

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

## Strategic Planning Retreat

### This is a Public and Open Meeting of the HCH/FH Co-Applicant Board

San Mateo Medical Center| 222 W. 39<sup>th</sup> Avenue 2<sup>nd</sup> Floor (Classroom 2) San Mateo

March 17, 2016, 8:00 A.M - 11:00 A.M.

### AGENDA

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*Documents for this meeting are provided in TAB 1.*

*Any additional documents will be available at meeting, and time will be provided for review.*

- |      |  |             |
|------|--|-------------|
| I.   | Opening Activities/Breakfast                           | 8:30-9:00   |
|      | a. Ice breaker   |             |
|      | b. Review of Mission/Vision (Jim)                      |             |
| II.  | Goals of the Day                                       | 9:00-9:10   |
| III. | Summary of Information to Date                         | 9:10-9:30   |
|      | a. Quantitative Data (Pat)                             |             |
|      | b. Overview of findings from Qualitative Data (Rachel) |             |
|      | c. Prioritization (Rachel)                             |             |
| IV.  | Service Gap Planning (Everyone)                        | 9:30-11:00  |
|      | a. Mental health and substance abuse                   |             |
|      | b. Dental  |             |
|      | c. Respite care  |             |
| V.   | Break  | 11:00-11:15 |
| VI.  | Program and Planning Gap Planning (Everyone)           | 11:15-12:45 |
|      | a. Program coordination                                |             |
|      | b. Board and staff growth                              |             |
|      | c. Measuring Data                                      |             |
| VII. | Next Steps/Lunch                                       | 12:45-1:30  |

#### **As you prepare for the retreat start thinking about each of the gaps:**

- 1. Articulate goal/objective**
- 2. Name three-five specific steps that will help achieve the goal.**
- 3. What resources are needed in terms of staff, money and time to achieve the goal?**
- 4. What other information is needed to move forward (think about what you must have and what would be nice to have)?**
- 5. Who is responsible for the next steps?**

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

# **TAB 1**

## **Strategic Plan data**

**Initial Findings**

**Data on homeless/farmworkers**

**Definition on homeless/farmworkers**

**HCH/FH Program 2015 Needs Assessment Report**

**HCH/FH Program 2015 Providers Survey results**

**Enabling Services Definition**

**Companion Animal Programs**

**Nutrition/Food Access Programs**

**Medical Respite Care**

**Mental Health/Substance Abuse Data**

**Dental Data**

**San Mateo County**  
**Health Care for the Homeless/Farmworker Health Program**  
**Three Year Vision Project: Initial Findings**  
**Final: February 23, 2016**

Prepared by: Rachel Metz

## **Introduction**

San Mateo County Health Care for the Homeless/Farmworker Health (HCH/FH) program started as a HCH program in 1991. Farmworker health was added in 2010. The mission of the program is to “provide our target communities of vulnerable individuals and families with access to and delivery of quality health care services directed to address their unique and comprehensive health needs.” The program has struggled over the last several years under intense scrutiny of the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA). The staff and the board entered into this visioning process with the intent of moving beyond the grant conditions and into developing a strategic vision for program development.

The HCH/FH program brings over \$2 million into the county directly as grant funding. In addition, the Section 330 designation allows the San Mateo Medical Center (SMMC), which is the primary provider of health care services to the homeless and farmworker population, to bill Federally Qualified Health Center (FQHC) rates across the non-homeless/farmworker portions of its safety-net population, accounting for a significant portion of the SMMC budget. The program is not big enough to directly address some of the outside barriers for the population like lack of affordable housing or shelter beds; however many of those interviewed felt that the program could do more coordination, advocacy and strategic contracting to improve services for the homeless and farmworkers in San Mateo County.

The key findings from the data review and interviews of internal and external stakeholders are presented in this paper, including:

- A brief summary of the number of homeless and farmworkers in San Mateo County and current services funded.
- A SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis, which summarizes the internal and external factors impacting the county.
- A description of the perceived primary gaps described in the interviews. In some cases statements that were made are perceptions and actual policy or practice may differ. In these cases, it may be indicative that more communication or information sharing is needed. The list is divided into two categories: 1) service gaps, and 2) program and planning gaps. These gaps are based on qualitative data and in some cases may need further data analysis to substantiate the need.
- Finally, there are brief findings from a few out-of-county organizations that highlight some best practices.

Below is the timeline for the visioning project. This document highlights potential areas of focus.

Next steps will include:

- More research and collecting more data in the areas that the Board want to pursue.
- Prioritize goals and develop an action plan (to be done at the HCH/FH retreat in March).

Date	Action
Nov 15- Nov 30, 2015	Review existing data and information
Nov 30- Dec 15, 2015	Schedule interviews with stakeholders
Dec 9, 2015- January 29, 2016	Conduct interviews with internal and external stakeholders
February 11, 2016	Present draft findings at Board meeting
February 11- February 29, 2016	Conduct additional research as needed
February 29, 2016	Complete draft three year vision document
March 17	Board Retreat- Review draft, prioritize, and develop next steps to operationalize
April 29, 2016	Final vision document complete

## Background

### Data on Numbers of Homeless and Farmworkers in San Mateo County

Pat Fairchild of John Snow Inc (JSI) has prepared reports on the homeless and farmworker populations in San Mateo County. The full documents are available. Very briefly, the reports find that data on the number of homeless, farmworkers and their families is limited and does not directly correspond with HRSA definitions. Estimates drawn from several data sources and using the HRSA definition are:

- Approximately **4,000-6,000** people are homeless in San Mateo County in a given year.
- Approximately **1,700-2,000** individuals currently employed in the agricultural/farmworker industry in the County each year. Including family members, who are also eligible for grant support, the total farmworker is at a **minimum 3,740-4,400**.

### Current HCH/FH Contracts and Services

The grid on the following page provides a summary of the current HCH/FH contractors and services provided. The SMMC services are not provided by contract. While many contracts have been on-going, this year the program has focused on increasing intensive care coordination developing a street medicine program, and expanding services to the Farmworker population in Pescadero.

Contractor	One Year Contract Amount	Target Population	Patient/visit target	Geographic Area	Services	Objectives/Outcomes
Behavioral Health and Recovery Services	\$ 90,000	Homeless: Street, shelter, transitional, Doubling up	300 unduplicated clients/ 900 visits	County-wide	Care Coordination	Behavioral health assessment, case management, establish a medical home
LifeMoves (formerly IVSN)	\$ 169,000	Homeless: Street, shelter, transitional, Doubling up	550 unduplicated clients/ 1500 visits	County-wide	Care Coordination, Intensive Care Coordination, eligibility assistance, health insurance enrollment	Initial assessments, establish medical home, SSI/SSDI enrollment, health insurance enrollment, transportation
Public Health-Mobile Health Van	\$ 277,500	Homeless: Street, shelter, transitional, Doubling up	1,250 unduplicated patients/ 2,500 visits	County-wide. Sites are in Redwood City, South San Francisco, San Mateo, and San Bruno.	Primary care services	Provide health screening for chronic disease and other health conditions, and referrals for other health and social services as needed.
Public Health-Mobile Health Van-Expanded Service Contract	\$ 178,500	Homeless and formerly incarcerated	626 unduplicated clients/ 782 visits	Service Connect and Maple Street Shelter, San Carlos and Redwood City	Primary health services	Primary Care to formerly incarcerated homeless, serve patients with chronic/complex health issues
Puente de la Costa Sur	\$ 113,000	Farmworkers	330 clients/ 350 visits	Coastside South-Pescadero	Care Coordination, Intensive Care Coordination, health insurance enrollment	Health insurance enrollment, Transportation, translation, education
Samaritan House	\$ 63,500	Shelter Homeless	175 Unduplicated clients/ 300 visits	Safe Harbor Shelter. South San Francisco	Care Coordination, Intensive Care Coordination	Assessment, establish medical home, health education, transportation
Sonrisas Community Dental Center	\$ 25,625	Farmworkers	50 Unduplicated patients/ 150 visits	Coordinate with Puente to outreach to farmworkers in Pescadero area	Dental Services	Major restorative services that include dental exam, cleaning and dental treatment plan and dentures as needed
Ravenswood Family Health Center	\$ 50,000	Homeless: Street, shelter, transitional, Doubling up	200 Unduplicated Patients/ 600 visits	East Palo Alto	Dental Services	Major restorative services that include dental exam, cleaning and dental treatment plan and dentures as needed
Ravenswood Family Health Center	\$ 90,000	Homeless: Street, shelter, transitional, Doubling up	600 Unduplicated patients/ 1,900 visits	East Palo Alto	Primary health services	Health Screening for chronic diseases, behavioral health screening, pap test and prenatal care
Public Health-Street Medicine	\$ 218,750	Street homeless and farmworkers	120 Unduplicated	Countywide and Pescadero	Primary care services	Provide medical assessments, health screenings and education, as well as appropriate referrals.
New services- pending approval						
Ravenswood Family Health Center	\$ 80,895	Homeless: Street, shelter, transitional, Doubling up	400 Unduplicated clients/1,200 visits	East Palo Alto	Care Coordination	Outreach, assessment, health navigation, education, expedited registration/intake, transportation, translation and discharge care/housing transitions coordination
LifeMoves (formerly IVSN)	\$ 75,000	Street homeless	150 unduplicated clients/ 300 visits	County-wide	Care Coordination	In partnership with H.O.T. team act as liaison between the Street Medicine Team and homeless, and provide transportation, translation, scheduling appointments.
<b>San Mateo Medical Center</b>		Homeless and Farmworkers	5,932 Unduplicated patients with 31,242 visits (2015 data)	<b>3</b> County-wide	Primary care, Dental Services, OBGYN, Pediatric and other speciality services	

## SWOT (Strengths, Weaknesses, Opportunities, and Threats) Analysis

A SWOT analysis can be used as the first step in strategic planning. It examines an organization’s internal strengths and weaknesses, the opportunities for improvement and potential external threats. It can be used to: 1) look at areas that could be improved (weaknesses that could be turned into strengths), and 2) as a tool to evaluate alternatives during the strategic planning process to assess the potential for success.

	Helpful to Objective	Harmful to Objective
Internal	<p><b>Strengths</b></p> <ul style="list-style-type: none"> <li>• Strong system of medical care with extensive services available</li> <li>• Great outreach teams</li> <li>• Good success reaching target populations</li> <li>• Mobile van and street medicine</li> <li>• History of service provision without regard to immigration status</li> <li>• Service expansion for farmworkers in Half Moon Bay and Pescadero</li> <li>• Passionate board and staff</li> <li>• Strong collaboration among partners</li> <li>• Number of homeless in County decreasing</li> </ul>	<p><b>Weaknesses</b></p> <ul style="list-style-type: none"> <li>• Lack of coordination of services throughout the County</li> <li>• Medical services are not tailored to needs of homeless or farmworker population</li> <li>• HCH/FH Program doesn’t have clinical or service coordination staff</li> <li>• HCH/FH Program is in a silo</li> <li>• Strained communication between HCH/FH staff and HCH/FH board</li> <li>• Minimal communication about available services available to community partners and health providers</li> <li>• Limited understanding about farmworker population location/demographics</li> <li>• Board composition</li> <li>• Limited program staff.</li> <li>• Lack of respite care.</li> </ul>
External	<p><b>Opportunities</b></p> <ul style="list-style-type: none"> <li>• Affluent county with financial and service resources</li> <li>• Strong program for low-income population not eligible for Medi-Cal (ACE)</li> <li>• More people are covered by Medi-Cal under the Affordable Care Act</li> <li>• Homeless redesign is a priority of the County</li> <li>• HRSA funding has been increasing and allows for program flexibility</li> </ul>	<p><b>Threats</b></p> <ul style="list-style-type: none"> <li>• Very high cost of housing</li> <li>• Income disparity</li> <li>• County departments are siloed</li> <li>• HRSA requirements are burdensome and hard to understand- bureaucracy is difficult to navigate</li> <li>• Geography of San Mateo- spread out and separated by mountain range</li> </ul>

## Top Homeless and Farmworker Health Service Gaps (from interviews)

These reported gaps are based on interviews (some interviewees may have had based their opinions on data that they have seen and others may be more anecdotal). As priorities are developed, the first step in planning would be to assess the scope of the need.

- **Respite Care.** Respite care was the most frequently named gap in service. Respite care provides a warm, safe environment that fosters rest and recuperation during the day and night to patients who are being discharged from the hospital. Programs vary in terms of the exact services provided (often access to medications, care coordination and medical follow-up) and the duration of care. This is a service that does not need to be provided directly through the HCH/FH program, but HCH/FH could play a role in advocating for the service and helping to coordinate the service. While a collaboration with an existing shelter is an alternative, the shelter would need to adjust policies to allow patients to stay during the day and allow medical staff to come in for follow-up.
- **Medical Case Management.** Medical case managers are responsible for developing, implementing and coordinating a care plan in conjunction with the clinical providers. A specific need for social workers and case managers to be part of the mobile service team to coordinate follow-up services was mentioned. Several interviewees mentioned that it is hard to get the population into an established medical home and getting people in for needed services, like labs, can be challenging.
- **Dedicated slots for homeless/farmworkers.** The homeless need to have access to immediate care because if they have to wait there is a risk of being lost to care. Several respondents who work with the homeless population requested that this issue be solved through dedicated slots for the homeless population emphasizing that the homeless should not be in the same line as everyone else. SMMC has created express care with same day appointments available for established patients. If a patient is not established, they need to go through patient services, but the patient can generally be seen. There may be some miscommunication about what is available, how to access it, and how to ensure an individual is eligible. To understand the root of the problem and recommend solutions, the following should be determined:
  - Do service providers know how to help clients access the express care?
  - What happens when all of the express care slots have been filled?
  - Do service providers know about express care, but still find it too difficult for homeless patients to navigate?
  - Is the challenge getting established patients in or new patients?
  - When a client is seen on the mobile van, their information goes into the electronic health record, but they are not considered an “established” patient in primary care recognized by the medical center and are not eligible for express care. Is there a way to help these patient become established patients?
  - Are there alternatives that would serve the patients better?
- **Transportation.** San Mateo is geographically dispersed. A key theme among providers was the need for transportation for clients. This was mentioned in particular for clients who live on the Coast and also for patients who are in East Palo Alto and can’t get to specialty appointments. People would like to think about shuttles, vans, more vouchers, increased case management,

etc. Puente currently uses MV transit for transportation with a 24 hour reservation required. Safe Harbor and LifeMoves (formerly InnVision Shelter Network) use taxi vouchers for their clients.

- **Dental.** There is a HCH mobile dental van, which was reported to be a good service, but limited in capacity. SMMC also provides dental services, although it is not a covered benefit of the ACE program. The HCH/FH contracts with Sonrisas to provide some dental to farmworkers in Pescadero and with Ravenswood to provide services to homeless in East Palo Alto; however there were people who said that there are currently long wait times for appointments. In addition, some claimed that homeless that engage tend to go because of acute pain and are not getting preventive, long-term care.
- **Substance abuse/drug treatment.** Both the homeless and farmworker populations experience substance abuse. There needs to be more coordination and case management to help people get into needed services. Currently the outreach to farmworkers does not include AOD services.
- **Geographic gaps.** The geographic needs that were called out as needing special attention were East Palo Alto (all services could be expanded) and Pescadero (where there is a clinic running one night a week, but a need for more).

#### **Top Healthcare for the Homeless-Farmworker Health Program and Planning Gaps (from interviews)**

- **Collecting data on homeless/farmworkers.** While there is some debate about whether the homeless/farmworker population should be treated like the general population, there are strong feelings among most of the board that it can help a provider to know that a patient is homeless or a farmworker so that services can be tailored and an appropriate care plan can be developed. Several clinic managers said that it is impossible to know who is homeless and that this makes knowing the needs of the population difficult. Another manager said that finding out whether someone is homeless is part of the initial registration process and that it gets placed in the electronic health record and reports can come from CORE. Additional program work needs to be done to establish whether: 1) the data is there and people need to be trained on how to access it, or 2) whether data collection needs to improve.
- **Measuring outcomes.** It is necessary to be able to pull system-wide health data on homeless and farmworkers. Clear outcome measures need to be developed that are aligned with the medical center goals around access, continuity, and quality. Data needs to be tracked regularly and used to establish quality improvement efforts. In addition, there were comments that the HCH/FH funding distribution and the RFP process should follow the needs more systematically. RFPs could be more targeted and driven from QI/QA findings as well as from the needs assessment and should include a comparison of the location and numbers of homeless and farmworkers to where resources are allocated.
- **Coordination, Advocacy, and Policy Work.** Many interviewees don't see HCH/FH doing desired policy work. There were some interviewees who thought that staff was trying to do some coordination work but that it is primarily with the grantees and not engaging the larger community. HCH/FH is a small program relative to the County, but could play an important advocacy role if done strategically, in partnership with other agencies, and if the funding were



used to effectively leverage other resources. Some examples of potential areas to start with are the San Mateo Medical Center, the homeless redesign initiative and the farmworker community, but being more involved in county-wide planning efforts in general with strategic partnerships in mind could help to further the mission of providing quality health services to the homeless and farmworkers in San Mateo County. However, taking on these additional roles and efforts could require additional program staff. Some examples of places where additional coordinating, advocacy, and/or policy work could benefit the homeless are:

- **San Mateo Medical Center.** The SMMC is the primary provider of health care services to the homeless but is not closely aligned with the program. Having tighter coordination with Medical Center management would improve services for the homeless and farmworkers and help to improve communication with HRSA. SMMC benefits financially from the FQHC status of the HCH/FH program. Closer coordination and alignment of goals could be used to: 1) direct a portion of the funding that SMMC leverages from the FQHC status towards the needs of the homeless/farmworker population, and 2) help to create a more united group when presenting to HRSA, which could result in fewer grant conditions. Potential ways to improve coordination are:
  - HCH/FH staff and or board could meet regularly with management staff within SMMC.
  - The Deputy Director of Ambulatory at the Medical Center meets with clinic directors monthly to look at outcome measures. HCH/FH could attend these meetings regularly and encourage regular review of the homeless and farmworker populations.
  - A homeless coordination council (see Alameda County) could be created at SMMC.
- **Homeless Redesign.** Homeless redesign is a major initiative of the County and there could be increased coordination with this effort including potentially having a staff member from the Center on Homelessness be on the HCH/FH board.
- **Farmworker Health Community.** Additional coordination with the farmworker community could be accomplished through developing relationships with farm worker organizations, growers, businesses, and service organizations serving farmworkers.
- **Board and Staff Roles and Responsibilities.** There is a significant amount of tension between the HCH/FH staff and board. While there was not consensus, several members of the board feel frustrated that they do not receive documents in a timely manner and they are being asked to “rubber stamp” documents. They feel like there is not enough time for policy discussion and too little action. They know that staff is spending time dealing with HRSA requirements but they do not really understand what the staff is doing. The staff feels like they do not have the capacity to meet all of the demands from HRSA and the board and also work on programs. Both the board and the staff feel like they are dealing with a lot of bureaucracy. While County Counsel attends board meetings, members of the staff and the board feel that counsel could be more proactive in helping the program meet its goals. Recent changes in County Counsel assignment may help with this objective. In addition, the board and the staff have been working together to improve communication and are in agreement about the desire to move forward with a strategic vision. Recommendations:
  - **Board Growth.** The program would benefit with more board members with expertise in finance, IT, communication and ties with other programs and initiatives in the County.

