ANNUAL REPORT 2023

County of San Mateo

Health Care for the Homeless & Farmworker Health Program

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PROGRAM BACKGROUND

OUR MISSION

The San Mateo County Health Care for the Homeless/Farmworker Health Program is dedicated to serving homeless and farmworker individuals and families by ensuring access to comprehensive primary health care, dental health care, and behavioral health services in a supportive, welcoming, and accessible environment.

OUR VALUES

Access
Providing full access to health care and social services for homeless and farmworker individuals and their families.

Dignity
Delivering respectful, culturally competent services that address both physical and behavioral health needs.

Integrity
Valuing homeless and farmworker individuals and their families as partners in their health care decisions.

Innovation
Continuously evolving services to incorporate current best practices and technological advances.

INTRODUCTION

San Mateo County's Health Care for the Homeless/Farmworker Health Program (HCH/FH) has been a cornerstone of community health initiatives since its inception in 1991. Initially focused on serving individuals experiencing homelessness, the program expanded its purview in July 2010 to encompass the farmworker population and their families/dependents.

Funded by the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) under Sections 330(g) and 330(h) of the Public Health Service Act, HCH/FH operates to provide vital services to medically underserved populations.

PROGRAM OVERVIEW

HCH/FH operates under the joint governance of an independent Co-Applicant Board and the San Mateo County Board of Supervisors. It functions as a conduit for individuals experiencing homelessness or working as farmworkers (along with their families) to access critical health services through various touch points within San Mateo County.

These touch points include San Mateo Medical Center's (SMMC) hospital and clinics, as well as numerous County and community-based organizations offering outpatient health services, regardless of insurance or documentation status. The program's compliance with HRSA regulations has granted SMMC Federally Qualified Health Center status.

POPULATION SERVED

HRSA's definition of homelessness extends beyond traditional categories to encompass individuals in transitional or permanent supportive housing (PSH), as well as those who are doubling up (i.e., couch surfing). Similarly, the definition of farmworkers includes both seasonal and migrant workers, along with their family members.

LETTER FROM THE BOARD CHAIR

The San Mateo County Health Care for Homeless/Farmworker Health (HCH/FH) Program's mission is to serve people experiencing homelessness and farmworkers by providing access to comprehensive healthcare in a supportive, welcoming and accessible environment.

HCH/FH program is currently overseen by a Co-applicant Board comprised of 12 board members and staffed by 3 administrative staff, and a Program Director who all work tirelessly to ensure that quality healthcare is available to our most vulnerable residents. The HCH/FH program contracts with San Mateo County Health divisions, including San Mateo Medical Center, Behavioral Health & Recovery Services and Public Health Policy & Planning, and community-based organizations to provide various health related services to our people experiencing homelessness and farmworkers. The HCH/FH Board has set strategic priorities to further guide our program in the coming years.

In 2023, the HCH/FH Program provided services to 3,532 individuals experiencing homelessness and 1,268 farmworkers and their families in the coastal areas of San Mateo County. HCH/FH serves these populations with medical, dental and other services in accessible locations where people experiencing homelessness and farmworkers can receive timely care for physical and behavioral health needs. Homelessness individuals and farmworkers and their families are valued and considered a partner in making decisions regarding their health care.

Providing quality and accessible healthcare is a team effort and just one component of what's necessary to support farmworkers and people experiencing homelessness in San Mateo County. Working together with our community partners in providing comprehensive and equitable healthcare to those in need is the true definition of public service.

I am pleased to share with you what HCH/FH has been working on in 2023 to meet that important challenge and what we're looking forward to in 2024.

Robert Anderson
Health Care for the Homeless/Farmworker Health Board Chair

PARTNERS DESCRIPTION

The Health Care for the Homeless/Farmworker Health Program works with the partners and county departments listed below to ensure people experiencing homelessness, and farmworkers and their families in San Mateo County receive case management, primary care, dental care, as well as behavioral health services.

Please note that these organizations provide a range of services beyond those described here. The following information focuses specifically on the contracted services offered by the HCH/FH Program.

Abode Services
HCH/FH has contracted with Abode Services to provide medical care coordination services to individuals who have recently been housed or are preparing to move into permanent housing.

Abode Services receives referrals from Abode case managers and shelters when they identify a homeless client who is ready to transition to permanent housing. The Abode case manager then assists the individual in connecting or staying connected to primary care, behavioral health, and dental services. This program is prioritized for newly housed individuals.

