HEALTH CARE FOR THE HOMELESS/FARMWORKER HEALTH PROGRAM (HCH/FH)
Co-Applicant Board Meeting
Fair Oaks Health Center- Redwood City
September 10, 2015, 9:00 A.M - 11:00 A.M.

AGENDA

A. CALL TO ORDER		Robert Stebbins		**9:00 AM**
B. HRSA PRE-TA				
1.	Discussion with HRSA consultant on TA	Larry Peaco (phone)		**9:02 AM**
C. CLOSED SESSION				
1.	No Closed Session this meeting			
D. PUBLIC COMMENT				**10:00 AM**
	Persons wishing to address items on and off the agenda			
E. CONSENT AGENDA				**10:02 AM**
1.	Meeting minutes from August 13, 2015 with handouts from meeting		**TAB 1**	
2.	Program Calendar		**TAB 2**	
F. BOARD ORIENTATION				
1.	No Board Orientation items this meeting.			
G. REGULAR AGENDA				
1.	Consumer Input to Board	Linda and Others	**TAB 3**	**10:05 AM**
2.	Ad Hoc Committee Reports	Committee Members		**10:15 AM**
	i. *Transportation*			
	ii. *Health Navigation*			
	iii. *Board Composition*			
	a. ***Action Item –Request to Appoint New Member***		**TAB 4**	
	Documents will be available at meeting. Time will be provided for review prior to consideration.			
3.	HCH/FH Program- Renew Board members expiring	Jim Beaumont	**TAB 5**	**10:20 AM**
	i. Action Item –Re-Appointment of Board Members			
	Documents will be available at meeting. Time will be provided for review prior to consideration.			
4.	Report & Discussion on Operational Site Visit Report	Pat Fairchild (phone) Jim Beaumont	**TAB 6**	**10:25 AM**
5.	HCH/FH Program Director's Report	Jim Beaumont	**TAB 7**	**10:40 AM**
6.	HCH/FH Program Budget/Finance Report	Jim Beaumont	**TAB 8**	**10:45 AM**
7.	HCH/FH Program QI Committee Report	Linda Nguyen	**TAB 9**	**10:50 AM**
	i. Action Item –Request to Approve QI Committee Recommendations			

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.

8. HCH/FH Program- Review Proposals for remaining funds — Jim Beaumont — **TAB 10 10:55 AM**

9. Budget tool presentation ***Instructions given at meeting*** — Jim Beaumont — **11:00 AM**

H. OTHER ITEMS

1. Future meetings – every 2nd Thursday of the month (unless otherwise stated)

ii. Next Regular Meeting – October 8, 2015; 9:00 A.M. – 11:00 A.M. at SMMC- San Mateo

I. ADJOURNMENT — Robert Stebbins — **11:00 AM**

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Parking Lot

- Bylaws Review
  (as needed)
- Annual Tactical Plan
  (no current deadline)
- Scope Discussion
  (no deadline set)
- Transportation
  (no deadline set)
- Program Website
  (no deadline set)
- How to engage our populations
- Respite Care

TAB 1

Meeting Minutes (Consent Agenda) with handouts from August 13, 2015 meeting

Healthcare for the Homeless/Farmworker Health Program (Program)
Co-Applicant Board Meeting Minutes
Thursday, August 13, 2015
Puente- Pescadero

Co-Applicant Board Members Present	County Staff Present	Members of the Public
Robert Stebbins, Chair	Linda Nguyen, HCH/FH Program Coordinator	
Daniel Brown	Glenn Levy, County Counsel	
Brian Greenberg	Frank Trinh, HCH/FH Medical Director	
Paul Tunison	Pernille Gutschick, BHRS	
Kerry Lobel, Vice Chair	Jonathan Mesinger, SMMC- Coastisde Clinic	
Steve Carey		
Jim Beaumont, HCH/FH Program Director (Ex-Officio)		
Beth Falls,		
Tayischa Deldridge		

Absent: Eric Brown, Julia Wilson, Kathryn Barrientos,

ITEM	DISCUSSION/RECOMMENDATION	ACTION
Call To Order	Robert Stebbins called the meeting to order at 9:37 A.M. Everyone present introduced themselves.	
Public Comment	No Public Comment at this meeting.	
Consent Agenda	All items on Consent Agenda (meeting minutes from and the Program Calendar) were approved. Please refer to TAB 1, 2	Consent Agenda was MOVED by Steve SECONDED by, Dan and APPROVED by all Board members present.
Board Orientation:	No Board Orientation for this meeting.	
Regular Agenda: Transportation *Sub-committee reports*	Oral Report was provided by Steve: Committee is still researching the options that include transportation via car and taxi voucher program in the effectiveness to serve all County residents including the Coastside. Will report back on progress on next meeting.	

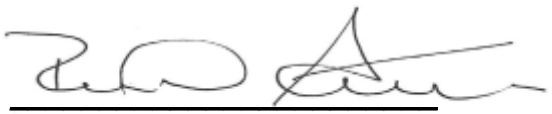
Patient Navigator Sub-committee reports	No report	
Board orientation Sub-committee reports	Beth provided an oral report: Currently working with County staff to research current Board recruitment policies. Dan working on draft letter to send out to recruit current Municipal Board members. Discussion on efforts needed to recruit (farmworker) consumers that included: • Changing Board meeting times to evening hours and locating to Coastside majority of time. • Barriers to consumer Farmworker recruitment: language, transportation, childcare • Majority of Board members willing to reschedule meetings to evenings • Coastside Clinic Manager offered to provide translation services if needed for consumers	
QI Committee Report ***Request to Approve HCH/FH Program QI Plan***	Dr. Frank Trinh, Medical Director for the HCH/FH Program summary of QI Committee efforts from last meeting. Review of Diabetes outcome reports for population wide data for all Homeless and Farmworker patients indicated important findings: • Homeless population is older than Farmworker population overall • Among farmworkers, more females are being seen- showing need to conduct more outreach to male farmworkers to come in for services. • Among homeless (street ,shelter and transitional) have far worse outcomes compared to other homeless categories- indicating that the more unstable ones housing is the more likely they will have poor health outcomes • A substantial amount are not getting tested (20% homeless and 11% farmworkers), may also be a result because the Mobile Van does not draw labs currently. • Extensive case management may be needed to conduct more outreach to patients • Next QI Committee meeting will come back with further recommendations on the Diabetes reports *Please refer to TAB 3 on the August 13 Board meeting packet.*	
Regular Agenda: HCH/FH Program *Director's Report*	A brief report was presented indicating: • Grant conditions summary of the 4 current conditions under 60 days due August 16th. • From NOA Grant period extension the program anticipates having additional funding looking to spend before end of the year. Members can submit expense ideas to staff	Linda- email board members suggestions on funding to be considered

	for consideration for next Board meeting. • Management Analyst position announced and currently working on holding interviews. • HRSA TA session is confirmed for September 22 & 24th, will confirm the times of the day. *Please refer to TAB 4 on the August 13 Board meeting packet*	at next Board meeting
Regular Agenda: HCH/FH Program *Budget & Financial Report*	Jim Beaumont, Director, reported on program: • Based on the information available, the program has expended $1,303,094 through July 31, 2015. • This represents about 64% of the current grant year and expenditures are at about 54% of the GY budget. These numbers have been updated to the new total grant award based on NOA 14-14. • Program continues to work on a number of options that hold promise for utilizing one-time or short-term expenditures and providing longer-term or ongoing benefits. *Please refer to TAB 5 on the August 13 Board meeting packet*	
Regular Agenda: ***Request to Approve Clinical Guidelines and direct Medical Director to develop 12 for HCH/FH target pop***	Conversation on clinical guidelines documents passed out during meeting included: • Diabetes measures and suggestions on getting tested even if patients are not identified as having Diabetes • Lead testing for farmworker children as a QI measures • Board members sparked interest in continuing the conversation on Clinical Guidelines at the next Board meeting **Action item: Request to Approve *the current SMMC Clinical Guidelines and direct the HCH/FH Medical Director to develop at least 12 common and Chronic conditions for the HCH/FH target populations.*** *Please refer to TAB 6 on the August 13 Board meeting packet* *Additional documents available at Board meeting for review.*	MOVED by Dan SECONDED by, Tay APPROVED by Beth, Dan, Steve, Brian, Tay Voted No by Robert, Kerry and Paul Motion approved with majority vote

Regular Agenda: *RFP Discussion and Review*	Conversation about the current RFP draft that included: • RFP will be release in next week or so. • Similar to RFP from 2 years ago, with substantial edits to make simpler. • County Counsel (Glen) suggested working with staff to make some of the current language simpler and clear *Please refer to TAB 7 on the August 13 Board meeting packet* *.*	Glen to work with staff on language of RFP
Regular Agenda: – ***Request to Approve* SAC submission in advance, with a few members approved to work on final draft.**	Conversation on the current SAC draft in Board packet. • Funding to be about a little over $2 million worth. • Some members will submit their revisions to staff • Working group agreed to work with grant writer on final SAC draft: Robert, Beth, Brian ***Request to Approve* SAC submission in advance, with a few members approved to work on final draft.** *Please refer to TAB 8 on the August 13 Board meeting packet* Additional documents at meeting for review.	MOVED by Beth SECONDED by, Kerry and APPROVED by remainder of Board members
Regular Agenda: *Request to Approve HCH/FH Program* – ***Request to Approve Program Scope***	Under the Bylaws Article 3.E, the Board has the authority and responsibility to set the scope and availability of services to be delivered by and the location and hours of operation of the Program. This responsibility is also represented by HRSA Program Requirements #2 – Required and Additional Services, and #4 – Accessible Hours of Operation/Location. Further, at the Board meeting of December 11, 2014, the Board established Program Policy for the Board to review and approve, annually, to coincide with submission of the program's Service Area Competition (SAC) application or the Budget Period Progress Report (BPR) submission. It is further established in the policy that the Board can undertake this review at additional other times as the Boards deems appropriate. With the SAC submission in preparation and due by September 1, 2015, the program calendar has established the August Board meeting as the time for Board review and approval of the Program's Scope (aka Services, Sites and Hours). This request is for the Board to vote to approve the attached Forms 5A & 5B. Approval of this item requires a majority vote of the Board members present.	MOVED by Beth SECONDED by, Kerry and APPROVED by remainder of Board members

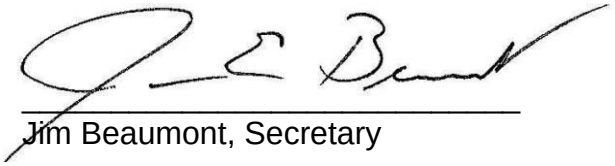
	Action item: Request to Approve Program Scope *Please refer to TAB 9 on the August 13 Board meeting packet*	
Regular Agenda: *Request to Approve HCH/FH Program* – ***Request to Approve dismantling of sub-committees***	As part of conducting Board business, it is necessary on occasion for the Board to establish Ad Hoc Committees for the purpose of effective and efficient Board operation. By definition, such Ad Hoc Committees are limited to the subject and directives as established in their creation, and are limited in duration. In the establishment of many previous Ad Hoc Committees, the establishing Board Action did not designate a termination date for the committees' efforts. As such, there are presently numerous committees that have been created by Board action and have completed the business for which they were formed, but are still on record as being in existence. Conversation about the need to still research Respite Care, request to place on Parking Lot. **Action item: Request to Approve *dismantling of sub-committees*** *Please refer to TAB 10 on the August 13 Board meeting packet*	MOVED by Paul SECONDED by, Beth and APPROVED by remainder of Board members Linda- move Respite Care to Parking Lot
Regular Agenda: Contractors 2nd Quarter Report Updates	The Health Care for the Homeless/Farmworker Health (HCH/FH) Program has contracts with four community based providers, plus two County-based programs for the 2015 grant year. Contracts are for primary care services (Ravenswood Family Health Center and Public Health Mobile Clinic), dental care services (Ravenswood Family Health Center), and enabling services such as case management and eligibility assistance (InnVision Shelter Network, Behavioral Health & Recovery Services, Puente de la Costa Sur, and Samaritan House). We are half way through the contract year and most contractors are about at 50% of their target goals, though it becomes more difficult to spend down money at end of year to find new clients to serve. *Please refer to TAB 11 on the August 13 Board meeting packet*	
Regular Agenda: Discussion on new population wide data	The program received a request from HRSA to produce universal data for our entire homeless and farmworker population for annual UDS report submission, rather than the 70 chart reviews that the program has submitted in the past. We have been working with our Business Intelligence team to produce reports for 10 of the outcome	

	measures to be ready for review by July 1, 2015. *Please refer to TAB 12 on the August 13 Board meeting packet*	
Regular Agenda: Discussion on clinic utilization	Tabled for next meeting	
Regular Agenda: Budget tool presentation	Tabled for next meeting	
Regular Agenda: Consumer Input	Kerry handed out document on progress of Pescadero Clinic. Other consumer input handouts to be discussed at next meeting.	
Adjournment	Time _11:35 a.m._____	Robert Stebbins



