

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

Co-Applicant Board Meeting Agenda

San Mateo Medical Center | 222 W. 39th Ave. 2nd floor (Classroom 1) San Mateo

April 11, 2019; 9:00 - 11:00am

AGENDA	SPEAKER(S)	TAB	TIME
A. CALL TO ORDER	Brian Greenberg		9:00am
B. CHANGES TO ORDER OF AGENDA			9:02am
C. PUBLIC COMMENT			9:05am
<p>Persons wishing to address on matters NOT on the posted agenda may do so. Each speaker is limited to three minutes and the total time allocated to Public Comment is fifteen minutes. If there are more than five individuals wishing to speak during Public Comment, the Chairperson may choose to draw only five speaker cards from those submitted and defer the rest of the speakers to a second Public Comment at the end of the Board meeting. In response to comments on a non-agenda item, the Board may briefly respond to statements made or questions posed as allowed by the Brown Act (Government Code Section 54954.2) However, the Boards general policy is to refer items to staff for comprehensive action or report.</p>			
D. CONSUMER INPUT/GUEST SPEAKER	Guest speaker		9:07am
E. BOARD ORIENTATION			
<i>a. Funding Opportunities</i>	HCH/FH Staff	Tab 1	9:30am
<i>b. Needs Assessment Discussion</i>			
F. CLOSED SESSION- There is no closed session at this meeting.			
G. MEETING MINUTES			
1. Meeting minutes from March 14. 2019	Linda Nguyen	Tab 2	9:50am
H. BUSINESS AGENDA			
1. Sliding Fee Scale	Linda/Jim	Tab 3	9:52am
<i>a. Action item Request to approve SFS</i>			
2. Public Health Policy and Planning contract	HCH/FH Staff	Tab 4	10:05am
<i>a. Action item Request to amend contracts</i>			
3. QI Plan approval	Frank/Danielle	Tab 5	10:15am
<i>a. Action item Request to approve plan</i>			
4. Travel requests	Linda/Jim	Tab 6	10:25am
<i>a. Action item Request to approve travel requests</i>			
5. New Board membership	Robert/Adonica	Tab 7	10:30am
<i>a. Action item Request to approve board members</i>			
G. REPORTING AGENDA			
1. Annual Report discussion	Irene		10:35am
2. Sub-committee reports	Steve/Brian/Steve	Tab 8	10:42am
3. HCH/FH Program Director's Report	Frank/Danielle	Tab 9	10:50am
4. HCH/FH Program Budget/Finance Report	Robert/Jim		10:55am
H. BOARD COMMUNICATIONS AND ANNOUNCEMENTS			
<p>Communications and Announcements are brief items from members of the Board regarding upcoming events in the community and correspondence that they have received. They are informational in nature and no action will be taken on these items at this meeting. A total of five minutes is allotted to this item. If there are additional communications and announcements, the Chairperson may choose to defer them to a second agenda item added at the end of the Board Meeting.</p>			
1. Future meetings – every 2 nd Thursday of the month (unless otherwise stated)			
a. Next Regular Meeting April 12, 2019; 9:00AM – 11:00AM at SMMC San Mateo			
I. ADJOURNMENT			11:00am

TAB 1
Funding
Oppurtunities

From: [Jim Beaumont](#)
To: [Jim Beaumont](#)
Cc: [Sofia Recalde](#); [Danielle Hull](#); [Linda Nguyen](#); [Irene Pasma](#); [Frank Trinh](#); [jim.beaumont](#)
Subject: Funding Opportunities Announced by HRSA
Date: Monday, April 1, 2019 5:36:12 PM
Attachments: [HRSA-19-100 IBHS final to post.pdf](#)
[HRSA-19-079 \(OHI\) final to post.pdf](#)
[HRSA 2019 Announced Funding Opportunities.docx](#)

I will be mailing out the below email to the Board members tomorrow morning. Please review and comment.

Linda, do we have a file, sheet, etc., with all of the Board members' emails on it?

=====

DO NOT FORWARD THIS EMAIL

DO NOT DISCUSS THIS EMAIL OR THE FUNDING OPPORTUNITY WITH OTHER BOARD MEMBERS, IN PERSON, BY PHONE OR ELECTRONICALLY.

As noted at the March Co-Applicant Board Meeting, HRSA was planning on releasing two (2) new Funding Opportunities (FOs). As we have experienced the past few years, these FOs will have very short turn-around times for the program to submit requests for the funding. As the Board has the responsibilities to select and approve program services and approve grant applications, this can present issues for Board involvement.

HRSA has released the expected FOs (Oral Health Infrastructure; Integrated Behavioral Health Services, updated summary attached). The FOs are both attached to this email. Please review them and think about what types of services the program might be able to offer based on the intent and requirements of the FOs. These will be on the Board meeting agenda for the April 11, 2019 Co-Applicant Board meeting for Board discussion, direction and decision.

UNDER THE BROWN ACT, YOU MAY NOT DISCUSS THESE WITH OTHER BOARD MEMBERS UNTIL THE MEETING.

If you have any questions about the FOs, the funding processes (there are two completely different processes for these FOs), or the requirements, please contact me or the other HCH/FH Program staff (contact numbers below). We will do our best to provide you with all of whatever information you need or to answer any questions you may have.

Program staff is working on these FOs based on our understanding of the FO requirements, our Strategic Plan, and our knowledge of the needs and potential benefits for our target populations. We anticipate a broad and extensive discussion of the possibilities at the Board meeting, hopefully completed with Board decisions on the directions to pursue with these FOs.

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Announced HRSA Funding Opportunities (FO)

TITLE	ORAL HEALTH INFRASTRUCTURE	INTEGRATED BEHAVIORAL HEALTH SERVICES
FO Type	Competitive	Non-competitive
Total Value	\$76 Million	\$200 Million
Number of Awards	~250 one-time	~1,375 awards (potentially ongoing)
Estimated award value	Up to \$300,000	~\$145,000
Release Date	March 22, 2019	March 29, 2019
Submission Date	April 22, 2019 & May 21, 2019 (two-step process)	May 13, 2019
Specifications	Not for services. To support underlying infrastructure needs: new operatories, equipment, etc. Includes automation, dental EHRs.	Expand on the previous two years expanded services awards (AIMS & SUD-MH). Requires addition of at least 0.5 new FTE.
Possibilities	Dental Electronic Health Record (EHR)	Add Behavioral Health (Mental Health and/or Substance Use Disorder) staff to Street/Field Medicine Team

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES



Health Resources & Services Administration

Bureau of Primary Health Care
Office of Policy and Program Development

Oral Health Infrastructure (OHI)

Funding Opportunity Number: HRSA-19-079
Funding Opportunity Type(s): Competing Supplement
Catalog of Federal Domestic Assistance (CFDA) Number: 93.527

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2019

Application Due Date in Grants.gov: April 22, 2019
Supplemental Information Due Date in HRSA EHBs: May 21, 2019

Ensure your SAM and Grants.gov registrations and passwords are current immediately!
HRSA will not approve deadline extensions for lack of registration.
Registration in all systems, including SAM.gov, Grants.gov, and HRSA EHBs,
may take up to 1 month to complete.

Issuance Date: March 22, 2019

Renetta Boyd or Robyn Bess
Public Health Analysts, Office of Policy and Program Development
Contact: <https://www.hrsa.gov/about/contact/bphc.aspx>
Telephone: (301) 594-4300
OHI Technical Assistance website:
<http://bphc.hrsa.gov/programopportunities/fundingopportunities/oralhealth/index.html>

Authority: Public Health Service Act, Section 330(e), (g), (h), and/or (i), as amended (42 U.S.C. 254b(e), (g), (h), and/or (i))

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA) is accepting applications for fiscal year (FY) 2019 Oral Health Infrastructure (OHI) under the Health Center Program. The purpose of this one-time, competitive supplemental funding opportunity is to support infrastructure enhancements to provide new or enhance existing high quality, integrated oral health services.

Funding Opportunity Title:	Oral Health Infrastructure (OHI)
Funding Opportunity Number:	HRSA-19-079
Due Date for Applications – Grants.gov:	April 22, 2019 (11:59 p.m. ET)
Due Date for Supplemental Information – HRSA EHBs	May 21, 2019 (5 p.m. ET)
Anticipated Total Available FY 2019 Funding:	\$76,000,000
Estimated Number and Type of Awards:	Up to 250 grants
Estimated Award Amount:	Up to \$300,000
Cost Sharing/Match Required:	No
Period of Performance:	OHI funding will be awarded as a supplement to your current Health Center Program award, for use from September 1, 2019 through the end of your FY 2021 budget period.
Eligible Applicants:	Existing Health Center Program award recipients that currently receive operational funding under section 330 of the Public Health Service Act (i.e., sections 330(e), (g), (h) and/or (i)). See Section III of this notice of funding opportunity (NOFO) for complete eligibility information.

Application Guide

You (the applicant organization/agency) are responsible for reading and complying with the instructions included in HRSA's *SF-424 Two-Tier Application Guide*, available online at <https://www.hrsa.gov/grants/apply/applicationguide/sf424programspecificappguide.pdf>, except where instructed in this NOFO to do otherwise.

Technical Assistance

HRSA will hold a pre-application technical assistance (TA) webinar for applicants seeking funding through this opportunity. Visit the [OHI technical assistance website](#) for webinar details and helpful resources. In addition, see [BPHC's Oral Health and Primary Care Integration website](#) for resources on improving oral health and primary care integration in health centers.

The HRSA Primary Health Care Digest is a weekly email newsletter containing information and updates pertaining to the Health Center Program, including competitive funding opportunities. Organizations interested in seeking funding under the Health Center Program are encouraged to have several staff subscribe at https://public.govdelivery.com/accounts/USHHSHRSA/subscriber/new?topic_id=USHHSHRSA_118.

HRSA-supported Primary Care Associations (PCAs) and/or National Cooperative Agreement recipients (NCAs) are available to assist you in preparing a quality application. For a listing of HRSA-supported PCAs and NCAs, refer to HRSA's [Strategic Partnerships website](#).

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I. Program Funding Opportunity Description

1. Purpose

This notice solicits applications for Fiscal Year (FY) 2019 Oral Health Infrastructure (OHI) funding. The purpose of the OHI supplemental funding is to support infrastructure enhancements to provide new or enhance existing high quality, integrated oral health services in health centers.

For purposes of this NOFO, the phrase “integrated oral health services” means preventive and primary dental health services and additional dental services, as appropriate, delivered through an interdisciplinary team-based approach in collaboration among health center professionals (e.g., medical, behavioral, dental). This funding opportunity will support one-time physical and organizational infrastructure investments, such as minor alteration and renovation (A/R), equipment purchases, health information technology (IT), and training, to enable health centers to establish or enhance integrated oral health services, including those provided using telehealth¹ and virtual dentistry. Virtual dentistry utilizes telehealth technology to provide patients preventive and early intervention therapeutic services in community settings where they live or receive other health services, and gives providers and staff in remote sites access to professional resources.²

2. Background

This program is authorized by Section 330(e), (g), (h) and/or (i) of the Public Health Service Act, as amended (42 U.S.C. 254b(e), (g), (h) and/or (i)).

This funding opportunity builds upon previous HRSA investments to support integrated care in health centers. In 2016, HRSA awarded 420 health centers approximately \$156 million in ongoing funding to increase access to integrated oral health care services and improve oral health outcomes for Health Center Program patients. Health centers used these funds to increase oral health service capacity by hiring approximately 1,660 new dentists and dental hygienists, assistants, and technicians to provide dental services to more than 450,000 new patients. HRSA-funded health centers served more than 6.1 million dental patients and provided nearly 15.7 million dental visits in 2017, an 8 percent increase from 2016.

¹ Telehealth is defined, for purposes of this NOFO, as the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications. See <https://www.hrsa.gov/rural-health/telehealth/index.html> for telehealth resources.

² Glassman, Harrington, Namakian, and Subar, “The virtual dental home: bringing oral health to vulnerable and underserved populations.” California Dental Association Journal, vol. 40, no. 7, pp. 569-77, July 2012.

Health Center Program award recipients (hereafter referred to as health centers)³ provide comprehensive required primary care services to medically underserved areas and populations, including preventive dental services. These services include basic dental screenings, oral health hygiene instruction and education, oral prophylaxis (commonly known as teeth cleaning), and the application of fluorides, and may include X-rays and the placement of dental sealants. Many health centers also offer additional dental services, such as diagnosis and treatment of tooth ailments, to address the oral health care needs of their patient population.

Health centers may face challenges providing integrated oral health services due to limitations in infrastructure, such as outdated equipment, insufficient space, and limited integration of primary care and oral health electronic health records. As a follow up to previous investments to expand oral health service capacity, OHI one-time funding will provide health centers an opportunity to make or build upon such infrastructure enhancements.

Proposal Requirements

Your application must demonstrate how you will use OHI funding to enhance your infrastructure to increase access to integrated oral health services. You must use funds provided under this NOFO for one-time physical and organizational infrastructure investments (e.g., minor A/R, equipment, health IT, training) to increase access to integrated oral health services, including telehealth and virtual dentistry. OHI funds may not support ongoing personnel or service provision costs. Infrastructure investments may occur at current, in-scope health center sites or new sites that are proposed through the OHI application for the purpose of expanding access to integrated oral health services. These sites (current or proposed) may be permanent or mobile. Proposed new sites must be located within the current service area. See the instructions for completing [Form 5B: Service Sites](#) for details.

Your application may request funding for as many as four minor A/R projects, equipment purchases, and/or other infrastructure investments such as training, telehealth, and health IT that do not fall under the equipment category. Refer to [Appendix A](#) for a list of sample infrastructure-focused funding uses that may support the implementation of integrated oral health services.

Minor A/R (with or without equipment): A minor A/R project is defined as all of the allowable A/R-related activities proposed at a single health center site, with a total site-specific project cost that is less than \$500,000.⁴ You may propose as many as four minor A/R projects, with each occurring at a different site. The total request for OHI funding across all proposed projects may not exceed \$300,000. Projects may include work required to modernize, improve, and/or reconfigure the interior arrangements or

³ For the purposes of this funding opportunity, the term “health center” means organizations funded under Section 330(e), (g), (h), and/or (i) of the Public Health Service Act, as amended.

⁴ The total project cost (less than \$500,000) includes both the federal funding request and all other funding sources, but excludes moveable equipment costs.

other physical characteristics of a facility and/or installation of equipment in an existing facility. A minor A/R project may not increase the total square footage of an existing building (e.g., by construction of a building addition) and may not be part of a larger construction project.

Equipment: Moveable items, including IT systems, with a per-unit cost of \$5,000 or more are considered equipment (see the [Equipment List Form](#) instructions for the full equipment definition). You may propose to purchase equipment for any number of health center sites, alone or in addition to proposing up to four minor A/R projects. Examples of equipment that you may propose include purchase of a mobile unit, dental chairs and other dental equipment, telehealth equipment, servers, and radiology equipment.

Other Infrastructure Investments: You may request funding for other infrastructure investments that do not fall under the categories of minor A/R and equipment. Examples include training, consulting, supplies, and licenses for health IT that enhance integrated oral health services.

II. Award Information

1. Type of Application and Award

Type of applications sought: Competing Supplement

HRSA will provide funding in the form of a grant.

2. Summary of Funding

HRSA expects approximately \$76,000,000 in one-time funding to be available to fund 250 recipients. You may apply for a ceiling amount of up to \$300,000 total cost (includes both direct and indirect costs). The period of performance is September 1, 2019 through the end of your FY 2021 budget period. If awarded, your OHI funding supplements your current Health Center Program award and will only be available in your FY 2020 and FY 2021 budget period if you are an active Health Center Program award recipient.

All HRSA awards are subject to the Uniform Administrative Requirements, Cost Principles and Audit Requirements at [45 CFR part 75](#).

III. Eligibility Information

1. Eligible Applicants

Your organization must be an existing Health Center Program award recipient⁵ to apply.

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

3. Other

HRSA will consider any application that exceeds the ceiling amount of \$300,000 on the [SF-424A](#) non-responsive and will not consider it for funding under this notice.

HRSA will consider any application that fails to satisfy the deadline requirements referenced in [Section IV.4](#) non-responsive and will not consider it for funding under this notice.

Applications that do not include the [Project Narrative](#), as described in Section IV.2.ii, will be considered non-responsive and will not be considered for funding under this notice.

Applications that propose either of the following unallowable projects will be considered non-responsive and will not be considered for funding under this notice:

- Construction (i.e., a project that will increase physical square footage – either by building on to an existing facility or constructing a new facility from the ground up).
- Major alteration/renovation activities (i.e., an A/R project that is part of a larger construction project or has a total project cost of \$500,000 or more).

NOTE: Multiple applications from an organization are not allowable.

HRSA will only accept your first validated electronic submission, under the correct funding opportunity number, in Grants.gov. Applications submitted after the first submission will be marked as duplicates and considered ineligible for review. If you wish to change information submitted in a Grants.gov application, you may do so in the HRSA Electronic Handbooks (HRSA EHBs) application phase.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA **requires** you to apply electronically through Grants.gov and the HRSA EHBs. You must use a two-tier submission process associated with this NOFO and follow the

⁵ Organization currently receiving operation funding under Section 330 of the Public Health Service Act (i.e., sections 330(e), (g), (h), and/or (i)).

directions provided at <http://www.grants.gov/applicants/apply-for-grants.html> and in the HRSA EHBs.

- **Phase 1 – Grants.gov** – Required information must be submitted and validated via Grants.gov with a due date of April 22, 2019 at 11:59 p.m. Eastern Time; and
- **Phase 2 – HRSA EHBs** – Supplemental information must be submitted via HRSA EHBs with a due date of May 21, 2019 at 5 p.m. Eastern Time.

Only applicants who successfully submit the workspace application package associated with this NOFO in Grants.Gov (Phase 1) by the due date may submit the additional required information in HRSA EHBs (Phase 2).

HRSA recommends that you supply an email address to Grants.gov on the grant opportunity synopsis page when accessing this notice of funding opportunity (NOFO) (also known as “Instructions” on Grants.gov) or workspace application package. This allows Grants.gov to email organizations in the event HRSA changes and/or republishes the NOFO on Grants.gov before its closing date. Responding to an earlier version of a modified notice may result in a less competitive or ineligible application. *Please note you are ultimately responsible for reviewing the [For Applicants](#) page for all information relevant to desired opportunities.*

2. Content and Form of Application Submission

Application Format Requirements

Section 5 of HRSA’s [SF-424 Two-Tier Application Guide](#) provides instructions for the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, and abstract. You must submit the information outlined in the Application Guide in addition to the program-specific information below. You are responsible for reading and complying with the instructions included in HRSA’s [SF-424 Two-Tier Application Guide](#) except where instructed in the NOFO to do otherwise. You must submit the application in the English language and in the terms of U.S. dollars (45 CFR § 75.111(a)).

See Section 9.5 of the *Application Guide* for the Application Completeness Checklist.

Application Page Limit

The total size of all uploaded files may not exceed the equivalent of **50 pages** when printed by HRSA. The page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support. Standard OMB-approved forms that are included in the workspace application package do not count in the page limit. The Indirect Cost Rate Agreement does not count in the page limit. **We strongly urge you to take appropriate measures to ensure your application does not exceed the specified page limit.**

Applications must be complete, within the specified page limit, validated by Grants.gov and submitted under the correct funding opportunity number prior to the Grants.gov and HRSA EHBs deadlines to be considered under this notice.

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

- 1) The prospective recipient certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
- 2) Failure to make required disclosures can result in any of the remedies described in 45 CFR § 75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. 3321.)
- 3) Where the prospective recipient is unable to attest to the statements in this certification, an explanation shall be included in [Attachment 4](#): Other Relevant Documents.

See Section 5.1 viii of HRSA's [SF-424 Two-Tier Application Guide](#) for additional information on all certifications.

Program-Specific Instructions

In addition to application requirements and instructions in Sections 4 and 5 of HRSA's [SF-424 Two-Tier Application Guide](#) (including the budget, budget narrative, assurances, certifications, and abstract), include the following:

i. Project Abstract

See Section 5.1.ix. of HRSA's [SF-424 Two-Tier Application Guide](#). In addition, provide your active Health Center Program grant number (H80CSXXXXX), and a brief summary of the proposed infrastructure project(s) and how the project(s) will support access to integrated oral health services.

ii. Project Narrative

This section provides a comprehensive framework and description of all aspects of the proposed project. It should be succinct, and well organized so that reviewers can understand the proposed project.

Successful applications will contain the information below. Please use the following section headers for the narrative: Need, Response, Impact, and Resources/Capabilities.

NEED – Corresponds to [Section V's Review Criterion 1: NEED](#)

- 1) Describe the current and anticipated integrated oral health needs of the patient population and/or underserved population in the service area.
- 2) Describe the infrastructure enhancements necessary to address these oral health needs.

RESPONSE – Corresponds to [Section V's Review Criterion 2: RESPONSE](#)

- 1) Describe your health center's current oral health services, including service delivery methods (i.e., the extent to which services are provided directly (Form 5A: Services Provided, Column I), through contracts or agreements for which the health center pays (Form 5A, Column II), or through formal referral arrangements (Form 5A, Column III)).⁶
- 2) Describe the proposed infrastructure investments necessary for increasing access to integrated oral health services. Specifically describe:
 - a) Any proposed minor alteration/renovation (A/R) activities. Your response should align with and reference the project-related information in the [Project Cover Page\(s\)](#). If the site to be renovated is leased, include the lease agreement or intent to lease documentation in [Attachment 2: Lease Documentation](#).
 - b) Any proposed equipment and supplies purchases, including dental, telehealth, and other equipment and technology to extend the reach of current dental providers through virtual dentistry. Your response should align with the Equipment List and budget information.
 - c) Any other infrastructure investments, such as training, improved workflows, systems consulting, and EHR enhancements.
- 3) If you are proposing to use OHI funds to enhance oral health services through the use of telehealth and/or virtual dentistry, specifically describe how this will be implemented.
- 4) If you are proposing to add a new service delivery site (permanent or mobile unit),⁷ describe the location of the new site(s) within your existing service area⁸ and how the site(s) are essential to addressing the identified oral health infrastructure needs. Provide evidence of support for the new site from other health care providers in the service area through letters of support uploaded as [Attachment 1: Collaboration Documentation](#). If you plan to use funds toward the purchase of a mobile unit, describe how and where the mobile unit will serve your existing service area.

⁶ Reference the [Supplemental Information Form](#) to view your current oral health services.

⁷ Proposed new site(s) must be indicated on [Form 1B: Funding Request Summary](#) and documented on [Form 5B](#).

⁸ Your service area, as of the NOFO release date, may not be expanded through this application. See instructions for completing [Form 5B](#) for details.

IMPACT – Corresponds to [Section V's Review Criterion 3: IMPACT](#)

- 1) Describe the integrated oral health services that will be added/expanded⁹ as a result of the infrastructure investments outlined in the RESPONSE section above.
- 2) If new dental personnel are required to expand integrated oral health services, describe how those providers will be supported. If new dental personnel are not required, describe how current dental personnel will ensure expanded integrated oral health services.
- 3) Describe how the completed project(s) will support the delivery of quality integrated oral health services.

RESOURCES/CAPABILITIES – Corresponds to [Section V's Review Criterion 4: RESOURCES/CAPABILITES](#)

- 1) Describe the capabilities and expertise that qualify the organization to carry out the proposed project, including:
 - a) Experience with successfully completing similar infrastructure projects, including how you avoided or minimized time and cost overruns.
 - b) The skills and experience of staff managing the project(s). If proposing minor A/R, your response should align with and reference the project-related information in the [Project Cover Page](#)(s).
 - c) The capability of key management staff to provide operational oversight.
- 2) Describe the health center's acquisition policies and procedures, as well as how the health center will comply with federal procurement requirements, as applicable.
- 3) Describe existing and planned collaboration and coordination of oral health services with other health care providers in the area. Provide evidence of support from such providers, community members, and/or other stakeholders through letters of support uploaded as [Attachment 1: Collaboration Documentation](#).

NARRATIVE GUIDANCE

To ensure that you fully address the review criteria, this table provides a crosswalk between the narrative language and where each section falls within the review criteria.

⁹ New and expanded oral health services may require an approved post-award Scope Adjustment or Change in Scope. Refer to the Form 5A Service Descriptors document for clarification on required and additional services:
<https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/scope/form5aservicedescriptors.pdf>.
Refer to the [Scope of Project website](#) for guidance on scope considerations.

<u>Narrative Section</u>	<u>Review Criteria</u>
Need	(1) Need
Response (including Project Description on Project Cover Page(s) for minor A/R projects)	(2) Response
Impact	(3) Impact
Resources/Capabilities (including Project Management on Project Cover Page(s) for minor A/R projects)	(4) Resources/Capabilities
Budget Presentation (Budget Forms, Budget Narrative, and A/R Project Budget Justification(s))	(5) Support Requested

iii. **Budget**

See Section 5.1.iv of HRSA’s [SF-424 Two-Tier Application Guide](#). Follow the instructions included in the Application Guide and the additional budget instructions provided below. A budget that follows the Application Guide will ensure that, if HRSA selects the application for funding, you will have a well-organized plan, and by carefully following the approved plan, you can avoid audit issues during the implementation phase.

Reminder: The Total Project or Program Costs are the total allowable costs (inclusive of direct and indirect costs) incurred by the recipient to carry out a HRSA-supported project or activity. Total project or program costs include costs charged to the award and costs borne by the recipient.

In addition, the OHI program requires the following:

You must present the total budget for the project, which includes OHI federal funds (up to \$300,000) and all non-OHI award funds that will support the proposed project. Health centers have discretion regarding how they propose to allocate the total budget between OHI federal funds and other funding that supports the project, provided that the projected budget complies with all applicable HHS policies and other federal requirements.¹⁰

Budget Information Form (SF-424A):

- In Section A and B, enter only the OHI funding requested in the Federal columns. The maximum amount that may be requested cannot exceed \$300,000.
- In Section A – Budget Summary, under New or Revised Budget, enter the federal funding requested in the Federal column for each type of section 330 funding

¹⁰ See [Chapter 17: Budget](#) of the Compliance Manual.

(Community Health Center, Migrant Health Center, Health Care for the Homeless, and/or Public Housing Primary Care). Funding must be requested and will be awarded proportionately for all population types for which you currently receive Health Center Program funding. No new population types may be added. Enter all other project costs in the Non-Federal column. Estimated Unobligated Funds are not applicable for this funding opportunity.

- In Section B – Budget Categories, enter an object class category (line item) budget for the entire 2-year budget period. The amounts for each category in the federal and non-federal columns, as well as the totals, should align with the Budget Narrative. If requesting funds for minor A/R, include that amount on the Construction line.
- In Section C – Non-Federal Resources, enter the amount of all other sources of funding for the proposal, not including the federal funding request. The total in Section C must be consistent with the Non-Federal Total in Section A. When providing Non-Federal Resources by funding source, include other federal funds supporting the proposed project in the “other” category.

The Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (P.L. 115-245), Division B, § 202 states, “None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.” See Section 5.1.iv Budget – Salary Limitation of HRSA’s [SF-424 Two-Tier Application Guide](#) for additional information. Note that these or other salary limitations may apply in the following FY, as required by law.

iv. **Budget Narrative**

See Section 5.1.v. of HRSA’s [SF-424 Two-Tier Application Guide](#).