Ayudando Latinos a Soñar (ALAS)
ALAS is located in Half Moon Bay, which is where the majority of farmworkers in San Mateo County reside. HCH/FH has contracted with ALAS to provide health education through the "Promotores de Salud" model, which uses "Promotores" or community health workers, to educate farmworkers and their families about health care topics and connect them to primary care.

The goal of the Promotores program is to increase farmworker knowledge of health care and facilitate connections to care. This program is prioritized for farmworkers and their families.

LifeMoves
The LifeMoves Community Health Outreach Worker (CHOW) team provides care coordination to people experiencing homelessness throughout San Mateo County, with the goal of helping them continue or establish primary care at either a San Mateo Medical Center (SMMC) or Behavioral Health Recovery Services (BHRS) clinic.

The CHOW team works closely with Street Medicine, the Health Coverage Unit, and the New Patient Connection Center to achieve this goal. This program is prioritized for people experiencing homelessness.

Puente de la Costa Sur
The Puente Community Health team provides care coordination and health insurance eligibility/enrollment services to farmworkers in the Pescadero region. This includes outreach, education, transportation, and translation services. Puente also collaborates with the Field Medicine Team to provide medical care to uninsured farmworkers. This program is prioritized for farmworkers and their families.

Sonrisas
Sonrisas provides comprehensive dental services to farmworkers and their families at Puente's Pescadero location once a week. Sonrisas and Puente work closely together to coordinate dental care for patients. This program is prioritized for farmworkers and their families.

Behavioral Health & Recovery Services (BHRS)
Health Care for the Homeless: One of the HCH/FH Program's longest standing agreements is with BHRS to provide care coordination to people experiencing homelessness with mental illness. The BHRS team assesses and links homeless clients to medical, mental health, and/or substance use treatment, acts as a liaison between clients and their health care providers, and provides peer support to homeless clients. The team works with both sheltered and unsheltered clients via referrals.

Homeless Engagement, Assessment, and Linkage (HEAL): This program began in July 2022. HEAL clinicians provide field-based mental health therapy to homeless clients who are interested in the service but not yet ready to link to a clinic. HEAL also provides groups and workshops to people experiencing street homelessness in partnership with the LifeMoves Homeless Outreach and Street Medicine Teams.

El Centro de Libertad: The HCH/FH Program has partnered with BHRS to support a contract with El Centro de Libertad. The program aims to conduct outreach and provide case management and substance use disorder education to farmworkers and their families. El Centro's Substance Use Disorder Case Manager works closely with ALAS's promotores to ensure effective and efficient support for the targeted population.

Public Health Policy & Planning (PHPP)
San Mateo County Mobile Health Clinic: A state-of-the-art van provides drop-in primary care services to people experiencing homelessness throughout San Mateo County at regularly scheduled sites.

San Mateo County Street/Field Medicine Team: To meet people where they are, this backpack medicine program provides primary care, mental health and alcohol and other drug (AOD) case management to people experiencing homelessness living on the street or in tent encampments and to farmworkers in the field.

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

San Mateo Medical Center (SMMC)

SMMC is the safety net hospital for all County residents with Medi-Cal, Medicare or San Mateo County Access and Care for Everyone (ACE) coverage. Outpatient clinics are located across San Mateo County. Anyone experiencing homelessness and/or is a farmworker or family member of a farmworker can receive health care services at any of these clinics. HCH/FH is a program within SMMC, with the program director reporting to the hospital's CEO.

Saturday Dental Clinic for Farmworkers: SMMC launched the Saturday Dental Clinic in June 2021 to provide free dental services to farmworkers who cannot easily take time off work to access dental care during the week. This monthly clinic aims to hold weekly dental clinics in the future, and the priority population for this program is farmworkers and their families.

PATIENT STORIES

Firsthand accounts submitted by providers and community partners

PHPP (Street Medicine): Pedro's Path to Recovery

Pedro, a 69-year-old homeless Spanish speaker, struggled with a chronic health condition for more than a year due to lack of access to proper treatment. Our street medicine team connected with Pedro in October 2023. Through trust-building and comprehensive care, they addressed his needs:

- Treated high blood pressure (stroke risk factor).
- Scheduled surgery for a long-standing, painful hernia.
- Connected him with cardiology and general surgery specialists.
- Provided medication management for depression.