Robert Stebbins, Chair

August 13, 2015_____
Date



Jim Beaumont, Secretary

August 13, 2015_____
Date

SMMC Community Acquired Pneumonia: Empiric Therapy for Adults

(Following guidelines are based on IDSA/ATS Guidelines in adults with normal renal function)

Non-ICU Pneumonia Patient	ICU Pneumonia Patient
Ceftriaxone 1g IV q24 + Azithromycin 500mg IV q24 Or **Ceftriaxone 1g IV q24 + Doxycycline 100 mg IV q12** Or ***For beta lactam allergy*:** **Levofloxacin 750 mg IV q24**	**Ceftriaxone 1g IV q24+ Levofloxacin 750 mg IV q 24** Or **Ceftriaxone 1g IV q24+ Azithromycin 500 mg IV q24** Or ***For suspected aspiration pneumonia*:** **Substitute Ampicillin/sulbactam 3g IV q6 for Ceftriaxone** ***For beta lactam allergy*:** **Aztreonam 1g IV q8 + Levofloxacin 750 mg IV q24**
These antibiotics are acceptable for NON-ICU patients with pseudomonal risk only.* (Must document this risk in admission H&P): **Piperacillin/Tazobactam 4.5 g IV q6** (OR Cefepime 2g IV q12) **AND Levofloxacin 750 mg IV q 24** Or **Piperacillin/Tazobactam 4.5g IV q6** (OR Cefepime 2g IV q12) **+ Gentamicin 7 mg/kg IV‡ AND Azithromycin 500 mg IV q24** (preferred in patients recently treated with fluoroquinolones) Or **Piperacillin/Tazobactam(IV) 4.5 g IV q6** (OR Cefepime 2g IV q12) **AND Gentamicin 7 mg/kg IV‡ AND Levofloxacin 750 mg IV q24** (preferred in patients recently treated with fluoroquinolones) ***For beta lactam allergy*:** **Substitute Aztreonam 2g IV q8 for Piperacillin/Tazobactam or Cefepime.**	***For high risk of pneumonia secondary to pseudomonas.* (Must document this risk in admission H&P)*** **Piperacillin/Tazobactam 4.5 g IV q6** (OR Cefepime 2g IV q12) **AND Levofloxacin 750 mg IV q24** Or **Piperacillin/Tazobactam 4.5 g IV q6** (OR Cefepime 2g IV q12) **AND Gentamicin 7 mg/kg IV q24‡ AND Azithromycin 500 mg IV q24** (preferred in patients recently treated with fluoroquinolones) Or **Piperacillin/Tazobactam(IV) 4.5 g IV q6** (OR Cefepime 2g IV q12) **AND Gentamicin 7 mg/kg IV‡ AND Levofloxacin 750 mg IV q24** (preferred in patients recently treated with fluoroquinolones) ***For beta lactam allergy*:** **Substitute Aztreonam 2g IV q8 for Piperacillin/Tazobactam or Cefepime.** ***For high risk of pneumonia secondary to MRSA.** (Must document this risk in admission H&P)*** **Add Vancomycin 1g IV q12** **OR Linezolid 600 mg IV q12**

- *****At risk for pseudomonas due to: structural lung diseases such as chronic bronchiectasis, cystic fibrosis, repeated exacerbations of COPD leading to frequent steroid use, prior antibiotic therapy, febrile neutropenia and pulmonary infiltrates, septic shock, underlying malignancy, or organ failure.
- **At risk for MRSA CAP due to end-stage renal disease, injection drug use, prior influenza, and prior antibiotic therapy (especially with fluoroquinolones)
- ‡ In critically ill patients, it is recommended that the initial dose of gentamycin be 7 mg/kg, with peak serum level between 16 and 24 mcg/mL. Assuming clinical improvement and continued normal renal function, dose could be decreased to 5.1 mg/kg/day during first few days of therapy. Peak level should be drawn 60 minutes after start of 30-45 minute infusion and should be drawn no sooner than 30 minutes after end of infusion (Mandell, Principles and Practice of Infectious Diseases, 7th Edition)

San Mateo Medical Center- Aminoglycoside Dosing Guidelines

Aminoglycosides are concentration dependent antibiotics, meaning that as aminoglycoside concentration increases, the rate and extent of bacterial killing increases. Optimum bactericidal activity for the aminoglycosides is achieved when the exposure concentration is approximately 8 to 10 times the minimum inhibitory concentration (MIC). Dosing adjustments should be based upon the results of serum drug concentration monitoring. Targeted peak serum concentrations are intended to take advantage of the pharmacodynamic properties to optimize the potential for efficacy, while specific trough concentrations are targeted to avoid concentration-related toxicity. These guidelines refer to dosing of aminoglycosides for the treatment of typical bacterial infections. Dosing for other indications, such as mycobacterial infections, should be done by an Infectious Disease physician in collaboration with a Pharmacist.

1. Determine creatinine clearance and dosing weight

a. Determine the dose using ideal body weight (IBW). An ideal body weight calculator is available on Up to Date or Global RPH. For obese patients (defined as actual weight >20% over ideal body weight), dosage requirement may best be estimated using adjusted body weight (ABW) of: IBW + 0.4(actual weight – IBW). For underweight patients, use actual weight to calculate dose.

b. Calculate creatinine clearance with the Cockcroft-Gault equation using an ideal body weight (IBW) or adjusted body weight if the patient is obese (actual weight >20% over IBW)

$$\text{CrCL (mL/min)} = \frac{(140 - \text{age}) \times \text{IBW}}{\text{SCr} \times 72} \quad (\times 0.85 \text{ for females})$$

IBW (male) = 50 kg + (2.3 x height in inches >60 inches)
IBW (female) = 45 kg + (2.3 x height in inches >60 inches)
ABW (kg) = IBW + 0.4(Actual weight – IBW)

2. Aminoglycoside Dosing Strategies

Because of comparable efficacy and safety with superior pharmacodynamic profiles and greater ease of administration, extended-interval (instead of traditional intermittent) aminoglycoside dosing is often preferred for patients with suspected or documented moderate to severe infections due to gram-negative aerobic bacteria and among whom this method has been clinically evaluated. These include:

- immunocompetent, nonpregnant adults and children >3 months of age with
- urinary tract infections
- intraabdominal infections
- respiratory tract infections
- gynecologic infections (including pelvic inflammatory disease)
- soft-tissue infections
- bacteremia
- women with postpartum endometritis
- febrile neutropenia patients with malignancy (adults and children)

a. High-dose Extended Interval Therapy (Once Daily Dosing)

i. Extended-interval aminoglycoside has efficacy comparable with traditional intermittent administration but offers three potential advantages:
   - Possibility of decreased nephrotoxicity, based primarily on data from animal models
   - Ease of administration and serum concentration monitoring
   - Reductions in administration and monitoring-related costs

Extended-interval dosing of aminoglycosides takes advantage of the post-antibiotic effect and concentration-dependent killing. The post-antibiotic effect refers to the persistent inhibitory effect against many gram-negative aerobic organisms that is seen after drug clearance.

ii. The Hartford nomogram method utilizes high-dose, once daily dosing to optimize the peak/MIC ratio in the majority of clinical situations by administering a dose of 7 mg/kg of either gentamicin or tobramycin. The second method of extended-interval therapy utilizes 5 mg/kg of gentamicin or tobramycin in patients without renal dysfunction.

iii. Exclusion criteria for High-Dose Extended Interval Therapy
   1. Renal insufficiency (CrCl <40 mL/min or rapidly declining renal function or needing dialysis)
   2. Pregnancy
   3. Synergy for gram-positive infections
   4. Ascites
   5. Burns (>20%)

b. Conventional/Traditional Dosing

i. Traditional dosing includes reduced doses and frequent administration of aminoglycosides using pharmacokinetic parameters to determine dose and frequency to achieve target peak and trough values.

c. Gram positive-synergy Dosing

i. Synergy dosing is a low dose of aminoglycoside in conjunction with an antimicrobial agent that exhibits activity against the cell wall of Gram-positive bacteria (i.e. beta-lactams, glycopeptides) for the treatment of Gram-positive infections. Lower concentrations of aminoglycosides are targeted when used in combination with other agents to treat serious gram-positive infections, whether traditional or extended dosing intervals are used. Traditional intermittent dosing of gentamycin for synergy should follow traditional dosing and monitoring above, and is generally used for invasive enterococcal infections, such as endocarditis in the absence of high level aminoglycoside resistance. Extended interval dosing of gentamicin (3mg/kg/day as a single daily dose) should be used for the treatment of native valve endocarditis due to penicillin sensitive Streptococcus viridans.

3. Dosing Guidelines

a. High Dose Extended Interval Empiric Dosing - A loading dose is not needed in the setting of extended-interval aminoglycoside administration.

b. Gentamycin & Tobramycin Initial Dosing

Table 1: Gentamycin and Tobramycin Initial Dosing

Creatinine Clearance (mL/min)	High-Dose Extended-Interval* (Gent/Tobra)	Conventional/Traditional (Gent/Tobra)	Synergy** (Gent/Tobra)
>60	4-7 mg/kg Q24H	1.7 mg/kg Q8H	1 mg/kg Q8H
40-59	4-7 mg/kg Q36H	1.7 mg/kg Q12H	1 mg/kg Q12H
30-39	4-7 mg/kg Q48H	1.7 mg/kg Q24H	1 mg/kg Q24H
20-29	Not recommended	1.7 mg/kg Q24H	1 mg/kg Q24H
<20	Not recommended	2 mg/kg load, then dose by level	1 mg/kg load, then dose by level
Hemodialysis	Not recommended	2 mg/kg load, then 1.5 mg/kg post-HD; Redose for post-HD Cp <1mg/L or pre-HD Cp <1 mg/L (mild UTI) Cp <2-3 mg/L (moderate-severe UTI) Cp <3-5 mg/L (severe GNR infection)	1 mg/kg Q48-72H; Redose for pre-HD or post-HD Cp <1 mg/L
CRRT	Not recommended	1.5-2.5 mg/kg Q24-48H	1 mg/kg Q24H, then by level

*See Hartford nomogram for monitoring of once-daily dosing regimens

**Alternative for synergy: 3 mg/kg Q24H for Streptococci and *Streptococcus bovis* endocarditis

c. Traditional Dosing Loading dose- The initial loading dose of gentamycin or tobramycin is determined by type or site of infection, for which different peak serum gentamicin concentrations are desired.

Table 2: Recommended loading dose for traditional, intermittent dosing of gentamicin or tobramycin in adults		
Site of infection or indication	Desired peak concentration (Conventional units)	Loading dose, mg/kg
Gentamicin synergy with beta-lactams for treatment of serious gram-positive infections	3 to 4 mcg/mL	1 (initial dose, not a loading dose)
Uncomplicated lower urinary tract infection	2 to 4 mcg/mL	1 (initial dose, not a loading dose)
Gram-negative sepsis or other serious gram-negative infections, including pseudomonal infection, gram-negative pneumonia, and acute life-threatening gram-negative infection in a critically ill patient	7 to 10 mcg/mL	2.5 to 3

d. **Amikacin Initial Dosing (Table 2):**

i. Amikacin Traditional Dosing- The usual loading dose is 7.5mg/kg with a subsequent maintenance dose of 15mg/kg per day. The maintenance dose is typically given in divided doses every 8-12 hours for patients with normal renal function.

