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

Co-Applicant Board Meeting Agenda

Half Moon Bay Library, 620 Correas St, Half Moon Bay, CA
September 10th, 2026, 10:00am - 12:00pm

This meeting of The Health Care for The Homeless/Farmworker Health board will be held in-person at
620 Correas St, Half Moon Bay, CA
Remote participation in this meeting will not be available. To observe or participate in the meeting please attend in-person at above location.
*Written public comments may be emailed to rnash@smcgov.org and such written comments should indicate the specific agenda item on which you are commenting.
***Please see instructions for written and spoken public comments at the end of this agenda.**

A. CALL TO ORDER & ROLL CALL	Victoria Sanchez De Alba	10:00am

B. PUBLIC COMMENT
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.

C. ACTION TO SET THE AGENDA & CONSENT AGENDA		10:02am
1. Approve meeting minutes from: a. August 13th Board Meeting		Tab 1
2. Budget and Finance Report		Tab 2
3. HCH/FH Director's Report		Tab 3
4. Quality Improvement/ Quality Assurance Report		Tab 4

D. COMMUNITY ANNOUNCEMENTS		
Communications and Announcements are brief items from members of the Board regarding upcoming events in the community and correspondence that they have received. They are informational in nature and no action will be taken on these items at this meeting. A total of five minutes is allotted to this item. If there are additional communications and announcements, the Chairperson may choose to defer them to a second agenda item added at the end of the Board Meeting.		
Community updates	Board Members	10:05am

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

E. BUSINESS AGENDA		
Request to Approve Updated Form 5B – Site Change for South San Francisco Clinic	Jim Beaumont	10:20am

F. REPORTING & DISCUSSION AGENDA		
Listening Session: Experiences Accessing Healthcare in San Mateo County	Members of the Public	10:30am

G. ADJOURNMENT	12:00pm
Future meeting**: October 8th, 2026** Time: **10am - 12pm** Location**: 500 County Center (COB 3) Manzanita Hall, Redwood City, CA 94063**	

*Instructions for Public Comment During Meeting

Members of the public may address the Members of the HCH/FH board as follows:

Written public comments may be emailed in advance of the meeting. Please read the following instructions carefully:
1. Your written comment should be emailed to rnash@smcgov.org.
2. Your email should include the specific agenda item on which you are commenting or note that your comment concerns an item that is not on the agenda or is on the consent agenda.
3. Members of the public are limited to one comment per agenda item.
4. The length of the emailed comment should be commensurate with the two minutes customarily allowed for verbal comments, which is approximately 250-300 words.
5. If your emailed comment is received by 5:00 p.m. on the day before the meeting, it will be provided to the Members of the HCH/FH board and made publicly available on the agenda website under the specific item to which your comment pertains. If emailed comments are received after 5:00p.m. on the day before the meeting, HCH/FH board will make every effort to either (i) provide such emailed comments to the HCH/FH board and make such emails publicly available on the agenda website prior to the meeting, or (ii) read such emails during the meeting. Whether such emailed comments are forwarded and posted, or are read during the meeting, they will still be included in the administrative record.

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Tab 1
Meeting Minutes

HEALTH CARE FOR THE HOMELESS/FARMWORKER HEALTH PROGRAM (HCH/FH)
Co-Applicant Board Meeting Minutes

455 County Center (Room 101), Redwood City, CA 94063
August 13th, 2026, 10:00am - 12:00pm

Co-Applicant Board Members Present	County Staff Present	Members of the Public	Absent Board Members/Staff
• Robert Anderson • Gabe Garcia • Jim Beaumont (Ex Officio) • Suzanne Moore • Tayischa Deldrige • Alison Superko • Janet Schmidt • Steve Carey • Victoria Sanchez De Alba • Tony Serrano • Steve Kraft	• Frank Trinh • Isabel Cassidy-Soto • Alejandra Paw • Linda Franco • Angela Leung • Amanda Hing-Hernandez • Raven Nash	• Carmen Vescia • Melissa Guevara • Dr. Torrey Rothstein • Norma Quinonez • Dagoberto Gavidia, Interpreter • Yolanda Congdon, Interpreter • Danny Hays • David Shearin • John Jurow • Dana Floro • Robert Vernon	• Brian Greenberg • Judith Guerrero

A. Call to order & roll call	Victoria called the meeting to order at 10:02 am and did a roll call.	
B. Public Comment	**Jim Beaumont** Reported that Alejandra will be taking parental leave for the next 7 to 8 months. Angela Leung has been hired to provide coverage during this period. Angela is a woman of color with experience with PHPP Epidemiology, as well as with Bridges to Wellness. Frank and Amanda have transitioned roles. Frank will serve as the Mobile Services Coordinator, and Amanda will serve as Medical Director. Gozel has accepted a permanent position with the CEO, and a Management Analyst position is currently open and available for promotion. **Carmen Vescia** Carmen reported that the organization recently held an event in partnership with HCU and visited local farms to assist with medical enrollment. Beginning this Friday, the Mental Health Team will lead Compadres, a men's mental health program, for an 8-to-12-week period. The organization will also continue its partnership with Second Harvest. Sunday clinic and dental clinic services are going well. The team is currently focusing on heat health and hydration education as part of its classes and community programming.	
C. Action to set the agenda and consent agenda.	1. Approve meeting minutes of July 2026 Board Meeting 2. Budget and Finance Report 3. HCH/FH Director's Report	**Request to approve the Consent Agenda was MOVED** by Suzanne **SECONDED** by Tayischa APPROVED by all Board members present.
D. Community Announcements	**Suzanne**	

	Thanked the Epidemiology team for its mortality report presentation and expressed interest in having the team present to the Quality Improvement Subcommittee. The Board discussed causes of death related to acute and chronic illness, as well as increased drug- and alcohol-related deaths near transit centers. Suzanne provided an update on the Safe Parking Program, noting continued advocacy in Pacifica and along the Coast. The program has been successful and there is interest in maintaining and expanding it; however, current funding is scheduled to expire at the end of September. The program currently includes approximately 10 RV spaces and five street spaces. The Board also discussed the impact of the encampment ordinance and road closures on individuals experiencing homelessness. Robert Anderson reported that no citations have been issued under the ordinance but noted that tracking where individuals relocate is difficult across jurisdictions. Steve Carey noted that LifeMoves has grant funding for encampment engagement. Gabe recommended that the County consider addressing these issues regionally rather than by individual jurisdiction. Tony Serrano provided an update on the wellness fair at a local farm and highlighted the strong relationships developed with seasonal farmworkers. A need for a refrigerator and other safe food storage resources was identified. The Board discussed ways to improve outreach and participation among farmworkers, including adjusting meeting times, providing stipends and transportation, and potentially hosting future events directly at farms in partnership with farm owners and organizations such as ALAS and Puente. Jim noted that this work aligns with the strategic plan and asked Isabel to prepare a related discussion for the October meeting.	

E. Business Agenda **Swearing-In Oath**	Glenn Levy facilitated the swearing-in oath for new Board member, Robert Vernon.	Motion to approve Robert Seconded by Gabe Approved by all Board members present
F. Reporting & Discussion Agenda **John Jurow, CEO, San Mateo County Health Foundation**	**John Jurow, CEO, San Mateo County Health Foundation** John presented an overview of the San Mateo County Health Foundation's direct-care programs, which address social determinants of health, including transportation, food access and other patient needs. The Foundation, established in 1999, is a private nonprofit organization separate from the County and hospitals and has served approximately 79,000 patients. Programs include Caring Hands in Health, Bundle of Joy and Food Farmacy. Patients must reside in San Mateo County, have a San Mateo County Health patient record number and be referred through a County Health care team. The Board expressed strong support for the Foundation and discussed opportunities for increased outreach and referrals.	
Behavioral Health and Recovery Services – HCH/FH Program	**Shirley Chu, LCSW, Clinical Services Manager, Crisis & Outreach Team** Shirley provided an overview of behavioral health services and the partnership with Healthcare for the Homeless. Services include care coordination, case management, crisis intervention and connections to mental health and substance use treatment. Shirley noted that some clients are redirected to more appropriate services or may become difficult to reach and highlighted a digital access program that provides phones to help clients maintain contact with providers. The Board discussed methamphetamine use, cultural competency, medication access and coordination with the court system. Shirley will provide	

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	additional information regarding the number of youth represented in the reported data.	
Program Services in the Peninsula	**Danny Hays, Outreach Coordinator, Street Life Ministries** Danny described their one-year residential program serving men experiencing homelessness and substance use disorders. The faith-based program provides housing, recovery support, life skills and aftercare, with participants remaining connected through weekly services following graduation. A women's program is currently in development. The program incorporates both an in-house curriculum and 12-step resources.	
Summary of National Healthcare for the Homeless Conference & Policy Symposium	**Tayischa Deldrige, Board Member** Reported that conference attendance was low and identified aftercare as a significant barrier for individuals transitioning from programs. She highlighted a one-year program with regular check-ins as a potential model.	
Federal Updates	**Jim Beaumont** Reported no significant operational changes. The Notice of Funding Opportunity for Expanding Nutrition Services is due September 9, and discussions with potential partners are underway. Housing readiness remains a priority, with continued focus on supporting clients transitioning to permanent housing.	
G. Adjournment	**Future meeting:** **September 10th, 2026** **Half Moon Bay Library, 620 Correas St, Half Moon Bay, CA**	The meeting was adjourned at 12:12pm

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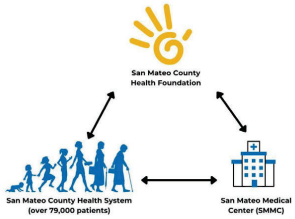
CARING FOR OUR COMMUNITY

John Jurow, CEO
Dana Floro, Director of Operations
San Mateo County Health Foundation

HEALTH FOUNDATION SAN MATEO COUNTY

ABOUT US

We are **San Mateo County Health Foundation**, the charitable arm of San Mateo Medical Center, dedicated to raising funds and providing temporary financial assistance for essential needs to **San Mateo County Health patients**.



HEALTH FOUNDATION SAN MATEO COUNTY

What if you had to

CHOOSE between

FEEDING your family **OR** **PAYING RENT** to avoid eviction

OR **TAKING** your medication?

HEALTH FOUNDATION SAN MATEO COUNTY

WHAT WE FUND

SMMC SUPPORT

Providing funds for the medical center's growth and improvement

Emerging Initiatives and Dynamic Healthcare Priorities: Keller Center, Ron Robinson Senior Care, Breast Health, Maternal Care, Equipment Needs, Staff Well-Being, Community Engagement

DIRECT PATIENT SUPPORT

Immediate assistance through dedicated programs

CARING HANDS IN HEALTH

Financial assistance program offering vital support to patients during times of immediate need. Serving as a critical safety net, it assists those who have exhausted all other options, including insurance benefits, government aid, and community resources. By bridging this gap, the program helps patients as they pursue more sustainable solutions for long-term well-being.

BUNDLE OF JOY

Helps families start off strong by providing essential newborn items. Our volunteers assemble tote bags filled with diapers, wipes, clothing, and blankets to help families navigate their baby's first few weeks at home. Additionally, we support expectant mothers by funding prenatal and newborn care books, which are distributed at SMMC's clinics to help them prepare for the arrival of their babies.

