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

Co-Applicant Board Meeting Agenda

455 County Center, Redwood City, CA 94063 (Room 101)

June 13th, 2024, 10:00am - 12:00pm

This meeting of The Health Care for The Homeless/Farmworker Health board will be held in-person at
455 County Center, Redwood City, CA 94063 (Room 101)
Remote participation in this meeting will not be available. To observe or participate in the meeting please attend in-person at above location.
*Written public comments may be emailed to masfaw@smcgov.org and such written comments should indicate the specific agenda item on which you are commenting.
***Please see instructions for written and spoken public comments at the end of this agenda.**

A. CALL TO ORDER & ROLL CALL	Robert Anderson	10:00am

B. PUBLIC COMMENT
Persons wishing to address on matters NOT on the posted agenda may do so. Each speaker is limited to three minutes and the total time allocated to Public Comment is fifteen minutes. If there are more than five individuals wishing to speak during Public Comment, the Chairperson may choose to draw only five speaker cards from those submitted and defer the rest of the speakers to a second Public Comment at the end of the Board meeting. In response to comments on a non-agenda item, the Board may briefly respond to statements made or questions posed as allowed by the Brown Act (Government Code Section 54954.2) However, the Boards general policy is to refer items to staff for comprehensive action or report.

C. ACTION TO SET THE AGENDA & CONSENT AGENDA	Robert Anderson	10:02am
1. Approve meeting minutes from May 9th, 2024, Board Meeting		Tab 1
2. Budget and Finance Report		Tab 2
3. HCH/FH Director's Report		Tab 3
4. Quality Improvement/Quality Assurance Update		Tab 4
5. Temporarily Subcommittee Update		Tab 5

D. COMMUNITY ANNOUNCEMENTS / GUEST SPEAKER		
Communications and Announcements are brief items from members of the Board regarding upcoming events in the community and correspondence that they have received. They are informational in nature and no action will be taken on these items at this meeting. A total of five minutes is allotted to this item. If there are additional communications and announcements, the Chairperson may choose to defer them to a second agenda item added at the end of the Board Meeting.		
1. Encampment Ordinance Implementation Plan Community updates	Iliana Rodriguez, Assistance County Executive	10:05am
2. Community updates	Board members	10:45am

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E. BUSINESS AGENDA

No Business Agenda

F. REPORTING & DISCUSSION AGENDA

1. Conflict of Interest Overview	Lauren Carroll, Deputy County Attorney	11:00am	
2. HCH/FH Board Approval for 2025-2027 RFP	Jim Beaumont	11:15am	Tab 6
3. National Healthcare for the Homeless 2024 Conference Attendees update	Jocelyn Vidales, Alejandra Alvarado, Tayischa Deldridge, & Kristy Coleman	11:30am	

G. ADJOURNMENT

12:00pm

Future meeting: **July 11th, 10am-12pm**
225 South Cabrillo Hwy Suite 100A (Coastside Clinic Conference Room)
Half Moon Bay, CA 94019

*Instructions for Public Comment During Meeting

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

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

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Tab 1
Meeting Minutes

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

Co-Applicant Board Meeting Agenda
455 County Center, Redwood City, CA 94063 (Room 101)
May 9th, 2024, 10:00am - 12:00pm

Co-Applicant Board Members Present	County Staff Present	Members of the Public	Absent Board Members/Staff
• Robert Anderson, Chair • Judith Guerrero • Tony Serrano • Steve Kraft • Janet Schmidt • Tayischa Deldridge • Suzanne Moore • Gabe Garcia • Victoria De Alba Sanchez, Vice Chair • Jim Beaumont (Ex officio)	• Gozel Kulieva • Frank Trinh • Alejandra Alvarado • Jocelyn Vidales • Meron Asfaw • Kapil Chopra • Amanda Hing Hernandez • Anessa Farber	• Sandra, ALAS • Christian, ALAS	• Steve Carey • Brian Greenberg • Francine Serafin-Dickson

A. Call to order & roll call	Robert Anderson called the meeting to order at 10:00 am and did a roll call.	
B. Public comment		
C. Action to set the agenda & consent agenda	• Approve meeting minutes from April 11th, 2024, Board Meeting • Budget and Finance Report • HCH/FH Director's report • Contractor and MOU's update • Quality Improvement/Quality Assurance Update • Contractors Financial Report Update	Request to approve the Consent Agenda was **MOVED** by Steve Kraft **SECONDED** by Tayischa Deldridge. Approved by all members present.
D. Community Announcements / Guest Speaker 1. Community Announcements	**Susan Moore** Susan updated the Board that the project will not proceed this year. **Robert Anderson** Shared an anecdote about an encounter with an individual experiencing a mental health crisis, highlighting the importance of mental health support and crisis intervention services.	

2. Enhanced Care Management (ECM) and Community Support services to Medi-Cal beneficiaries	**Amy Scribner, HPSM's Chief Health Officer & Gale Carino, Director of Integrated Care** Health Plan of San Mateo (HPSM) is one of two Medi-Cal plans in San Mateo County. Amy and Gale discussed the work HPSM has been doing under the California Advancing and Innovating Medi-Cal (CalAIM) initiatives, specially the Enhance Care Management (ECM). The program rolled out in January 2022 and was set to address medical and behavioral health needs, improve and integrate care, and be a catalyst for justice. HPSM was the only health plan in California that integrated dental services. What is ECM? ECM is a Medi-Cal benefit to support comprehensive in-person care management by way of its core service components for enrollees with complex needs that must often engage several delivery systems to access care. It includes: • Outreach and engagement • Comprehensive assessment and care management plan To be eligible, a member must meet one or more populations of focus, which includes adults at risk of homelessness, adults who are high ED utilizers, have SMI, individuals transitioning from incarceration, adults nursing facility residents transitioning to the community, children and youth involved in child welfare, and birth equity population in focus. Currently HPSM works with the following Community Based Organizations and County partners: CBOs: • Institute on Aging 4. Healthcare In Action • Bridges to Wellness • Upward Health County Partners: • Aging and Adult Services (AAS - ECM) • California Childrens Services (CCS - ECM) FQHCs: • North East Medical Services • Ravenswood Family Health Center • Gardner Health Services What are Community Supports? - Housing Transition Navigation Services	

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	- Housing Deposits - Housing Tenancy and Sustaining Services - Respite - Nursing Facility Transition - Diversion to Assisted Living Facilities such as RCFE and Adults Residential Facilities - Personal Care/Homemaker Services (beyond IHSS) - Home Modifications - Meal/Medically Tailored Meals Members who are eligible for the Enhanced Care Management (ECM) benefit are eligible for Community Supports. If not eligible for ECM, a member may be eligible for Community Supports if they meet the following basic qualifications: – Active HPSM Medi-Cal or Care Advantage member – Engaged with a Care Manager or Care Coordinator - Willing to receive Community Supports Statistics: there are currently about 40 thousand HPSM members, with about 1-2 thousand ECM enrollees 400 of which are individuals experiencing homelessness.	
E. BUSINESS AGENDA HCH/FH Board Approval for 2025-2027 RFP	**Jim Beaumont** Part of the program's Federal grant requirements includes maintaining a list of service sites in scope of the program project. San Mateo Medical Center is currently planning on providing services at the new site - Cordilleras and the ask to the Board is to include this site to be in the program's scope. In addition to the Cordilleras, Jim also requested to Board to approve the Redwood City Navigation Center to be in the HCHFH Program's scope.	Request to add Cordilleras and Navigation Center to the Program's scope was MOVED by Susan Moore, and SECONDED by Janet Schmidt. All members approved.
F. REPORTING & DISCUSSION AGENDA **1.** Uniform Data System (UDS) Reporting **2.** Single Audit Report **3.** RFP	**Gozel Kulieva, & Alejandra Alvarado** Gozel and Alejandra presented the UDS report to the Board covering patient demographics and quality improvement related statistics reported last year. Jim updated the Board that the annual federal Single Audit report was passed without any findings. Jim presented the current RFP timeline and services, which include: Case Management/Care Coordination, Dental, Behavioral Health, and new Behavioral Health Services Expansion.	.

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G. ADJOURNMENT	**Future meeting:** June 13th, 10am-12pm 455 County Center, Redwood City, CA 94063 (Room 101)	The meeting was adjourned at 11:58 am

Meeting Minutes respectfully submitted by Gozel Kulieva

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2023 UDS
Annual HCH/FH Performance

HCH/FH Board Meeting April 11th, 2024

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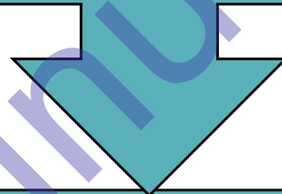
What is Uniform Data System (UDS)?

Annual performance report



Clients seen across SMMC, BHRS, PHPP, HCHFH Contractors

Demographics	Costs & Revenues	Quality of Care

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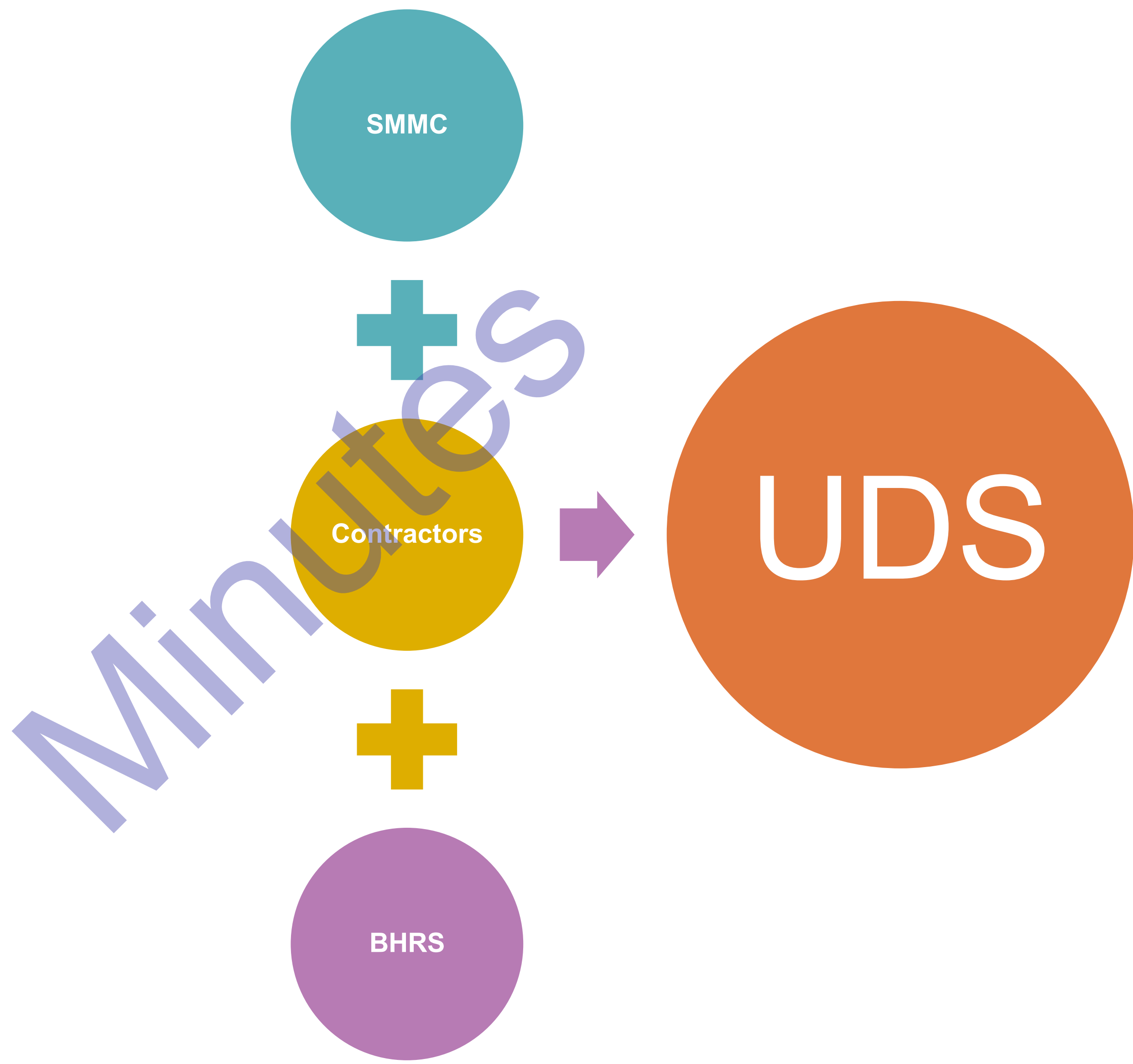
The Process