Table 2: Amikacin Dosing		
Creatinine Clearance (mL/min)	**High-Dose Extended-Interval* (Amikacin)**	**Conventional/Traditional (Amikacin)**
>60	15-20 mg/kg Q24H	5-7.5 mg/kg Q8H
40-59	15 mg/kg Q36H	5-7.5 mg/kg Q12H
30-39	15 mg/kg Q48H	5-7.5 mg/kg Q24H
20-29	Not recommended	5-7.5 mg/kg Q24H
<20	Not recommended	5 mg/kg load, then dose by level
Hemodialysis	Not recommended	5-7.5 mg/kg post-HD
CRRT	Not recommended	10 mg/kg load, then 7.5 mg/kg Q24-48H

See Hartford nomogram for monitoring of once-daily dosing regimens – divide level by half then plot on graph

4. Drug Concentration Monitoring

a. High Dose Extended Interval Drug Concentration Monitoring- Concentrations should be targeted using below nomogram that extrapolates desired dosing interval based on a single drug concentration. Drug level should be repeated if changing renal function or duration of therapy beyond 7-10 days. Sampling time should be documented on the electronic laboratory requisition. Extended interval dosing should also be specified in this requisition. **All gentamycin and tobramycin levels should be ordered STAT so that timely testing can be done in our local contracted laboratory.**

b. Traditional Dosing Drug Concentration Monitoring -Serum concentrations should be determined after two to three doses from the initiation of therapy or after adjustment of the dose. Trough concentrations are measured within 30 minutes of the next dose and peak concentrations 30 to 45 minutes after the end of an intravenous infusion or approximately 60 minutes after an intramuscular injection. Sample times and traditional dosing should be documented on the electronic laboratory requisition. Desired peak concentrations for gentamicin and tobramycin are dependent upon the indication and site of infection (Table 2). ~~Trough concentrations for gentamicin and tobramycin should be below 2 mcg/mL.~~ Target serum concentration for traditional dosing of amikacin are a peak of 20-30 mcg/mL and a trough of < 8 mcg/mL.

c. **Timing of drug levels:**

Table 3 a: High-Dose Extended-Interval
A. Initial level testing: Single level drawn 8-12 hours after the first dose (Only applicable for 7 mg/kg – plotting doses lower or higher than 7 mg/kg may under or overestimate clearance) B. Follow up trough level testing i. Trough monitoring (30-60 minutes prior to dose) should be considered in patients demonstrating acute changes in renal function or suspicion of extended interval failure ii. Maintenance trough levels should be monitored at least once weekly

Table 3 b: Conventional/Traditional					
	Q8H	Q12H	Q24-48H	Hemodialysis	CRRT
PEAK	30 minutes after 3rd dose*	30 minutes after 3rd dose	30 minutes after 3rd dose	30 minutes after 2nd dose* Target peak Cp post-HD ~8 mg/L (6-10 mg/L)	30 minutes after 2nd dose
TROUGH	30-60 minutes before 4th dose	30-60 minutes before 3rd dose	30-60 minutes before 2nd dose	Immediately before HD; Redose for pre-HD or post-HD level: Cp <1 mg/L	30-60 minutes before 3rd dose
Gram-Positive Synergy					
	Q8H	Q12H	Q24-48H	Hemodialysis	CRRT
TROUGH	30-60 minutes before the 4th dose	30-60 minutes before the 3rd dose	30-60 minutes before the 2nd dose	Immediately before HD; Redose for pre-HD or post-HD level: Cp <1 mg/L	30-60 minutes before 3rd dose

*Peaks are drawn 30 minutes after the end of the infusion; Cp = concentration in plasma

d. Target levels- See Table 4 below. Trough serum concentrations should be less than 1 mcg/mL (most often undetectable) because of the long dosing interval.

Table 4: Target levels							
	Gentamicin/Tobramycin				Amikacin		
Dose	1 mg/kg	1.5-2 mg/kg	7 mg/kg*	10 mg/kg**	5-7.5 mg/kg	15 mg/kg	20 mg/kg
Usual Interval	Q8H	Q8H	Q24H***	Q24H***	Q12H	Q24H***	Q24H***
Peak	3-5	4-8	20-25	20-30	20-35	35-50	40-60
Trough	<1	<1-2	<1	<1	<5-8	<4	<4

*7 mg/kg once daily dosing does not require routine monitoring of target peaks and troughs unless the patient is having fluctuations in renal function or has failed extended interval dosing. Follow the Hartford nomogram and check an 8-12 hour post-dose level, this can be done after the first dose

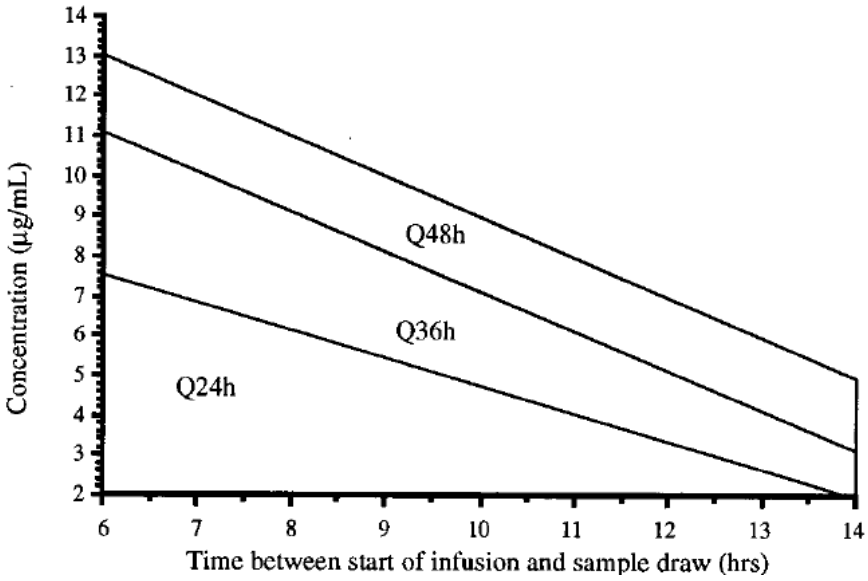
**This dose is generally used for cystic fibrosis patients

***Extended interval dosing can be Q24H, Q36H, or Q48H

e. Dose Adjustments

i. In general, changes in the dose will result in proportional changes in both peak and trough concentration values. Changes in the dosing interval while keeping the dose constant will also result in similar directional changes to both peak and trough, although such changes are not proportional. Inpatient pharmacists will calculate patient-specific pharmacokinetic parameters to determine needed dose and frequency modification based on serum concentration values.

ii. **High-Dose Extended-Interval**- A single serum concentration should be obtained 8-12 hours after the first dose. Results from this measurement are used to determine the dosing interval.



1. Gentamicin/tobramycin (7 mg/kg/dose): Plot level on graph
2. Amikacin (15 mg/kg/dose): Divide level in half, then plot on graph
3. If the level falls on a borderline, use the longer interval
4. If the level falls above the Q48H dosing interval, reevaluate the need for continued aminoglycoside therapy and discuss suitable alternatives with the physician
5. If the level is <2 mg/L, assess the patient's clinical status and continue current regimen if the patient's clinical status is clinically stable or improving. If patient is not clinically improving, re-evaluate clinical situation (e.g. repeat level, change to traditional dosing, change antibiotics, etc.)

5. **Initial maintenance dose and dosing interval-** For maintenance dosing, a specific percentage of the loading dose is given at a specific dosing interval, both of which depend on the creatinine clearance. In order to meet the desired target concentrations, both the maintenance dose and the dosing interval may need to be adjusted based on the results of drug concentration monitoring. Serum aminoglycoside concentration monitoring is needed to avoid toxicity when these drugs will be used for > 24 hours (see Table 5).

Table 5: Maintenance dose nomogram for traditional, intermittent dosing of gentamicin and tobramycin in adults

Creatinine clearance[•] conventional unit (mL/minute)	Creatinine clearance[•] SI unit (mL/second)	Maintenance dose (percent of loading dose[Δ])	Dose interval (hours)
>90	>1.5	84	8
80 to 90	1.3 to 1.5	80	8
70 to 79	1.2 to <1.3	76	8
60 to 69	1 to <1.2	84	12
50 to 59	0.8 to <1	79	12
40 to 49	0.7 to <0.8	72	12
30 to 39	0.5 to <0.7	86	24
20 to 29	0.33 to <0.5	75	24 to 36
<20[◊]	<0.33[◊]		

References:

1. Derenski, Mui, and Robilotti. Stanford Hospital & Clinics Vancomycin Dosing Guidelines 2013. Accessed February 18, 2015. http://bugsanddrugs.stanford.edu/dosing.html
2. Canadian Society of Hospital Pharmacists Regina Qu'Appelle Health Region. Guidelines for Drug Prescribing and Monitoring – Aminoglycoside Protocol. Accessed February 18, 2015. http://www.cshp-sk.org/documents/Aminoglycoside%20Protocol%20RQHR.pdf
3. Up to Date. Dosing and administration of parenteral aminoglycosides. Accessed March 23, 2015

SAN MATEO MEDICAL CENTER 2014 ANTIBIOGRAM

(To include Isolates >=30 only per CLSI guideline)

Organisms	No. Isolates	Amikacin	Ampicillin	Ampicillin/Sulbactam	Aztreonam	Cefazolin	Ceftriaxone	Cefatazidime	Cefuroxime	Cephalophin (Urine)	Ciprofloxacin	Clindamycin	Erythromycin	Gentamycin	Imipenem	Levofloxacin	Linezolid	Oxacillin	Pip/Tazo	Piperacillin	Tetracycline	Tobramycin	Trimeth/Sulfa	Vancomycin	Nitrofurantoin (Urine)
E. coli	1207	100	50	55	93	91	94	94	94	53	82			90		83				51	65	90	68		98
K. pneumoniae	106	100	0	84	94	95	93	93	93	70	94			96		94				42	83	94	93		61
P. aeruginosa	32	100			73			88			76			97	85	73			97	92		100			
P. mirabilis	81	100	80	89	91	94	99	100	98	73	91			98		96				86	0	98	80		0
Enterococcus	73		90								62					74	97				23			90	96
MSSA	167			99		99	99				86	88	73	97		89	100	100			96		100	100	100
MRSA	119			0		0	0				32	79	7	97		34	100	0			93		100	100	100
Staph coag neg	73			44		44	38				77	71	50	98		81	99	44			88		86	100	100

SMMC Empiric Antibiotic Treatment Guidelines for Adults

CONDITION	CULTURE NEEDED	1ST CHOICE	ALTERNATIVES (Drug allergies)	DURATION
Abdominal Infections				
Community-acquired acute cholecystitis or cholangitis	Blood if febrile	Ceftriaxone 2g IV q24 AND Metronidazole 500 mg IV q6 **OR** Moxifloxacin 400 mg IV q 24	Ciprofloxacin 400 mg IV q 12 AND Metronidazole 500 mg IV q6 AND Vancomycin 15 mg/kg IV q12 **OR** Azteonam 2g IV q8 AND Metronidazole 500 mg IV q6 AND Vancomycin 15 mg/kg IV q12	4-7 days if source control achieved **Concomitant surgical management important for source control**
		Life threatening /ICU: Imipenem 500 mg IV q6	**Life threatening /ICU:** Levofloxacin 750 IV q 24 AND Metronidazole 500 mg IV q6 **OR** Azteonam 2g IV q8 AND Metronidazole 500 mg IV q6 AND Vancomycin 15 mg/kg IV q12	
Healthcare-associated biliary infection (post bilio-enteric anastomosis, ERCP) of any severity [1]	Blood if febrile, biliary fluid	Imipenem 500 mg IV q6 AND Vancomycin 15 mg/kg IV q12	Levofloxacin 750 IV q 24 AND Metronidazole 500 mg IV q6 AND Vancomycin 15 mg/kg IV q12	
Community-acquired diverticulitis, appendicitis, secondary peritonitis, perirectal abscess	Blood if febrile	**Outpatient:** Levofloxacin 750 po daily AND Metronidazole 500 mg po 4 times daily **OR** Moxifloxacin 400 mg po daily	**Outpatient:** Moxifloxacin 400 mg po daily	
		Inpatient: Ceftriaxone 2g IV q24 AND metronidazole 500 mg IV q6 **OR** Moxifloxacin 400 mg IV q24	**Inpatient:** Levofloxacin 750 IV q 24 AND Metronidazole 500 mg IV q6	
		Life threatening /ICU : Imipenem 500 mg IV q6 **OR** Cefepime 2g IV q8 AND Metronidazole 500 mg IV q6	**Life threatening /ICU :[2]** Azteonam 2g IV q8 AND Metronidazole 500 mg IV q6 AND Vancomycin 15 mg/kg IV q12 **OR** Ciprofloxacin 400 mg IV q 12 AND Metronidazole 500 mg IV q6 AND Vancomycin 15 mg/kg IV q12	