FOOD FARMACY

Ensures food insecure patients and their families have access to nutritious meals. In partnership with Samaritan House, we deliver fresh produce, proteins, dairy, and pantry staples to hundreds of households each week. Nearly 1,100 food packages are distributed every Monday to six locations: county clinics and our Foundation office.

BUNDLE OF JOY

The high cost of infant care in California, more than $15,000 annually on average can force families to choose between paying for child care and meeting other basic needs.*

VITAL ASSISTANCE
Providing essential items for newborns and alleviating financial burdens including diapers, wipes, clothing, and blankets.

We supply clinics with pre- and post-natal books in English and Spanish to guide parents through their journey.

IMPACTFUL DISTRIBUTION
2,000-2,400 bags given each year to OB/GYN and Pediatrics.

*Source: California Budget & Policy Center, analysis of California Department of Education Regional Market Rate Survey

FOOD FARMACY

Many households facing food insecurity earn too much to qualify for public assistance yet still struggle to afford enough nutritious food, increasing reliance on community food programs.*

We partner with the Samaritan House to distribute 1,100 food packages each week to locations throughout the county.

Food Box = fresh produce, eggs, dairy
Bag of Groceries = rice/grains, canned goods

Every Monday (except holidays)
- Clinics: Coastside, Daly City, Edison, Fair Oaks, South San Francisco
- Foundation Office at SMMC

Any community member can obtain a food package—no questions asked.

*Source: Second Harvest of Silicon Valley (2026 Client Survey); San Mateo County Board of Supervisors, Measure K funding for food assistance (2025).

CARING HANDS IN HEALTH

ESSENTIAL NEEDS
Groceries, personal care items, baby supplies

EMERGENCY HOUSING *One-time award
Half-rent assistance **or** temporary motel accommodations

MEDICAL & DENTAL BILLING
Co-pays, prescriptions, medical needs/supplies, home health services, accessibility equipment, dental procedures for special cases

TRANSPORTATION
Rides not covered by insurance

SENIOR MEALS
Meal plans for people over 60 years old

Intended as a last resort for those who have exhausted all other options, including insurance, government aid, and community resources.

Applications should be submitted only for patients with a substantial, demonstrated need—not simply as an additional source of support.

Requirements
- SMC Health patient record number
- Resident of San Mateo County
- Application submitted by care team
- No more than 3 applications/year/patient

***Restrictions apply: Emergency Housing, Transportation**

HEALTH FOUNDATION SAN MATEO COUNTY

CARING HANDS PROCESS

Caring Hands application: https://smchf.org/caring-hands-in-health-application/

Before submitting an application
- Confirm there is a genuine need and explore other resources first.
- Gather all relevant background and details upfront to avoid unnecessary follow-up.
- Applications must be submitted by staff. **Do not refer patients directly to the Foundation or website.**

Plan ahead
- Foundation hours are **Monday-Friday, 9 AM-4 PM**. Late-day requests may be addressed the following day.
- When possible, contact us in advance before coming to the Foundation.
- Patients should only contact the Foundation when asked to provide additional information.

Be responsive
- Respond promptly to requests from the CH Coordinator to prevent delays.
- Work closely with the Foundation so we can **best advocate for the patient**.

HEALTH FOUNDATION SAN MATEO COUNTY

EXAMPLES OF CARING HANDS DENIALS

Assistance Requested: Emergency Housing – Temporary Lodging (Case A)
Patient is a survivor of domestic violence and has been homeless for an extended period, living in shelters and on the streets. She is exhausted from taking the bus and walking to her appointments and would like temporary lodging where she can work on applying for government assistance and focus on her medical appointments.

Result: While we recognize this patient's challenging circumstances as someone who is chronically homeless, they do not have a definitive plan for housing stability after the temporary assistance ends.

Assistance Requested: Emergency Housing – Temporary Lodging (Case B)
"The member is currently homeless, requesting hoteling for the next 30 days. After that, they plan on moving in with one of their friends to live with after the stay."

Result: This request does not meet the criteria for an immediate emergency.

Policy:
Temporary lodging assistance is designated for individuals requiring recuperative care due to medical reasons, in an active domestic violence situation, or families (patients with children) awaiting confirmed shelter placement. Patients must be working with a social worker or case manager. If the Foundation approves a special circumstance outside of these reasons, the patient must have a clear plan or pathway to a more permanent housing solution.

HEALTH FOUNDATION SAN MATEO COUNTY

EXAMPLES OF CARING HANDS DENIALS

Assistance Requested: Emergency Housing – Rent (Case A)
Patient gave a friend access to her bank account, and they stole all her money, leaving her without funds to pay for rent. Her housing is subsidized through Brilliant Corners, and she is pending income from CAPI (Cash Assistance Program for Immigrants).

Result: Denied because patient cannot pay for the other half of her rent.

Assistance Requested: Emergency Housing – Rent (Case B)
Patient lost his roommate in May 2024 and would be facing a rent increase when a new person moves in. After losing his job in June, a job offer was withdrawn over a past medication overdose on his record. He received rental assistance from the Mental Health Association but has exhausted aid. His attempt to get help from CORE Agency YMCA failed due to the landlord refusing to sign a required W9. He owed $1,800 for December rent. He planned to secure a stable, higher-paying job and find a financially reliable roommate.

Result: Seven months had passed since he initially lost his roommate, but the patient still did not have a more permanent housing solution—securing a stable job and finding a roommate are too uncertain.

Policy
Patients must be able to pay for half of their rent, working with a social worker/case manager, and have a solid housing plan underway.

HEALTH FOUNDATION SAN MATEO COUNTY

EXAMPLES OF CARING HANDS DENIALS

Assistance Requested: Basic Needs (Case A)
Heather received a 48-hour notice to pay her PG&E account—a total bill due of $458.36. Typically, she manages her bills and rent independently and on time. Over the past three months, she had faced financial hardship due to expenses related to her dog's illness which has increased her anxiety. Her income is limited to social security, and she was requesting assistance to pay for her utilities.

Result: The Foundation does not cover bills—including utilities.

Assistance Requested: Basic Needs (Case B)
"Patient is married and travels for work. He is homeless and camping out, he is diabetic, so it is hard to find healthy food for him. He said it would help him a lot if we could help him with some cards to buy food. He is originally from Orange County, passing through SMC."

Result: Applicants must be a resident of San Mateo County. Unhoused cannot just be "passing through".

Assistance Requested: Basic Needs (Case C)
Patient is 28 weeks pregnant, seeks immediate assistance with baby supplies (clothing, diapers, wipes, bottles, car seat, stroller) after giving birth. She is single, unemployed, and homeless from losing her home in a fire last year. She is living in her car, with no support from the baby's father. She is also asking for gas money and temporary motel assistance.

Result: The Foundation does not cover vehicle expenses—including gas. Although the patient was awarded baby supplies, she was denied for the motel stay. There was no immediate emergency that qualified her for temporary lodging assistance, and she was not actively working with a social worker to develop a stable housing plan.

HEALTH FOUNDATION SAN MATEO COUNTY

CONNECT WITH US

Visit our Website For our programs & services
www.smchf.org

Follow Us @SMCHFoundation

Have Questions? Reach out Monday-Friday, 9AM-4PM

Email: info@smchf.org
Call: (650) 573-2655
Visit: SMMC Link Building A16

John Jurow, CEO
Dana Floro, Director of Operations
Ksenia Chistykova, Program Coordinator
Adriana Najera-Cervantes, Program Assistant
Maria Reyes, Office Coordinator
We're in the county directory—email or Teams us!

San Mateo County Health Foundation is a
501(c)(3) nonprofit organization.
Tax ID 94-3116070

HEALTH FOUNDATION SAN MATEO COUNTY

Health Care for the Homeless

August 13, 2026

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

BHRS HCH

Provides BH care coordination & case management services for individuals experiencing homelessness.

- **Goals:** Enhance service connections and access to medical, dental, and behavioral health care needs of homeless individuals
- **Services:** Outreach/Engagement, screening (BH focus)*, case management linkage*, and brief counseling*
- **Target populations:** All ages, mild to moderate and severely mentally ill (SMI) sheltered homeless individuals
- **Referral:** HS_BHRS_HEAL@smcgov.org or specific HCH staff

Overview of HCH

- **Source of Referrals:** All shelters & other providers
  - Stationed at the Nav Ctr weekly; by-appointment for other shelters
- **Consent for Services:** HCH services are voluntary
- **Duration for HCH:** Short Term
- **Staff:** One full-time mental health counselor &
  One full-time certified peer specialist

Overview of HCH

- **Collaboration with HEAL**
- **Coordination with ACCESS & HPSM (mild/moderate BH needs)**
- **Coordination with all BHRS Outpatient Clinics (youth & adult)**
- **Multi-Disciplinary Team meetings (MDTs)**
- **Field Crisis Collaborative Care monthly meetings**

Outcome Measures & 2025 Data

1. Number of homeless individuals provided with behavioral health care coordination services (T/A: 150/163)
2. Connect those agree to behavioral health treatment at appropriate level of care: mild to moderate & SMI (157 out of 163 – 84 PPN & 73 BHRS)
3. Of those referred, attend at least one scheduled treatment appointment (100% - 157)
4. Of those referred, attend two complete visits for care appointment (~67% - 105)

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Thank you!

Shirley Chu, Clinical Services Manager
schu@smcgov.org

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

STREET LIFE MINISTRIES PRESENTS

Transformation House
A Damascus Road to Change

A One-Year Journey of Transformation

ABOUT — STREET LIFE MINISTRIES

Sharing God's love on the streets

A faith-based nonprofit serving people experiencing homelessness across the San Francisco Peninsula — meeting people where they are, in encampments and outdoor meal locations.

- Hot meals, clothing, hygiene supplies, case management, resource navigation, and spiritual care
- Partners with churches, nonprofits, and businesses to move people toward stability and self-sufficiency
- Focused on restoring dignity, building hope, and creating pathways off the streets

45,000+
hot meals served each year

16,000+
volunteer hours mobilized annually

THE PROGRAM

Rescue a man... and you rescue a family.

Damascus Road Transformation House is a Christ-centered residential program guiding men through a one-year journey of transformation.

Built on the 12 Steps, biblical discipleship, accountability, work, and community.

OUR MISSION

We help men...

1. Develop a relationship with Jesus Christ
2. Experience freedom from addiction
3. Restore their families
4. Become responsible fathers, husbands, employees, and community members
5. Live lives of purpose and service

> *"Transformation isn't just about overcoming addiction. It's about becoming a new man in Christ.*

OUR PHILOSOPHY

We don't simply help men stop using.

We help them become the men God created them to be — through a program that combines:

- Biblical Discipleship
- The 12 Steps
- Daily Structure
- Meaningful Employment
- Service to Others
- Accountability
- Ongoing Aftercare

THE ONE-YEAR TRANSFORMATION JOURNEY

One Step. One Month. One Year. One Transformed Life.

Each month represents one step — twelve steps across twelve months.