The OHI program requires a budget narrative that outlines federal and non-federal costs for the entire two-year budget period. Refer to the sample budget narrative available on the [OHI technical assistance website](#).

Your budget narrative must:

- Clearly detail calculations for each line item on the SF-424A Budget Information Form, including cost per unit.
- Explain how each cost relates to your OHI project(s) to enable HRSA to determine if costs are allowed.¹¹
- Align with the separate minor A/R project budget justification(s) and Equipment List Form, as applicable. See descriptions of requirements under Minor A/R Forms and Equipment List below.

¹¹ Refer to the cost principles embedded in 45 CFR part 75, see <http://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75> for details on allowable costs.

v. **Program-Specific Forms**

Program-Specific Forms must be completed electronically in HRSA EHBs. To preview the forms to be completed in HRSA EHBs, visit the [OHI technical assistance website](#).

FORM 1B: BPHC FUNDING REQUEST SUMMARY (REQUIRED)

Before completing Form 1B, the SF-424A Budget Information Form must be completed. See the [Budget](#) section for instructions on completing the SF-424A.

1. OHI FUNDING REQUEST

- The form displays the OHI funding request, pre-populated from the SF-424A Budget Information Form, Section A.
- The maximum amount of federal funding that can be requested is \$300,000.
- If changes are required, modify the appropriate section of the SF-424A.

2. OHI FUNDING ACTIVITIES

- Indicate if the one-time funds are for:
 - 1) Equipment only;
 - 2) Minor A/R with equipment;
 - 3) Minor A/R without equipment; or
 - 4) Activities other than minor A/R and equipment.
- If you select equipment only, you must enter the amount requested for equipment on the equipment line in Section B of the SF-424A.
- If you select minor A/R with equipment, you must enter the amount requested for minor A/R on the construction line and for equipment on the equipment line in Section B of the SF-424A.
- If you select minor A/R without equipment, you must enter the amount requested for minor A/R on the construction line in Section B of the SF-424A.
- If you select activities other than minor A/R and equipment (e.g., training, health IT consulting), the following forms will not be available in your application: Equipment List, A/R Project Cover Page, and Other Requirements for Sites.

3. ADDITION OF SITES

- Indicate if you are proposing to add a new service delivery site (permanent or mobile and only within your existing service area) to address identified oral health infrastructure needs.

FORM 5B: SERVICE SITES (REQUIRED FOR ADDITION OF NEW SITES)

New service delivery sites may be added through this application if necessary to address identified oral health infrastructure needs. You must provide a street address for the proposed site(s). You may not list “to be determined” or provide a post office box as the site address.

Ensure that any proposed site meets the definition of a service site (see PIN 2008-01: Defining Scope of Project and Policy for Requesting Changes available at <https://bphc.hrsa.gov/programrequirements/policies/pin200801.html>). Providing intermittent services at locations using portable equipment would not be considered a service site.

Because OHI funds are intended to increase access to oral health services in your existing service area, your service area, as of the NOFO release date, may not be expanded through this application. Note the following requirements:

- Site Physical Address – The zip code of the Site Physical Address (where the new permanent site is located or where the new mobile unit will be parked) must be included in your current service area (based on the Service Area zip codes listed across all current sites in scope on Form 5B).
- Service Area Zip Codes – All service area zip codes listed for proposed site(s) must be included in your existing service area (based on the service area zip codes listed for current sites in your scope of project).

MINOR ALTERATION/RENOVATION FORMS

If you are requesting funding for minor A/R (with or without moveable equipment), you must complete the Project Cover Page and Other Requirements for Sites forms for each site where minor A/R is proposed (up to four). **OHI funding cannot be used for new construction activities (e.g., additions or expansions), the installation of trailers/pre-fabricated modular units, or major A/R. For a minor A/R activity, the total federal and non-federal cost of the project cannot exceed \$500,000, excluding the cost of moveable equipment.**

An allowable minor A/R project must be a stand-alone project consisting of work in an existing facility, which may include:

- Installing dental operatories;
- Modernizing or improving dental operatories;
- Reconfiguring the interior arrangements or other physical characteristics of a facility;
- Repairing and/or replacing the exterior envelope;
- Improving accessibility such as curb cuts, ramps, or widening doorways; and/or
- Addressing life safety requirements.

The project may include the costs of permanently affixed items such as windows, signs in or on the existing building, or lighting. Fixed equipment includes items that require modification of the facility for its satisfactory installation or removal and is included in the construction contract. Examples include HVAC units, ductwork, generators, fume hoods, sinks, fixed shelving, built-in sterilizers, built-in refrigerators, and drinking fountains. You **cannot** increase the total square footage of an existing building or require ground disturbance (such as new parking surfaces or expansion of a building footprint).

PROJECT COVER PAGE (REQUIRED FOR MINOR A/R PROJECTS)

You must complete the A/R Project Cover Page and provide the following information for each site where minor A/R activities will occur:

1. Site Information

- Enter the name and physical address of the site where minor A/R will occur.
- In the box for **Improved Project Square Footage**, enter the total square feet of the area to be altered/renovated.

2. Project Description (Maximum 4,000 characters including spaces)

- Provide a detailed description of the scope of work of the minor A/R project. Identify the major clinical and non-clinical spaces to be improved by the project.
- List key improvements, such as permanently affixed equipment to be installed; modifications and repairs to the building exterior (including windows); HVAC modifications (including the installation of climate control and duct work); electrical upgrades; and plumbing work.
- Describe how potential adverse impacts on the environment will be minimized. Indicate whether, and, if so, how the project will implement green/sustainable design practices/principles (e.g., using project materials, design/renovation strategies).

***Example Project Description** – Project will renovate 500 square feet of space previously used for medical records storage that is adjacent to the dental clinic. The renovation work will create two additional dental operatories. Renovation work within the existing interior space will include: demolition of one wall; plumbing and electrical work to accommodate the dental operatories; installation of two dental chairs; and installation of 150 feet of interior ductwork and a condenser unit on the exterior roof.*

3. Project Management (Maximum 4,000 characters including spaces)

- Explain the oversight for the minor A/R project, including the Project Manager and the Project Team, if applicable, responsible for managing the project.
- Describe how the Project Team has the expertise and experience necessary to successfully manage and complete the project within the timeframe and achieve the goals and objectives established for this project.

4. Is the proposed minor A/R project part of a larger scale renovation, construction, or expansion project?

- Select “no” to certify that the proposed project is a stand-alone project and includes only minor A/R costs, or select “yes” if the proposed project is part of a larger scale renovation, construction, or expansion project. NOTE: Projects that are part of larger scale renovation, new construction, or expansion are unallowable and may cause your application to be ineligible.

5. Project Budget Justification

Attach a project budget justification for the minor A/R project. Describe in detail each cost element and explain how the costs contribute to meeting the project's objectives/goals. Clearly identify other funding sources needed to support the minor A/R project and indicate whether these funds are secured or not. See the [OHI technical assistance website](#) for a sample A/R Budget Justification in the One-Time Funding section of the website.

The following chart lists sample allowable and unallowable minor A/R project costs.¹²

COST CATEGORIES	ALLOWABLE	UNALLOWABLE
Administrative and legal expenses	<ul style="list-style-type: none"> • Salary and consultant fees that are directly related to the administration of the technical aspects of the proposed project. Administrative and legal expenses should be less than 10% of total project costs. • Costs associated with the evaluation of the environmental and historic preservation effects of the proposed project, obtaining public input, producing the necessary studies, analysis, and resultant reports, as well as compliance with other environmental and historic preservation laws • Bid advertising 	<ul style="list-style-type: none"> • Costs of groundbreaking and dedication ceremonies and items such as plaques • Costs related to other sources of project financing • Costs for preparing grant applications
Relocation	<ul style="list-style-type: none"> • Costs to move and store furnishings temporarily during renovations 	<ul style="list-style-type: none"> • The cost of moving furnishings back into the renovated areas
Architectural and engineering fees	<ul style="list-style-type: none"> • Fees associated with architectural and engineering professional services including, but not limited to, preparation of bid documents and inspections • Associated expenses for preparation of specifications and reproduction of design documents • Costs incurred no more than 90 days before award for architect's 	<ul style="list-style-type: none"> • Architectural and engineering fees for work that is not within the scope of the approved project • Elaborate or extravagant designs or projects that are above the known local costs for comparable buildings/spaces

¹² Refer to the cost principles embedded in 45 CFR part 75 at <http://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75> for details on allowable costs.

COST CATEGORIES	ALLOWABLE	UNALLOWABLE
	<p>fees and consultant's fees necessary to the planning and design of the project, if the project is approved and funded and the costs comply with federal procurement requirements (when applicable)</p> <ul style="list-style-type: none"> • Sustainable design services, such as LEED, including commissioning • Costs associated with the preparation of the Environmental Assessment and SHPO consultation 	<ul style="list-style-type: none"> • Costs of abandoned designs (i.e., costs associated with a design that will not be used) • Costs for work not directly related to the project
Project inspection fees	<ul style="list-style-type: none"> • Clerk-of-the-works, inspection fees, structural certification, etc., to be provided by architectural engineering firm or applicant's staff 	<ul style="list-style-type: none"> • Fees not directly related to the project
Site Work	<ul style="list-style-type: none"> • Minor alteration at entrances and adjacent sidewalks as required for ADA compliance 	<ul style="list-style-type: none"> • Fees not directly related to the project • Exterior building work such as paving, retaining walls, foundations, etc. • Landscaping costs
Demolition and removal	<ul style="list-style-type: none"> • Costs of demolition or removal of structures for improvements such as wall finishings and fixtures. Reduce the costs on this line by the amount of expected proceeds from the sale of salvage. 	<ul style="list-style-type: none"> • Costs not directly related to the project • Hazardous materials remediation/abatement • Demolition and removal of debris that will not result in a usable structure
Alteration/ Renovation	<ul style="list-style-type: none"> • Costs of acquisition and installation of fixed equipment necessary for the functioning of the facility • Costs for remodeling and alteration of an existing building that will be used for the project • Special features for seismic code requirements. Use nationally recognized codes adopted by authorities having jurisdiction. 	<ul style="list-style-type: none"> • Abandoned projects • Relocation of utilities that are off site and off-site improvements • Prorated cost of existing central utility plant and distribution systems, which serve the proposed facility

COST CATEGORIES	ALLOWABLE	UNALLOWABLE
	<ul style="list-style-type: none"> • Costs of eliminating architectural barriers to the handicapped • Bid guarantees and performance and payment bonds • Costs of pollution-control equipment for the facility's boilers, incinerators, waste water treatment, etc., which may be required by local, state, or federal regulations. The facility must meet requirements of both current and future pollution abatement regulations as described in currently approved pollution plans. 	<ul style="list-style-type: none"> • Interior and exterior decorating fees and purchases (e.g., artwork, sculpture) • Elaborate or extravagant materials that are above the known local costs for comparable buildings/spaces • Fixed equipment if it is not part of the construction contract • Bonus payments to contractors
Equipment	<ul style="list-style-type: none"> • Moveable equipment that is pertinent to the project (include details on Equipment List from) • Mobile dental unit 	<ul style="list-style-type: none"> • Donated equipment • Leased equipment • Luxury furniture • Vehicles for transportation
Contingencies	<ul style="list-style-type: none"> • Contingencies are limited to 5% of the A/R and Demolition/Removal Lines. The contingency does not include moveable equipment costs. 	<ul style="list-style-type: none"> • Contingency costs above the allowable percentage

6. Environmental Information and Documentation (EID) Checklist

Attach an EID Checklist for each site where minor A/R activities will occur. A template is available in HRSA EHBs for you to download, complete, and upload to the A/R Project Cover Page. You must explain each response of "yes" on the EID Checklist.

The National Environmental Policy Act of 1969 (NEPA) (P.L. 91-190; 42 U.S.C. 4321 et seq.), the National Historic Preservation Act (NHPA) (P.L. 89-665; 16 U.S.C. 470 et seq.), and other associated laws require, among other things, that HRSA consider the environmental impacts and potential effects on historical and archeological resources of any federal action, including minor A/R projects supported with federal funds. The EID Checklist will initiate reviews under NEPA and NHPA.

If funded, you must receive HRSA approval prior to beginning any projects involving minor A/R. Such approval may be contingent on the provision of additional documentation such as a hazardous materials survey, abatement plans, or initiation of NHPA Section 106 consultation. If you do not have in-house expertise in environmental

and historic preservation compliance, you are advised to secure the services of a consultant with the appropriate background.

Until any required environmental and historic preservation reviews are completed and any associated conditions are lifted from the Notice of Award, award recipients are not authorized to acquire fixed equipment or initiate work beyond the design and permitting stage of the project. For additional information on environmental and historic preservation compliance, see <https://bphc.hrsa.gov/about/nepa-nhpa/capital-development.html>.

7. Floor Plans/Schematic Drawings/Site Plan

Attach line drawings for each site where minor A/R activities will occur. These drawings should:

- Be legible on an 8.5" x 11" sheet of paper.
- Include a scale and the linear dimensions for each room.
- Clearly show the work described in the project description and budget justification.
- Indicate the location of the proposed renovation area in the existing building.
- Distinguish improved space from unaffected space.
- Note the total net and gross square footage of space to be renovated, and any changes or additions to existing mechanical and electrical systems.
- Provide an overall site plan (or key plan) that shows the location of the project within the overall facility and, if applicable, shows any allowable exterior improvements included for the project.

These drawings are not required to be completed by an architect.

OTHER REQUIREMENTS FOR SITES (REQUIRED FOR MINOR A/R PROJECTS)

You must complete the Other Requirements for Sites form for each site where minor A/R activities will occur. This form addresses site control, federal interest, cultural resources, and historic preservation considerations related to the project.

1. Site Control and Federal Interest

Identify if you own the site. If you do not own the site, regardless of whether you currently or will pay a recurring fee to use the property, select "leased."

If the site is leased, certify that:

- The existing lease will provide you reasonable control of the project site for at least a period of 5 years after the renovation is completed.
- The existing lease is consistent with the proposed scope of project.
- You understand and accept the terms and conditions regarding federal interest in the property.

The federal government retains a reversionary interest in property improved with federal funds. The federal interest is based on the total allowable project costs (federal), excluding movable equipment, as a percent of the value of the property after completion of the project.

For minor A/R projects, federal interest exists for the useful life attributable to the A/R funded under this award. Since new construction and major A/R projects are not allowable under this award, you are not required to file a Notice of Federal Interest (NFI). However, if funded, by accepting the Notice of Award and drawing down funds, you are acknowledging that federal interest exists. You must maintain documentation to track and protect the federal interest. Such documentation includes communications between the lessor and the lessee related to protecting such interest, in accordance with the standard award terms and conditions.

2. Cultural Resource Assessment and Historic Preservation Considerations

Respond to the following questions:

- Was the project facility constructed prior to 1975?
- Is the project facility 50 years or older?
- Does any element of the overall work at the project site include:
 - Any renovation/modification to the exterior of the facility (e.g., roof, HVAC, windows, siding, signage, exterior painting, generators); or
 - Ground disturbance activity (e.g., expansion of building footprint, parking lot, sidewalks, utilities)?
- Does the project involve renovation to a facility that is, or near a facility that is, architecturally, historically, or culturally significant?
- Is the site located on or near Native American, Alaskan Native, Native Hawaiian, or equivalent culturally significant lands?

A/R projects will be reviewed under the terms of section 106 of the National Historic Preservation Act (NHPA). Prior to the expenditure of funds, an assessment must be made of the potential effects of undertakings on historic properties (including any prehistoric or historic district, site, building, structure, or object) that are eligible for listing or are listed on the National Register of Historic Places (NRHP). Pursuant to the regulations at 36 CFR Part 800, HRSA determines the project's effect on historic properties in consultation with the State Historic Preservation Officer (SHPO), Tribal Historic Preservation Officers (THPO), representatives of the local government, and other affected Indian tribes and interested parties.

For the purpose of OHI funding, interior renovations to be made to a building that is over 50 years old or is historically, architecturally, or culturally significant will constitute an undertaking under the NHPA. For projects that require section 106 review, funds may not be drawn down until HRSA receives documentation from the SHPO/THPO concurring whether the property is:

- Not historic; or
- Historic, with the project causing no potential adverse effects; or
- Historic and the project may cause adverse effects, including a resolution to the adverse effects through a fully executed MOA finalized by all parties.

Section 106 and any related historic preservation reviews must be completed and conditions of award must be lifted prior to commencing work outside of purchasing

moveable equipment, engaging architectural and engineering services, or acquiring necessary licenses, permits, and other approvals for the project. Section 106 reviews are project specific; therefore, previous consultations for a particular site are not valid for the purposes of this project. For additional information regarding compliance with section 106, see <https://bphc.hrsa.gov/about/nepa-nhpa/capital-development.html>.

3. Landlord Letter of Consent

If you are proposing a minor A/R project at a leased site, you must provide a Landlord Letter of Consent, signed by both you and the owner. This document must include:

- The property owner's agreement to the proposed minor A/R;
- An appropriate length of the lease relative to the scope of project (generally, the lease must extend for a minimum of 5 years from the project end date); and
- Recognition of the federal interest. Both you and the owner must sign it.

This attachment is also required if you propose a minor A/R project at a site provided "in-kind" (i.e., at no charge). A sample Landlord Letter of Consent is available at the [OHI technical assistance website](#).

While leasehold improvements are allowed, please note:

- The lease agreement must provide you reasonable control.¹³
- Funds may not be used to pay lease costs.
- Funds may not address needs that are part of the terms of the lease (i.e., the responsibility of the lessor/property owner).
- If funds address improvements that would impact terms of the lease (e.g., double paned windows), you must have written evidence on file of negotiated offset in the rent.

EQUIPMENT LIST FORM (IF APPLICABLE)

If you are requesting funding for equipment purchases, with or without minor A/R, list the equipment items on the Equipment List Form. Equipment includes moveable items that are non-expendable, tangible personal property (including information technology systems¹⁴) having a useful life of more than 1 year and a per-unit acquisition cost which equals or exceeds the lesser of the capitalization level established by the applicant for its financial statement purposes, or \$5,000. Moveable equipment can be readily shifted from place to place without requiring a change in the utilities or structural characteristics of the space. Dental chairs and radiographic equipment are considered moveable equipment.

¹³ For the purpose of the Health Center Program, "reasonable control" is considered the ability to implement the project and realize the benefits of the project without unnecessary demands, such as unreasonably restrictive access and limited control at the site.

¹⁴ Licenses for electronic health records or health information technology should be reported in "Other Costs" in your budget, not as equipment.

Permanently affixed equipment (e.g., heating, ventilation, and air conditioning (HVAC), generators, and lighting) is considered fixed equipment and is categorized as minor A/R (not equipment).

Equipment that does not meet the \$5,000 per unit cost threshold could be considered Supplies and should not be entered on the Equipment List Form. The total on the Equipment List Form must equal the total amount of funding requested on the Equipment line item on the [SF-424A](#) Budget Information Form.

For each equipment item listed, complete the following fields:

- **Type** – Select clinical or non-clinical.
- **Item Description** – Provide a description of each item.
- **Unit Price** – Enter the price of each item.
- **Quantity** – Enter the number of each item to be purchased.
- **Total Price** – The system will calculate the total price by multiplying the unit price by the quantity.

Any equipment purchased with award funds must be:

- Pertinent to the OHI project,
- Procured through a competitive process, and
- Maintained, tracked, and disposed of in accordance with 45 CFR part 75.

The selection of equipment should be based on a preference for recycled content, non-hazardous substances, non-ozone depleting substances, energy and water efficiency, and consideration of final disposal (disposed in a manner that is safe, protective of the environment, and compliant with all applicable regulations), unless there are conflicting health, safety, and/or performance considerations. You are strongly encouraged to employ the standards established by either the Electronic Product Environmental Assessment Tool (EPEAT) or Energy Star, where practicable, in the procurement of equipment. Additional information for these standards can be found at <http://www.epeat.net> and <http://www.energystar.gov>.

SUPPLEMENTAL INFORMATION FORM (REQUIRED)

1. SCOPE OF SERVICES

- The form displays your currently approved scope of project for Preventive Dental and Additional Dental services (Form 5A: Services Provided).
- Indicate whether you will need a post-award Scope Adjustment or Change in Scope to ensure that all planned oral health services are accurately reflected in the appropriate columns on Form 5A.

To maximize the impact of OHI funding, oral health care must be provided directly (Form 5A, Column I) or through contract/agreement for which the health center pays (Form 5A, Column II). If you are not already providing Preventive Dental services via Form 5A Column I or II, you must request a Scope Adjustment prior to providing services.

You may also need to adjust your scope for other reasons. Refer to the [Scope of Project website](#) for more information regarding health center scope of project.

2. TELEHEALTH/VIRTUAL DENTISTRY

- Indicate if you are proposing to use OHI funding to initiate or enhance telehealth and/or virtual dentistry.

vi. **Attachments**

Provide the following items in the order specified below. **Unless otherwise noted, attachments count toward the application page limit.** Indirect cost rate agreements (if applicable) will not count toward the page limit. **You must clearly label each attachment.**

Attachment 1: Collaboration Documentation

Upload dated letters of support to demonstrate support for the proposed OHI project(s) by other health care providers in the service area, community members, and/or other stakeholders.

Attachment 2: Lease Documentation, as applicable

If you are proposing a minor A/R project at a site that is leased, upload the lease agreement or intent to lease documentation. The length of the lease should extend for a minimum of 5 years after the project is completed. For minor A/R projects proposed in leased facilities, you must ensure that the lease/occupancy agreement includes language required by HRSA. For details, see the Leasehold Improvements document on the [OHI technical assistance website](#).

Attachment 3: Indirect Cost Rate Agreement, as applicable

If indirect costs are requested, upload your Indirect Cost Rate Agreement.

Attachment 4: Other Relevant Documents

Include other relevant documents to support the proposed project, such as photos showing the existing building conditions. Reminder: These attachments count against the total page limit.

3. **Dun and Bradstreet Data Universal Numbering System (DUNS) Number and System for Award Management**

You must obtain a valid DUNS number, also known as the Unique Entity Identifier, for your organization/agency and provide that number in the application. You must also register with the System for Award Management (SAM) and continue to maintain active SAM registration with current information at all times during which you have an active federal award or an application or plan under consideration by an agency (unless the applicant is a federal agency that is exempted from those requirements under 2 CFR §

25.110(b) or (c), or has an exception approved by the agency under 2 CFR § 25.110(d)).

HRSA may not make an award to an applicant until the applicant has complied with all applicable DUNS and SAM requirements and, if an applicant has not fully complied with the requirements by the time HRSA is ready to make an award, HRSA may determine that the applicant is not qualified to receive an award and use that determination as the basis for making an award to another applicant.

If you have already completed Grants.gov registration for HRSA or another federal agency, confirm that the registration is still active and that the Authorized Organization Representative (AOR) has been approved.

The Grants.gov registration process requires information in three separate systems:

- Dun and Bradstreet (<http://www.dnb.com/duns-number.html>)
- System for Award Management (SAM) (<https://www.sam.gov/SAM/>)
- Grants.gov (<http://www.grants.gov/>)

For further details, see Section 3.1 of HRSA's [SF-424 Two-Tier Application Guide](#).

UPDATED SAM.GOV ALERT: For your SAM.gov registration, you must submit a [notarized letter](#) appointing the authorized Entity Administrator. The review process changed for the Federal Assistance community on June 11, 2018. Read the [updated FAQs](#) to learn more.

If you fail to allow ample time to complete registration with SAM or Grants.gov, you will not be eligible for a deadline extension or waiver of the electronic submission requirement.

4. Submission Dates and Times

Application Due Date

The due date for applications under this NOFO in Grants.gov (Phase 1) is *April 22, 2019 at 11:59 p.m. Eastern Time*. The due date to complete all other required information in HRSA EHBs (Phase 2) is *May 21, 2019 at 5 p.m. Eastern Time*. HRSA suggests submitting applications to Grants.gov at least **3 days before the deadline** to allow for any unforeseen circumstances.

See Section 9.2.5 – Summary of emails from Grants.gov of HRSA's [SF-424 Two-Tier Application Guide](#) for additional information.

5. Intergovernmental Review

The Health Center Program is subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100.

See Section 5.1.ii. of HRSA's [SF-424 Two-Tier Application Guide](#) for additional information.

6. Funding Restrictions

You may request funding for a period of performance of up to 2 years, at no more than \$300,000 total per application.

The General Provisions in Division B of the Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (P.L. 115-245) apply to this program. Please see Section 5.1 of HRSA's [SF-424 Two-Tier Application Guide](#) for additional information. Note that these or other provisions will apply in the following FY, as required by law.

[45 CFR part 75](#) and the [HHS Grants Policy Statement](#) (HHS GPS) include information about allowable expenses. Please note that funds under this notice may not be used for:

- Incentives (e.g., gift cards, food)
- Fundraising
- Lobbying
- Construction activities, including additions or expansions
- Major alteration/renovation, defined as A/R in excess of \$500,000 in total federal and non-federal costs (excluding the cost of allowable moveable equipment)
- Installation of trailers and pre-fabricated modular units
- Facility or land purchases
- Vehicle purchases (a mobile unit is not considered a vehicle in this case)
- Pre-award A/R activities (e.g., site grading, installation of utilities, demolition), with the exception of architect's fees and consultant's fees necessary to the planning and design of the project incurred no more than 90 days before award
- Operating costs (e.g., funding for direct services, rent/mortgage payments)
- Creation of shell space for future use
- Concrete or asphalt paving of new areas outside of a building

Pursuant to existing law and consistent with Executive Order 13535 (75 FR 15599), health centers are prohibited from using federal funds to provide abortion services (except in cases of rape or incest, or when the life of the woman would be endangered). This includes all funds awarded under this notice and is consistent with past practice and long-standing requirements applicable to awards to health centers.

You are required to have the necessary policies, procedures and financial controls in place to ensure that your organization complies with all legal requirements and restrictions applicable to the receipt of federal funding including statutory restrictions on use of funds for lobbying, executive salaries, gun control, abortion, etc. Like those for all other applicable grants requirements, the effectiveness of these policies, procedures and controls is subject to audit.

All program income generated because of awarded funds must be used for approved project-related activities. Post-award requirements for program income can be found at [45 CFR part 75.307](#). In accordance with Sections 330(e)(5)(D) and 330(k)(3)(D) the health center must use any non-grant funds as permitted under section 330, and may use such funds for such other purposes as are not specifically prohibited under section 330, if such use furthers the objectives of the health center project.

V. Application Review Information

1. Review Criteria

HRSA has procedures for assessing the technical merit of applications to provide for an objective review of applications and to assist you in understanding the standards against which your application will be reviewed. HRSA has developed critical indicators for each review criterion to assist you in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. See the review criteria outlined below with specific details and scoring points.

These criteria are the basis upon which the reviewers will evaluate and score the merit of the application. The entire proposal will be considered during objective review.

Review criteria are used to review and rank applications. The OHI supplement has five review criteria:

Criterion 1: NEED (15 points) – *Corresponds to [Section IV.2.ii NEED](#)*

- 1) The extent of the current and anticipated integrated oral health needs of the patient population and/or underserved population in the service area.
- 2) The extent of the need for infrastructure enhancements to address current and anticipated integrated oral health services.