Pedro's commitment to his recovery is showcased by his willingness to undergo pre-surgical detox with the support of our substance use case specialist, Frank Vargas.

Pedro's story exemplifies the impact of street medicine. By building trust and rapport, we connect vulnerable populations with vital healthcare services, leading to improved health outcomes. It also highlights the collaborative spirit between our team and clients.

Abode Patient Story: Pi Mo

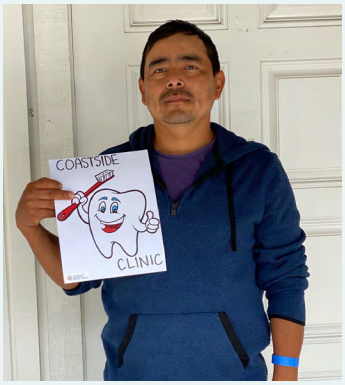
Pi Mo entered the Health Care for the Homeless (HCH) program on January 6, 2023, facing numerous health challenges. The HCH program has significantly improved his ability to navigate the healthcare system, building trust with medical providers and wellness specialists. This support enabled him to identify underlying medical issues, leading to a recent cancer diagnosis. Grateful for the program's assistance, Pi Mo now understands the importance of healthcare and medical treatment, holding himself accountable for his health.

Before joining HCH, Pi Mo struggled with missed appointments, understanding medical terminology, and lacked support and trust. For instance, untreated hip pain persisted due to his unawareness of its potential severity. Frequent ER visits were ineffective due to misunderstandings of medical instructions. The wellness specialist's guidance helped him overcome these challenges, fostering a commitment to his health.

Though hesitant initially, Pi Mo is now considering connecting with behavioral health services. He appreciates the program's broad range of resources, including behavioral health support. Today, Pi Mo is proactive in making medical appointments, connected to a team of doctors, and benefits from coordinated care and transportation provided by HCH.

Previously living in a shelter, Pi Mo now resides in stable housing without needing wraparound services and is open to ongoing medical care coordination. His story underscores the significant impact of the HCH program in improving medical care coordination, ensuring transportation to appointments, and enhancing overall health outcomes. The HCH program has enabled Pi Mo and other clients to maintain stable housing and stay connected to essential healthcare services.

Puente Ensures Prompt Dental Care for Participant in Pain



A recent interaction exemplifies Puente's commitment to responsive healthcare access for participants. A participant contacted Puente experiencing a severe toothache. Recognizing the urgency of the situation, Puente's Community Health Associate swiftly connected the participant with Coastside Dental Clinic's morning emergency drop-in hours.

The participant promptly followed through, visiting the clinic the very next day. Thanks to a referral provided by Coastside Dental Clinic, this rapid response ensured the participant received immediate dental attention for their painful toothache.

This successful encounter highlights two key points:

- **Importance of Timely Care:** Toothaches can be serious, and timely access to dental care is crucial. Puente's prompt action ensured the participant received the attention they needed.
- **Bridge to Dental Services:** Puente serves as a valuable bridge, connecting participants with essential healthcare services, even for urgent needs.

By facilitating rapid access to care, Puente plays a vital role in ensuring the well-being of its participants.

LifeMoves Patient Success Story: OsVa

OsVa had been experiencing homelessness for the last 15 years with minimal medical support. In March 2023, the LifeMoves Homeless Outreach Team (HOT) and Community Health Outreach Worker (CHOW) team encountered him at the Marsh encampment in East Palo Alto. After a month of persistent outreach, OsVa accepted services in April.

The CHOW team quickly assisted OsVa with obtaining insurance, enrolling him in ACE within two weeks. With this insurance, OsVa gained access to essential medical services. He promptly began undergoing lab tests and worked with his medical team to create a comprehensive care plan, which included scheduling hernia surgery.

Furthermore, the CHOW team referred OsVa for dental care. He diligently attended all scheduled appointments, regularly met with the street medicine team, and utilized the dental van services.

OsVa's transformation was remarkable; he began presenting himself well-groomed and dressed in his best outfits. His commitment to his health grew significantly, and he now manages it more independently.

OsVa has developed a strong relationship with his care team, who continue to provide support as needed. This journey from neglecting his health to being fully invested in it highlights the profound impact of dedicated, comprehensive healthcare services.