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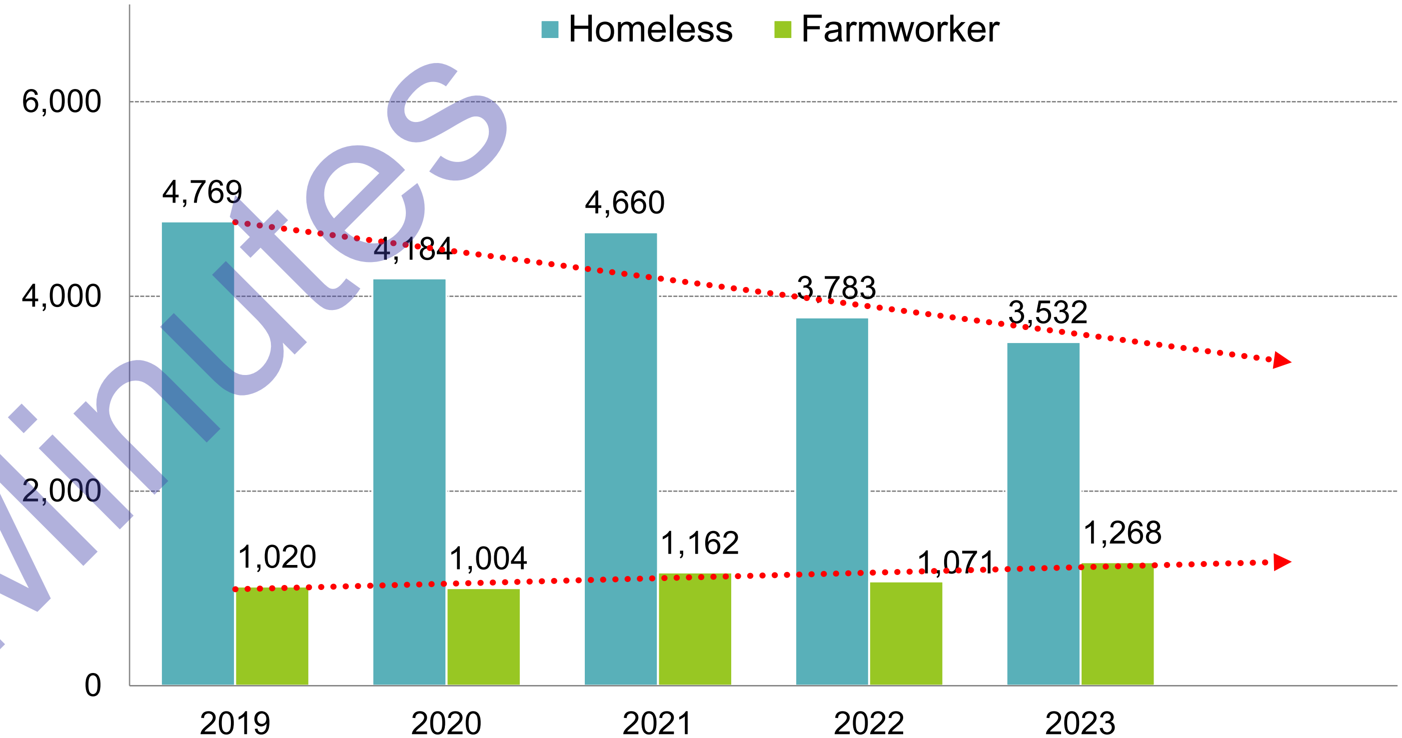
2023 UDS Performance

4,679 Unique Clients Total
- 3.6% decrease from 2022

30,513 Visits
- <12% decrease from 2022
- 26,674 In-person visits
- 3,839 Virtual visits



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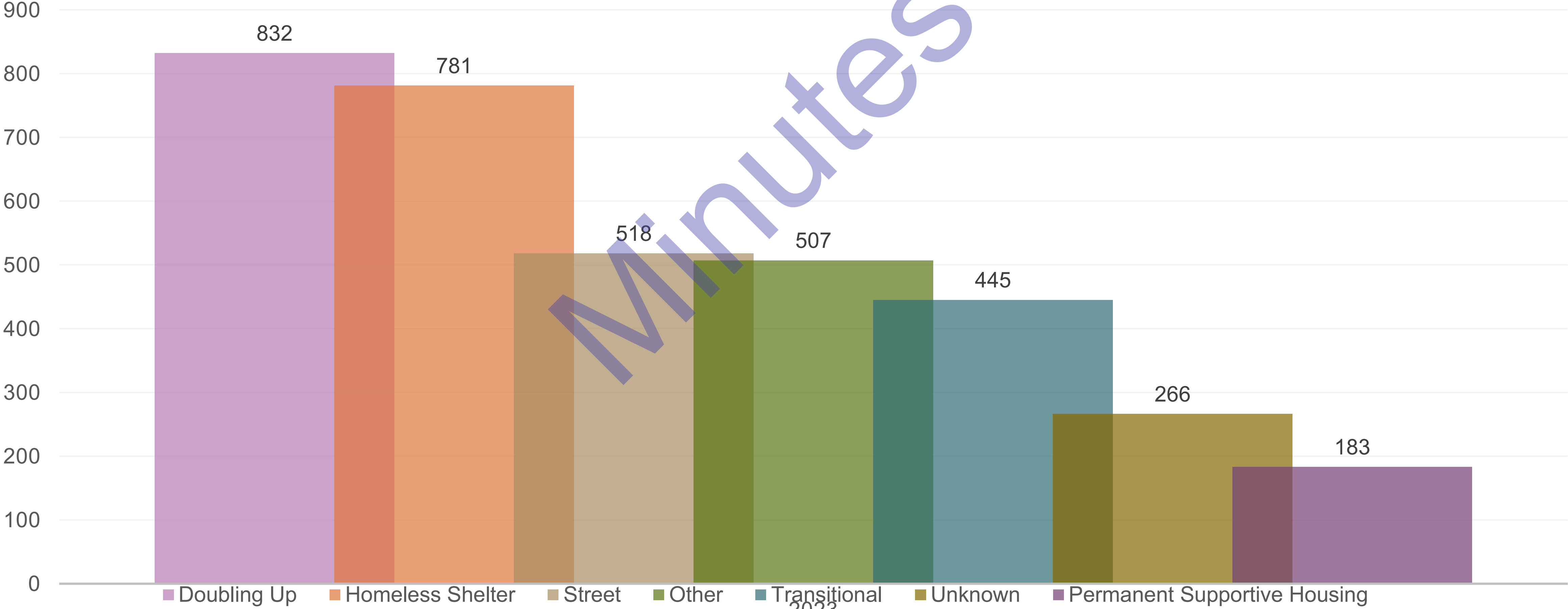
2023 Homeless Count & Categories



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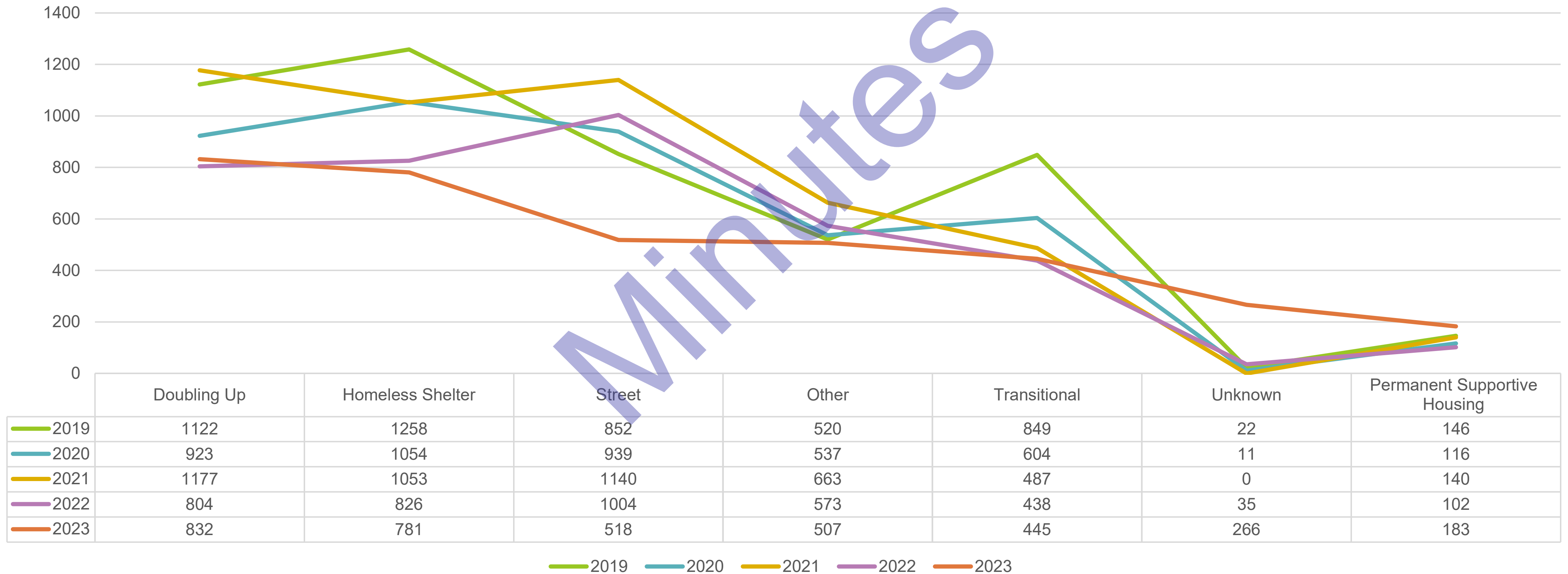
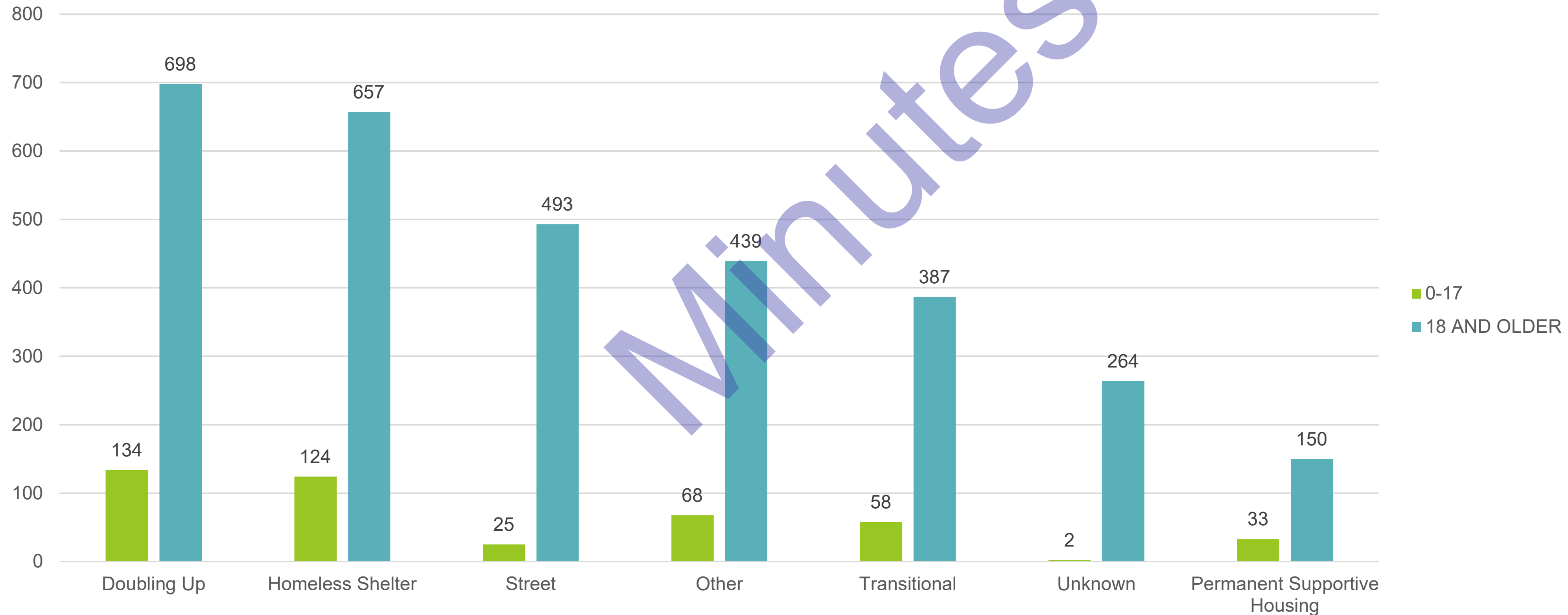
2023 Homeless Count & Categories Trend



