Code	Hispanic Ind	Lang Cd	Homeless Status	MSFW Status	Last Visit Clinic	Last Visit Insurance	Last Visit Date	Last HbA1C Collected	HbA1C Value

7/1/2015

UDS - Table6B Section G - Tobacco Cessation
UDS Reporting Year: 2014

Report Criteria:
All Unduplicated Patients
Born on or before 1996 (Age 18 and over at the end of Reporting Year)
Had at least 1 Medical visit during the Reporting Year
Had 2 or more Medical visits ever in our Health System
Flag patients who smoke and diagnosed with Tobacco Use Disorder (ICD9 - 305.1,649.00,649.01,649.02,649.03,649.04) during last 2 years from
their last visit in the Reporting Year

Total number of Patients born on or before 1996 (Denominator)	4,484
Total number of Patients who are non smokers or smokers who were intervened (Numerator)	4,101
Total number of Patients who are smokers	883
Total number of Patients who are smokers and were intervened	500

MRN	Last Name	First Name	Gender	Birth Date	Race Cd	Hispanic	Lang Cd	Homeless Status	Msfw Status	Last Visit Clinic	Last Visit Insurance	Last Visit Date	Question Asked	Response	Tobacco Cessation flag

7/1/2015

UDS - Table 6B Section J - Ischemic Vascular Disease
UDS Reporting Year: 2014

Report Criteria:
All Unduplicated Patients
Born on or before 1996 (Age 18 and over at the end of Reporting Year)
Had at least 1 Medical visit during the Reporting Year
Diagnosed with Ischemic Vascular Disease (ICD9 codes - refer to UDS manual) during last 2 calender years
Flag patients who were prescribed with aspirin or another antithrombotic drugs in the Reporting Year

Total number of Patients diagnosed with Ischemic Vascular Disease (Denominator)	237
Total number of Patients diagnosed with Ischemic Vascular Disease and were prescribed Aspirin or another Antithrombotic drugs (Numerator)	203

MRN	Last Name	First Name	Gender Cd	Birth Date	Race Cd	Hispanic Ind	Lang Cd	Homeless Status	Msfw Ind	Last Visit Clinic	Last Visit Insurance	Last Visit Date	Medication Flag

7/1/2015

UDS - Table 6B Section I - Patient With Coronary Artery Disease
UDS Year: 2014

Report Criteria:
Birth year equal to or less than 1996 (18 years or older)
More than 2 medical visits during life time
At least 1 medical visit during reporting year
Diagnosed with Coronary Artery Disease ICD9 Code (410.X, 411.X, 412.X, 413.X, 414.0X, 414.8, 414.9, V45.81, V45.82)
Flag on patients who were given Lipid Lowering Drugs in the Reporting Year

Total Number of patients diagnosed with Coronary Artery Disease (Denominator)	307
Total Number of patients diagnosed with Coronary Artery Disease and were given lipid lowering drugs (Numerator)	242

MRN	Last Name	First Name	Gender	Birth Date	Race Cd	Hispanic Ind	Lang Cd	Homeless Status	Msfw Status	Last Visit Clinic	Last Visit Insurance	Last Visit Date	Medication Flag

7/1/2015

UDS -Table 6B Section H - Asthma Pharmacological Therapy
UDS Reporting Year: 2014

Report Criteria:
All Unduplicated Patients
Born between 1974 and 2009 (Age between 5 and 40 at the end of Reporting Year)
Had at least 1 Medical visit during the Reporting Year
Had 2 or more Medical visits ever in our Health System
Diagnosed with Persistant Asthma (ICD9 codes- refer to manual)
Flag patients who were prescribed with medication for Presistent Asthma in the Reporting Year

Total number of Patients diagnosed with Persistent Asthma (Denominator)	475
Total number of Patients diagnosed with Persistent Asthma and were given Asthma Medications (Numerator)	319

MRN	Last Name	First Name	Gender	Birth Date	Race Cd	Hispanic Ind	Lang Cd	Homeless Status	Msfw Status	Last Visit Clinic	Last Visit Insurance	Last Visit Date	Medication Flag