1	2	3	4
MONTHS 1–3	MONTHS 4–6	MONTHS 7–9	MONTHS 10–12
Foundation	**Healing**	**Restoration**	**Living the Mission**
Surrender, hope, and trust	Honesty, humility, healing	Amends and restored relationships	Growth and helping others

"When you rescue a man, you save a family." — Charles Knuckles, City Team

MONTHS 1 – 3

Foundation

STEP 1 **Surrender**

STEP 2 **Hope**

STEP 3 **Trust**

Real transformation begins when we admit we cannot do it alone and place our trust in God.

MONTHS 4 – 6

Healing

STEP 4 **Honest Self-Examination**

STEP 5 **Confession**

STEP 6 **Becoming Ready for Change**

God transforms us through honesty, humility, and healing.

MONTHS 7 – 9

Restoration

STEP 7 **Humility**

STEP 8 **Preparing to Make Amends**

STEP 9 **Restoring Relationships**

Transformation becomes visible as broken relationships begin to heal.

MONTHS 10 – 12

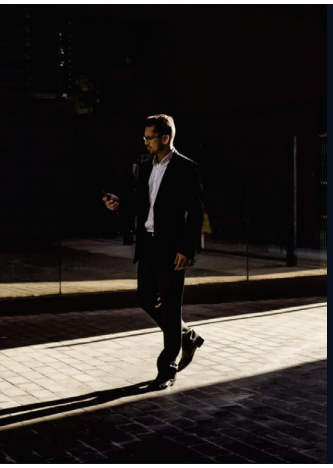
Living the Mission

STEP 10 **Daily Growth**

STEP 11 **Deepening Our Relationship with God**

STEP 12 **Helping Others Experience Transformation**

A transformed life naturally pours into others.



LIFE AFTER GRADUATION

Transformation doesn't end after one year.

Every graduate keeps growing through:

- Weekly Aftercare
- Continued Sponsorship
- Church Community
- Accountability
- Employment Support
- Service Opportunities

Most graduates transition into sober-living environments while continuing to grow with their sponsor and support network.

WHAT TRANSFORMATION LOOKS LIKE

A transformed man is...

- ✓ Walking with Christ
- ✓ Living with integrity
- ✓ Employed and dependable
- ✓ Financially responsible
- ✓ Restoring his family
- ✓ Serving others
- ✓ Connected to his church
- ✓ Mentoring other men
- ✓ Living independently

OUR VISION

We aren't simply helping men overcome addiction.

We are transforming lives.
We are restoring families.
We are strengthening communities.

Because when you rescue one man, you rescue a family.

DAMASCUS ROAD TRANSFORMATION HOUSE

"Therefore, if anyone is in Christ, he is a new creation. The old has passed away; behold, the new has come."

— 2 Corinthians 5:17

One Year. One Transformed Life.

Full Session Description / Abstract

Housing is often deemed as the gateway out of homelessness, but the journey to long-term housing stability does not end with keys to the door. The first six to twelve months in housing is a time of increased vulnerability due to new social, cognitive, and physical demands of daily life. The self-identity, roles, and routines developed for survival of homelessness can be shocked by the adjustment to housing and long-term planning. The more an individual remains in or returns to homelessness, the greater risk to health and wellbeing. Without targeted support to (re)learn these daily life demands such as cooking, cleaning, budgeting, health management and social participation, poor health outcomes or the loss of housing may result.

Despite this risk, robust evidence-based life skills training is often absent from housing settings. Occupational therapy (OT) provides an integrative approach to address the physical, cognitive, mental health, and environmental factors affecting an individual's life, with a core focus on function and community re-integration. Our nonprofit is exclusively dedicated to providing innovative OT services to people experiencing and exiting homelessness to maximize the success of housing transition, health, and survival by providing assertive outreach outdoors, in shelters, and in housing.

We will present common challenges faced in the housing transition such as hoarding, social isolation, and chronic condition management. Various trauma-informed, harm reductionist occupational therapy strategies for assessment and skill development will be discussed, along with determining appropriate levels of support and referrals to make when physical or cognitive impairments call for long-term community based care to prevent institutionalization. Patient stories will engage the audience in a facilitated discussion on application of strategies to replicate this specialty service and collaboration in their own communities.

Building a bridge between housing and healthcare in Los Angeles: A three-part series

The Center for Care Innovations is launching a new program to advance integrated care for people experiencing homelessness in Los Angeles.

By Chris Rubeo, DrPH

Sept 18, 2024

Our research on efforts to integrate health care and homeless services in Los Angeles has resulted in a new two-year initiative to fund and support community health centers, street medicine teams, and community-based organizations working to bridge housing and healthcare in Los Angeles County.

This three-part series will touch on some of the highlights from the last two years' work and the findings that led to our new initiative. In Part 1, we explore the growth of street medicine programs in California. In Part 2, we describe the changing landscape of housing and health care services in Los Angeles County and the forces driving those changes. And in Part 3, we share the findings from our recent study on integrated housing and health services in Los Angeles County.

Key findings:

- The use of integrated care models like street medicine and medical respite is on the rise due to funding and regulatory changes.
- Providers are motivated to integrate care but still face significant challenges working across sectors.
- Strong relationships are essential for integrated care. But organizations have to design the work in ways that make it easy for those relationships to develop.
- Organizations are pursuing cross-sector partnerships to integrate care. Many are also building new cross-sector capabilities within their own organizations such as hiring staff from another sector.
- Without upstream investments to build more housing and ensure the availability of community resources, efforts to integrate care won't achieve their full potential.

Part 1: The growth of street medicine in California

Street medicine team members Dr. Coley King, left, and USC student Francesca Reinisch speak with a homeless patient at Reed Park in Santa Monica. (Brian van der Brug / Los Angeles Times via Getty Images). Used with permission.

If you've seen a doctor with a backpack full of medical supplies examining someone at a tent encampment, you've likely seen street medicine in action.

Street medicine is the practice of providing medical care and social services to people experiencing unsheltered homelessness, often in locations like parks, riverbeds, and under bridges. Many of the people street medicine teams encounter have untreated medical conditions but struggle to access care in a traditional medical setting like a doctor's office.

As Carrie Kowalski, a street medicine provider from Venice Family Clinic explains, "Street medicine means that we literally bring medicine to people in the streets. I carry a backpack with me that's full of diagnostic equipment and medications. So, I'm able to do a full physical assessment in the field and diagnose and treat."

Street medicine is being embraced as part of a broad set of federal and state reforms that make it easier to bill for care delivered on the streets.[1] The number of street medicine programs across the state more than doubled over the past two years, growing from 26 to 64 programs between August 2022 and August 2024.[2] Brett Feldman, director and co-founder of USC Street Medicine and co-

author of the California Street Medicine Landscape Survey and Report, expects growth to continue.[3]

Street medicine, like many of the models the Center for Care Innovations explored in our recent study (described in part two of this series), works by more effectively integrating housing and healthcare, building a bridge between the two historically siloed care systems and radically upending the traditional power dynamics that can exist between patients and their doctors.

A typical team might include a housing case manager, substance use counselor, mental health professional, medical provider, and someone with lived experience of homelessness working side by side in the field, with the proximity and camaraderie making it much easier to coordinate care and help patients find housing.[4]

"What we see with people who have become chronically homeless [is that] it takes a lot of effort from a lot of different professionals in multiple different fields to get that person back on their feet." - Carrie Kowalski, Physician Assistant, Venice Family Clinic.

Care integration means aligning structures, processes, relationships, and norms within and across organizations to ensure people receive services that address their full range of needs.[5,6] And it's increasingly needed.

Despite significant state and local investments in services and efforts to streamline the production of affordable housing, the homeless population of Los Angeles continues to grow by an estimated 20 people every day.[7] One reason the crisis is outpacing progress is that the healthcare and housing systems mostly work in isolation from one another. [8,9,10]

Complex and bureaucratic processes get in the way of unhoused and recently housed people getting the care they need. People jump through hoops to qualify for help, be it a housing voucher or a medical appointment. And when people go without needed care, they are at much higher risk of ending up in emergency departments, getting evicted, or worse.

A recent report from the LA County Department of Public Health found that in 2021 and 2022, unhoused individuals were 41 times more likely to die from an overdose and about 18 times more likely to die of both homicide and traffic-related injuries compared to all LA County residents.[11]

By helping providers work together more seamlessly, share information, share accountability, and develop a unified approach to care based on a patient's needs and preferences, integration aims to cut through some of those hurdles and make care more accessible and effective.

People's needs can be complex. And many people, especially those who have experienced chronic homelessness, have overlapping needs that extend beyond what any one organization or provider has the resources or skills to address. "They're tri-morbid," as one street medicine provider told us, "meaning they have addiction, mental health, physical health [issues], not just comorbid like we used to call it in the past."

Accordingly, organizations are seeking partnerships that help them meet the full range of their patients' or residents' needs. But forming cross-sector partnerships is challenging. Health care and homeless services organizations have different funding streams, strategic priorities, cultures, and data systems and are governed by different laws and regulations.[12,13,14] People who work in

each sector have different backgrounds, training, and priorities, which can lead to disagreements over the right approach to care.[15]

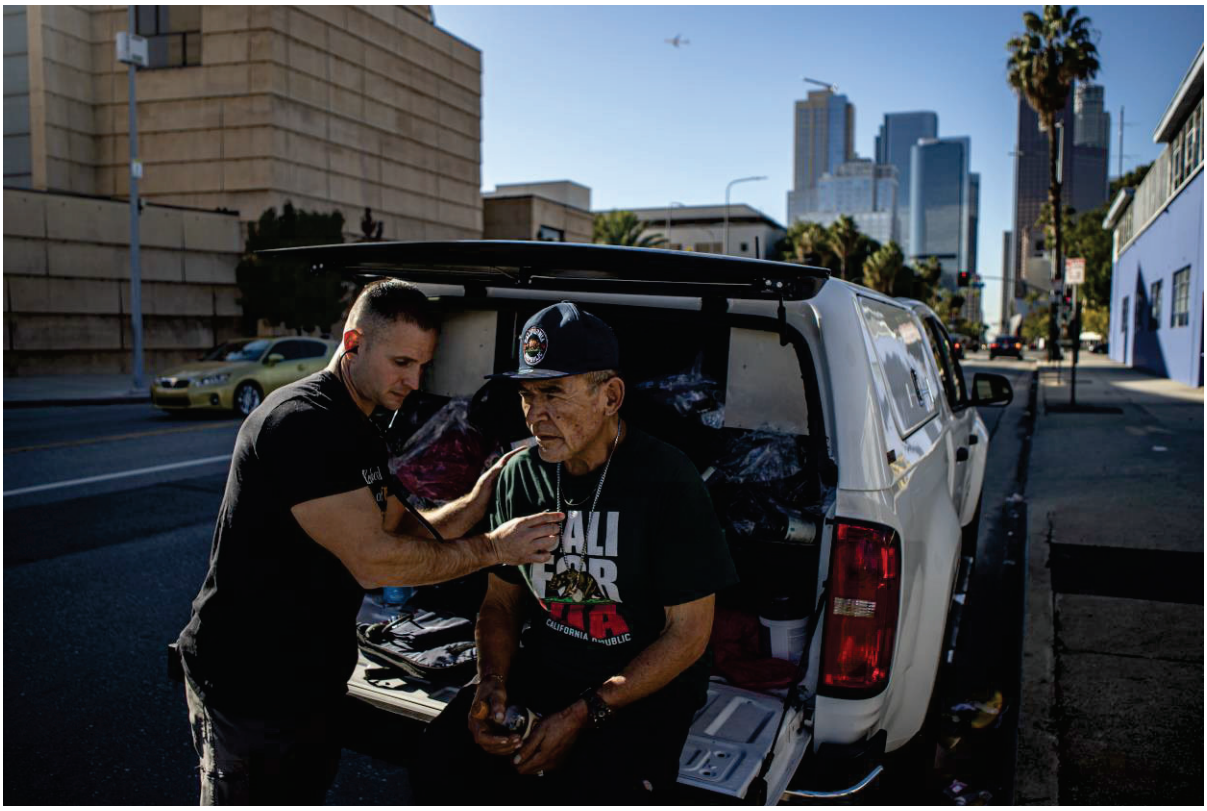
Despite these challenges, organizations are taking steps to work more closely together, because ending homelessness requires coordination and cooperation between many organizations across multiple sectors. As one homeless services leader put it, "Not one person is housed through just one agency, it just doesn't work that way."