[1] **Obtain ID consultation**

[2] **Obtain ID consult for life-threatening illness and drug allergy**

CONDITION	CULTURE NEEDED	1ST CHOICE	ALTERNATIVES (Drug allergies)	DURATION
Healthcare-associated intraabdominal infection[3]	Blood if febrile, Abdominal fluid	Imipenem 500 mg IV q6 AND Vancomycin 15mg/kg IV q12 **OR** Cefepime 2g IV q8 AND Metronidazole 500 mg IV q6 AND Vancomycin 15mg/kg IV q12	Ciprofloxacin 400 mg IV q 12 AND Metronidazole 500 mg IV q6 AND Vancomycin 15 mg/kg IV q12 AND Gentamycin 7 mg/kg IV q24	
Spontaneous bacterial peritonitis	Peritoneal fluid and blood	Ceftriaxone 2g IV q24	Levofloxacin 500 mg IV q 24	5 days (if not bacteremic) If bacteremic, 14 days
Surgical Site Infection for surgery involving GI tract and female GU	Wound/ abscess	**Outpatient:** Amoxicillin/clauvulanate-ER 1000/62.5 2 tablets BID **AND** TMP-SMX DS (160/800mg) 2 tablets po BID	**Outpatient:** Levofloxacin 750 mg po daily AND Metronidazole 500 mg po 4 times daily	4-7 days if source control achieved **Concomitant surgical management important for source control**
		Inpatient Ertapenem 1g IV q24 AND Vancomycin 15mg/kg IV q12	**Inpatient** Azteonam 2g IV q8 AND Metronidazole 500 mg IV q6 AND Vancomycin 15 mg/kg IV q12	
Meningitis				
Age 1 mo-50 years	CNS Blood	Ceftriaxone 2g IV q 12 AND Vancomycin 15 mg/kg IV q8	Chloramphenicol 12.5 mg/kg IV q6* AND TMP/SMX 5 mg/kg IV q8 AND Vancomycin 15 mg/kg IV q8	7-21 days, depending on pathogen
Age>50, alcoholism, impaired cellular immunity[4]		Ampicillin 2g IV q 4 AND Ceftriaxone 2g IV q 12 AND Vancomycin 15 mg/kg IV q8	Meropenem 2g IV q8 **OR** TMP/SMX 5 mg/kg IV q8 (for severe PCN allergy) AND Vancomycin 15 mg/kg IV q8	7-21 days, depending on pathogen
Pneumonia				
Community Acquired, Nonhospitalized	Sputum Blood	**No comorbidity:** Azithromycin 500 mg x 1, then 250 mg po daily x 4 days	**No comorbidity:** Doxycycline 100 mg po BID x 5 days	5 days
		Comorbidity present: Levofloxacin 750 mg po daily	**Comorbidity present:** Moxifloxacin 400 mg po daily	

[3] Obtain ID consultation

[4] Obtain ID consultation for possible listeria meningitis and for meningitis with drug allergies

CONDITION	CULTURE NEEDED	1ST CHOICE	ALTERNATIVES (Drug allergies)	DURATION
Community Acquired, Hospitalized		See "SMMC Community Acquired Pneumonia: Empiric Therapy for Adults"		5 days - non ICU 8 days - ICU
Hospital Acquired or Ventilator-Associated[5]		Piperacillin/tazobactam 4.5 g IV q6 AND Levofloxacin 500 mg IV q 24 AND Vancomycin 15 mg/kg IV q 12	Imipenem 500 mg IV q6 AND Levofloxacin 500 mg IV q 24 AND Vancomycin 15 mg/kg IV q 12	8 days
Skin and Soft Tissue Infections				
Abscesses	Fluid Blood (if febrile)	**Low risk (<5 cm)**: I&D, no antibiotics	**SAME**	
		High risk (>5 cm): I&D **AND** TMP/SMX DS 2 tabs BID	**High risk (>5 cm):** I&D **AND** Clindamycin 300-450 mg TID-QID **OR** Doxycycline 100 mg po BID	5 -10 days
Cellulitis (Extremities)	Blood	**Non diabetic, outpatient:** Dicloxacillin 500 mg po q6 **OR** Cephalexin 500 mg po q6	**Non diabetic, outpatient:** Clindamycin 450 mg po TID-QID	5 -10 days
		High risk of MRSA,[6] Outpatient TMP-SMX DS (160/800mg) AND Dicloxacillin 500 mg po q6 **OR** TMP-SMX DS (160/800mg) AND Cephalexin 500 mg po q6	**High risk of MRSA, Outpatient** Clindamycin 450 mg po TID-QID **OR** TMP-SMX DS (160/800mg)	
		Non diabetic, inpatient: PCN 1-2 million units IV q6 AND Vancomycin 1 mg IV q 12 **OR** Cefazolin 1g IV q8 AND Vancomycin 1 mg IV q 12	**Non diabetic, inpatient:** Clindamycin 900 mg IV q8 **OR** Vancomycin 1 mg IV q 12	5-10 days
		Diabetes or peripheral arterial disease, severe[7] Ampicillin/sulbactam 3g IV q6 AND Clindamycin 900 mg IV q8	**Diabetes or peripheral arterial disease, severe**** Levofloxacin 750 mg IV q24 AND Clindamycin 900 mg IV q8	

[5] Obtain ID consultation

[6] High risk of MRSA: nasal culture positive, infection secondary to MRSA as documented by culture, recent broad spectrum antibiotic exposure

[7] Consider diagnosis of necrotizing infection if patient has: 1) Severe, constant pain; 2) Bullae; 3) Skin necrosis or ecchymosis preceding necrosis; 4) Gas in soft tissues by palpation or imaging; 5) Cutaneous anesthesia; 6) Systemic toxicity/sepsis; 7) Rapid spread. Needs Surgical and ID consult

CONDITION	CULTURE NEEDED	1ST CHOICE	ALTERNATIVES (Drug allergies)	DURATION
Diabetic foot infections	Blood Deep tissue biopsy or curettage	**Outpatient:** Amoxicillin-clavulanate 875/125 PO BID	**Outpatient:** Levofloxacin 500 mg PO daily	7-14 days
		Inpatient: Ampicillin/sulbactam 3g IV q6 AND Vancomycin 1 mg IV q 12	**Inpatient:** Moxifloxacin 400 mg IV q24 AND Metronidazole 500 mg IV q6	14-28 days
Urinary Tract Infections				
Cystitis (females)	Urine	TMP-SMX DS (160/800mg) 1 tablet po BID x 3 days **OR** Nitrofurantoin 100 mg po BID x 5 days	Ciprofloxacin 500 mg po BID x 3 days **OR** Levofloxacin 500 mg po BID x 3 days	3 days, unless using nitrofurantoin (5 days) ***Recurrent UTI should be referred to ID Clinic**
Pyelonephritis	Urine Blood (if febrile)	**Outpatient:** Ceftriaxone 1g IV x 1 AND Ciprofloxacin 500 mg PO BID x7 days **OR** Ceftriaxone 1g IV x 1 AND Levofloxacin 750 mg po QD x 5 days	**Outpatient:** Gentamycin 5 mg/kg IV x 1 AND TMP/SMX DS 1 tab BID x 14 days	7 days, unless using TMP-SMX, (14 days)
		Inpatient: Ciprofloxacin 400 mg IV q 12 **OR** Ceftriaxone 1g IV q 24	**Inpatient:** Levofloxacin 750 mg IV q24	7 days
Catheter-associated	Urine Blood (if febrile)	Piperacillin/tazobactam 4.5 g IV q6	Ciprofloxacin 400 mg IV q 12 **OR** Levofloxacin 750 mg IV q24	7-14 days, depending on resolution of symptoms and source control **Concomitant replacement of foley catheter important for source control**

Providers should obtain ID consult for any of the following infections: Endocarditis, encephalitis, post-neurosurgery meningitis, bacterial meningitis in patient with PCN allergy, severe intra-abdominal infections or surgical site infections, healthcare-acquired intraabdominal or biliary infections, prosthetic joint infections, osteomyelitis, animal bites, any infections in immunocompromised hosts, fungal sinusitis, deep neck space or odontogenic infections, recurrent urinary tract infections, infections secondary to multidrug resistant organisms

Sources:

1) IDSA/ATS Guidelines: Consensus Guidelines on the Management of Community-Acquired Pneumonia in Adults. CID 2007; 44:S27–72

2) IDSA Guidelines (2012): Clinical Practice Guideline for the Diagnosis and Treatment of Diabetic Foot Infections. CID 2012; 54(12): 132-173

3) IDSA Guidelines (2010): Diagnosis and Management of Complicated Intra-abdominal Infection in Adults and Children.

4) IDSA Guidelines (2010): Diagnosis, Prevention and Treatment of Catheter-Associated UTI in Adults. CID 2010; 50: 625-663

5) ATS Guidelines (2005): Guidelines for the Management of Adults with Hospital-Acquired, Ventilator-associated, and Healthcare-associated Pneumonia. Am J Respir Crit Care Med 2005; 171: 388-416

6) IDSA Guidelines (2011): International Clinical Practice Guidelines for the Treatment of Acute Uncomplicated Cystitis and Pyelonephritis in Women: CID 2011; 52(5): e103-e120

7) IDSA Guidelines (2005): Practice Guidelines for Diagnosis and Management of Skin and Soft-Tissue Infections. CID 2005; 41: 1373-406

8) Sanford Guide 2012 42nd Edition

INITIAL VISIT: CLASSIFYING ASTHMA SEVERITY AND INITIATING THERAPY

(in patients who are not currently taking long-term control medications)

Level of severity (Columns 2–5) is determined by events listed in Column 1 for both impairment (frequency and intensity of symptoms and functional limitations) and risk (of exacerbations). Assess impairment by patient's or caregiver's recall of events during the previous 2–4 weeks; assess risk over the last year. Recommendations for initiating therapy based on level of severity are presented in the last row.

Components of Severity		Intermittent			Persistent								
					Mild			Moderate			Severe		
		Ages 0–4 years	Ages 5–11 years	Ages ≥12 years	Ages 0–4 years	Ages 5–11 years	Ages ≥12 years	Ages 0–4 years	Ages 5–11 years	Ages ≥12 years	Ages 0–4 years	Ages 5–11 years	Ages ≥12 years
Impairment	Symptoms	≤2 days/week			>2 days/week but not daily			Daily			Throughout the day		
	Nighttime awakenings	0	≤2x/month		1–2x/month	3–4x/month		3–4x/month	>1x/week but not nightly		>1x/week	Often 7x/week	
	SABA* use for symptom control (not to prevent EIB*)	≤2 days/week			>2 days/week but not daily	>2 days/week but not daily and not more than once on any day		Daily			Several times per day		
	Interference with normal activity	None			Minor limitation			Some limitation			Extremely limited		
	Lung function												
	→ FEV_1* (% predicted)	Not applicable	Normal FEV_1 between exacerbations >80%	Normal FEV_1 between exacerbations >80%	Not applicable	>80%	>80%	Not applicable	60–80%	60–80%	Not applicable	<60%	<60%
	→ FEV_1/FVC*		>85%	Normal†		>80%	Normal†		75–80%	Reduced 5%†		<75%	Reduced >5%†
Risk	Asthma exacerbations requiring oral systemic corticosteroids‡	0–1/year			≥2 exacerb. in 6 months, or wheezing ≥4x per year lasting >1 day AND risk factors for persistent asthma	≥2/year		*Generally, more frequent and intense events indicate greater severity.*					
		*Consider severity and interval since last asthma exacerbation. Frequency and severity may fluctuate over time for patients in any severity category. Relative annual risk of exacerbations may be related to FEV_1.**											
Recommended Step for Initiating Therapy *(See "Stepwise Approach for Managing Asthma Long Term," page 7)* *The stepwise approach is meant to help, not replace, the clinical decisionmaking needed to meet individual patient needs.*		Step 1			Step 2			Step 3	Step 3 medium-dose ICS* option	Step 3	Step 3	Step 3 medium-dose ICS* option or Step 4	Step 4 or 5
								Consider short course of oral systemic corticosteroids.					
		In 2–6 weeks, depending on severity, assess level of asthma control achieved and adjust therapy as needed. For children 0–4 years old, if no clear benefit is observed in 4–6 weeks, consider adjusting therapy or alternate diagnoses.											