7/1/2015

UDS - Table 6B Section K - Patients With Colorectal Cancer Screening
UDS Reporting Year: 2014

Report Criteria:
All Unduplicated Patients
Born between 1940 and 1963 (Age between 51 to 74 at the end of Reporting Year)
Had at least 1 Medical visit during the Reporting Year
Exclusions: Patients diagnosed with Colorectal Cancer (ICD9 Code - 153.XX,154.XX)
Flag patient who have completed or Colonoscopy in the last 5 years or Sigmoidoscopy in the last 10 years
or Colon Cancer Screening in the reporting year or Blood occult test in the reporting year

Total Number of patients (Denominator)	1,673
Total Number of patients with Colonoscopy in last 5 years or Sigmoidoscopy in last 10 years or Fecal occult blood test or Colon Cancer screening in the reporting year (Numerator)	854

MRN	Last Name	First Name	Gender	Birth Date	Race Cd	Homeless Status	Msfw Status	Last Visit Clinic	Last Visit Insurance	Last Visit Date	Fecal Occult Blood Test	Sigmoidoscopy	Colonoscopy	Colon Cancer Screening

7/1/2015

UDS - Table 6B Section E - Weight Assessment Child Adoloscent
UDS Reporting Year: 2014

Report Criteria:
All Unduplicated Patients
Born between 1997 and 2011 (Age between 3 and 17 at the end of Reporting Year)
Had at least 1 Medical visit during the Reporting Year
First seen before 17th Birthday
Who had Pedi BMI recorded in the latest visit
Flag patients who had BMI recorded, Nutritional and Physical activity counseling given in the Reporting Year

Total Number of Pediatric Patients:(Denominator)	1,336
Total Number of Pediatric Patients with Pedi BMI percentile Recorded and received both Nutritional and Physical Activity Counseling (Numerator)	888
Total Number of Pediatric Patients with Pedi BMI percentile Recorded	983
Total Number of Pediatric Patients W/who were given Nutritional Counseling	912
Total Number of Pediatric Patients W/who were given Physical Activity Counseling	911

MRN	Last Name	First Name	Gender	Birth Date	Race Cd	Hispanic Ind	Lang Cd	Homeless Status	Msfw Status	Last Visit Clinic	Last Visit Insurance	Last Visit Date	Last BMI Recorded Date	Last BMI Recorded Value	Nutrition Counsel Flag	Physical Activity Counsel Flag

7/1/2015

UDS - Table 6 Section D - Pap Tests
UDS Reporting Year: 2014
Homeless & MSFW Merged

Report Criteria:
All Unduplicated Female Patients
Born between 1950 and 1990 (Age between 24 and 64 at the end of Reporting Year)
Had At least 1 Medical visit in the Reporting Year
Had Pap test performed in the last 3 years
OR Pap and HPV test done simultaneously in the last 5 Year and were aged >=30
Exclusions: Patient who had Hysterectomy done in the past
ICD-9 (68.4-68.8, 618.5) or CPT codes (Based on Manual from Table 6B Section D)

Total Number of Female patients (Denominator)	1648
Total Number of Female patients who have completed Pap test (Numerator)	357
Total Number of Female patients who have completed their paptest or HPV in the last 3 years	291
Total Number of Female patients who performed paptest and HPV simultaneously in the first 2 years of 5 year period from the reporting year	66

MRN	Last Name	First Name	Gender	Birth Date	Race cd	Hispanic Ind	Lang Cd	Homeless status	Msfw status	Last Visit Clinic	Last Visit Insurance	Last Visit Date	Pap in 3Y/ 5Y	Pap Test Y/N

7/1/2015

UDS - Table6B SectionF - Weight Assessment Adult
UDS Reporting Year: 2014

Report Criteria:
All Unduplicated Patients
Born on or before 1996 (Age 18 and above at the end of Reporting year)
Had at least 1 medical visit during the Reporting Year
Seen after their 18th Birthday
Flag patients who had BMI recorded on their last visit or within the six month from the last visit of the Reporting Year
Flag patients who had dietary counseling
Exclusions: Patients who are Pregnant (ICD9 Code - V22.XX,V23.XX)