	Doubling Up	Homeless Shelter	Street	Other	Transitional	Unknown	Permanent Supportive Housing
2019	1122	1258	852	520	849	22	146
2020	923	1054	939	537	604	11	116
2021	1177	1053	1140	663	487	0	140
2022	804	826	1004	573	438	35	102
2023	832	781	518	507	445	266	183

Homeless status by age



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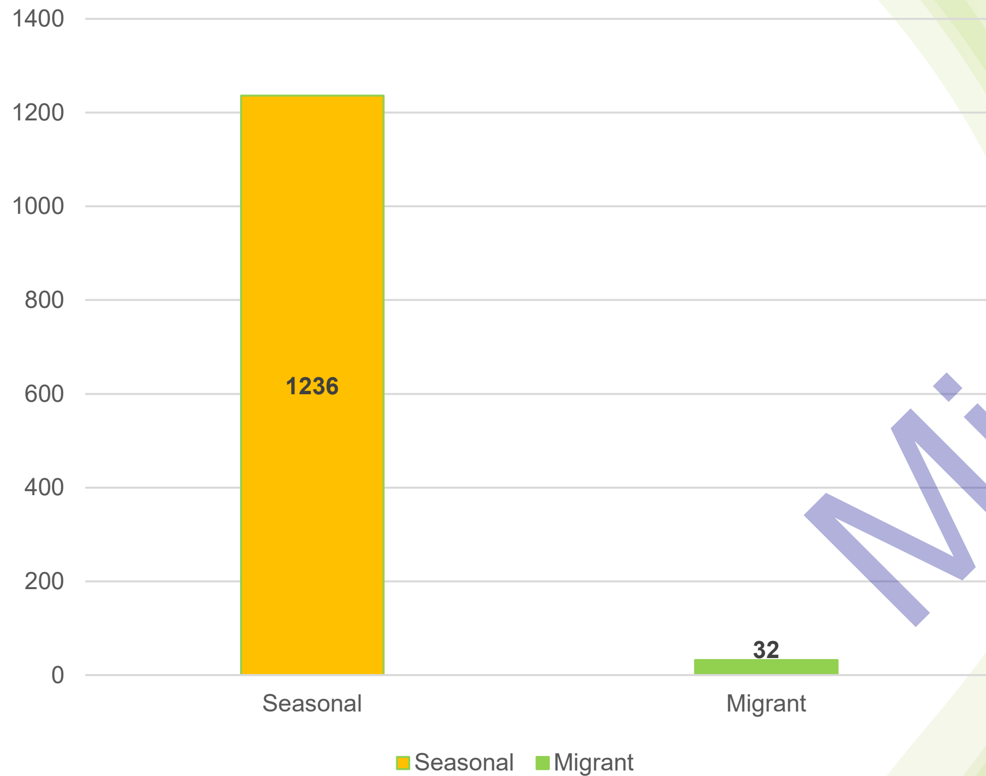

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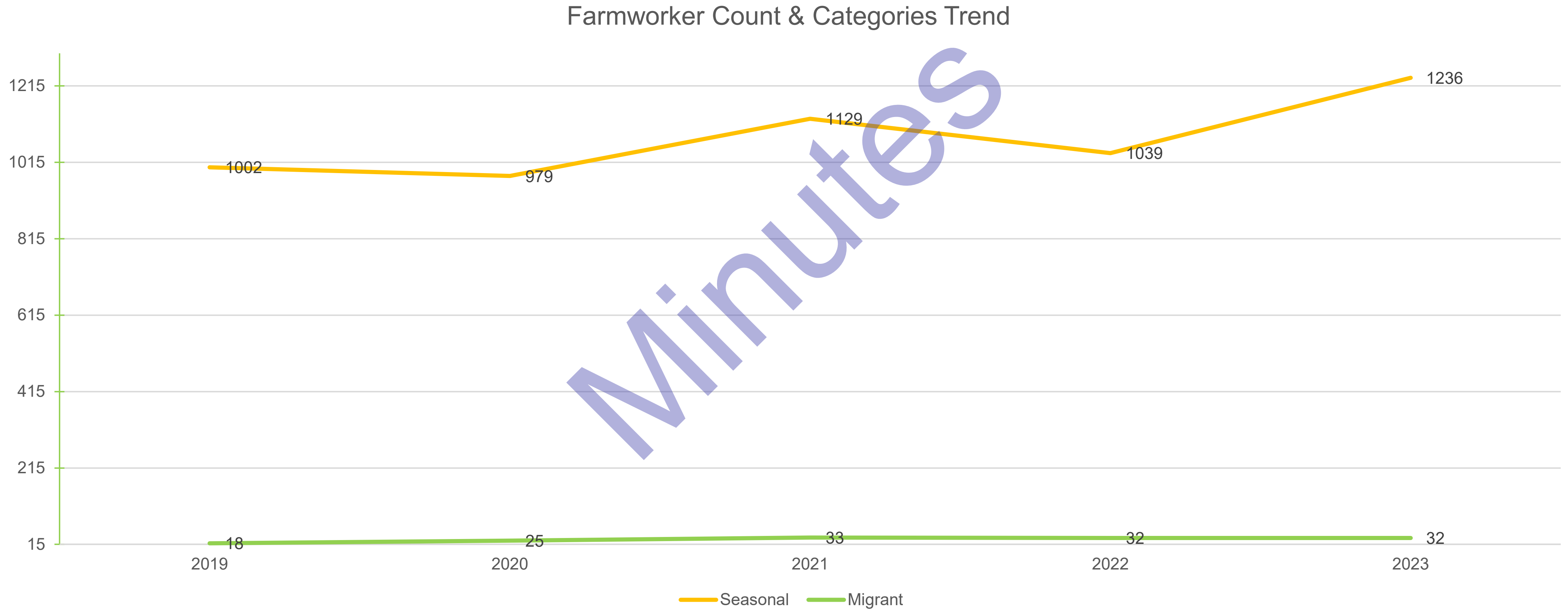
2023 Farmworker Count & Categories

2023 Farmworker Count & Categories Trend



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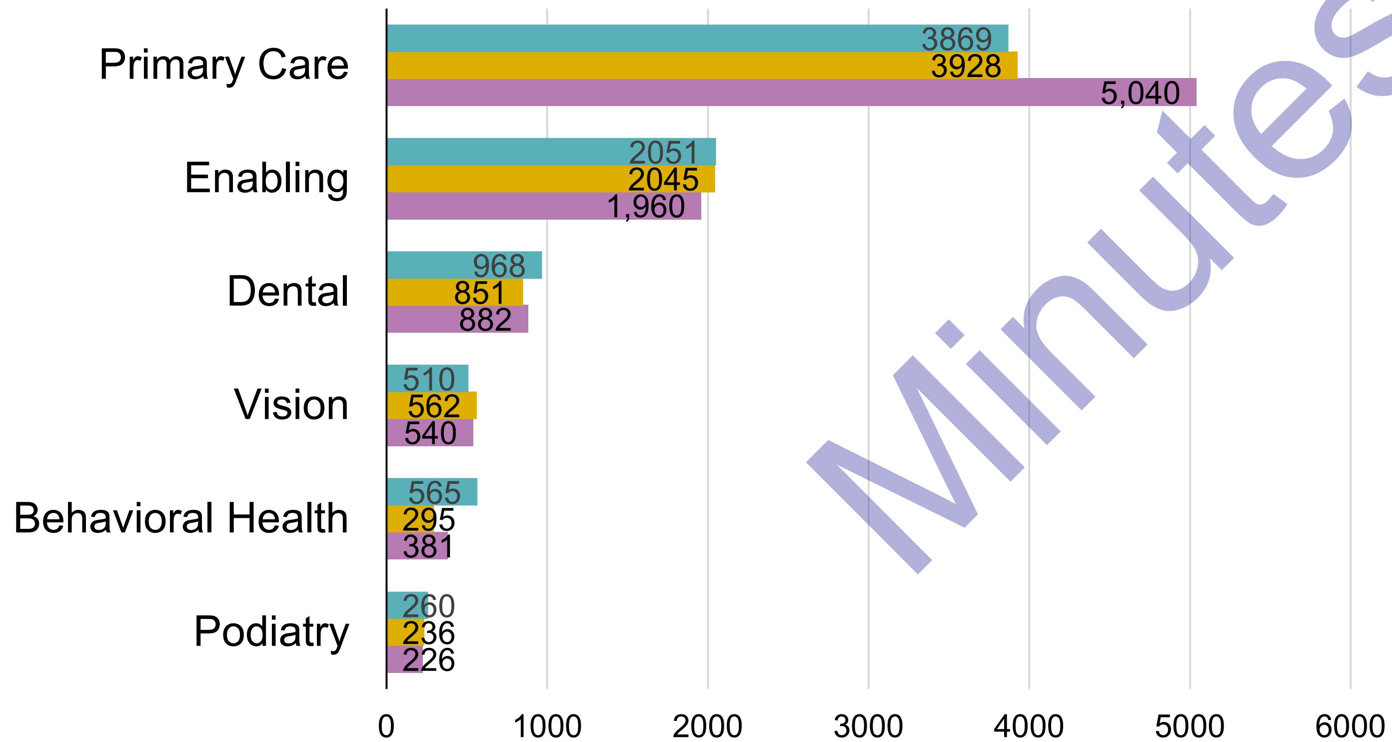
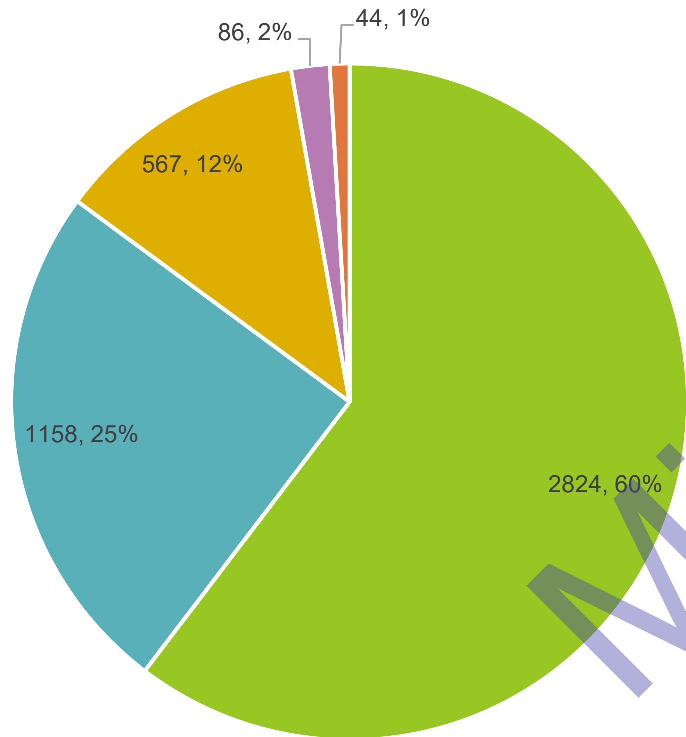


2023 Total Patients 4,679
2022 Total Patients 4854
2021 Total Patients 5777

Health Insurance Status



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UDS Clinical Quality Measures