To support efforts to build a more seamless and effective care system for people experiencing homelessness, the Center for Care Innovations partnered with UC Berkeley researchers to study partnerships to integrate social and medical care for people experiencing homelessness in Los Angeles County.

We spent a year interviewing health care and homeless services providers involved in integrating care within and between their organizations. We also spoke with managed care plan and local government leaders who fund and oversee housing and health care services. To observe integrated care models in action, we shadowed street medicine teams as they did outreach to people living in encampments. And we visited shelters and supportive housing buildings that have clinical care available on-site for their residents.

The goal of our research was to understand the current landscape of housing and healthcare integration and to identify opportunities to advance integrated care for people experiencing homelessness in Los Angeles County. In part two of this series, we'll look at the changing landscape of services in Los Angeles County and its increasingly integrated approach to healthcare and housing.

Part 2: The changing landscape of housing and health services in Los Angeles County



Physician assistant Brett Feldman checks his patient Gary Dela Cruz on the side of the road near his homeless encampment in downtown Los Angeles in November. Feldman is the director and co-founder of Street Medicine at the Keck School of Medicine at the University of Southern California. Photo by Larry Valenzuela, CalMatters/Catchlight Local. The CalMatters story appeared on December 8, 2022. Used with permission.

"We've always had this challenge," said one of the homeless services agency directors. Her two colleagues nodded in agreement. "What do we do for the handful of folks this just doesn't work for? Cases where we've tried everything, we've gotten creative, and they are still not going to make it in housing because of property management, and landlords, you know, all the pieces."

My interview notes spread out on the table in front of me, I was sitting across from three leaders of a prominent homeless services agency in Los Angeles, with two of my colleagues from the Center for Care Innovations beside me, also taking notes. That morning, we had visited a shelter to observe a mobile medical team set up a temporary clinic in the shelter's lobby. Now, we were seated around a conference room table, about to tour a project-based housing site where agency leaders said they were trying to bring more medical and psychiatric care into the building to support their formerly homeless residents. A field recorder to document the conversation sat on the table midway between me and the agency directors:

"Could you say more about that" I asked. "Why are they not going to make it in housing?"

Often, she said, it comes down to people needing better access to medical and mental health care: "Typically, we are talking about someone with severe mental illness that's lifelong—say, schizophrenia or bipolar disorder—who, as part of their mental illness, one of the symptoms is an inability to understand your need for treatment. Many have co-occurring severe medical stuff going on: perhaps an amputation, perhaps in a wheelchair, perhaps they are chaotically using substances to manage their mental illness. Many have early-onset dementia or traumatic brain injuries."

The adjustment to living indoors can be a shock, she explained. And it's made even harder when there are ongoing health issues: "These folks struggle to transition into housing; they miss their community and are isolated and lonely. Often, property damage is an issue. They steal a scooter, plug it in, and light a building on fire. Or shove wads of paper towels in the toilet and flood it and get kicked out in their first week of being housed because of the flooding damage. We are seeing people die every day because we can't meet their needs, and the institutions have failed them."

And it's not just in her buildings. Many supportive housing providers face similar challenges paying for enough services to adequately support their residents.[16] Permanent supportive housing that uses a housing first approach has been shown to help people come indoors and stay housed successfully.[17] It means offering someone housing without first requiring sobriety and then providing access to voluntary services.

However, over the past several years, the level of vulnerability and impairment of people entering housing has increased significantly, beyond what many housing operators currently have the resources to deal with. As a result, many homeless services organizations are looking for ways to fill the gap.

"We need a system that funds higher levels of support and care that includes housing, medical, and meals," she said, sounding frustrated, as if she has said the same thing before, many times. Without increased support, she expects to see people with the most complex needs continue to cycle from the streets to housing, and back to the streets.

***

Pioneering medical and homeless services providers have developed integrated approaches to care. But until recently, progress has been slow. One reason is that there were very few options to fund and sustain these approaches, and most survived on a patchwork of time-limited grants and philanthropic funding.

Since the 1990s, organizations that work with people experiencing homelessness have been piloting multidisciplinary outreach teams, street medicine, medical respite, supportive housing, and other models. What these approaches have in common is that they bring some combination of medical, mental health, substance use treatment, and housing support into the same location or onto the same team to make it more accessible and effective.

After years of slow growth, recently there has been an explosion in the use of integrated housing and health models. "I believe that genuine transformation is now underway," writes Dr. Michelle Schneidermann, Director of People-Centered Care at California Health Care Foundation, reflecting on what has caused the sudden change. "Several colliding forces have made this moment possible,

including widespread acceptance among service providers and policymakers that housing and health are connected."

Several new Medi-Cal funding opportunities are driving this transformation. Through the Housing and Homelessness Incentive Program (HHIP), Medi-Cal managed care plans can earn incentive funds for making investments and progress in addressing homelessness and keeping people housed. Meanwhile, CalAIM Enhanced Care Management and Community Supports contracts offer provider organizations a new source of ongoing funding. In pursuit of those contracts and supported by one-time capacity building funding through the Providing Access and Transforming Health (PATH) program, many are developing new cross-sector capabilities.

Regulatory shifts have also played a role. Last year, the state of California released new guidance (APL 24-001) that allows street medicine providers to become contracted Medi-Cal providers. And federal regulators introduced a new rule that allows hospitals, physicians and other providers to be reimbursed for delivering health care to people experiencing homelessness.[18] These changes are driving the growth of street medicine programs across the state, which could expand access to care for people experiencing unsheltered homelessness.

Finally, public discontent with the current approaches has also contributed to a changing state and local conversation about how to move forward. During the COVID-19 pandemic, the visibility of homelessness increased dramatically as shelters depopulated to allow for social distancing and encampments grew. In the years since, the public pressure on politicians and organizations to demonstrate progress has also steadily grown, resulting in new efforts to house people who have increasingly gathered in parks, bus stops, and other public places.

In part three of this series, we'll share the findings from our recent research on housing and healthcare integration in Los Angeles County.

Part 3: Findings from our research on housing and healthcare integration in Los Angeles County

Outreach workers talk to homeless people in their tents on the streets of Skid Row, where they are testing for coronavirus. (Al Seib/Los Angeles Times) via Getty Images. Used with permission.

In this moment of rapid change in the healthcare and homelessness fields, CCI partnered with UC Berkeley to study care integration in Los Angeles County. We were eager to learn from the great work others were already doing and the challenges they faced, always with the idea that our findings might inform the development of a program to support organizations navigating these new dynamics in their funding and operating environments.

The findings below are based on 54 interviews we conducted with staff at homeless services agencies, health care provider organizations, local government agencies, and managed care plans, between October 2022 and September 2023. Everyone we spoke with was directly involved in efforts to integrate social and medical care. And we spoke with a mix of frontline staff, managers, and senior leaders for the study.

As described above, we also conducted six site visits to observe care integration in the field, including shadowing street medicine teams and visiting shelters and permanent supportive housing buildings that provide on-site medical services for their residents.

The research and our upcoming program that builds on the findings was funded by Cedars-Sinai. More details about our study design and methods are provided at the end of the article.

We found that:

1. Integrated care is becoming more common in healthcare and homeless services. But providers still face significant challenges when coordinating across sectors. These are historically siloed systems that operate very differently. They use different data systems, have different work cultures, and have different funding and priorities. Despite these institutional barriers, providers themselves were highly motivated to figure out how to integrate care for their unhoused or recently housed patients, clients, and residents. Some homeless services providers and street medicine providers had reservations about becoming part of the managed care ecosystem but acknowledged and appreciated that representatives from the managed care plans were taking time to listen and respond to their concerns.

> *"Now we have the managed care plans playing a bigger role and having a lot more visibility and discussions with street medicine providers. So, I think it's a time for curiosity and caution for street medicine because anytime you start to monetize care in a new way, there's always this tendency to lose the story, the humanity, the spirit of what street medicine is, and now look at it as just another program, another mechanism, another way to bill and see numbers versus caring for lives." - Street Medicine Provider, Healthcare.*

2. Strong relationships are essential for integrated care. But organizations have to design the work in ways that make it easy for those relationships to develop. Several challenges including high turnover, low wages, and differing beliefs about care can interrupt the relationship building process. There's no one solution. But ensuring staff have weekly care coordination meetings or daily huddles, providing adequate supervision and training so staff feel supported, and creating liaisons or boundary spanner roles are a few of the ways organizations can design work to support strong relationships between staff who deliver integrated services.

> *"Partnerships are respect and relationship driven. But good relationships are facilitated by good organizations that are well funded, that take care of their employees, that have intact management systems, that have very good mid-level and upper-level management, and excellent chief officers that believe in the mission. I see two fundamental flaws when it's a struggle. One is when an agency is suffering from bad management. And they don't get paid a lot, so it's tough. [...] The other is when they do not share the same fundamental health care belief that we share, whether it's believing in harm reduction or motivational interviewing. We strongly believe in the idea of giving long-acting injectable antipsychotics. If they don't believe in treating psychiatric conditions with medications that is going to be a big impasse." - Street Medicine Provider, Healthcare.*

> *"When you are co-locating staff in the same location, and you're asking them to work together and be accountable to one another, what happens is suddenly*

their performance is on display to one another. If our two organizations are jointly putting staff in the building, I'm hearing from my workers that your staff are terrible. And then I'm thinking, 'Oh, that organization does a terrible job.' All of the things that usually go on behind closed doors within organizations are on display for one another. And people can see each other's organizational faults and weaknesses in ways they never saw them before.

That was an ah-ha moment for me in partnership development. We used to say the frontline workers had to have regular meetings for case conferencing. And the executive directors used to come together as a leadership group. But we realized that the managers of the frontline workers also had to meet regularly to engage in collaborative problem-solving to support their teams. Because if each organization had slightly different policies about leaving early on the Friday before a holiday weekend or other little things that caused friction when your workers were working together, you had to have those supervisors of the frontline workers actually see themselves as a team so that they could be a unified front in supporting their workers and in communicating back to their executive leadership about more structural changes that needed to be made to bring those organizations in more alignment in their practices in working together." - Consultant, Healthcare.