- **Board Training.** The Board should have a clear job description and orientation on their roles and responsibilities.
- **Increase Staff.** Staff is busy administering the program and has not had the time to do needed policy and advocacy work to help address the service gaps. For example, the program could benefit from the addition of a service coordinator and/or a liaison who closely coordinates with the SMMC.
- **Cultural Competence.** The San Mateo Medical Center provides extensive and high quality primary and specialty care services, but there is a feeling that many of the staff don't understand the needs of the homeless and farmworker populations. In addition, there are reports that homeless feel unwelcome and uncomfortable when they have tried to access services. Several interviewees felt that SMMC staff needs to be more sensitive to the needs of the homeless/farmworker patients. Recommendations include:
  - Staff training on the needs of the homeless and farmworker population and development of standard protocols for treating the homeless.
  - Navigators within the medical center could be hired to help the homeless and farmworkers get the care that they need and coordinate with community providers (this would also help with communication and coordination).
  - More Spanish-speaking providers and translation services, keeping in mind that translation will not be enough for people who cannot read.
- **Communication.** There was a general sense that more communication was needed. This was both about describing and communicating about what the HCH/FH program is and also about ensuring that people, including health providers, know how to access services for the homeless and farmworkers. In order to provide whole-person care, providers need to know how to access services in other areas. Primary care providers need know how to connect a client to housing assistance, substance –abuse program, or other wrap-around services.
- **Farmworker engagement.** While some stakeholders felt that there should be stronger farmworker participation on the board, many others felt that this was not necessary. The key is to get farmworker needs and issues understood and addressed by the board. This could be done through focus groups, surveys, community meetings, or information from community providers serving the farmworker population.

#### **Summary of Findings from outside agencies:**

- **Alameda Homeless Coordinating Office.** Alameda County's Health Care for the Homeless program is separate from the public hospital, but also provides the FQHC status for the hospital through a "sub-recipient" arrangement. The County originally encountered challenges from HRSA, which did not understand the model. The public hospital created the Homeless Coordination Office Advisory Committee, which meets monthly and focuses on homeless issues including timely service analysis, design, project planning, and other needs as they come up. Since the creation of the body, the County has been able to come together in a more coordinated way, which has eased the tension with HRSA. The hospital is now also directly paying for respite care and is planning to take over mobile services because through the planning body they realized these were important needs for the homeless population.

- **Santa Clara Grant Administration.** The grant administration was recently moved from Health Care to the Homeless to the hospital. A health center manager within the hospital structure was hired to deal with all of the HRSA reporting.
- **Santa Clara Farmworkers.** Although Santa Clara does not have 330g (farmworker) funding, they do serve farmworkers. They focus on patient health education and they have a psychologist. All of their staff is bilingual and they have driver who has been part of the community for years and is a community health worker. They are mostly serving men and are focusing on patient health education around proper foods and exercise. They also have a psychologist who helps people with the impacts of isolation and depression. Based on a site visit done by Dr. Robert Stebbins in November 2015, Valley Homeless Healthcare Program operates a Medical Mobile Unit to provide medical care, social work and psychology services. Referrals are made to Santa Clara Valley Medical Center for specialty follow-up. Appointments are made on a drop-in basis. The following clinics are run out of the Medical Mobile Unit. The mobile unit (Saludos) serves migrant farmworkers in South County. The Saludos clinic is open from April through November, Monday evenings from 5-9pm. They had eight staff members with the van and all were bilingual.
- **Salud Para La Gente,** serving Santa Cruz and Monterey Counties, with clinics in Watsonville, Santa Cruz and Seaside, is a Federally Qualified Health Center that provides care to farmworkers. They have found that most of the care is for chronic pain management, immunizations for children, and diabetes management. They have felt that the relationships that they have developed with the farm businesses have been very critical including working with the human resources teams at the farms. The care coordination work is substantial and shouldn't be underestimated.
- **Communicare.** Communicare, serving Yolo County, with clinics in Davis, Woodland, and West Sacramento, is a Federally Qualified Health Center and has a certified migrant farmworker grant. They serve both seasonal farmworkers and migrant workers. They provide chronic disease prevention classes, basic health screenings, and mammogram clinics through mobiles services and full primary care services at their brick and mortar sites. They have found that when they are collecting information to determine whether someone is a farmworker, it is critical to ask the question in the right way or you may not capture everyone who meets the federal definition.
- **Clinica de Salud Del Valle de Salinas** (based on October 9, 2012 site visit by Dr. Robert Stebbins). Clinica de Salud is a Federally Qualified Health center providing health care to residents of Monterey County with a focus on families working in the agriculture industry. There are nine clinic locations including one mobile clinic which operated three days a week providing medical and dental services primarily to homeless individuals. They have found that it is critical to have broad collaboration with institutions and agencies in the service area. They collaborate with farm worker organizations, growers, businesses, schools, and non-profit organizations, to enhance care delivery and education for patients. Migrant Education meetings at schools have been a good opportunity for outreach staff to inform families about services and to provide education. The best outreach is the patients themselves. If you treat them well, they will spread the word.

## Addendum

### Mental health/ substance abuse

At the February 11, 2016 HCH/FH Board Meeting, the draft document was reviewed. There was a request to add mental health and substance abuse as an additional service gap to be prioritized. The needs include:

- **timely access for mental health services** for the homeless population. Currently, HCH/FH providers can reach out to the BHRS team, but it does not mean that clients get into a service quickly. Suggestions were that psychiatry be added to the mobile van unit, that BHRS provide phone access to a psychiatrist for primary care providers to help with medications, and/or that homeless patients be provided same day access.
- **Lack of feedback loop**- while the BHRS team is responsive, there is not a current feedback loop so that a providers knows whether a client was linked to services and if not, what the reason was.
- **A better understanding of BHRS services available.** BHRS has a lot of teams geared towards specific populations, but it is a challenge to understand how to navigate it and a lack of understanding of how clients are prioritized.
- **Farmworkers.** The issues are a little different because there is stigma about mental health and substance abuse and the population is isolated, but more could be done to design innovative approaches to care.

### Prioritization

After the board meeting the Board was asked to prioritize the service gaps and the program and planning gaps.

The top three services gaps were:

1. Mental health and substance abuse
2. Dental
3. Respite care

The top three program and planning gaps were:

1. Program coordination
2. Board and staff growth
3. Measuring data

## **List of Key Stakeholders Interviewed**

### Healthcare for the Homeless- Farmworker Health Staff and Support

- Jim Beaumont
- Nirit Ericksson
- Elli Lo
- Linda Nguyen
- Frank Trinh

### Healthcare for the Homeless-Farmworker Health Board Members

- Kathryn Barrientos
- Daniel Brown
- Steve Carey
- Tayischa Deldridge
- Brian Greenberg
- Robert Stebbins
- Paul Tunison
- Julia Wilson
- Molly Wolfes

### External San Mateo Stakeholders

- Dirk Alvarado, Sonrisas
- Rebeca Ashe, Coastside Clinic
- Jeannette Aviles, San Mateo Medical Center, Primary Care Medical Director
- Laura Bent, Anje Rodriguez, Julia Parmer, Samaritan House
- Luisa Buada, Ravenswood
- Anita Booker, Clinical Services Director for Mobile Clinic
- Tosan Boyo, San Mateo Medical Center, Ambulatory Deputy Director
- Teri Chin, Fair Oaks Community Center
- Eric Debode, Catholic Worker
- Susan Ehrlich, San Mateo Medical Center, CEO
- Pat Fairchild, JSI
- Patrick Grisham, Mid Region Health Center
- Pernille Gutschick, San Mateo Behavioral Health and Recovery Services
- Kerry Lobel, Puente
- Jonathon Mesinger, Coastal Region Health Center
- Jessica Silverberg and Brian Eggers, Center on Homelessness
- Fatima Soares, Coastside Hope
- Srija Srinivasan, Family Health Services

### Out of County Research

- Damon Francis and Suzanne Warner, Alameda County Healthcare for the Homeless
- Sara Doorley, Santa Clara County Healthcare for the Homeless
- Julia Still, Salud Para La Gente, Watsonville
- Sandra Johnson, Sacramento Healthcare for the Homeless
- Allison Ulrich, Consultant to Veteran's Affairs Palo Alto Health Care System
- Genevieve Hansen, Communicare

# SAN MATEO COUNTY HEALTH CARE FOR THE HOMELESS/FARMWORKER HEALTH PROGRAM

## Planning Data

12/9/15

Prepared by: Pat Fairchild John Snow Inc. (JSI)

### Data on Homeless Population

Data on the San Mateo County homeless population is limited. Almost every source/publication, including the most recent Community Health Needs Assessment and the Analysis of Homeless System Performance Assessment uses the data from the San Mateo County Homeless Census and Survey (a point-in-time count). However, because definitions and methodologies differ, this data significantly understates the number of people who are homeless at some time during the year as well as the number of people who are eligible for Healthcare for the Homeless services.

Estimates from other parts of the country are that the number of people who are homeless at some point during the year is between 3-5 times the number counted in the point-in-time census. This would mean that there could be between 5,316 and 8,860 people in San Mateo County who are homeless at some point in the year. Another calculation (see methodology for counting homeless from the National Coalition for the Homeless) is that between 6.2-10% of the population living in poverty or 1% of the total population nationally is homeless. For San Mateo, because the proportion of people living in poverty is relatively low, this methodology yields a huge range – from 3,574 (6.2% of those living in poverty) 5,765 (10% of those living in poverty) to 7,585 (1% of the population).

Given all sources, for planning purposes it is reasonable to estimate that there are **4,000-6,000** people who are homeless in SMC according to the Health Resources and Services Administration (HRSA) definition in a given year.

Following is a summary of the data available.

### **San Mateo County Homeless Census and Survey<sup>1</sup>**

**Description:** Point-in-time count of homeless in San Mateo County (SMC) - a count on a single night of persons living on the streets, in vehicles, homeless shelters, transitional housing and institutional settings (jails, hospitals, substance abuse treatment programs).

**Definition of Homelessness:**

- o Federal McKinney-Vento Homeless Assistance Act definition:
  1. An individual who lacks a fixed, regular and adequate nighttime residence, and
  2. An individual who has a primary nighttime residence that is:
    - a. A supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); or
    - b. An institution that provides a temporary residence for individuals intended to be institutionalized; or
    - c. A public or private place not designated for, or ordinarily used as, a regular sleeping accommodation for human beings.

This definition does not include people who are at risk of homelessness (i.e. living in unstable housing situations) including those who are “doubling up”.

- **Data:**

- o 2015 Census: (most recent count)
  - **1772** homeless people in San Mateo County on the night of Jan 22, 2015.
    - 775 unsheltered, 997 sheltered.

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<sup>1</sup> <https://hsa.smcgov.org/sites/hsa.smcgov.org/files/2015%20SMC%20Homeless%20Count%20%20Final%20Report.pdf>

- The 1772 homeless people comprised 1387 households: 1240 adult only households, 147 family households with children.
  - 2013 Census: 2281 individuals
  - 2011 Census: 2149 individuals
  - 2009 Census: 1796 individuals

**Analysis:** The 2015 data shows a significant drop in unsheltered homeless: 40% since 2013. Overall the drop was 24% compared to 2013. The data does not count "hidden" homeless – people not found during the search, either because they were staying in vehicles or non-accessible places, or staying with families and friends.

### Location of Homeless in SMC 2015 Homeless Census

City	Unsheltered	Sheltered	Total
Airport	1	0	1
Atherton	1	0	1
Belmont	11	0	11
Brisbane	21	0	21
Burlingame	7	24	31
Colma	3	0	3
Daly City	32	11	43
East Palo Alto	95	83	178
Foster City	0	0	0
Half Moon Bay	84	0	84
Hillsborough	0	0	0
Menlo Park	27	146	173
Millbrae	8	0	8
Pacifica	63	0	63
Portola Valley	0	0	0
Redwood City	223	314	537
San Bruno	8	3	11
San Carlos	20	0	20
San Mateo	82	186	268
South San Francisco	55	86	141
Unincorporated	32	0	32
Coastside	22	0	22
Central - Highlands/Baywood	0	0	0
North - Broadmoor	0	0	0
South - N Fair Oaks, Emerald Lk, West MP	10	0	10
Woodside	2	0	2
Scattered Sites	0	95	95
Confidential	0	49	49
<b>TOTAL</b>	<b>775</b>	<b>997</b>	<b>1,772</b>

## Analysis of Homeless System Performance (uses Homeless Management Information System Data (HMIS))<sup>2</sup>

**Description:** Analysis of Homeless System performance with data from SMC’s Homeless Management information System (HMIS) from July 2012-June 2014. HMIS data shows the number of people who use Homeless Services (not the number of actual homeless individuals).

**Data:**

- HMIS data shows that 5,207 unduplicated people were served over a **two** year period (2012-2014) by HMIS participating services
  - 3716 adults and 1491 individuals under age 18
- Over a two year period in SMC:
  - 3516 people used Emergency Shelters

<sup>2</sup><https://hsa.smcgov.org/sites/hsa.smcgov.org/files/SMC%20Homeless%20System%20Performance%20Report%20-%20June%202015.pdf>

- 2348 people used Transitional Housing
- 623 people used Rapid Re-Housing services
- 520 people used Permanent Supportive Housing
- 205 people used Support Services Only (includes homelessness prevention services)

All the above numbers are unduplicated – people may have used more than one service.

**Data quality:** Data from HMIS is “excellent” as evaluated by the consulting group authoring the report

**Analysis:** Though this report also used the point-in-time Census data to measure the size of the homeless population, the numbers showing that 5207 individuals used homeless service over a 2 year period indicate that there are individuals not captured in the point-in-time count that are using homeless services

## Analysis of SMC Homeless UDS Data

**Description:** Data on patients who are homeless and who utilize the Homeless and Farmworker Healthcare Program services during a calendar year. Patient data is an unduplicated count.

**Definition:** Uses the Health Resources and Services (HRSA) definition. The definition includes the following categories of living situations. Numbers are from the 2014 UDS report:

- Homeless shelter: 1,562
- Transitional Housing: 1,083
- Doubling up: 1,867
- Street: 488
- Other (includes permanent supportive housing): 596

Total: 5596

**Analysis:** The data supports the assessment that, using the HRSA definition, there are significantly more people who are homeless in the County in a given year than are reported in the point-in time census. People listed in the “doubling up” and “other” categories (the categories of homelessness not included in the point-in-time count) make up 44% of the patients served by the Homeless and Farmworker Healthcare Program.

### Data on Farmworkers

HRSA uses several NAICS codes to define who is classified as a migrant or season agricultural worker for purposes of eligibility for HRSA support. However, most of the available data sources do not use the NAICS codes, but rather grouped all agricultural work as part of the “farm industry” or merge farming with hunting, mining, and fishing. Given the type of agricultural work in SMC, using the farm industry classification accounts for the vast majority of farmworkers in the County including workers in floral and nursery industries, which is the largest agricultural industry in the County.

Most sources state there are about **1,700-2,000** individuals currently employed in the agricultural/farmwork industry in SMC. Only the 2012 USDA Census of Agriculture had specific numbers on migrant farmworkers, defined as farmworkers whose employment requires travel that prevents the worker from returning to his or her permanent place of residence the same day. There were estimated to be 88 migrant farmworkers according to that Census, meaning most farmworkers in SMC live in the area and work in the industry on a seasonal or full-time basis. There was no data available broken down geographically within San Mateo County.

Farmworker family members are also eligible for HRSA-supported services. No data could be located on the average size of farmworker families in SMC. The US Department of Agriculture estimates that nationally that there are 1.2 family members for every farmworker. Using that number, the total population eligible for SMC’s Homeless and Farmworker Healthcare program living in the County would be at a **minimum 2,040 – 2,400**. However, the demographics of SMC farmworkers are not comparable to national statistics. Most farmworkers are settled in the County and many have



families living with them. An analysis of the 2005 National Agricultural Worker Survey (NAWS)<sup>3</sup> found that 54% of farmworkers in California had children and that 76% of those lived with their children. The median number of children was two. Using that data and assuming a majority of farmworkers with children live with a spouse or partner, produces an estimate of **4370-5670** farmworkers and family members living in the County. The fact that the Homeless/Farmworker Health Program is already serving 2265 farmworkers and their families on an annual basis, indicates the higher numbers are probably closer to reality. However, getting a better estimate of farmworkers and their families in the County should be priority for the program.

Following is a summary of data on agricultural/farm workers.

#### USDA Census of Agriculture 2012 – Issued May 2014<sup>4</sup>

- **Description:** USDA Census of Agriculture is conducted every 5 years. Survey of farmers and ranchers.
- **Definition of farmworker:** None. Contains count of number of workers hired. Migrant workers and unpaid workers are defined below.
- **Numbers:**
  - o 2012 Farmworker data from San Mateo County:
    - **1722** hired farm workers
    - Total Migrant workers: 88 (on 15 farms):
      - Definition: Data are for total migrant farm workers whose employment requires travel that prevents the worker from returning to his or her permanent place of residence the same day.
    - Unpaid workers: 325:
      - Definition: Includes agricultural workers not on the payroll who performed activities or work on a farm or ranch.
- **Limitations:** Data is self-reported from farmers and ranchers, who may not know where their workers are commuting to/from, and who may be hesitant to report unpaid or underpaid workers.

#### State of California Employment Development Department<sup>5</sup>

- **Description:** County data on people in farm industry available for every month up until December 2014. After December 2014, the only data available groups San Mateo County with San Francisco County data
- **Definition of farmworker:** None given. Numbers are for “Farm” industry.
- **2014 data:** Average of 1716.67 individuals in the labor force in farm industry in 2014. Data per month is below:

Month	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Total # labor force in Farm	1,600	1,600	1,600	1,700	1,700	1,700	1,700	1,800	1,800	1,800	1,800	1,800

#### Data from SMC RFP for an Agricultural Workforce Housing Needs Assessment – March 2015<sup>6</sup>

**Description:** Data below is pulled from an RFP from the County of San Mateo Department of Housing for an Agricultural Workforce Housing Needs Assessment.

<sup>3</sup> <http://agcenter.ucdavis.edu/documents/CalifFarmLaborForceNAWS.pdf>

<sup>4</sup> [http://www.agcensus.usda.gov/Publications/2012/Full\\_Report/Volume\\_1\\_Chapter\\_2\\_County\\_Level/California/st06\\_2\\_007\\_007.pdf](http://www.agcensus.usda.gov/Publications/2012/Full_Report/Volume_1_Chapter_2_County_Level/California/st06_2_007_007.pdf)

<sup>5</sup> [http://www.labormarketinfo.edd.ca.gov/LMID/Employment\\_by\\_Industry\\_Data.html](http://www.labormarketinfo.edd.ca.gov/LMID/Employment_by_Industry_Data.html)

<sup>6</sup> <http://housing.smcgov.org/sites/housing.smcgov.org/files/Revised%20RFP%20020615-FINAL.pdf>

**Data:**

- The Federal Bureau of Labor Statistics (BLS) estimates that 1,737 employees were engaged in all occupations related to agriculture, forestry, fishing and hunting in 2009, in the county.<sup>7</sup> Excluding fishing, hunting, and trapping occupations, the remaining estimate is **1,692** employees. These totals include all farm-related occupations, including management, post-farm production activities, and other related work.

**American Community Survey Data (US Census Data)**

**Description:** American Community Survey Data available from United States Census Bureau

**Definition of Farmworker:** Total employed for Agriculture, forestry, fishing and hunting, and mining. Though the ACS uses NCAIS codes, there was no option to search for total individuals employed by code at a county level.

**Data:**

- Total employed in Agriculture, forestry, fishing and hunting, and mining in San Mateo County, aged 16 years and older:
  - 2014: 2459 individuals (margin of error +/- 990)
  - 2013: 1485 individuals (margin of error +/- 791)
  - 2012: 1767 individuals (margin of error +/- 713)
  - 2011: 3209 individuals (margin of error +/- 1056)

**Limitations:** Margin of error is very high for each year. Data is very different from year to year.

**Analysis of SMC Farmworkers UDS Data**

**Description:** Data on patients who are homeless and who utilize the Homeless and Farmworker Healthcare Program services during a calendar year. Patient data is an unduplicated count.