UTILIZATION & FINANCE

UTILIZATION OVERVIEW

4,679 UNIQUE CLIENTS

- 3.61% decrease from 2021
- 1,268 (~27%) FW
- 3,532 (~75%) PEH

34,112 VISITS

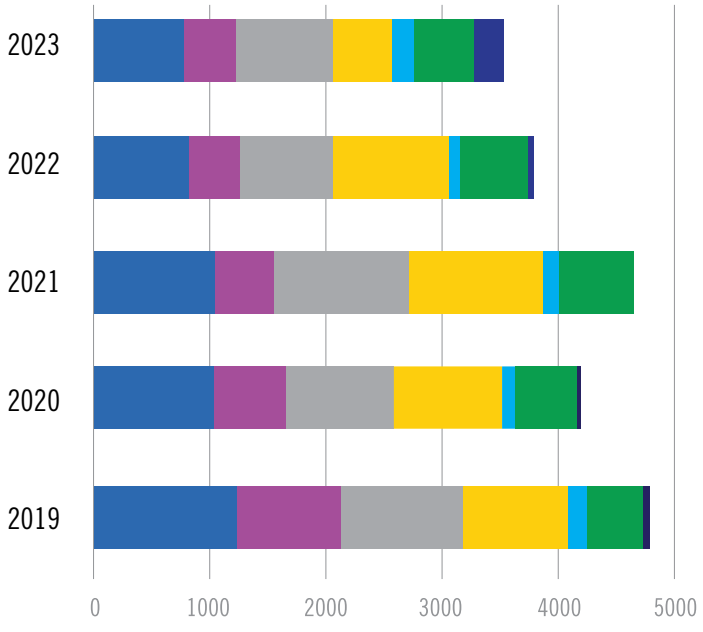
- 1.86% decrease from 2021
- 29,103 In-person visits
- 5,006 Virtual visits

In 2023 the HCH/FH Program served 4,679 unique individuals, 3,532 (~75%) of which were Patients Experiencing Homelessness (PEH), and 1,268 (~27%) Farmworkers. Of the total 4,679 unique individuals 121 identified as both PEH and Farmworker.

The total patients served in 2023 represents a 3.61% decrease from 2022 where the total was 4,854 individuals.

Of the two populations this program serves the decline in unique patients from 2022 to 2023 represents a 7% percent decline in PEH which was 3,783 in 2022, and 3,532 in 2022.

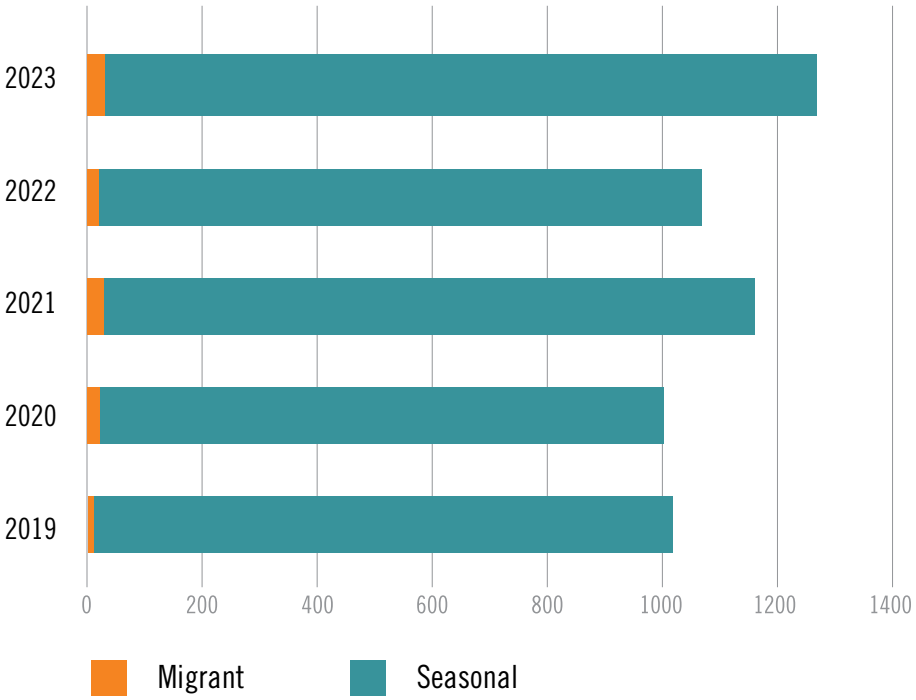
Number of patients experiencing homelessness receiving services (by living situation type)



Of the 3,532 patients experiencing homelessness in 2023, the program served:

Sheltered homeless	781
Transitional housing	445
Individuals doubling up	832
Street homeless	518
Permanent supportive housing (PSH)	183
Other arrangements	507
Unknown homeless arrangement	266

Number of farmworker patients receiving services



There was an increase in farmworkers individuals, which rose from 1,071 in 2022 to 1,268 in 2023.