Criterion 2: RESPONSE (30 points) – *Corresponds to [Section IV.2.ii RESPONSE](#)*

- 1) The extent to which the applicant describes current oral health services provided and service delivery methods.
- 2) The extent to which the applicant clearly describes the proposed infrastructure investments, including:
 - a) Any proposed minor alteration/renovation (A/R) activities, including project-related information in the [Project Cover Page\(s\)](#) and [Attachment 2: Lease Documentation](#), as applicable.
 - b) Any proposed equipment and supplies purchases.

- c) Any other infrastructure investments.
- 3) If the applicant proposes to use OHI funds to enhance oral health services through the use of telehealth and/or virtual dentistry, the extent to which the applicant describes steps for successful implementation.
- 4) If the applicant proposes to add a new service delivery site, the extent to which:
 - a) The applicant describes the location of the new permanent site(s) within the existing service area and/or how and where the new mobile unit site(s) will serve the existing service area.
 - b) The site(s) are essential to addressing the identified oral health infrastructure needs.
 - c) The applicant provides evidence of support for the new site(s) from other health care providers in the service area through letters of support uploaded as [Attachment 1: Collaboration Documentation](#).

Criterion 3: IMPACT (15 points) – Corresponds to [Section IV.2.ii IMPACT](#)

- 1) The extent to which the proposed infrastructure investments will increase access to integrated oral health services.
- 2) The extent to which the applicant demonstrates that any required new dental personnel will be secured, and/or existing dental personnel will be leveraged to expand integrated oral health services.
- 3) The extent to which the completed project(s) will support the delivery of quality integrated oral health services.

Criterion 4: RESOURCES/CAPABILITIES (25 points) – Corresponds to [Section IV.2.ii RESOURCES/CAPABILITIES](#)

- 1) The capabilities and expertise of staff managing the project(s) and key management staff to successfully implement the proposed project(s), including experience with similar projects and related information in the [Project Cover Page](#)(s), if proposing minor A/R.
- 2) The extent to which the applicant demonstrates appropriate acquisition policies and procedures, in compliance with federal procurement requirements, as applicable.
- 3) The extent of demonstrated collaboration and coordination of oral health services with other health care providers in the area, to include evidence of support from health care providers, community members, and/or other stakeholders through letters of support documented in [Attachment 1: Collaboration Documentation](#).

Criterion 5: SUPPORT REQUESTED (15 points)

- 1) The extent to which the budget presentation (Budget Forms and Budget Narrative; A/R Project Budget Justification(s) and equipment list, as applicable) are consistent, clear, complete, and reasonable to complete the project(s).

2. Review and Selection Process

The independent review process provides an objective evaluation to the individuals responsible for making award decisions. The highest ranked applications receive consideration for award within available funding ranges. HRSA may also consider assessment of risk and the other pre-award activities described in Section 3 below.

See section 6.3 of HRSA's [SF-424 Two-Tier Application Guide](#) for more details.

Compliance Status¹⁵

You will not receive OHI funding if you have an active 60-day or 30-day Health Center Program requirement-related condition on your award at the time HRSA makes final OHI funding decisions.

3. Assessment of Risk and Other Pre-Award Activities

HRSA may elect not to fund applicants with management or financial instability that directly relates to the organization's ability to implement statutory, regulatory or other requirements ([45 CFR § 75.205](#)).

HRSA reviews applications receiving a favorable objective review for other considerations that include past performance, as applicable, cost analysis of the project/program budget, assessment of your management systems, ensuring continued applicant eligibility, and compliance with any public policy requirements, including those requiring just-in-time submissions. HRSA may ask you to submit additional programmatic or administrative information (such as an updated budget or "other support" information) or to undertake certain activities (such as negotiation of an indirect cost rate) in anticipation of an award. However, even at this point in the process, such requests do not guarantee that HRSA will make an award. Following review of all applicable information, HRSA's approving and business management officials will determine whether HRSA can make an award if special conditions are required, and what level of funding is appropriate.

Award decisions are discretionary and are not subject to appeal to any HRSA or HHS official or board.

¹⁵ See [Chapter 2: Health Center Program Oversight](#) of the Compliance Manual.

Effective January 1, 2016, HRSA is required to review and consider any information about your organization that is in the [Federal Awardee Performance and Integrity Information System \(FAPIIS\)](#). You may review and comment on any information about your organization that a federal awarding agency previously entered. HRSA will consider any of your comments, in addition to other information in [FAPIIS](#) in making a judgment about your organization's integrity, business ethics, and record of performance under federal awards when completing the review of risk posed as described in [45 CFR § 75.205 HHS Awarding Agency Review of Risk Posed by Applicants](#).

HRSA will report to FAPIIS a determination that an applicant is not qualified ([45 CFR § 75.212](#)).

4. Anticipated Announcement and Award Dates

HRSA anticipates issuing/announcing awards prior to the start date of September 1, 2019.

VI. Award Administration Information

1. Award Notices

HRSA will issue the Notice of Award prior to the start date of September 1, 2019. See Section 6.4 of HRSA's [SF-424 Two-Tier Application Guide](#) for additional information.

2. Administrative and National Policy Requirements

See Section 2.1 of HRSA's [SF-424 Two-Tier Application Guide](#).

Requirements of Subawards

The terms and conditions in the Notice of Award (NoA) apply directly to the recipient of HRSA funds. The recipient is accountable for the performance of the project, program, or activity; the appropriate expenditure of funds under the award by all parties; and all other obligations of the recipient, as cited in the NoA. In general, the requirements that apply to the recipient, including public policy requirements, also apply to subrecipients under awards. See [45 CFR § 75.101 Applicability](#) for more details.

Accessible Design Requirements

The Architectural Barriers Act of 1968, as amended, the Federal Property Management Regulations 101-19.6 (41 CFR 101-19.6), and the Uniform Federal Accessibility Standards issued by the General Services Administration (41 CFR 101-19.6, Appendix C) set forth minimum design standards for making facilities designed, built, altered, or leased with federal funds accessible to, and usable by, the physically handicapped. In addition, the Americans with Disabilities Act (ADA; 42 USC 12101 et

seq.), as revised in 2010, included accessibility standards, called the 2010 Standards for Accessible Design (2010 Standards), which establish minimum criteria for accessibility in design and construction. More information about the ADA and Architectural Barriers Act Accessibility Requirements are available online at <https://www.access-board.gov/guidelines-and-standards/buildings-and-sites>.

Sustainable Design

Applicants should demonstrate incorporation of appropriate sustainability principles and federal green building requirements detailed in the following federal statutes to the extent practical for each project:

- Executive Order (EO) 13693: <https://www.federalregister.gov/documents/2015/03/25/2015-07016/planning-for-federal-sustainability-in-the-next-decade>
- The Guiding Principles for Federal Leadership in High Performance and Sustainable Buildings (Guiding Principles): <https://www.epa.gov/greeningepa/guiding-principles-federal-leadership-high-performance-and-sustainable-buildings>

For further guidance, reference:

- EPA Federal Green Building Requirements: <http://www.epa.gov/oaintrnt/projects/requirements.htm>
- Green Guide for Health Care™: <http://www.gghc.org/>
- The Healthier Hospitals Initiative: <http://healthierhospitals.org/>
- U.S. Green Buildings Council: <https://new.usgbc.org/>
- Facility Guidelines Institute: <http://www.fgiguilines.org/>

Procurement

You may acquire a variety of commercially available goods or services in connection with an award-supported project. You can use your own procurement procedures that reflect applicable State and local laws and regulations, as long as those procedures conform to the applicable U.S. Department of Health and Human Services (HHS) regulations, and the HHS Grants Policy Statement. For more information regarding procurement requirements, including your responsibilities, competitive bidding requirements, bonding, and conflicts of interest, review the procurement resource at <https://bphc.hrsa.gov/programopportunities/fundingopportunities/pdf/faqprocurement.pdf>.

Force Account Labor

If you choose to use your in-house personnel for in-house design work and/or in-house renovation work in lieu of selecting a private firm, you must obtain approval from HRSA prior to beginning the design phase. The total cost for in-house personnel plus the fee for the architect and engineer must not exceed the prevailing architectural and engineering fee costs (usually 5 to 15 percent of the construction bid cost).

Detailed information regarding the format and content of the justification needed for an assessment of the use of force account labor is available at <https://bphc.hrsa.gov/programopportunities/fundingopportunities/pdf/forcefaq.pdf>.

3. Reporting

Award recipients must comply with Section 7 of HRSA's [SF-424 Two-Tier Application Guide](#) and the following reporting and review activities:

- 1) **Progress Reports** – The recipient must submit to HRSA a narrative description of progress via the Budget Period Progress Report (BPR) beginning in FY 2021.
- 2) **Ad Hoc Submissions** – Throughout the period of performance, HRSA may determine that a project requires additional information to be submitted beyond the standard deliverables. This information may include, but is not limited to, the following:
 - Purchase orders
 - Contract documentation
 - Project implementation photos
- 3) **Integrity and Performance Reporting** – The NoA will contain a provision for integrity and performance reporting in [FAPIS](#), as required in [45 CFR part 75 Appendix XII](#).

VII. Agency Contacts

You may request additional information and/or technical assistance regarding business, administrative, or fiscal issues related to this NOFO by contacting:

Travis J. Wright
Grants Management Specialist
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, MSC 10SWH03
Rockville, MD 20857
Telephone: 301-443-0676
Email: TWright@hrsa.gov

Joi M. Grymes-Johnson
Grants Management Specialist
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, MSC 10SWH03
Rockville, MD 20857
Telephone: 301-443-2632
Email: JGrymes@hrsa.gov

You may request additional information regarding the overall program and/or technical assistance related to this NOFO by contacting:

Renetta Boyd or Robyn Bess
Public Health Analysts
Office of Policy and Program Development
Bureau of Primary Health Care (BPHC)
Health Resources and Services Administration
5600 Fishers Lane, 16N34B
Rockville, MD 20857
Telephone: 301-594-4300
Contact: <https://www.hrsa.gov/about/contact/bphc.aspx>

You may need assistance when working online to submit your application forms electronically. Always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, 7 days a week, excluding federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726 (International Callers, please dial 606-545-5035)
Email: support@grants.gov
Self-Service Knowledge Base: <https://grants-portal.psc.gov/>

You may need assistance when working online to submit the remainder of your information electronically through HRSA EHBs. Always obtain a case number when calling for support. For assistance with submitting the application in HRSA EHBs, contact Health Center Program Support, Monday-Friday, 8:30 a.m. to 5:30 p.m. ET:

Health Center Program Support
Telephone: 1-877-464-4772
Web: <https://www.hrsa.gov/about/contact/bphc.aspx>

VIII. Other Information

Technical Assistance

HRSA will hold a pre-application technical assistance (TA) webinar for applicants seeking funding through this opportunity. Visit the [OHI technical assistance website](#) for webinar details, frequently asked questions, sample documents, and additional resources.

Federal Tort Claims Act (FTCA) Coverage

FTCA coverage for new services and sites is dependent, in part and where applicable, on HRSA approval of a post-award change in the scope of the project. Applicants should also note that FTCA coverage, under section 224(g)(5) of the PHS Act, 42 USC

233(g)(5), is not available for “part-time” individual contractors in the field of dentistry.¹⁶ Additional requirements apply to eligibility for FTCA coverage. For more information, review the FTCA Health Center Policy Manual, available at <https://bphc.hrsa.gov/sites/default/files/bphc/ftca/pdf/ftcahcpolicymanualpdf.pdf>.

Tips for Writing a Strong Application

See Section 5.7 of HRSA’s [SF-424 Two-Tier Application Guide](#).

¹⁶ Under 42 USC 233(g)(5), to be eligible for coverage, an individual contractor not in the fields of family practice, general internal medicine, general pediatrics, or obstetrics/gynecology “normally performs on average at least 32½ hours of service per week for the entity for the period of the contract.”

Appendix A: Sample Activities for Infrastructure Enhancements for Oral Health Services

Minor alteration and renovation

- Enhance and install dental operatories
- Reconfigure office space to support integrated, team-based oral health and primary care services

Equipment and Supplies

- Purchase new or enhance an existing mobile unit
- Purchase equipment to support the provision of oral health services
- Purchase portable dental equipment to provide preventive dental services (e.g., screenings, fluoride varnish) in other settings accessible to the patient population (e.g., schools, community organizations, homeless shelters)
- Purchase supplies related to oral health services

Training

- Collaborate with educational institutions to serve as a rotation site for dental students or community site for residency program¹⁷
- Engage in interdisciplinary training and integration of oral health services with other priority areas (e.g., obesity, mental health, substance use disorder/opioid use, diabetes)
- Enhance integration of oral health and primary care practice by improving the oral health core clinical competencies of primary care providers (e.g., training to maximize the accessibility of preventive oral health care such as dental screenings, oral health education, and application of fluoride varnish)
- Provide training on infection control and prevention/risk management, and develop procedures based on evidence-based guidelines

Telehealth

- Purchase telehealth equipment
- Redesign workflows to support the use of telehealth and virtual dentistry to increase access to oral health services

Health information technology

- Improve interoperability of oral health and medical electronic health record (EHR) systems

¹⁷ Teaching activities, including, for example, the teaching of medical students, medical residents, and nursing students within facilities operated by a covered entity, qualify for FTCA coverage if the services provided or the medical or dental services being taught by the preceptor, including monitoring and oversight of services provided by the student, are within the scope of project of the covered entity and the scope of employment of the covered individual with the covered entity. The covered entity and the employed teaching provider (i.e., the covered individual) are covered by FTCA in this instance. The student or resident is not covered by FTCA unless he also is a covered individual in his own right. Except as described above, covered entity providers are not covered when supervising care provided by students and residents to non-health center patients in non-health center facilities.

- Enhance population data management of oral health data (e.g., development and use of data analytic tools) for quality improvement
- Enhance technological infrastructure to support and facilitate health information exchange and optimize care coordination (e.g., referral and follow up with clinicians to improve oral health outcomes)



**Fiscal Year 2019 Integrated Behavioral Health Services (IBHS)
Supplemental Funding**

**HRSA-19-100
Assistance Listing #: 93.527**

Funding Opportunity Title:	Fiscal Year (FY) 2019 Integrated Behavioral Health Services (IBHS)
Funding Opportunity Number:	HRSA-19-100
Funding Opportunity Releases:	March 29, 2019
EHBs Application Opens:	April 5, 2019
Application Due Date:	May 13, 2019 by 5 p.m. ET
Anticipated Total Available Funding:	\$200 million
Estimated Number of Awards:	Up to 1,375 awards
Estimated Award Amount:	\$145,000
Cost Sharing/Match Required:	No
Period of Performance:	IBHS funding will be awarded as a supplement to your current Health Center Program operational grant (H80) award, for use from September 1, 2019 through the end of your FY 2020 budget period.
Eligible Applicants:	Organizations receiving H80 funding at the time of this funding opportunity release are eligible to apply.

TECHNICAL ASSISTANCE

The Health Resources and Services Administration (HRSA) will offer pre-application technical assistance (TA) to applicants seeking IBHS funding. TA will provide an overview of these instructions and an opportunity for applicants to ask questions on application processes and proposal requirements. Visit the IBHS technical assistance web page at <https://bphc.hrsa.gov/program-opportunities/funding-opportunities/ibhs> for details about live and recorded TA events, frequently asked questions, sample documents, and other resources. See [Agency Contacts](#) for program, business, and fiscal questions.



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I. PROGRAM FUNDING OPPORTUNITY DESCRIPTION

1. Purpose

These instructions detail the fiscal year (FY) 2019 Integrated Behavioral Health Services (IBHS) supplemental funding opportunity. Behavioral health services encompass an array of services that address both substance use disorders (SUDs) and mental health.¹ Existing Health Center Program operational grant (H80) award recipients (also referred to as health centers)² will use this supplemental funding to increase access to high quality integrated behavioral health services, including prevention or treatment of mental health conditions and/or SUDs, including opioid use disorder (OUD).

2. Authority

The Health Center Program is authorized by Section 330(e), (g), (h) and/or (i) of the Public Health Service Act, as amended (42 U.S.C. § 254b(e), (g), (h), and/or (i)). Specifically, IBHS supplemental funding will be awarded under section 330(e)(6)(B) of the Public Health Service Act, as amended (42 U.S.C. § 254b(e)).

3. Background

Behavioral health integration is the collaborative health care that results when a team of primary care and behavioral health clinicians work together with patients, families, and community organizations to provide patient-centered care. Integrated behavioral health services can address mental health conditions and SUDs that may manifest from a complex blend of psycho-physiological symptoms, co-morbid conditions, personal situations, and social determinants of health.³

Integrating SUD, mental health, and primary care improves the prevention, detection, and treatment of SUDs and mental illness,⁴ as well as the management of co-occurring

¹ Refer to the Form 5A Service Descriptors document for definitions of SUD and mental health services. Available at <https://bphc.hrsa.gov/programrequirements/scope.html>, in the Resources section, under Services.

² For the purposes of this funding opportunity, the term "health center" means organizations funded under section 330(e), (g), (h), and/or (i) of the Public Health Service Act, as amended.

³ Peek CJ and the National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. Available at <http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf>.

⁴ Collins C, Hewson DL, Munger R, Wade T. Evolving Models of Behavioral Health Integration in Primary Care. New York: Milbank Memorial Fund; 2010



physical conditions and addictions,⁵ life expectancy,⁶ and cost efficacy.⁷ Additionally, behavioral health service integration can ensure that patients have access to safer, more effective pain management, while reducing the number of people who misuse, abuse, and overdose from opioids.⁸

The inter-professional, team-based, comprehensive primary care service delivery model used by the nearly 1,400 HRSA-funded health centers nationwide continues to provide a strong framework for integrated behavioral health and primary care services, and for addressing SUDs, including OUD. The model's use of patient-centric approaches, care management, enabling services, and coordinated care has demonstrated success in overcoming common barriers to patients initiating and continuing mental health and SUD services. As a result, health centers are well-positioned to address the existing unmet OUD needs in their communities.

From 2008 to 2017, the number of patients receiving behavioral health services at HRSA-funded health centers increased from 770,000 to 2.2 million patients (188 percent). In 2017, the 2,973 health center providers with a [Drug Addiction Treatment Act of 2000 \(DATA 2000\)](#) waiver provided medication-assisted treatment (MAT) for OUD to approximately 65,000 patients.⁹

IBHS builds upon previous HRSA funding opportunities to support health centers in overcoming immediate barriers to patient access to behavioral health services.

- In 2018, HRSA awarded more than \$352 million in ongoing and one-time funding to implement and advance evidence-based strategies to expand access to integrated SUD and mental health services.¹⁰
- In 2017, HRSA awarded more than \$200 million to increase SUD provider full-time equivalents (FTEs), patients, and visits.
- In 2016, HRSA awarded \$94 million to increase SUD providers and delivery of MAT for OUD services.

With the support provided by these supplements some health centers have introduced SUD and mental health services while others are building or expanding behavioral health teams that may include care managers, peer and professional counselors, navigators, community health workers, translators, and transportation workers. This

⁵ For more information about co-morbid mental health conditions and SUDs, see <https://www.drugabuse.gov/sites/default/files/rrcomorbidity.pdf>.

⁶ Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 June;49(6):599-604

⁷ For more information on the cost efficacy of integrated care, see <http://www.ibhpartners.org/why/cost-effectiveness/>.

⁸ Centers for Disease Control and Prevention Guidelines for Prescribing Opioids for Chronic Pain. Available at <https://www.cdc.gov/drugoverdose/prescribing/guideline.html>.

⁹ Medication-assisted treatment (MAT) for opioid use disorder is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to treatment. For more information, see <https://www.samhsa.gov/medication-assisted-treatment>.

¹⁰ For more information about this award, see <https://bphc.hrsa.gov/programopportunities/fundingopportunities/sud-mh/>.



integrated, team-based care facilitates the work of behavioral health providers, improves quality and effectiveness, and makes adding treatment strategies like MAT possible.

For information on HRSA-supported behavioral health resources, technical assistance, and training, visit the HRSA webpages on [behavioral health](#) and [the opioid crisis](#). Additionally, this funding opportunity aligns with the U.S. Department of Health and Human Services (HHS) [Five-Point Opioid Strategy](#), specifically providing better prevention, treatment, and recovery services.

INFORMATION

1. Summary of Funding

Approximately \$200 million in federal funding is available to support IBHS in FY 2019. HRSA anticipates making ongoing awards of up to \$145,000 per year to supplement health centers' existing H80 grants. In FY 2019, you may request up to \$145,000 in IBHS funding to support the expansion of high quality integrated behavioral health services through such activities as workforce expansion, professional development and training, clinical workflow and practice transformation, opioid prevention, pain management,¹¹ and advancement of telehealth¹² and other health information technologies. Your application must propose to:

- Increase new and/or existing patients receiving SUD and/or mental health services as reported in the 2020 Uniform Data System (UDS) report; and
- Add at least 0.5 SUD and/or mental health service personnel FTE within 8 months of award. This may include expanding a current personnel's FTE (e.g., 0.5 FTE to 1.0 FTE).¹³

¹¹ For the purposes of this funding opportunity, pain management refers to the comprehensive, collaborative, and interprofessional services available to prevent and treat acute and chronic pain, including traditional, alternative, and complementary medicine methodologies.

¹² Telehealth is the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications. For more information, see <https://www.hrsa.gov/rural-health/telehealth/index.html>.

¹³ While many will add more, the flexibility introduced by the 0.5 FTE requirement allows health centers to use IBHS funding to meet proposal requirements and fill essential and often expensive behavioral health provider vacancies.



IBHS funds for personnel increases must be used to expand services and may not replace existing H80 support. Depending on the number of approvable IBHS applications, HRSA may adjust your award amount, consistent with available funds.

FY 2019 IBHS awards will provide 12 months of funding for activities covering the period of September 1, 2019 through the end of your FY 2020 H80 budget period, and will be available through the submission of an approvable carryover request.

The ongoing IBHS funding available in FY 2020 and beyond is contingent upon:

- Availability of appropriated funds for the Health Center Program in subsequent fiscal years;
- Satisfactory recipient performance; and
- A decision that continued funding is in the best interest of the federal government.

Progress toward achieving the proposed minimum 0.5 FTE personnel increase will be monitored via your responses to triannual progress updates. HRSA may take appropriate actions, including not awarding or reducing future IBHS funding, if you fail to add at least 0.5 FTE within 8 months of award.

Ongoing progress toward implementing your IBHS project will be monitored via annual Budget Period Progress Report (BPR) Non-Competing Continuation (NCC) reports and annual UDS reports. If you do not demonstrate adequate progress toward achieving proposal requirements, HRSA may reduce or discontinue your ongoing IBHS funding.

II. ELIGIBILITY INFORMATION

1. Eligible Applicants

Organizations receiving Health Center Program operational grant (H80) funding at the time of this funding opportunity release are eligible to apply.

2. Cost Sharing/Matching

Cost sharing or matching is not required. IBHS funding must be requested consistent with and, if approved, will be made available to each award recipient in the same sub-program funding proportions as the existing H80 award.

3. Proposal Requirements

Your proposal must demonstrate how you will use IBHS supplemental funding to achieve, at a minimum, the following:



- **Patient Impact:** Increase new and/or existing patients receiving SUD and/or mental health services, as indicated on your [Patient Impact Form](#). Your achievement of the proposed increase will be demonstrated through IBHS progress updates and the 2020 UDS report.
 - If you project unduplicated new patients, the new patient value will be added to your H80 patient target.
- **Personnel Impact:** Add at least 0.5 SUD and/or mental health service personnel FTEs to support expanded services within 8 months of award, as indicated on your [Staffing Impact Form](#). Your achievement of the proposed increase will be demonstrated through IBHS progress updates and the 2020 UDS report.

If you must add SUD or mental health services to scope or adjust how such services are provided to implement your proposed IBHS activities, you must request a scope adjustment or submit a change in scope request post-award.

If you propose to use IBHS funding to support the purchase of equipment, your application must include an [Equipment List Form](#).

4. Sample Funding Uses

The Agency for Healthcare, Research, and Quality's [Academy for Integrating Behavioral Health and Primary Care](#) offers resources and tools to integrate behavioral health with primary care, and support the use of MAT for OUD. Health centers are encouraged to advance MAT use for OUD, as appropriate. Refer to [Appendix A](#) for a list of sample uses of IBHS funding. Additional resources are available on the [IBHS technical assistance web page](#).

5. Partnership Resources

[HRSA strategic partners](#) are available to help you to identify high impact and cost effective uses for IBHS funding. These include your respective Primary Care Association and Health Center Controlled Network, as applicable, along with relevant National Training and Technical Assistance Cooperative Agreements. Your state and/or local health department and HRSA-supported state Primary Care Office¹⁴ are additional resources.

6. Ineligible Costs

All proposed budget items must directly support the IBHS [funding purpose](#), as demonstrated in the [Budget Narrative](#) and [Project Overview Form](#).

¹⁴ For the list of State Primary Care Offices, see: <https://bhw.hrsa.gov/shortage-designation/hpsa/primary-care-offices>.



You may **not** use IBHS funding for the following:

- Purchase or upgrade of an electronic health record (EHR) that is not certified by the Office of the National Coordinator for Health Information Technology;¹⁵
- New construction activities, including additions or expansions;
- Minor alteration or renovation (A/R) projects;¹⁶
- Installation of trailers and pre-fabricated modular units; or
- Facility or land purchases.

Pursuant to existing law and consistent with Executive Order 13535 (75 FR 15599), health centers are prohibited from using federal funds to provide abortion services (except in cases of rape or incest, or when the life of the woman would be endangered). This includes all funding awarded under this opportunity and is consistent with past practice and long-standing requirements applicable to grant awards to health centers.

III. APPLICATION AND SUBMISSION INFORMATION

1. Application Announcement, Deadline, and Award Notice

On April 5, 2019, HRSA will send an email to the individuals registered as project director, business official, and authorizing official in the H80 grant folder in the HRSA Electronic Handbooks (EHBs). This email will specify the current sub-program funding¹⁷ proportions and provide details on how to access the application module in EHBs.

Applications are due in EHBs by **5 p.m. ET on May 13, 2019**. HRSA anticipates making awards in September 2019.

2. Application Requirements

Your proposal must respond to the [funding purpose](#) and fulfill the [proposal requirements](#). Refer to [Appendix B](#) for detailed instructions on how to complete each application component.

¹⁵ The Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) have established standards and other criteria for structured data. For additional information, refer to <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Certification.html>

¹⁶ Minor A/R projects include work to repair, improve, and/or reconfigure the interior arrangements or other physical characteristics of a location.

¹⁷ Health Center Program sub-program funding streams are: Community Health Centers (CHC), Migrant Health Centers (MHC), Health Care for the Homeless (HCH), and/or Public Housing Primary Care (PHPC).



3. DUN and Bradstreet Universal Numbering System and System for Award Management

Every applicant is required to have a valid [Dun and Bradstreet Universal Numbering System \(DUNS\)](#) number, also known as the Unique Entity Identifier, and to maintain an active [System for Award Management \(SAM\)](#) registration at all times. If you have not fully complied with the requirements by the time HRSA is ready to make an award, HRSA may determine that you are not qualified to receive an award.

Effective June 11, 2018, entities renewing or updating their SAM registration are required to submit an original, signed notarized letter confirming you are the authorized entity administrator associated with the DUNS number before the registration is activated.

4. Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

By submission of this proposal, you certify that neither you nor your principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency. Failure to make required disclosures can result in any of the remedies described in [45 C.F.R. § 75.371](#), including suspension or debarment. (See also 2 C.F.R. parts [180](#) and [376](#), and [31 U.S.C. § 3321](#).)

5. Financial Management and Accounting

Recipients must have accounting structures and internal controls in place that provide accurate and complete information for costs associated with this award. HRSA funding and expenditures for IBHS must be tracked and documented in alignment with the specifications described in 45 C.F.R. § 75.302.

V. REPORTING REQUIREMENTS

1. Reporting and Additional Requirements

IBHS funding impact will be determined, in part, by the personnel FTEs added and the number of patients accessing SUD and/or mental health services. You will describe progress through IBHS-specific progress updates submitted triannually for a period of 2 years after award, and the [BPR](#) submission, starting with the FY 2021 BPR submitted in calendar year 2020. Projected patient increases will also be monitored through annual UDS reports, which will include information on:

- Patients and visits for SUD and mental health services;



- Patients and visits for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services;
- Newly hired/contracted personnel who will expand access to SUD and/or mental health services;
- Providers who have obtained a DATA 2000 waiver;
- Patients who received MAT for OUD from a physician, certified nurse practitioner, or physician assistant with a DATA 2000 waiver working on behalf of the health center;
- Patients aged 12 years and older screened for depression with a follow-up plan documented on the date of the positive screen; and
- Use of telehealth for primary care or mental health services.

2. Application Reviews

HRSA will conduct internal reviews for completeness, eligibility, and allowable costs. HRSA reserves the right to request budget modifications and/or narrative revisions if an application is not fully responsive to the IBHS instructions or if ineligible activities or purchases are proposed.

Before award, HRSA will assess the H80 award status of all applicants. You are not eligible to receive IBHS funding if you meet any of the following exclusionary criteria at the time of award:

- Have stopped receiving H80 funding.
- Have any conditions on your H80 award related to Health Center Program requirement area(s) that are in the 30-day final phase of Progressive Action.
- Are in the process of phasing out your H80 award (e.g., relinquishment, discontinuation).

Additionally, BPHC will make award decisions to maintain a ratio of grants serving medically underserved populations in rural areas to urban areas that is not less than 2 to 3 and not greater than 3 to 2.

The Health Center Program is subject to the provisions of Executive Order 12372, as implemented by [45 C.F.R. part 100](#). See Executive Order 12372 in the [HHS Grants Policy Statement](#). Award recipients must comply with applicable requirements of all other federal laws, executive orders, regulations, and policies governing the Health Center Program.

3. Assessment of Risk and Other Pre-Award Activities

HRSA may elect not to fund applicants with management or financial instability that directly relates to the organization's ability to implement statutory, regulatory, or other requirements ([45 C.F.R. § 75.205](#)).



HRSA reviews applications receiving a favorable prefunding review for other considerations that include past performance, as applicable, cost analysis of the project/program budget, assessment of management systems, ensuring continued applicant eligibility, and compliance with any public policy requirements, including those requiring just-in-time submissions. HRSA may ask you to submit additional programmatic or administrative information (such as an updated budget or “other support” information) or to undertake certain activities (such as negotiation of an indirect cost rate) in anticipation of an award. However, even at this point in the process, such requests do not guarantee that HRSA will make an award. Following review of all applicable information, HRSA’s approving and business management officials will determine if HRSA can make an award, if special conditions are required, and what level of funding is appropriate. HRSA may conduct onsite visits and/or use the organization’s current compliance status to inform final funding decisions.

Award decisions, including funding level, are discretionary and are not subject to appeal to any HRSA or HHS official or board.

HRSA is required to review and consider any information about your organization that is in the [Federal Awardee Performance and Integrity Information System](#) (FAPIIS). You may review and comment on any information about your organization that a federal awarding agency previously entered. HRSA will consider your comments, in addition to other information in FAPIIS in making a judgment about your organization’s integrity, business ethics, and record of performance under federal awards when completing the review of risk posed as described in [45 C.F.R. § 75.205 HHS Awarding Agency Review of Risk Posed by Applicants](#).

HRSA will report to FAPIIS a determination that an applicant is not qualified ([45 C.F.R. § 75.212](#)).



VII. AGENCY CONTACTS

For assistance completing the IBHS application, contact the appropriate resource below.

Table 1: IBHS Points of Contact

Electronic submission issues	Technical assistance resources
Health Center Program Support Send ticket through Web Request Form 1-877-464-4772	IBHS technical assistance web page Provides sample forms, responses to frequently asked questions, and other resources.
Proposal and submission questions	Business, administrative, and fiscal questions
IBHS technical assistance team Submit inquiries about this funding opportunity to sud-mh@hrsa.gov 301-594-4300	Mona D. Thompson Office of Federal Assistance Management Division of Grants Management Operations mthompson@hrsa.gov 301-443-3429



APPENDIX A: EXAMPLE IBHS FUNDING USES

Following are example activities and purchases that may support achieving the [proposal requirements](#), increased access to high quality integrated behavioral health services, including prevention or treatment of mental health conditions and/or SUDs, including OUD.

Workforce Expansion

- Directly hire or contract with behavioral health and enabling services providers¹⁸ and other personnel who can deliver or support SUD and/or mental health services, including those prepared to engage in clinical teams addressing co-occurring SUD and mental health conditions.
- Directly hire or contract with SUD and/or enabling service providers and other personnel to support the service delivery and care coordination necessary to provide comprehensive addiction treatment services, including MAT.
- Directly hire or contract with providers and other personnel who will work with behavioral health specialists as part of multidisciplinary teams to provide acute and chronic pain management services (e.g., pain management specialist, acupuncturist, chiropractor, physical therapist).
- Directly hire or contract with providers and other personnel who will work with behavioral health providers in a multidisciplinary team to manage SUD and/or mental health conditions for women and infants before, during, and after pregnancy.

Professional Development and Training

- Support the preparation of licensed and pre-license professionals and allied health students to provide SUD and/or mental health services through such activities as recruiting trainees; developing, implementing, and evaluating experiential training; coordinating student and post-graduate rotations, residencies, and/or fellowships; and building academic partnerships.
- Support providers to serve as on-hand consultants for their colleagues in topics essential to quality integrated SUD, including OUD, and mental health and treatment services (e.g., diagnosing co-occurring mental health conditions, providing MAT, patient engagement, care coordination, HIV and hepatitis virus prevention and treatment).
- Support training and accredited continuing education in SUD, including OUD, mental health and trauma-informed care.
- Support training and accredited continuing education to maximize the success of MAT; increase the number of eligible providers with DATA 2000 waivers; and

¹⁸ For more information and the definitions of enabling services and providers, see the Uniform Data System Manual. Available at <https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/reporting/2018-uds-reporting-manual.pdf>.



increase the number of DATA 2000 waiver patients per provider to reach maximum levels.

- Provide training and accredited continuing education on evidence-based pain prevention and treatment options, including for primary and secondary pain conditions such as sickle cell disease, diabetic neuropathy, fibromyalgia, odontalgia, and rheumatoid diseases.

Telehealth

- Enhance the use of telehealth to deliver SUD and mental health services by establishing contracts with specialists to provide virtual services, embedding live streaming consulting into EHR, and leveraging the technical assistance available through HRSA-funded [Telehealth Resource Centers](#) and [Health Center Controlled Networks](#).
- Purchase systems and/or contract for services to provide virtual care, such as those that increase patient engagement and self-management, home monitoring of symptoms and medication adherence, 24-hour access, and synchronous and asynchronous patient visits.
- Purchase telehealth supplies necessary to support accurate clinical interviewing and assessment (e.g., physical examination equipment, audio-visual equipment, sound dampeners, supplemental lighting, carts, cases to decrease equipment fan noise, backdrops, window coverings).
- Provide training and education to personnel, students and trainees, patients, and families on the use of virtual and mobile self-management tools and resources, including those used for pain and addiction management.

Clinical Workflow and Practice Transformation

- Strengthen the integrated health care team's ability to implement evidence-based prevention and treatment strategies by redefining roles, creating new roles, and modifying workflows.
- Contract with a practice transformation facilitator to guide the health center's adoption or enhanced use of an evidence-based model that integrates behavioral health into primary care.
- Build new and enhance existing clinical workflows to further integrate and support the delivery of SUD and mental health services integrated with primary care, HIV care, viral hepatitis care, and pain management services, including virtual care modalities.
- Build new and enhance existing clinical workflows to expand case/care management services.
- Implement strategies that support informed prescribing decision-making and increase patient initiation, engagement, and self-management.



Health Information Technology

- Enhance health information technologies to improve patients' access to their own data and enhance patient-provider shared decision making.
- Enhance the EHR to include domains to record SUD and mental health risk factors, treatment adherence, post-hospitalization or emergency department follow up, co-occurring disorders, and related infectious diseases, such as HIV and viral hepatitis, and add clinical decision supports to facilitate appropriate management.
- Enhance the EHR to support or improve health information exchange with clinical and community-based partners.
- Enhance the EHR by adding case/care management software to develop, implement, and monitor treatment plans across the multidisciplinary team.
- Implement technologies to help patients comply with referrals (e.g., digital calendar appointments with programmed reminders, referred provider website and location services).
- Establish a patient registry for SUD diagnoses, chronic opioid use, neonatal abstinence syndrome, and mental health conditions to improve care integration, patient safety, treatment efficacy, and enhance data-driven quality improvement.
- Strengthen participation in cybersecurity information sharing and analysis systems that protect patients' clinical information, and provide necessary training to personnel to ensure robust and consistent security of patients' mental health and SUD information.

Outreach, Partnerships, and Community Integration

- Strengthen community partnerships to better leverage SUD and mental health-related community resources and support more effective and efficient treatment and [recovery support](#) referrals between clinical partners, including [certified community behavioral health clinics](#), [opioid treatment programs](#), community mental health centers, health departments, emergency departments, emergency medical services, and other community-based organizations.
- Improve awareness of and facilitate access to SUD and mental health services by supporting community-based behavioral health outreach and awareness activities, peer support, and enabling services.
- Partner with health departments to maximize prevention efforts including community education and screening campaigns, or referrals to community-based wrap around services.
- Strengthen partnerships with technical assistance providers to support implementation of evidence-based practices, such as the [Addiction Technology Transfer Centers](#), the [Provider's Clinical Support System](#), and the [State Targeted Response Technical Assistance Consortium](#).
- Provide training and education to patients, families, and communities focusing on SUD prevention and treatment, mental health, stigma, neo-natal abstinence syndrome, trauma-informed care, suicide prevention, and opioid overdose.



Other

- Implement evidence-based strategies to improve access to and quality of integrated behavioral health services, such as universal screening, trauma-informed care, and zero suicide.
- Provide training and education to patients, families, and communities on evidence-based strategies to prevent and/or treat SUDs, mental health conditions, neo-natal abstinence syndrome, suicide, and overdoses.
- Purchase U.S. Food and Drug Administration (FDA)-approved opioid agonist medications (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination and buprenorphine mono-product formulations) for the maintenance treatment of OUD, and opioid antagonist medication (e.g., naltrexone products) to prevent relapse to opioid use, and naloxone to treat opioid overdose.
- Purchase tests necessary to support treatment plans that address chronic pain and SUDs, including OUD.
- Support enabling services to increase patient access to SUD and mental health services (e.g., translation, transportation, outreach, care coordination).



APPENDIX B: APPLICATION INSTRUCTIONS

You will complete and submit your IBHS application in EHBs starting on April 5, 2019. There is no Grants.gov submission requirement.

Application components are listed below, followed by detailed instructions. This information should be used in conjunction with the EHBs User Guide. The EHBs User Guide and other resources to help you complete your application are available on the [IBHS technical assistance web page](#).

- I. [SF-424A Basic Information and Budget Forms](#)
- II. [Federal Object Class Categories Form](#)
- III. [Budget Narrative](#)
- IV. [Project Overview Form](#)
- V. [Project Plan Form](#)
- VI. [Staffing Impact Form](#)
- VII. [Patient Impact Form](#)
- VIII. [Equipment List Form \(if applicable\)](#)

I. SF-424A Basic Information and Budget Forms

Enter or update required information on the SF-424A Parts 1 and 2, and the Budget Information Form. Fields that are not marked as required may be left blank.

- Budget Information Form: In Section A, enter the federal (up to \$145,000) and non-federal costs for a 12-month period for each currently funded sub-program (i.e., CHC, HCH, MHC, and PHPC).¹⁶ IBHS funding must be requested by and will be provided to award recipients in the same sub-program funding proportions as their existing H80 award.
- Project Description/Abstract: A project description/abstract is not required for this application; however, an attachment must be provided in SF-424A Part 2. You may upload a blank document.

II. Federal Object Class Categories Form

Enter federal and non-federal expenses by object class category for all proposed IBHS activities and purchases for a 12-month period. Limit federal expenses to the IBHS funding you are requesting (up to \$145,000) that will support increased access to high quality integrated behavioral health care. The total funding requested on this form must align with the total funding request amounts on the SF-424A Budget Information Form and your Budget Narrative. If equipment costs are requested, you must also complete the [Equipment List Form](#).



III. Budget Narrative (attachment)

Upload a Budget Narrative that clearly explains and justifies the federal and non-federal IBHS expenditures for a 12-month period by cost category.¹⁹ The sum of line item costs for each category must align with those presented on the [Federal Object Class Categories Form](#). Refer to the sample Budget Narrative available on the [IBHS technical assistance web page](#) for guidance. All contractual arrangements must be appropriate for health center oversight of the proposed project, to include any contractors and sub-recipients, or parent, affiliate, or subsidiary arrangements. Your Budget Narrative must clearly detail proposed costs for each federal object class category, with calculations for how each cost is derived, including cost per unit; and not include any [ineligible cost](#).

Guidance by Federal Object Class Category

- Personnel: List costs for each direct hire staff who will be supported by IBHS funding, not including fringe benefits and travel. The example Staffing Impact Form on the IBHS technical assistance web page lists the allowable position types.
- Fringe benefits: List the components of the fringe benefit rate for proposed direct hire staff. Fringe benefits should be directly proportional to the personnel costs allocated for the IBHS project.
- Travel: Identify expenses associated with travel for consultants, direct hire staff, and/or contractors. Detail travel costs consistent with the organization's established travel policy and in compliance with 45 CFR §75.474.
- Equipment: List tangible personal property (including information technology systems) that have a useful life of more than one year and a per-unit acquisition cost of at least \$5,000. Ensure that the total equipment costs entered in the Federal Object Class Categories, Budget Narrative, and the Equipment List forms are equal.
- Supplies: List supplies that support your IBHS project individually, separating items into three categories: office, medical, and educational. Equipment that does not meet the \$5,000 threshold listed above should be included here.
- Contractual: Clearly state the purpose of each contract, including specific deliverables. You must have an established and adequate procurement system with fully developed written procedures for awarding and monitoring contracts. The example Staffing Impact Form on the IBHS technical assistance web page lists the allowable position types.
- Other: Include all costs that do not fit into any other category and provide an explanation of each cost. EHR license fees for new staff, if any, should be listed here.

¹⁹ For details on allowable costs, see 45 C.F.R. part 75. Available at <http://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75>.



- Indirect costs: Include indirect costs in your budget request only if your organization has a negotiated indirect cost rate agreement or has previously claimed a de minimis rate of 10 percent of modified total direct costs.

Personnel Justification Table

In the Budget Narrative attachment include a Personnel Justification Table. Provide the following information for all direct hire staff and contractors you propose to support with IBHS funding: name, position title, annualized base salary, adjusted annual salary based on salary limitation requirements, percent of FTE, and the amount of federal funding requested. Before calculating personnel costs, annual salaries must be adjusted to not exceed the [Executive Level II salary](#), currently set at \$189,600. This salary rate limitation also applies to sub-awards/sub-contracts under a HRSA grant. The sample Budget Narrative available on the [IBHS technical assistance web page](#) includes a sample Personnel Justification Table.

IV. Project Overview Form

Indicate if you propose to use IBHS funding to support expanded SUD and/or mental health services through telehealth, and if you propose to help prevent SUDs through enhanced pain management services.²⁰ Next, indicate the technical assistance topics that would support the successful implementation of your IBHS project, if any.

Finally, you will review your approved Form 5A: Services Provided to determine if a scope adjustment or change in scope request is necessary to ensure that all planned services are in scope. Access the technical assistance materials on the [Scope of Project resource website](#) and contact your HRSA H80 project officer for guidance in determining if a scope adjustment or change in scope will be necessary.

If changes are required based on the proposed project, provide an overview of the changes along with a timeline for making necessary requests. You must submit a scope adjustment or change in scope request post-award (e.g., to move mental health services from formal referral (Column III) to direct provision (Column I), to add SUD services for the first time).

V. Project Plan Form

Provide a project plan to clearly and succinctly depict how you will achieve the [IBHS purpose](#) and meet the [proposal requirements](#). Your plan will state objectives, the activities you will take to achieve them, and the related outputs. You are strongly encouraged to review the sample project plan on the [IBHS technical assistance web page](#).

²⁰ For the purposes of this funding opportunity, pain management refers to the comprehensive, collaborative, and interprofessional services available to prevent and treat acute and chronic pain, including traditional, alternative, and complementary medicine methodologies.



- Objectives
 - You must propose at least two objectives, one for each [proposal requirement](#).
 - Objectives should be specific, measurable, and achievable.
 - You may propose a maximum of five objectives.
- Activities
 - List the action steps that you will take to achieve each objective.
 - You must propose at least two activities per objective.
 - The action steps should align with the costs proposed on your Budget Narrative and include existing resources that you will leverage.
 - Activities that address more than one objective should be listed separately under each relevant objective.
- Outputs
 - List the main accomplishments that will result from each activity, including final and key progress milestones.
 - You must propose at least two outputs per objective.
 - Provide a target date by which you propose to accomplish each output.
 - Outputs that relate to more than one objective should be listed separately under each relevant objective.

V. Staffing Impact Form

Enter the direct hire staff and/or contractor FTEs that will expand access to integrated behavioral health services according to the allowed position types listed on this form. Adding at least 0.5 SUD and/or mental health services personnel FTE to support expanded services within 8 months of award is required. You may support multiple part-time positions that combine to meet the 0.5 FTE threshold (e.g., 0.1 FTE direct hire psychiatrist and 0.4 FTE contracted licensed clinical social worker). Position descriptions are available in the [2018 Uniform Data System \(UDS\) Manual](#).

VI. Patient Impact Form

You must propose to increase the number of existing and/or new patients accessing SUD and/or mental health services as a result of IBHS funding. Provide separate patient projections for existing patients and new patients. Patient definitions are available in the [2018 Uniform Data System \(UDS\) Manual](#).

- Existing patients are current health center patients who will newly access SUD and/or mental health services because of IBHS funding.
- New patients are individuals not currently being seen by the health center who will access SUD and/or mental health services because of IBHS funding.



On the Patient Impact Form, you must provide a projection for Question 1 (existing patients) and/or Question 3 (new patients). A sample patient impact form is available on the [IBHS technical assistance web page](#).

Existing Patient Impact

- 1. Total Unduplicated Existing Patients:** Enter the total number of existing patients who will newly access SUD and/or mental health services in calendar year 2020 as a result of IBHS funding (e.g. existing medical patients not currently accessing these services that will begin to do so). Attribute each patient to either SUD or mental health services. Count each patient only once in this unduplicated total, even if some patients will access both services.
- 2. Existing Patients by Service Type:** Enter the total number of existing patients who will newly access each service as a result of IBHS funding in calendar year 2020. Count each projected existing patient according to the service(s) they are expected to access. If a patient will start accessing both SUD and mental health services, they should be counted once for SUD and once for mental health. Enter zeros if your response to Question 1 is zero.

New Patient Impact

- 3. Total Unduplicated New Patients:** Enter the number of patients new to the health center who will access SUD and/or mental health services in calendar year 2020 as a result of IBHS funding. Attribute each patient to either SUD or mental health services. Count each patient only once in this unduplicated total, even if some patients will access both services. While Question 1 counts *existing* health center patients newly accessing SUD and/or mental health services, Question 3 counts unduplicated patients considered *new* to your health center that will access SUD and/or mental health services.

Note: New unduplicated projected patients entered in response to this question will be added to your H80 patient target. Failure to achieve this new patient projection in calendar year 2020, may result in a funding reduction when your service area is next competed through Service Area Competition (SAC). See the [SAC technical assistance website](#) for patient target resources.

- 4. New Patients by Service Type:** Enter the number of patients new to the health center from “Total Unduplicated New Patients” (Question 3) who will access each service in calendar year 2020:
 - A. SUD Services Patients
 - B. Mental Health Services Patients

Count each projected new patient according to the service(s) they are expected to access. If a new patient will start accessing both SUD and mental health



services, they should be counted once for SUD and once for mental health. Enter zeros if your response to Question 3 is zero.

- 5. New Patients by Population Type:** Enter the number of patients new to the health center from “Total Unduplicated New Patients” (Question 3) according to the H80 sub-program type:
- A. Community Health Centers
 - B. Migrant Health Centers
 - C. Health Care for the Homeless
 - D. Public Housing Primary Care

The sum must equal the number of new unduplicated patients entered in response to Question 3, if any. Enter zeros if your response to Question 3 is zero. The information entered here will be used to populate future BPR submissions.

VII. Equipment List Form (if applicable)

If IBHS funding is requested in the Equipment line item on the [Federal Object Class Categories Form](#), list the proposed equipment purchases. The total on this form must equal the amount of funding requested on the Equipment line item on the [Federal Object Class Categories Form](#). Any equipment purchased with award funds must be pertinent to the IBHS project, procured through a competitive process, and maintained, tracked, and disposed of in accordance with [45 C.F.R. part 75](#).

Federal equipment means tangible personal property (including information technology systems) having a useful life of more than one year and a per-unit acquisition cost that equals or exceeds the lesser of the capitalization level established by the non-federal entity for financial statement purposes, or \$5,000.

Equipment that does not meet the \$5,000 per unit cost threshold should be considered Supplies and would not be entered on the Equipment List Form. Licenses for electronic health records (EHRs) or health information technology should be reported in “Other” costs in your budget, and not considered equipment.

Moveable equipment can be readily shifted from place to place without requiring a change in the utilities or structural characteristics of the space. Permanently affixed equipment (e.g., heating, ventilation, and air conditioning (HVAC), generators, lighting) is categorized as minor alteration or renovation (A/R). Using IBHS funding for permanently affixed equipment is not allowed.

For each item on the Equipment List Form, the following fields must be completed:

- **Type** – Select clinical or non-clinical.
- **Item Description** – Provide a description of each item.
- **Unit Price** – Enter the price of each item.



- **Quantity** – Enter of the number of each item to be purchased.
- **Total Price** – The system will calculate the total price by multiplying the unit price by the quantity entered.

The selection of all equipment should be based on a preference for recycled content, non-hazardous substances, non-ozone depleting substances, energy and water efficiency, and consideration of final disposal (disposed in a manner that is safe, protective of the environment, and compliant with all applicable regulations), unless there are conflicting health, safety, and performance considerations. You are strongly encouraged to employ the standards established by either the Electronic Product Environmental Assessment Tool (EPEAT) or Energy Star, where practicable, in the procurement of equipment. Following these standards will mitigate the negative effects on human health and the environment. Additional information for these standards can be found at <http://www.epeat.net> and <http://www.energystar.gov>.

TAB 2

Meeting Minutes

Request to Approve

**Healthcare for the Homeless/Farmworker Health Program (Program)
Co-Applicant Board Meeting Minutes (March 14, 2019)
SMMC**

Co-Applicant Board Members Present

Brian Greenberg
Tayischa Deldridge
Eric DeBode
Robert Anderson
Adonica Shaw
Mother Champion
Jim Beaumont, HCH/FH Program Director (Ex-Officio)

County Staff Present

Linda Nguyen, Program Coordinator
Frank Trinh, Medical Director
Danielle, Hull, Clinical Coordinator
Andrea Donahue, County Counsel's Office
Irene Pasma, Program Implementation Coordinator
Sofia Recalde, Management Analyst
Melissa Rombaoa, PCMH Manager
Gina Quiney, Office of Supervisor Groom

Members of the Public

Victoria Sanchez De Alba, De Alba Communications

Absent: Steven Kraft, Steve Carey, Christian Hansen

ITEM	DISCUSSION/RECOMMENDATION	ACTION
Call To Order	Brian Greenberg called the meeting to order at <u>9:03</u> A.M. Everyone present introduced themselves.	
Regular Agenda Public Comment	No Public Comment at this meeting.	
Consumer Input- Migrant conference Danielle/Sofia	Staff presented on attendance to Western Migrant Conference in Portland in February on workshops attended. Discussion on various workshop topics: changes in Public Charge, California policies on immigration (AB 60, SB 54, SB 244), outreach to immigration groups, Farmworker advisory board participation, AG worker access 2020 campaign, and specialty care. Please refer to TAB 1	
Board Orientation NA- SUD Funding Opp	Irene presented on a summary and results from the Substance Use Disorder Needs Assessment conducted by our consultant JSI. Data came from many sources including 32 interviews and focus groups held. There was a discussion on what drugs are prevalent in San Mateo County. Meth is rolled into "other drugs" in the report. Issue of some providers not willing to serve challenging populations like the chronically homeless. Oral health and Integrated behavioral health expanded funding may be announced within a month. Handout summary of the funding was passed out. Staff will email board members once the announcement of the funding is public. Please refer to TAB 2	
No Closed session		
Regular Agenda Consent Agenda	All items on Consent Agenda (meeting minutes from Feb 7, 2019) were approved. Please refer to TAB 3	Consent Agenda was <u>MOVED</u> by Tay <u>SECONDED</u> by Mother Champion, and <u>APPROVED</u> by all Board members present.