**Definition:** Uses HRSA definition. Definition includes family members. Two categories of farmworkers are reported. Numbers are from the 2014 UDS report:

- Migratory: 329
- Seasonal: 1936

Total: 2265

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<sup>7</sup> Note – could not find this data anywhere on the Bureau of Labor Statistics site

## San Mateo County Homeless and Farmworker Data Analysis

### Definitions of Farm Workers/Agricultural Workers and Homelessness

12/9/15

#### DEFINITIONS OF MIGRATORY AND SEASONAL AGRICULTURAL WORKERS – HRSA

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

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

For both categories of workers, the term agriculture means farming in all its branches as defined by the OMB-developed North American Industry Classification System (NAICS), and includes seasonal workers included in the following codes and all sub-codes within: 111, 112, 1151, and 1152.

**Note:** Most of data sources do not use the NAICS codes used by HRSA, but rather group all farm work as part of the “farm industry” or merged farming with hunting, mining, and fishing.

#### DEFINITIONS OF HOMELESSNESS – HRSA and HUD

##### From the National Health Care for the Homeless Council – HHS and HUD definition

There is more than one “official” definition of homelessness. Health centers funded by the U.S.

##### Department of Health and Human Services (HHS) uses the following:

A homeless individual is defined in section 330(h)(5)(A) as "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing." A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation. [Section 330 of the Public Health Service Act (42 U.S.C., 254b)]

An individual may be considered to be homeless if that person is "doubled up," a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended

family members. In addition, previously homeless individuals who are to be released from a prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return. A recognition of the instability of an individual's living arrangements is critical to the definition of homelessness. (HRSA/Bureau of Primary Health Care, Program Assistance Letter 99-12, Health Care for the Homeless Principles of Practice).

The UDS Manual includes the following categories of Homelessness – all of which are included in the definition.

- **Shelter.** Patients who are living in an organized shelter for homeless persons at the time of their first visit. Shelters generally provide for meals as well as a place to sleep, are seen as temporary and often have a limit on the number of days or the hours of the day that a resident may stay at the shelter.
- **Transitional Housing.** Transitional housing units are generally small units (six persons is common) where persons who leave a shelter are provided extended housing stays – generally between six months and two years – in a service rich environment. Transitional housing provides for a greater level of independence than traditional shelters, and may require that the resident pay rent, participate in the maintenance of the facility and/or cook their own meals. Count only those persons who are “transitioning” from a homeless environment. Do not include those who are transitioning from jail, an institutional treatment program, the military, schools or other institutions.
- **Doubled Up.** Patients who are living with others. The arrangement is generally considered to be temporary and unstable, though a patient may live in a succession of such arrangements over a protracted period of time.
- **Street.** This category includes patients who are living outdoors, in a car, in an encampment, in makeshift housing/shelter or in other places generally not deemed safe or fit for human occupancy.
- **Other.** This category may be used to report previously homeless patients who were housed when first seen *but who were still eligible for the program.* (HCH rules permit a patient to continue to be seen for 12 months after their last visit as a homeless person regardless of their current housing status.) **Patients residing in SRO (single room occupancy hotels) or motels or other day-to-day paid for housing should also be classified as “other,” Line 21. People living in permanent supportive housing are also counted under “other”.**

**Programs funded by the U.S. Department of Housing and Urban Development (HUD)** use a different, more limited definition of homelessness [found in the Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009 (P.L. 111-22, Section 1003)].

- An individual who lacks a fixed, regular, and adequate nighttime residence;
- An individual who has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
- An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing);
- An individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided;
- An individual or family who will imminently lose their housing [as evidenced by a court order resulting from an eviction action that notifies the individual or family that they must leave within 14 days, having a primary nighttime residence that is a room in a hotel or motel and where they lack the resources necessary to reside there for more than 14 days, or credible evidence indicating that the owner or renter of the housing will not allow the individual or family to stay for more than 14 days, and any oral statement from an individual or family seeking homeless assistance that is found to be credible shall be considered credible evidence for purposes of this clause]; has no subsequent residence identified; and lacks the resources or support networks needed to obtain other permanent housing; and
- Unaccompanied youth and homeless families with children and youth defined as homeless under other Federal statutes who have experienced a long-term period without living independently in permanent housing, have

experienced persistent instability as measured by frequent moves over such period, and can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, the presence of a child or youth with a disability, or multiple barriers to employment.

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# **San Mateo County Health Care for the Homeless and Farmworker Health Program**

**2015 Needs Assessment  
DRAFT**

Prepared January 2016 for San Mateo Health Care for the Homeless and  
Farmworker Health Program



## Introduction

The San Mateo Medical Center provides health services for San Mateo County's 758,581 residents.<sup>1</sup> Almost half of the county's residents (46%) speak a language other than English at home, and 4.6% of the population under 65 years of age lives with a disability.<sup>1</sup> Although per capita yearly income is close to \$50,000, 7.5% of the county's residents live in poverty.<sup>1</sup>

The San Mateo Medical Center's Health Care for the Homeless and Farmworker Health Program provides care for two of the county's vulnerable and underserved populations. As part of an effort to improve access to and quality of health care for these populations, they have conducted a health needs and health utilization survey among homeless and farmworker residents. The aim of the survey is to gather information on how these populations access care and the kind of care and services they need. Results will inform decisions on health care planning and delivery. This survey is an update to a similar needs assessment completed with the same target populations in San Mateo County in 2013.

## Methods

Structured surveys were delivered to 9 service sites in San Mateo County. Surveys were administered from June through August 2015, with a small number of additional surveys conducted at Ravenswood in the following month. A total of 425 English language and 117 Spanish language surveys were distributed, and were completed with assistance from service providers of homeless patients and farmworkers. Responses from 429 surveys conducted at nine health centers were ultimately collected and recorded. Table 1 below identifies which health centers contributed recorded surveys.

**Table 1: Participating service sites and recorded surveys**

Health Center	Number	Percent
Ravenswood Family Health Center	135	31%
Samaritan House/Safe Harbor	86	20%
InnVision Shelter Network	61	14%
Puente de la Costa Sur	41	10%
Mental Health Association (Spring Street Shelter)	30	7%
Saint Vincent De Paul	27	6%
Public Health Mobile Clinic	17	4%
Coastside Hope	17	4%
Coastside Mental Health	15	4%
<b>Total</b>	<b>429</b>	<b>100%</b>

Self-reported survey data was entered into Microsoft Excel and analyzed with the same program, using the survey questions and previous findings as a guide for analysis.

<sup>1</sup> "San Mateo County, California." *QuickFacts*. United States Census Bureau, 2015. <<http://www.census.gov/quickfacts/table/PST045215/06081>>.



## Findings

### Demographics

Survey respondents ranged in age from four to 83 years old. The median age of respondents was 49; half fell between age 33 and 57. The majority of participants were male, non-Veteran English speakers. Over one-third were White/Caucasian and a quarter were Latino/Hispanic. Complete participant demographic data can be found in Table 2.

**Table 2: Respondent demographics**

	<b>Number n=429</b>	<b>Percent</b>
<b>Gender</b>		
Male	266	62%
Female	158	37%
Decline to answer	5	1%
<b>Ethnicity/Race*</b>		
White/Caucasian	174	37%
Latino/Hispanic	117	25%
African American	77	17%
Asian/Pacific Islander	49	11%
Native American	28	6%
Other	21	5%
<b>Language Spoken*</b>		
English	343	75%
Spanish	84	18%
Tongan	15	3%
Tagalog	10	2%
Other	5	1%
<b>Number of people in household/family</b>		
1 person	280	68%
2 people	33	8%
3 people	27	7%
4 people	19	5%
5 people	21	5%
6 or more people	34	8%
<b>Veteran</b>		
Yes	41	10%
No	381	89%
<b>Don't know</b>	2	0.5%
No answer	5	1%

*\*Some participants reported multiple answers.*

### ***Housing, Work, and Income***

Participants were asked where they sleep, and specifically where they stayed “last night”. Almost half (49%) of respondents listed a homeless shelter as the place they live, followed by an apartment or house (12%) and treatment programs (11%). Eighteen percent of respondents sleep outside, in a vehicle, or in a structure not meant for residence (bus or train station, garage or shed without running water and sewer). The aggregated responses across all health centers are displayed in Table 3 below.

**Table 3: Current housing\***

	<b>Number n=429</b>	<b>Percent</b>
Homeless shelter	210	49%
Apartment/house (rent/own/on lease)	53	12%
Treatment program	49	11%
Car/truck/van	29	7%
Outside	28	7%
Couch surfing/shared housing (paying no/little rent)	22	5%
Farmworker housing	18	4%
Transitional housing	18	4%
Hotel/motel	14	3%
Place not meant for living (bus or train station)	10	2%
Structure without running water and sewer (garage, shed, basement, etc)	8	2%

*\*Some participants reported multiple answers.*

All Puente de la Costa Sur respondents reported living either in farmworker housing (15) or an apartment or house (25), and 44% of them live with five or more people. At Ravenswood Family Health Center, 34% of participants reported living in a treatment program, which is significantly higher than the 11% average for respondents across the county. Similarly, Samaritan House and Mental Health Association respondents have a disproportionately high rate of living in a shelter, at 85% and 67% respectively. Over half (59%) of Coastside participants, at both Coastside Hope and Coastside Mental Health, reported living in a vehicle, outside, or in a structure not meant for residence.

Eight of nine reporting health centers had all or most of their participants report monthly incomes below \$1,350 (see Table 4 for complete income data). Puente de la Costa Sur, which has a large proportion of farmworkers, was the exception, with 61% of participants reporting a monthly income over \$1,350. In contrast, at Ravenswood Family Health Center, 61% of people reported incomes in the lowest bracket (less than \$500 per month). Only three respondents reported a monthly income of \$4,000 or more, which is equivalent to the county per capita income.

Nearly one-third of respondents (29%) reported receiving income from a job. However, 88% of participants at Puente de la Costa Sur received income from a job, likely primarily farm work. Over one-fifth (22%) of respondents had no income at all; this figure more than tripled for

clients participating at the Public Health Mobile Clinic (71%). Forty-six percent of respondents received some form of government assistance (social security, disability, or general assistance). Among respondents from the Mental Health Association, 77% identified a form of government assistance as a source of income.

**Table 4: Income**

	<b>Number n=429</b>	<b>Percent</b>
<b>Monthly Income (last month)</b>		
\$0-\$500	196	48%
\$500-\$1349	139	34%
\$1350-\$2000	55	14%
\$2000-\$4000	12	3%
>\$4000	3	0.7%
No Answer	24	6%
<b>Source of Income*</b>		
Job	125	29%
No income	93	22%
General Assistance	81	19%
Social Security	72	17%
Disability	41	10%
Other	32	7%

*\*Some participants reported multiple answers.*

Fourteen percent (59) of respondents reported that they or a family member had worked as a farmworker in the past two years; 85% (363) reported that they had not, and 2% (7) declined to answer. Farmworkers and their families were concentrated among two health centers; 83% of participants at Puente de la Costa Sur and 50% of Coastside participants (from both Coastside Hope and Coastside Mental Health) reported being farmworkers or their family members. Other health centers had few or no reported farmworkers.

### **Health Care and Insurance**

Participants were asked to identify the type of insurance coverage they have, if any. Fifteen percent were uninsured, and no respondents identified Healthy Kids as their source of insurance. During the previous needs assessment conducted in 2013, 22% of respondents were receiving insurance through Medi-Cal, and 28% were covered through the Medicaid Coverage **Expansion (the latter was not an option in this year's survey). This year, 63% of respondents** reported being covered by Medi-Cal, a 13 percentage point increase over the combined Medicaid coverage in 2013.

Several health centers had participants that reported a higher level of Medi-Cal coverage than the average across all reporting health centers. Seventy-four percent of Saint Vincent De Paul participants were covered by Medi-Cal, as were 88% of Public Health Mobile Clinic participants and 90% of Mental Health Association respondents. Participants from InnVision Shelter Network reported lower rates of Medi-Cal coverage (52%) and higher than average rates of being

uninsured (26%). Of the 66 participants county-wide that reported having no insurance, 23% are Spanish speakers.

**Table 5: Source of health care and insurance**

	<b>Number n=429</b>	<b>Percent</b>
<b>Health Insurance*</b>		
Medi-Cal	271	63%
No insurance	66	15%
Medicare	55	13%
ACE	33	8%
Private insurance	33	8%
Healthy Kids	0	0%
<b>Source of Health Care*</b>		
SMMC clinics	116	27%
SMMC emergency department	72	17%
Public Health Mobile Van	61	14%
Ravenswood Family Health Center	60	14%
Elsewhere	51	12%
Private clinic/other clinic	48	11%
SMMC Mobile Dental	47	11%
Veterans Administration Hospital/facility	33	8%
Other emergency department	31	7%
Pescadero Clinic/Puente Coast Clinic	14	3%

*\*Some participants reported multiple answers.*

The most commonly reported sources of health care for participants were San Mateo Medical Center (SMMC) clinics (27%), the San Mateo Medical Center emergency department (17%), the Public Health Mobile Van (14%), and Ravenswood Family Health Center (14%). SMMC clinic use was particularly common among Mental Health Association clients, half of whom reported receiving care from them. Although only 8% of respondents county-wide reported using the Veterans Administration Hospital and facilities, 39% of InnVision Shelter Network participants identified it as a source of care.

Participants were also asked if they are satisfied with their current health care provider. Sixty-nine percent of respondents agreed or strongly agreed that they are satisfied, and only 8% disagreed or strongly disagreed (meaning they are not satisfied with their current provider). Participants at the Public Health Mobile Clinic and Coastside Hope reported less satisfaction than the county-wide average (47% and 41% respectively), while Mental Health Association respondents were more satisfied than average (83%).

**Table 6: Satisfaction with current provider**

	<b>Number n=415</b>	<b>Percent</b>
Strongly Agree	125	30%
Agree	161	39%
Neither Agree nor Disagree	42	10%
Disagree	26	6%
Strongly Disagree	10	2%
Not Applicable	51	12%

***Knowledge and Awareness***

Survey participants were asked about their knowledge of where to get different types of care (medical, dental, mental health and substance abuse, and accurate and confidential health information). More than half of respondents agreed or strongly agreed that they knew where to find each type of care. Table 7 below contains the full results.

Participants felt most confident about finding medical care; 80% agreed or strongly agreed that they knew where to find it. This figure is even higher among participants at Mental Health Association (90%). However, only 47% of respondents from the Public Health Mobile Clinic agreed or strongly agreed.

Sixty-one percent of respondents felt that they knew where to find dental care, including 76% of participants at Puente de la Costa Sur. Coastside Mental Health (33%) and the Public Health Mobile Clinic (35%) had the lowest reported levels of knowledge.

A similar proportion of participants (66%) felt that they knew how to find mental health and substance abuse services. Interestingly, participants at the two mental health-specific health centers had differing levels of reported awareness about where to access mental health and substance abuse services. At Mental Health Association, 83% of respondents agreed or strongly agreed that they knew where to find mental health services; at Coastside Mental Health, only 60% agreed or strongly agreed. This range of responses persisted at other health centers as well; respondents at the Public Health Mobile Clinic (24%), Coastside Hope (47%), Puente de la Costa Sur (49%), and InnVision Shelter Network (80%) all reported levels of knowledge that varied significantly from the county-wide average. Additionally, 43% of those across the county who disagreed or strongly disagreed that they knew where to find mental health care speak a language other than English.

Finally, when asked if they knew where to find accurate and confidential health information, 61% of respondents reported that they did (agreed or strongly agreed). The **service sites** with the highest rate of reported knowledge on these services was Mental Health Association (73%), while the Public Health Mobile Clinic (24%) and Saint Vincent De Paul (41%) respondents had the lowest.

**Table 7: Knowledge of where to find services**

	<b>Number n=418</b>	<b>Percent</b>
<b>Medical Care</b>		
Strongly Agree	145	35%
Agree	190	45%
Neither Agree nor Disagree	35	8%
Disagree	18	4%
Strongly Disagree	14	3%
Not Applicable	16	4%
<b>Dental Care</b>		
Strongly Agree	100	24%
Agree	157	37%
Neither Agree nor Disagree	47	11%
Disagree	55	13%
Strongly Disagree	41	10%
Not Applicable	19	5%
<b>Mental Health &amp; Substance Abuse Services</b>		
Strongly Agree	98	24%
Agree	175	42%
Neither Agree nor Disagree	43	10%
Disagree	30	7%
Strongly Disagree	23	6%
Not Applicable	48	12%
<b>Accurate and Confidential Health Information</b>		
Strongly Agree	80	19%
Agree	175	42%
Neither Agree nor Disagree	64	15%
Disagree	37	9%
Strongly Disagree	27	6%
Not Applicable	34	8%

**Health Care Needs and Priorities**

To identify which health care needs are most important to homeless and farmworker populations in San Mateo County, participants were asked to rank their top five health care needs from a list of eight potential priorities. However, this process was not consistently completed, and in many cases respondents either checked the boxes of their selections (without putting them in rank order), or applied a ranking multiple times (for example, listing two priorities as number one). As a result, Table 8 displays the frequency with which each item was identified as a need (but not its weighted ranking).

The most frequently identified priority was basic medical care (82%), followed by dental care (70%) and mental health care (43%). A modified analysis of the weighted rankings was also completed, to identify a rank order among those respondents who completed the answer as instructed. In this analysis, the top three priorities match the frequency-only analysis.

**Table 8: Patient-identified health care needs**

	<b>Number n=429</b>	<b>Percent</b>
Basic medical/health care	353	82%
Dental care	300	70%
Mental health care	185	43%
Substance abuse care	127	30%
Help getting to medical appointment/doctor	127	30%
Help to obtain health insurance	122	28%
Accurate and confidential health information and education	121	28%
Help to manage health/medical care	116	27%

The fourth and fifth priorities in the frequency-only analysis were substance abuse care and transit to health care services, with 30% of respondents identifying each. These were ranked fifth (substance abuse) and sixth (transit) in the weighted analysis, following the need for help in obtaining health insurance. In both analyses, health information and education, and help managing medical care were least important (seventh and eighth respectively).

Participants from several health clinics reported priorities that varied from the county-wide rankings. Among respondents from Puente de la Costa Sur, transit was identified as being more important than mental health, and respondents from Saint Vincent De Paul identified transit as being more important than both mental health and substance abuse services. Mental Health Associates participants prioritized mental health, substance abuse services, and health education above dental care and help obtaining health insurance.

### ***Barriers to Care***

Survey participants were asked about potential barriers that make accessing health care **problematic. The first category of barriers could be described as “infrastructural” barriers** which make it difficult to set appointments or get to a health center. These include the time it takes to make an appointment, the need for transit to get to an appointment, and the ability to take time off from work and find child care in order to attend an appointment. Table 9 outlines the full set of responses.

Thirty-one percent of respondents agreed or strongly agreed that it takes too long to get an appointment, and another 31% agreed or strongly agreed that finding transportation to get to an appointment is problematic. Sixty percent of participants from Coastside Mental Health agreed or strongly agreed that they have problems accessing health care because it takes too long to get an appointment, but only 18% of Public Health Mobile Clinic respondents felt the same way. Similarly, only 18% of Coastside Hope participants felt that transportation was a barrier to care, while 44% of Saint Vincent De Paul respondents identified it as problematic.

Being unable to take time off from work was identified as a barrier to care by 14% of respondents; this figure doubles (28%) among those who report getting income from a job (which can be considered a proxy for being employed). Twenty-nine percent of respondents from Samaritan House agreed or strongly agreed that they had problems getting health care

because they were unable to take time off work, as did 20% of Coastside Mental Health participants. However, only 6% of participants from both Coastside Hope and Ravenswood Family Health Center, and zero participants from the Public Health Mobile Clinic, identified needing to take time off from work as problematic in accessing care.