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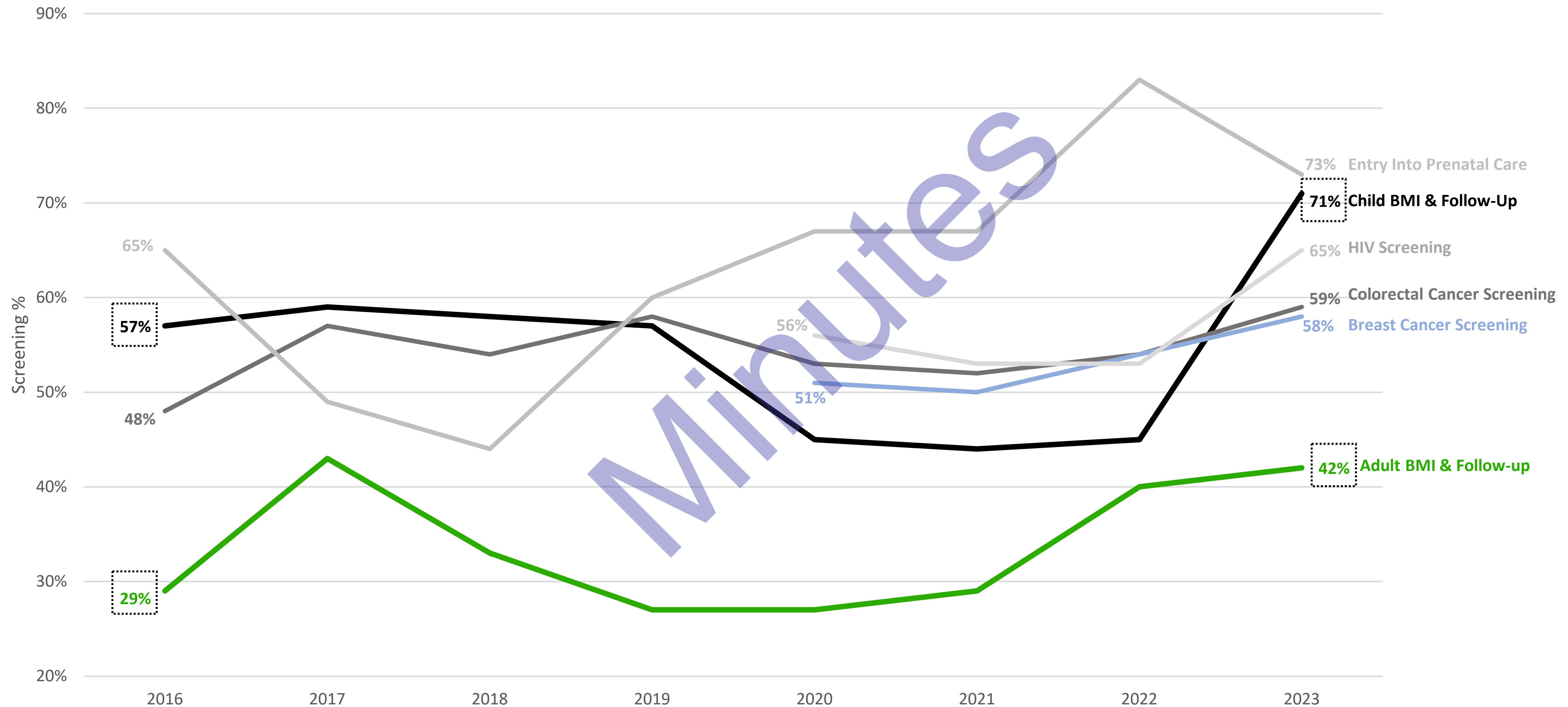
Priority CQMs

- Early Entry into Prenatal Care
- Cervical Cancer Screening
- Breast Cancer Screening
- Adult Body Mass Index (BMI) Screening & Follow-Up Plan
- Diabetes > 9% or missing
- Colorectal Cancer Screening
- Depression Screening & Follow-Up
- Hypertension Controlled

- Statin Therapy
- Aspirin Therapy in Ischemic Vascular Disease (IVD) Patients
- HIV Linkage to Care
- HIV Screening
- Depression Remission at Twelve Months
- Dental Sealants for Children between 6-9 Years
- Normal Birthweights
- Tobacco Screening & Cessation Intervention
- Weight Assessment and Counseling for Nutrition & Physical Activity for Children/Adolescents
- Childhood Immunization Status

Best Performing Measures

In the last 8 years, most improved measures were BMI Adult (+13%) and Child (+14%). All 6 measures surpassed COVID-19 declines.



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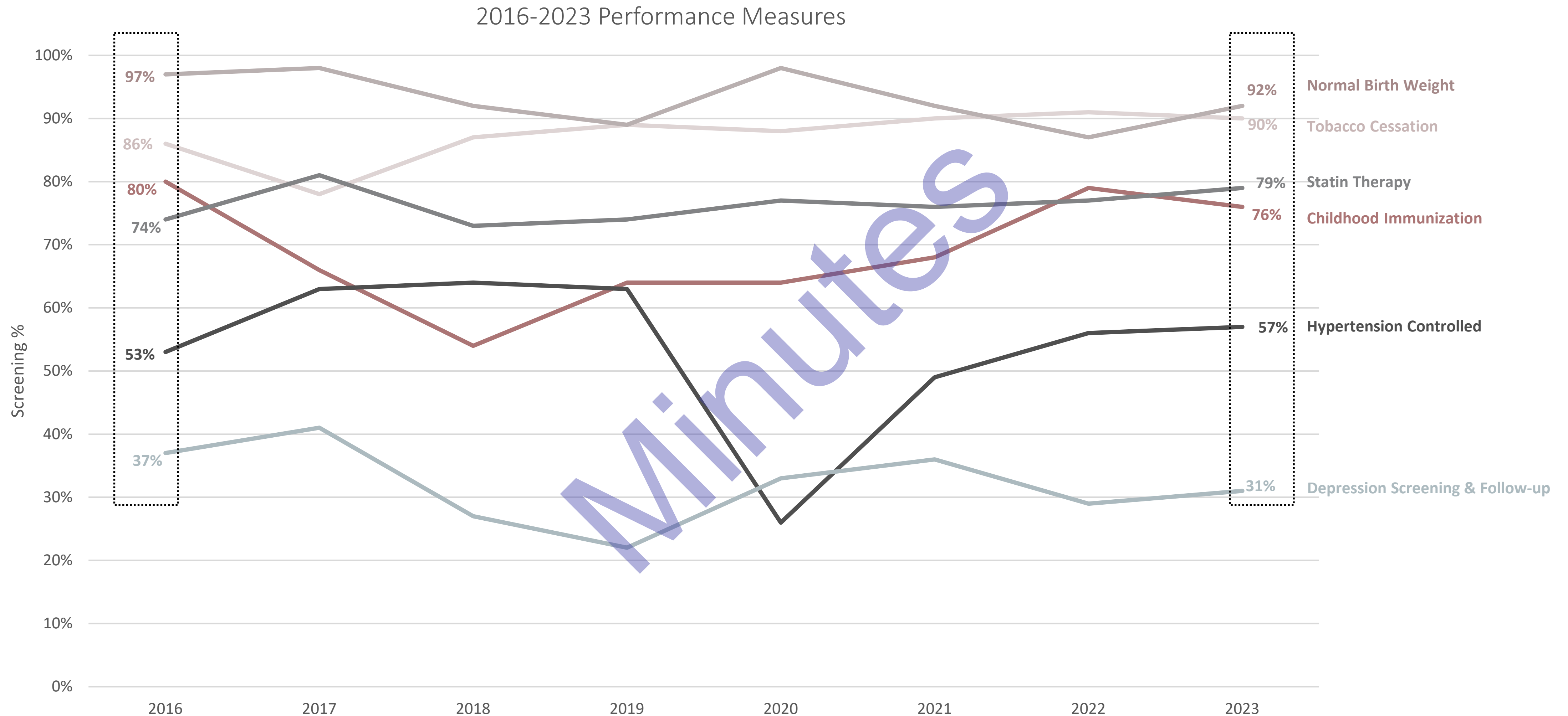
Definitions:
Entry into Prenatal Care: Percentage of prenatal care patients who entered prenatal care during their first trimester
Child BMI & Follow-Up: Patients 3–17 yrs of age with BMI documented during a medical visit, & who received nutrition counseling if outside of normal parameters
HIV Screening: Percentage of patients aged 15–65 at the start of the measurement period who were between 15–65 years old when tested for HIV
Colorectal Cancer Screening: Percentage of adults 45–75 years of age who had appropriate screening for colorectal cancer*
Breast Cancer Screening: Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer in the last 27 months*
Adult BMI & Follow-Up: Patients 19+ yrs of age with BMI documented during a medical visit, & who received nutrition counseling if outside of normal parameters

Neutral Performing Measures

In the last 8 years, all 6 performance measures showed minimal growth.

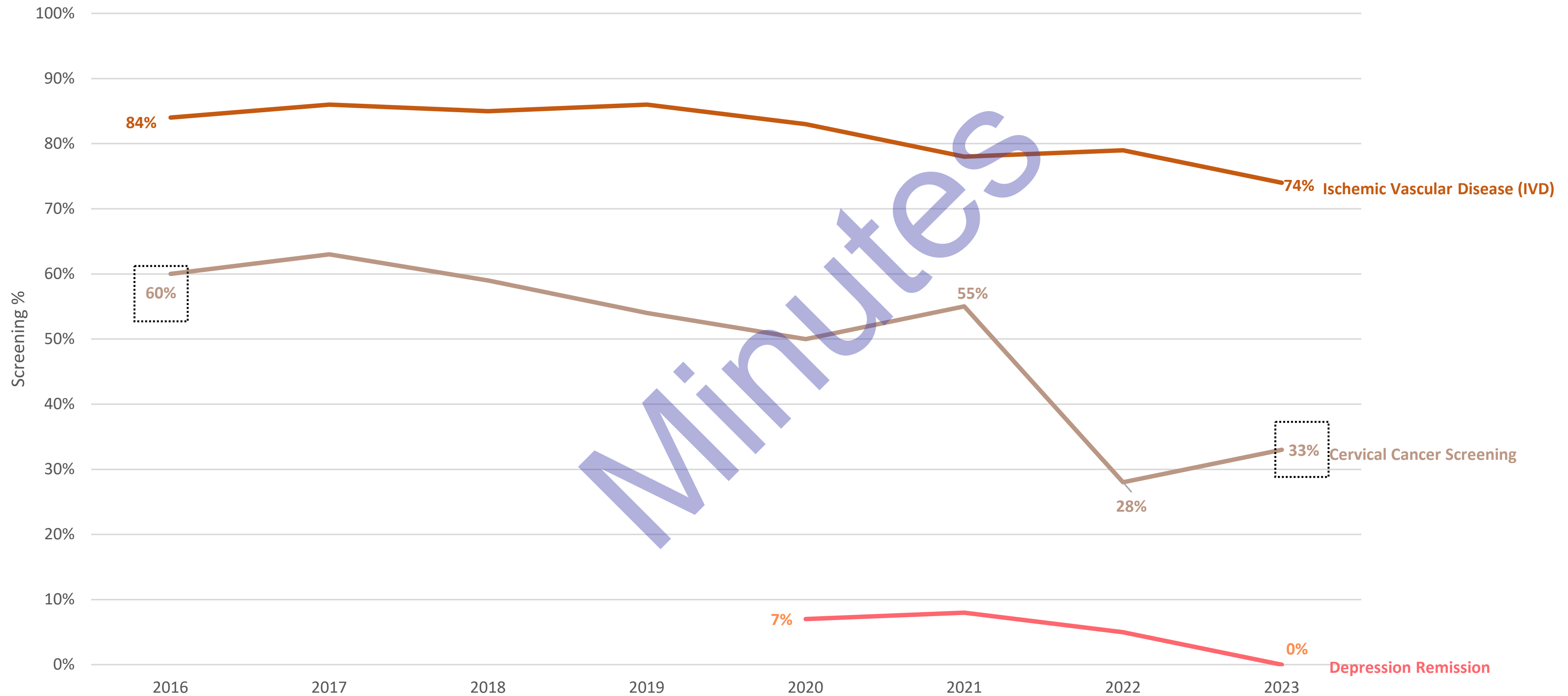


Definitions:
Normal Birth Weight: Percentage of babies of health center prenatal care patients born whose birth weight was below normal (less than 2,500 grams)
Tobacco Cessation: Percentage of patients 18+ yrs screened for tobacco use one or more times during the year, & who received tobacco cessation intervention if identified as a tobacco user
Statin Therapy: Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the year
Childhood Immunization: Percentage of children 2 years of age who received age-appropriate vaccines by their 2nd birthday
Hypertension Patients 18–85 years of age diagnosed with hypertension, and whose most recent blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the year
Depression Screening & Follow-Up: Patients aged 12+ yrs screened for depression and, if positive, a follow-up plan is documented on the date of or up to two days after the visit

Underperforming Measures

Out of the top 3 underperforming measures, Cervical Cancer Screening dropped -27% in the last 8 years.