3. Organizations have developed strategies to form and sustain cross-sector partnerships to integrate care. They go to conferences and participate in regional gatherings where they can identify potential partners. Early on, they take time to meet with new partners to build trust and establish a shared vision. As they start working together, they set up cross-cutting structures to facilitate coordination (many of the same relational job design features mentioned above), including regular meetings, data sharing agreements, co-locating staff and services, and hiring staff who have worked in the other sector. Finally, to sustain the work, they celebrate wins, proactively resolve disagreements, and identify and track the outcomes that matter to each partner. To read more about cross-sector partnership strategies, see our partnership strategies toolkit.

"When we developed new programs, we always sat down with all of the stakeholders — community stakeholders, law enforcement, fire, the Department of Mental Health, the Department of Health Services, and everybody, and said, 'Let's get the parameters right.' You need to get people on board, and you've got to keep that communication going. You've got to be public facing. We are forever giving a talk somewhere, all the time. We are always going to gatherings and listening. We, and by 'we,' I mean the executives on my team. We spend a lot of time on calls, on listening. And then we make sure that we contact organizations when it seems like they need our services, or we need theirs. But we spend a lot of time on CMS and state calls, advisory committees. And there are a lot of stakeholders on those calls. We just listen and then take the next step." - Chief Executive Officer, Homeless Services.

4. Without upstream investments to build more housing and ensure the availability of community resources, efforts to integrate care won't achieve their full potential. Medi-Cal investments in social services like medically tailored meals and housing navigation can be life changing for the patients who qualify for and receive services. But the success of these new Medi-Cal services depends on the availability of community resources outside of healthcare. Today, many of those resources are scarce. There is an especially urgent need for more housing that is affordable to people with very low incomes. People we spoke with from each sector emphasized that CalAIM ECM and CS services are not a substitute for upstream investments in housing, transportation, and food access and affordability that help whole communities thrive.

> *"There are clear systems problems outside of the world of homeless services that until we address are going to continue to worsen homelessness across the country, let alone within Los Angeles. We see the consequences of mass incarceration, the war on drugs, unchecked capitalism, no rent control, no affordable housing, the loss of industrial jobs, moving into the service sector jobs, racism, structural and systemic racism, classism, oppression, those things. We can do our best to work with folks that are traumatized and homeless as a result of the clashing of many of these pieces. But inflow [of new people into homelessness]? Until we address those major issues, I don't know what we can do with that. I'm not saying it's not resolvable because I think it is, but I think there are larger systemic issues that we have no control over. There is a shift towards starting to recognize that." - Coordinator, Homeless Services.*

> *"In CalAIM, the investments in social care services almost came as an afterthought. In terms of, well, if we are bringing all of these folks into case management that are experiencing significant hardship, but we haven't invested in the social supports out in the community to provide those additional resources, where do we refer them? All housing organizations are maxed out right now, food pantries the same thing." Senior Leader, Community Health Center.*

> *"Housing navigation itself doesn't help without the housing part." - Director, Managed Care Plan.*

Ultimately, what we found is that cross-sector care integration relies on both the relationships people build and the systems organizations design to support those relationships. Organizations can achieve integration through partnerships, or they can build new cross-sector capabilities internally within their own organization (in fact, they often do both). How organizations go about pursuing partnerships matters. And this work is hugely impacted by the availability or scarcity of basic resources outside of both healthcare and homeless services.

Despite challenges, providers in both sectors see this work as fundamental to ending homelessness. As a health care provider in Skid Row described:

> *"The pandemic forced us to come to the table together. I remember when the pandemic first started in March 2020, we had LAPD, LA Fire, interim housing*

providers, we had Department of Mental Health, we had all of these care entities coming together to have this huge meeting in Skid Row to say, 'How do we get out into the community, get testing, identify folks who are suffering with COVID, who can't reliably isolate? Let's just be all-hands-on-deck.' And it was so beautiful, honestly. And I would say that that kind of thread of being forced to come to the table because we were dealing with a pandemic, and obviously disproportionately impacted our community of folks experiencing homelessness, I would say that really changed the landscape from, 'Hey, we should work together', to, 'Oh no, we have to work together.'" - Medical Provider, Community Health Center.

At CCI, we believe this moment of growth and change is an opportunity to advance cross-sector care integration for people experiencing homelessness. Our new program which is called Innovation Accelerator: Housing and Health, will fund and support community health centers, street medicine teams, and community-based organizations working to bridge housing and healthcare in Los Angeles County.

Now that there is funding available to help scale and sustain integrated care models (e.g., CalAIM, PATH, HHIP), we believe that it's important that the people who have been doing this work for years lead and are central to bringing these models to scale. There is so much experience to tap into, share, and build upon as these integrated models become adopted more widely. Which is why our program will include teams from organizations in both the healthcare and homeless services sectors and will be guided by an advisory group with representation from health plans, local government, community advocates, and people with lived experience of homelessness.

For more information about our upcoming program or to stay in touch, you can sign up for our Housing and Health Learning Community here. Or reach out directly to Chris Rubeo at chris@careinnovations.org.

Acknowledgments

The insights in this article represent the accumulated knowledge of many dedicated and passionate providers. We are grateful that they were so generous and willing to share what they have learned. We hope you find the study helpful in your work. And we hope you will find ways to use this study to make care more humane, equitable, and effective.

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Citations

1. Liu, M., Sandhu, S., Feldman, B. J., & Munson, D. G. (2024). Health Care beyond Clinic Walls-Sustaining and Scaling Up Street Medicine. The New England journal of medicine.

2. Personal communication with Brett Feldman on September 10, 2024.

3. National Health Care for the Homeless Council. (2023). Dissecting the Street Medicine Landscape Analysis with Street Medicine Leaders [Video]. YouTube.

4. Feldman, B. J., Feldman, C. T., Kogan, A. C., Saluja, S., & Cousineau, M. (2023). The California Street Medicine Landscape Survey and Report. California Health Care Foundation.

5. Crocker, H., Kelly, L., Harlock, J., Fitzpatrick, R., & Peters, M. (2020). Measuring the benefits of the integration of health and social care: qualitative interviews with professional stakeholders and patient representatives. BMC Health Services Research, 20, 1-9.

6. Singer, S. J., Kerrissey, M., Friedberg, M., & Phillips, R. (2020). A comprehensive theory of integration. Medical Care Research and Review, 77(2), 196-207.

7. Adarkar, A., Gjika, T., Ward, T., Woetzel, J., & Wong, Y. (2023). Homelessness in Los Angeles: A unique crisis demanding new solutions. McKinsey & Company.

8. Howle, E. M. (2021). Homelessness in California: The State's Uncoordinated Approach to Addressing Homelessness Has Hampered the Effectiveness of Its Efforts. California State Auditor.

9. King, M. (2021). Los Angeles City and County Health Service Coordination for People Experiencing Homelessness: Rapid Response Landscape Analysis. People's Health Solutions.

10. Mosley, J. E. (2021). Cross-Sector Collaboration to Improve Homeless Services: Addressing Capacity, Innovation, and Equity Challenges. The ANNALS of the American Academy of Political and Social Science, 693(1), 246-263.

11. Los Angeles County Department of Public Health. (2024). New Public Health Report Shows Homeless Mortality Rate Plateaued in 2022. Center for Health Impact Evaluation.

12. Chuang, E., & Safaeinili, N. (2023). Addressing Social Needs in Clinical Settings: Implementation and Impact on Health Care Utilization, Costs, and Integration of Care. Annual Review of Public Health, 45.

13. Fichtenberg, C., Delva, J., Minyard, K., & Gottlieb, L. M. (2020). Health and Human Services Integration: Generating Sustained Health and Equity Improvements. Health Affairs, 39(4), 567-573.

14. Willison, C. E., Lillvis, D., Mauri, A., & Singer, P. M. (2021). Technically Accessible, Practically Ineligible: The Effects of Medicaid Expansion Implementation on Chronic Homelessness. Journal of health politics, policy and law, 46(6), 1019–1052.

15. Kerrissey, M. J., Mayo, A. T., & Edmondson, A. C. (2021). Joint problem-solving orientation in fluid cross-boundary teams. Academy of Management Discoveries, 7(3), 381-405.

16. Reid, C. (2023). Permanent Supportive Housing as a Solution to Homelessness: The Critical Role of Long-Term Operating Subsidies. Terner Center for Housing Innovation

17. Office of Policy Development and Research. (2023). Housing First: A Review of the Evidence. Evidence Matters.

18. Birnbaum, M., & Burns, J. (2023). Under historic rule, providers will get paid for treating the homeless. Association of Health Care Journalists.

Study design and methods

We used stratified purposeful sampling to select organizations that were identified as leaders in effectively coordinating medical and social care for unhoused people in Los Angeles County. Between October 2022 and September 2023, we conducted 54 interviews with staff at homeless services agencies (n=19), health care provider organizations (n=17), local government agencies (n=12), and managed care plans (n=6). All study participants were directly involved with efforts within their organizations to integrate social and medical care for people experiencing homelessness.

We also conducted six site visits to observe coordination in the field. Our observations included shadowing street medicine and multidisciplinary teams as they provided care in encampments and shelters. We also visited shelters and housing sites that had co-located medical care on site for their residents. Interview transcripts and observation notes were coded and analyzed using an iterative inductive and deductive approach.

The study was exempt from internal research review board review by the UC Berkeley Institutional Review Board under 45 CFR 46.102. (Protocol ID: 2024-04-17332); all study participants provided their verbal informed consent to participate in this study.

Sustainable Transitions And Building Lasting Empowerment (STABLE)

Name or Initials:_____ Date: _____

Living environment:

☐ Unsheltered ☐ Sheltered ☐ Transitional housing ☐ Permanent housing ☐ Other:_____

Mark whether you agree or disagree with the statements below.

#	As of today…	Yes	Sometimes	No	Comments
1	I sleep in a safe place				
2	I get enough sleep				
3	I eat enough food				
4	I get enough clean water				
5	I use a toilet whenever I need to				
6	I shower or wash my body at least once per week				
7	I take care of my hygiene daily (ex: brush teeth, wash hands, use deodorant)				
8	I have enough clean clothes				
9	I get to the all the places I need to go				
10	I keep track of all my belongings				
11	I pay for everything I need without running out of money				
12	I prepare food for myself to eat				
13	I use a phone to stay in touch with others				
14	I keep my living space clean enough to feel comfortable				
15	I manage my responsibilities so I'm not asked to leave the place I stay.				
16	I take all my medications when I need to				

Flip the page for more questions.

Sustainable Transitions And Building Lasting Empowerment (STABLE)

#	As of today…	Yes	Sometimes	No	Comments
17	My physical health care needs are met				
18	My dental / teeth care needs are met				
19	My vision / eye care needs are met				
20	My mental health care needs are met				
21	I have a primary care doctor to ask questions about my health				
22	I have health insurance or other payment coverage for my health care				
23	I get help when I need urgent medical attention				
24	I have enough personal space				
25	I have housing that I am not worried about losing				
26	I find things to do when I'm bored				
27	I set goals for myself				
28	I work to achieve my goals				
29	I solve most problems if I try hard enough				
30	I have social supports that I can trust				
31	I feel like my life has purpose				

For rows you selected "No", write in the "Comments" ***why*** it is difficult to do.
Choose up to 4 of your "No" items to set as goals. You may also add goal(s) not included on this form.