**Table 9: Infrastructural barriers to care**

	<b>Number n=417</b>	<b>Percent</b>
<b>Takes Too Long to Get an Appointment</b>		
Strongly Agree	36	9%
Agree	92	22%
Neither Agree nor Disagree	71	17%
Disagree	79	19%
Strongly Disagree	91	22%
Not Applicable	45	11%
<b>Can't Find Transportation to Doctor</b>		
Strongly Agree	46	11%
Agree	84	20%
Neither Agree nor Disagree	80	19%
Disagree	88	21%
Strongly Disagree	83	20%
Not Applicable	36	9%
<b>Unable to Take Time Off from Work</b>		
Strongly Agree	12	3%
Agree	47	11%
Neither Agree nor Disagree	63	15%
Disagree	106	25%
Strongly Disagree	90	22%
Not Applicable	99	24%
<b>Do Not Have Child Care</b>		
Strongly Agree	15	4%
Agree	29	7%
Neither Agree nor Disagree	45	11%
Disagree	92	22%
Strongly Disagree	96	23%
Not Applicable	134	33%

A lack of child care was identified as a barrier to accessing health services by 11% of respondents. This figure was similar (10%) among female respondents. Among InnVision Shelter Network respondents, 2% agreed or strongly agreed that a lack of child care made accessing health care problematic; zero participants from Coastside Hope felt the same.

Participants were asked about four additional potential financial and emotional barriers to care, including the cost of care, being treated disrespectfully, fear of arrest or deportation, and



concerns about privacy. The data on whether or not these barriers impact access to health care for the survey populations is outlined in Table 10.

**Table 10: Financial and emotional barriers to care**

	<b>Number n=416</b>	<b>Percent</b>
<b>Can't Afford the Bills</b>		
Strongly Agree	50	12%
Agree	94	23%
Neither Agree nor Disagree	67	16%
Disagree	84	20%
Strongly Disagree	76	18%
Not Applicable	45	11%
<b>Not Treated with Respect</b>		
Strongly Agree	17	4%
Agree	26	6%
Neither Agree nor Disagree	61	15%
Disagree	126	30%
Strongly Disagree	119	29%
Not Applicable	68	16%
<b>Fear Deportation or Arrest<sup>2</sup></b>		
Strongly Agree	16	4%
Agree	37	9%
Neither Agree nor Disagree	4	11%
Disagree	78	19%
Strongly Disagree	150	36%
Not Applicable	86	21%
<b>Worried about Privacy of Health Care</b>		
Strongly Agree	51	12%
Agree	103	25%
Neither Agree nor Disagree	89	21%
Disagree	78	19%
Strongly Disagree	64	15%
Not Applicable	31	7%

Thirty-five percent of respondents agreed or strongly agreed that they have problems getting health care because they cannot afford the bills. This number is as high as 47% among respondents at Coastside Mental Health, and as low as 18% among participants at the Public Health Mobile Clinic.

One-tenth (10%) of all respondents agreed or strongly agreed that they have problems receiving health care because they are not treated with respect. However, zero participants at the Public Health Mobile Clinic agreed with this notion, as did only 2% from Puente de la Costa Sur and 3%

<sup>2</sup> n=371

from InnVision Shelter Network. Twenty-two percent of respondents from Saint Vincent De Paul identified not being treated with respect as a barrier to care. Among county-wide respondents who agree or strongly agree that they have problems receiving health care because they are not treated with respect, 19% speak a language other than English, and 67% are non-White.

The identification of fear of arrest or deportation as a barrier to accessing health care varied widely across clinics and subpopulations. County-wide, 13% of respondents agreed or strongly agreed that they had problems getting health care because they are afraid of being deported or arrested. Of those who agree or strongly agree, 66% are non-White. Coastside Mental Health and Saint Vincent De Paul respondents had significantly higher levels of agreement with this barrier (27% and 30% respectively), while only 2% of InnVision Shelter Network respondents and none from the Public Health Mobile Clinic agreed or strongly agreed.

Over one-third of patients (37%) reported that they are worried about the privacy of their health care. This is nearly double the level of concern reported in the previous survey in 2013, at which time 19% of respondents expressed concerns about privacy. Participants from clinics like Coastside Hope (18%) and InnVision Shelter Network (26%) were on average less worried about privacy, while respondents from Saint Vincent De Paul (48%), Puente de la Costa Sur (49%), and Coastside Mental Health (60%) reported greater levels of concern.

## Conclusions

Survey participants were more heavily male than the county population (63% male respondents, compared to 50% male population within the county), but White and Hispanic/Latino participant proportions (37% and 25%) were similar to the population of the county. African Americans and Native Americans were disproportionately represented in the survey, and Asian American and Pacific Islanders were underrepresented.

Poverty, employment, and housing are challenges for the study population. Almost all (99.3%) of the survey participants earn less than the county per capita income, and half live on less than \$500 per month. Twenty-two percent had no income at all in the last month, and 71% are likely unemployed (reported no income from a job in the last month). Only 12% of participants live in a house or apartment that they own or rent.

Medi-Cal coverage within these populations is increasing, but 15% remain uninsured. One quarter of respondents receive medical care from emergency departments in the county. The level of knowledge about where to find basic medical care is high (80%), but fewer respondents knew how to find other types of care and health information.

The amount of time it takes to get an appointment, finding transportation to appointments, the cost of care, and concerns about privacy are the largest reported barriers to accessing care among these populations. Privacy concerns in particular are on the rise within these groups. Two-thirds of participants who reported fear of arrest or deportation or not being treated with respect as barriers to care were non-White, highlighting the need for culturally competent solutions.

**Health Care for Homeless & Migrant Health Program  
 Provider Survey, June- July 2015  
 n = 39 responses**

<b><u>More Access is Needed (top 5)</u></b>	<b><u>Percent of Affirmative Responses</u></b>
Substance Abuse Services	86%
Dental Care	83%
Case Management/health Care Navigator	83%
Primary Medical Care	82%
Mental Health Services	81%

*Note: In general, more access was needed for all services.*

<b><u>Top Areas (3)</u></b>	<b><u>Number of Respondents</u></b>
#1 Priority – Provide or increase health care services via mobile/portable clinics or alternative sites	11
#2 Priority – Transportation assistance	9
#3 Priority- More weekend and/or evening hours at local, fixed clinic sites	8

<b><u>Barriers to care (Top 5)</u></b>	<b><u>Number of Respondents</u></b>
Mental Health related issues	27
Transportation	26
Takes too long to get an appointment	25
Inadequate/no health insurance coverage	23
Patient not know where to go to get health care	22

## APPENDIX C

### Case Management Enabling Services

Because the terms “Case Management” and “Case Manager” have become used for sometimes very different aspects of enabling services care, we are redefining them for this RFP. Instead of this singular reference, we have selected a broader set of terms/descriptions which we believe will be more explicit in describing the services provided. These descriptions can generally be seen as on a continuum involving more complex patient and health system/care team interaction as you move along the continuum.

#### **Community Health Worker/Promotora**

**Community Health Worker** (CHW) - lay (non-clinical) members of the communities who usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. Typical services provided by CHWs include:

- interpretation and translation services,
- providing culturally appropriate health education and information,
- assisting people in receiving the care they need,
- giving informal counseling and guidance on health behaviors,
- advocating for individual and community health needs

CHWs may also be referred to as: community health advisors, lay health advocates, outreach educators, community health representatives, peer health promoters, and peer health educators.

**Promotora** - lay Hispanic/Latino community member who receives specialized training to provide basic health education in the community without being a professional health care worker. Promotores(as) are members of the target population and trusted members of their community. Promotores(as) provide culturally appropriate services and serve as a patient advocate, educator, mentor, outreach worker, and translator. This approach is widely used in rural communities to improve the health of migrant and seasonal farm workers and their families, particularly where transportation is limited and travel to the target population is difficult.

#### **Health Navigator/Patient Navigator**

Health Navigator/Patient Navigator - very generally defined as “someone who helps assist patients overcome barriers to care.” More specifically, health/patient navigation refers to the assistance offered to patients in “navigating” through the complex health-care system to overcome barriers in accessing quality care and timely treatment (e.g., arranging financial support, coordinating among providers and setting, arranging for translation services, etc.).

The role of the Health/Patient Navigator varies widely depending on the organization. Health Navigators sometimes act more as a Care Coordinator/Manager and coordinate appointments or

accompany clients to tests and consultations, while Patient Navigators often draw upon considerable clinical skills and operate more like a disease specific case manager. Many Patient Navigators focus on one type of disease such as cancer, heart disease or diabetes. Discussions of Health/Patient Navigators note that many navigators are not health care professionals; i.e. patient navigators are healthcare representatives, not healthcare providers. If a health care professional fills the role of Health/Patient Navigator, he/she does not provide direct care to patients or offer opinions about medical care unless he/she is also part of the healthcare team. In this way, Health/Patient Navigators are similar to Community Health Workers.

Typical functions of a Health/Patient Navigator would include:

### **Facilitate patient healthcare:**

Health/Patient Navigators facilitate and coordinate patient care to ensure that patients receive timely diagnoses and treatment.

- Maintain communication with patients and possibly the healthcare team
- Making appointments
- May contact patients who are “at risk” for missing appointments
- Coordinating transportation
- Provide health information, coordinate screening services
- Help connect patients to other supportive services

### **Support patients while they learn to self-navigate:**

Empowering patients to navigate the healthcare system on their own is one goal of health/patient navigation.

- Coach patients to become advocates for their own care
- Empower patients to self-navigate the healthcare system
- Model behaviors for patients such as checking on appointments or arranging assistance

### **Build awareness of patient navigator services**

Actively building awareness of health/patient navigator services among the health care team is important because they will assist you in coordinating patient care and locate “at-risk” patients that need health/patient navigation services.

- Build professional relationships with health care team members
- Provide information about health/patient navigator services
- Maintain communication to locate patients who are “at risk” for barriers to treatment.

**NOTE:** There are now two very distinct usages of the term “Navigator” related to healthcare. With the implementation of the Affordable Care Act (ACA), “Patient Navigator” now frequently refers to individuals who assist patients in accessing, acquiring and enrolling in healthcare coverage/insurance.

Since Eligibility Assistance is also a defined Enabling Services, please be very specific in the utilization of the term “Navigator” in your proposal. Our preference is for use of “Health/Healthcare Navigator” for those who are helping patients with getting around the healthcare system and

“Eligibility Assistor” for those who help patients with finding and enrolling in health coverage/insurance.

## **Care Coordinator/ Manager**

**Care Coordinator/Manager** - acts as a liaison between the target population patient and health care organizations. They offer support by providing some or all of the following:

- information on health and community resources,
- coordinating transportation,
- making appointments,
- delivering appointment reminders,
- tracking whether appointments are kept, and
- accompanying people at appointments.
- help clients and providers develop a care management plan and
- assist clients to adhere to the plan.

Care Coordinators/Managers providing care for clients with chronic conditions and/or clients who need help navigating the health care system, must have a strong understanding of the local health care system and resources available in their community, including emergency services. Although not trained health providers,

Care Coordinators/Managers frequently have disease-specific or target population-specific education and training, and they are generally paired with a medical professional or team who coordinates with them and who they can call with questions. Care Coordinators/Managers perform some but not all of the functions of professional Case Managers (see below). An important distinction is these Care Coordinators/Managers are lay health workers who may have some special training while the Case Managers described below have related healthcare professional degrees.

The functions performed by CHWs under this title are very similar to the Health/Patient Navigator functions defined above.

## **Case Manager/Medical Case Management**

**Case Managers** - The Case Management Society of America (Society) defines case management as a “collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.” The Society defines case managers as “healthcare professionals (Registered Nurses, Social Workers, Physical Therapists for example) who help provide an array of services to assist individuals and families cope with complicated health or medical situations in the most effective way possible, thereby achieving a better quality of life.” The Certified Case Manager (CCM) credential is available to health care providers licensed to practice independently in the American health care system.

The definition cited by the Society is widely quoted in the literature and clearly requires that Case Managers in a healthcare program be professionals who are able to exercise judgment about a patient’s care needs and the best way to meet them. Using this definition, the title of Case Manager

requires some type of professional credential. However, some Case Management functions may be carried out by non-health care professionals.

Professional Case Managers are also known as **Medical Case Managers**.

In most health care settings, the Case Manager's responsibilities include the following functions:

- Advocacy & Education – ensuring the patient has an advocate for needed services and any needed education
- Clinical Care Coordination/Facilitation – coordinating multiple aspects of care to ensure the patient progresses
- Continuity/Transition Management – transitioning of the patient to the appropriate level of care needed, making, coordinating and tracking referrals
- Utilization/Financial Management – managing resource utilization and reimbursement for services
- Performance & Outcomes Management – monitoring, and if needed, intervening to achieve desired goals and outcomes for both the patient and the health care provider
- Psychosocial Management – assessing and addressing psychosocial needs including individual, familial, environmental, etc
- Research & Practice Development – Identifying practice improvements and using evidence based data to influence needed practice changes

While some of these functions sound similar to those listed for Care Coordinators above, there is a clear distinction that Case Managers who are professionals have significantly more responsibility for independent decision-making, the ability to provide direct care/counseling and authority to make changes in care delivery/systems to improve patient care and/or cost-effectiveness.

**San Mateo County Health Care for Homeless/Farmworker Health Program  
Summary of Enabling Staff Key Functions for “Case Management”**

<b>Key Functions</b>	Community Health Worker/ Promotora	Health(care) Navigator/ Patient Navigator	Care Coordinator/ Care Manager	Case Manager/ Medical Case Manager	<b>Comments</b>
Community Health Education	<b>X</b>				
Outreach to engage patients in care	<b>X</b>	<b>X</b>	<b>X</b>		
Advocate for Individual/ population health needs	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	
Provide culturally and language appropriate health education	<b>X</b>	<b>X</b>	<b>X</b>	<b>X**</b>	**Case Managers may provide individual/group health education or counseling. Lay workers may provide material and “informal” education.
Provide Interpretation Services	<b>X</b>	<b>X</b>	<b>X</b>		
Make and track appointments	<b>X</b>	<b>X</b>	<b>X</b>	<b>X**</b>	**Case Managers may have discretion on when and for what services appointments are made. They also often provide clinical information for the appointment. Lay workers manage appointments under the direction of providers.
Accompany patients to appointments	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	
Educate on how to use the health system		<b>X</b>			
Develop and implement Care Plan		<b>X</b>	<b>X</b>	<b>X**</b>	**Case Managers are part of the care team developing the plan and may have autonomy /authority in implementing/ modifying the plan. Lay workers may contribute to the plan and recommend changes but responsibility for the plan is with the providers or care team. Both types of staff support patients in adhering to the plan.
Support Care Transitions	<b>X</b>	<b>X</b>	<b>X</b>		**Case Managers both plan and



Plan and implement care transitions				<b>X**</b>	facilitate care transitions (e.g. hospital discharge). Lay workers support patients during transitions.
Determine/Implement most cost-effective way to deliver care for desired outcomes				<b>X</b>	
Assess outcomes and manage/revise care				<b>X</b>	

# San Mateo County Health Care for Homeless/Farmworker Health Program

## Support and Companion Animal Programs

Prepared by John Snow Inc. (JSI)

January 2016

This paper explores how homeless shelters can work with clients to accommodate service and companion animals. Nationally, an estimated 5-10% of homeless individuals have pets, although this rate is as high as 24% in some areas.<sup>1</sup> Among homeless populations, those who are more likely to have animal companions include chronically homeless individuals and women experiencing homelessness as a result of domestic violence.

Pet ownership among homeless individuals has been shown to provide companionship, emotional support and comfort, a sense of responsibility, a source of motivation, protection or safety, and decreased loneliness and social isolation. Pets may also provide health benefits including reduced stress, anxiety, and depression among their owners.<sup>2</sup> They can also serve as “social facilitators” for homeless individuals, making it easier for them to interact with others, and engender “a sense of home” for transient individuals.<sup>3</sup> In these ways, pet ownership may improve one’s overall quality of life. Like all pet owners, homeless individuals experience a profound sense of grief when an animal is lost.

Pets can provide both physical and psychological health benefits, including reduced anxiety and depression. In a study of homeless youth in Los Angeles, pet owners reported significantly fewer symptoms of loneliness and depression than their non-pet-owning peers.<sup>4</sup> Other research suggests that pet ownership may also reduce blood pressure, improve cardiovascular health, and encourage physical activity among owners. Particularly among homeless individuals, pet ownership can help alleviate social isolation by providing a mutual relationship built on emotional support, comfort, unconditional love, and acceptance.<sup>5</sup> The study of homeless youth in LA found that the majority of pet-owners reported that

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<sup>1</sup> Pets of the Homeless. Available at: <http://www.petsofthehomeless.org/about-us/faqs/>

<sup>2</sup> Labrecque J and Walsch CA. Homeless Women’s Voices on Incorporating Companion Animals into Shelter Voices. *Anthrozoös*, 2011;24(1):79-95.

<sup>3</sup> Labrecque J and Walsch CA, 2011.

<sup>4</sup> Rhoades H, Winetrobe H, Rice E. Pet Ownership among Homeless Youth: Associations with Mental Health, Service Utilization, and Housing Status. *Child Psychiatry Human Dev*, 2015;46:237-244.

<sup>5</sup> Labrecque J and Walsch CA, 2011.

their pets keep them company, and made them feel loved and safe. Along with this companionship, research suggests that pet ownership can give individuals “a sense of responsibility, instilling self-worth by providing care for the pet and feeling needed,” even when providing this care proved challenging.<sup>6</sup>

An additional benefit of pet companionship reported by homeless individuals is that of “social facilitation.” Research suggests that pets can facilitate and mediate social interactions between people that may otherwise be potentially awkward or uncomfortable. For example, “Pet ownership can be understood as a way to connect with the social environment (peers, service providers, the general public, and the housed) for homeless individuals who typically have limited social networks and low levels of social support.”<sup>7</sup> In addition, homeless pet-owners in one study reported that “other people treated homeless pet-owners better than they treated homeless people without pets” and that “pets facilitated conversation or communication between people.”<sup>8</sup> Pet owners in the same study “reported that the presence of a pet made other people more friendly” towards them. In this role, pets may help homeless individuals connect with other people in a variety of contexts by introducing a common interest or reducing barriers to interaction.

Despite these health and social benefits, pet ownership can also serve as a barrier for service utilization for this population, including both health services and housing/shelter, as many facilities do not allow animals and homeless individuals are unlikely to have a safe place to leave the pet or are unwilling to leave a pet alone. Research shows, not surprisingly, that homeless individuals would rather not be housed if they cannot stay with their pet.<sup>9</sup> Homeless pet owners may also face challenges in providing their pets with adequate food; however, research consistently shows that pet owners feed their animals first, even if it means sacrificing their own food.<sup>10</sup> In addition, access to veterinary care can be problematic due to the cost of medical care and a perceived fear that an animal may be confiscated if unlicensed or unvaccinated.<sup>11</sup> Homeless pet owners may also encounter stigma in public based on the perception that they do not have the capacity to care for an animal.<sup>12</sup>

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<sup>6</sup> Labrecque J and Walsch CA, 2011.

<sup>7</sup> Kidd AGH and Kidd RM. Benefits and Liabilities of Pets for the Homeless. *Psychological Reports*, 1994; 74:715-722.

<sup>8</sup> Kidd AGH and Kidd RM, 1994.