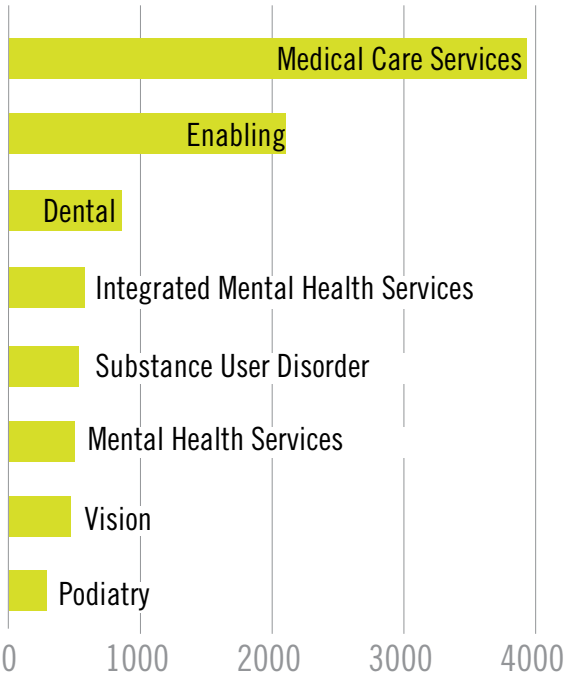
Of the two farmworker categories (seasonal and migrant), this increase was for the seasonal workers, which was 1,236 in 2023 and 1,039 in 2022.

Migrant farmworkers numbers in 2023 are unchanged from 2022, and are reported at 32 individuals.

Although the total number of unique individuals served by this program decreased from 2022, services utilization continues to remain strong, which was 34,112 visits in 2023 compared to 34,760 visits in 2022. The 34,112 visits conducted in 2023, 85% represent in-person visit (29,103) compared to 15% (5,006) virtual visits.

- Primary care is the largest service and is used by roughly 83% (3,869 of 4,679) of patients served under the HCH/FH Program.
- Enabling services, which include case management, transportation assistance, translation, navigation assistance, and more, represent the second largest service accessed by over 43% of patients (2,051 of 4,679).
- Dental services were accessed by 20% of program's total number of patients, and represent this program's investment and commitment, though two separate contracts, to making dental care accessible and available for individuals experiencing homelessness and farmworkers.
- Vision, behavioral health, and podiatry saw the smallest service utilization accessed by 11%, 12%, and 5% of total patients respectively.

Number of patients by Service Utilization (2023)



FINANCIAL OVERVIEW

In 2023, HCH/FH received $2,858,632 from HRSA to support programmatic activities, nearly $2M of which was allocated to contracts and MOUs to support healthcare and enabling services for people experiencing homelessness and farmworkers and their families in San Mateo County.

Revenue	Financial 2021	Financial 2022	Financial 2023
HRSA Health Center Program Grant (HRSA 3330 Farmworker & Homeless)	$2,910,173	$2,684,036	$3,433,200
Patient Revenue	$4,957,896	$4,375,010	$5,301,865
COVID-19 Supplemental	$632,864	$539,834	$1,083,526
Non-Federal/Local Support	$9,791,314	$10,802,677	$ 12,835,582
TOTAL	**$18,292,247**	**$18,401,557**	**$22,654,173**

Item Cost	2021	2022	2023
Clinical Visits	$8,452,831	$8,514,587	$12,010,158
Enabling Services	$789,616	$975,558	$916,726
Facility & Non-Clinical Support	$9,049,800	$8,911,412	$9,727,289
TOTAL	**$18,292,247**	**$18,401,557**	**$22,654,173**

The HCH/FH Program continues to monitor its current contracts[1], which were initiated in the 2020/2021 Request for Proposal (RFP) cycle.