2016-2023 Performance Measures



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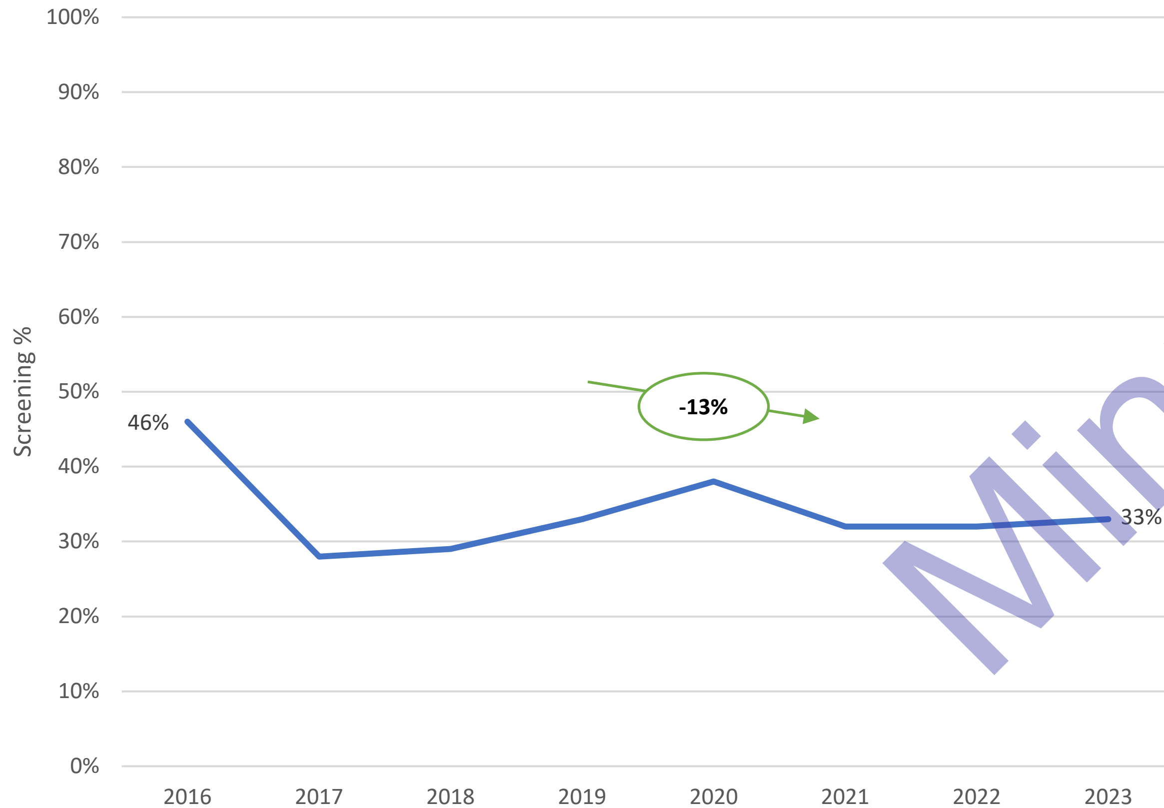
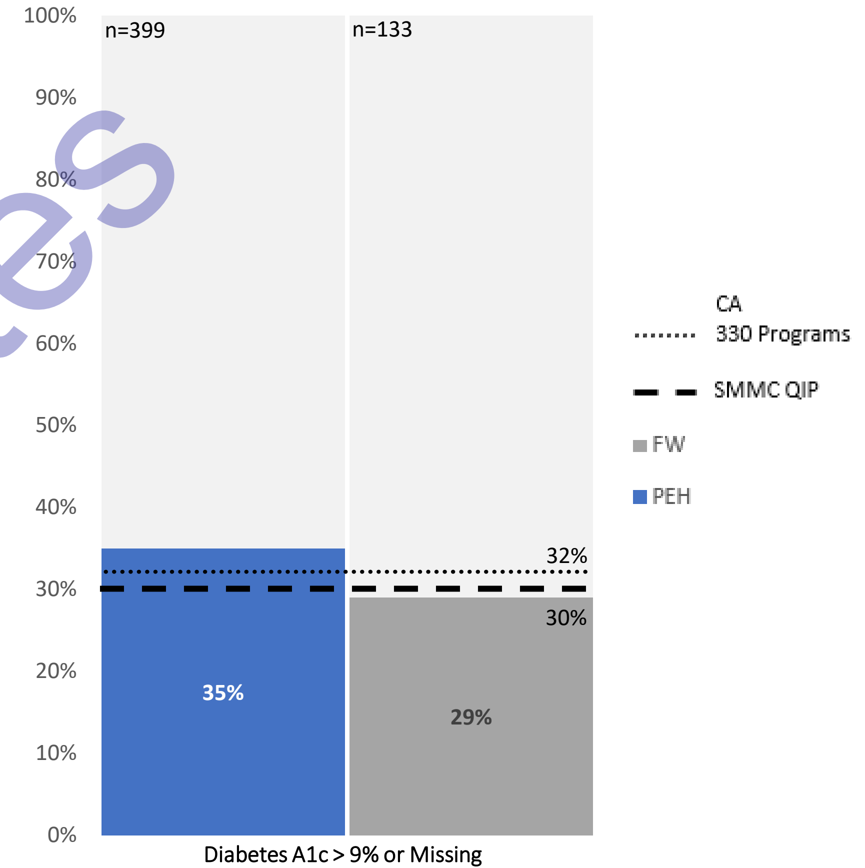
Definitions:
IVD: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet
Cervical Cancer Screening: Percentage of women 24-64 years of age who were screened for cervical cancer
Depression Remission: Percentage of patients 12 years of age and older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event

Diabetes A1c > 9% or Missing

HCH/FH patients improved diabetes measures (A1c) by 13% over 8-years.





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Definition:
Diabetes A1c > 9% or missing: Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period

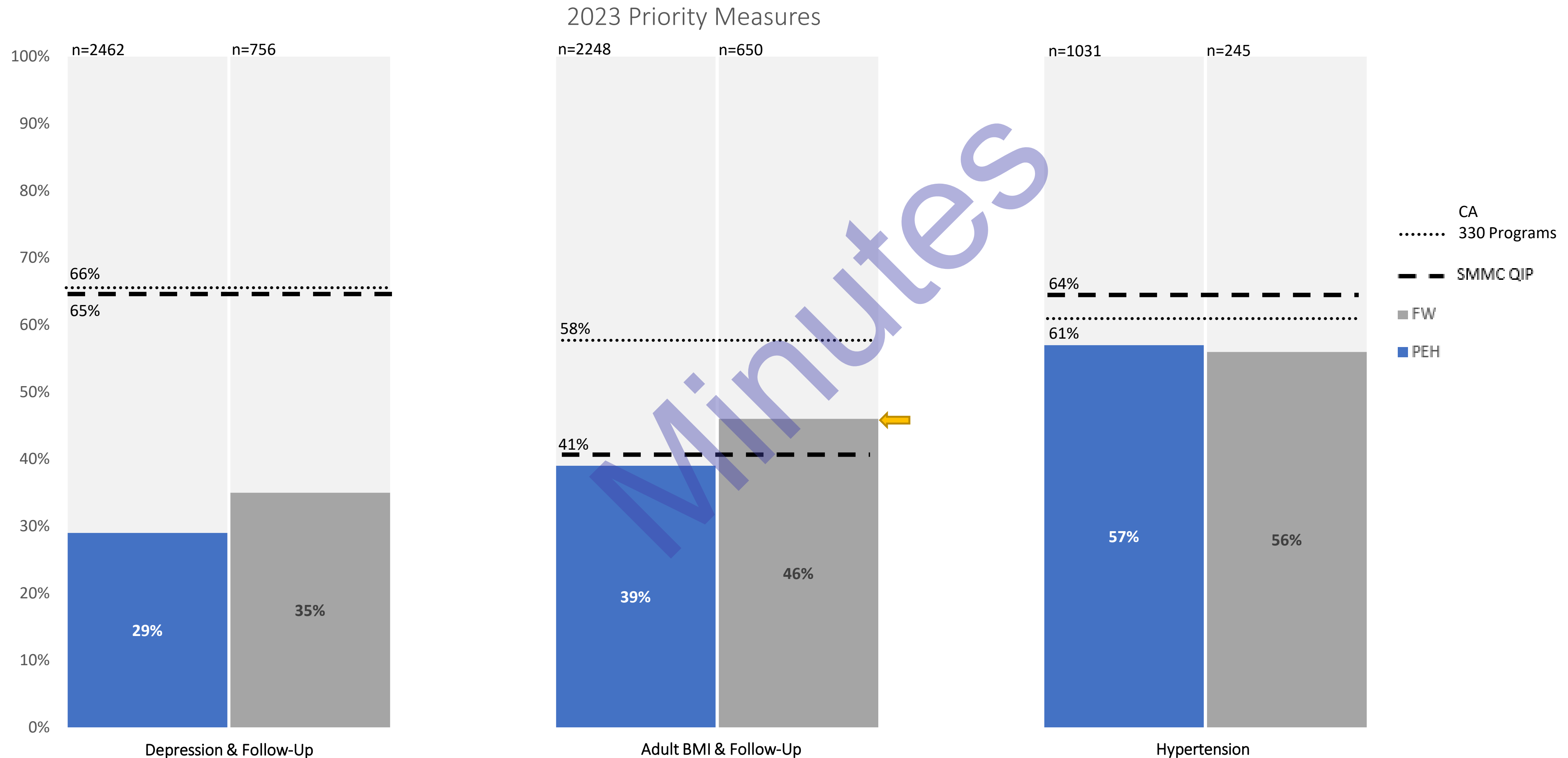
Homeless Vs. Farmworker Comparison

Farmworker patients show improvement, outperforming SMMC QIP for 2 out or 3 cancer screening measures.

Definitions:
Cervical Cancer Screening: Percentage of women 24-64 years of age who were screened for cervical cancer
Colorectal Cancer Screening: Percentage of adults 45–75 years of age who had appropriate screening for colorectal cancer*
Breast Cancer Screening: Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer in the last 27 months*

Homeless Vs. Farmworker Comparison

Farmworkers, within Adult BMI, helped HCH/FH surpass the SMMC QIP metric in 2023.



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Definitions:

Depression Screening & Follow-Up: Patients aged 12+ yrs screened for depression and, if positive, a follow-up plan is documented on the date of or up to two days after the visit

Adult BMI & Follow-Up: Patients 19+ yrs of age with BMI documented during a medical visit, & who received nutrition counseling if outside of normal parameters

Hypertension: Patients 18–85 years of age diagnosed with hypertension, and whose most recent blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the year

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

Health Care for Homeless/Farmworker Health (HCH/FH) 2024– 2027 Strategic Plan

Mission

Serve homeless and farmworker individuals and families by ensuring they have access to comprehensive primary, dental, and behavioral health services in a supportive, welcoming, and accessible environment.

Vision

Provide patient-centered health care services at optimal locations and advocate for the health needs of our target populations by addressing access barriers and reducing health disparities that affect them.

Values

- *Access*: Homeless and farmworker individuals and their families have full access to the continuum of health care and social services.
- *Dignity*: Services provided are respectful, culturally competent, and the treat the whole person's physical health and behavioral health.
- *Integrity*: Homeless and farmworker individuals and their families are valued and considered a partner in making decisions regarding their health care.
- *Innovation*: Services will continuously evolve to reflect current best practices and technological advances.

Priority Areas

Decrease barriers to accessing health care services.

- Fund and coordinate enabling services.
- Fund and coordinate delivery of primary care, dental, and behavioral health
- Collaborate with SMMC, BHRS, and PHPP to optimize clinic operations and reduce patient grievances
- Collaborate with Health Coverage Unit (HCU) and other partners to ensure patients have and maintain insurance coverage

Improve health outcomes for homeless individuals and farmworkers (and their families).

- Follow work outlined in HCH/FH Quality Improvement/Quality Assurance Plan
- Provide outreach & health education to patients
- Identify sub-populations for additional data analysis and efforts to reduce health disparities
- Ensure social determinants of health are embedded in clinic and HCH/FH workflows

Support health care and service providers.

- Develop and provide relevant training
- Provide financial support for professional development and well-being initiatives
- Connect SMMC, BHRS, and PHPP care teams with external case managers and community resources

Meet and exceed all HRSA compliance requirements.

- Pass HRSA Site Visit audits with minimal to no findings
- Timely and accurate annual Uniform Data System (UDS) reporting
- Have a well-functioning Co-Applicant Board with consumer representation
- Regularly monitor and evaluate financial performance of contracted services/contractors,
- Maximize all available HRSA opportunities and relationships

Seek innovation and expansion opportunities.