<sup>9</sup> Rhoades H, Winetrobe H, Rice E. Pet Ownership among Homeless Youth: Associations with Mental Health, Service Utilization, and Housing Status. *Child Psychiatry Human Dev*, 2015;46:237-244.

<sup>10</sup> Kim CH and Newton EK. My Dog Is My Home: Increasing Awareness of Inter-Species Homelessness in Theory and Practice.

<sup>11</sup> Kidd AGH and Kidd RM, 1994.

<sup>12</sup> Kim CH and Newton EK. My Dog Is My Home: Increasing Awareness of Inter-Species Homelessness in Theory and Practice.

Providing pet-friendly shelters and transitional housing facilities reduces barriers to entry and allows homeless individuals to maintain the benefits of pet ownership and facilitate their utilization of necessary health and other services. Currently, few shelters and service facilities in the U.S. make accommodations for pets; however, it appears that pet-friendly accommodations are becoming more common. In the next sections, we describe: 1) rules and regulations regarding service and companion animals, and 2) existing practices in place to support homeless clients with pets and companion animals.

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## Defining the Rules and Regulations Regarding Service and Companion Animals

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Per the Federal Americans with Disabilities Act (ADA), special accommodations are required for service and companion animals.<sup>13</sup> Per ADA regulations, service animals are typically allowed wherever their owners are allowed, including all public buildings and spaces. Support/companion animals may share some of the same privileges, depending on local regulations.

Under the ADA, a **service animal is a “dog [or miniature horse] that has been individually trained to do work or perform tasks for an individual with a disability. The task(s) performed by the dog must be directly related to the person's disability.”** Qualifying tasks themselves are not defined by the ADA, but examples include alerting owners with hearing loss, reminding individuals with medical conditions to take medications, or assisting individuals with physical disabilities to complete basic activities of daily living. The following rules apply to service animals:

- Service animals do not need to be professionally trained; the ADA allows for owners to train their animals.
- Business owners, landlords, etc. may only ask individuals two questions: 1) if a dog/miniature horse is a service animal trained to assist with a disability, and 2) what task he/she is trained to perform. They may not ask individuals to specify their disability.

**Support animals (also known as companion or therapy animals) are animals that provide companionship to owners and are not trained to perform specific tasks.** The ADA does not consider animals that solely provide emotional support or comfort to be service dogs.<sup>14</sup> For this reason, individuals with support animals may not have the same privileges as those with service animals. In

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<sup>13</sup> Service Animals and Frequently Asked Questions about Service Animals and the ADA. US Department of Justice. Available at: [http://www.ada.gov/regs2010/service\\_animal\\_qa.html](http://www.ada.gov/regs2010/service_animal_qa.html) and [http://www.ada.gov/service\\_animals\\_2010.htm](http://www.ada.gov/service_animals_2010.htm)

<sup>14</sup> ADA Service Animal Q&A: [http://www.ada.gov/regs2010/service\\_animal\\_qa.html](http://www.ada.gov/regs2010/service_animal_qa.html)

addition, San Mateo County does not recognize or certify support animals. However, other California counties may recognize support animals – for example, San Francisco allows support animals in most housing situations with a certification letter from a health care provider.

The state of California does not require service and support animals to be registered, however, San Mateo County requires Service Dog Registration.<sup>15</sup> Service dogs are also not required to wear vests, harnesses, or service tags to identify them as such, however, this is often recommended as a way for landlords, business owners, and others in public places to recognize them.

All dogs in San Mateo County (including cities, towns, and unincorporated areas) are required to be registered annually with the County Department of Animal Licensing for an annual fee of \$8-50.<sup>16</sup> Owners are required to register dogs “by 4 months of age or within 60 days of acquiring the animal. New residents of the county must license their dog or cat within 60 days.” Registration requires proof of the animal’s age, rabies vaccination, and proof of spay/neuter if applicable. Animals with certain medical conditions may be exempt from vaccinations.

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<sup>15</sup> <http://www.smchealth.org/sites/default/files/docs/PHS/Animal/Form%20-%20ACL%20service%20dog%20application%2011615.pdf>

<sup>16</sup> <http://www.smchealth.org/AnimalLicensing>

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## Accommodations for Homeless Clients with Pets, Companion or Service Animals

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According to the director of Pets for the Homeless, the majority of homeless shelters and other transitional housing facilities do not provide accommodations for homeless clients and their pets. The majority of shelters allowing pets are available to women and families experiencing domestic violence; even so, these shelters are still uncommon in California. Because the State of California does not license or certify homeless shelters, any regulations regarding pets in shelters would be made at the county or city level; currently, San Mateo does not have any regulations prohibiting pets in shelters. A perceived barrier to accommodating pets among shelters is the desire to ensure the safety of other clients and be sensitive to those with allergies or fear of animals.

However, within the past 10 years, a small number of shelters have created pet-friendly facilities, recognizing the importance of supporting pet ownership among homeless individuals. These facilities range from having dedicated rooms for clients with pets, to separate kennels or outdoor spaces for animals, to allowing clients to share a bed with their pet. In many cases, shelters also help clients get veterinary care, food, and registration for their pets. A key benefit that pet-friendly shelters can also provide is a space for clients to leave their animal while they attend appointments at facilities that are not pet-friendly – for example, to enroll in social services or seek housing.

Below, we discuss specific examples of how homeless shelters have made accommodations for clients with pets. Table 1 on page 9 summarizes the pet-friendly features of these shelters.

### California Examples

The recently opened **Mission Street Navigation Center Pilot Program** in San Francisco (run by Episcopal Community Services) provides accommodations for clients with pets (which have included dogs, cats, and rabbits thus far).<sup>17</sup> Owners are required to be with their pet at all times, although they can also ask friends to watch their pet for them. Pets often sleep in the beds with their owners, but the shelter can also provide a crate if needed. In terms of sleeping arrangements, a case manager at the Center stated that “people ended up getting dormed depending on how their pets are interacting or tolerating each other. We didn’t realize that the chemistry between the dogs would be so important but it’s a big thing in the dorm assignments.” The facility also has a dog run with a drainage system, used mostly to let animals relieve themselves. In addition, they have an internal courtyard where animals can run around.

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<sup>17</sup> Available at: <http://www.ecs-sf.org/programs/navcenter.html> and <http://navigationcenter.org/>

It is expected that pets staying at the shelters are well-behaved and clients are responsible for ensuring this. In specific cases where dogs have been aggressive, the Center has required that owners keep their dogs on a leash or muzzled while on campus.

Through a community partnership, the Navigation Center also helps clients obtain any required vaccinations, licenses, or registration paperwork for their pets. For example, the agency pays for vaccinations and will escort the client to Animal Care & Control to make an appointment for pet vaccinations. They also have donated dog food that is distributed to those with pets and connect clients to a program that provides free food through the city's Animal Care & Control Department.

The Navigation Center also helps homeless clients get pet documentation as part of the housing assistance process. For most clients, this includes getting a letter of certification for an animal to be considered a companion animal (allowed in most housing types in the City of San Francisco); clients work with a case manager to get a mental health assessment from a licensed clinician (usually a MSW). Part of the assessment asks what symptoms the companion animal helps them to reduce. According to Julie Leadbetter, Director of the Navigation Center, most clients have a qualifying condition (such as depression or anxiety) that would be eligible for a companion animal. According to a case manager at the Center, certification letters "are written liberally unless we see the caretaker is having issues with the animal (for example, neglect or abuse)." The City of San Francisco allows clients with companion animals to utilize services for up to 10 days without paperwork; clients have a 10 day window to obtain it, during which time their animals are considered pets.

In addition to the Navigation Center, three other shelters in San Francisco have pet-friendly facilities:

- [Multi-Service Center South](#), San Francisco (run by St. Vincent de Paul Society)
- [The Sanctuary](#), San Francisco (run by Episcopal Community Services)
- [Next Door](#), San Francisco (run by Episcopal Community Services) – Accepts companion animals with a certification letter and provides a separate kennel area for dogs.

The **Invision Shelter Network**, based in San Mateo County, currently works to accommodate a limited number of clients with pets (mostly small dogs) at the Maple Street Inn. While they do not have a formal pet policy in place, they take pets on a case-by-case basis. Generally, pets must be non-aggressive and well-behaved, housetrained, able to be under voice control, up-to-date on vaccinations, and cannot bother other clients. The current director also noted that they typically see more service or companion

dogs than pets among their clients. Invision will be renovating the Maple Street Inn in Spring 2016 to include 140 beds and, in response to client interest, a large pet kennel. The kennel will be outdoors (separated from client beds) and will include both individual kennels and a large group space.

Through a grant from PetCo, the **PetCo Place at the PATH Shelter** in Hollywood, CA is able to accommodate homeless clients with pets.<sup>18,19</sup> The shelter was designed to encourage LA's homeless population to utilize emergency shelters without having to leave pets behind. The shelter is structured as a "a shelter within a shelter" – a place where the homeless can stay and still visit their dogs and cats in a nearby enclosed kennel." The shelter can only accommodate 5-6 pets at once. Staff from the Pets Are Wonderful Support/Los Angeles<sup>20</sup> organization provide donated food and veterinary care.

The **Homeless Campus Pet Kennel** at the City of Riverside Access Center, CA provides kennel and animal services to local shelter residents as well as to unsheltered homeless.<sup>21</sup> The 400-square-foot shelter was built in 2011 with the goal of meeting the needs of homeless clients with pets. While the kennel is not attached to a shelter, it is adjacent to Path of Life Ministries and the Riverside Access Center, which both provide services to homeless clients; clients are able to leave pets at the kennel while they seek services.<sup>22</sup> The kennel is staffed by the City of Riverside Access Center staff, and is run in collaboration with the County Animal Control and a local animal shelter. The shelter can accommodate up to 18 total dogs and cats and provides access to pet bathing areas, a dog park, food, and veterinary care. Clients using the kennel must follow kennel policies, which differ for shelter residents versus unsheltered homeless.

### Examples from Outside California

The **PetSmart Promise program** offered by PetSmart (a national pet supply chain) has provided grants to build pet care facilities in a number of places. One notable example is the **PetSmart Promise facility at the Salem Interfaith Hospitality Network (SIHN)** in Salem, Oregon. The facility opened in October 2015 and will allow the shelter network to accommodate up to six dogs and two cats (with potential space for more in the future) for homeless families.<sup>23</sup> The pet facility is located the network's Day Center and has

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<sup>18</sup> <http://www.sfgate.com/bayarea/article/Shelter-welcomes-homeless-their-pets-3274379.php>

<sup>19</sup> <http://www.epath.org/site/IfYouAreHomeless/hours.html>

<sup>20</sup> <http://www.pawsla.org/>

<sup>21</sup> [http://www.sbcounty.gov/Uploads/DBH/SBCHP/LinkDocuments/Homeless\\_Summits/2012/AttachmentA2.pdf](http://www.sbcounty.gov/Uploads/DBH/SBCHP/LinkDocuments/Homeless_Summits/2012/AttachmentA2.pdf)

<sup>22</sup> <http://losangeles.cbslocal.com/2011/05/06/riverside-homeless-shelter-opens-pet-kennel/>

<sup>23</sup> <http://www.statesmanjournal.com/story/news/2015/10/27/salem-gets-homeless-shelter-takes-pets/74475540/>



outdoor space for pets to roam and provides food, beds, leashes, and toys. The facility is separate from where homeless families are housed (in local churches); owners care for the pets during the day but facility volunteers care for the pets when their owners are temporarily sheltered. Pet services are available as long the family remains within the shelter network. Through the same program, SIHN was also able to install a fish tank for families to use.

PetSmart has also provided funding for 24 PetsHotels across the country, including three in California – in Folsom, Northridge, and Tustin. According to the PetSmart website, “these locations provide dogs and cats in transition a safe place to call home while their families get back on the road to independent housing” and provide free boarding to pets. As part of the program, families can also access free veterinary consultations and services, treats, baths, and Doggie Day Camp.

The recently opened **Hale Mauiola transitional housing shelter** with 90 beds in Sand Island, Oahu, Hawaii allows pets in client rooms (which are made from shipping containers), working with the local humane society to do so.<sup>24</sup> Allowing pets is one of a number of measures the new shelter has taken to reduce barriers to entry for homeless individuals and was one of the suggestions from the public during the development of the shelter. During their stay (up to 60 days), clients are connected with housing resources.

**Barry House** in Halifax, Canada has housed pets for homeless clients since 2006 in order to encourage homeless youth and women to use their facility.<sup>25</sup> The shelter provides outdoor kennels to accommodate dogs (although cats have also been housed in the past) and to separate animals from potential clients with allergies or fears. Pets are required to be cared for by their owners, and are not the responsibility of shelter staff.

The **New Fountain Shelter** (part of the Lookout Shelter Network) in Vancouver, Canada allows pets to stay in homeless clients’ rooms.<sup>26</sup> Pets are also allowed to freely roam one floor of the shelter, allowing them to interact with other residents who may not own pets themselves. Another floor of the shelter is pet-free for those with allergies or fears. Most pets, except for large dogs, are allowed; the majority of

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<sup>24</sup> <http://khon2.com/2015/11/18/hale-mauiola-transitional-housing-services-center-opens-on-sand-island/>

<sup>25</sup> Available at: <http://www.shelternovascotia.com/facilities-and-services/barry-house>

<sup>26</sup> <http://www.canada.com/theprovince/news/story.html?id=e988e6a5-b349-46d8-8d1b-300c2abb63ed>

pets they house are cats. The shelter also works with local nonprofit organizations to secure pet food donations and veterinary care for clients.

A group of housing programs run by **St. Mungo's Broadway** in London, UK allows residents up to three pets (typically dogs) in their hostels.<sup>27</sup> Residents also have access to free veterinary care as needed and regular animal welfare checks through the center's partnerships with local animal organizations. Residents must sign a "dog contract" upon getting placed in housing, which "ensures the animal is fed and walked regularly and that another resident is nominated to take care of the dog should its owner be unable to."

### Shelters for Victims of Domestic Violence

There are also a number of examples of shelters for victims of domestic violence that allow pets, including:

**Noah's Animal House** in Las Vegas, NV provides on-site shelter and care services for the pets of the victims of domestic violence. The animal shelter is on the grounds of The Shade Tree shelter for domestic violence victims. The shelter's website also lists domestic violence shelters allowing pets on their website at <http://noahsanimalhouse.org/directory/>.

**Safe Embrace**, a women's shelter in Reno, Nevada, recently built a facility to house up to a dozen dogs and cats.<sup>28</sup> There are three indoor/outdoor enclosures for small and large dogs (with a doggy door providing outdoor access) and a climate-controlled area for cats. Funding was provided by Sacramento-based Red Rover, which has helped fund similar facilities, and local partners.<sup>29</sup>

Similarly to Safe Embrace, the **Sojourner Center** in Phoenix, Arizona recently built a pilot Pet Companion Shelter with indoor space and an outdoor dog run area.<sup>30</sup> The space can accommodate eight cats and eight dogs, as well as a small number of birds and fish. According to the Center's website, individuals "staying at the shelter will be responsible for feeding, exercising and socializing with their pet at least twice a day."<sup>31</sup>

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<sup>27</sup> [http://www.mungosbroadway.org/contact/faqs/does\\_st\\_mungos\\_take\\_homeless\\_people\\_and\\_their\\_pets](http://www.mungosbroadway.org/contact/faqs/does_st_mungos_take_homeless_people_and_their_pets)

<sup>28</sup> <http://www.ktvn.com/story/28493278/new-pet-facility-at-womens-shelter>

<sup>29</sup> <https://redrover.org/domestic-violence-safe-housing-grants>

<sup>30</sup> [http://www.huffingtonpost.com/2015/05/22/domestic-violence-center-pets\\_n\\_7421378.html](http://www.huffingtonpost.com/2015/05/22/domestic-violence-center-pets_n_7421378.html)

<sup>31</sup> <http://www.sojournercenter.org/about-us/our-programs/sojourner-pet-companion-shelter/>

**Table 1. Pet-Friendly Shelter Practices**

	<b>Maple Street Inn (Innvision Shelter Network)</b>	<b>Mission Street Navigation Center</b>	<b>Barry House</b>	<b>New Fountain Shelter</b>	<b>St. Mungo's Broadway</b>	<b>PetCo Place</b>	<b>Homeless Campus Pet Kennel*</b>	<b>PetSmart Promise*</b>
Location	San Mateo	San Francisco	Halifax, Canada	Vancouver, Canada	London, UK	Hollywood, CA	Riverside, CA	Eugene, OR
Allows pets in rooms/beds	X	X		X	X			
Separate area for pets (e.g., kennels, crates, or other space)			X	X		X	X	X
Separate rooms for pet owners								
Outdoor area for pets		X	X				X	X
Can leave pet at shelter during the day								X
Provides assistance with pet care (veterinary care, vaccinations, pet food)		X		X	X	X	X	X
Provides assistance with pet documentation and registration		X						
Residents must sign a "dog contract" or adhere to other policies regarding their pet	X – Pets must be well-behaved and non-aggressive				X		X – Policies differ depending on whether client is sheltered or unsheltered	

\*Kennel is a separate facility, not attached to housing.

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## Providing Services for Pets

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Based on a review of existing pet policies in homeless shelters and transitional housing facilities, the following best practices emerged as recommendations:

- When possible, shelters and drop-in centers should provide access to free or low-cost pet food for animals. Shelters and other safety-net facilities should explore local opportunities for free pet food; many national pet suppliers have food donation programs.
- Shelters should provide access or referrals to free or low-cost routine or emergency veterinary care for clients with pets by partnering with local organizations such as the Humane Society.
- If possible, pet-friendly shelters and facilities should ensure designated spaces for pets so as to accommodate other individuals who are allergic to or fearful of animals. Making kennels or crates available to clients with pets may assist in making other clients more comfortable. Providing outdoor kennel space can also reduce the risk of flea infestation.

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## Available Resources for Homeless Pet Owners in San Mateo County

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The following organizations in or nearby San Mateo County provide free or low-cost services for clients who need assistance obtaining food, veterinary care, and other basic needs for their pets.

**Peninsula Humane Society/SPCA** offers low-cost vaccination and microchipping clinics for pets once a month. Homeless individuals may not otherwise be able afford necessary vaccinations, spaying/neutering, or emergency care for pets. Some vaccinations – including rabies – are typically required for pets to be registered with the city. More information is available at <http://www.peninsulahumanesociety.org/services/community.html> and <http://www.peninsulahumanesociety.org/services/vaccination.html>.

The **Palo Alto Humane Society** website lists free or low-cost resources to aid clients in accessing pet care. The list is available at <http://www.paloaltohumane.org/programs/intervention/resources.html>. Resources specific to San Mateo are attached in Appendix B.

The **Humane Society of Silicon Valley** has a Pet Pantry Program to provide free pet food to homeless animals and others in need. Individuals must apply to the program. More information is available at: <http://www.hssv.org/what-we-do/pet-care-services/pet-pantry.html#landingpage>.

**Pets in Need** in Redwood City, CA offers free spaying and neutering for any California resident through their mobile clinic, with an appointment. Pets must have a current rabies vaccination and no known health problems. More information is available at:

[http://www.petsinneed.org/services/veterinary\\_services/](http://www.petsinneed.org/services/veterinary_services/).

**Pets of the Homeless**, a national non-profit, works with food pantries and homeless shelters across the country to help provide care for homeless pets through a number of services. The organization helps food pantries, soup kitchens, and homeless shelters to serve as pet food distribution sites. The organization also runs The Crate Project, which provides collapsible and reusable pet sleeping crates to homeless shelters that accommodate pets. For more information about these programs, visit

<https://www.petsofthehomeless.org/help-us/other-ways-to-help/>. Individuals can search for pet-friendly shelters, food and supplies, and other resources by location at <https://www.petsofthehomeless.org/get-help/>.