[1] *Refer to pages 5-7 for the current Program partners overview.*

STRATEGIC PLAN UPDATE

The Board's 2020-2023 Strategic Plan can be found here: https://www.smchealth.org/smmc-hchfh-board

STRATEGIC PRIORITY	GOAL & STATUS
1. Increase homeless & farmworker patient utilization of SMMC & BHRS Services.	By EOY 2023, 50% of clients receiving care coordination will have at least one brick and mortar health care visit (primary care, behavioral health, or dental care) within a 12-month period at SMMC or BHRS. While HCH/FH did not meet this goal, the program achieved a 42.7% rate of clients receiving care coordination who had at least one brick and mortar healthcare visit at SMMC or BHRS by the end of 2023. This outcome presents a significant increase from 35.8% in 2021 and 35.9% in 2022. The program's progress underlines the positive impact that care coordination, which includes transportation to appointments and health care navigation, has on the number of homeless individuals and farmworkers that access health care services from SMMC or BHRS.
	By EOY 2023, increase percent of people experiencing homelessness (PEH) receiving mental health & AOD services by 40% from 2019 baseline. HCH/FH achieved a remarkable 111% increase in the number of individuals experiencing homelessness who received mental health and AOD services, exceeding the initial goal of a 40% increase from the 2019 baseline. The AOD Counselor, funded by HCH/FH, that accompanies the Street Medicine team, and BHRS regional clinics saw the largest increase in PEH patients in 2023.
	By EOY 2023, increase percent of farmworkers receiving mental health & AOD services by 20% from 2019 baseline. HCH/FH did not meet this goal. Though mental health stigma has reduced, it still deters individuals from accessing these services. Our farmworker population has also voiced a preference for more culturally rooted forms of therapy, as identified by our partners that serve this population. HCH/FH is committed to enhancing access to mental health and AOD services for farmworkers, striving to bridge the gap between their needs and available services.

2. Decrease barriers for homeless and farmworker patients to access health care.

By EOY 2023, decrease the number of un-insured homeless and farm-worker patients seen by HCH/FH by 5% and 10% respectively.

By the end of 2023, HCH/FH reduced uninsured homeless and farmworker patients seen by the program to 12% and 27%, respectively, with the homeless patient outcome notably surpassing the 2019 baseline of 20%, while the farmworker patient outcome exceeded the 2019 baseline of 14%.

Numerous factors impacted the farmworker patient outcome. Many farmworkers, more specifically those who were undocumented and between the ages 26-49, were ineligible for Medi-Cal in 2023. Although farmworker visits to HCH/FH increased, so did the number of uninsured patients. In addition, the Half Moon Bay shooting and subsequent flood in early 2023 disrupted the community and hindered efforts to connect patients to health insurance. HCH/FH remains committed to addressing these challenges and improving healthcare access for these vulnerable populations.

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3. Support health care providers serving homeless and farm-worker patients.

Refer to QI/QA Plan for patient satisfaction related outcomes.

- Support Health Care Providers and Case Managers

While specific metrics weren't established for supporting homeless and farmworker patient providers, the program undertook several initiatives. The program supported homeless and farmworker patient providers through a needs assessment to understand their beliefs, needs, and availability of the resources required to care for their patients. Furthermore, tailored trainings, including resource navigation, equipped providers with the knowledge and skills to continue effectively serving these populations and connecting them to relevant services.

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4. Decrease health disparities among people experiencing homelessness & farmworker patients

As an integral component of HCH/FH's Quality Improvement and Quality Assurance (QI/QA) Plan, 18 Clinical Quality Measures (CQMs) are identified, with 8 designated as priority CQMs due to their collective significance in assessing patient health status.

These 8 include:

- Early Entry into Prenatal Care
- Cervical Cancer Screening
- Breast Cancer Screening
- Colorectal Cancer Screening
- Adult Body Mass Index (BMI) Screening & Follow Up
- Diabetes Control
- Hypertension Control
- Depression Screening & Follow Up

San Mateo Medical Center's (SMMC) Quality Improvement Plan uses the Healthy People 2023 Report data as a benchmark for their Quality Assurance goals. As a health center under HRSA, HRSA recommends that HCH/FH also use Healthy People 2030 data as the standard for evaluating HCH/FH efforts.

Using SMMC's 2023 performance as a proxy for the Healthy People 2030 benchmark, a few of HCH/FH's 2023 notable achievements in reducing disparities among persons experiencing homelessness and farmworker patients include:

Colorectal Cancer Screening
Measurement: Percentage of adults (ages 45-75) who had appropriate screening for colorectal cancer.
Outcome: HCH/FH farmworker patients (69%) exceeded the SMMC benchmark (60%), while HCH/FH homeless patients approached the benchmark (55%).