<p>Travel Requests</p> <p>Action Item- Request to approve travel requests from board members (2)</p> <p>Action Item- Request to approve travel requests from non-board members (4)</p>	<p>The program received numerous travel requests to attend the upcoming National Health Care for the Homeless conference (NHCHC) in D.C. from board members as well as San Mateo Medical Center (SMMC) staff. There were two travel requests from Board members and four requests from SMMC staff. There was a discussion on who the program can support to attend the conference and staff confirmed that the budget will allow for support of all those that have requested.</p> <p>Board member Robert Anderson requested funds to attend for Board training in the amount of \$2,015.</p> <p>Board member Adonica Porter Shaw requested funds to attend conference for Board training in the amount of \$1,960.</p> <p>Melissa Rombaoa, Manager of Patient Centered Medical Home at SMMC requested funds to attend in the amount of \$1,854. Melissa's statement on the benefit of her attendance: "My current role at San Mateo Medical Center supports transforming ambulatory care, developing high performing care teams, improving quality outcomes, meeting social needs within the clinic, and reducing disparities. In order to do this well for our entire system, it is essential to incorporate the perspective of our homeless patients into any possible solutions or interventions."</p> <p>Wil Cerrato, Clinic Manager of Coastside Clinic requested funds to attend in the amount of \$2,610; for the benefit of the patients seen at their clinic with multiple needs.</p> <p>Alexandra Gutierrez, Community Worker at Coastside Clinic requested funds to attend in the amount of \$2,610, for the benefit of the patients seen at their clinic with multiple needs.</p> <p>Simone Heron-Carmignani, a Psychologist of Integrated Behavioral Health at SMMC, requested funds to attend in the amount of \$2,870, to "Increase skills in trauma-informed and culturally-sensitive care for a diverse population of mental health patients with homelessness or housing insecurity in a primary care setting."</p> <p>Action item: Request to approve travel requests Please refer to TAB 4</p>	<p>Request to approve Robert Anderson travel request <u>MOVED</u> by Tay <u>SECONDED</u> by Brian, <u>Recused</u>- Robert and APPROVED by all Board members present</p> <p>Request to approve Adonica Porter Shaw travel request <u>MOVED</u> by Tay <u>SECONDED</u> by Mother Champion , <u>Recused</u>- Adonica and APPROVED by all Board members present</p> <p>Request to approve Melissa travel request <u>MOVED</u> by Adonica <u>SECONDED</u> by Tay, and APPROVED by all Board members present</p> <p>Request to approve Wil travel request <u>MOVED</u> by Brian <u>SECONDED</u> by Tay, and APPROVED by all Board members present</p> <p>Request to approve Alexandra travel request <u>MOVED</u> by Robert <u>SECONDED</u> by Mother Champion, and APPROVED by all Board members present</p> <p>Request to approve Simone travel request <u>MOVED</u> by Robert <u>SECONDED</u> by Mother Champion, and APPROVED by all Board members present</p>
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<p>Board recruitment/membership committee plan</p> <p>Action Item- Request to approve CAB plan</p>	<p>The Board membership/recruitment sub-committee is tasked with reviewing and making recommendations on board composition, recruitment, and selection, and other areas that may impact these activities. The sub-committee was tasked with researching ideas to receive homeless and farmworker patient/consumer input routinely, such as forming community advisory boards and how to recruit for such. Committee members and staff met to discuss and draft guidelines for the community advisory groups.</p> <p>The San Mateo County Health Care for the Homeless/Farmworker Health (HCH/FH) program is seeking to create two Advisory Boards, one composed of people with experience being homeless and the other composed of people who are farmworkers or family members of farmworkers. The Advisory Boards will support the HCH/FH Co-Applicant Board by providing lived experience for decision making purposes.</p> <p>The Board membership/recruitment sub-committee drafted an “Advisory Board Plan” to guide the committee on recruiting for both Advisory committees.</p> <p>Action item: Request to approve the Advisory Board Plan</p> <p>Please refer to TAB 5</p>	<p>Request to approve CAB plan</p> <p><u>MOVED</u> by Adonica <u>SECONDED</u> by Tay, and APPROVED by all Board members present</p>
<p>Action Item- Request to amend Ravenswood contract</p>	<p>During the July 2018 HRSA Operational Site Visit (OSV), the reviewers expressed significant concerns related to the HCH/FH’s Primary Care contract with RFHC. Ultimately, the OSV Final Report found the program out of compliance on two requirements (Accessible Location & Hours of Operation and Required & Additional Services) for our scope of Project Documents – Forms 5A Services and 5B Sites – being inaccurate, based on their view of the contract with RFHC being unacceptable. HRSA subsequently issued grant conditions for these two requirements.</p> <p>In response to the grant conditions, the HCH/FH Program submitted documentation detailing how the RFHC Primary Care contract was compliant with HRSA’s policies and other requirements, and that the Program’s Forms 5A & 5B were correct and did not require being changed. To enable the Program to respond quickly should HRSA not accept the Program’s position and to provide for some maintenance of funding from the HCH/FH Program to RFHC, Program opened discussions with RFHC to amend their Enabling Services contract.</p> <p>Based on those discussions, Program has prepared for the Board four (4) options. All of these options are intended to only be utilized if HRSA does not accept Program’s submission on the two (2) relevant grant conditions and some action is required to achieve compliance for the conditions to be lifted. Should HRSA accept Program’s submissions and lift the grant conditions, then no actions would take place, the status quo would be maintained, and all current contracts with RFHC would remain as is.</p> <p>If HRSA decided that the program was out of compliance and had to eliminate RFHC Primary care contract the 2 options were : Option 1 (RFHC): terminating the Primary Care contract with RFHC and amend the Enabling Services contract with changes in services, volumes and rates to \$204,100 per year, an increase of \$107,100 per year which is equal to the value of the Primary Care contract (Amendment Option 1). This represents the amendment request from RFHC or Option 2 (staff proposal) which terminates the Primary Care contract with RFHC and amends the Enabling Services contract</p>	<p>Request to direct</p>

	<p>with changes in volumes and new services and rates to \$177,400 per year, an increase of \$80,400 per year (Amendment Option 2). This option developed by Program staff. Based on the current approved contracts and current Program budget, and in consideration of RFHC history of collaboration with the HCH/FH Program and their historical contract performance, Program is recommending the 2nd option to the Board. This option maintains most of the anticipated funding level to RFHC, while maintaining the integrity of the original negotiated Enabling Services contract and providing a slight increase in budgetary flexibility to the Program.</p> <p>There was discussion/concern on whether the loss in contract revenue would affect the level of services for the homeless population in East Palo Alto area. Staff provided historical information on the level of funding increase the program has supported to RFHC over the years, from 2 contracts to 3 starting in 2016. Currently RFHC is underspending on their contracts and will not meet their targets from the contracts.</p> <p>Request to direct Program action if HRSA determines that further Program action is required related to the RFHC Primary Care contract in order for the Program to come into compliance- Option 2 (staff recommendation \$177,400)- to amend Ravenswood contract</p>	<p>Program action if HRSA determines that further Program action is required related to the RFHC Primary Care contract in order for the Program to come into compliance- Option 2 (staff recommendation \$177,400) <u>MOVED</u> by Brian <u>SECONDED</u> by Robert, and APPROVED by remaining Board members present. <u>Abstained by</u>- Adonica, Mother Champion <u>Recused</u>- Tay</p>
<p>Contractors quarterly report Q4- monitoring levels of service</p>	<p>The Board is required to review services provided on an on-going basis. Staff provides data from contract services regarding expenditures, qualitative objectives as well as successes and trends on a quarterly basis at minimum.</p> <p>The program has contracts with seven community-based providers as well as two County based programs for 2018 grant year. Contracts are for primary care services (Public Health, Policy and Planning and RFHC), dental care services (Sonrisas and RFHC), and enabling services such as care coordination and eligibility assistance (RFHC, LifeMoves, Puente, Samaritan House, Mission Hospice and El Centro). There was discussion on how the contractors are spending down their contracts and why some contractors may be under performing. Issues such as staffing issues and patient no shows affected the number of patients seen. On-going issues of lack of affordable housing, the aging homeless population, and farmworkers having trouble taking time off work were recurring issues. Contractors worked well in collaboration to refer to other services and link patients.</p> <p>Please refer to TAB 6</p>	
<p>Discussion on Annual report</p>	<p>Staff provided a draft mock-up of the Annual plan and the format to all present at the board meeting for feedback. Board members were asked if their photos could be provided for the annual plan and staff will coordinate with a photographer. Input was provided to include the following: the four strategic goals measured from 2018 as well as overview of the program with the 2018 data and cost hi-lights. Staff will revise the annual plan and email Board members for further feedback before presenting again at next Board meeting in April.</p>	<p>Staff will reach out to board members for additional feedback.</p>
<p>Regular Agenda: HCH/FH Program QI Report</p>	<p>The San Mateo County HCH/FH Program QI Committee met on February 28th, 2019. The topics discussed were as follows:</p>	

	<ul style="list-style-type: none"> • <u>Diabetes Action Plan</u>: In collaboration with the SMMC Ambulatory Services Director, the HCH/FH Program is finalizing workgroup participants and beginning to send invitations for the workgroup. Workgroup to convene prior to April 15th (Q2 report date). • <u>Reviewed QI Annual Plan Draft</u>: The QI Committee reviewed and provided feedback to the QI Annual Plan draft. The HCH/FH program staff will incorporate feedback and send final draft to QI/QA Committee members for final input prior to the April Co-Applicant Board meeting. <p><i>Please refer to TAB 7 on the Board meeting packet</i></p>	
<p>Regular Agenda: HCH/FH Program Directors report</p>	<p>Director's report: <u>Grant Conditions/Operational Site Visit (OSV) Report</u>- On February 7th we received notice that HRSA had lifted the six (6) grant conditions we had submitted, not including those related to our agreement with Ravenswood Family Health Center (RFHC). On March 4, 2019, our Project Officer confirmed that those two (2) conditions are still under review with the Policy Branch. The three (3) remaining conditions – related to Credentialing and Privileging – are all in process as staff works to complete the required effort with the SMMC Medical Staff Office and Human Resources. The submissions for these conditions are due by March 17, 2019 and are expected to be submitted this week.</p> <p><u>Uniform Data System (UDS)</u> – submitted on time and expect to receive notice that the report has been fully accepted and final.</p> <p><u>HRSA Funding Opportunity</u>- HRSA has released information on a couple of upcoming Funding Opportunities (FOs). They are expected to soon release a limited, competitive FO for Oral Health Infrastructure. This will provide between 300 – 400 grantees with an average of ~\$175,000 in one-time funding for equipment, minor renovations, and other one-time infrastructure improvements.</p> <p><u>Pacifica City Council Parking Ban Ordinance</u> At their February 11, 2019 meeting, the Pacifica City Council held extensive discussions on the topic, and subsequently deferred it their upcoming Goal Setting Session. In effect, no action was taken on the proposal at the meeting.</p> <p><i>Please refer to TAB 8 on the Board meeting packet.</i></p>	
<p>Regular Agenda: HCH/FH Program Budget & Financial Report</p>	<p>Estimated grant expenditures to-date are \$331,178. In addition, we have an estimated \$2,729 in expenditures for items not claimable on the grant, for total estimated expenditures of \$333,907. Current projections for year-end are, at best, guesses at this point in the year. Nonetheless, we project that total grant expenditures will be \$2,953,650 by the end of the year, which would leave an estimated \$58,341 in unexpended grant funds. However, approximately \$138,000 of our grant funds have some level of spending restrictions, so we are still around our original estimate of being potentially \$80,000 over-extended with our grant funds. We expect this number to come down as we get further into the year and can clearly identify where we have been able to expend the restricted funds and having a better idea on the rate of expenditures for our contracts and MOUs.</p> <p><i>Please refer to TAB 9 on the Board meeting packet.</i></p>	
<p>Adjournment</p>	<p>Time <u>11:01</u></p>	<p>Brian Greenberg</p>

San Mateo County Substance Use Needs Assessment

Purpose:

- Assess the prevalence of substance use in San Mateo County
- Identify the service and resource needs of consumers and providers
- Identify where gaps exist and how to strengthen the current substance use disorder treatment system in San Mateo County

Target audience:

SMC Health employees, community partners, county residents, private SUD providers

Data Sources:

- 32 interviews
- 3 focus groups [residents at a shelter, several farmworkers, privately insured individuals]
- Provider survey
- Existing epidemiology data

“There are a lot of people ready to help once you raise your hand and ask for help.”
– Focus Group Participant

“SMC BHRS and Contracting Agencies seem to lack a coordinated procedure to refer clients through the continuum of care. We need referral process to move clients from one agency to another.”
– Survey respondent

“Addiction falls in a grey area between primary care and psychiatry, so somebody needs to step up to the plate.”
– Key informant interviewee



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San Mateo County Substance Use Needs Assessment (cont).

Main Findings:

- Substance use and substance use disorder in San Mateo County **are consistent with neighboring counties and California statewide trends**
- Mortality rate due to overdoses from all drugs was 6.78 per 100,000 in 2016 (vs. 12 statewide)
- Housing and the cost of living in San Mateo County were identified as the greatest barriers to successful recovery **among people experiencing homelessness**
- Geographic barriers, distrust or fear of government, and past trauma are barriers to care **for farmworker populations**

Limitations:

- The positioning of the HCH/FH Program in the County structure allowed for easier access to information on and from County-contracted providers
- County-specific quantitative data on substance use and unmet substance use treatment needs were not available for homeless and farmworker populations

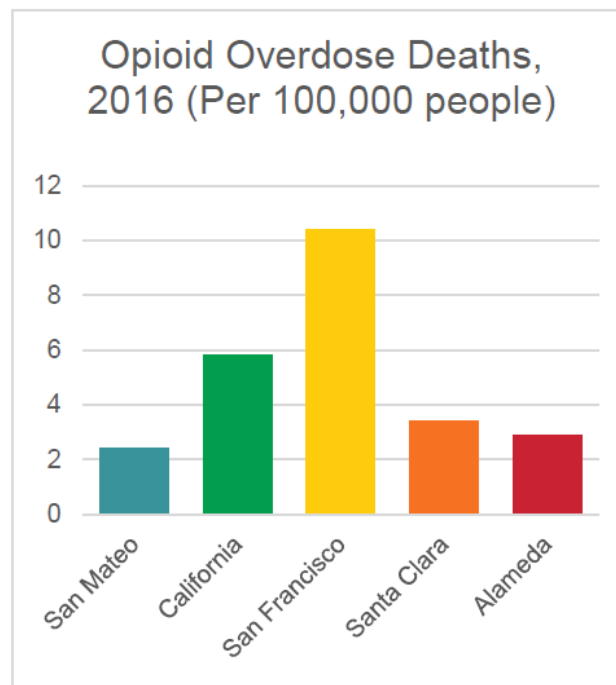


Figure 1: Opioid overdose death rates per 100,000 people in California and Bay Area Counties

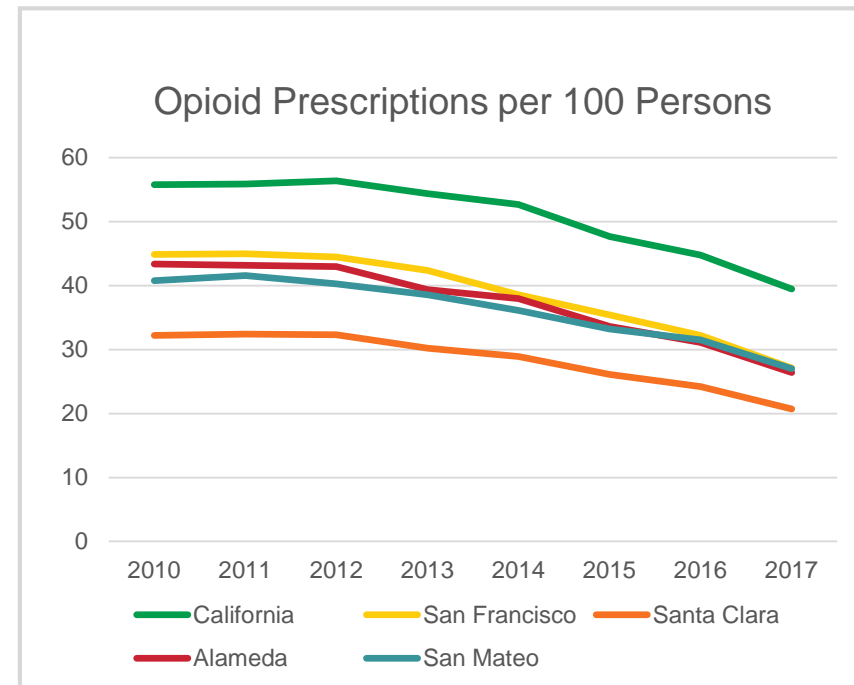






Figure 2: Opioid prescription rates per 100 people in California and Bay Area Counties

Recommendations:

Most of the recommendations are geared for other components of the health system, though HCH/FH can partner on efforts where possible/relevant

- Improve timeliness of access to residential treatment beds for men.
- Increase availability of inpatient medical detox for individuals with Medi-Cal.
- Facilitate more connection and collaboration with schools around substance use, to improve engagement and connection to services among youth.
- Increase motivation and capacity for psychiatrists and primary care providers to prescribe buprenorphine.
- Enhance coordination and communication among County-contracted providers and between County-contracted and private providers.  Partner with Behavioral Health and Recovery Services
- Reconsider the prioritization process for affordable housing for individuals who have completed residential substance use disorder treatment.  Staff to conduct Policy/Advocacy work with State/Federal Housing Authorities
- Provide trauma-informed care and improve engagement with farmworker populations through consistent presence at community events and linkages to churches and other community-based organizations.  Requires discussion and brainstorming
- Provide capacity building or additional administrative support around the implementation of the Drug Medi-Cal Organized Delivery System.
- Assess the need for capacity building around screening and motivational interviewing among primary care providers.  Partnering with Behavioral Health and Recovery Services on SBIRT, patient/provider facing SUD materials




2019 Western Migrant Forum

Highlights and Implications



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Public Charge

Public charge is **not retroactive**, meaning it will **not punish past use** of newly included programs, such as Medicaid, housing assistance and SNAP (Food Stamps) if they were used before the final rule goes into effect.

The proposal would consider if the person received:

- Non-emergency Medicaid (with limited exceptions)
- Supplemental Nutrition Assistance Program (SNAP)
- Medicare Part D Low Income Subsidy
- Housing assistance (e.g. Section 8 - housing vouchers, rental assistance)
- Cash assistance and institutional long-term care (as at present)

DHS will NOT consider:

- **benefits received by an immigrant's family members**
- disaster relief, emergency medical assistance, other **state, local, tribal programs**
- **Sliding fee scale discounts offered by FQHCs**

CA policies & impact on immigration access to healthcare

- AB 60: Undocumented immigrants can obtain driver's licenses
- SB 54: Restrict use of state and local resources from engaging in deportations and creates safe spaces
- SB 244: Prohibits state and local agencies from sharing personal information during enrollment of public services
- Governor Newsom proposal to increase the Medi-Cal age cut-off to 26



The Silent Crisis: How to do outreach in an Anti-Immigrant Climate

Describes barriers and solutions and provides resources to address challenges faced by immigrants:

- Policy and enforcement actions against immigrants
- Discrimination and Mistreatment of immigrants
- Impact on mental and physical health
- Impact on children and families
- Fear of accessing healthcare and other services
- Misinformation and lack of trust in systems

<https://outreach-partners.org/wp-content/uploads/2018/02/Silent-Crisis-2018.pdf>

Considerations for Farmworker Advisory Board participation

1. Transportation
 - Select location(s) that is convenient and safe for farmworkers
 - Select location where farmworkers already meet
2. Distrust or fear of governmental entities
 - Work with trusted partners in the community for introduction and guidance
 - May take time to develop trust and interest in participation
3. Language barriers
 - Interpreter needed
 - Languages other than Spanish?
4. Financial constraints
 - Transportation, childcare
5. Availability
 - Select time that is convenient for farmworkers (before or after work, weekends)
 - Quarterly meetings



Increasing access to quality health care for Migratory and Seasonal Agricultural Workers

Task force convened to help develop strategies for federally funded health centers to improve quality of healthcare for migrant and seasonal agricultural workers:

1. Identifying Agricultural Workers:

Take measures to accurately identify the population being served and reported (i.e. misidentification during registration)

2. Access for Unserved Agricultural Workers:

Increase access for pockets of overlooked agricultural workers by identifying new ways to engage farmworkers

3. Building and Increasing Capacity:

Consider using additional or increased funding to assure integration of outreach, case management, patient navigation, and bilingual services as critical elements of a standard practice management system

SMC HCH/FH Program Implications

Calls on every migrant health center grantee to increase the number of agricultural workers served by 15% each year over the next five years.

Resources & Support:

1. Board Migrant Health Orientation Outline
 1. Basics in Migrant Health
 2. Farmworker Verification & Eligibility
2. Becoming a Leader in Migrant Health
 1. Online Training Toolkit
 2. Purpose: to empower representatives of agricultural workers to participate in leadership and governance



*On-site trainings available

**More resources at <http://www.ncfh.org/health-center-toolbox.html>



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Specialty Care for Agricultural Workers

- Consider the use of telehealth in community settings such as community centers, parishes or religious centers
- Unidos: example program that used community mobilization strategy to bring skin cancer treatment to a rural area
 - See appendix for detailed approach

Need to think of creative access points and outreach strategies:

- “Hooks”: leverage other existing efforts
- Promotoras/Community Health Workers (trusted members of communities)
- Traditional & Alternate Media
 - Radio, TV, Social Media, iPhone, Instagram, etc.
- Interventions at the different “touch points” along the “continuum of care” and that are “outside the box” (beyond the classic “cover-up”, “use sun screen”, pamphlets/brochures campaigns).



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APPENDIX



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Immigration – “Public Charge”

- Last fall, the Administration issued a proposed rule that would make it much harder for legally present immigrants to become Lawful Permanent Residents (i.e., get a Green Card.)



- It would do this by greatly expanding the definition of “public charge” – a term referring to a person’s use of means-tested, publicly-funded benefits.



NATIONAL ASSOCIATION OF
Community Health Centers

What makes someone a “public charge”?

- **Currently:** Being “primarily dependent” on government assistance – defined as receiving either:
 - means-tested cash assistance such as SSI or TANF, or
 - government-funded coverage for long-term care in an institution
- **Proposed:** Receiving – or *being likely to receive* -- more than a minimum amount of one or more of a longer list of government benefits.

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Community Health Centers

Proposed Definition of Public Charge

- The proposal would consider if the person received:
 - Non-emergency Medicaid (with limited exceptions)
 - Supplemental Nutrition Assistance Program (SNAP)
 - Medicare Part D Low Income Subsidy
 - Housing assistance (e.g. Section 8 - housing vouchers, rental assistance)
 - Cash assistance and institutional long-term care (as at present)
- DHS will NOT consider:
 - benefits received by an immigrant’s family members
 - disaster relief, emergency medical assistance, other state, local, tribal programs
 - Sliding fee scale discounts offered by FQHCs
- Proposal asks for input on whether to include Children’s Health Insurance Program (CHIP)

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Things to Keep in Mind

- Some immigrant groups are not subject to “public charge.”
 - Refugees, asylees, survivors of domestic violence, and other protected groups NOT directly affected by proposed rule.
 - Public charge not considered when lawful permanent residents (green card holders) apply to become U.S. citizens.
 - Active duty service-members and their families would not be subject to public charge test.
- Overall circumstances considered – no one factor definitive.
 - Public charge statute — which cannot be changed by regulations — requires immigration officials look at all factors that relate to person’s ability to support themselves: age, health, income, assets, resources, education/skills, family support, etc.

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Community Health Centers

What Now?

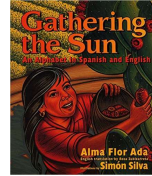
- 1. The comment period on the proposal has ended; it is unclear if/ when a final rule will be published. Submit comments on the proposed reg.**
 - Over 200,000 public comments were submitted. DHS must review all before publishing final version, and then final rule won’t go into effect for 60 days after published
 - See NACHC website for more info.
- 2. Make sure your patients understand that for the newly-added programs (e.g., Medicaid, SNAP):**
 - There is no benefit to withdrawing at this time.
 - The rule will NOT be retroactive. Even if the proposal is finalized as written, future Green Card decisions will not consider if the person used these benefits prior to the effective date of the final rule.

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RISKS/NEEDS (CONT'D)

- Exposed to long hours of ultra-violet radiation
- Excess risk of melanoma and other skin cancers; workers who apply certain pesticides to farm fields are twice as likely to contract melanoma.
- Perceived low risk (Latinos) have resulted in delayed diagnosis, advanced disease at presentation, and a poorer prognosis.
- Access to skin cancer prevention, screening, and specialized care are often nonexistent or difficult to obtain.



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UNIDOS GOALS

- Mobilize farmworker communities around skin cancer prevention.
- Increase access to skin cancer health care services for farmworkers.
- Ensure sustainability.
- Disseminate information widely to increase awareness nationally.
- Conduct advocacy with public and private decision makers locally and nationally.

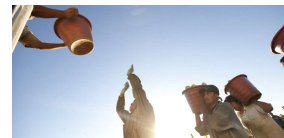
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UNIDOS OBJECTIVES

- Two year demonstration in Homestead, Florida and North San Diego County, California.
- Promote community integration and reduce the impact of skin cancer among farmworkers and their families.
- Community mobilization and participatory learning and action to: analyze needs/situation, identify solutions, and implement action plans.



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UNIDOS APPROACH

- Local Steering Committees - cross-community integrated strategy to skin cancer prevention (primary, secondary, tertiary)
- Evidence-based/culturally-competent approach: *promotores de salud* to help “navigate the system”: basic information, coordinating access to screenings and facilitating access and use of specialized skin cancer treatment.
- Interventions at the different “touch points” along the “continuum of care” and that are “outside the box” (beyond the classic “cover-up”, “use sun screen”, pamphlets/brochures campaigns).



WWW.NACHC.ORG

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DATE: March 14, 2019

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

FROM: Jim Beaumont, Director
Health Care for the Homeless/Farmworker Health Program

SUBJECT: REQUEST FOR BOARD ACTION TO APPROVE AN AMENDMENT TO THE RAVENSWOOD FAMILY HEALTH CENTER'S (RFHC) ENABLING SERVICES CONTRACT CONTINGENT ON HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) ACTION

During the July 2018 HRSA Operational Site Visit (OSV), the reviewers expressed significant concerns related to the HCH/FH's Primary Care contract with RFHC. Ultimately, the OSV Final Report found the program out of compliance on two requirements (Accessible Location & Hours of Operation and Required & Additional Services) for our scope of Project Documents – Forms 5A Services and 5B Sites – being inaccurate, based on their view of the contract with RFHC being unacceptable. HRSA subsequently issued grant conditions for these two requirements.

In response to the grant conditions, the HCH/FH Program submitted documentation detailing how the RFHC Primary Care contract was compliant with HRSA's policies and other requirements, and that the Program's Forms 5A & 5B were correct and did not require being changed. To enable the Program to respond quickly should HRSA not accept the Program's position and to provide for some maintenance of funding from the HCH/FH Program to RFHC, Program opened discussions with RFHC to amend their Enabling Services contract.

Based on those discussions, Program has prepared for the Board four (4) options. All of these options are intended to only be utilized if HRSA does not accept Program's submission on the two (2) relevant grant conditions and some action is required to achieve compliance for the conditions to be lifted. Should HRSA accept Program's submissions and lift the grant conditions, then no actions would take place, the status quo would be maintained, and all current contracts with RFHC would remain as is.

The four (4) options being presented to the Board contingent on HRSA's actions are:

1. Maintain current contracts as they are, including the Primary Care contract, recognizing that Program will no longer be able to count the patients, visits and services under the Primary Care contract on the annual Uniform Data System Report.





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2. Terminate the current Primary Care contract with RFHC and leave the remaining two (2) contracts with them – for Dental Care and for Enabling Services – as they are.
3. Terminate the Primary Care contract with RFHC and amend the Enabling Services contract with changes in services, volumes and rates to \$204,100 per year, an increase of \$107,100 per year which is equal to the value of the Primary Care contract (Amendment Option 1). This represents the amendment request from RFHC.
4. Terminate the Primary Care contract with RFHC and amend the Enabling Services contract with changes in volumes and new services and rates to \$177,400 per year, an increase of \$80,400 per year (Amendment Option 2). This option developed by Program staff.

Based on the current approved contracts and current Program budget, and in consideration of RFHC history of collaboration with the HCH/FH Program and their historical contract performance, Program is recommending option #4 to the Board. This option maintains most of the anticipated funding level to RFHC, while maintaining the integrity of the original negotiated Enabling Services contract and providing a slight increase in budgetary flexibility to the Program.