The **Safe Place for Pets** website helps locate temporary boarding for pets of domestic violence victims. Clients can search for boarding by location, available at: <http://safeplaceforpets.org/>.

## Appendix A – Pet-Friendly Shelters

### **American Red Cross**

Imago Dei Community Church  
1302 SE Ankeny St.  
Portland, Oregon

### **Austin Resource Center for the Homeless**

500 East 7th St.  
Austin, Texas 78701  
512-305-4100

### **Boulder Shelter for the Homeless and Emergency Warming Center**

Boulder, Colorado  
303-442-4646

### **Community Partnership for Homeless**

South Miami-Dade Center  
28205 SW 125 Ave  
Homestead, Florida 33033  
877-994-4357  
<http://www.cphi.org/>

### **Doorways for Woman & Families of Domestic Violence**

Arlington, Virginia  
703-237-0881

### **Family Promise**

7221 E. Belleview St.  
Scottsdale, Arizona 85257  
480-659-5227  
<http://familypromiseaz.org/>

### **Family Promise**

429 E. Story Street  
Bozeman, Montana 59715  
406-582-7388  
<http://www.familypromisegv.org/>

### **Fred Victor Bethlehem United Shelter**

1161 Caledonia Road  
North York, Ontario, Canada M6A 2W9  
416-644-1734  
<http://www.fredvictor.org>

### **Good Samaritan Rescue Mission**

210 S. Alameda St.  
Corpus Christi, Texas  
361-883-6195

### **Haven for Hope**

1 Haven for Hope Way  
San Antonio, Texas 78207  
210-220-2100  
<http://www.havenforhope.org>

### **Homeless Campus Pet Kennel**

(adjacent to Path of Life Ministries)  
2880 Hulen Place  
Riverside, California

### **King's Harvest Foster Care for Pets**

824 W. 3rd St.  
Davenport, Iowa 52802  
563-570-4536 call for information

### **L.A. Family Housing**

7843 Lankershim Blvd.  
North Hollywood, California 91605  
211  
<http://www.lafh.org>

### **Lost Our Home Pet Foundation**

16211 N. Scottsdale Rd Suite A6A#274  
Scottsdale, Arizona 85254  
602-230-4357  
<http://lostourhome.org>

### **Noah's Animal House @ The Shade Tree**

Las Vegas, Nevada 89125  
702-385-0072

### **Path of Life Ministries - Year Round Riverside Emergency Homeless**

2840 Hulen Place  
Riverside, California 92507  
951-683-4101

**PAWS Chicago**

1997 N. Clybourn Ave.

Chicago, Illinois 60614

773-475-9426

<http://www.pawschicago.org/about-paws-chicago/>

**Petco Place at PATH Hollywood**

5627 Fernwood Ave.

Los Angeles, California 90028

323-644-2200

**Rockin' AA Sanctuary**

Mena, Arkansas 71953

479-234-0417

<http://rockinaa.com/index.php>

**Safe Place for Youth**

685 Westminster Avenue

Los Angeles, California 90291

<http://safeforcefor youth.org/>

**St. Vincent de Paul's Eugene Service St.**

485 Highway 99

Eugene, Oregon 97402

541-461-8688 DAY CENTER

**The Shade Tree Shelter for Women, Children  
and their Pets**

1 West Owens

N. Las Vegas, Nevada

702-385-0072

## Appendix B – Nearby Resources for Pet Owners in San Mateo County

From: <http://www.paloaltohumane.org/programs/intervention/resources.html>

### Palo Alto 24-hour Emergency Animal Clinic

#### South Peninsula Veterinary Emergency Clinic

3045 Middlefield Road  
Palo Alto, CA  
(650) 494-1461

[Get Map](#)

### Other local 24-hour Emergency Animal Clinics

#### Adobe Animal Hospital

396 1st Street  
Los Altos, CA  
(650) 948-9661

[Get Map](#)

#### Emergency Animal Clinic of San Jose

5440 Thornwood Drive  
San Jose, CA  
(408) 578-5622

[Get Map](#)

#### United Emergency Animal Clinic

905 Dell Avenue  
Campbell, CA  
(408) 371-6252

[Get Map](#)

### Vaccinations and Microchipping: low cost local options

#### Palo Alto Animal Services

3281 E. Bayshore Road  
Palo Alto, CA 94303  
(650) 496-5971

[http://www.cityofpaloalto.org/depts/pol/animal\\_services.asp](http://www.cityofpaloalto.org/depts/pol/animal_services.asp)

#### Peninsula Humane Society & SPCA

12 Airport Blvd.  
San Mateo, CA 94401  
(650) 340-8200

<http://www.phs-sPCA.org>

#### VIP Pet Care Services

*Offers canine and feline vaccinations, microchipping, blood and fecal testing, flea and tick control, ear mite treatment, deworming, and heartworm prevention at mobile clinic locations. Services are provided by a state licensed veterinarian without an examination fee.*

<http://happypet.com/mobile.php>

### Spay and Neuter Surgeries: low cost local options

#### Palo Alto Animal Services

3281 E. Bayshore Road  
Palo Alto, CA 94303  
(650) 496-5971

[http://www.cityofpaloalto.org/depts/pol/animal\\_services.asp](http://www.cityofpaloalto.org/depts/pol/animal_services.asp)

#### Peninsula Humane Society & SPCA

12 Airport Boulevard  
San Mateo, CA 94401  
(650) 340-8200

<http://www.phs-sPCA.org>

### Financial Assistance Programs for Veterinary Care

In Memory of Magic

[www.imom.org](http://www.imom.org)

AAHA Helping Pets Fund

[www.aahahelpingpets.org](http://www.aahahelpingpets.org)

Cats in Crisis - *For cats only.*

[www.catsincrisis.org](http://www.catsincrisis.org) - *For cats only.*

Help-A-Pet – *Focuses on helping the disabled and seniors with pet help.*

[www.help-a-pet.org](http://www.help-a-pet.org) – *Focuses on helping the disabled and seniors with pet help.*

Shakespeare Animal Fund Options – *Provides the public with various funding assistance options and*



links.

[www.shakespeareanimalfund.org](http://www.shakespeareanimalfund.org)

United Animal Nations – Lifeline Grants, Crisis Relief Grants, and more

[www.uan.org](http://www.uan.org)

The Pet Fund

[www.thepetfund.com](http://www.thepetfund.com)

### Financial Assistance Programs for Veterinary Care: California-specific

PALS: Pets Are Loving Support - *For seniors, disabled or ill pet owners.*

[www.sonic.net/~pals/index.html](http://www.sonic.net/~pals/index.html)

PAWS San Francisco - *For seniors, disabled or ill pet owners.*

[www.pawssf.org](http://www.pawssf.org)

SF SPCA Animal Hospital - *For seniors, disabled or ill pet owners.*

[www.sfspca.org/veterinary-hospital/financing-options](http://www.sfspca.org/veterinary-hospital/financing-options)

### Spay/Neuter, Food, and Other

Bad Rap: San Francisco - *Pit bull-specific assistance for finding rental housing and insurance.*

[www.badrap.org](http://www.badrap.org)

VET SOS: San Francisco - *Free veterinary care and supplies for pets of the homeless.*

[www.vetsos.org](http://www.vetsos.org)

### Shelters in San Mateo, Santa Clara, and San Francisco Counties

Santa Clara County

#### Palo Alto Animal Services

3281 E. Bayshore Road

Palo Alto, CA 94303

(650) 496-5971

[http://www.cityofpaloalto.org/depts/pol/animal\\_services.asp](http://www.cityofpaloalto.org/depts/pol/animal_services.asp)

#### Humane Society of Silicon Valley

901 Ames Avenue

Milpitas, CA 95035

(408) 262-2133

<http://www.hssv.org>

#### San Martin Animal Shelter

12370 Murphy Avenue

San Martin, CA 95046

(408) 683-4186

<http://www.fosmas.org>

San Mateo County

#### Pets In Need

873 Fifth Avenue

Redwood City, CA 94063

(650) 367-1405

<http://www.petsinneed.org>

#### Peninsula Humane Society & SPCA

12 Airport Blvd.

San Mateo, CA 94401

(650) 340-8200

<http://www.phs-spca.org>

San Francisco County

#### The San Francisco SPCA

2500-16th Street

San Francisco, CA 94103-6589

(415) 554-3000

<http://www.sfspca.org/>

#### Animal Care and Control

1200 15th Street (at Harrison)

San Francisco, CA 94103

(415) 554-6364

### Pet Insurance

Pet Plan - Insurance for dogs and cats.

[www.gopetplan.com](http://www.gopetplan.com)

### Pet-friendly Hotels

AAA offers a great list AAA-rated pet-friendly hotels.

<http://www.aaa.com/PetBook/>

Paw Nation provides their choices for best hotels for pets.

[Link here](#)

# **San Mateo County Health Care for Homeless/Farmworker Health Program**

## **Promising Nutrition and Food Access Programs**

**Prepared by John Snow Inc. (JSI)**

**January 2016**

This paper examines approaches to improving nutritional status among homeless, farmworker, and other low-income clients. Individuals at risk of poor nutrition may require a comprehensive approach that includes a combination of clinical nutrition services, nutrition education, and assistance enrolling in food assistance programs. We also offer general recommendations and considerations for providing nutritional advice to these clients.

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### **Background**

For homeless, farmworker, and other low-income populations, good nutritional status largely depends upon having an adequate and healthy food supply. In general, these populations may encounter challenges to food security that supersede their ability—or desire to—achieve nutritional goals. Food security is a state when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life. In 2012, 32% of low-income households in San Mateo County were food insecure.<sup>1</sup>

Food insecure individuals may rely on a number of different sources of food assistance, including federal or state programs like the Supplemental Nutrition Assistance Program (SNAP, or CalFresh in California) and the Women, Infants, and Children (WIC) Program, and may also receive food from a large network of safety-net providers including congregate meal programs, soup kitchens, food pantries, brown bag programs, and homeless shelters (see Appendix A for a description of these programs). Reliance on these programs may also depend on one's employment status, particularly among migrant and seasonal farmworkers.<sup>2</sup> Among California counties, San Mateo has one of the lowest CalFresh participation rates among those who are income-eligible.<sup>3</sup> According to the most recent San Mateo County Homeless Census (July 2015), among the 1,772 homeless individuals surveyed, 79% reported currently accessing free meals and 59% used a food pantry.<sup>4</sup>

## Barriers to adequate nutrition for homeless, farmworker, and low-income clients

First, it is important to understand the barriers that homeless, farmworker, and other low-income clients may face in accessing food—particularly healthy food—and maintaining good nutritional status. Food access, and therefore nutritional status, is shaped by both individual-level and community-level factors including socioeconomic factors, food assistance, transportation, retail food environment, crime and safety, and health conditions (Figure 1).<sup>5</sup> Barriers specific to homeless, farmworker, and low-income clients are described below.

Figure 1. Factors Influencing Food Access



- Homeless shelters have varying rules about food storage. For those staying in homeless shelters, meals are generally provided but they must adhere to restrictions that prohibit residents from bringing in or storing perishable food. Usually, food must be consumed outside the shelter. If allowed in the shelter, food must be nonperishable and must be stored in clients' rooms or lockers.
- Availability of cooking and food storage facilities vary across homeless shelters and other temporary housing. These range from a kitchen in a common area, to in-room kitchenettes, to those with no kitchen facilities available for resident use. Local shelters typically prepare meals for the residents.<sup>6</sup>
- The nutritional quality and content of meals provided at homeless shelters or through other sources of food assistance (such as meal programs, food pantries, brown bag programs, and emergency food programs) varies depending on organizations' funding and donations. Shelters rely primarily on donations or a local food bank (e.g., Second Harvest Food Bank serves San Mateo and Santa Clara Counties) for the majority of the food they prepare and provide to residents. They may have limited funds to purchase additional meals or snacks for residents.
- For shelter residents, most homeless shelters provide an average of 1.4 meals per day, forcing individuals to seek other sources of food throughout the day.<sup>7</sup>
- Food availability and dietary patterns are often cyclical for those who receive food assistance or other benefits. Meaning, individuals may have adequate food supply early in the month but rely more heavily on shelters and free meals for food once benefits have run out.<sup>8</sup> Benefits for an individual receiving SNAP/CalFresh are approximately \$190/month.

- In general, clients' ability to purchase foods from retail food stores, such as convenience or grocery stores, may be limited due to lack of availability, geographic proximity, lack of transportation, and/or being turned away by business owners.
- Among farmworkers, food access and eating patterns are likely to be limited by work schedules, transportation, and income fluctuations (particularly among migrant and seasonal farmworkers).<sup>9</sup> For farmworkers, a typical day consists of a quick breakfast (with an emphasis on foods that need minimal preparation such as cereal, breads, and packaged foods) and dinner. They may go without a midday meal given the limited break times during the day, no food storage or reheating opportunity in the field, and often no portable water. Some may bring packaged foods that do not need to be refrigerated. Some may also eat the crop they are harvesting. Many may be reliant on their crew leader or other workers for transportation to grocery shopping.
- Statewide, the vast majority of farmworkers are of Hispanic/Latino descent; based on anecdotal evidence, it is likely that San Mateo County follows this trend.<sup>10</sup> As such, their eating patterns are likely to be shaped by cultural food preferences, their country of origin, and their degree of acculturation. In the U.S., they may lack access to ethnic and culturally preferred foods. Dietary habits often change while living in the U.S., with immigrants reporting dining out more frequently, eating more fast food, eating more processed (such as sodas and meats) and less fresh foods (vegetables, dairy), and having less time to cook meals due to demanding work schedules.
- Farmworkers may experience additional challenges accessing food assistance, including public benefit programs as well as other community assistance that require documentation of legal immigration status.<sup>11</sup> Farmworkers may be hesitant or fearful of using these programs in case they "jeopardize their ability to work and make a living."
- Individuals of Hispanic/Latino descent are at greater risk of food insecurity, obesity, and diabetes compared to the general population.<sup>12,13</sup> Farmworkers represent a particularly vulnerable population; the California Agricultural Workers Health Survey indicated a high prevalence of risk factors and indicators of chronic diseases, including obesity and diabetes but low utilization of healthcare.<sup>14</sup>

## Public Food Assistance Services in San Mateo County

A crucial component for improved nutritional status is ensuring that clients have access to an adequate food supply. As such, many community health centers and other safety-net providers offer on-site eligibility and/or enrollment assistance or provide referrals for clients to CalFresh/SNAP and WIC programs. Enrollment for both SNAP and WIC can be completed in person at a Human Services Agency office, online, or through the Second Harvest Food Bank Food Connection Hotline. The hotline provides information about other available food assistance programs in the area (see Appendix B for Food Connection Hotline information). Public food assistance programs and their eligibility criteria are described in the table below and in Appendix A.

Program	Program Description and Eligibility
<p><b>CalFresh/Supplemental Nutrition Assistance Program (SNAP)</b></p> <p><a href="http://hsa.smcgov.org/food-assistance">http://hsa.smcgov.org/food-assistance</a></p>	<p>Financial assistance provided to individuals and families with household incomes at or below 200% of the Federal Poverty Level. In California, individuals receiving Supplemental Security Income (SSI) benefits are not eligible for CalFresh. Benefits can only be redeemed at SNAP-authorized retail outlets. Non-US citizens must provide a resident alien card or other proof of legal immigration status.*</p> <p>The state of California also offers SNAP-Education (SNAP-Ed), which provides funding and resources for local providers to provide nutrition education to SNAP participants.<sup>15</sup></p>
<p><b>Women, Infants, &amp; Children (WIC) Program</b></p> <p><a href="http://smchealth.org/wic">http://smchealth.org/wic</a></p>	<p>Food vouchers provided to pregnant women and women with children under the age of 5 with household incomes at or below 185% of the Federal Poverty Level. Food vouchers can only be redeemed for certain food items and at WIC-authorized retail outlets. WIC also provides breastfeeding support and nutrition education classes. Individuals must provide a form of identification and proof of residency (e.g., addressed mail or bills), but are not required to provide documentation of legal immigration status.</p>
<p><b>Senior Nutrition Program</b></p> <p><a href="http://smchealth.org/node/1031">http://smchealth.org/node/1031</a></p>	<p>Daily congregate meal program provided to seniors over the age of 60 and the spouse of an eligible participant regardless of age. Meal sites that receive funding from the Older Americans Act are required to follow dietary guidelines for meals. “The menus at the OAA sites are approved by Registered Dietitians to meet the U.S. Dietary Reference Intakes and are low in fat, sodium and cholesterol.”</p>

\*For more information about immigration status requirements, see: [http://www.fns.usda.gov/snap/eligibility#Immigrant\\_Eligibility](http://www.fns.usda.gov/snap/eligibility#Immigrant_Eligibility)

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## Promising Practices for Improving Nutritional Status among At-Risk Clients

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For health centers and other safety-net providers serving homeless individuals, farmworkers, and other low-income clients, there are a range of services recommended to improve nutritional status. Services fall broadly into the following categories: 1) clinical nutrition services, 2) nutrition education, and 3) community food assistance services. The appropriate services for a given individual may vary based on their health status and living situation and may fluctuate over time. For example, a homeless individual with diabetes may require clinical nutrition services to manage diabetes symptoms and develop a diabetes-friendly meal plan.

**Clinical nutrition services** provided in a healthcare or community setting typically include a range of services that are considered medical nutrition therapy (and may be covered by health insurance). This includes nutrition screening and assessment, intervention, and counseling for clients on a variety of topics, including diabetes, cardiovascular disease, digestive health, pregnancy, weight management, and others. Some of these services, such as nutrition screenings and assessments, may be provided by a primary care doctor instead of a registered dietician. Clinical services are often offered in conjunction with nutrition education classes. Both can be beneficial for homeless, farmworker, and low-income clients, but clinicians and educators should consider tailoring nutrition advice to clients' particular circumstances. Some of these considerations are described below and it is recommended that "pharmacists and other health care providers should be willing to modify recommendations based upon the patient's ability to adhere."<sup>16</sup> For specific recommendations from the National Healthcare for the Homeless, see Appendix C.<sup>17</sup>

- **Affordability and availability of nutritious foods.** Homeless and low-income clients likely have limited and variable food budgets. Therefore, foods recommended by clinical staff should be affordable and easy to find in their community.
- **Eligibility for or enrollment in SNAP or WIC.** If clients utilize SNAP or WIC benefits, they may be limited to shopping at certain stores that accept these benefits. For women using WIC vouchers, only certain food items are eligible for purchases. Note that per California laws, individuals receiving Supplemental Security Income (SSI) are not eligible to receive SNAP benefits.
- **Time constraints.** Depending on their employment status and child care needs, clients may not be able to attend regular counseling appointments or classes. If possible, these services should

be offered on evenings and weekends. In addition, transportation needs and challenges may affect clients' ability to attend services or shop for food.

- **Existing health conditions.** Existing health conditions may impact clients' ability to eat nutritious foods, particularly among homeless individuals. For example, poor dental health can impair one's ability to eat certain foods (e.g., hard or chewy foods) while mental health conditions may lower one's cognitive ability to obtain and prepare foods. Management of chronic diseases such as diabetes and cardiovascular disease may also be challenging if clients rely on charitable food assistance, since they will likely have a limited selection of foods.
- **Access to healthcare.** Low-income clients may lack health insurance as well as access to regular healthcare. Particularly among farmworkers, demanding work schedules can make "continuity of care difficult and highlights the need for disease prevention and early detection."<sup>18</sup>
- **Cultural food preferences and traditions.** Considering the ethnic and cultural food preferences of Hispanic/Latino clients is critical to ensuring that diet advice and materials are well-received and encourage adherence. These preferences will likely depend on one's country of origin.