1. _____
2. _____
3. _____
4. _____

Housed, now what?

Occupational therapy skills training to maintain the transition out of homelessness

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OUTREACH THERAPY
Occupational Therapy for Health and Housing
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NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL

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About Us

- Independent nonprofit in Pittsburgh, PA
- Julia founded in 2023 based on volunteer street med and OT needs assessment
- Rachael and Jordann joined in 2025 after completing doctoral capstone 2024-2025
- You're looking at our whole nonprofit right now!
- We provide OT services following people from street, shelter, and into housing supporting successful transition out of homelessness
- Funded by public and private grants

OUTREACH THERAPY
Occupational Therapy for Health and Housing

Learning Objectives

1. Explain increased risks in the transition from homelessness to housing.
2. Describe the role of occupational therapy in supporting housing transitions.
3. Identify one strategy to improve housing transition outcomes in your community of practice.

If this sounds familiar, raise your hand and keep it up:

Someone moves into housing after homelessness and…

- Is suddenly isolated from their support systems
- Is unable to meet the responsibilities of housing (cleaning, bill paying)
- Is unable to keep up with getting groceries, doing laundry
- Their housing fills with clutter / hazards / trash
- Their health / chronic conditions lead to difficulty with self-care tasks
- Returns to homelessness

You're not alone!

We see it too! So much that I started a nonprofit!

Vulnerability of housing transitions

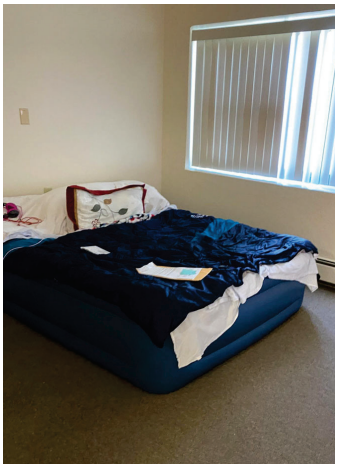
- In the U.S., **returns to homelessness range from 5-45%,** depending on housing pathway and time points measured [1]
- **First 6 months in housing has highest risk of death** [2]
- **It's a Coin Flip!** In 2025 in Allegheny County (where we are from), **only 56% of people finish their housing program still housed.**[3]
  - ~42% left program doubled up, homeless, institutionalized, or unknown
  - Doesn't include non-program housing (e.g. Section 8) with less supports
- The longer you are homeless, *or return to homelessness*, the worse health outcomes [4]

1. Tsai & Byrne 2023, 2. Henwood 2015, 3. Allegheny Analytics, 4. Richards 2023

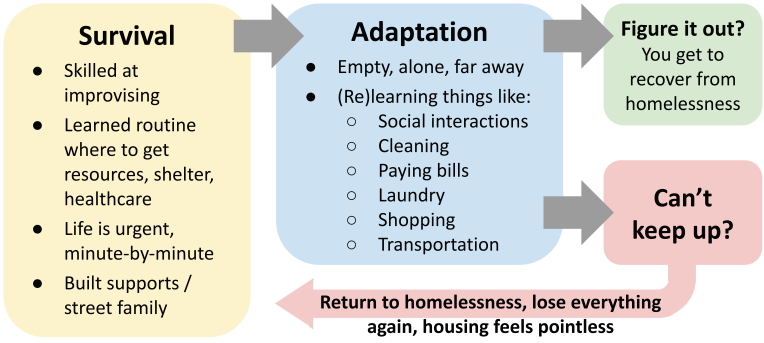
I feel so guilty. I've been dreaming of this for years, and everyone else is dying to get a place.

I'm struggling and don't want to be ungrateful. *But it's been months and none of my friends from the shelter sent me a single text. To get anywhere I need to take two buses for hours each way. There's no grocery store. I'm in too much pain to cook, sweep, or wash my dishes. I don't have an income to pay this rent.*

I can't lose this and have to start over.



Adjusting to housing is difficult and high stakes.



Based on Marshall (2023) Bridging the Transition to Housing Framework (2nd Edition)

Figuring this out shouldn't be left to chance.

Adaptation

- Empty, alone, far away
- (Re)learning things like:
  - Social interactions
  - Cleaning
  - Paying bills
  - Laundry
  - Shopping
  - Transportation

Figure it out? You get to recover from homelessness

Based on Marshall (2023) Bridging the Transition to Housing Framework (2nd Edition)

Figuring this out shouldn't be left to chance.

Occupational therapy (OT) is "doing" therapy to help you do the things that **occupy** your life.

Adaptation

- Empty, alone, far away
- (Re)learning things like:
  - Social interactions
  - Cleaning
  - Paying bills
  - Laundry
  - Shopping
  - Transportation

Figure it out? You get to recover from homelessness

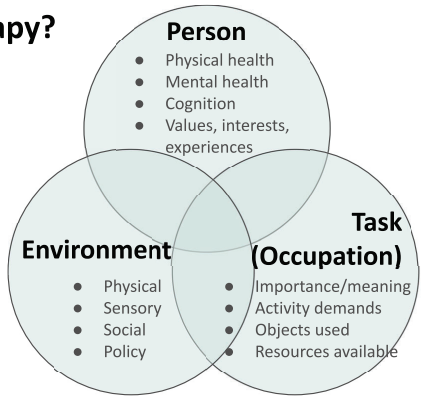
Based on Marshall (2023) Bridging the Transition to Housing Framework (2nd Edition)

Why Occupational Therapy?

We are experts in **problem-solving function in daily life.**

Our countywide rate of **56%** housing retention in 2025?

That year, our patients had **100%** housing retention 6 months post move-in.



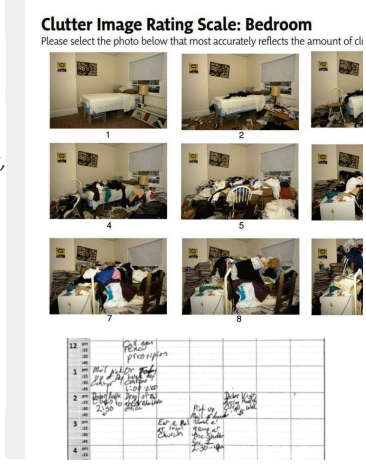
Occupational Therapy is vastly underutilized in homelessness

- Origin in mental health and community settings 100+ yrs ago
- OT is currently commonly known in hospitals, outpatient clinics, pediatrics, schools, home health
- **OT is not yet a default part of homeless services despite being evidence-based to:**
  - Increase independence in daily living skills after homelessness [1, 2]
  - Increase successful transition from shelter to housing [3, 4]

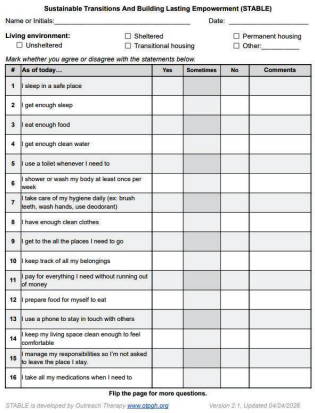
1. Synovec et al. 2020,, 2017 2. Helfrich & Fogg, 2007, 3. Marshall et al., 2023, 4. Gutman & Raphael-Greenfield

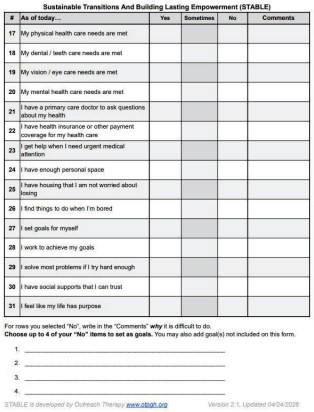
The OT Process: Evaluation

- Develop occupational profile
  - *Get to know the person, their values, interests, strengths, barriers, contexts, goals*
- Specific functional assessment based on their values and needs (e.g., managing appointments, cleaning)
- Set goals together!



Our in-house tool (STABLE) for OTs and non-OTs alike to identify and set collaborative goals

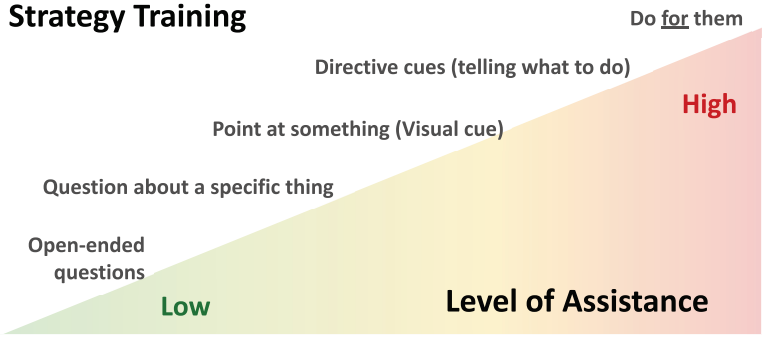




The OT Process: Intervention

- **THEN WE DO IT!!**
- **We analyze and problem-solve a solution that works for them**
- Self-manage pain, fatigue, chronic health conditions
- Meta-cognitive strategies for organization, memory, planning
- Cook, clean, do laundry
- Budget, pay bills
- Navigate community (e.g. bus, walking, medical transit)
- Build daily routines
- Use technology (phone, computers)
- Job search
- Find and participate in social, leisure activities
- Adapt environment and use equipment for disabilities
- Assess function and recommend appropriate levels of care

Strategy Training



"Do with" instead of **"do for"** someone

The OT Process: Outcomes

- We reassess every ~3 months to see if they are making progress on goals
- Update goals and renew plan of care, or discharge once they meet all goals and stably maintain housing
- If they aren't able to develop independence with the skill and this will risk health/housing, we facilitate connection to long term services (e.g. PACE/LIFE programs for age 55+)

Where You Are At the Center
PACE
Program of All-inclusive Care for the Elderly

Your turn!

Passing out scenarios to discuss in small groups

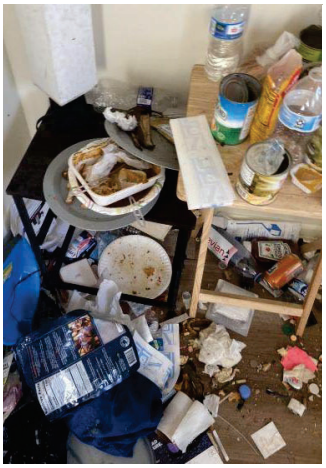
Scenario 1: Clutter

A **man in his 70s with Chronic Obstructive Pulmonary Disease (COPD)** moved into an apartment after 30 years of homelessness.

He is **struggling to clean**, and it has caught the attention of neighbors and the building management due to odor and pests.

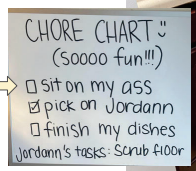
Scattered throughout the home is **clutter that covers 80% of the floor (trash, rotting food, dirty dishes, used cigarettes)**. There are many flies in the air and no walkways to safely transport his oxygen tank.