- Continuously explore and engage partnerships that align with the program goals adn apply for supplemental awards when appropriate
- Be active thought partners and leaders in the County's program evaluation efforts
- Be an active partner in the County's EPIC implementation initiatives
- Collect data and advocate for medically fragile homeless individuals' needs
- Partner, engage, and collaborate with relevant stakeholders to explore impacts of CalAIM and other policies on quality of care and finance

Minutes

San Mateo County Health Care for Homeless/Farmworker Health Program

Summary of Enabling Staff Key Functions for “Case Management”

Key Functions	Community Health Worker/ Promotora	Health(care) Navigator/ Patient Navigator	Care Coordinator/ Care Manager	Case Manager/ Medical Case Manager	**Comments**
Community Health Education	**X**				
Educate on how to use the health system		**X**			
Outreach to engage patients in care	**X**	**X**	**X**		
Advocate for Individual/ population health needs	**X**	**X**	**X**	**X**	
Provide culturally and language appropriate health education	**X**	**X**	**X**	**X**	
Provide Interpretation Services	**X**	**X**	**X**		
Make and track appointments	**X**	**X**	**X**	**X****	**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	**X**	**X**	**X**	**X**	
Develop and implement Care Plan		**X**	**X**	**X****	**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 support patients in adhering to the plan.
Support Care Transitions	**X**	**X**	**X**		**Case Managers both plan and facilitate care transitions (e.g. hospital discharge). Lay workers support patients during transitions.
Plan and implement care transitions				**X****	
Determine/Implement most cost-effective way to deliver care for desired outcomes. Assess outcomes and manage/revise care plan				**X**	

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HPSM: CalAIM Enhanced Care Management & Community Supports

Amy Scribner, Chief Health Officer
Gale Carino, Director of Integrated Care

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HealthPlan OF SAN MATEO
Healthy is for everyone

Agenda

HealthPlan OF SAN MATEO
Healthy is for everyone

- CalAIM Transformation
- Enhanced Care Management
- Community Supports
- Requesting ECM and CS Services
- Partnership Opportunities/Ideas
- HPSM's CalAIM Provider Webpage
- Helpful Resource Links

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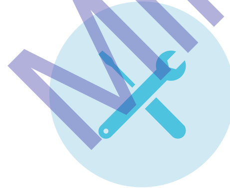
CalAIM Transformation

HealthPlan OF SAN MATEO
Healthy is for everyone

ADDRESS PHYSICAL AND MENTAL HEALTH NEEDS

IMPROVE AND INTEGRATE CARE

BE A CATALYST FOR EQUITY AND JUSTICE



WORK TO BUILD A HEALTHIER STATE

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What is Enhanced Care Management (ECM)?

HealthPlan OF SAN MATEO
Healthy is for everyone

- ECM is a Medi-Cal benefit to support comprehensive in-person care management by way of its core service components for enrollees with complex needs that must often engage several delivery systems to access care.

Minutes

Outreach and Engagement

Comprehensive Assessment and Care Management Plan

Enhanced Coordination of Care

Coordination of and Referral to Community and Social Support Services

Member and Family Supports

Health Promotion

Comprehensive Transitional Care

ECM Eligibility

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- ECM is a Medi-Cal only benefit.
- To be eligible for ECM, members must be enrolled in a Medi-Cal Managed Care Plan and meet at least one of the ECM Populations of Focus.

ECM Populations of Focus		Adults	Children & Youth
1a	Individuals Experiencing Homelessness: *Adults without Dependent Children/Youth Living with Them Experiencing Homelessness*	✓	
1b	Individuals Experiencing Homelessness: *Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness*	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization (*Formerly "High Utilizers"*)	✓	✓
3	Individuals with Serious Mental Health and/or SUD Needs	✓	✓
4	Individuals Transitioning from Incarceration	✓	✓
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	✓	✓

Minutes

ECM Providers

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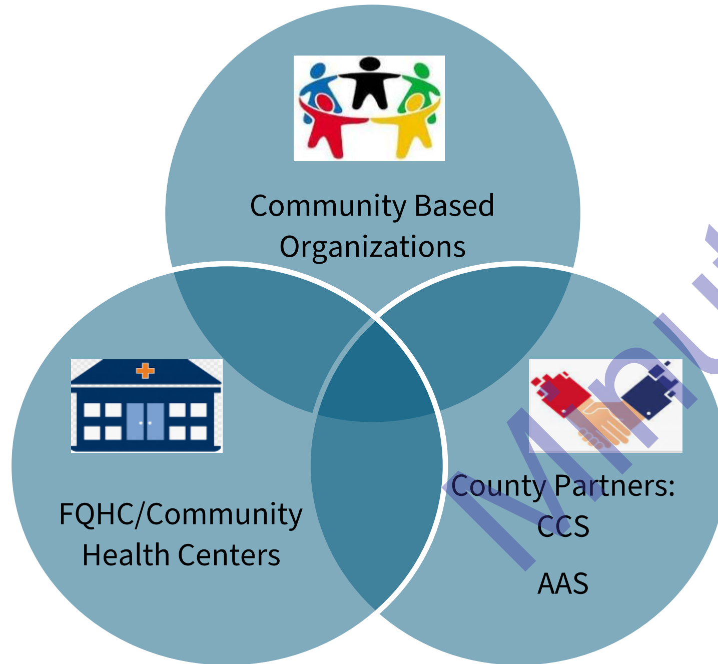

CBOs:

1. Institute on Aging
2. Bridges to Wellness
3. Upward Health
4. Healthcare In Action

County Partners:

5. Aging and Adult Services (AAS - ECM)
6. California Childrens Services (CCS - ECM)

FQHCs:

7. North East Medical Services
8. Ravenswood Family Health Center
9. Gardner Health Services

For a detailed listing of our ECM Providers and the POFs they serve, visit our CalAIM Provider Webpage.

Minutes

What are Community Supports?

HealthPlan OF SAN MATEO
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- Community Supports are cost effective alternatives to traditional medical services or settings. Community Supports are intended to address social drivers of health for members. *Community Supports are optional for plans to implement.*

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite
7. Day Habilitation Programs
8. Nursing Facility Transition
9. Diversion to Assisted Living Facilities such as RCFE & Adult Residential Facilities
10. Personal Care/Homemaker Services (beyond IHSS)
11. Home Modifications
12. Meal/Medically Tailored Meals
13. Sobering Centers
14. Asthma Remediation

Minutes

Community Supports Eligibility

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- Members who are eligible for the Enhanced Care Management (ECM) benefit are eligible for Community Supports.
- If not eligible for ECM, a member may be eligible for Community Supports if they meet the following basic qualifications:
  - Active HPSM Medi-Cal or Care Advantage member
  - *Engaged with a Care Manager or Care Coordinator
  - Willing to receive Community Supports

Minutes

***Member has a CM serving as point of contact who has or can assess the member's health, medical and/or SDOH who is able to connect member to services and supports to address their needs.*

Community Supports Providers

HealthPlan OF SAN MATEO
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Housing Navigation
- Brilliant Corners
- Mental Health Association*

Housing Tenancy
- Brilliant Corners,
- MidPen*
- Mental Health Association

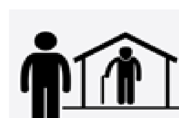
Housing Deposits
- Brilliant Corners
- Mental Health Association*

Home Modifications
- Brilliant Corners
- Institute on Aging

Medically Tailored Meals
- Mom's Meals

Respite Care
- Aging and Adult Services
- 24 Hour Home Care

Personal Care and Homemaker Services
- Aging and Adult Services
- 24 Hour Home Care



Nursing Facility Transition/Diversion to Assisted Living Facilities
- Institute on Aging

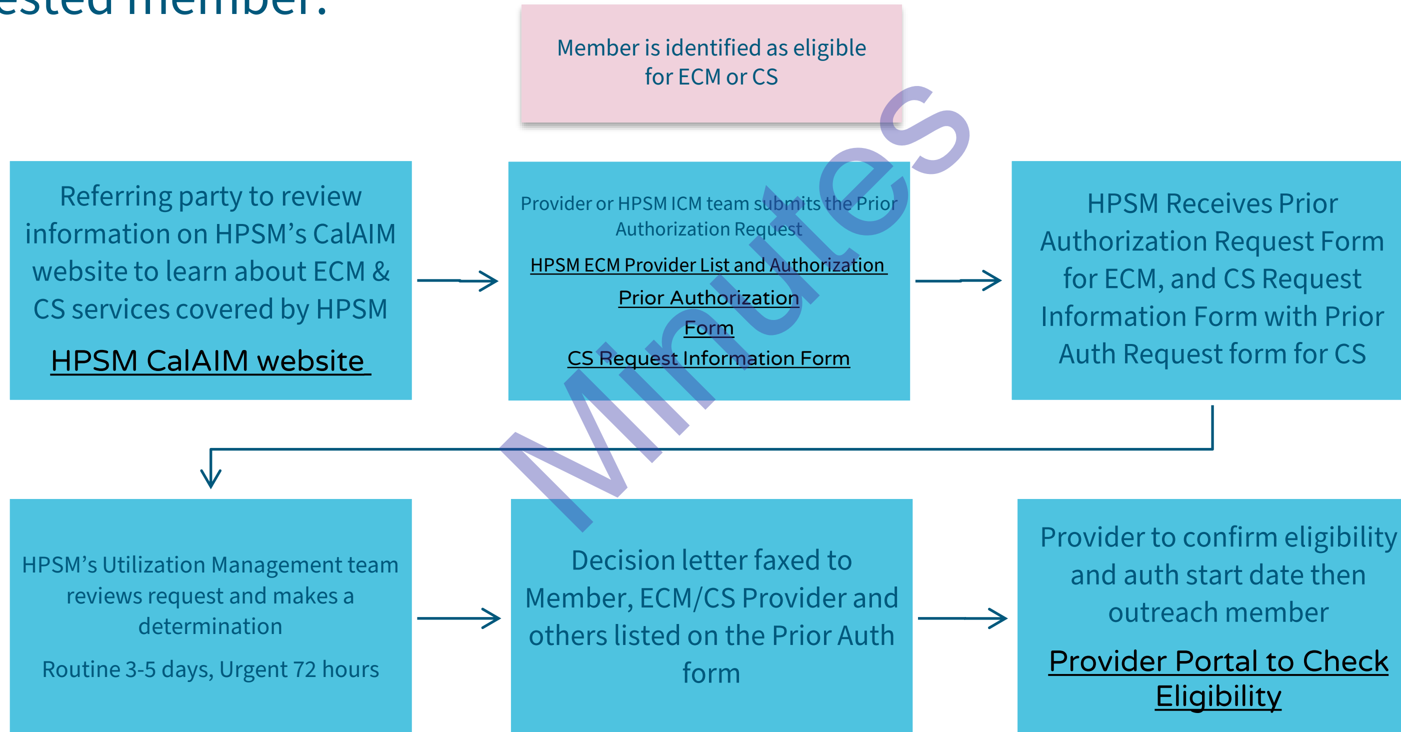
Community Transition Services/NF Transition to a Home
- Institute on Aging
- Aging and Adult Services

Minutes

Request for ECM or CS Services

HealthPlan OF SAN MATEO
Healthy is for everyone

- All requests should occur in coordination with interested member.



Minutes

Partnership Opportunities / Ideas

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- Member data sharing
- Identifying HPSM Medi-Cal members for ECM access
- Preventing duplication of services, i.e. housing services.
- Developing a simplified referral pathway for ECM and CS eligible members.

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HPSM's CalAIM Provider Webpage

HealthPlan OF SAN MATEO
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- Highlights the information providers need to know about CalAIM, ECM and Community Supports
- Provides more specific eligibility criteria and information for ECM & CS services
- Provides guidance on how to request services to include links to all required documents
- Provides resources and helpful links

Minutes

Please visit HPSM's CalAIM webpage for more information regarding ECM and CS services and eligibility: **HPSM CalAIM Webpage**

Important Resource Links

HealthPlan OF SAN MATEO
Healthy is for everyone

- HPSM CalAIM Provider Webpage
- CalAIM Provider Frequently Asked Questions
- ECM and CS Provider List and Authorization Tips
- HPSM Prior Authorization Request Form
- ECM Information for HPSM Members
- DHCS-ECM-Policy-Guide
- DHCS Community Supports Policy Guide
- HPSM Integrated Care Management/Care Coordination

Minutes

Questions?

Thank you!

Minutes

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Because the terms “Case Management” and “Case Manager” have become used for sometimes very different aspects of enabling services care, we are removing them from use for this RFP. Instead, we have selected a different set of terms 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.

Minutes

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 settings, 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.

Minutes

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.

Minutes

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.

#

Minutes

RFP Scope of Work

Minutes

HCH/FH Program

Co-Applicant Board Meeting

May 09, 2024

DRAFT RFP TIMELINE

RFP for Services Starting Jan 2025	Deadlines
RFP Release Date	Target: June 14, 2024
Proposal Due Date and Time	Mid-July 2024 @ 1PM
• Pre-Proposal Meeting	Mid – June 2024
• Deadline for Questions, Comments, Exceptions	Mid - June 2024
Review Proposals and Make Recommendations	July - August 2024
Co-Applicant Board Selection/Approval of Recommendations	August - September 2024
Contract Negotiations	September 2024
C-Applicant Board Approval of final Contracts	October-November 2024
Submission to County Board for Approval	October – November 2024
Anticipated Contract Award Date	October – November 2024
Expected Service Start Date	January 1, 2025

Minutes

SERVICE STREAMS

1. Case Management/Care Coordination
2. Dental
3. Behavioral Health
4. NEW: BHSE (Mental health and AOD/SUD)

Minutes

Case Management/Care Coordination (CC)

a. General Case Management

1. Promotores
2. Street Medicine CC, Brick & Mortar CC
3. Newly Housed CC
4. Domestic/Intimate Partner Violence, Human Trafficking CC

Health Insurance Assistance
Health Education and Promotion
Support in scheduling/attending appointments, using patient portal
Transportation Services (for primary care, dental, and mental health)
Translation
Nutrition Education
Other Enabling Services

Minutes

Dental

- South Coast Dental Services

Behavioral Health

- AOD and SUD

NEW: BHSE (Mental health and AOD/SUD)

Minutes

Tab 2
PROGRAM BUDGET and FINANCIAL REPORT

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

DATE: June 13, 2024

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

FROM: Jim Beaumont
Director, HCH/FH Program

SUBJECT: HCH/FH PROGRAM BUDGET and FINANCIAL REPORT

Preliminary grant expenditures for May 2024 total $210,917. This amount does not include some of the routine monthly service charges from county departments as they are accounted for during the month-end closing process (which doesn't complete until around the 10th). For the year-to-date, expenditures total $1,210,721.