**Nutrition education** can be provided in a variety of formats including one-on-one counseling, classes, online learning, distributed materials, and in-person demonstrations.<sup>a</sup> A recent study conducted in San Mateo County indicated that use of community resources providing nutrition and physical activity education were associated with better diets among a low-income Hispanic/Latino immigrant population; however, these resources are currently underutilized.<sup>19</sup> Based on research among homeless, low-income Hispanic/Latino and other populations in different clinical settings, there are several recommendations that have emerged for providing nutrition education to this and other low-income populations:

- Nutrition counseling should utilize motivational interviewing (MI) techniques and provide support for self-management of dietary concerns. MI and "MI-consistent" techniques include the following elements: empathy, "affirmation, emphasis of control, providing support, and asking permission."<sup>20</sup>
- Nutrition counseling should include identifying barriers to good nutrition and working with patients to problem solve ways to overcome these barriers.<sup>21</sup> Barriers to consider include not only a client's food preferences and purchasing habits, but should also include social and

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<sup>a</sup> Some nutrition counseling and education services may be reimbursable by public and commercial health insurance plans as preventive visits under 2016 ICD-10-CM Diagnosis Code Z71.3 Dietary counseling and surveillance. More information at: <http://www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z69-Z76/Z71-/Z71.3>

environmental barriers (e.g., housing situation, high density of fast food restaurants, lack of full-service grocery stores, lack of transportation, etc.).

- Nutrition counseling should address self-management approaches to chronic diseases that are common among homeless populations, including diabetes, hypertension, and cholesterol. Screening for these chronic diseases can be included as part of nutrition counseling or primary care visits.
- Educational materials should be developed in a low-literacy format and at a 6th grade reading level to increase understanding. Materials should be visually engaging and available in multiple languages (English and Spanish, at a minimum).
- Nutrition education programs should include hands-on, interactive lessons using experiential learning techniques such as demonstrations, cooking, and taste tests.<sup>22,23</sup>
- Individual classes should be able to stand alone as a comprehensive nutrition lesson, given that clients may not be able to attend multiple or sequential classes due to other demands on their time.<sup>24</sup>
- In addition to providing clinical nutrition services, service organizations can also provide enabling services to support nutrition needs, such as enrollment and eligibility assistance for SNAP and WIC, food pantry programs, etc. Ideally, staff can provide eligibility determination for public benefits, have services onsite, or provide a referral to another community resource to assist with enrollment.
- The SNAP-Education (SNAP-Ed) Program may provide a potential funding source for general nutrition education provided to low-income populations (the target audience for SNAP/CalFresh); however, funding restricts use of SNAP-Ed dollars for medical nutrition therapy.<sup>25,26</sup>
- Find opportunities to integrate general nutrition education into existing interactions with patients and “make use of ancillary staff for general nutrition patient education,” such as staff assisting with patient intake, waiting room, insurance enrollment, and existing counseling and group sessions.<sup>27</sup> For example, educational materials on nutrition topics could be distributed when clients check in for appointments.
- Utilize existing curriculum materials tailored to low-income populations. The California Department of Public Health’s Nutrition Education and Obesity Prevention Branch offers a range of curriculum materials for the SNAP-Ed program.<sup>28</sup> The New Leaf, Choices for Healthy Living manual is “a theory-based diet and physical activity assessment and tailored counseling program



designed for use in clinical settings serving lower-income populations” (see Appendix D).<sup>29</sup> The USDA’s SNAP-Ed Connection portal offers meal planning, shopping, and budgeting tools designed for SNAP participants (see Appendix E).<sup>30</sup>

The table below lists several recommended topics for nutrition classes tailored to low-income clients.

<b>Suggested Nutrition Education Curriculum Topics for Homeless &amp; Farmworker Populations</b>
<ul style="list-style-type: none"><li>● How to choose nutrition foods and beverages in a shelter or temporary housing environment</li><li>● Shopping and meal planning on a limited budget</li><li>● Eligibility and enrollment in SNAP/CalFresh or WIC programs</li><li>● Meal planning, food storage, and food safety without refrigeration or cooking facilities</li><li>● Understanding food labels</li><li>● MyPlate meal planning concepts</li><li>● Meal planning to reduce symptoms of diabetes, hypertension, and heart disease</li><li>● Food safety precautions (especially for those without refrigeration)</li><li>● Nutrition for pregnant and lactating women</li><li>● Adapting ethnic/cultural recipes to meet nutritional guidelines and/or utilize seasonally or locally available foods</li></ul>

### [Innovative Practices to Improve Nutritional Status among Homeless, Farmworker, and Low-income Clients](#)

There have been a limited number of clinical nutrition and education programs tailored specifically to homeless and farmworker populations; however, there are a handful of innovative practices that could provide insights into promising practices for improving nutritional status among at-risk clients.

The **Northpoint Health & Wellness Center** (a Federally Qualified Health Center (FQHC)) in Minneapolis provides a Community Food Shelf to health center clients in addition to the health and dental services they provide on a daily basis.<sup>31</sup> The food shelf is available to clients on a monthly (every 30 days) and emergency basis. Registered clients can obtain a 3-4 day supply of food once per month while new clients or those who are from outside the service area can receive an emergency package (meant to last

1 day). Clients are able to “shop” the food shelf, which consists of donated and purchased foods and may also request additional nonfood items (such as diapers). During the summer, the food shelf also distributes free fresh produce to the public once per week. The clinic receives funding from the State of Minnesota, as well as donations from local partners and individuals. Notably, the health center also has an on-site WIC program in collaboration with the Hennepin County Human Services Department. The WIC program provides eligibility and enrollment assistance, health and nutrition assessment, referrals to health and social services, breastfeeding support, as well as WIC food vouchers.

The **Central Valley Health Network** (representing FQHCs across the Central Valley region of California) has implemented a SNAP-Ed program for clients and identified key insights and recommendations for providers.<sup>32</sup> Although these recommendations applied specifically to SNAP-Ed funded activities, they are applicable to any nutrition counseling provided to low-income clients. Three key recommendations from the SNAP-Ed program include: 1) offering practical options for nutrition, 2) taking a client-centered approach, 3) helping clients build self-esteem and social support, and 4) developing culturally and language-appropriate materials. These recommendations are described in detail below.

- **Offering practical options:** CVHN providers work with clients to provide practical nutrition advice that takes into account the social and environmental context of individual behavior change. For example, recommended recipes should include foods that are affordable and likely to be accessible for the client.
- **Client-centered approach:** The SNAP-Ed program aims to provide care that is “respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.” Therefore, clinical nutrition services should encourage small, incremental changes in nutrition-related behaviors and emphasize setting personal goals. This type of “collaborative goal-setting” has been previously shown to be effective in engaging individuals in their care plans.<sup>33</sup>
- **Self-esteem and social support:** SNAP-Ed providers help clients build self-esteem, provide opportunities for social support (e.g., by including family members in counseling or providing group counseling sessions), and maintain a non-judgmental tone.
- **Developing culturally and language-appropriate materials:** CVHN providers have developed or sourced culturally and language-appropriate materials to meet the needs of their clients and to support the rest of their counseling methods.

The **Codman Square Health Center** in Dorchester, MA has a number of services aimed at improving nutritional status for clients, including clinical nutrition services, group nutrition education, cooking classes, SNAP referrals, an on-site WIC program, and nearby food pantry and farmers' market.<sup>34</sup>

Nutrition education includes diabetes and weight management and is offered through group sessions. The health center also offers a monthly cooking class for seniors (ages 50+). In 2008, the health center jointly founded a farmers' market with the Neighborhood Development Council in Dorchester. The farmers' market was moved from its original location in the health center parking lot to a larger, more visible space across the street. In addition, there is a food pantry located down the street that is open one day per week. The health center provides referrals and information for both the market and pantry to its clients.

**The New York Children's Health Project (NYCHP)** provides healthcare in an FQHC setting to homeless children and families, including a nutrition education program targeted at children called the Cooking, Health Eating, Fitness and Fun (CHEFFs) program.<sup>35</sup> The 15-week program is aimed at homeless children 6 to 14 years old and is designed to increase knowledge and skills around healthy eating and physical activity through a curriculum entailing core nutritional concepts, taste-tests, and meal preparation. Evaluation of the program has shown that children who participated in the program increased their knowledge of nutrition concepts but that their dietary intake and quality was still heavily influenced by homeless shelters' meal policies.

### *Programs and recommendations tailored to farmworkers*

The **Yakima Valley Farm Workers' Clinic** (a network of health clinics in Washington and Oregon) offers nutrition services that are integrated into primary care services.<sup>36</sup> Services are provided by Registered Dietitian Nutritionists (RDNs) to patients "with nutrition-related conditions (diabetes, cardiovascular disease, weight management, digestive issues, food allergies, etc.), as well as for preventative education (Well Child Checks, prenatal counseling, healthy families) and for general nutrition questions and concerns." RDNs utilize a motivational interviewing approach and work with clients to tailor counseling to their needs. Clients may receive same-day counseling from an RDN via a warm handoff from their primary care provider.

The **Maine Migrant Health Program (MHHP)** provides mobile health outreach to farmworkers across the state of Maine.<sup>37</sup> The MHHP provides medical and nursing services through mobile units at

farmworker camps, serving over 1200 patients annually. In addition, “MMHP maintains over 50 voucher contract sites to complement the mobile care, and offers transportation, interpretation, and care coordination services to link a patient from the mobile unit to a community provider. To maximize access, our mobile units and outreach workers travel throughout the blueberry, apple, eggs, Christmas trees/wreath, tree-planting, and broccoli harvests.” The program also coordinates a resource center during the blueberry harvest season (a major crop in Maine and source of work for many farmworkers) that includes educational services, social services, a food pantry, and legal aid.

**Community Health Service, Inc.** (CHSI, formerly known as Migrant Health Services, Inc.) provides health services to migrant and seasonal agricultural workers in Minnesota and North Dakota.<sup>38</sup> Within their health center network, CHSI provides health assessments, health and nutrition education (including bilingual materials), and interpreter services free of charge to all patients. They have also implemented a successful program to provide diabetes care to a Hispanic migrant farmworker population.<sup>39</sup> Diabetic patients can attend “cluster clinics”—temporary clinics with various diabetic-specific services—that allow patients to get a variety of healthcare needs taken care of at once, including a basic dental exam, retinopathy eye exam, pharmacist consult and diet/exercise education by a diabetic educator and/or nutritionist. Clinics are staffed by a multidisciplinary team consisting of PCPs, Hispanic bilingual health outreach workers (BHOs) and diabetes lay educators (DLEs) to provide culturally and linguistically appropriate care. To reduce barriers to attendance, clinics are held in the evening, after workers are finished with fieldwork. Clinics are typically provided at non-healthcare settings such as a school, church, or social service agency. Patients also receive healthy food while attending, which reinforces nutrition education and provides a meal and incentive to attend since many patients may come directly from the fields. The effectiveness of the program stems from “the barriers of cultural relevance, cultural appropriateness, and language differences are being addressed in this program through education of MHSI staff, the work of the DLEs, the timing and location of services, and the inclusion of family members in all program activities.”<sup>40</sup> The organization also provides training and education on diabetes and Hispanic farmworker culture to a regional network of providers as well as the nurses and bilingual health outreach workers (BHOs) that staff the health centers.

A pilot study of the **Community Diabetes Education (CoDE) program** was conducted in Dallas to determine the feasibility of a culturally appropriate diabetes management care intervention.<sup>41</sup> The CoDE program relies on “a single specially trained community health worker [CHW] to provide primary diabetes education classes and nutritional counseling, as well as quarterly care-management

sessions....designed to be an abbreviated low-cost, one-to-one educational intervention directly integrated into an existing urban community clinic.” The model consists of three individual education visits with diabetics (all uninsured) addressing diabetes knowledge and self-assessment followed by a quarterly assessment and case management visits, all conducted by a bilingual CHW. The pilot study showed that implementation of the model resulted in improved HbA1C levels among participants.

Research suggests that nontraditional health workers—including bilingual *promotoras* and CHWs—may be particularly well-suited to provide culturally and linguistically appropriate health interventions and care to Hispanic/Latino farmworker populations.<sup>42,43</sup> For example, a recent pilot study indicated that community health workers could provide non-invasive risk assessment for diabetes and cardiovascular disease among a sample of migrant farmworkers in rural Virginia.<sup>44</sup> A review of diabetes self-management educational programs targeted to racial/ethnic minorities (41% of studies included were targeted to Latinos) suggested that future programs should:

- Be delivered face to face (rather than using telecommunication techniques);
- Be delivered on an individual basis so as to improve patient engagement;
- Employ cognitive reframing techniques in counseling; and
- Involve peer providers/educators to deliver education.<sup>45</sup>

In general, the following promising practices regarding providing culturally and linguistically appropriate nutrition counseling and related care to Hispanic/Latino farmworker populations have emerged:

- Utilize staff such as diabetes lay educators, *promotoras*, community health workers, peer patient educators, and bilingual health outreach workers.
- If possible, provide mobile services and extended service hours at health centers, other service organizations, and/or non-traditional health settings. Availability of evening and weekend appointments can reduce barriers for farmworkers working during the day or those needing childcare.
- Provide materials and classes in both English and Spanish. When demonstrations (e.g., cooking classes) are utilized, food items included should be relevant to Hispanic/Latino preferences.
- When possible, include other family members in patient care (e.g., cluster clinic example) to encourage social support as well as improve adherence to self-management and dietary advice.

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<sup>40</sup> Heuer L, Hess CW, Klug MG. Meeting the Health Care Needs of a Rural Hispanic Migrant Population with Diabetes. *The Journal of Rural Health*, Special Issue/Summer 2004;20(3):265-270.

<sup>41</sup> Culica D, 2008.

<sup>42</sup> Lujan J, Ostwald SK, Ortiz M. *Promotora* Diabetes Intervention for Mexican Americans. *The Diabetes Educator*, 2007;33(4):660-70.

<sup>43</sup> Culica D, Walton JW, Harker K, Prezio EA. Effectiveness of a Community Health Workers as Sole Diabetes Educator: Comparison of CoDE with Similar Culturally Appropriate Interventions. *Journal of Health Care for the Poor and Underserved*, 2008;19:1076-95.

<sup>44</sup> Thompson RH, 2015.

<sup>45</sup> Ricci-Cabello, et al. Characteristics and effectiveness of diabetes self-management educational programs targeted to racial/ethnic minority groups: a systematic review, meta-analysis and meta-regression. *BMC Endocrine Disorders*, 2015;14(60).

## Appendix:

- **Appendix A.** Types of Food Assistance Programs
- **Appendix B.** Second Harvest Food Bank Food Connection Hotline
- **Appendix C.** National Healthcare for the Homeless Recommendations
- **Appendix D.** Community Nutrition Education (CNE) Logic Model Overview (USDA)
- **Appendix E.** Homeless Nutrition Education Toolkit: A Resource for Nutrition Educators and Emergency Food Providers
- **Appendix F.** Diabetes Compendium: A Compilation of Educational Resources for Spanish speaking Patients with Diabetes (National Center for Farmworker Health, Inc., 2012)



## Appendix A – Types of Food Assistance Programs<sup>b</sup>

Program Type	Description	Settings	Eligibility Requirements	Cost	Primary population served
CalFresh (Supplemental Nutrition Assistance Program/SNAP) <sup>c</sup>	Clients receive financial assistance monthly to purchase food at eligible retailers.	Food retail outlets	<ul style="list-style-type: none"> <li>Households with gross income &lt;200% Federal Poverty Level.</li> <li>May need to meet resource limit of \$2250.</li> <li>May need to meet work requirements, including “certain employment and training activities such as searching for work, performing community service, or going to school or training.”<sup>d</sup></li> <li>Non-U.S. citizens must be lawfully present and may be subject to residency requirements.<sup>e</sup> Undocumented individuals are not eligible.</li> <li>Both homeless and migrant workers may be subject to reporting any changes in income on a regular basis.</li> </ul>	Free of cost	Low-income individuals
Women, Infants, & Children (WIC) <sup>f</sup>	Clients receive financial assistance monthly to purchase food at eligible retailers.	Food retail outlets	Households with gross income <185% Federal Poverty Level	Free of cost	Low-income pregnant women or women with children under 5
Meal Programs	Provide prepared meals or snacks on-site to clients in need who may or may not reside on the agency’s premises.	<ul style="list-style-type: none"> <li>Soup Kitchens</li> <li>Churches</li> <li>Homeless Shelters</li> </ul>	Depends on the program. May need to be a resident to receive meals at homeless shelters.	Generally provided free of cost	Homeless

<sup>b</sup> Table adapted from: San Jose Food Access Assessment. Prepared by JSI and Brian Fulfroost & Associates for The Health Trust. September 2015.

<sup>c</sup> More information at: <http://www.calfresh.ca.gov/Pg841.htm>

<sup>d</sup> Work requires vary by county and depend on whether individuals are receiving other benefits, disability status, and other factors. More information at: <http://www.calfresh.ca.gov/Pg841.htm>

<sup>e</sup> More information in the SNAP Non-Citizen Guidance document: [http://www.fns.usda.gov/sites/default/files/Non-Citizen\\_Guidance\\_063011.pdf](http://www.fns.usda.gov/sites/default/files/Non-Citizen_Guidance_063011.pdf)

<sup>f</sup> More information at: <http://smchealth.org/wic>

Program Type	Description	Settings	Eligibility Requirements	Cost	Primary population served
Brown bags, grocery, or pantry programs	Distribute non-prepared foods, groceries, and other household supplies for off-site use, usually for preparation in the client's home. Bags may be prepared for clients or clients may be able to choose foods from a pantry.	<ul style="list-style-type: none"> <li>• Food Pantries</li> <li>• Soup Kitchens</li> <li>• Churches</li> <li>• Homeless shelters</li> </ul>	Depends on the program. Some are for families only.	Generally provided free of cost	Homeless
Informal feeding groups	Distribute prepared meals at parks or other outdoor venues.	<ul style="list-style-type: none"> <li>• Parks</li> <li>• Popular intersections</li> <li>• Senior centers</li> <li>• Community centers</li> <li>• Community-based organizations</li> </ul>	None	Free of cost	Homeless
Senior Nutrition Program <sup>8</sup>	County- and City-sponsored program providing congregate hot meals to seniors.	<ul style="list-style-type: none"> <li>• Senior centers</li> <li>• Community centers</li> <li>• Community-based organizations</li> </ul>	Seniors over the age of 60 with some exceptions. No income requirement.	Suggested \$3 donation per meal	Seniors
San Mateo County Meals on Wheels Program	Distribute hot and frozen meals delivered to homebound individuals in their homes.	Home delivery	<ul style="list-style-type: none"> <li>• Over the age of 60</li> <li>• Resident of San Mateo County</li> <li>• Must be homebound and have difficulty preparing meals</li> </ul>	Suggested \$4.75 donation per meal	Homebound seniors and/or disabled
Second Harvest Food Bank Brown Bag Programs (Family Harvest & Seniors)	Distribute non-prepared foods and groceries for off-site use, usually for preparation in the client's home.	<ul style="list-style-type: none"> <li>• Senior centers</li> <li>• Community centers</li> <li>• Community-based organizations</li> </ul>	<ul style="list-style-type: none"> <li>• Family Harvest: Low-income families &lt;200% Federal Poverty Level.</li> <li>• Seniors: Seniors (age 60+) or disabled individuals (age 55+) registered for program with Second Harvest Food Bank</li> </ul>	Free of cost	Seniors

<sup>8</sup> More information at: <http://smchealth.org/node/1031>

# **San Mateo County Health Care for Homeless/ Farmworker Health Program**

## **Medical Respite Care**

**Prepared by John Snow Inc. (JSI)  
March 2016**

### **Background**

People experiencing homelessness are three to four times more likely to die prematurely than non-homeless persons, and have high rates of physical and mental illness exacerbated by a life on the streets or in shelters.<sup>1</sup> As of 2010, homeless individuals were making 550,000 emergency department visits per year, or 72 visits for every 100 homeless people each year.<sup>2</sup> Hospital stays by people experiencing homelessness were also nearly twice as long as the 4.6-day average stay for most patients in the United States, and cost \$2,559 more on average.<sup>3,4</sup> These visits were four times more likely to take place within three days of a prior emergency department visit, and four times as likely to take place within a week of hospitalization.<sup>2</sup> One study conducted in 2012 found that half of all hospitalizations of homeless patients resulted in a 30-day hospital inpatient readmission, and 70% resulted in either an inpatient readmission, emergency department visit, or observation status stay within 30 days of discharge.<sup>5</sup> This same study found that the strongest correlate of readmission was discharge location, with discharge to the streets or shelter being associated with higher readmission risk.<sup>5</sup> The frequency of hospital readmissions among homeless patients is the result of the challenges faced by patients who are discharged to the streets or a shelter.<sup>1</sup> Without food to eat, a clean place to sleep, or transportation to and from follow-up appointments, treatment and recovery are disrupted.<sup>1</sup> Hospitals often have to choose between keeping a homeless patient in a hospital bed after their acute needs have been met, or discharging them to the street before they are fully recovered.