* **Abbreviations:** EIB, exercise-induced bronchospam; FEV_1, forced expiratory volume in 1 second; FVC, forced vital capacity; ICS, inhaled corticosteroid; SABA, short-acting $beta_2$-agonist.

† Normal FEV_1/FVC by age: 8–19 years, 85%; 20–39 years, 80%; 40–59 years, 75%; 60–80 years, 70%.

‡ Data are insufficient to link frequencies of exacerbations with different levels of asthma severity. Generally, more frequent and intense exacerbations (e.g., requiring urgent care, hospital or intensive care admission, and/or oral corticosteroids) indicate greater underlying disease severity. For treatment purposes, patients with ≥2 exacerbations may be considered to have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

FOLLOW-UP VISITS: ASSESSING ASTHMA CONTROL AND ADJUSTING THERAPY

Level of control (Columns 2–4) is based on the most severe component of impairment (symptoms and functional limitations) or risk (exacerbations). Assess impairment by patient's or caregiver's recall of events listed in Column 1 during the previous 2–4 weeks and by spirometry and/or peak flow measures. Symptom assessment for longer periods should reflect a global assessment, such as inquiring whether the patient's asthma is better or worse since the last visit. Assess risk by recall of exacerbations during the previous year and since the last visit. Recommendations for adjusting therapy based on level of control are presented in the last row.

Components of Control		Well Controlled			Not Well Controlled			Very Poorly Controlled		
		Ages 0–4 years	Ages 5–11 years	Ages ≥12 years	Ages 0–4 years	Ages 5–11 years	Ages ≥12 years	Ages 0–4 years	Ages 5–11 years	Ages ≥12 years
Impairment	Symptoms	≤2 days/week	≤2 days/week but not more than once on each day	≤2 days/week	>2 days/week	>2 days/week or multiple times on ≤2 days/week	>2 days/week	Throughout the day		
	Nighttime awakenings	≤1x/month		≤2x/month	>1x/month	≥2x/month	1–3x/week	>1x/week	≥2x/week	≥4x/week
	Interference with normal activity	None			Some limitation			Extremely limited		
	SABA* use for symptom control (not to prevent EIB*)	≤2 days/week			>2 days/week			Several times per day		
	Lung function ➡ FEV_1* (% *predicted*) or peak flow (% *personal best*) ➡ FEV_1/FVC*	Not applicable	>80% >80%	>80% Not applicable	Not applicable	60–80% 75–80%	60–80% Not applicable	Not applicable	<60% <75%	<60% Not applicable
	Validated questionnaires† ➡ ATAQ* ➡ ACQ* ➡ ACT*	Not applicable	Not applicable	0 ≤0.75‡ ≥20	Not applicable	Not applicable	1–2 ≥1.5 16–19	Not applicable	Not applicable	3–4 Not applicable ≤15
Risk	Asthma exacerbations requiring oral systemic corticosteroids§	0–1/year			2–3/year	≥2/year		>3/year	≥2/year	
		Consider severity and interval since last asthma exacerbation.								
	Reduction in lung growth/Progressive loss of lung function	Not applicable	Evaluation requires long-term follow-up care.		Not applicable	Evaluation requires long-term follow-up care.		Not applicable	Evaluation requires long-term follow-up care.	
	Treatment-related adverse effects	*Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.*								
Recommended Action for Treatment *(See "Stepwise Approach for Managing Asthma Long Term," page 7)* *The stepwise approach is meant to help, not replace, the clinical decisionmaking needed to meet individual patient needs.*		*Maintain current step.* *Regular follow-up every 1–6 months.* *Consider step down if well controlled for at least 3 months.*			Step up 1 step	Step up at least 1 step	Step up 1 step	*Consider short course of oral systemic corticosteroids.* *Step up 1–2 steps.* *Reevaluate in 2 weeks to achieve control.*		
					Reevaluate in 2–6 weeks to achieve control. *For children 0–4 years, if no clear benefit observed in 4–6 weeks, consider adjusting therapy or alternative diagnoses.*					
					Before step up in treatment: *Review adherence to medication, inhaler technique, and environmental control. If alternative treatment was used, discontinue and use preferred treatment for that step. For side effects, consider alternative treatment options.*					

* **Abbreviations:** ACQ, Asthma Control Questionnaire©; ACT, Asthma Control Test™; ATAQ, Asthma Therapy Assessment Questionnaire©; EIB, exercise-induced bronchospasm; FVC, forced vital capacity; FEV_1, forced expiratory volume in 1 second; SABA, short-acting $beta_2$-agonist.

† Minimal important difference: 1.0 for the ATAQ; 0.5 for the ACQ; not determined for the ACT.

‡ ACQ values of 0.76–1.4 are indeterminate regarding well-controlled asthma.

§ Data are insufficient to link frequencies of exacerbations with different levels of asthma control. Generally, more frequent and intense exacerbations (e.g., requiring urgent care, hospital or intensive care admission, and/or oral corticosteroids) indicate poorer asthma control.

STEPWISE APPROACH FOR MANAGING ASTHMA LONG TERM

The stepwise approach tailors the selection of medication to the level of asthma severity (see page 5) or asthma control (see page 6). The stepwise approach is meant to help, not replace, the clinical decisionmaking needed to meet individual patient needs.

ASSESS CONTROL:

STEP UP IF NEEDED (first, check medication adherence, inhaler technique, environmental control, and comorbidities)

STEP DOWN IF POSSIBLE (and asthma is well controlled for at least 3 months)

At each step: Patient education, environmental control, and management of comorbidities

0–4 years of age

	Intermittent Asthma	Persistent Asthma: Daily Medication Consult with asthma specialist if step 3 care or higher is required. Consider consultation at step 2.				
	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6
Preferred Treatment†	SABA* as needed	low-dose ICS*	medium-dose ICS*	medium-dose ICS* + either LABA* or montelukast	high-dose ICS* + either LABA* or montelukast	high-dose ICS* + either LABA* or montelukast + oral corticosteroids
Alternative Treatment†,‡		cromolyn or montelukast				
If clear benefit is not observed in 4–6 weeks, and medication technique and adherence are satisfactory, consider adjusting therapy or alternate diagnoses.						
Quick-Relief Medication	▪ SABA* as needed for symptoms; intensity of treatment depends on severity of symptoms. ▪ With viral respiratory symptoms: SABA every 4–6 hours up to 24 hours (longer with physician consult). Consider short course of oral systemic corticosteroids if asthma exacerbation is severe or patient has history of severe exacerbations. ▪ Caution: Frequent use of SABA may indicate the need to step up treatment.					

5–11 years of age

	Intermittent Asthma	Persistent Asthma: Daily Medication Consult with asthma specialist if step 4 care or higher is required. Consider consultation at step 3.				
	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6
Preferred Treatment†	SABA* as needed	low-dose ICS*	low-dose ICS* + either LABA,* LTRA,* or theophylline[(b)] **OR** medium-dose ICS	medium-dose ICS* + LABA*	high-dose ICS* + LABA*	high-dose ICS* + LABA* + oral corticosteroids
Alternative Treatment†,‡		cromolyn, LTRA,* or theophylline§		medium-dose ICS* + either LTRA* or theophylline§	high-dose ICS* + either LTRA* or theophylline§	high-dose ICS* + either LTRA* or theophylline§ + oral corticosteroids
		Consider subcutaneous allergen immunotherapy for patients who have persistent, allergic asthma.**				
Quick-Relief Medication	▪ SABA* as needed for symptoms. The intensity of treatment depends on severity of symptoms: up to 3 treatments every 20 minutes as needed. Short course of oral systemic corticosteroids may be needed. ▪ Caution: Increasing use of SABA or use >2 days/week for symptom relief (not to prevent EIB*) generally indicates inadequate control and the need to step up treatment.					

≥12 years of age

	Intermittent Asthma	Persistent Asthma: Daily Medication Consult with asthma specialist if step 4 care or higher is required. Consider consultation at step 3.				
	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6
Preferred Treatment†	SABA* as needed	low-dose ICS*	low-dose ICS* + LABA* **OR** medium-dose ICS*	medium-dose ICS* + LABA*	high-dose ICS* + LABA* **AND** consider omalizumab for patients who have allergies††	high-dose ICS* + LABA* + oral corticosteroid§§ **AND** consider omalizumab for patients who have allergies††
Alternative Treatment†,‡		cromolyn, LTRA,* or theophylline§	low-dose ICS* + either LTRA,* theophylline,§ or zileuton‡‡	medium-dose ICS* + either LTRA,* theophylline,§ or zileuton‡‡		
		Consider subcutaneous allergen immunotherapy for patients who have persistent, allergic asthma.**				
Quick-Relief Medication	▪ SABA* as needed for symptoms. The intensity of treatment depends on severity of symptoms: up to 3 treatments every 20 minutes as needed. Short course of oral systemic corticosteroids may be needed. ▪ Caution: Use of SABA >2 days/week for symptom relief (not to prevent EIB*) generally indicates inadequate control and the need to step up treatment.					

San Mateo Medical Center Primary Care (Adapted from NHLBI Asthma Preventive Care)

* **Abbreviations:** EIB, exercise-induced bronchospasm; ICS, inhaled corticosteroid; LABA, inhaled long-acting beta$_2$-agonist; LTRA, leukotriene receptor antagonist; SABA, inhaled short-acting beta$_2$-agonist.

† Treatment options are listed in alphabetical order, if more than one.

‡ If alternative treatment is used and response is inadequate, discontinue and use preferred treatment before stepping up.

§ Theophylline is a less desirable alternative because of the need to monitor serum concentration levels.

** Based on evidence for dust mites, animal dander, and pollen; evidence is weak or lacking for molds and cockroaches. Evidence is strongest for immunotherapy with single allergens. The role of allergy in asthma is greater in children than in adults.

†† Clinicians who administer immunotherapy or omalizumab should be prepared to treat anaphylaxis that may occur.

‡‡ Zileuton is less desirable because of limited studies as adjunctive therapy and the need to monitor liver function.

§§ Before oral corticosteroids are introduced, a trial of high-dose ICS + LABA + either LTRA, theophylline, or zileuton, may be considered, although this approach has not been studied in clinical trials.

SUBJECT:	PRESCRIBING GUIDELINES FOR CONTROLLED MEDICATIONS
CHAPTER:	MEDICATION MANAGEMENT
AUTHOR:	PAIN MANAGEMENT COMMITTEE

POLICY:

A. First time CII Medication or Benzodiazepines are prescribed by a provider. (The medication may be inherited or initiated by the provider).

If a provider's medical judgment concludes that CII controlled medication is needed for a patient, the provider will ensure the following is done before prescribing a controlled medication:

1. For opioid prescribing, the screening tool SOAPP-5 will be used and placed in the chart to predict possible opioid abuse in chronic pain patients. If a patient scores four or more, the patient is at high risk for addiction, and other treatment options should be considered.

2. Drug Urine Test will be performed to determine if patient is using other substances. The prescription for a controlled medication can be written before the result of the urine drug test has been received.

3. CURES report will be generated and placed in the patient's chart to address any past controlled medication use with the patient before writing a new prescription.