This current projection continues to show that the Program will expend a little over $3.3M for the 2024 Grant Year (GY). Based on the total amount authorized by HRSA and the amount expected to be carried over for the GY, this will leave around $200K of unexpended funds that would be available for carryover into the 2025 GY. We are in the process of finalizing the carryover for this year and, as the Program goes through the upcoming RFP and contracting process for the next 3 years, we will be refining the unexpended funds amount to spread it across the contract period to ensure sufficient funding for the period.

The first quarter drawdown of grant funds based on total expenditures for the quarter (thus picking up those expenditures that may not show up in the monthly reports) has been submitted for a total of $617,119.

Attachment:

- GY 2024 Summary Grant Expenditure Report Through 05/31/24

GRANT YEAR 2024

Details for budget estimates	Budgeted [SF-424]	*April $$*	To Date **(04/30/24)**	Projection for end of year	Projected for GY 2025
EXPENDITURES					
Salaries					
Director, Program Coordinator					
Management Analyst ,Medical Director					
new position, misc. OT, other, etc.					
	745,000	*88,841*	294,864	725,000	795,000
Benefits					
Director, Program Coordinator					
Management Analyst ,Medical Director					
new position, misc. OT, other, etc.					
	245,000	*27,509*	92,608	215,000	290,000
Travel					
National Conferences (2500*8)	30,000		5,202	30,000	25,000
Regional Conferences (1000*5)	10,000			5,000	5,000
Local Travel	1,500			1,000	1,000
Taxis	500			500	500
Van & vehicle usage	1,500			1,500	1,500
	43,500		5,202	38,000	33,000
Supplies					
Office Supplies, misc.	10,000	*3,068*	15,914	19,000	10,000
Small Funding Requests					
	10,000		15,914	19,000	10,000
Contractual					
2022 Contracts			185,329	185,329	
2022 MOUs			26,571	26,571	
Current 2023 MOUs	1,200,000		306,488	1,185,000	1,100,000
Current 2023 contracts	875,000	*86,499*	244,927	850,000	775,000
---unallocated---/other contracts					
	2,075,000		763,315	2,246,900	1,875,000
Other					
Consultants/grant writer	20,000		11,996	25,000	15,000
IT/Telcom	25,000	*2,465*	11,230	30,000	25,000
New Automation				0	-
Memberships	7,500			5,000	5,000
Training	5,000			5,000	5,000
Misc	1,000	*2,535*	15,592	25,000	1,000
	58,500		38,818	90,000	51,000
TOTAL	3,177,000	*210,917*	1,210,721	3,333,900	3,054,000
GRANT REVENUE					
Available Base Grant	2,858,632		2,858,632	2,858,632	2,858,632
Prior Year Unexpended to Carryover	675,000 est.		675,000	675,000	
Other					199,732 carryover
HCH/FH PROGRAM TOTAL	3,533,632		3,533,632	3,533,632	3,058,364
BALANCE	**356,632**	**Available**	**2,322,911**	**199,732**	**4,364**
			Current Estimate	**Projected**	based on est. grant of $2,858,632
Non-Grant Expenditures					
Salary Overage	20,000	*375*	2,715	20,000	30,000
Health Coverage	85,000	*9,211*	44,968	85,000	90,000
base grant prep	0			0	
food	2,500	*300*	1,231	2,500	3,000
incentives/gift cards	1,000			1,000	1,500
	108,500		48,914	108,500	124,500
TOTAL EXPENDITURES	**3,285,500**	*220,803*	**1,259,635**	**3,442,400**	**NEXT YEAR 3,178,500**

Tab 3
HCH/FH Director's Report

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

DATE: June 13, 2024

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

FROM: Jim Beaumont, Director, HCH/FH Program

SUBJECT: DIRECTOR'S REPORT & PROGRAM CALENDAR

Program activity update since the May 09, 2024, Co-Applicant Board meeting.

HRSA/BPHC has released two (2) additional Notices of Funding Opportunity (NOFO).

The Expanded Hours (EH) NOFO was released on May 21st. The purpose of this opportunity is to expand access to services (primary care) by increasing operating hours to meet patient and community needs. Initial project abstract is due June 24th with completed applications due July 23rd. There are 120 awards planned at $500,000 per year for each of two years beginning December 1, 2024.with the potential for the award to become ongoing.

HCH/FH has initiated internal discussions within SMMC and with PHPP on possible options to increasing operating hours that will benefit our homeless and farmworker population. As a government entity, there are some specific inherent difficulties in adding new staff which cam significantly impact these types of projects.

HRSA has also released its New Access Point (NAP) NOFO. These awards are intended to support health centers in adding additional service sites within their scope of services by providing financial support to their implementation. They expect to make only 77 awards with a maximum available of $650,000 for one (1) year. This funding would be expected to become ongoing. Initial abstract submission deadline is August 15th, with the full application due September 30th. The awards would start June 1, 2025.

The NAP NOFO is expected to be very competitive. HCH/FH has begun thinking about if/where this may make sense for us, as it is a quite completed process.

We are also moving forward with the application process for the Behavioral Health Service Expansion (BHSE), having filed the required initial abstract and initiated conversations with a number of community partners and county programs. The deadline for full application submission is June 21st.

While all of these opportunities are very competitive and may not result in an immediate award, HRSA scores all application and all that pass are placed on a list. If additional funding becomes available, HRSA uses the existing list to continue to make awards. Based on this there is significant value in submitting a quality application and at least getting placed on the list of approved-but-not-funded applications.

HCH/FH did not submit an initial abstract for the HRSA NOFO for Transitions in Care for Justice Involved Populations. Designed as a single year pilot program with no continuation of funding and very limited awards made it an unattractive project to take on.

HCH/FH continues to work through issues with establishing the dental services at the Navigation Center under a contract with University of Pacific (UoP). UoP has encountered delays in securing their necessary staff, which has delayed opening of the clinic.

Program has also been working to package the required RFP for services in 2025 through 2027 based on the Board's direction at the April meeting. Board review and approval of the RFP is elsewhere on today's agenda.

HCH/FH staff continue to engage with Epic/Integr8 implementation team to ensure that data requirements and reporting capabilities are as expected. We anticipate continued discussions throughout the implementation process leading up to "go live" on November 2nd.

Seven Day Update

ATTACHED:

- Program Calendar

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

County of San Mateo Health Care for the Homeless & Farmworker Health (HCH/FH) Program

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

MONTH	AREA		
	Programmatic	Learning/Conferences	Recognition (Health, DEI, Holidays and Misc.)
JANUARY			• Glaucoma Awareness Month • Cervical Cancer Screening Month • International Holocaust Remembrance Day • New Year's Day • Martin Luther King Day (15)
FEBRUARY	• UDS submission	• NCFH Western Forum for Migrant and Community Health (Seattle, WA, Feb 22-24)	• National Children's Dental Health • American Heart Month • National Cancer Prevention Month • World Day of Social Justice • Lunar New Year (Feb 10) • National Wear Red Day • Lincoln's Birthday • Valentine's Day • Washington's Birthday • Lent begins (14)
MARCH	• Sliding Fee Scale Update	• Innovations and Solutions for Ending Unsheltered Homelessness. (San Francisco, CA - Mar 4-6)	• Colorectal Cancer Awareness Month • Self-Injury Awareness Month • Developmental Disabilities Awareness Month
APRIL	• SMMC Annual Audit	• Conference for Agricultural Worker Health (Atlanta, GA - April 23-25) • 2024 Midwest Stream Forum- Agricultural Worker Conference (Albuquerque, NM- April 16-18, 2024)	• Alcohol Awareness Month • Counseling Awareness Month • National Minority Health Month
MAY		• National Healthcare for the Homeless Conference. (Phoenix, AZ – May 13-16) • NRHA Health Equity Conference. (New Orleans, LA – May 6-7)	• American Stroke Awareness Month • High Blood Pressure Education Month • Mental Health Awareness Month
JUNE	• Services/Locations Form 5A/5B – Approve		• PTSD Awareness Month • Cancer Survivor's Month
JULY	• Budget Renewal (Program) Approve		• Healthy Vision Month
AUGUST			• National Breastfeeding Month • National Immunization Awareness Month
SEPTEMBER	• Program Director Annual Review	• September 15-18 International Street Medicine Symposium. Kansas City, MO	• Healthy Aging Month • National Suicide Prevention Month • Sexual Health Awareness Month
OCTOBER	• Board Chair/Vice Chair Nomination		• Breast Cancer Awareness Month • Depression Awareness Month • Domestic Violence Awareness Month

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NOVEMBER	• Board Chair/Vice Chair Elections • Strategic Plan Target Overview	• East Coast Migrant Stream- Agricultural Worker Conference Forum (Date TBA, previously Nov. 2023) (Winston-Salem, NC- Nov 29-Dec 1, 2023)	• American Diabetes Month • Diabetes Awareness Month
DECEMBER		• December 8-11 Institute for Healthcare Improvement (IHI) Forum for 2024. Orlando, FL	• Seasonal Affective Disorder Awareness Month

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

Tab 4
QI/QA REPORT

SAN MATEO COUNTY HEALTH
SAN MATEO
MEDICAL CENTER

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

DATE: June 13th, 2024

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

FROM: Frank Trinh, Medical Director HCH/FH Program
Alejandra Alvarado, Clinical Services Coordinator HCH/FH Program

SUBJECT: QI/QA COMMITTEE REPORT

- **2024 Q2 HCH/FH QI/QA Subcommittee Meeting**
  - HCH/FH will be hosting the second QI/QA Subcommittee meeting of the year, where we will review the Q1 2024 performance measures data, program updates, and upcoming program events. The Q1 2024 has been reviewed by HCH/FH in collaboration with the BI team (analytics team) to extract SMMC patients who are people experiencing homelessness and farmworkers. The meeting will be held after the June 13th board meeting in COB Room 402.
- **Cancer Data Set**
  - HCH/FH received the first draft of the Cancer Data set and is currently reviewing the data received. The goal of this project is to identify disparities between HCH/FH patients and the general patient population at SMMC. The primary disparities being identified are disparities among cancer screenings and prevalence of cancer diagnoses between both patient groups. Further analysis will be done to determine this disparity and this information will then be disseminated to the appropriate SMMC staff and leadership.

Tab 5
Temporary Subcommittee Update

Hello Subcommittee and Board Members,

Here are the initial objectives of our Subcommittee. This draft summary, for Subcommittee review, attempts to fulfill our first objective. Please provide feedback so that we can supply our final draft in time for Meron to include in the June Board packet.

The objectives of the subcommittee include:
1. Reviewing existing data and research on healthcare access for individuals experiencing homelessness.
2. Investigating the feasibility of collecting relevant data to assess outcomes for individuals who accept shelter versus those who decline.
3. Identifying any barriers to healthcare access and potential strategies for improvement.
4. Collaborating with relevant stakeholders, including the HOT staff, Navigation Center, and other community partners.

Here are points found in our literature review: Please note, the points are intended to summarize recurring themes in the literature. The quotes are chosen to exemplify the theme and are not a critique of that position.

1. Forced removal or displacement from encampments is associated with an increase in healthcare risks. One study notes a subset of clients using heroin are potentially at an increased risk of morbidity and mortality. (1, 2, 3)

"Population-Level Health Effects of Involuntary Displacement of People Experiencing Unsheltered Homelessness Who Inject Drugs in US Cities
Continual involuntary displacement may contribute to between 15.6% and 24.4% of additional deaths.
Involuntary displacement of people experiencing homelessness may substantially increase drug-related morbidity and mortality." (2)

2. Removal of encampments is associated with poor outcomes including prolongation of homelessness. (1, 6, 7, 13)

"The study makes evident how criminalization not only fails to reduce homelessness in public space, but also perpetuates homelessness, racial and gender inequality, and poverty even once one has exited homelessness." (7.)