Breast Cancer Screening
Measurement: Percentage of women (ages 50-74) who had a mammogram to screen for breast cancer within the last 27 months.
Outcome: HCH/FH farmworker patients (81%) exceeded the SMMC benchmark (77%), while HCH/FH homeless patients did not meet the benchmark (54%).

Adult BMI Screening & Follow Up
Measurement: Percentage of adults with a BMI within normal parameters, and who received a follow-up if their measurement was outside of normal parameters.
Outcome: HCH/FH farmworker patients (46%) exceeded the SMMC benchmark (41%), while HCH/FH homeless patients nearly met the benchmark (39%).

Diabetes A1c > 9% or Missing
Measurement: Patients whose diabetes A1c values are outside of normal parameters
Definition: Patients whose diabetes A1c value is > 9% or missing, so by definition we're trying to capture the most at risk patients in our population. By isolating patients under this criteria, we are able to determine how many patients are left that fall within normal parameters, and have diabetes under control.
Outcome: HCH/FH farmworker patients (29%) exceeded the SMMC benchmark (30%), while HCH/FH patients approached the benchmark (34%).

In addition, HCH/FH will continue to prioritize the outcome measures as listed in the QI/QA Plan. Continuous evaluation and assessment will occur to assure that the appropriate outcome measures are being prioritized, as the QI/QA Plan gets amended on an annual basis. Quality improvement

efforts will be determined based off data received by the San Mateo Medical Center, in order to target certain outcome measures and prioritize our patient population in clinic. Health education and resource awareness for prioritized outcome measures, and other relevant topics to homeless and farmworkers, will continue to be a focus.

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5. Meet and exceed all HRSA compliance requirements

- Following a site visit, have no more than 5 immediate enforcement actions, fewer than 2 conditions enter the 90-day phase of Progressive Action and 0 conditions enter the 30-day phase of Progressive Action.

Program did not have a site visit in 2023.

- Program will have not more than 5% of funds remaining at the end of the current grant cycle (December 2023).

HCH/FH demonstrated meticulous financial management and commitment to financial stewardship, as evidenced by the 5.4% of funds remaining at the end of the grant cycle.

SPOTLIGHT ON 2023 PROJECTS

HMB LIBRARY COLLABORATION – BP CUFFS

HCH/FH works in collaboration with Half Moon Bay Library to provide blood pressure (BP) cuffs for library patrons.

IPV SAFETY CARDS

HCH/FH collaborated with county partners to distribute intimate partner violence safety cards to farmworkers.

PHONES PROJECT

HCH/FH provided phones to homeless patients to increase virtual engagement.

PROVIDER TEMPLATES

HCH/FH created templates with community resources for providers to share with patients.

ABODE SERVICES MEDICAL CARE COORDINATION

Abode Services initiated their first program to provide medical care coordination for newly housed individuals. By 2023, the program was fully operational, receiving referrals and introducing services in county programs and shelters to assist individuals without attached case management to their housing status.

NEEDS ASSESSMENT (2022-2023)

HCH/FH conducted a comprehensive needs assessment in collaboration with San Mateo Medical Center (SMMC) to improve access to healthcare for homeless individuals and farmworkers. Surveys were administered to care teams and patients to understand their perspectives, needs, and satisfaction levels. The findings informed both the 2024-2027 HCH/FH Strategic Plan and recommendations to enhance service delivery, reduce barriers, and improve patient satisfaction.

STRATEGIC PLANNING (2024 - 2027)

The HCH/FH Co-applicant board finalized the 2024-2027 HCH/FH Strategic Plan at the end of 2023. The Strategic Plan outlines major strategic priority areas and recommended action steps that inform the Board's decision-making in selecting which services will go out to Request for Proposal (RFP) in 2024; with contracts starting in 2025.

LOOKING AHEAD

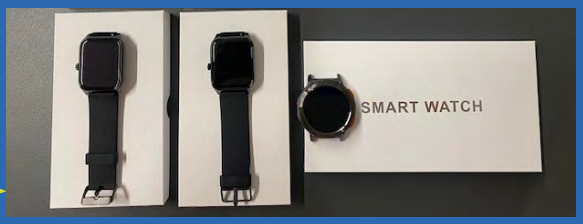
2024 is in full swing, with many exciting projects underway:

LIBRARY COLLABORATION EXPANSION – BLOOD PRESSURE (BP) CUFFS

HCH/FH is expanding its collaboration with SMC libraries to provide BP cuffs to residents.