This request is for the Board to approve one of the options cited above, or another of the Board's design, to direct Program action if HRSA determines that further Program action is required related to the RFHC Primary Care contract in order for the Program to come into compliance. Program is being directed by the Board's decision to take whatever actions are necessary to accomplish the activities given HRSA submission requirements, County contract amendment processes and timelines, and any dollar values already expended under any contract terminated or amended. It requires a majority vote of the Board members present to approve this action.

Attached:

- RFHC Enabling Services Amendment Option 1 Exhibits A & B (RFHC proposal)
- RFHC Enabling Services Amendment Option 2 Exhibits A & B (Staff proposal)
- Proposed Changes to RFHC table

Proposed changes to Ravenswood contracts

Current Status

Service	Original Care Coordination Contract	
	Unduplicated Max Patients	Rate / unit
Care Coordination	500	\$194
Intensive Care Coordination		
Health Coverage Enrollment Assistance		
Non-Clinical Integrated Behavioral Health Coaching		
Transportation to/from SMMC hospital and outpatient clinics		
Care Coordination		\$ 97,000
Primary Care		\$ 107,100
Dental		\$ 54,725

Ravenswood Total \$ 258,825

Options if HRSA directs HCH/FH to discontinue primary care contract

No Changes		Ravenswood proposal		Staff proposal	
Unduplicated Max Patients	Rate / unit	Unduplicated Max Patients	Rate / unit	Unduplicated Max Patients	Rate / unit
500	\$194	330	\$350	450	\$194
		50	\$530	50	\$500
		280	\$120	280	\$120
		40	\$375	40	\$450
		300	\$45	300	\$45
Care Coordination	\$ 97,000	Care Coordination	\$ 204,100	Care Coordination	\$ 177,400
Primary	\$ -	Primary	\$ -	Primary	\$ -
Dental	\$ 54,725	Dental	\$ 54,725	Dental	\$ 54,725

Ravenswood Total \$ 151,725
Financial Impact \$ (107,100)

Ravenswood Total \$ 258,825
\$ -

Ravenswood Total \$ 232,125
\$ (26,700)

OPTION 1: EXHIBIT A

The project described below is supported by Grant Number H80CS00051 pursuant to Section 330 of the Public Health Service Act ("Section 330"), which program is administered by the Health Resources and Services Administration ("HRSA") within the United States Department of Health and Human Services ("DHHS").

In consideration of the payments set forth in **Exhibit B**, Contractor shall provide the following services for each reporting period.

Each reporting period shall be defined as one (1) calendar year running from January 1st through December 31st, unless specified otherwise in this Agreement.

The County of San Mateo Health Care for the Homeless/Farmworker Health (HCH/FH) Program is contracting with Ravenswood Family Health Center (RFHC) to provide enabling health care services to individuals who are homeless in San Mateo County.

RFHC will provide a full range of enabling services, centered on care coordination of health care services, to a maximum of **330 unduplicated homeless individuals** for a total of at least **350 visits**. An unduplicated individual is one who has not been previously served and invoiced for during each reporting period. The individuals served under this agreement must meet the Bureau of Primary Health Care's (BPHC) definition as a homeless individual. RFHC will provide care coordination, including outreach, assessment and assistance of immediate needs & barriers, care management of health services, health navigation assistance, expedited health center registration and intake procedures, education on system navigation, motivational interventions, transportation, translation, discharge and coordination of care/housing transitions. At least 50% of the homeless individuals served by RFHC under this Agreement each contract year will be living in shelters, transitional housing or on the street.

Intensive Care Coordination for New Patients: Pursuant to the Care Coordinator/Manager definition, RFHC shall act as a liaison between the target population patient and health care organizations. RFHC shall provide ongoing care coordination to at least 50 new unduplicated homeless patients. A new patient is defined as a patient who has not been seen in primary care in the past two years, from the date of this Agreement. RFHC's ongoing care coordination shall include the provision of some or all of the following services to qualifying homeless individuals under this Agreement: providing information on health and community resources, coordinating transportation, making appointments, delivering appointment reminders, tracking whether appointments are kept, and accompanying people at appointments; help clients and providers develop a care management plan and assist clients to adhere to the plan. The determination of a patient's status as a new unduplicated homeless individual shall be determined by Contractor through use of a standard information gathering protocol, as approved by the HCH/FH Program, which may include self-attestation by the patient.

The enabling health care services to be provided by RFHC will be implemented as measured by the following objectives and outcome measures.

Objective 1: Provide access to enabling services for homeless individuals. RFHC shall deliver care coordination services to at least 330 unduplicated homeless individuals annually through at least 350 encounters and intensive care coordination services for at least 50 unduplicated homeless individuals annually through at least 100 encounters. Care coordination services is defined to include some or all of the following: outreach, health navigation, health coverage enrollment assistance, transportation assistance, personal health and hygiene support, and care management services.

Outcome Measure 1.A. Of those unduplicated homeless individuals identified as having a health care need, at least 85% will receive ongoing care coordination services from RFHC and will create individualized **health care case plans**.

Outcome Measure 1. B. Of those unduplicated homeless individuals receiving ongoing care coordination services, at least 60% will be compliant with their health care case plans.

Objective 2: Provide health coverage eligibility assistance to at least 280 unduplicated homeless individuals to support health coverage enrollment. RFHC Community Health Advocates (CHA) shall: screen homeless individuals for health coverage eligibility, obtain required identification for health coverage applications, provide translation and interpretation services for completing health coverage forms and meetings with external parties, and work with the Health Coverage Unity to resolve any enrollment application issues for homeless individuals.

Outcome 2.A: 100% of these homeless individuals will be screened for health coverage eligibility.

Outcome 2.B: At least 90% of these homeless individuals will complete their applications for health coverage

Objective 3: At least 40 unduplicated homeless individuals served within each contract year shall receive behavioral health screenings from RFHC. RFHC shall use a behavioral health assessment tool as a guide and document which individuals have been connected to behavioral health treatment services

Outcome 3.A: RFHC shall provide some or all of the following services to these homeless individuals: conducting motivational interviewing to engage and activate homeless individuals in their care and working with them to identify barriers and solutions to barriers; referrals to the appropriate level of behavioral health services after completion of non-clinical, same-day behavioral health assessments, referrals to other supportive services through external agencies and serving as a liaison between homeless individuals and external agencies, making appointments, and contacting individuals who are “at risk” for missing appointments.

Outcome 3B: RFHC shall document the number of these individuals assessed as severely mentally ill who have been referred to County behavioral health treatment services.

Outcome 3C: RFHC shall document the number of patients referred to private provider network - ACCESS, for behavioral health treatment services.

RESPONSIBILITIES:

The following are the contracted reporting requirements that RFHC must fulfill:

Obtain all demographic information as defined by the HCH/FH Program from each homeless individual receiving enabling services from RFHC during the reporting period. Collect all encounter information as defined by the HCH/FH Program for each encounter. Submit demographic and encounter data to the HCH/FH Program with the monthly invoice. **This may include data for homeless individuals for whom the Contractor is not reimbursed.** Assess and report each individual’s homeless status as defined by BPHC.

Use a sliding fee scale policy if there are charges for services under this Agreement.

Report any **revenue** received from services provided under this Agreement on a quarterly basis.

Site visits by the County at least annually to review patient records and program operations, to verify the accuracy of invoicing and to assess the documentation of client activities/outcome measures. The HCH/FH Program will work with RFHC reasonably accommodate scheduling for routine site visits and will provide minimum notice of two (2) weeks for routine site visits, regardless. If the HCH/FH Program identifies issues, such as, but not limited to, the following, HCH/FH will advise RFHC of the issue and provide notice to RFHC that it may conduct an unannounced site visit.

- Lack of timely reporting, especially repeatedly
- Multiple invoicing errors: billings for duplicates; spreadsheet and invoice don’t match; etc.
- Ongoing difficulties in scheduling routine site visits

- Complaints or reports that raise concerning issues; etc.

Reporting requirements- Monthly and quarterly submission of invoices and reports are required via template supplied to RFHC by HCH/FH. If the HCH/FH program pursues a cloud-based data depository (database) for monthly and quarterly data, RFHC will be required to upload/submit data into database.

A monthly invoice detailing the number of new unduplicated individuals served in the previous month and the total encounters provided to all homeless individuals in this same time period will be submitted to the HCH/FH Program by the 10th of the following month. A separate transportation encounter spreadsheet will also be provided monthly. Invoices shall be sufficiently detailed to allow for tracking an individual to their provided demographic data.

Quarterly reports providing an update on the contractual goals, objectives, and outcome measures shall be submitted no later than the 15th of the month following the completion of each calendar quarter throughout the Agreement.

If RFHC observes routine and/or ongoing **problems in accessing specialty services within San Mateo Medical Center (SMMC)**, RFHC is required to track and document problematic occurrences and submit this information to designated HCH/FH staff for follow up.

Participate in planning and quality assurance activities related to the HCH/FH Program.

Participate in HCH/FH Provider Collaborative Meetings and other workgroups.

Participate in community activities that address homeless issues (i.e., Homeless One Day Count, Homeless Project Connect, etc.).

Provide information for annual UDS report on patients to include universal data or case sample of 70 clients as requested.

Provide quarterly update on the 330 Program grant conditions issued by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA).

Provide a report within 60 days of the beginning of the contract on any current HRSA grant conditions, and report within 30 days the issuance of any grant conditions by HRSA.

Provide active involvement in the Bureau of Primary Health Care Office of Performance Review Process.

The following are the contracted reporting requirements that **the HCH/FH Program** must fulfill:

- Monitor RFHC's progress to assess it is meeting its contractual requirements with the HCH/FH Program.
- Review, process and monitor monthly invoices.
- Review quarterly reports to assure that goals and objectives are being met.
- Provide technical assistance to RFHC on the HCH/FH Program as needed.

EXHIBIT B

In consideration of the services provided by Contractor in **Exhibit A** and subject to the terms of the Agreement, County shall pay Contractor based on the following fee schedule and terms:

- A. County shall pay Contractor at a rate of \$350.00 for each unduplicated homeless individual invoiced for care coordination services, per contract year, up to the maximum per contract year of 330 individuals, and limited as defined in Exhibit A.

- B. County shall pay a Contractor at a rate of \$530.00 for each new, unduplicated homeless individual invoiced for intensive care coordination services, per contract year, up to the maximum per contract year of 50 individuals, and as limited in Exhibit A as “new”.
- C. County shall pay a Contractor at a rate of \$120.00 for each unduplicated homeless individual invoiced for health coverage assistance, per contract year, up to the maximum per contract year of 280 individuals, and limited as defined in Exhibit A.
- D. County shall pay a Contractor at a rate of \$375.00 for each unduplicated homeless individual invoiced for non-clinical integrated behavioral health coaching, per contract year, up to the maximum per contract year of 40 individuals, and limited as defined in Exhibit A.
- E. County shall pay Contractor at a rate \$45.00 per unduplicated one-way trip by homeless individuals invoiced during each reporting period for the delivery of transportation services to/from SMMC Hospital and outpatient clinics, up to a maximum of 300 trips per contract year. A separate transportation encounter spreadsheet will also be provided monthly. Contractor will invoice the HCH/FH Program by the 10th of month after rendered services with the number of homeless individuals and encounters for the previous month. Invoices will be approved by the HCH/FH Program Director.

The term of this Agreement is January 1, 2018 through December 31, 2020. Maximum payment for services provided under this Agreement will not exceed FIVE HUNDRED and FIVE THOUSAND TWO HUNDRED DOLLARS (\$505,200).

Budget Overview January 2018 – December 2018

	Service	Unduplicated Maximum	Payment per Unit
Case Management, Eligibility Assistance, Transportation, & other Enabling Services	Care Coordination	500	\$194
Totals		500 patients	\$ 97,000

Budget Overview January 1, 2019 – December 31, 2019

	Service	Unduplicated Maximum	Payment per Unit
Must be unduplicated across the two categories and invoiced only once in the one category	Care Coordination	330	\$350
	Intensive Care Coordination	50	\$530
Can be invoiced in addition to any care coordination	Health Coverage Enrollment Assistance	280	\$120
	Non-Clinical Integrated Behavioral Health Coaching	40	\$375
	Transportation to support patient travel to/from SMMC hospital and outpatient clinics	300	\$45/one-way trip
Totals		545 patients & 300 trips	\$204,100

OPTION 2: EXHIBIT A

The project described below is supported by Grant Number H80CS00051 pursuant to Section 330 of the Public Health Service Act ("Section 330"), which program is administered by the Health Resources and Services Administration ("HRSA") within the United States Department of Health and Human Services ("DHHS").

In consideration of the payments set forth in **Exhibit B**, Contractor shall provide the following services for each reporting period.

Each reporting period shall be defined as one (1) calendar year running from January 1st through December 31st, unless specified otherwise in this Agreement.

The County of San Mateo Health Care for the Homeless/Farmworker Health (HCH/FH) Program is contracting with Ravenswood Family Health Center (RFHC) to provide enabling health care services to individuals who are homeless in San Mateo County.

RFHC will provide a full range of enabling services, centered on care coordination of health care services, to a maximum of **450 unduplicated homeless individuals** for a total of at least **675 visits**. An unduplicated individual is one who has not been previously served and invoiced for during each reporting period. The individuals served under this agreement must meet the Bureau of Primary Health Care's (BPHC) definition as a homeless individual. RFHC will provide care coordination, including outreach, assessment and assistance of immediate needs & barriers, care management of health services, health navigation assistance, expedited health center registration and intake procedures, education on system navigation, motivational interventions, transportation, translation, discharge and coordination of care/housing transitions. At least 50% of the homeless individuals served by RFHC under this Agreement each contract year will be living in shelters, transitional housing or on the street.

Intensive Care Coordination for New Patients: Pursuant to the Care Coordinator/Manager definition, RFHC shall act as a liaison between the target population patient and health care organizations. RFHC shall provide ongoing care coordination to at least **50 new unduplicated homeless patients**. A new patient is defined as a patient who has not been seen in primary care in the past two years, from the date of this Agreement. RFHC's ongoing care coordination shall include the provision of some or all of the following services to qualifying homeless individuals under this Agreement: providing information on health and community resources, coordinating transportation, making appointments, delivering appointment reminders, tracking whether appointments are kept, and accompanying people at appointments; help clients and providers develop a care management plan and assist clients to adhere to the plan. The determination of a patient's status as a new unduplicated homeless individual shall be determined by Contractor through use of a standard information gathering protocol, as approved by the HCH/FH Program, which may include self-attestation by the patient.

The enabling health care services to be provided by RFHC will be implemented as measured by the following objectives and outcome measures.

Objective 1: Provide access to enabling services for homeless individuals. RFHC shall deliver care coordination services to at least 450 unduplicated homeless individuals annually through at least 675 encounters and intensive care coordination services for at least 50 unduplicated homeless individuals annually through at least 100 encounters. Care coordination services is defined to include some or all of the following: outreach, health navigation, health coverage enrollment assistance, transportation assistance, personal health and hygiene support, and care management services.

Outcome Measure 1.A. Of those unduplicated homeless individuals identified as having a health care need, at least 85% will receive ongoing care coordination services from RFHC and will create individualized **health care case plans**.

Outcome Measure 1. B. Of those unduplicated homeless individuals receiving ongoing care coordination services, at least 60% will be compliant with their health care case plans.

Objective 2: Provide health coverage eligibility assistance to at least 280 unduplicated homeless individuals to support health coverage enrollment. RFHC Community Health Advocates (CHA) shall: screen homeless individuals for health coverage eligibility, obtain required identification for health coverage applications, provide translation and interpretation services for completing health coverage forms and meetings with external parties, and work with the Health Coverage Unity to resolve any enrollment application issues for homeless individuals.

Outcome 2.A: 100% of these homeless individuals will be screened for health coverage eligibility.

Outcome 2.B: At least 90% of these homeless individuals will complete their applications for health coverage

Objective 3: At least 40 unduplicated homeless individuals served within each contract year shall receive behavioral health screenings from RFHC. RFHC shall use a behavioral health assessment tool as a guide and document which individuals have been connected to behavioral health treatment services

Outcome 3.A: RFHC shall provide some or all of the following services to these homeless individuals: conducting motivational interviewing to engage and activate homeless individuals in their care and working with them to identify barriers and solutions to barriers; referrals to the appropriate level of behavioral health services after completion of non-clinical, same-day behavioral health assessments, referrals to other supportive services through external agencies and serving as a liaison between homeless individuals and external agencies, making appointments, and contacting individuals who are “at risk” for missing appointments.

Outcome 3B: RFHC shall document the number of these individuals assessed as severely mentally ill who have been referred to County behavioral health treatment services.

Outcome 3C: RFHC shall document the number of patients referred to private provider network - ACCESS, for behavioral health treatment services.

RESPONSIBILITIES:

The following are the contracted reporting requirements that RFHC must fulfill:

Obtain all demographic information as defined by the HCH/FH Program from each homeless individual receiving enabling services from RFHC during the reporting period. Collect all encounter information as defined by the HCH/FH Program for each encounter. Submit demographic and encounter data to the HCH/FH Program with the monthly invoice. **This may include data for homeless individuals for whom the Contractor is not reimbursed.** Assess and report each individual's homeless status as defined by BPHC.

Use a sliding fee scale policy if there are charges for services under this Agreement.
Report any **revenue** received from services provided under this Agreement on a quarterly basis.

Site visits by the County at least annually to review patient records and program operations, to verify the accuracy of invoicing and to assess the documentation of client activities/outcome measures. The HCH/FH Program will work with RFHC reasonably accommodate scheduling for routine site visits and will provide minimum notice of two (2) weeks for routine site visits, regardless. If the HCH/FH Program identifies issues, such as, but not limited to, the following, HCH/FH will advise RFHC of the issue and provide notice to RFHC that it may conduct an unannounced site visit.

- Lack of timely reporting, especially repeatedly
- Multiple invoicing errors: billings for duplicates; spreadsheet and invoice don't match; etc.
- Ongoing difficulties in scheduling routine site visits
- Complaints or reports that raise concerning issues; etc.

Reporting requirements- Monthly and quarterly submission of invoices and reports are required via template supplied to RFHC by HCH/FH. If the HCH/FH program pursues a cloud-based data depository (database) for monthly and quarterly data, RFHC will be required to upload/submit data into database.

A monthly invoice detailing the number of new unduplicated individuals served in the previous month and the total encounters provided to all homeless individuals in this same time period will be submitted to the HCH/FH Program by the 10th of the following month. A separate transportation encounter spreadsheet will also be provided monthly. Invoices shall be sufficiently detailed to allow for tracking an individual to their provided demographic data.

Quarterly reports providing an update on the contractual goals, objectives, and outcome measures shall be submitted no later than the 15th of the month following the completion of each calendar quarter throughout the Agreement.

If RFHC observes routine and/or ongoing **problems in accessing specialty services within San Mateo Medical Center (SMMC)**, RFHC is required to track and document problematic occurrences and submit this information to designated HCH/FH staff for follow up.

Participate in planning and quality assurance activities related to the HCH/FH Program.

Participate in HCH/FH Provider Collaborative Meetings and other workgroups.

Participate in community activities that address homeless issues (i.e., Homeless One Day Count, Homeless Project Connect, etc.).

Provide information for annual UDS report on patients to include universal data or case sample of 70 clients as requested.

Provide quarterly update on the 330 Program grant conditions issued by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA).

Provide a report within 60 days of the beginning of the contract on any current HRSA grant conditions, and report within 30 days the issuance of any grant conditions by HRSA.

Provide active involvement in the Bureau of Primary Health Care Office of Performance Review Process.

The following are the contracted reporting requirements that **the HCH/FH Program** must fulfill:

- Monitor RFHC's progress to assess it is meeting its contractual requirements with the HCH/FH Program.
- Review, process and monitor monthly invoices.
- Review quarterly reports to assure that goals and objectives are being met.
- Provide technical assistance to RFHC on the HCH/FH Program as needed.

EXHIBIT B

In consideration of the services provided by Contractor in **Exhibit A** and subject to the terms of the Agreement, County shall pay Contractor based on the following fee schedule and terms:

- A. County shall pay Contractor at a rate of \$194.00 for each unduplicated homeless individual invoiced for care coordination services, per contract year, up to the maximum per contract year of 450 individuals, and limited as defined in Exhibit A.

- B. County shall pay a Contractor at a rate of \$500.00 for each new, unduplicated homeless individual invoiced for intensive care coordination services, per contract year, up to the maximum per contract year of 50 individuals, and as limited in Exhibit A as “new”.
- C. County shall pay a Contractor at a rate of \$120.00 for each unduplicated homeless individual invoiced for health coverage assistance, per contract year, up to the maximum per contract year of 280 individuals, and limited as defined in Exhibit A.
- D. County shall pay a Contractor at a rate of \$450.00 for each unduplicated homeless individual invoiced for non-clinical integrated behavioral health coaching, per contract year, up to the maximum per contract year of 40 individuals, and limited as defined in Exhibit A.
- E. County shall pay Contractor at a rate \$45.00 per unduplicated one-way trip by homeless individuals invoiced during each reporting period for the delivery of transportation services to/from SMMC Hospital and outpatient clinics, up to a maximum of 300 trips per contract year. A separate transportation encounter spreadsheet will also be provided monthly. Contractor will invoice the HCH/FH Program by the 10th of month after rendered services with the number of homeless individuals and encounters for the previous month. Invoices will be approved by the HCH/FH Program Director.

The term of this Agreement is January 1, 2018 through December 31, 2020. Maximum payment for services provided under this Agreement will not exceed FOUR HUNDRED FIFTY-ONE THOUSAND EIGHT HUNDRED DOLLARS (\$451,800).

Budget Overview January 2018 – December 2018

	Service	Unduplicated Maximum	Payment per Unit
Case Management, Eligibility Assistance, Transportation, & other Enabling Services	Care Coordination	500	\$194
Totals		500 patients	\$ 97,000

Yearly Budget Overview January 1, 2019 – December 31, 2020

	Service	Unduplicated Maximum	Payment per Unit
Must be unduplicated across the two categories and invoiced only once in the one category	Care Coordination	450	\$194
	Intensive Care Coordination	50	\$500
Can be invoiced in addition to any care coordination	Health Coverage Enrollment Assistance	280	\$120
	Non-Clinical Integrated Behavioral Health Coaching	40	\$450
	Transportation to support patient travel to/from SMMC hospital and outpatient clinics	300	\$45/one-way trip
Totals		545 patients & 300 trips	\$177,400



SAN MATEO COUNTY HEALTH CARE FOR THE HOMELESS & FARMWORKER HEALTH

2018
Annual Report

OUR MISSION:

To serve homeless and farmworker individuals and families by providing access to comprehensive health care in a supportive, welcoming, and accessible environment.



LETTER from the BOARD CHAIR

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-Brian Greenberg

Placeholder

ROAD TO RECOVERY – A CLIENT’S STORY

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- A hospital patient experiencing homelessness in San Mateo.

Placeholder





BACKGROUND

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

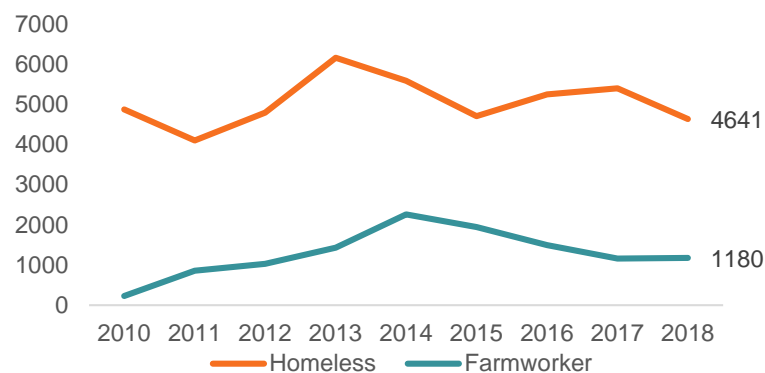
San Mateo County's Health Care for the Homeless/Farmworker Health Program is a federally funded program which has delivered and coordinated health care and support services for homeless individuals and families since 1991. In July 2010, the program received additional funding to provide similar services to farmworkers and their families/dependents.

HCH/FH is funded by United States Department of Health and Human Services Health Resources and Services Administration ("HRSA") pursuant to Sections 330(g) and 330(h) of the Public Health Service Act to support the planning for and delivery of services to medically underserved populations. It is jointly governed by an independent Co-Applicant Board and San Mateo County Board of Supervisors.

People in San Mateo County experiencing homelessness or farmworkers can access any San Mateo County Health touch point – San Mateo Medical Center and satellite clinics, mobile clinics and numerous other County and community-based organizations - to receive health services regardless of insurance or documentation status. HCH/FH has agreements with county and nonprofit organizations to provide these services.

Homeless and Farm worker in San Mateo County who have accessed health services

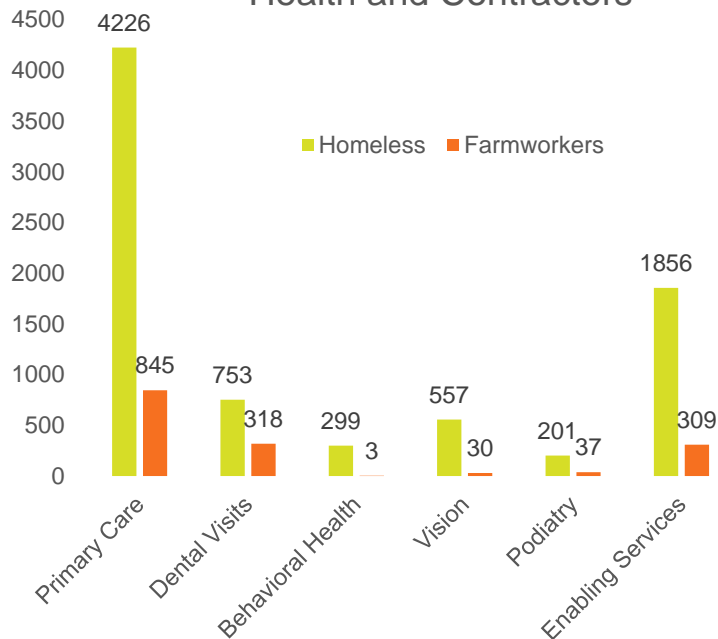
The Center on Homelessness conducts a one-day count every two years. In 2017, the number of street homeless using the Housing Authority's definition was about 600. HCH/FH uses a broader definition of homelessness, which includes people who are doubling up (i.e. couch surfing). In 2018, the number of homeless patients who received health care services (primary, dental, etc) was 4600 patients.



The term farmworkers is also very broad from HRSA's perspective, and includes both migrant workers who have multiple employers or just one, aged and disabled workers and their families. According to Legal aid society of San Mateo County, fears of deportation plague immigrant families in our community and across the United States.

2018 in Review

Unique Patients Seen by SMC Health and Contractors



Health Outcomes Actuals and Targets

The goal is to reduce health disparities among people experiencing homelessness and farmworkers.

• Childhood Immunizations Complete by Age 2-3	66% (90% goal)
• Pap Test in Last 3 Years	63% (70% goal)
• Child & Adolescent BMI & Counseling	*59% (85% goal)
• Adult BMI & Follow-up Plan	43% (75% goal)
• Tobacco Use Queried	*78% (96% goal)
• Treatment for Persistent Asthma	*90% (100% goal)
• Lipid Therapy in CAD Patients	*80% (96% goal)
• Aspirin Therapy in Ischemic Heart Disease Patients	*86% (96% goal)
• Colorectal Screening Performed	*57% (60% goal)
• Babies with Normal Birth Weight (all babies)	98% (95% goal)
• Hypertension Controlled (<140/90)	*63% (80% goal)
• Diabetes Controlled (<9 HgbA1c)	*72% (75% goal)
• First Trimester Prenatal Care	49% (80% goal)

Spotlight: Mental Health Services and Substance Use Disorder

Substance use disorders impact the health and well-being of individuals, families, and entire communities across the country, and have been called “one of the critical public health problems of our time. HCH/FH until 2018 was not able to allocate many resources to mental health.