Total Number of patients (Denominator)	4,482
Total Number of Patients who had normal BMI or Patients who's BMI was out of normal range and received counseling (Numerator)	1,138
Total Number of patients with BMI Recorded	2,789
Total number of patients who needed dietary counseling	1,577
Total Number of patients that qualified for dietary counseling and were given dietary counseling	326

MRN	Last Name	First Name	Gender	Birth Date	Race Cd	Hispanic Ind	Lang Cd	Homeless Status	Msfw Status	Last Visit Clinic	Last Visit Insurance	Last Visit Date	Last BMI Recorded Date	Last BMI Recorded Value	Dietary Counsel Given Flag	Need Dietary Counsel Flag

TAB 13
Discussion on Clinic Utilization

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: August 13, 2015

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

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: PRESENTATION TO BOARD FOR DISCUSSION OF THE 2015 SMMC CLINIC UTILIZATION DATA

As part of the Board's responsibilities in determining and directing appropriate services for our service populations, the Board needs to have a range of information to assist with those discussions. At the March Board meeting, Program was requested to provide data on SMMC Clinic utilization and to have it broken down by service population. The presentation and discussion of this information was subsequently tabled to today's meeting.

Utilizing the San Mateo Medical Center (SMMC) data provided for use in the recently completed annual Uniform Data System (UDS) report covering calendar year 2014, Program has calculated the utilization information requested. The data is provided by physical site and by clinic type (pediatrics, OB-GYN, etc.). All of the data is broken down by homeless, farmworker, and homeless and farmworker. The data spreadsheet is attached.

Attachments:

SMMC Clinic Utilization for 2014 for Homeless & Farmworkers

HCH/FH SMMC CLINIC UTILIZATION

2014

Physical Location

Farmworker Only	Homeless & Farmworker	Homeless Only		Total		
3236	429	13263		16928		Main Campus
19	106	4932		5057		Mobile Vans
4443	278	714		5435		Coastside
689	116	2675		3480		Fair Oaks
100	31	1170		1301		Daly City
42	3	1013		1058		South San Francisco
5	0	51		56		Daly City Youth
48	0	68		116		Sequoia Teen Center
30	7	548		585		South County Mental Health
1	4	204		209		San Mateo Mental Health
8613	974	24638		34225		

NOTE: There were 63 visits (23/3/37) for “OB Delivery Outside” for which there was not a specified physical site. This accounts for the differences in total visits across the two tables

Service Category

Farmworker Only	Homeless & Farmworker	Homeless Only		Total	
2273	365	14031		16669	Adult Primary Care
4217	325	1617		6159	Pediatrics
429	91	4311		4831	Specialty Services
785	96	2234		3115	Dental
700	79	1094		1873	OBGYN
133	10	958		1101	Optometry
99	11	430		540	Podiatry
8636	977	24675		34288	

TAB 14
Consumer Input

CIC for Health www.cicforhealth.com

Bigotry, Harassment and Denial of Care

A Population at Risk

Emerging data shows transgender and gender non-conforming individuals regularly face harassment, humiliation, indifference and outright denial of care when seeking even routine health services, because of who they are. As a group they need safe medical homes where they will be treated with understanding and dignity. Will health centers provide that safe medical home? Would your health staff know how?

On April 30, HRSA held a webinar entitled "Addressing the Healthcare Needs of the Transgender Patient." Afterward, CIC/for/Health spoke with one of the webinar's presenters, Elizabeth Sekera, RN, of San Francisco's Lyon-Martin Health Services, about her experience and advice on improving care for this vulnerable and underserved population.

A POPULATION AT RISK

Transgender and gender non-conforming individuals — people whose gender identity does not conform to the sex they were assigned at birth — are still largely invisible in federal data and are often conflated with the LGB population, although trans people face distinct challenges and have unique needs.

Independent studies like the 2011 National Transgender Discrimination Survey (NTDS), a survey of 6,450 transgender and gender non-conforming individuals across the U.S. and its territories conducted by the National Center for Transgender Equality and National Gay and Lesbian Task Force, paint a sobering picture of a trans population that is **medically underserved not only as a group, but often on an individual level**.