4. A copy of the Controlled Medication Agreement is given to patient. The Controlled Medication Agreement needs to be signed within the 30 days.

B. Chronic use of CII - CIV Medication

If a provider's medical judgment concludes that use of CII - CIV Medication is needed for a patient, the provider will ensure the following is done before prescribing a controlled medication:

1. For opioid prescribing, the screening tool SOAPP-5 will be used and placed in the chart to predict possible opioid abuse in chronic pain patients. If a patient scores four or more, the patient is at high risk for addiction, and other treatment options should be considered.

2. Drug Urine Test will be performed to determine if patient is using other substances. The prescription for a controlled medication can be written before the result of the urine drug test has been received.

3. CURES report will be generated and placed in the patient's chart to address any past controlled medication use with the patient before writing a new prescription. *See SMMC MM Chapter Policy "Monitoring Controlled Medication Prescriptions Using CURES PDMP".*

4. A copy of the Controlled Medication Agreement is given to patient. The Controlled Medication Agreement needs to be signed within the 30 days. *See attachment (use current version from SMMC Medical Record Forms and should be scanned into the medical record.)*

C. <u>If a provider's medical judgment concludes that a patient requires long term treatment with a CII -CIV medication, the following will be done within the time interval specified below:</u>

1. Drug Urine Test done at least yearly.
2. CURES report printed and placed in chart every 3 months.
3. A new Controlled Medication Agreement is signed by provider and patient every 2 years, unless the agreement is broken or if medication regiment is changed, in which case a new agreement must be written.
4. The patient will need to be seen by the provider in an appointment every 3 months to assess if medication can be decreased or stopped.

PURPOSE:

To establish safe prescribing habits of Controlled Medications for providers and patients consistent with best practices. The Health System will support providers in prescribing these medications the safest way for staff and providers. For opioids, the Health System has reviewed best practices, and discourages the long-term use of opioids for chronic pain (outside palliative care) especially the short-acting formulations of opioids.

DEFINITIONS:

- Controlled Substance includes but is not limited to the following medications

Schedule	Generic (Brand)
Schedule CII	• Codeine • Dextroamphetamine & Amphetamine (Adderall) • Fentanyl (Duragesic) • Hydromorphone (Dilaudid) • Methadone • Methylphenidate (Concerta, Ritalin) • Morphine (ex. MS Contin, Roxanol, etc.) • Oxycodone (OxyContin) • Oxycodone combination products (ex. Percocet) •
Schedule CIII	• Buprenorphine (Butrans) • Ketamine
Schedule CIV	• Benzodiazepines (ex. alprazolam, diazepam, etc.) • Carisoprodol (Soma) • Codeine containing products 90mg/du (ex. Tylenol #3) • Tramadol (Ultram) • Zolpidem (Ambien)
Schedule CV	• Codeine preparations 200mg/100mL (ex. Robitussin AC) • Diphenoxylate less than 2.5mg combination products (Lomotil) • Pregabalin (Lyrica)

- Controlled Substance Utilization Review and Evaluation System (CURES): Report that provides providers with a timely history of dispensed medication for a specific person. CURES is managed by the California Prescription Drug Monitoring Program (PDMP).

- Controlled Medication Agreement: An agreement between a provider and patient about the use of controlled substances.

- Chronic use of CII Medication: Any amount of medication written for more than three months.

- Chronic use of CIII and CIV Medication: Medication written for more than 15 pills per month for more than 3 months continuously.

Implementation:	4/15	
Reviewed and approved by:	Date:	
Director of Pharmacy	4/15	
Chapter Chair	4/15	
Pharmacy & Therapeutics Committee		
Primary Care Committee		
Pain Management Committee	4/15	
Chief Medical Officer	4/15	
Medical Executive Committee	4/15	
County Counsel		
		04/13/2015
Old number(s):		
Received for review: 04/13/15 CMO/Pain Management		
NOTES: *FYI: a.)Director HIM; Completed Patient Form to be scanned and added to MR. b.)MSO to distribute to all department committees/medical staff (together/both MM Chapter Policies: "Monitoring Controlled Medication Prescriptions Using CURES PDMP", and, "Prescribing Guidelines For Controlled Medications")*		
STATUS:		

San Mateo Medical Center
Patient Controlled Medication Agreement

Our goal is to treat your medical conditions effectively and safely. Controlled medications can be used to increase your ability to participate meaningfully in your daily activities, but they have several serious safety risks. This agreement is designed to prevent misunderstandings about the medication(s) that you are being prescribed. This is intended to provide for your safety, as well as to ensure that your provider is following ethical and legal standards of appropriate care.

By signing this, I _____, agree to and understand that:

1. I am being prescribed a controlled medication for the treatment of pain or another condition. The purpose of this treatment is to increase my ability to engage in my daily activities, not to eliminate my pain, anxiety, or other condition. I may need to continue these medications on an ongoing basis, and I may not achieve a condition where I feel completely well.
2. The long-term use of controlled medications may result in the development of physical dependence on the medication. Should I need to suddenly decrease or discontinue the use of this substance, **I may experience symptoms of withdrawal**. Withdrawal from opioids and stimulants is uncomfortable, but not life-threatening. However, withdrawal from benzodiazepines could require medical attention
3. The use of these medications is only one part of my therapeutic treatment regimen. I understand that I am required to comply with the **other prescribed methods of treating my condition** (therapy, specialty appointments, etc.)
4. I agree to **take these medications ONLY as they are prescribed**. I will not increase the frequency or dose of any medication without first discussing and gaining authorization from my provider. Controlled medications will NOT be refilled early.
5. In the event that an unplanned incident arises (acute injury, dental problems, stressor), I might need additional medication on a short-term basis. I will **not simply increase the use of my current medication** (which could lead to accidental overdose and death), but will contact my provider for suggestions on how to effectively and safely manage this problem.
6. I agree to tell my provider about all other medicines and treatments that I am receiving. **I will not request or accept controlled substances/medications from any other provider or individual (including friends, family, etc.)** *without the agreement of all my providers.* The only exception is medication prescribed while I am admitted to a hospital. **Refills for controlled medications will only be made at the time of an office visit** with my regular provider's clinic. Refills will not be made in the evening, on weekends or in the Emergency Department/Urgent Care Clinic.
7. I will safeguard my medications from loss or theft. **Lost or stolen medications will not be refilled.**
8. These medications are for **my use only**. I understand that sharing, trading or selling these medications is against the law.

Draft: Last modified 03-25-2015

9. I agree to **abstain from alcohol or illicit substances** while taking any controlled medications as I understand that it is very dangerous. I will submit **to random blood and/or urine tests** when requested to determine my compliance with this agreement
10. I will **ONLY** fill my prescriptions at _____ Pharmacy Phone: _____ Fax: _____
11. I authorize my provider and pharmacy to cooperate fully with any city, state or federal law enforcement agency in the investigation of possible misuse, sale or other diversion of my medication. My provider may provide a copy of this contract to my other providers and my pharmacy. **I agree to waive my right of privacy or confidentiality with respect to these authorizations.**
12. If I break any part of this contract, my provider may be required to discontinue prescribing controlled medications. In this case, I will consult with my provider to determine the next steps for achieving the best therapeutic outcome- with or without controlled medications.
13. This contract is modifiable and flexible and may be altered or discontinued after discussion with my provider. Any changes will be initialed and dated.
14. At all times, I agree to treat all staff calmly and with respect.
15. OTHER: _____

_____

_____

Medications

Medication	Dose	#/week, month	Start Date	Stop Date

Non Medication Agreement

In addition to medications, my treatment includes: (PT, psychotherapy, other appointments, etc)

1. _____
2. _____
3. _____

_____ Patient/Guardian Signature

_____ Provider Signature

_____ Patient/Guardian Signature

_____ Provider Signature

Date: _____

Draft: Last modified 03-25-2015

BASIC GUIDELINES for DIABETES CARE

PHYSICAL AND EMOTIONAL ASSESSMENT:

Blood Pressure, Weight/BMI – Every visit. For adults:** Blood pressure target goal <130/80 mmHg; Lower or higher systolic pressure may be appropriate based on patient characteristics and response to therapy; BMI (body mass index) target goal < 25 kg/m2. ***For children: Blood pressure target goal <90th percentile adjusted for age, height, and gender; BMI-for-age <85th percentile.

Foot Exam – **Every visit:** thorough visual inspection; **Annually:** comprehensive foot examination - assessment of pedal pulses and 10-g monofilament pressure sensation plus one of following 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold. Provide general foot self-care education to all patients with diabetes. Consider refer very high risk patients to a foot care specialist.

Comprehensive and Dilated Eye Exam (note: high-quality fundus photographs with interpretation by a trained eye care provider may be incorporated into follow-up plan) - ***Type 1: Five years post diagnosis*****,** then ***annually***. ***Type 2: Shortly after diagnosis***, then ***annually***. May be individualized to more or less often. ***Note****: Women with diabetes who become pregnant should have a retinal exam within the first trimester.*

***Depression** - Evaluate for depression; treat aggressively with counseling, medication, and/or referral.

Dental** – Encourage exam at least ***yearly. Assess oral symptoms that require an urgent referral.

LAB EXAM

A1C (HbA1c) - *Quarterly*,* if treatment changes or if not meeting goals; ***Twice a year*** if stable.
Target goal **7.0%.** (Less stringent A1C goals (such as <8%) may be appropriate for patients with severe hypoglycemia, limited life expectancy, advanced complications, extensive comorbid conditions, or longstanding diabetes in whom goal is difficult to attain despite treatment. More stringent A1C goals (such as <6.5%) may be appropriate for patients with short duration of diabetes, long life expectancy, and no significant CV, if this can be achieved without significant hypoglycemia or other adverse effects of treatment.)
For Children: Consider age when setting glycemic goals.

***Albumin-to-creatinine ratio – annually** in patients with *Type 1 >five years* and with *Type 2 beginning at diagnosis*.
Normal < 30.

***Serum Creatinine**: annually in all adults.
Use serum creatinine to estimate glomerular filtration rate (eGFR). Stage chronic kidney disease if present

Blood Lipids –** On ***initial visit, then ***annually*** or as needed to monitor adherence.
Selection of statin should take into consideration overall CV risk with moderate or high intensity statin indicated for those with CVD risk factors and high intensity statin for those with overt CVD (based on 2015 ADA guidelines). *see explanatory notes

SELF MANAGEMENT TRAINING:

Management Principles and Prevention of Complications - *Initially and ongoing*:* Focus on helping the patient achieve the AADE 7 self-care behaviors: healthy eating, being active, monitoring, taking medications, problem solving, healthy coping, and reducing risks. Screen for problems with and barriers to self-care; assist patient to identify achievable self-care goals. ***For children: As appropriate*** for developmental stage.

Self-Glucose Monitoring –*Non-insulin therapy or Medical Nutrition Therapy alone: As needed* to meet treatment goals.

Multiple insulin injections or pump: Typically test ***3-4 times a day***.

Medical Nutrition Therapy (by trained expert) - *Initially**:* Assess needs/condition, assist patient in setting nutrition goals.
Ongoing*:* Assess progress toward goals, identify problem areas.

Physical Activity - *Initially and ongoing**:* Assess and prescribe physical activity based on patient's needs/condition (goal of at least 150 min/week of moderate intensity exercise spread over at least 3 days per week and resistance training 2 times per week if no contraindications) *Refer to Physical Activity Recommendations Fact Sheet for more information.*

Weight Management - *Initially and ongoing**:* Must be individualized for patient.'

INTERVENTIONS:

Preconception, Pregnancy, and Postpartum Counseling and Management - *Consult* with high-risk, multidisciplinary perinatal/neonatal programs, and providers where available through the California Diabetes and Pregnancy (CDAPP) Sweet Success (http://cdappsweetsuccess.com) ***For adolescents: Age appropriate counseling advisable, beginning with puberty.***

Aspirin Therapy (for adults) – 75-162 mg/day as a primary prevention strategy for those at increased cardiovascular risk (10 year risk > 10%). This includes most Men >50, women >60 with one additional risk factor (family history of CVD, hypertension, smoker, dyslipidemia, albuminuria).