Mental health and substance use are particularly and intricately connected to the overall well-being of vulnerable populations.

In 2018, HRSA announced supplemental funding for Substance Use Disorder and Mental Health Services (SUD MH), which was in addition to a similar announcement in 2017 for Access Increases in Mental Health and Substance Abuse Services (AIMS).

HCH/FH was able to secure funding from both mental health and substance use opportunities. This led to the development of two new community partnerships – StarVista and El Centro – to find ways of increasing services for farmworker and people experiencing homelessness.

Additionally, the funding was used to conduct a county-wide Substance Use Needs Assessment, develop resources for people struggling with substance use, and a website framework. This work is being finalized in the early 2019 months as El Centro and StarVista are ramping up to provide services, all of which are exciting developments for the HCH/FH program.

Budget

Contracts

San Mateo County BHRS	\$90,000
Samaritan House	\$81,000
LifeMoves	\$296,500
Puente	\$183,500
Sonrisas	\$131,675
Ravenswood	\$251,825
San Mateo Mobile Clinic	\$532,250
San Mateo Street Medicine	\$249,750
El Centro	\$82,500
StarVista	\$180,000
Consultants	\$40,000
Staff Salaries	\$560,000
Staff Benefits	\$220,000
Travel	\$25,000
Supplies	\$10,000
Other	\$20,000
QI Award	\$13,000

Total

\$2,099,000

SERVICES FOR PEOPLE EXPERIENCING HOMELESSNESS AND FARMWORKERS IN SAN MATEO COUNTY

The Health Care for the Homeless/Farmworker Health Program works with the below organizations to ensure people experiencing homelessness and farmworkers in San Mateo County are able to receive primary care, dental care, behavioral and substance use services, and care coordination services.

**Indicates HCH/FH holds a contract or an MOU with the organization. Most of these organizations provide services beyond those described here, which focus on HCH/FH contracted services.*

Primary Care

Mobile Health Clinic



A state-of-the-art van which provides drop-in, no appointment necessary primary care services to homeless patients throughout San Mateo County at regularly scheduled sites.

Dental Care



Provides comprehensive dental services to farmworkers in the Southcoast region of San Mateo County.

Street/Field Medicine



In an effort to meet patients where they are, this backpack medicine program provides primary care to people experiencing homelessness on streets, encampments and to farmworkers in the fields.

San Mateo Mobile Dental Clinic



Provides dental services to San Mateo County residents throughout San Mateo County at various locations.

San Mateo Medical Center and Clinics

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Placeholder



S1

- S-130** Edison Clinic Express Care
Clínica Edison Atención
- S-131** Ron Robinson S Care Center
Centro para Personas Avanzada Ron Robins
- S-132** Respiratory Care
Cuidados Respiratori

SERVICES FOR PEOPLE EXPERIENCING HOMELESSNESS AND FARMWORKERS IN SAN MATEO COUNTY

The Health Care for the Homeless/Farmworker Health Program works with the below organizations to ensure people experiencing homelessness and farmworkers in San Mateo County are able to receive primary care, dental care, behavioral and substance use services, and care coordination services.

**Indicates HCH/FH holds a contract or an MOU with the organization. Most of these organizations provide services beyond those described here, which focus on HCH/FH contracted services.*

Behavioral Health

Includes mental health and substance use treatment/outreach.



Provides a broad spectrum of services for children, youth, families, adults and older adults for the prevention, early intervention and treatment of mental illness and/or substance use conditions.

EL CENTRO DE LIBERTAD

The Freedom Center

Provides outreach/prevention education programs, screening and navigation assistance on substance use to homeless and farmworkers throughout San Mateo county. One of HCH/FH's newest partnerships.



Provides outreach/engagement services, including engagement with Medication Assisted Treatment services, and substance abuse and mental health services to homeless and farmworkers throughout San Mateo County.

Enabling Services

Are non-clinical services that aim to increase access to healthcare and improve health outcomes, i.e. transportation, health literacy



Provides care coordination, health insurance enrollment including SSI/SSDI to homeless patients throughout San Mateo County.



Provides care coordination, health insurance enrollment to farmworkers in the South Coast of San Mateo County



Provides care coordination services to homeless clients of Safe Harbor shelter in South San Francisco.

Placeholder

HCH/FH Board Members

Meet our 2019 Board Members, and their reason for joining the Board. Board Members are passionate San Mateo County residents who are not employed by San Mateo County Health.

Board Member Name
Role/Job

Board Member Name
Role/Job

Board Member Name
Role/Job

Board Member Name
Role/Job

Board Member Name
Role/Job

Board Member Name
Role/Job

Board Member Name
Role/Job

Board Member Name
Role/Job

Board Member Name
Role/Job

Looking Ahead to 2019

Medical Respite, also referred to as recuperative care, provides acute and post-acute medical care for people who are homeless and too ill to be on the street/shelter but not ill enough to be in a hospital. Research has shown reduced health costs to hospitals and the overall health system when Medical Respite is a discharge option or Emergency Room deterrent. Currently, San Mateo County does not have a comprehensive model. Due to a confluence of events including increased hospital interest, it has become a large focus of the HCH/FH program in late 2018. In partnership with the San Mateo Hospital Consortium, a Community Task Force composed of diverse stakeholders has been formed to identify a comprehensive medical respite plan for the County in the first half of 2019.

HCH/FH is focusing on numerous other initiatives in 2019 ranging from **data quality** improvement projects to seeking new and innovative projects. Examples include **increasing dental services** to farmworkers on the coast and exploring ways to improve **nutrition** which can in turn alleviate the burden of chronic illness. Additionally, HCH/FH will be conducting a **program needs assessment** and updating its **strategic plan**.

Staff

Jim Beaumont
Program Director

Frank Trinh, M.D.
Medical Director

Danielle Hull
Clinical Coordinator

Irene Pasma
Implementation Coordinator

Linda Nguyen
Program Coordinator

Sofia Recalde
Management Analyst

Get Involved

- Attend a Board Meeting
- Join the Board as a voting member
- Join one of two Advisory Boards
- Keep an eye out for RFPs to submit a proposal



TAB 3

Request to Approve Sliding fee Scale Matrix

DATE: April 11, 2019

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

FROM: Jim Beaumont, Program Director HCH/FH Program

SUBJECT: REQUEST TO APPROVE REVISIONS TO THE SLIDING FEE DISCOUNT SCHEDULE

One of the Federal Program Requirements is having an approved Sliding Fee Discount Program (SFDP). This Board approved policy for the SFDP in October 2014 and was subsequently updated on June 9, 2016, October 12, 2017, February 08, 2018 & April 12, 2018.

According to the Program's Sliding Fee Discount Program Policy "The income levels included in the SFDS shall be updated annually based on the annual release of the Federal Poverty Level". The attached revisions to the Sliding Fee Scale Schedule are based on the updates to the 2019 (FPL) guidelines.

This Action Request is for the Co-Applicant Board to approve revisions to its approved Sliding Fee Discount Program Policy Schedule to make adjustments for the new FPL for 2019.

A majority vote of the members present is necessary and sufficient to approve the request.

Attachments:

- Revised 2019 SFDP Schedule

San Mateo County
Health Care for the Homeless/Farmworker Health (HCH/FH) Program
 (HRSA 330 Program/FQHC)

Sliding Fee/Discount Schedule

Effective April 12, 2019

Monthly Income Thresholds by Family Size for Sliding Fee/Discount Policy Coverage for Service Charges

Poverty Level ⁺	0 - 100%	101% - 138%	139% - 160%	161% - 200%	>200%
Family Size					
1	\$1,041	\$1,437	\$1,666	\$2,082	\$2,083
2	\$1,409	\$1,945	\$2,255	\$2,819	\$2,820
3	\$1,778	\$2,453	\$2,844	\$3,555	\$3,556
4	\$2,146	\$2,962	\$3,434	\$4,292	\$4,293
5	\$2,514	\$3,470	\$4,023	\$5,029	\$5,030
6	\$2,883	\$3,978	\$4,612	\$5,765	\$5,766
7	\$3,251	\$4,487	\$5,202	\$6,502	\$6,603
8	\$3,619	\$4,995	\$5,791	\$7,239	\$7,240
For each additional person, add	\$368	\$509	\$590	\$737	\$738
Patient Cost ==>	No Charge	\$20	\$25	\$30	No Sliding Fee Discount⁺⁺

⁺ Based on 2019 HHS Poverty Guidelines (<https://aspe.hhs.gov/poverty-guideline>)

⁺⁺ Reduced payments may be available through other state/local funded discount programs.

TAB 4
Request to
amend PHPP
contracts

DATE: April 1, 2019

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

FROM: Sofia Recalde, Associate Management Analyst
Health Care for the Homeless/Farmworker Health Program

SUBJECT: REQUEST FOR BOARD ACTION TO APPROVE AMENDMENTS FOR PUBLIC HEALTH, POLICY AND HEALTH DIVISION'S MOBILE VAN AND STREET MEDICINE SERVICE MOUs

The HCH/FH program (Program) currently has two MOUs with Public Health, Policy and Planning Division (PHPP) to deliver primary care service via the mobile van and street medicine program. The Program is looking to extend both MOUs with PHPP to December 31, 2020. This request is for the board to take action to amend the MOUs with PHPP.

Included with this request are:

- Exhibits A & B for the PHPP Mobile Van and Expanded Services MOU** – The proposed amendment is to extend the service period from June 30, 2019 to December 31, 2020 and to increase the contract value from \$532,250 to \$989,500. The maximum number of patients to be served will increase for each year of the contract from 700 patients served in 2019 to 1,200 per year in both 2019 and 2020. The service costs will remain the same.

	Period of Performance	Contract total	2019	2020
Existing MOU	Jan 1 – Jun 30, 2019	\$ 300,250	\$ 300,250	\$ 0
Amendment	Jan 1 – Dec 31, 2020	\$ 989,500	\$ 507,250	\$ 482,250

- Exhibits A & B for the PHPP Street Medicine MOU** – The proposed amendment is to extend the service period from June 30, 2019 to December 31, 2020 and to increase the total MOU value from \$138,750 to \$499,500. The maximum number of patients to be served will increase for each year of the contract from 75 patients served in 2019 to 135 patients per year in both 2019 and 2020. The service costs will remain the same.

	Period of Performance	Contract total	2019	2020
Existing MOU	Jan 1 – Jun 30, 2019	\$ 138,750	\$ 138,750	\$ 0
Amendment	Jan 1 – Dec 31, 2020	\$ 499,500	\$ 249,750	\$ 249,750

This request is for the Board to approve the proposed amendments with PHPP for 1) the Mobile Van and Expanded Services MOU and 2) the Street Medicine MOU. It requires a majority vote of the Board members present to approve this action.

Attachments:

- Exhibits A & B for the PHPP Mobile Van and Expanded Services MOU
- Exhibits A & B for the PHPP Street Medicine MOU



Memorandum of Understanding Between
San Mateo Medical Center
And
Health System, Public Health, Policy and Planning Division

The purpose of this Memorandum of Understanding (MOU) is to memorialize the agreement between the San Mateo Medical Center (SMMC) and the Public Health, Policy and Planning Division of San Mateo County Health (PHPP), regarding the provision of primary health care services through Health Care for the Homeless/Farmworker Health Program funding. These funded services will be provided by PHPP's Mobile Health Clinic at locations including shelters, on the streets, in transitional housing programs, and other places in San Mateo County where there are individuals who are homeless.

I. Background Information

SMMC is a 509-bed public hospital and clinic system fully accredited by the Joint Commission. SMMC operates outpatient clinics throughout San Mateo County, an acute-care hospital, and long-term care facilities in San Mateo and Burlingame. SMMC serves the health care needs of all residents of San Mateo County, with an emphasis on education and prevention, and without regard for ability to pay. SMMC is part of San Mateo County Health and receives financial support from the San Mateo County Health Foundation.

The Health Care for the Homeless/Farmworker Health (HCH/FH) Program is a program within SMMC. The HCH/FH Program oversees the provision of primary health care, dental health care, behavioral health care, and supportive and enabling services to individuals and families who are homeless or at-risk of being homeless, and to the farmworker community in San Mateo County. In order to ensure access to a continuum of services for individuals in the homeless and farmworker communities, the HCH/FH Program utilizes federal funding under Section 330 (h & g) of the Public Health Service Act to provide primary health care Services to these individuals through PHPP.

II. Goals and Objectives

PHPP shall work to achieve the following objectives during the term of this MOU:

Goal: To provide an array of preventive and primary medical care services throughout the County that 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, This includes formerly incarcerated and homeless individuals receiving services through Service Connect the homeless residents of Maple Street Shelter.

Objective 1: To provide primary health care services to up to 1,210 unduplicated homeless individuals residing in shelters, on the streets, or in transitional housing programs through a minimum of 2,420 visits each year. This number may include individuals who are at risk of becoming homeless.

Of the total unduplicated individuals, up to 210 will be identified as formerly incarcerated and homeless individuals served through Service Connect or Maple Street Shelter, through at least 420 encounters annually under this MOU.

At least 50 of the 210 formerly incarcerated and homeless individuals referenced in the prior paragraph will be seen at Maple Street Shelter

Outcome Measure a) At least 80% of the homeless individuals seen each year will receive a comprehensive health screening for chronic diseases and other health conditions including hypertension, tobacco, drug and alcohol use, and diabetes. This health screening will be indicated by a primary diagnostic code of Z00.00, Z00.01 or Z72.1. The screening will include, at a minimum, blood pressure screens, blood sugar screening (if appropriate), height, weight, and BMI.

Objective 2: At least 20% of all homeless patient encounters annually under this MOU will be related to a chronic disease, including, but not limited to, asthma, chronic obstructive pulmonary disease (COPD), diabetes, and hypertension.

Outcome Measure a) At least 20% of all encounters each year will be provided to homeless patients seen at the Mobile Clinic with a primary diagnosis of **asthma and/or COPD**. At least 20% of these homeless patients with a primary diagnosis of asthma and/or COPD will return for repeat medical visits. These visits shall include screenings, treatment, and/or asthma and/or COPD recorded in the visit as a primary diagnosis.

Outcome Measure b) At least 20% of all encounters each year will be provided to homeless patients seen at the Mobile Clinic with a primary diagnosis of either **Type 1 or Type 2 diabetes**. At least 20% of these homeless patients with a primary diagnosis of Type 1 or Type 2 diabetes will return for repeat medical visits. These visits include screenings, treatment, and/or Type 1 or Type 2 diabetes recorded as a primary diagnosis. Of these homeless patients with a diagnosis for Type 1 or Type 2 diabetes who return for a follow-up visit, at least 90% will have their blood sugar tested each year. Random chart reviews each quarter will be completed to document recent HgA1C levels of these patients. At least 70% of homeless patients diagnosed with Type 1 or Type 2 diabetes each year will have HbA1c levels less than or equal to 9%.

Outcome Measure c) At least 20% of all encounters each year will be provided to homeless patients seen at the Mobile Clinic with a primary diagnosis of **Hypertension**. At least 20% of these homeless patients with a primary diagnosis of hypertension will return for repeat medical visits. These visits shall include screenings, treatment, and/or hypertension recorded as a primary diagnosis. Random chart reviews each quarter will be completed to document recent systolic and diastolic pressure levels of these patients. At least 70% of these homeless patients with diagnosed hypertension will have had a blood pressure reading of less than 140/90.

Objective 3: To ensure continuity of care and to provide referrals to other health and social services as needed.

Outcome Measure a) At least 75% of all homeless patients seen each year under this MOU at the SMMC Podiatry Clinic will be referred to the Mobile Clinic's Registered Nurse (RN) or Nurse Practitioner for a medical visit.

Outcome Measure b) At least 75% of homeless patients contacted at Service Connect each year under this MOU will be seen at the Mobile Clinic for a medical visit.

Outcome Measure c) At least 75% of homeless patients with mental health and/or alcohol and other drug (AOD) issues seen each year will be referred to the County's Behavioral Health and Recovery Services.

Outcome Measure d) At least 75% of homeless patients in need of case management and/or eligibility assistance each year will be referred to LifeMoves.

Outcome Measure e) Women's Health- 100% of homeless women with a positive pregnancy test will be referred to SMMC's OB-GYN clinic each year.

Outcome Measure f) The Mobile Clinic will survey women to measure their interest in being able to receive Pap tests at the Mobile Clinic and will provide ongoing reporting of the survey data as part of the quarterly reports.

III. Term of Agreement

The term of this MOU shall be from January 1, 2019 through December 31, 2020.

IV. Responsibilities

The HCH/FH Program is responsible for the following under this MOU:

1. Monitor the performance of PHPP to assure it is meeting its requirements.
2. Review, process, and monitor monthly invoices.
3. Review quarterly reports to track progress on goals and objectives.
4. Provide technical assistance to the Mobile Clinic related to program development, data collection, or other HCH/FH Program-related issues as needed.
5. If determined by HCH/FH, the MOU may require an amendment upon HCH/FH's review of the MOU expenditures after the second quarter of the MOU period.

PHPP is responsible for the following under this MOU:

1. All demographic information will be obtained from each homeless and farmworker individual receiving primary care services by the Mobile Clinic during the agreement period. This data will be submitted to the HCH/FH Program with the monthly invoice. **This may include homeless and farmworker individuals for whom PHPP is not reimbursed.** PHPP will also assess and report each individual's farmworker status as defined by the Bureau of Primary Health Care (BPHC).
2. A monthly invoice detailing the number of new unduplicated individuals served in the previous month and the total encounters provided to all homeless individuals in this same time period will be submitted to the HCH/FH Program by the 10th of the following month. Invoices shall be sufficiently detailed to allow for tracking an individual to their provided demographic data.
3. Quarterly reports providing an update on progress made on goals, objectives, and outcome measures under this MOU shall be submitted no later than the 15th of the month following the completion of each calendar quarter throughout the contract.
4. Participate in planning and quality assurance activities related to the HCH/FH Program.
5. Participate in HCH/FH Provider Collaborative Meetings, Quality Improvement Committee meetings, and other workgroups as requested.
6. Participate in community activities that address homeless issues (i.e., Homeless One Day Count, Homeless Project Connect).

7. Provide active involvement in the BPHC Office of Performance Review Process.
8. Site visits will occur at a minimum of on an annual basis, to review patient records and program operations, to verify the accuracy of invoicing and to assess the documentation of patient activities/outcome measures. The HCH/FH Program will work with PHPP to try and accommodate scheduling for routine site visits and will provide PHPP with a minimum notice of two (2) weeks for routine site visits, regardless. If the HCH/FH Program has identified issues, such as, but not limited to:
 - Lack of timely reporting, especially repeatedly
 - Multiple invoicing errors: billings for duplicates; spreadsheet and invoice don't match; etc.
 - Ongoing difficulties in scheduling routine site visits
 - Complaints or reports that raise concerning issues; etc.,

The HCH/FH Program will advise PHPP of the issue and provide notice to PHPP of the possibility to perform an unannounced site visit.

9. In response to staff turn-over, the HCH/FH program will require notice from PHPP (within 10 days) of staff changes involving services provided under this contract, and a plan on how to move forward to resolve the issue. HCH/FH staff will also want to meet with new staff members soon after they have started to orient them with the contract and program, including contracting and related staff.
10. Provide the HCH/FH Program with the schedule of sites and times for the Mobile Clinics, and provide updates when that schedule changes, including temporary suspension of the schedule due to staffing, van maintenance, etc.

V. Amount and Source of Payment

PHPP shall be paid \$330.00 (THREE HUNDRED THIRTY DOLLARS) for each unduplicated individual who meets the homeless criteria and receives primary health care services, up to a maximum of 1,000 unduplicated homeless individuals per year.

PHPP shall be paid \$725.00 (SEVEN HUNDRED TWENTY-FIVE DOLLARS) for each unduplicated individual who meets the formerly incarcerated and homeless criteria and receives primary health care services or is a homeless resident of Maple Street Shelter and receives primary health care services at Maple Street Shelter, up to a maximum of 210 unduplicated individuals per year.

PHPP shall be paid \$10,000.00 upon submission of a Data Collection Progress Report (due by May 20, 2019) for review and acceptance. The Progress Report will detail action steps taken, research findings, scheduled meetings, and subsequent action steps that will be taken, in continuation of the Data Collection Plan and Progress Reports from 2018. Retrieving and automating data for collection is dependent on Business Intelligence Group's capacity which is separate from payments tied to PHPP's submission of the Data Collection Progress Reports.

PHPP shall be paid \$15,000.00 upon submission of a Revenue Investigation Plan (due June 30, 2019) and Revenue Generation Report (due by October 15, 2019) for review and acceptance. The Report should identify all available revenue sources to PHPP and make recommendations to maximize revenue to support the delivery of primary care services on the Mobile Clinic.

The total amount of HCH/FH funding for primary health services paid under this MOU, will not exceed \$989,500 (NINE HUNDRED EIGHTY-NINE THOUSAND FIVE HUNDRED DOLLARS).

January 1, 2019 – December 31, 2019

Budget Overview	Service	Unduplicated Maximum	Payment per Unit
Must be unduplicated across all two categories and invoiced only once in one category	Primary Care Services to Homeless on Mobile Clinic	1,000 patients	\$330/patient
	Primary Care services to formerly incarcerated and homeless individuals, or to homeless residents of Maple Street Shelter who receive services at Maple Street Shelter	210 patients total (include 50 patients at Maple Street)	\$725/patient
Data Collection Report	Progress Report (due May 20 th , 2019)	1 Report	\$10,000
Revenue Investigation Plan	Plan (due June 30, 2019)	1 Plan	\$5,000
Revenue Generation Report	Report (due October 15, 2019)	1 Report	\$10,000

January 1, 2020 – December 31, 2020

Budget Overview	Service	Unduplicated Maximum	Payment per Unit
Must be unduplicated across all two categories and invoiced only once in one category	Primary Care Services to Homeless on Mobile Clinic	1,000 patients	\$330/patient
	Primary Care services to formerly incarcerated and homeless individuals, or to homeless residents of Maple Street Shelter who receive services at Maple Street Shelter	210 patients total (include 50 patients at Maple Street)	\$725/patient

SIGNATURES

Jim Beaumont, Director of Health Care for the
Homeless/Farmworker Health Program
San Mateo Medical Center

Date

David McGrew
Chief Financial Officer
San Mateo Medical Center

Date

Chester J. Kunnappilly, MD
Chief Executive Officer
San Mateo Medical Center

Date

Anessa Farber, Finance Services Manager
Public Health, Policy and Planning Fiscal Officer

Date

Cassius Lockett, Director of Public Health,
Policy and Planning

Date

Memorandum of Understanding Between
San Mateo Medical Center
And
Health System, Public Health, Policy and Planning Division

The purpose of this Memorandum of Understanding (MOU) is to memorialize the agreement between the San Mateo Medical Center (SMMC) and the Public Health, Policy and Planning Division of the San Mateo County Health (PHPP), regarding the provision of primary health care services through Health Care for the Homeless/Farmworker Health Program funding. These funded services will be provided by PHPP's Mobile Health Clinic at locations including shelters, on the streets, in transitional housing programs, at rural farms, and other places in San Mateo County where there are individuals who are homeless, at-risk of being homeless, farmworkers and farmworker family members.

I. Background Information

SMMC is a 509-bed public hospital and clinic system fully accredited by The Joint Commission. SMMC operates outpatient clinics throughout San Mateo County, an acute-care hospital, and long-term care facilities in San Mateo and Burlingame. SMMC serves the health care needs of all residents of San Mateo County, with an emphasis on education and prevention, and without regard for ability to pay. SMMC is part of San Mateo County Health and receives financial support from the San Mateo County Health Foundation.

The Health Care for the Homeless/Farmworker Health (HCH/FH) Program is a program within SMMC. The HCH/FH Program oversees the provision of primary health care, dental health care, behavioral health care, and supportive and enabling services to individuals and families who are homeless or at-risk of being homeless, and to the farmworker community in San Mateo County. In order to ensure access to a continuum of services for individuals in the homeless and farmworker communities, the HCH/FH Program utilizes federal funding under Section 330(h & g) of the Public Health Service Act to provide Primary Health Care Services to these individuals through PHPP.

II. Goals and Objectives

Goal: The Street and Field Medicine Service is an initiative of the HCH/FH Program and PHPP through its Mobile Clinic. The Street and Field Medicine Team will provide high-quality medical assessments and treatments, health screening and education, and appropriate primary care and specialty care referrals for up to 135 unduplicated unsheltered homeless and farmworker individuals in the areas where they live and

work throughout San Mateo County through 270 encounters each year. An unsheltered homeless person is an individual living 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.

PHPP shall work to achieve the following objectives during the term of this MOU:

Objective 1: To provide initial primary care services in the field to up to 135 unduplicated unsheltered street homeless individuals and farmworkers, including family members of farmworkers, who are not accessing existing medical resources or are otherwise in immediate need through at least 270 encounters each year.

Outcome Measure a) At least 75% of unsheltered homeless individuals and farmworkers, including family members of farmworkers, seen each year will have a health assessment for chronic medical conditions and physical examination performed. The physical exam will be indicated by diagnostic code Z00.00 or Z00.01.

Objective 2: To screen unsheltered street homeless individuals and farmworkers, including family members of farmworkers, in the field for depression given its high prevalence in these communities.

Outcome Measure a) At least 75% of unsheltered homeless individuals and farmworkers, including family members of farmworkers, seen each year will have a formal Depression Screening performed as part of their initial health assessment.

Objective 3: To provide more intensive primary care services in the field to unsheltered street homeless individuals and farmworkers, including family members of farmworkers with chronic medical illnesses.

Outcome Measure a) At least 75% of unsheltered homeless individuals and farmworkers, including family members of farmworkers, with an existing diagnosis of Type 1 or Type 2 diabetes mellitus seen each year will have their diabetes addressed during their visit.

Outcome Measure b) At least 75% of unsheltered homeless individuals and farmworkers, including family members of farmworkers, seen each year under this MOU with an existing diagnosis of Hypertension will have their Hypertension addressed during their visit.

Objective 4: To provide appropriate referrals to primary care clinical services to unsheltered homeless individuals and farmworkers, including family member of farmworkers, who do not have established primary care providers.

Outcome Measure a) At least 50% of unsheltered homeless individuals and farmworkers, including family members of farmworkers, seen each year under this MOU will be referred to primary care services within San Mateo County Health.

Objective 5: To provide women's health services to female farmworkers, including female family members, who have limited access to women's health services.

Outcome Measure a) At least 20% of female patients seen each year will be provided a cervical cancer screening/Pap test.