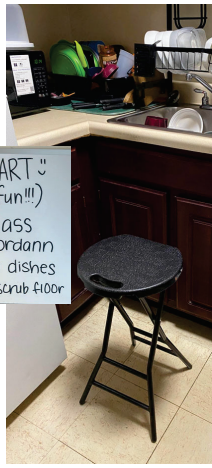
How do you help him stay housed?



Scenario 1: Clutter

- Initially high levels of assist; difficulty due to fatigue and 30+ years out of habits
  - *Practical needs while skills develop: fly tape*
- Taught energy conservation and education on cause of flies
  - *Shower chair*
  - *Stool in kitchen for rest breaks*
  - *Cart to push, garbage cans in each room to decr energy needed per task*
- Decreased level of assist as he learned





Scenario 2: Appointments

A woman in her 60s with **bipolar disorder, ADHD and chronic pain** moved into her own apartment after years of street homelessness and opioid use disorder (now stabilized on methadone).

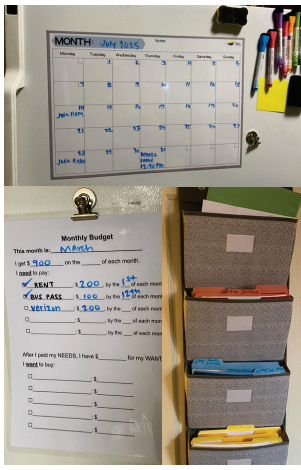
Her providers tell you that she has **not followed up on important appointments**, she is **behind on paying rent and utilities.**

When you meet her, she shows you a pile of papers with notes scrawled on edges or in texts on her phone with unsaved numbers.

How do you help her stay housed?

Scenario 2: Appointments

- Education on pacing and cognition
- Visible and easily accessible executive function strategies
  - Whiteboard calendar on fridge
  - "Drop-in" over-door document organizer
- Created and practiced script to use for calling to make appts
- Now keeping up with appts, payments



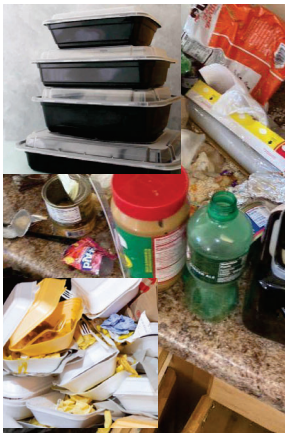
Scenario 3: Odor

A man in his late 40's with **schizophrenia and autism** is living in permanent supportive housing after **years of street homelessness.** His room is odorous and **cluttered with items piled high, snacks spread across counters, and shoes covering the floor**.

He hangs car fresheners in to try to make it smell better, but is **distressed that the smell just keeps coming back.**

He tries to clean but gets overwhelmed, abandoning the task within minutes.

How do you help him stay housed?

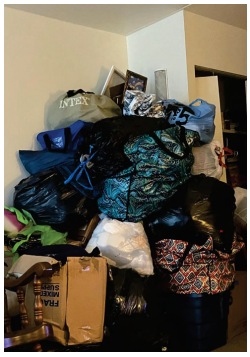


Scenario 3: Odor

- Chunk it! Snack section first to teach the skill
- Discovered spoiled food was cause
- He started routinely clearing out snack and fridge area
- Educated refrigerated vs. shelf stable, identifying mold / spoiled food
- Written/visual chart of cleaning routine for when OT is not present

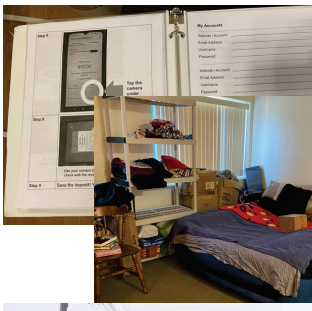
Scenario 4: Chronic conditions

A woman in her late 50's with a history of stroke, chronic pain, unmanaged type 2 diabetes, hypertension, depression, complex PTSD, ADHD and autism, **moves into a Section 8 apartment after years of sheltered homelessness**.
Once housed, she retrieves belongings from a storage locker, which are now **blocking paths to walk around**. She **does not take any of her medications**, runs out of her SSI check within the first 4 days of each month, has **piles of dishes in her sink attracting flies**, does not leave her apartment for appts or shopping, and needs help to use the computer to order groceries online with her SNAP.
How do you help her stay housed?



Scenario 4:

- Bags of items: Together wash all clothes and sort into keep, donate, throw away
- "How-to" binder on phone/ computer use, logins, call to pay rent
- Energy conservation, executive function
- After 1 year of skills training, still needed mod-max assist for much cleaning, shopping
  - During this year, had a 2nd stroke
- Months and multiple attempts of facilitating waiver / PACE program onboarding until agreement to participate after hospitalization and alternative was SNF



Add an OT to your team

- While non-OTs can try basics of these strategies, having the specialized training and dedicated time of an OT for this is most effective
- Collaborate or recruit from:
  - Universities, Hospitals
  - State OT associations
  - Mental health OT fellowships
- Grant funding: can be related to disability, SUD, mental health, housing
- Mobile outpatient vs Home Health
  - Billing may be possible: CPT 97535 Self-Care/Home Management Training

Conclusion

- Transitioning from homelessness to housing poses **new challenges that may risk loss of housing, illness, injury, or death**
- **Occupational therapy is the missing link of homeless housing services** as a profession **specialized in helping people live as independently as possible**
- While there are some strategies from OT that can be used by non-OT teams, it is possible and most effective to **utilize licensed OTs in housing transitions to maximize successful outcomes**

Questions?

Want help adding an OT to your team,
or have other questions after conference?
Email me! julia@otpgh.org

References

Allegheny Analytics. (2018) People Using Homelessness Programs: Interactive Dashboard. Accessed June 6, 2026. https://analytics.alleghenycounty.us/2018/07/26/clients-using-allegheny-county-homelessness-programs-interactive-dashboard/

Boland, L. (2018). Transitioning from homelessness into a sustained tenancy: What enables successful tenancy sustainment? (The Moving on Project). University of Plymouth. http://dx.doi.org/10.24382/722

Frost, R. O., Steketee, G., Tolin, D. F., & Renaud, S. (2008). Development and validation of the clutter image rating. Journal of psychopathology and behavioral assessment, 30(3), 193-203. https://doi.org/10.1007/s10862-007-9068-7

Goering, P., Veldhuizen, S., Nelson, G. B., Stefancic, A., Tsemberis, S., Adair, C. E., ... & Streiner, D. L. (2016). Further validation of the pathways housing first fidelity scale. Psychiatric services, 67(1), 111-114. https://doi.org/10.1176/appi.ps.20140035

Gutman, S. A., & Raphael-Greenfield, E. I. (2017). Effectiveness of a supportive housing program for homeless adults with mental illness and substance use: A two-group controlled trial. *British Journal of Occupational Therapy, 80*(5), 286-293. https://doi.org/10.1177/0308022616680368

Helfrich, C. A., & Fogg, L. F. (2007). Outcomes of a life skills intervention for homeless adults with mental illness. The journal of primary prevention, 28(3), 313-326. https://doi.org/10.1007/s10935-007-0103-y

Henwood, B. F., Byrne, T., & Scriber, B. (2015). Examining mortality among formerly homeless adults enrolled in Housing First: An observational study. BMC public health, 15, 1-8. https://doi.org/10.1186/s12889-015-2552-1

Marshall, C., Gewurtz, R., Barbic, S., Roy, L., Cooke, A. & Lysaght, R. (2023). Bridging the Transition to Housing: A Social Justice Framework to Guide the Practice of Occupational Therapists and other Professionals who Support Individuals with Experiences of Homelessness (2nd Edition). https://doi.org/10.13140/RG.2.2.24013.41443

Munthe-Kaas, H. M., Berg, R. C., & Blaasvær, N. (2018). Effectiveness of interventions to reduce homelessness: a systematic review and meta-analysis. Campbell Systematic Reviews, 14(1), csr-2018. https://doi.org/10.4073/csr.2018.1

Richards, J., Henwood, B. F., Portor, N., & Kuhn, R. (2023). Examining the role of duration and frequency of homelessness on health outcomes among unsheltered young adults. Journal of Adolescent Health, 73(6), 1038-1045. https://doi.org/10.1016/j.jadohealth.2023.06.013

Stefancic, A., Tsemberis, S., Messeri, P., Drake, R., & Goering, P. (2013). The Pathways Housing First fidelity scale for individuals with psychiatric disabilities. American Journal of Psychiatric Rehabilitation, 16(4), 240-261. https://doi.org/10.1080/15487768.2013.847741

Synovec, C. E., Merryman, M., & Brusca, J. (2020). Occupational therapy in integrated primary care: addressing the needs of individuals experiencing homelessness. The Open Journal of Occupational Therapy, 8(4), 1-14. https://doi.org/10.15453/2168-6408.1699

Tsai, J., & Byrne, T. (2023). Returns to homelessness: key considerations for using this metric to improve system performance. American Journal of Public Health, 113(5), 490-494. https://doi.org/10.2105/AJPH.2023.307263

Tab 2
Program Budget and Financial Report

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

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

DATE: September 10, 2026

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 FINANCE REPORT

Preliminary grant expenditures for August 2026 total an estimated $136,193. Missing from the preliminary report are county support area charges (such as IT, etc.). However, the largest component of HCH/FH expenditures is contract/MOU and salaries/benefits, both of which are close to fully reported for August.

Based on the expenditures to date, we anticipate expending about $3.6M, including our BHSE and Expanded Hours (EH) grants. This would leave us with approximately $524,000 in carryover for next year. This is a little better than originally anticipated, partly due to staff Work-Out-of-Class outside of HCH/FH, which reduces our Salary & Benefit costs.