Smoking Cessation - **Ask** every patient if they use tobacco, **Advise** them to quit, **Refer** them to the California Smokers' Helpline at **1-800-NO-BUTTS** (1-800-662-8887) or to Breathe California

Immunizations** – Influenza, Pneumococcal and Hepatitis B ***per CDC recommendations.

Adapted from *Basic Guidelines for Diabetes developed by the Diabetes Coalition of California and the California Diabetes Program, revised June 2012.* For further information: www.diabetescoalitionofcalifornia.org or www.caldiabetes.org or (916) 552-988. Modificiations based on 2015 ADA Diabetes guidelines.

EXPLANATORY NOTES

BASIC GUIDELINES for DIABETES CARE

1. These Guidelines are intended for use by primary care professionals to diagnose mange and educate patients with type 2 diabetes. While providing recommendations the Guidelines are not intended as a substitute for the advice of a physician or other health care professional. These Guidelines are updated every two years or as significant changes or recommendations are identified.

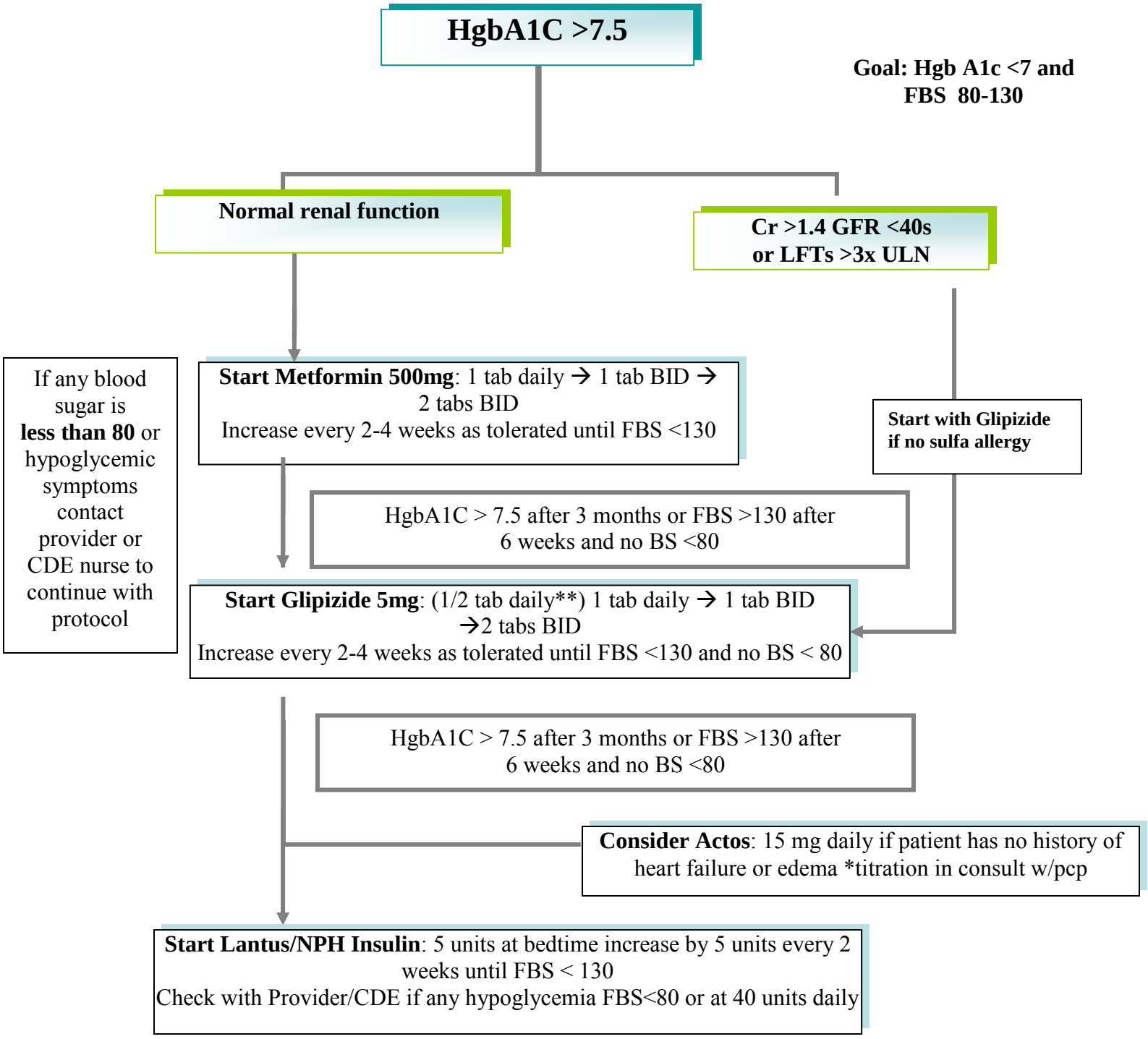
2. One or more of the following criteria were used for inclusion of an item in these Guidelines:
   - Published evidence demonstrated either the efficacy or the effectiveness of the item.
   - Published studies on cost-identification, cost-effectiveness, or cost-benefit analysis of the item demonstrated favorable economic results.
   - A preponderance of expert opinion held that the item is considered to be essential to the care of persons with diabetes.

3. It is assumed that the following are routinely occurring in the medical setting:
   - A history and physical appropriate for a person with diabetes are performed. Visits are sufficiently frequent to meet the patient's needs and treatment goals.
   - Abnormal physical or laboratory findings result in appropriate and individualized interventions.
   - Expert multi-disciplinary health professionals provide self-management training. For children/adolescentsand their families, training from a diabetes team or team member with experience in child and adolescentdiabetes is strongly recommended to begin at diagnosis.
   - Physicians should consult current references for normal values and for appropriate treatment goal values,both for children and adults.
   - Specialists should be consulted when patients are unable to achieve treatment goals in a reasonable timeframe, when complications arise, or whenever the primary care physician deems it appropriate. Under similar circumstances, children/adolescents should be referred to specialists who have expertise in managing children and adolescents with diabetes.

4. Additional comments on specific items included in these Guidelines:
   - **Blood Pressure/BMI** – For children, to determine blood pressure percentile adjusted for age, height, and gender use http://www.cdc.gov/nccdphp/dnpa/growthcharts/training/modules/module3/text/bloodpressure.htm To calculate and determine BMI percentile use http://www.cdc.gov/nccdphp/dnpa/bmi/childrens_BMI/about_childrens_BMI.htm
   - **Dental –** Refer all patients with diabetes for a dental examination, as a component of the comprehensive diabetes evaluation, regardless of oral findings or complaints.
   - **A1C / Self-Glucose Monitoring** – Certification by the National Glycohemoglobin Standardization Program as traceable to the DCCT reference ensures portability of A1C results. Verify that the laboratory is certified in this method. A1C target goals should be achieved gradually over time. Target goals should be less stringent for children, the elderly, and other fragile patients. Clinicians have found that making the patient aware of his/her A1C values and their significance helps motivate the patient toward improved glycemic control. This principle also applies to self-glucose monitoring. Target goals should be individualized for each patient.
   - **Microalbuminuria** – See Screening and Initial Management of Diabetic Microalbuminuria and Nephropathy algorithm.
   - **Glomerular Filtration Rate (GFR)** – See Screening and Initial Management of Diabetic Microalbuminuria and Nephropathy algorithm and explanatory notes for purpose and calculation of GFR.
   - **Blood Lipids** – Abnormal blood lipids are often under-treated. An active, progressive treatment and monitoring plan should be instituted. Based on 2015 ADA guidelines use moderate or high intensity statin for those with CVD risk factors (LDL >100; smoker; overweight/obesity; high blood pressure) and high intensity statin for those with overt CVD (prior CV events or acute coronary syndrome). Use of ACC/AHA calculator can also be considered to assist in assessing risk with high intensity statin recommended for those with ASCVD risk >10%..
   - **Immunizations** – See CDC schedules at http://www.cdc.gov/vaccines/schedules/index.html
   - **Children / Adolescents** – For specific diabetes care recommendations, see references.
   - **Psychosocial Assessment** – Assess barriers to self-care: common environmental obstacles, cultural issues, beliefs and feelings about diabetes, disorders of eating and mood, life stresses, and substance use. Consider using PHQ9 as a depression monitoring tool (http://www.phqscreeners.com) or the Edinburgh Postnatal Depression Scale for use during pregnancy found @ http://www.cdph.ca.gov/programs/cdapp/Pages/default.aspx

5. A list of general and specific references is included in the Basic Guidelines for Diabetes Care Packet.

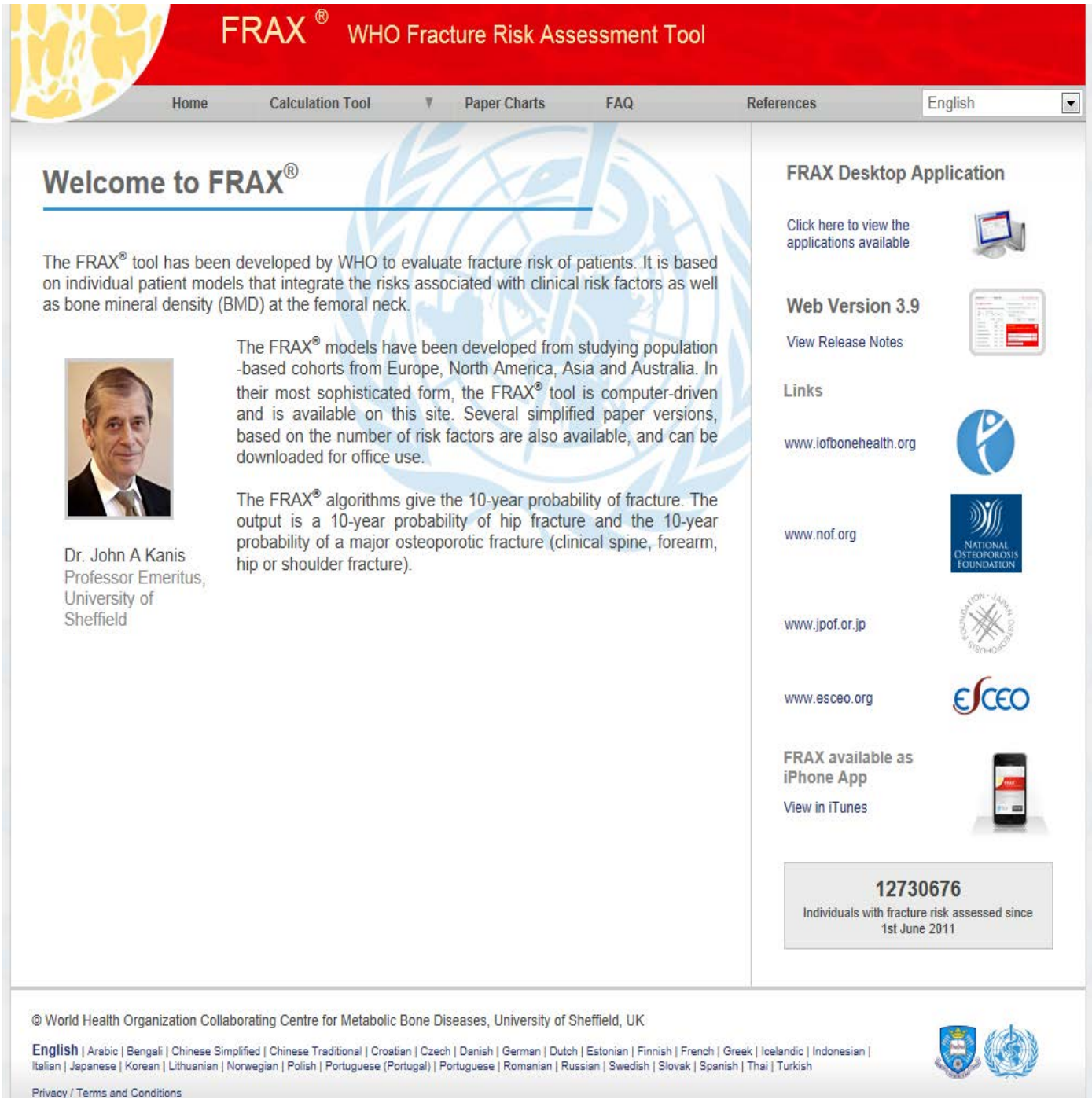
SAN MATEO MEDICAL CENTER
DIABETES MEDICATION PROTOCOL
Inclusion Criteria - A1C > 7.5 and AGE < 75 and
has either seen DM nurse or gone to DM class
Exclusion Criteria- No BS < 80 or patients with life expectancy < 5 years