Outcome Measure b) As a new service effort, PHPP will count the number of unduplicated women who access to the Women's Health Services pilot. As part of the quarterly report, PHPP will provide a narrative of the services delivered and the Women's Health pilot experience based on a minimum of five (5) chart reviews per quarter. In addition, PHPP will work with the Business Intelligence Group to implement and retrieve data for women's health services, which may include:

- 1) Pap smears/pelvic exams;
- 2) STD screenings and treatments;
- 3) Pregnancy tests and pregnancy option counseling;
- 4) Women's health acute issues (vaginal/pelvic complaints etc.)
- 5) Birth Control counseling and administration of selected method

III. Term of Agreement

The term of this MOU shall be from January 1, 2019 through December 31, 2020.

IV. Responsibilities

The HCH/FH Program is responsible for the following under this MOU:

1. Monitor the performance of PHPP to assure it is meeting its requirements.
2. Review, process, and monitor monthly invoices.
3. Review quarterly reports to track progress on goals and objectives.

4. Provide technical assistance to the Mobile Clinic related to program development, data collection, or other HCH/FH Program related issues as needed.
5. If determined by HCH/FH, the MOU may require an amendment upon HCH/FH's review of the MOU expenditures after the second quarter of the MOU period.

PHPP is responsible for the following under this MOU:

1. All demographic information will be obtained from each homeless and farmworker individual receiving enabling services by the Mobile Clinic during the agreement period. This data will be submitted to the HCH/FH Program with the monthly invoice. **This may include homeless and farmworker individuals for whom PHPP is not reimbursed.** PHPP will also assess and report each individual's farmworker status as defined by the Bureau of Primary Health Care (BPHC).
2. A monthly invoice detailing the number of new unduplicated individuals served in the previous month and the total encounters provided to all homeless individuals in this same time period will be submitted to the HCH/FH Program by the 10th of the following month. Invoices shall be sufficiently detailed to allow for tracking an individual to their provided demographic data.
3. Quarterly reports providing an update on progress made on the goals, objectives, and outcome measures under this MOU shall be submitted no later than the 15th of the month following the completion of each calendar quarter throughout the contract.
4. Participate in planning and quality assurance activities related to the HCH/FH Program.
5. Participate in HCH/FH Provider Collaborative Meetings, Quality Improvement Committee meetings, and other workgroups as requested.
6. Participate in community activities that address homeless issues (i.e., Homeless One Day Count, Homeless Project Connect).
7. Provide active involvement in the Bureau of Primary Health Care Performance Review Process.
8. Site visits will occur at a minimum of on an annual basis, to review patient records and program operations, to verify the accuracy of invoicing and to assess the documentation of patient activities/outcome measures. The HCH/FH Program will work with PHPP to try and accommodate

scheduling for routine site visits but may be required to unilaterally schedule site visits. The HCH/FH Program will provide PHPP with a minimum notice of two (2) weeks for routine site visits. If the HCH/FH Program has identified issues, such as, but not limited to:

- Lack of timely reporting, especially repeatedly
- Multiple invoicing errors: billings for duplicates; spreadsheet and invoice don't match; etc.
- Ongoing difficulties in scheduling routine site visits
- Complaints or reports that raise concerning issues; etc.,

The HCH/FH Program will advise PHPP of the issue and provide notice to PHPP of the possibility to perform an unannounced site visit.

9. In response to staff turn-over, the HCH/FH Program will require notice from PHPP (within 10 days) of staff changes involving services provided under this contract, and a plan on how to move forward to resolve the issue. HCH/FH staff shall be permitted to meet with new staff members promptly after they have started to orient them with the contract and program, including contracting and related staff.

V. Amount and Source of Payment

PHPP will be paid \$1,850.00 (ONE THOUSAND EIGHT HUNDRED FIFTY DOLLARS) for each unduplicated individual who meets the homeless or farmworker criteria and receives primary health care services, up to a maximum of 135 unduplicated homeless and farmworker individuals per year. The total amount of HCH/FH funding for primary health services paid under this MOU will not exceed \$499,500 (FOUR HUNDRED NINETY-NINE THOUSAND FIVE HUNDRED DOLLARS).

January 1, 2019 – December 31, 2019

Budget Overview	Service	Unduplicated Maximum	Payment per Unit
Must be unduplicated	Primary Care and Specialty Care referrals unsheltered homeless and farmworker individuals in the areas where they live and work	135 patients	\$1,850/patient

January 1, 2020 – December 31, 2020

Budget Overview	Service	Unduplicated Maximum	Payment per Unit
Must be unduplicated	Primary Care and Specialty Care referrals unsheltered homeless and farmworker individuals in the field where they live and work	135 patients	\$1,850/patient

SIGNATURES

 Jim Beaumont, Director of Health Care for the Homeless/Farmworker Health Program
 San Mateo Medical Center

 Date

 David McGrew
 Chief Financial Officer
 San Mateo Medical Center

 Date

 Chester J. Kunnappilly, MD
 Chief Executive Officer
 San Mateo Medical Center

 Date

 Anessa Farber, Finance Services Manager
 Public Health, Policy and Planning Fiscal Officer

 Date

 Cassius Lockett, Director of Public Health,
 Policy and Planning

 Date

TAB 5

**Request to
Approve QI Plan**



DATE: April 11th, 2019

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

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

SUBJECT: QI COMMITTEE REPORT

The San Mateo County HCH/FH Program QI Committee did not meet in March. The following are several QI updates:

- **2019 QI Annual Plan:** The QI/QA Committee finalized the 2019 QI Annual Plan and have submitted it to the Co-Applicant Board for approval.
- **HCH/FH Program Needs Assessment:** The HCH/FH Program has begun preliminary planning meetings for the biennial program needs assessment. The assessment will begin in April with a tentative completion date of June 30th, 2019. The QI/QA Committee will review and approve initial planning efforts at the April 25th, 2019 meeting.
- **2018 HCH/FH Program Patient Satisfaction Survey Report:** The 2018 Patient Satisfaction Survey Report has been completed. Surveys were administered by contracted agencies in September of 2018, and results were analyzed by the HCH/FH Program Clinical Services Coordinator. The report will be discussed at the next QI/QA Committee meeting.
- **AIMS One-Time Funding SUD-MH Patient Education Materials:** JSI completed the Substance Use Disorder patient education material documents as part of the AIMS One-Time Grant Funding and were forwarded to collaborators. The documents are currently in the process of being translated to Spanish. The QI/QA Committee will discuss the dissemination plan at the April 25th meeting.

The next HCH/FH QI Committee meeting will be on April 25th, 2019.



**SAN MATEO
COUNTY HEALTH**
All together better.

HCH/FH Program QI/QA Committee

2019-2020 QI Annual Plan

Quality Improvement Purpose

To evaluate and ensure the effectiveness of health care provided to homeless and farmworker patients and families, achieve success in meeting utilization targets, meet or exceed clinical and financial performance objectives, and provide the highest levels of patient satisfaction.



Major Changes



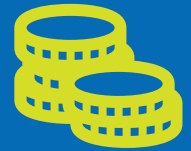
- QI Plan reporting time period is now April 2019 to April 2020
- Goals will be based on clinical performance data from 2018 UDS Report



- Inclusion of additional clinical performance goals from SAC/BPR (grant application and report)
- Patient grievances and provider satisfaction



- 4 clinical quality measures of focus selected based on:
 1. Hospital efforts
 2. National quartile ranking
 3. Feasibility of “moving the needle”



- Structure reflects HRSA quality improvement initiatives to improve the overall quality, efficiency, and value of health care services

Clinical Quality Measures (CQM)	2016*	2017*	2018*	SAC/BPR Goals	Healthy People 2020 Goals	SMMC Goals (Prime/QIP)	CA 330 Programs	2017 Adjusted Quartile Ranking**
Cervical Cancer Screening	60%	63%	59%	70%	93%	70%	60%	1
Diabetes	54%	72%	71%	75%	85%	65%	66%	1
Prenatal Care 1st Trimester	65%	50%	44%	80%	78%	----	78%	4
Depression Screening & Follow-up	37%	41%	27%	65%	<i>No comparable measure</i>	----	64%	4

*Data from UDS Report of corresponding year

**Ranking (from 1 to 4) of health center clinical performance compared to other health centers nationally

Clinical Quality Measures of Focus

Goals (Detailed)

1. Cervical Cancer Screening

- a. **Goal: Improve the percentage of women ages 21 to 68 with a medical visit who are screened for cervical cancer in 2019 by 5%.**
- b. Criteria
 - i. Numerator: Women with one or more screenings for cervical cancer using either of the following criteria:
 1. Women age 23-64 who had cervical cytology during the measurement period or the 2 years prior to the measurement period
 2. Women age 30-64 who had cervical cytology/HPV during the measurement period or the 4 years prior to the measurement period
 - ii. Denominator: Women 23-64 with a medical visit during the measurement period

2. Diabetes

- a. **Goal: Improve the percentage of known diabetic patients ages 18 to 75 with a medical visit who had HbA1c < 9.0% in 2019 by 5%.**
- b. Criteria
 - i. Numerator: Patients whose most recent HbA1c level during the measurement year is greater than 9.0% or who had no test conducted during the measurement period
 - ii. Denominator: Patients 18 to 75 years of age with a medical visit during the measurement period

3. Prenatal Care in the First Trimester

a. Goal: Improve the percentage of prenatal care patients who enter prenatal care during their first trimester in 2019 by 5%.

b. Criteria

- i. Numerator: Women beginning prenatal care at the health center or with a referral provider, or with another prenatal care provider during the first trimester.
- ii. Denominator: Women seen for prenatal care during the year.
- iii. Trimester of entry based on last menstrual period

4. Depression Screening and Follow-up

a. Goal: Improve the percentage of patients ages 12 and older screened for depression on the date of the visit using an age-appropriate standardized depression screening tool, and, if screening is positive, for whom a follow-up plan is documented on the date of the positive screen in 2019 by 5%.

b. Criteria

- i. Numerator: Patients screened for depression on the date of the visit using an age-appropriate standardized tool, and, if screened positive for depression, a follow-up plan is documented on the date of the positive screen.
- ii. Denominator: Patients aged 12 years and older with at least one medical visit during the measurement period.

Other Measures of Focus

The QI/QA Committee will monitor and review the following measures:

Service Area Competition (SAC)/Budget Progress Report (BPR) Clinical Performance Measures



- i. Percentage of farmworker patients ages 13 to 64 with one or more medical visits during the measurement year with documented, current tetanus, diphtheria, acellular pertussis (Tdap) immunizations
- ii. Percentage of female farm worker patients ages 13 to 50 with one or more medical visits during the measurement year with documented family planning education and counseling.



Monthly patient grievances received by the San Mateo Medical Center

Select UDS Annual Report Clinical Quality Measures



- i. Hypertension
- ii. Child Weight Assessment
- iii. Adult Weight Assessment
- iv. Colorectal Cancer Screening
- v. Tobacco Use and Cessation
- vi. Coronary Artery Disease (CAD): Lipid Therapy
- vii. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

TAB 6
Request to
approve
Travel Requests



SAN MATEO COUNTY HEALTH

SAN MATEO MEDICAL CENTER

DATE: April 11, 2019

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

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 and Jim Beaumont, Director HCH/FH Program

SUBJECT: TRAVEL REQUESTS

The HCH/FH Program (Program) Co-Applicant Board (Board) approved policy regarding **travel reimbursement for Non-Board members** requesting funds to travel for conferences (March 10, 2016) and according to the policy:

It is understood that enhancing the knowledge and skills of those working with the homeless and farmworkers, and their families, for the maintenance and improvement of their health is a beneficial activity for the HCH/FH Program and the populations that it serves. Further, it is understood that the HCH/FH Program has a limited budget, and for training and skills development, the primary focus is on doing so for the Co-Applicant Board members, to enhance their capabilities in Board decision-making, and Program Staff, in enhancing their capabilities in program operations:

- For national or regional events outside of California, the Board may choose to consider the equivalent of full travel reimbursement of up to one (1) individual.

The program has already approved 2 Board members and 4 non-board members from attending the NHCHC. The program has received an additional 2 request from Non-Board member for the upcoming 2019 National Health Care for Homeless Conference in D.C. (May 22-25): Brighton Ncube, Ambulatory Director and Amanda Hing-Hernandez Nurse Practitioner with Mental Health Primary Care at North County:

Name	position/role	benefit of attendance	request (ex: registration)	Request amount	org contribution (optional)
Amanda Hing-Hernandez	Nurse practitioner with Mental Health Primary Care at the North County Clinic	I specifically work with patients that have serious mental illness and have been linked to regional behavioral health services. As such, many of my patients are chronically homeless or deal with intermittent homelessness. Our team also sees patients that are in and out of Maguire, thus have to make jail-to-community care transitions. I am particularly interested in learning about care models for this population---individuals returning from incarceration.	registration	I could use my CME funds for the registration	\$500-670
			flight	\$430	
			hotel	\$700	
			Meals/per diem	\$160	

TOTAL \$1290

Name	position/role	benefit of attendance	request (ex: registration)	Request amount	org contribution (optional)
Brighton Ncube	Ambulatory Director		registration	\$ 610.00	
			flight	\$600.00	
			hotel	\$735.00	
			Meals/per diem	\$266.00	

TOTAL \$2,211.00



TAB 7

**Request to
Approve new
Board
membership**



DATE: April 11, 2019

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

FROM: Board Membership/Recruitment Committee
HCH/FH Program

SUBJECT: BOARD NOMINATION FOR VICTORIA SANCHEZ DE ALBA AND SUZANNE MOORE

The Co-Applicant Board of the HCH/FH Program may periodically elect new members to the Board as desired and in accordance with Board Bylaws.

The Board Composition Committee has interviewed a candidate it wishes to present to the Board. Summaries of Board Composition Committee evaluation and recommendation for each candidate accompany this TAB.

This request is for the approval of new Board members to enlarge the knowledge and expertise available to the Board for its review and planning duties.

Board Recruitment/membership committee members interviewed Victoria on April 4th on the phone. Victoria has a passion for the farmworker community and she will be an advocate for their healthcare needs. She has been advocating for social justice and equality for much of her life and presently works as a Public Relations/Communications professional continuing that work with various sectors of the community. Victoria has done outreach to coastside farmworkers and she has a good grasp of their lives working in the agriculture sector. Victoria served as a farmworker along with her family in Monterey County. Victoria expressed an interest on working on a subcommittee.

Suzanne Moore served as a Family Nurse Practitioner at Daly City and South San Francisco Clinics and provided care to mostly adults with chronic mental health issues. She remains active in her community volunteering for organizations such as: Fair Rents 4 Pacifica, Pacifica Housing 4 All, Anti-Displacement Coalition of San Mateo, and Pacifica Resource Center.

The Board Recruitment/Membership Committee nominates Victoria Sanchez De Alba and Suzanne Moore for a seat on the Co-Applicant Board of the Health Care for the Homeless/Farmworker Health Program.

ATTACHMENT:

- VICTORIA SANCHEZ DE ALBA APPLICATION
- SUZANNE MOORE APPLICATION



**Board Composition Committee
Nomination to Board**

**Welcome to the San Mateo County Health Care for the Homeless/Farm Worker Health Co-Applicant
Board Application for Board Membership.**

1. What is your name, residence address and contact information (phone and email)?

Victoria Sanchez De Alba
482 San Pablo Terrace
Pacifica, CA 94044

650-270-7810 / victoria@dealba.net

2. What is your place of employment and title, if applicable?

Entrepreneur / self employed
De Alba Communications
President

3. What experience and/or skills do you have that would make you an effective member of the Board? (Skills & experiences that will be of benefit to the Board.)

I've been advocating for social justice and equality for all since I was a young girl working alongside my family in the agricultural fields of the Salinas Valley harvesting produce and fruit. And now in my career as a PR/Communications professional, I work on campaigns of social impact for various sectors in our community.

The following Bilingual English and Spanish Health campaigns include:

*National Heart Health Month Campaign” for Sequoia Hospital in Redwood City.

*The Latina Breast Cancer Agency - Mujeres Cuidando Mujeres / Women Caring for Women” Program focused on breast cancer awareness and the importance of early detection. San Francisco & San Mateo County.

*UC Davis Latino Mental Healthcare Disparities Report Unveiled. This was a community-based research study, the UC Davis Center for Reducing Health Disparities delved into the complex issues of Latinos and mental health.

*“Take Charge of your Heart Health: Know your numbers” for UC Davis Health Systems.

*"The nationwide “Spanish and Multi-Language Prescription Label Service” public awareness campaign for Walgreens.

I received my Bachelor of Arts in Communications-Mass Media, with emphasis in Media Law, from the University of San Francisco, San Francisco, CA.

4. Why do you wish to be a Board member?

Because I care and I bring valuable perspectives for the SMC Health Care for the Homeless/Farmworker Health Program. In essence, I want to help improve people's lives, as I have always been passionate about helping to create a more socially responsible world.

5. Are you homeless, formerly homeless, a farmworker, retired farmworker, or a dependent of a farmworker? (Not a requirement)

As a young girl I worked in the fields with my family, until I graduated from high school, harvesting produce and fruit during my summer vacations. I witnessed health issues and social inequities related to working conditions such as pesticide poisoning and law enforcement abuses. At a young age, I learned "things were not right." From then on, my life goal was to help create a more equitable world and help raise public awareness via mass media of the harsh conditions of farmworkers' lives.

My father died of non-Hodgkin's-lymphoma (NHL), a cancer associated with pesticide exposure. Raising public awareness on this issue became an additional priority for me. I was recently nominated for The Leukemia & Lymphoma Society (LLS), San Francisco Woman of the Year candidate. My LLS candidate campaign was the first in the U.S. to put the spotlight on the environmental and health concerns related to farmworkers exposed to pesticides. My work came from the heart to honor my father and all of the farmworkers who risk their lives to feed the world. Pacifica Magazine and the SF Chronicle featured my work: Speaking up - Pacifica Resident Gives Voice to Farmworkers / Farmworkers encounter pesticide dangers.

We highly encourage applicants who are homeless, formerly homeless, a farmworker, retired farmworker, or a dependent of a farmworker.

The Board requires a member to be a **resident of San Mateo County**.

Federal regulations require that Board members observe the following Conflict of Interest policy: Health Center bylaws or written corporate Board-approved policy include provisions that prohibit conflict of interest by Board members, employees, consultants, and those who furnish goods or services to the health center.

- No Board member shall be an employee of the health center or an immediate family member of an employee. The Chief Executive may serve only as a non-voting ex-officio member of the Board.
(45 CFR Part 74.42 and 42 CFR Part 51c.304b)

**Board Composition Committee
Nomination to Board**

**Welcome to the San Mateo County Health Care for the Homeless/Farm Worker Health Co-Applicant
Board Application for Board Membership.**

1. What is your name, residence address and contact information (phone and email)?
Suzanne Moore, 11 Milagra Court Pacifica 94044. (650)557 0867. suzyqettu2@gmail.com

2. What is your place of employment and title, if applicable?
Retired Family Nurse Practitioner

3. What experience and/or skills do you have that would make you an effective member of the Board? (Skills & experiences that will be of benefit to the Board.)

As a former San Mateo County employee, I practiced at the Daly City and South San Francisco Clinics as a primary care provider. My client panel consisted mostly of adults with chronic mental health issues - and especially at the Daly City Clinic, I worked closely with Behavioral Health. I feel this direct experience could prove useful to the Board, though I acknowledge I will have a learning curve.

At the end of my clinical career, I realized that many of my clients had their health directly impacted by the housing crisis. Upon retirement, I became more active as a community volunteer:

- Volunteer coordinator for Fair Rents 4 Pacifica, Steering Committee member for Pacifica Housing 4 All as well as their Treasurer;
- Member of the Anti-Displacement Coalition of San Mateo,
- Outreach volunteer for Pacifica Resource Center.

In my volunteer efforts, I have come to learn that the housing crisis in my home town demonstrates itself in increased homelessness, displacement, worker shortages, and long commutes/transportation problems. I am hoping that participation in HCH/FW may make a difference for every community in San Mateo.

4. Why do you wish to be a Board member?
To learn, to share, and to make a difference.

5. Are you homeless, formerly homeless, a farmworker, retired farmworker, or a dependent of a farmworker? (Not a requirement)
No

We highly encourage applicants who are homeless, formerly homeless, a farmworker, retired farmworker, or a dependent of a farmworker.

The Board requires a member to be a **resident of San Mateo County**.

Federal regulations require that Board members observe the following Conflict of Interest policy: Health Center bylaws or written corporate Board-approved policy include provisions that prohibit conflict of interest by Board members, employees, consultants, and those who furnish goods or services to the health center.

- No Board member shall be an employee of the health center or an immediate family member of an employee. The Chief Executive may serve only as a non-voting ex-officio member of the Board.
(45 CFR Part 74.42 and 42 CFR Part 51c.304b)

TAB 8
Director's
Report



SAN MATEO COUNTY HEALTH

**SAN MATEO
MEDICAL CENTER**

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

DATE: April 11, 2019

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

FROM: Jim Beaumont Director, HCH/FH Program

SUBJECT: DIRECTOR'S REPORT & PROGRAM CALENDAR

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

1. Grant Conditions/Operational Site Visit (OSV) Report

On March 28, 2019, we received a NOA lifting one of the clinical grant conditions (relating to privileging for OLCPs). In addition, we have had numerous correspondence with our Project Officer on the other two (2) clinical grant conditions, one of which we understand will also be lifted imminently, and for the other, we have collected the necessary information and documents to submit. HRSA's processing will require them to issue a 60-day grant condition to create the submission environment for us to provide the information and documents. This should occur within the next week or so.

We have yet to hear any further information on the grant conditions related to our agreement with Ravenswood Family Health Center (RFHC). Our Project Officer has confirmed that those two (2) conditions are still under review with HRSA's Policy Branch.

2. HRSA Funding Opportunities

As anticipated, HRSA released two (2) Funding Opportunities; 1.) Oral Health Infrastructure and 2.) Integrated Behavioral Health Services Expansion. As requested by the Board, the information on these FOs was forwarded to each individual Board member for review in order to better prepare for a substantive discussion at today's Board meeting, since there is a very small window of time in which to develop the submissions for these FOs. That discussion is scheduled elsewhere on today's agenda.

Seven Day Update

ATTACHED:

- Program Calendar



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

EVENT	DATE	NOTES
<ul style="list-style-type: none"> Board Meeting (April 11, 2019 from 9:00 a.m. to 11:00 a.m.) QI Meeting Provider Collaborative meeting Needs Assessment 	April	@ San Mateo Medical Center
<ul style="list-style-type: none"> Board Meeting (May 9, 2019 from 9:00 a.m. to 11:00 a.m.) 2019 NHCHC conference in DC- May 22-25 Review UDS submission on Board agenda SMMC annual audit review Funding opportunities (Oral health and IBH) applications due 	May	@ San Mateo Medical Center
<ul style="list-style-type: none"> Board Meeting (June 14, 2019 from 9:00 a.m. to 11:00 a.m.) QI Meeting 	June	
<ul style="list-style-type: none"> Board Meeting (July 11, 2019 from 9:00 a.m. to 11:00 a.m.) Provider Collaborative meeting 	July	
<ul style="list-style-type: none"> Board Meeting (August 8, 2019 from 9:00 a.m. to 11:00 a.m.) QI Meeting SAC/BPR due Approve program annual budget 	August	

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

TAB 9

**Budget &
Finance Report**



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

DATE: April 11, 2019

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

FROM: Jim Beaumont
Director, HCH/FH Program

SUBJECT: HCH/FH PROGRAM BUDGET and FINANCIAL REPORT

Estimated grant expenditures to-date are \$711,607. In addition, we have an estimate \$4,554 in expenditures for items not claimable on the grant, for total Program estimated expenditures of \$716,161.

Current projections for year-end are, at best, guesses at this point in the year. Our current projection is that total grant expenditures will be \$2,923,734 by the end of the year, which would leave an estimated \$29,916 in unexpended grant funds. However, approximately \$138,000 of our grant funds have some level of spending restrictions, so we have an estimate of being potentially \$100,000 over-extended with our grant funds. We expect this number to come down as we get further into the year and can clearly identify where we have been able to expend the restricted funds and having a better idea on the rate of expenditures for our contracts and MOUs.

Based on the current numbers, we would not be able to recommend any new or additional expenditures.

Attachment:

- GY 2019 Summary Grant Expenditure Report Through 03/31/19



GRANT YEAR 2019

Details for budget estimates	Budgeted [SF-424]	To Date (03/31/19)	Projection for GY (+~39 weeks)	Projected for GY 2020
EXPENDITURES				
<u>Salaries</u>				
Director				
Program Coordinator				
Medical Director				
Management Analyst				
new position, misc. OT, other, etc.	554,324	144,367	576,680	582,035
<u>Benefits</u>				
Director				
Program Coordinator				
Medical Director				
Management Analyst				
new position, misc. OT, other, etc.	224,198	50,456	183,887	235,407
<u>Travel</u>				
National Conferences (2500*8)	20,000		30,000	15,000
Regional Conferences (1000*5)	5,000	1,859	2,500	5,000
Local Travel	1,000	47	1,000	1,000
Taxis	3,500	160	1,500	3,000
Van & vehicle usage	3,000	197	1,250	2,500
	32,500	2,263	36,250	26,500
<u>Supplies</u>				
Office Supplies, misc.	7,500	1,735	7,250	10,000
Small Funding Requests	7,500	1,735	7,250	10,000
<u>Contractual</u>				
2017 Contracts		55,827	55,827	50,000
2017 MOUs		23,540	23,540	45,000
Current 2018 contracts	951,500	245,388	905,500	951,500
Current 2018 MOUs	872,000	179,455	825,000	872,000
ES contracts (AIMS/SUD-MH)	262,500	4,350	262,500	232,500
---unallocated---/other contracts				
	2,086,000	508,560	2,072,367	2,056,000
<u>Other</u>				
Consultants/grant writer	30,000		25,000	30,000
IT/Telcom	12,000	1,926	12,000	12,000
New Automation			0	-
Memberships	4,000	2,300	2,300	2,000
Training	10,000		7,500	3,000
Misc	750		500	500
	56,750	4,226	47,300	47,500
TOTAL	2,961,272	711,607	2,923,734	2,957,442
<u>GRANT REVENUE</u>				
Available Base Grant *	2,648,400		2,648,400	2,755,454
Available Expanded Services Awards **	305,250		305,250	
HCH/FH PROGRAM TOTAL	2,953,650	711,607	2,953,650	2,755,454
BALANCE	(7,622)	PROJECTED AVAILABLE	29,916	(201,988)
				based on est. grant of \$2,755,454
* includes \$13,196 of QI targeted funding				
** includes \$175,000 of one-time funding (SUD-MH) (\$125,250 unallocated)				
Total special allocation required	\$ 138,446			
<u>Non-Grant Expenditures</u>				
Salary Overage	13090	4,039	13,090	13,750
food	2500	515	2,500	2,500
incentives/gift cards	1,000		1,000	1,000
	16,590	4,554	16,590	17,250
TOTAL EXPENDITURES	BUDGETED 2,977,862	PROJECTED 716,161	2,940,324	NEXT YEAR 2,974,692

MOUs		Est. to date
bhrs	90,000	16500
phpp mv	532,250	76005
phpp sm	249,750	86950
	872,000	179455

CONTRACTS		
lm	296,500	83505
puente	183,500	48050
rfhc pc	107,100	19,737
rfhc d	54,725	13,134
rfhc e	97,000	19,982
sh	81,000	19,760
sonrisas	131,675	41,220
	951,500	245,388.00

Expanded Services Contracts		
el centro	82,500	4350
sv	180,000	-
	262,500	4,350