SMARTWATCHES PROJECT

HCH/FH is providing smartwatches to homeless and farmworker patients to increase engagement and improve health education.



MATERNAL HEALTH - PATIENT SAFETY KITS

HCH/FH will provide educational programs on a variety of women's health topics, including screenings and maternal/child health.

DENTAL CLINIC AT THE NAVIGATION CENTER

The San Mateo County Navigation Center, located in Redwood City, encompasses 240 temporary living units and intensive on-site support services to individuals and couples experiencing homelessness. On-site services include case management, social services, and health services, including medical, behavioral health, and dental care. HCH/FH has contracted with University of the Pacific Dugoni School of Dentistry to staff the dental clinic and provide general and specialty dental services for residents at the Navigation Center.

RFP (REQUEST FOR PROPOSAL)

In Spring 2024, the HCH/FH Co-applicant Board will decide which services and programs go out to RFP. After the proposal deadline, the Board and HCH/FH staff will evaluate proposals to determine which community organizations and agencies will be awarded contracts for the 2025-2027 service period. These community organizations will provide services that aim to increase access to, remove barriers to, and improve the quality of health services for homeless individuals and farmworkers (and their families) .

MEET OUR BOARD

The Co-Applicant Board plays a pivotal role in steering the strategic direction of the HCH/FH Program, overseeing service selection, and evaluating progress.

Comprised of dedicated individuals committed to the welfare of San Mateo County residents, the Board ensures the program effectively meets the diverse needs of the community. Board members are required to be residents of San Mateo County and are ineligible for employment with San Mateo County Health.

The HCH/FH Program extends a warm invitation to passionate individuals residing in San Mateo County to join our Board. We value diverse perspectives and actively encourage individuals with lived experiences to apply, although homelessness or farm-worker status is not a prerequisite for membership.

Through collaboration and expertise, our Board members make significant contributions to the success of the HCH/FH Program. We express our sincere gratitude for their unwavering dedication and commitment to enhancing the well-being of our community.

Robert Anderson, *Chair*

Victoria Sanchez De Alba, *Vice Chair*

Steve Carey

Tayischa Deldridge

Gabe Garcia

Brian Greenberg

Judith Guerrero

Steve Kraft

Suzanne Moore

Francine Serafin-Dickson

Janet Schmidt

Tony Serrano

If you are interested in joining our team, please visit our website for more information:

https://www.smchealth.org/smmc-hchfh-board

WANT TO GET INVOLVED?

ATTEND A BOARD MEETING

- Our board meetings are open to the public and provide an opportunity to learn more about our program.
- Join us to gain insights into our initiatives, share your ideas, and actively participate in shaping our direction.
- Scan this QR code for more information on upcoming board meetings.

BECOME A BOARD MEMBER: https://www.smchealth.org/smmc-hchfh-board

- Consider applying to become a board member and play a pivotal role in guiding our program's progress.
- Visit our website for detailed information on the application process, eligibility criteria, and expectations.

SHARE YOUR STORY

- We believe in the power of personal narratives to inspire and bring about positive change.
- Share your story and experiences to help raise awareness about homelessness and farmworker health.
- Become a guest speaker and share your story in our board meeting.
- Connect with Meron Asfaw at masfaw@smcgov.org to share your story.

HCH/FH STAFF

Jim Beaumont, HCH/FH Program Director

Kapil Chopra, Behavioral Health Medical Director

Amanda Hing-Hernandez, Clinical Liaison

Frank Trinh, Medical Director

Alejandra Alvarado, Clinical Services Coordinator

Meron Asfaw, Community Program Services Coordinator

Gozel Kulieva, Management Analyst

Irene Pasma, Implementation & Planning Coordinator

Jocelyn Vidales, Incoming Implementation & Planning Coordinator *(started in early 2024)*

WE APPRECIATE YOUR INTEREST IN GETTING INVOLVED WITH OUR PROGRAM.
TOGETHER, WE CAN MAKE A SIGNIFICANT IMPACT ON THE LIVES OF THOSE IN NEED.