### **Medical Respite Care**

Medical respite care programs are designed to meet the post-acute medical needs of homeless patients who are no longer sick enough to be in the hospital, but who are unlikely to successfully and fully recover in a shelter or on the streets.<sup>6</sup> These short-term residential treatment centers vary in size, services offered, and setting; they can take place in freestanding facilities, homeless shelters, nursing homes, transitional housing, and motels.<sup>7</sup> Patients are referred primarily by hospitals and health centers, and have a median length of stay of 30 days.<sup>4,8</sup> Many respite care centers also provide case management and links to social services including housing placement, entitlement programs, and substance abuse treatment to help patients maintain their health and stability once they leave the respite care program.<sup>4</sup>

## **Details of Services**

Though varying levels of medical care are offered by respite care programs, all provide a minimum level of care including clinical assessment, oversight and minor clinical interventions, and bed rest.<sup>9</sup> Some of the specific clinical services provided include: wound care and infection control; pain management; physical therapy; medication monitoring; development of disease management plans; and discharge planning.<sup>3</sup> Patients may also receive education around care navigation, disease prevention and management, and are linked to primary care providers for future health services.<sup>3</sup>

Medical care is provided by physicians, physician assistants, nurses, and volunteer providers.<sup>3,4</sup> These providers may be onsite 24-hours a day, only during set hours, or accessed through referral and transportation to local clinics.<sup>3,4,9</sup> Non-medical support services, including links to housing and transportation services, are often provided by social workers, case managers, or community health workers.<sup>3</sup> The level of care offered in a respite care program depends on its model and available resources; programs based in existing facilities like shelters and transitional housing may have established hours for clinician visits or provide transportation to a nearby clinic, while stand-alone facilities offer more intensive and accessible services.<sup>9</sup>

Minimum standards for medical respite programs have been proposed, including standards around the safety and quality of accommodations, quality of environmental services, timeliness and safety of care transitions, and quality improvement mechanisms.<sup>10</sup> These proposed national standards are currently being piloted by several programs through the Respite Providers' Clinicians Network of the National Health Care for the Homeless Council.<sup>7</sup>

## **Policy**

Federal health policy provides for the operation of medical respite programs under Section 330 of the Public Health Services Act. This allows Federally Qualified Health Centers (FQHCs), which operate nearly half of medical respite programs in the country, to provide respite care as an additional health service.<sup>9</sup> Additionally, the Centers for Medicare and Medicaid Services (CMS) have proposed a rule that would revise discharge planning requirements for hospitals, encouraging them to explore non-traditional health care services and supportive housing availability in their discharge planning.<sup>11</sup>

## **Evidence of Impact**

Although to date there have been no randomized control trials assessing the impact of medical respite centers on long-term health and care outcomes, numerous studies have used observational data to examine their impact on various cost and utilization measures.

## **Hospital Readmission**

Evidence shows that medical respite programs can be effective at reducing hospital readmission rates. A study done in Chicago involving 407 homeless adults with chronic medical illness found that after 18 months, significantly fewer patients who received medical respite care had two or

more hospitalizations (48% vs 59%), or three or more emergency department visits (33% vs 50%) compared with those receiving standard care.<sup>12</sup> Another study comparing patients discharged to medical respite care with patients discharged to their own care or to another planned discharge location (such as a skilled nursing facility) found that patients discharged to medical respite care had reduced odds of 90-day hospital readmission compared to each of the other groups.<sup>4</sup> This reduction in hospital readmissions also holds true at twelve months post-discharge.<sup>13</sup>

Another study examined the impact of medical respite programs on hospital readmission rates by comparing outcomes for patients who completed medical respite programs and those who left against medical advice or became absent without leave.<sup>14</sup> Rates of emergency department visits and 90-day hospital readmissions were twice as high among those who left the medical respite program early (41% vs. 20%).

### **Hospital Length of Stay**

Several studies also reveal that medical respite programs can reduce current and future hospital length of stay. A study examining the impact of a medical respite program on lengths of stay at a Veterans Administration hospital found that homeless patients being discharged to respite care had preceding hospital lengths of stays that were similar to those of non-homeless patients; without discharge to respite care, homeless patients remained hospitalized for longer than their non-homeless counterparts.<sup>15</sup>

A study examining the impact of respite care on 225 hospitalized homeless adults found that those who received respite care experienced 58% fewer hospital days (3.7 vs. 8.3 days) in the 12 months following completion of a medical respite care program as compared to those who did not receive medical respite care.<sup>16</sup> Notably, this effect was greatest among patients whose index admission was for HIV/AIDS (6.5 vs 17.8 days).

### **Costs**

As a result of their impact on hospital length of stay and readmission rates, medical respite programs can be cost saving. One study found an average respite care cost of \$706 per hospital day avoided, compared to an estimated cost of \$1,500 per day in hospital.<sup>16</sup> Another study examining a comprehensive intervention, which included services beyond respite care, found an average annual savings of over \$6,000, primarily attributable to reduced hospitalizations.<sup>4</sup> Other studies have found mixed results on costs and cost savings associated with medical respite programs, but these did not take into account the characteristics associated with being a respite candidate, the non-hospital costs associated with homeless patients being discharged to “home care”, or the savings associated with reduced hospital readmissions.<sup>4,17</sup>

Numerous hospitals and communities have found success in reducing costs through partnership with a medical respite program. Oregon Health and Science University invested \$500,000 in a local respite program and as a result averted \$3.5 million in costs over three years.<sup>3</sup> Hospitals in other cities have found similar results: \$11.2 million in cost avoidance over two years for three health systems in Richmond, Virginia; \$6.2 million in annual cost avoidance for three hospitals

and the community in Cincinnati, Ohio; and \$5.5 million in total annual cost avoidance for a hospital in Salt Lake City, Utah.<sup>18</sup>

### **Housing and Other Impacts**

Medical respite programs can provide benefits in addition to their impact on hospital utilization and costs. An evaluation of 10 medical respite programs found that upon hospital admission, one-third of participants listed the hospital as their place of residence; upon completing a medical respite program, only 8% listed the hospital as their residence.<sup>1</sup> The evaluation also found increased access to income sources like Supplemental Security Income and food stamps among medical respite program participants. Other studies have found that medical respite clients have fewer future days of homelessness than non-respite clients, and were discharged to improved housing conditions compared to their housing at respite program entrance.<sup>4</sup> One study in Boston also found that the odds of becoming stably housed for chronically homeless persons are higher for those who have received respite care.<sup>4</sup>

## **Existing Programs**

As of 2015, there were 73 known medical respite programs in the US, 22 of which were in California.<sup>8</sup> Several examples are briefly described below.

### **Barbara McInnis House, Boston, MA<sup>8</sup>**

Boston's Health Care for the Homeless Program has been providing medical respite care as a component of their continuum of services since 1988. The Barbara McInnis House provides comprehensive medical care for men and women through their on-site physicians and nurses. Average length of stay at McInnis House is 12 days. The 104-bed facility shares a building with the Boston Health Care for the Homeless Program and its services for the broader homeless population; as a result, McInnis House also provides on-site behavioral health, dental care, specialty care, and pharmacy services.

### **Interfaith House, Chicago, IL <sup>8,19,20,21</sup>**

Interfaith House (now called "The Boulevard") was established in Chicago in 1994, before the growth of respite centers across the country. In its first year, Interfaith House served almost 1,000 homeless clients in a 64-bed, freestanding facility; this number has dropped to around 300 clients per year as social services offered and average length of stay have increased (90-day average). Interfaith House emphasizes placement in stable housing upon completion of the respite care program, and has doubled the number of clients placed in permanent housing. Patients are assigned a case manager upon arrival who coordinates their medical care and facilitates access to social services. Interfaith House maintains an on-site health clinic, staffed by physicians and nurses through a collaboration with a local community wellness center. Clinical staff provide health assessments and monitoring, and patients can access primary care services at the clinic eight hours per day, five days a week. Interfaith House also offers mental health care referrals and substance abuse assessment and support through a partner hospital, and provides transportation to off-site medical visits if necessary.

### **Recuperative Care Centers, Los Angeles and Orange Counties, CA<sup>8,20,22</sup>**

More than 40 healthcare providers across Los Angeles and Orange Counties participate in Recuperative Care Center programs, which have treated more than 1,500 homeless patients since 2010. Patients spend an average of 10 to 12 days in a former motel that has been converted to a care center to continue their recovery; at a total cost of \$250 per day per patient, the program has saved area hospitals more than \$12 million. Professional nurses provide care on-site, and coordinate necessary off-site primary and preventative care. On-site social workers provide connections to social services and assistance with transitions into permanent housing through intensive case management, and formerly homeless on-site managers act as patient advocates. Only 10% of patients who have recovered at Recuperative Care Centers have been readmitted to a hospital.

### **Medical Respite and Sobering Center, San Francisco, CA<sup>8,20,23</sup>**

San Francisco's Medical Respite and Sobering Center is a tax-funded program of the Department of Public Health. The Center receives 300-400 clients per year, 80% of whom come from San Francisco General Hospital. On-site medical staff, including registered and advance practice nurses, physicians, physician assistants, and medical assistants, are available seven days a week and on call 24 hours a day. The on-site medical team provides urgent care, basic follow-up of acute health problems, health education services, and referrals and transportation to primary and specialty care. On-site social workers and community health workers provide case management and support services, as well as referrals to behavioral health care. According to program staff, the medical respite program has resulted in declines in hospital readmissions and emergency department visits. Average length of stay is four weeks; two-thirds of patients complete their recovery at the center, and 40% of these patients transition into permanent housing upon exiting the program.

### **Mercy Care Services Recuperative Care Program at the Gateway, Atlanta, GA<sup>8</sup>**

Since 2008, Mercy Care Services has been operating a 19-bed medical respite facility in a converted prison in Atlanta. Before a patient can be admitted into the Recuperative Care Program, a nurse coordinator completes an initial assessment in the hospital, discusses the program with the patient, and determines whether the patient can be accepted into the program. Once a patient is admitted, a case manager conducts a comprehensive patient evaluation and creates an individualized care plan, program goals, and post-discharge plan. Patient stays are limited to 30 days. Nurses, nurse practitioners, social workers, and community health workers are on-site to offer wound management, medication administration counseling, and training in activities of daily living and self-care skills. Transportation is provided for necessary outpatient services, and referrals are made for behavioral health services, substance abuse and mental health counseling, job training, and housing assistance.

## **Challenges and Considerations**

Medical respite programs face considerable challenges and programmatic considerations. Because much of the cost savings that result from medical respite programs are savings to hospitals, collaboration with a hospital or multiple hospitals is critical to the success of a respite



program.<sup>24</sup> Hospitals can provide funding, patient referrals, and data monitoring in exchange for the benefits of reduced readmissions and hospital stays. Agreements or partnerships between medical respite centers and hospitals can be complicated, and need to take many resources and assets into account, including medications, equipment, access to labs, patient information, level of financial support, specialty care, and ability to refer back to the hospital. Financial agreements between hospitals and respite programs can take many forms, including per-patient, per-day payments (as in Los Angeles), one-time per-patient payments (as in Portland, Oregon), or annual investments (as in San Jose, California).<sup>24</sup>

Internally, medical respite program implementers need to anticipate the varied program needs, including environmental safety, staffing needs and coordination, cultural competence, admission criteria and policies, and safe discharge protocols.<sup>25</sup> Programs may require a wide variety of staff members in addition to physicians and nurses, possibly including a nurse manager, medical director, medical evaluations assistant, health worker, convalescent care manager, convalescent care clinical case manager, behavioral health consultant, and social worker.

Medical respite programs may also face external pressures, including the changing health needs of homeless populations and the environment of the health care delivery system. Other service providers, including homeless shelters and skilled nursing facilities, may feel protective of the services they offer, and wary of programs they view as duplicative. Nearby neighborhoods and communities may also provide resistance to new programs being established in their area.<sup>25</sup>



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**San Mateo Healthcare for the Homeless/Farmworker Health**  
**Follow-up on Mental Health/Substance Abuse Services for Retreat: Initial Findings**  
Prepared by: Rachel Metz

**Summary of Need (based on interviews) for the Homeless/Farmworker Population**

- **Timely access for mental health services** for the homeless population. Currently, HCH/FH providers can reach out to the BHRS team, but it does not mean that clients get into a service quickly. It can be challenging to get a patient to keep a future appointment. In addition, some patients don't meet the Seriously Mentally Ill (SMI) standard on the day that they are assessed and then are not offered care.
- **Lack of feedback loop**- while the BHRS team is responsive, there is not a current feedback loop so that a providers knows whether a client was linked to services and if not, the reason why.
- **A better understanding of BHRS services available.** BHRS has a lot of teams geared towards specific populations, but it is a challenge to understand how to navigate it and a lack of understanding of how clients are prioritized.
- **Farmworkers.** The issues are a little different because there is stigma about mental health and substance abuse and the population is isolated, but more could be done to design innovative approaches to care.

**Services**

- **Case Management for the Homeless.**
  - BHRS has two case managers that provide intensive case management services for homeless population, Peter Field and Fatima Olivares. The services are documented in Avatar. The case managers try to connect with clients within 24 hours, but it may take weeks to get an appointment with doctor. The staff feel that they are able to get clients in for appointments if they meet the Seriously Mentally Ill (SMI) criteria. If they have "mild to moderate" needs, they are referred to primary care.
  - Homeless Outreach Team (HOT). The HOT (a team of 5 people) reach out to homeless who wouldn't otherwise get help and provide intensive case management. The HOT also provide services to homeless who are not on the HOT list if someone needs help. And there is a nurse practitioner on the street medicine team who is providing primary care (new service).
- **AOD Services.** The County has a full continuum of AOD services: prevention, early intervention, housing support and treatment. Services are contracted out to a network of 13 agencies throughout the county. The department believes that the access to services is good with the exception of residential treatment; however, expansions under Drug Medi-Cal will increase residential treatment services (services likely to expand in June or July). The County has not provided services targeted to the farmworkers. While there have been opportunities for service providers to provide those services, no one has responded to the RFPs. Because the number of people is relatively small, providers may not find it cost effective to provide services under the traditional model. The department believes that may need to look at innovative ways of

providing services (for example, telehealth or using mobile devices) in order to reach the farmworker population.

- ***Mental Health Services***

- Mild to Moderate. The Interface program provides case management and brief intervention (up to 8 visits) for the mild to moderately mentally ill. The mental health services are embedded in the San Mateo County primary care clinics. Patients get in by being referred through primary care. The patient must be an established primary care patient because the mental health provider wants to be able to work with the primary care provider. In addition to the county providers, there is a contracted private provider network (PPN). This means that there is a better geographic dispersion of providers (the PPN is only available to Medi-Cal patients, not ACE patients, but ACE patients can be seen at the county clinics). If someone comes in for mild to moderate care and is determined SMI, then they will be referred to a SMI provider.
- Seriously Mentally ILL (SMI). Services are provided at five regional clinics (East Palo Alto, San Mateo, Daly City, Half Moon Bay, Fair Oaks) and the BHRS is in the process of contracting out to community providers. There is a psychiatric emergency team that partners with the Sheriff, a specially trained paramedic team, and regular visits to homeless shelters. If a patient does not meet SMI standards they are referred out. In addition, AB1421 (Laura's Law) is being designed to engage SMI who haven't previously engaged.

### **Data/Information Sharing**

Current state policies allow the sharing of mental health data, but perceived barriers create obstacles and there can be additional challenges due to the use of separate electronic health records. Sharing substance abuse data is more challenging. Both mental health data and substance abuse data can always be shared in the aggregate. The California HealthCare Foundation report, "Fine Print: Rules for Exchanging Behavioral Health Information in California" provides a good overview of how and when information can be shared.

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20F/PDF%20FinePrintExchangingBehavioral.pdf>

Following is information (to the extent it was available) on the number of homeless being seen:

- ***Case Management***.

- Behavioral Health and Recovery Services, Adult Resource Management (BHRS ARM). In 2015, 454 homeless clients were served:
  - § 98 in mental health shelter beds
  - § 208 services through outreach and support
  - § 118 through AOD outreach and support
  - § 30 through hospital discharge intensive care program.
- HOT Team. 180 unduplicated patients received services in the last six months.

- **AOD Services.** In FY 2014-15 there were 144 homeless patients seen in non-residential outpatient and 1,147 who received inpatient services. In order to share individual data, patient consent is needed. The AOD providers to attempt to get this consent in order to share information with the primary care provider.
- **Mental Health Services.**
  - Data is entered into Avatar about whether someone is homeless. It is unclear whether farmworker information is entered and whether you could separate out “mild to moderate” data from “SMI” data. In theory, BHRS should be able to report on the number of homeless patient seen, but the data was not readily available. Information sharing is happening between BHRS and SMMC.

### Potential Next Steps

- HCH/FH staff meet with Adult Resource Manager (Pernille Gutschick), Laura’s Law Implementation (Terry Wilcox-Rittgers), Interface (Elizabeth Alvarez), and AOD program (Clara Boyden) to discuss:
  - the needs of homeless in terms of immediate care,
  - how mobile van and street medicine referrals and communication should work (since they are part of SMMC), and
  - clarity about the various programs offered through BHRS and which ones are available to HCH/FH clients.
- Develop recommendations about how to increase access to psychiatry for the homeless, some potential options are to:
  - add psychiatry to the mobile van unit,
  - have BHRS provide phone access to a psychiatrist for primary care providers to help with medications,
  - and/or that homeless patients be provided same day access.
- HCH/FH staff work with farmworker health providers to develop a list of potential innovative approaches to better serve the population. Recommendations can be shared with BHRS.
- Request a data run from Avatar to find out how many Homeless patients are being seen.

**DENTAL DATA**

Clinic Visits (tab 3)

			<b>HCH</b>	<b>FH</b>
<b>Coastside</b>	724		135	599
<b>39th</b>	450		315	139
<b>MDC</b>	1079		1045	62
<b>NCDEN</b>	46		37	10
<b>SOD</b>	758		667	94
	3057			
FH	904			904
HCH	2199		2199	

<b>Total Population</b>	6556	4714	1947
<b>Unduplicated Individuals</b>	906 13.8%	594 12.6%	325 16.7%

**Homeless Status**

Homeless Shelter	228
Street	32
Transitional	64
Doubling Up	37
Other	233

594

FH

**HI Coverage**

C20	2
C72	723
C79	32
E25	11
E50	1
F75	2
G86	68
O87	1
W10	14
W22	50

904