Many trans people face significant economic barriers to care. Fifteen percent of respondents to the 2011 NTDS reported incomes of less than $10,000 a year and a further 12% made between $10,000 and $20,000 a year; 19% of all respondents said they had no health insurance. However, economic factors represent only part of the problem. **An alarming 19% of NTDS respondents reported having been denied medical service due to their gender identity**; the figures were significantly higher for some ethnicities. Of respondents who did receive care, 28% said they had experienced verbal harassment from providers and 2% reported having been physically assaulted by one or more providers.

Unsurprisingly, fewer than half of all NTDS respondents said they were 'out' as trans or gender non-conforming to most or all of their healthcare providers; respondents who were out were

substantially more likely to be denied care or face harassment than those who were not. Since discrimination on the basis of gender identity is still legal in many areas, patients who face such harassment often have little recourse.

Such experiences lead many trans people to delay or avoid seeking medical care. Thirty-three percent of all NTDS respondents reported delaying preventive care out of fear of discrimination and **28% said fear of discrimination led them to delay seeking care for illness or injury**. This understandable reluctance to seek care has serious implications for the overall health of this population, which according to the NTDS report also has much higher rates of HIV infection, drug and alcohol abuse, smoking, and suicide attempts than the general population.

CREATING SAFE CARE ENVIRONMENTS

The HRSA webinar invited a number of grantees to describe their organizations' work in addressing the enormous healthcare disparities faced by transgender patients. While the focus and scope of those efforts varied, the common goal was to promote a more inclusive healthcare environment for patients of all gender identities.

Among the presenters was Elizabeth Sekera, RN, clinic director of San Francisco's Lyon-Martin Health Services (now a program of HealthRIGHT 360), which serves a substantial number of transgender patients. Ms. Sekera offered practical advice for making health centers more welcoming to trans and gender non-conforming individuals, including staff as well as patients; her tips are summarized in sidebar A below.

We asked Ms. Sekera to talk more about Lyon-Martin's experience and what other health centers should recognize about serving transgender patients.

CIC: At what point did Lyon-Martin begin serving trans patients?

ES: I would say we've always served trans patients. Around 2005, we formalized it and created a structure and policies and procedures. It was a natural progression because we were serving some people who had identified as bulldaggers or butch lesbians, but later looked into transitioning. Since we were already serving those patients, it made sense.

CIC: Was there any pushback on the decision to expand the center's focus to more formally include transgender patients?

ES: I think it was pretty seamless because it was already naturally happening. So, it made sense to respect patients' gender identities.

CIC: Could you describe Lyon-Martin's progression in making the center safer and more welcoming for trans patients? Was this something you approached as a comprehensive effort or has the center's strategy evolved over time?

ES: It's definitely a progression over time. Ultimately, it really reflects where the trans community is at — they're kind of guiding us as to where the need is. In 2006, for example, we decided to change our logo, which was a women's symbol. That meant we could be outing [trans] people just by providing them with a letter on our letterhead, so we updated our logo. It's some simple things that actually matter.

There are a couple of things we look at generally. If people are filling out the 'other' [gender] category on any of our intake forms, we look at the trends of how people are identifying. For instance, in the past few years, there have been more people using 'they/them' pronouns, so we updated the forms to include that.

I really utilize a lot of our staff and their feedback, whether from interacting with clients or if staff members are trans-identified themselves. Obviously, creating a patient environment and creating a work environment are not quite the same, but there's a lot of symbiosis.

CIC: What sort of complications, if any, have you run into in the course of this effort? How did you address those issues?

ES: The issues begin when we have to interact outside of our "bubble." Electronic health records are a big issue: We are a small clinic and don't have a lot of voice in how things should be done, yet as a customer, 55% of our patients identify as trans or genderqueer, so working with EHR vendors [to create appropriate fields and workarounds] is a big thing.

We also run into friction when working out of house with referrals and trying to ensure that our patients are safe when seeking specialty and follow-up care. For example, we had a place we'd send patients for mammograms. We got complaints from transmen who said there was no process there for them, so they felt ostracized.