Attachment:

- GY 2026 Summary Grant Expenditure Report Through 08/31/26

COUNTY OF SAN MATEO CALIFORNIA

GRANT YEAR 2026

Details for budget estimates	Budgeted [SF-424]	Aug-26	To Date (07/31/26)8	Projection for end of year	Projected for GY 2027	
EXPENDITURES						
Salaries						
Director, Program Coordinator						
Management Analyst ,Medical Director						
new position, misc. OT, other, etc.						
	740,000	*47,354*	387,579	625,000	750,000	
Benefits						
Director, Program Coordinator						
Management Analyst ,Medical Director						
new position, misc. OT, other, etc.						
	230,000	*14,312*	122,610	180,000	260,000	
Travel						
National Conferences (2500*8)	12,000		4,652	7,250	12,000	
Regional Conferences (1000*5)	1,500		0	250	1,500	
Local Travel	250		40	100	250	
Taxis	250			0	250	
Van & vehicle usage	1,000		0	500	1,000	
	15,000		4,692	8,100	15,000	
Supplies						
Office Supplies, misc.	2,000		9,785	12,000	5,000	
Small Funding Requests						
	2,000		9,785	12,000	5,000	
Contractual						
2022 Contracts			140,872	140,872		
2022 MOUs			237,696	237,696		
Current 2023 MOUs	1,150,000		664,317	1,125,000	1,400,000	
Current 2023 contracts	1,250,000	*74,353*	735,519	1,150,000	1,200,000	
---unallocated---/other contracts						
	2,400,000		1,778,404	2,653,568	2,600,000	
Other						
Consultants/grant writer	60,000		15,835	40,000	60,000	
IT/Telcom	110,000	*174*	48,871	95,000	120,000	
New Automation				0	-	
Memberships	5,000		0	3,000	5,000	
Training	5,000			0	5,000	
Misc	30,000		7,119	15,000	30,000	
	210,000		71,825	153,000	220,000	
TOTAL	3,597,000	*136,193*	2,374,895	3,631,668	3,850,000	
GRANT REVENUE						
Available Base Grant	2,858,632	*w/BHSE & EH*	**3,525,299**	**3,525,299**	3,858,632	w/ BHSE and EH
Prior Year Unexpended to Carryover (verified)	630,529		630,529	630,529		
Other					524,160	carryover
HCH/FH PROGRAM TOTAL	3,489,161		4,155,828	4,155,828	4,382,792	
***Once 2025 carry-over is estabished. We will roll BHSE & EH into 2026 grant year reporting {DONE}						
BALANCE	**(107,839)**	**Available**	**1,780,933**	**524,160**	**532,792**	
			Current Estimate	**Projected**		
2025 Carryover is from:	39950 Exp Hours				based on est. grant of $3,858,632	
	365000 BHSE					
	225579 Base Grant					
	630529					
Non-Grant Expenditures						
Salary Overage	12,000	*250*	1,500	9,000	15,000	
Health Coverage	143,000	*6,954*	45,579	110,000	150,000	
base grant prep	0			0		
food	7,500	*386*	1,987	6,500	8,000	
incentives/gift cards	1,500			1,500	1,500	
	164,000		49,066	127,000	174,500	
TOTAL EXPENDITURES	**3,761,000**	***143,783***	**2,423,961**	**3,758,668**	**NEXT YEAR**	**4,024,500**

Tab 3
HCH/FH Director's Report

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

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

DATE: September 10, 2026

TO: Co-Applicant Board, 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 August 13, 2026, Co-Applicant Board meeting.

The HCH/FH Program has submitted a grant application in response to HRSA's Expanding Nutrition Services funding opportunity. HCH/FH requested $350.000 for each of 2 years ($700,000 total) to support the implementation of two projects to increase nutrition services to the homeless population. One project will work directly with newly and soon-to-be Permanent Supportive Housing residents on nutrition education and the necessary skills – purchasing, storing, cooking, etc. – to support a healthier life as they move into supportive housing. The second will replicate an expansion of Abundant Grace's farmwork apprentice program with additional lean-in to the nutritional aspects related to the food they are growing. We are excited and very hopeful for successful funding of our application.

HCH/FH continues to pursue ways to improve the utilization and efficacy of the twice-monthly Sunday Coastside Primary Care Clinic. Recognizing the significant access impact that the recent and proposed federal and state changes to Medicaid/MediCal are and will have on the farmworker population, HCH/FH has opened discussions across SMMC to look into covering as many ancillary costs as possible with our Expanded Hours grant to enable us to add uninsured/under-insured farmworkers to the population being served on Sundays.

As the Board may be aware, our HCH/FH Management Analyst, Gozel Kulieva, has accepted a permanent position with the County CEO Office. We immediately opened a recruitment to fill the position, and it closed at midnight last Thursday night. There was a very good response to the recruitment, and we are screening the applications this week. We are hopeful to fill the position by early November.

Seven Day Update

ATTACHED: Program Calendar

COUNTY OF SAN MATEO CALIFORNIA

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

San Mateo Medical Center
222 W. 39th Avenue
San Mateo, CA 94403
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County of San Mateo
Health Care for the Homeless & Farmworker Health (HCH/FH) Program
2026 Co-Applicant Board Calendar

Board meetings are in-person on the 2nd Thursday of the Month 10am-12pm

MONTH	AREA			
	Programmatic	**Learning/Conferences**	**Recognition (Health, Historical/ Cultural, Holidays)**	
JANUARY	- HCH/FH Board Meeting (1/8)		• Glaucoma Awareness Month • Cervical Cancer Screening Month • National Human Trafficking Prevention Month • International Holocaust Remembrance Day (1/27)	• New Year's Day (1/1) • Martin Luther King Day (1/19)
FEBRUARY	- HCH/FH Board Meeting/ Finance Subcommittee Meeting (2/12) - UDS submission - Review	• American Hospital Association Rural Health Care Leadership Conference (San Antonio, TX – February 8-11, 2026)	• National Children's Dental Health • American Heart Month • National Cancer Prevention Month • National Wear Red Day (2/6) • Black History Month • World Day of Social Justice	• Lincoln's Birthday (2/12) • President's Day (2/16) • Lunar New Year (2/17)
MARCH	- HCH/FH Board Meeting/ QI/QA Subcommittee Meeting (3/12) - Updated Sliding Fee Discount Scale (SFDS) - Approve	• Leadership Summit on Ending Homelessness (San Diego, CA – March 2-4 2026)	• Colorectal Cancer Awareness Month • Developmental Disabilities Awareness Month • National Doctors Day (3/30)	
APRIL	- HCH/FH Board Meeting (4/9) - SMMC Annual Audit - Approve	• National Center for Farmworker Health Spring Symposium (New Orleans, LA – April 15-17 2026)	• Alcohol Awareness Month • Sexual Assault Awareness Month • Counseling Awareness Month • National Minority Health Month • Defeat Diabetes Month • National Public Health Week (4/6-4/12)	
MAY	- HCH/FH Board Meeting/ - Finance Subcommittee Meeting (5/14)	• NRHA Rural Health Access Conference (San Diego, CA – May 8-19)	• American Stroke Awareness Month • High Blood Pressure Education Month • Mental Health Awareness Month • National Trauma Awareness Month • Asian Pacific American Heritage Month	• Memorial Day (5/25)
JUNE	- HCH/FH Board Meeting/QI/QA Subcommittee Meeting (6/11) - Services/Locations Form 5A/5B – Approve	• National Healthcare for the Homeless Conference. (Orlando, Florida – June 8-11 2026)	• PTSD Awareness Month • Cancer Survivor's Month • LGBTQIA+ Pride Month	• Juneteenth (6/19)

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JULY	- HCH/FH Board Meeting (7/9) - Budget Renewal (Program) Approve		• National Minority Mental Health Awareness Month • Healthy Vision Month	• Independence Day (observed on (7/3)
AUGUST	- HCH/FH Board Meeting/ - Finance Subcommittee Meeting (8/13)		• National Breastfeeding Month • National Immunization Awareness Month • National Health Center Week (8/2 – 8/8)	
SEPTEMBER	- HCH/FH Board Meeting/ QI/QA Subcommittee Meeting (9/10) - Program Director Annual Review	• International Street Medicine Symposium. (TBD – September or October 2026)	• Healthy Aging Month • National Suicide Prevention Month • Gynecological Cancer Awareness Month • Hispanic Heritage Month (Starts 9/15)	• Labor Day (9/7)
OCTOBER	- HCH/FH Board Meeting (10/8) - Annual Conflict of Interest Statement due - Board Chair/Vice Chair Nominations		• Breast Cancer Awareness Month • Depression Awareness Month • Domestic Violence Awareness Month • Health Literacy Month • Patient-Centered Care Awareness Month • Child Health Day (10/6)	• Indigenous Peoples' Day/Columbus Day (10/12)
NOVEMBER	- HCH/FH Board Meeting/ - Finance Subcommittee Meeting (11/12) - Board Chair/Vice Chair Elections		• American Diabetes Month • National Sexual Health Month • Native American Heritage Day (11/27)	• Veteran's Day (11/11) • Thanksgiving (11/26)
DECEMBER	- HCH/FH Board Meeting/QI/QA Subcommittee Meeting (12/10)	• Institute for Healthcare Improvement (IHI) Forum (Phoenix, AZ – December 6-9, 2026)	• Seasonal Affective Disorder Awareness Month	• Christmas Eve (12/24) • Christmas Day (12/25) • New Year's Eve (12/31)

BOARD ANNUAL CALENDAR	
Project	**Timeframe**
SMMC Annual Audit - Review	April/May
UDS Submission - Review	Spring
Sliding Fee Discount Scale (SFDS)	Spring
Services/Locations Form 5A/5B – Approve	June/July
Budget Renewal - Approve	July/August/September (Program)– December/January (Grant)
Annual Conflict of Interest Statement	October (and during new appointments)
Program Director Annual Review	Winter
Annual QI/QA Plan – Approve	Winter
Board Chair/Vice Chair Elections	November/December

Tab 4
QI/QA 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
www.sanmateomedicalcenter.org
www.facebook.com/smchealth

DATE: September 10th, 2026

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

FROM: Amanda Hing-Hernandez, HCH/FH Medical Director
Angela Leung, HCH/FH Clinical Services Coordinator (WOC)

SUBJECT: QI/QA COMMITTEE REPORT

Q3 2026 HCH/FH QI/QA Subcommittee Meeting

- The HCH/FH QI/QA Subcommittee meeting for Q3 2026 will be held on September 10th, 2026 from 12:30pm to 2:00pm following the board meeting. Board members and staff have previously been notified of this meeting. This meeting will cover program updates, 2026-2027 QI/QA plan review, and performance metric updates.

Cancer Screening Project

- HCH/FH is working on a Cancer Screening Project (i.e. Breast, Cervical, and Colorectal) to compare cancer screening trends and needs within the PEH/FW population against the general SMMC population. An analysis of the HCH/FH quality metric data has been performed. HCH/FH to collaborate with BI team to create cancer screening report that includes general SMMC population.

Homeless Mortality Report

- Public Health Epidemiology has completed their analysis of the homeless mortality data. Epidemiology will create final products (i.e. data brief, executive summary, and/or data dashboards). HCH/FH, Center of Homelessness, and Epidemiology will collaborate on dissemination of the final product.

San Mateo Medical Center Updates

- As for general San Mateo Medical Center efforts that impact HCH/FH, all ambulatory clinics have started to screen for food insecurity at every visit. Also, there has been a greater focus on ensuring depression screening questions are appropriately asked when due.

Tab 5

Request to Approve Changes to Form 5B

COUNTY OF SAN MATEO
HEALTH SYSTEM

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

DATE: September 10. 2026

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

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: REQUEST FOR THE BOARD TO APPROVE CHANGES TO FORM 5B – LOCATIONS AS NECESSARY WITH SMMC'S OPENING OF THE NEW SOUTH SAN FRANCISCO CLINIC

In accordance with HRSA's Compliance Manual and the Board's Bylaws, one of the Board's responsibilities is determining the locations for the delivery of program services, and the maintenance of HRSA From 5B reflecting the locations of services.

With San Mateo Medical Center replacing the current South San Francisco Clinic with a new clinic located in the San Mateo County Wellness Center in South San Francisco, Form 5B will need to be updated to reflect this change. These changes will occur as necessary over the upcoming 3-4 months, exact timing to be determined.

We are requesting approval to update and submit HRSA Form 5B as appropriate and necessary to reflect the clinic change in location in South San Francisco as timely with the planned opening of the clinic. Approval of this item requires a majority vote of the Board members present.

San Mateo Medical Center
A County System of Healthcare

COUNTY OF SAN MATEO CALIFORNIA