3. Housing is health. (3, 5)

USICH Releases New Encampment Guidance for Communities April 28, 2024
"Housing is health care, and without it, people struggle to survive." (5)

4. The known causes of homelessness are poverty and the lack of affordable housing (4)

"(First is) the shortage of affordable housing nationwide and acute shortages in certain metropolitan areas combined with the lack of sufficient resources to prevent and end homelessness in certain cities" (4)

5. It is important to understand factors which influence solution-building efforts.

    a. Cost (6)

U.S. Department of Housing and Urban Development | Office of Policy Development and Research
Exploring Homelessness Among People Living in Encampments and Associated Cost
City Approaches to Encampments and What They Cost
" The report also indicates that responding to encampments is resource-intensive for local governments, costing cities between $1,672 and $6,208 per unsheltered individual per year and requiring coordination across government and non-governmental actors. Since HUD funding is largely not being used for encampment related activities, city governments cover the vast majority of these costs out of their own budgets.

As of 2019, homeless encampments were appearing in numbers not seen in almost a century. The growth of encampments mirrored the increase in unsheltered homelessness overall and seemed to reflect a complex set of societal factors, including a lack of affordable housing and the persistence of deep poverty and chronic homelessness." (4)

b. Policy influenced by political and community pressures (14)

Pacifica Tribune - Addressing real cause of our homeless crisis
Mar 14, 2023 0
"Gorfido provides additional thoughts: "In 2015, the U.S. Department of Housing and Urban Development conducted the most extensive survey ever undertaken regarding homelessness, and found that, at a minimum, 25 percent of Americans are homeless. Of homeless Americans, 45 percent are mentally ill. Americans endorse holding stigmatizing beliefs regarding people who have mental illness — (s)pecifically, beliefs that mentally ill people are dangerous, incompetent, punishable, commit crimes and that they are shameful and blameworthy. With these beliefs in combination with the overall American perception of homeless people being deviant, it is no surprise that the United States does not have or has not chosen to implement better policies to help this population."

c. The law: in transition as we await feedback from our Supreme Court

Protecting the Health and Well-Being of People Living Unsheltered by Stopping Forcible Displacement of Encampments Policy Date: November 14, 2023 Policy Number: 20234
"The Ninth Circuit Court of Appeals in 2012 held that state destruction of a homeless individual's personal property, even when temporarily unattended, was an unreasonable seizure and a Fourth Amendment violation.
More recently, in Martin v. Boise and Johnson v. Grants Pass, the 9th Circuit held that cities cannot enforce anti-camping ordinances if they do not have enough shelter beds available for their homeless populations.

In December 2022, a U.S. magistrate ruled against the City of San Francisco on behalf of seven plaintiffs represented by the Coalition on Homelessness and the American Civil Liberties Union. The judge's emergency injunction banned the San Francisco Police Department and the city from clearing encampments.

A Superior Court judge in Seattle, Washington, ruled in July 2023 that the city's regulations regarding displacements were unconstitutional (the city was using an overly broad definition of "obstruction"), resulting in excessive encampment displacements. Courts so far are upholding the Constitution's Eighth Amendment by prohibiting cities from punishing people for the mere act of sleeping outside or for sleeping in their vehicles at night when there is no other place for them to go.

The mandate of the United Nations (UN) Special Rapporteur on the right to adequate housing was established by the former Commission on Human Rights in Resolution 2000/9 and renewed in Human Rights Council Resolution 52/10.[5,6] The argument for housing as a human right is based on three international legal instruments: the UN's 1948 Universal Declaration of Human Rights; the 1966 International Covenant on Economic, Social and Cultural Rights; and the 1966 International Covenant on Civil and Political Rights. Despite an international human right to decent housing established by the UN, few states have protected this right by providing housing through mechanisms outside of market forces". (1)

6. There are hopeful models which are potentially more cost effective and successful at helping our unhoused become housed.

a. Housing First (1, 5, 8, 9)

" Peer-reviewed evidence supports several strategies to end homelessness and stop or mitigate the harm caused by encampment displacements, including Housing First, permanent supportive housing (PSH), rapid rehousing (RRH), engagement and individual choice, and tailoring services to subpopulations, including people with physical or mental health disabilities". (1)

b. Harm reduction (4, 9, 10, 11)

“Our findings suggest that access to harm reduction housing promotes recovery among encampment residents. We found that harm reduction housing diminished concerns related to health and safety for nearly all participants who were placed at these sites, whereas displacement exacerbated health or safety concerns for most others. Unsheltered homelessness has been shown to heighten the risk for serious health and safety concerns compared with sheltered homelessness. Previous studies show that involuntary displacements and criminalization of homelessness may further heighten these risks, suggesting an urgent need for alternative interventions. Our findings bolster the growing evidence of the efficacy of Housing First models and suggest that harm reduction housing may be particularly well suited for people leaving encampments.” (10)

c. Service-enriched models with wrap around services (4, 9, 11)

“We provide an overview of the pilot and evaluation measures used for an independent evaluation of the Encampment Resolution Pilot (ERP) wherein the City of Philadelphia closed two homeless encampments in May 2018 and sought to assist those displaced by the closures with housing and treatment services. The evaluation used the Rapid Assessment, Response, and Evaluation method to collect qualitative findings on service use barriers and facilitators from open-ended interviews with people staying in the encampments (N = 27) and service providers (N = 10). We assessed how the ERP allowed providers to “push the system” by removing access barriers, and providing amenable, effective, and accessible housing and drug treatment services that led to more widely adopted best practices. However, there was a clear need for additional supportive services and aftercare for those exiting treatment. Providers also cited a need for more integrated medical and mental health services.” (11)

d. Human rights approach involving residents (5, 6, 9)

“Research has shown that, once housed, formerly homeless clients with mental health issues exhibit substantial improvements to their

social and psychological integration if they can identify one or more ‘‘locus of meaningful activity’’ within their housing or neighborhood (Yanos et al., 2004). Staff strives to make the Vendome a ‘‘locus of meaningful activity ’’where clients feel a sense of proprietorship and responsibility. “ (9)

7. Next steps to consider for implementation of our County ordinance

a. Mitigate risk to encampment residents to be moved: provide navigation through the complex systems of housing, health/mental health/substance use resources, legal resources

b. Collect data to evaluate efficacy of the program and further program improvement. Data on outcome of those who decline shelter is lacking.

c. Involve the voices of the impacted - our unhoused - in decision making.

d. Strengthen services that quicken the path to permanent housing to reduce recidivism.

e. Consider use of subsidies and a living wage to counter poverty and housing affordability.

Literature reviewed: Please note - this is not intended to be a comprehensive list of current literature.

1. Protecting the Health and Well-Being of People Living Unsheltered by Stopping Forcible Displacement of Encampments Policy Date: November 14, 2023 Policy Number: 20234

2. JAMA | Original Investigation
Population-Level Health Effects of Involuntary Displacement of People Experiencing Unsheltered Homelessness Who Inject Drugs in US Cities
Joshua A. Barocas, MD; Samantha K. Nall, MPH; Sarah Axelrath, MD; Courtney Pladsen, DNP; Alaina Boyer, BS; Alex H. Kral, PhD; Ashley A. Meehan, MPH; Alexandra Savinkina, MSPH; David Peery, JD; Michael Bien, MPH; Christine Agnew-Brune, PhD; Jesse Goldshear, MPH; Joey Chiang, MD; Benjamin P. Linas, MD;

Gregg Gonsalves, PhD; Ricky N. Bluthenthal, PhD; Emily Mosites, PhD; for the NHBS Study Group

3. Volume 2, December 2022, 100064 Qualitative Research on Health

Harms of encampment abatements on the health of unhoused people
Jamie Suki Chang a, Philip Boo Riley b, Robert J. Aguirre 1, Katherine Lin a c, Marius Corwin a d, Nicole Nelson a, Madison Rodriguez e

4.U.S. Department of Housing and Urban Development | Office of Policy Development and Research
Exploring Homelessness Among People Living in Encampments and Associated Cost : City Approaches to Encampments and What They Cost
Submitted by: Lauren Dunton Jill Khadduri Kimberly Burnett Nichole Fiore Will Yetvin Abt Associates
February 2020

5.USICH Releases New Encampment Guidance for Communities
April 28, 2024
A Message From USICH Director Jeff Olivet

6. ORIGINAL ARTICLE
International Journal on Homelessness, 2023, 3(2): page 124-138.
'Forced to Become a Community': Encampment Residents ' Perspectives on Systemic Failures, Precarity, and Constrained Choice
Nicholas Olson 1|Bernadette (Bernie) Pauly, RN, Ph.D 1|

7. Punishing the Poorest How the Criminalization of Homelessness Perpetuates Poverty in San Francisco
Coalition of Homelessness, San Francisco
PUBLICATION DATE: 2015 LOCATION: San Francisco, California, USA

8. 2024
Basic Income Grants to Reduce Homelessness in Los Angeles

Gary Blasi Professor of Law Emeritus, UCLA Law School
Benjamin F. Henwood Professor, USC
Suzanne Dworak-Peck School of Social Work
Sam Tsemberis Executive Director, Pathways Housing First Institute;
HS Associate Professor, Psychiatry
Dan Flaming President, Economic Roundtable.

9.Supportive housing best practices in a mid-sized US urban community
Brian Greenberg, Sophia Korb, Kristen Cronon and Robert Anderson

10. By Michael Mayer, Yesenia Mejia Urieta, Linda S. Martinez, Miriam Komaromy, Ursel Hughes, and Avik Chatterjee
Encampment Clearings And Transitional Housing: A Qualitative Analysis Of Resident Perspectives
(Two groups: harm reduction housing vs displacement and perceived impact - negative outcome of encampment sweep including death)
doi: 10.1377/hlthaff.2023.01040 HEALTH AFFAIRS 43,
NO. 2 (2024): 218–225

11. At the Intersection of Homeless Encampments and Heroin Addiction: Service Use Barriers, Facilitators, and Recommendations from the City of Philadelphia's Encampment Resolution Pilot
January 2021Social Work in Public Health 36(6):1-14
January 202136(6):1-14
DOI:10.1080/19371918.2021.1877591

12. Illegal Homeless Encampments In California:
Using The COM-B Framework to Transform A Public Health Nuisance Into A New Housing Development Model
Desiree Gonzales Orozco
School of Nursing and Health Professions, University of San Francisco
MPH 683: Integrated Learning Experience (ILEX)
Dr. Kelly McDermott
August 12, 2022

13. Rankin, S. (2019). Punishing homelessness. New. Criminal Law Review, 22(1), 99-135. https://doi. org/ 10. 1525/ nclr. 2019. 22.1. 99

Rankin, S. (2020). Civilly criminalizing homelessness. Harvard Civil Rights - Civil Liberties Law Review.
http://dx.doi.org/10.2139/ssrn.3677531

14. 3/14/23 Pacifica Tribune. Addressing real cause of our homeless crisis. Suzanne Moore

15. International Journal of Politics, Culture, and Society (2023)
36:35–56 https://doi.org/10.1007/s10767-022-09426-x
Reclaiming Placemaking for an Alternative Politics of Legitimacy and Community in Homelessness
Gordon C. C. Douglas1
Accepted: 28 April 2022 / Published online: 23 May 2022

Tab 6
HCH/FH 2025-2027 RFP

COUNTY OF SAN MATEO
HEALTH SYSTEM

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www.facebook.com/smchealth

DATE: June 13, 2924

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

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: BOARD REVIEW AND DISCUSSION OF HCH/FH REQUEST FOR PROPOSALS (RFP) FOR SERVICES FOR 2025 THROUGH 2027

Previously, this Board has approved the set of services and funding ranges for prospective services for the Homeless and Farmworker populations for the time period of Calendar year 2025 through 2027. Recognizing that a number of these services may best be delivered though community-based partner programs, HCH/FH staff has developed an RFP to solicit proposals to deliver these services.

Today's action is to provide the Board with the opportunity to review, comment and discuss the scope of work for the RFP. Staff has included the services specified by the Board that are likely best provided by non-county entities. The intent is simply for the Board to understand how this RFP process, and this scope of work, will support the Board's decisions on services to be delivered.

Of note for the Board, it is intended for proposals to be received by the end of July 2024. Thereafter, evaluation groups – to likely include some Board members – will review and evaluate the proposals, leading to recommendations to the Board for proposals to accept and turn into contracts for services. The Board can review the proposed schedule of activities in the timeline at the beginning of the scope of work.

There is no specific action required by the Board at this time.

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