We work with referral providers to create procedures that are a lot more streamlined for those clients. If a patient has had a negative incident, sometimes we send someone with them for advocacy or find someone else to send them to.

It used to be a much bigger issue, but in San Francisco, there are so many resources now for the trans community that patients are a lot more savvy in standing up for themselves, which gives a lot of other agencies impetus to change.

One example was around the implementation of the ACA. We had to deal with a state agency that required the use of nametags and user logins for certified enrollment counselors. The agency had no place for preferred names or pronouns, which created problems for our staff. Luckily, the agency listened, and now Covered California [California's state healthcare exchange] has preferred name fields. It took a while, but we got through it.

It takes some finessing in how you approach it. Covered California listened because it was about creating a safe work environment for our employees.

CIC: To what extent would you say the center's trans staff members have shaped your approach to trans issues?

ES: People will say, "Why don't we do this?" and a lot of times it's a great idea. For example, someone suggested we put people's pronouns on nametags, since we all wear nametags.

CIC: By making it something everyone does, it also avoids inadvertently stigmatizing trans staff members.

ES: It also gives us a reciprocal way for clients to interact with our staff rather than just the other way around. It makes it everyone's responsibility.

CIC: You mentioned in the webinar that you had recently started putting staff members' pronouns in email signatures as well.

ES: Putting the pronouns in people's email signatures also was an employee-driven item. After our merger with HealthRIGHT 360, a lot of us are sending out a lot more emails than we had before, so someone said, "Why don't we just add this?" It's worked out really well.

There are some clients who may not understand the pronouns, and it can definitely be a conversation. Our employees are really capable of engaging in those discussions in ways that are not triggering for either party.

CIC: Many parts of the country are currently experiencing a major legal backlash against LGBT rights. What would you say to a health center that's concerned about getting pushback from conservative patients or the local community if the center focuses on trans and/or LGB inclusiveness?

ES: I would say, "I hear you, but I think we need to set the bar higher." Our responsibility is to serve all marginalized and disproportionately served communities.

It's worrisome to me when boards or administrators make fear-based decisions. Inevitably, you are impacting someone's health care because of that. Engaging with your clients rather than assuming pushback is important.

Engage in conversations with your clients about how they feel and how they think you could incorporate more inclusiveness. A lot of times, you can do stuff that would be pretty invisible to people who weren't looking for it.

CIC: How would you respond to a health center or provider that doesn't understand why trans inclusiveness is even something they need to be concerned about?

When I'm providing trainings [for organizations] where the staff doesn't know anyone who's trans and it's a new thing for them, what I always say is, "We're trying to create a safe space for everyone. Imagine walking into a place and not being sure you can receive safe health care."

I give them the numbers: harassment, unemployment rates, suicide rates. I say, "FQHCs are the safety net. That's our responsibility and this is a part of that." I stress the importance of doing that for all communities rather than just specific communities we might or might not identify with.

For providers, who have taken an oath to do no harm, I also remind them, "By turning away patients or looking the other way, you are actively doing harm."

CIC: They also may have trans patients already and just not realize it.

ES: Yes. I say to people, "You don't know you don't have trans patients because you aren't asking or because you aren't creating an environment where they feel safe disclosing that to you."

The other thing I will say to providers is that by making it the responsibility of the patient to train and teach the provider, you make [your interaction] a traumatizing experience for the patient. The healthcare environment is a very vulnerable place for patients and it's extremely risky to out yourself within that space without knowing what the repercussions could be.

It's also stressful if you have to wonder, "Does the doctor even know how to treat my body?"

CIC: For providers who do have questions, I understand you're the contact for Project HEALTH and the TransLine. Tell us a little about that.

ES: TransLine [*http://project-health.org/transline/*] is an amazing resource. The TransLine is a national web-based platform where providers can submit questions regarding transgender

healthcare. We will get back to them within two business days with a response from volunteer providers across the country.

CIC: Finally, if you could offer one piece of advice to every health center director or CEO in the country regarding serving trans patients, what would it be?

ES: Do it! It's a shame that the trans community has come to expect that they will receive substandard or sub-par care. Changing that expectation brings so much reward.