***optional lower starting dose if concern for hypoglycemia*

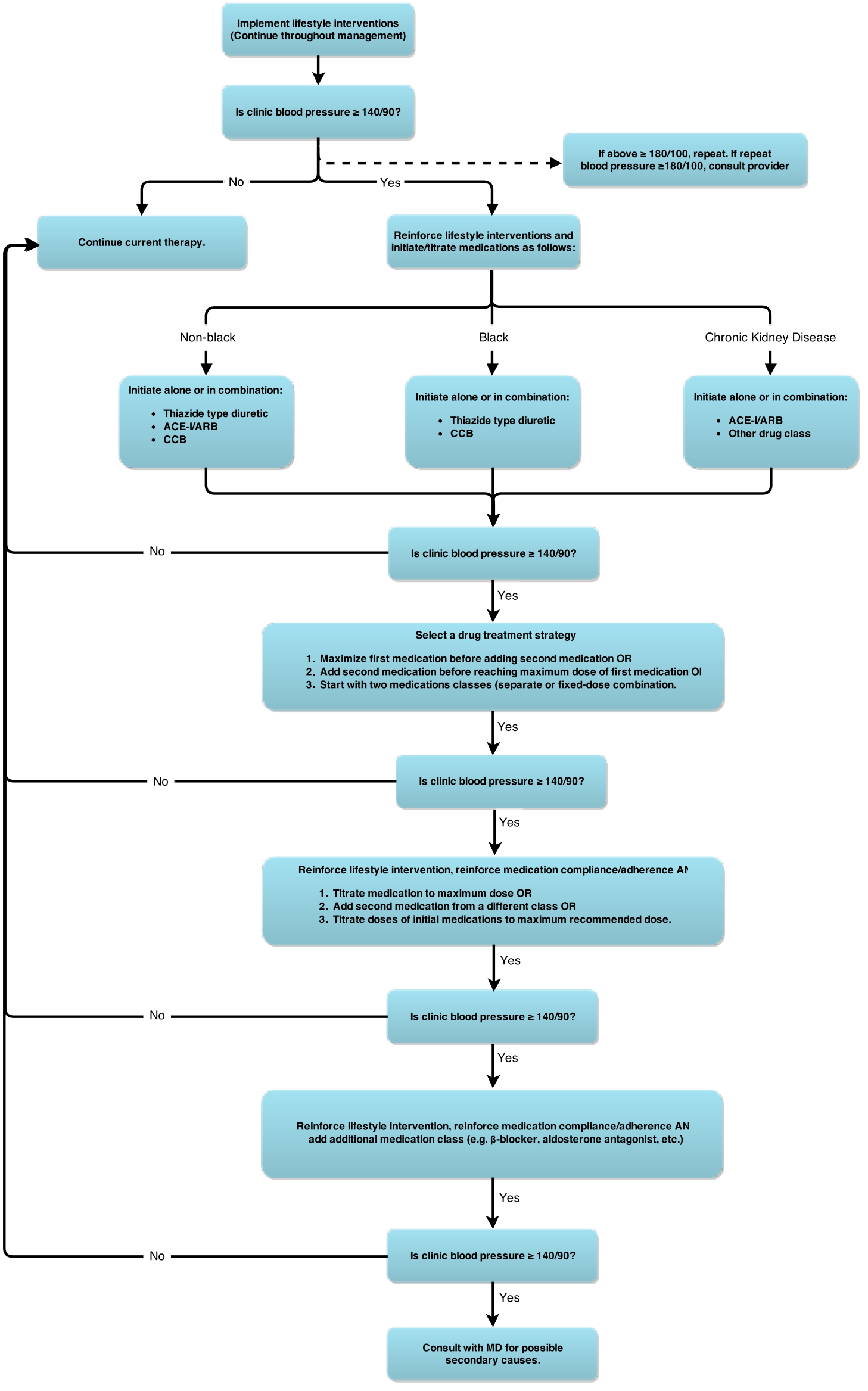
Updated 3/2012

Fracture Risk Assessment Tool



http://www.shef.ac.uk/FRAX/

Attachment 1: Hypertension Medication Protocol for patients that meet inclusion/exclusion criteria



Adult Immunization Guidelines

San Mateo Medical Center
San Mateo County Health System
June 2014

San Mateo County
Immunization Guidelines

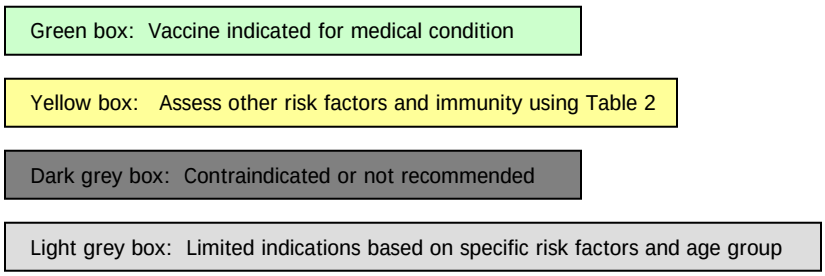
TABLE OF CONTENTS

Adult Immunization Guidelines: Notes, legends, and usage algorithm

The following immunization guidelines are written for adults aged 19 years and older. In contrast to pediatric immunization guidelines, adult immunizations are administered based on medical conditions and other risk factors, and are less dependent on age. The tables on the following pages describe which vaccines to administer, based on underlying medical conditions, evidence of previous immunity, specific risk factors, and age.

Table 1 on page 3 outlines each vaccine, and the underlying medical conditions in which the vaccine is absolutely indicated, contraindicated, or conditionally indicated if other risk factors are present. Table 2 on page 4 outlines the vaccine type and other risk factors in which each immunization would be indicated. The legends and algorithms below provide guidance to use these tables. The ACIP-recommended adult immunization schedule is outlined on pages 5-7. Special notes for each vaccine, eligibility for state-supplied vaccine, vaccine doses, route, site, and needle size, as well as screening assessment are also described. The next section provides more detailed guidelines by describing indications, contraindications, and adverse reactions specific to each type of vaccine administered.

Legend:



Usage algorithm

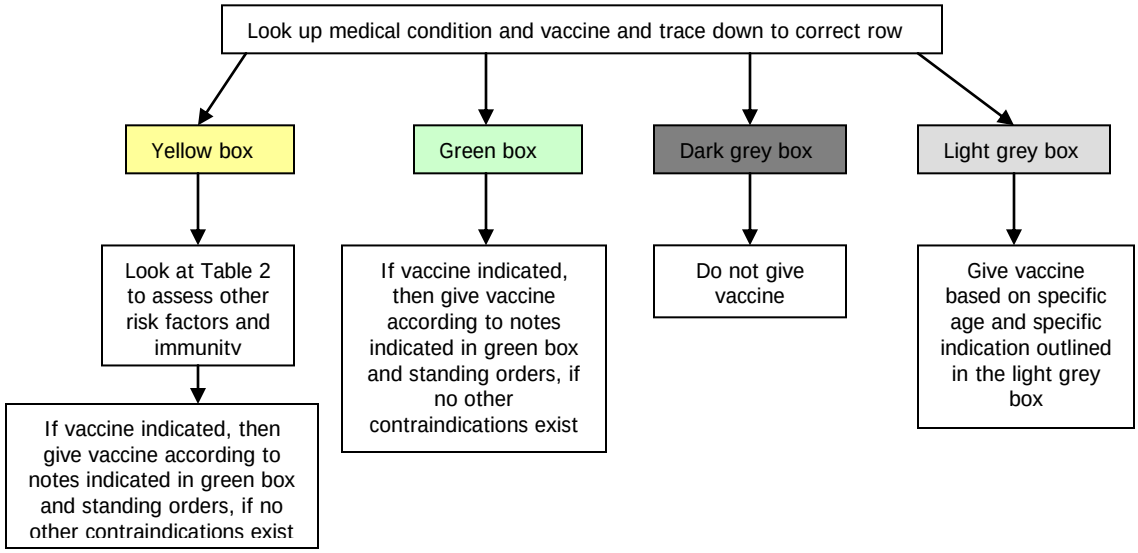


Table 1: Vaccines to administer based on medical and other indications

Medical conditions and indications	Vaccines												
	Hepatitis A	Hepatitis B	Human Papilloma Virus		Influenza	Meningococcal	MMR	PPSV 23	PCV 13	Td	Tdap	Varicella	Zoster
			Male	Female									
Pregnancy	a	a	N/A	Not recommended	Use preservative free vaccine	a	Contraindicated	a	Not recommended		1 dose each pregnancy	Contraindicated	Contraindicated
Immunocompromising conditions, excluding HIV, asplenia and complement deficiencies.	a	a	3 doses indicated in adult men through age 21 years. For HIV+ or MSM, may vaccinate through age 26 years	3 doses indicated in adult women through age 26 years	Use inactivated influenza vaccine (IIV) or recombinant influenza vaccine (RIV)	a	Contraindicated	If PCV 13 given first, give 1 dose 8 weeks after. Give 1-2*doses (2nd vax 5 years after first dose)	¥If PPSV given first, give 1 dose one or more years after last PPSV 23 dose.		Give 1 dose in place of regular Td booster in adults aged 19 or older	Contraindicated	Contraindicated
• **HIV/AIDS** **CD4< 200**	a	2 doses indicated				a	Contraindicated for CD4<200					Contraindicated in AIDS (CD4<200)	Contraindicated in AIDS (CD4<200)
• **HIV/AIDS** **CD4 >200**	a	2 doses indicated				a	b					c	1 dose recommended in those 60 and older by ACIP, but FDA licensed for 50 and older
Men who have sex with men (MSM)	2 doses indicated	2 doses indicated			May use IIV or LAIV	a	b	A	A			c	
• **Heart disease** • **Chronic lung disease (including asthma)** • **Chronic alcoholism**	a	a			Use IIV or RIV vaccine	a	b		A			c	
• **Asplenia (functional or anatomical)** • **Terminal complement component deficiencies**	a	a				Give 2 doses of quadrivalent vaccine at least 2 months apart. Revaccination recommended every 5 years	b	Give 1 dose 8 wks after PCV or *2 doses	¥Give 1 dose 1 or more years after last PPSV 23 dose.			c	
• **Chronic liver disease**	2 doses indicated	3 doses indicated				a	b		A			c	
• **Renal failure** • **ESRD on dialysis**	a					a	b	Give 1 dose 8 wks after PCV or 1 or *2 doses	¥Give 1 dose 1 or more years after last PPSV 23 dose.			c	
Diabetes	a					a	b		a			c	
Health care worker	a					a	b	a	a			c	
No medical problems	a	a			Encourage use of LAIV in adults aged 19-49 y	a	b	If 65 years or older	N/A			c	

[a] **Use table 2 to perform risk factor and/or immunity assessment**

[b] **Use table 2 to perform risk factor and immunity assessment. 1-2 doses indicated in those with no immunity. 2nd dose recommended if: 1) exposed in outbreak setting, 2) previously vaccinated with killed vaccine or vaccinated during 1963-1967, 3) student of postsecondary educational institutions, 4) work in healthcare facility, 5) planning to travel internationally, and 6) in age group where outbreak has occurred**

[c] **Use table 2 to perform risk factor and immunity assessment. 2 doses indicated in those with 1) no immunity to varicella, 2) those with high risk of exposure and transmission, 3) in close contact with the immunosuppressed**

***Give second dose in five years if first PPSV dose is given in a person<65 years of age or if patient has immunocompromising conditions or renal failure**

[¥] **PCV 13 designated for patients who are immunocompromised or have renal failure**

	Table 2: Risk factor and immunity assessment [a,b,c]					
Vaccine	**Occupational**	**Behavioral**	**High risk contacts and facilities**	**Endemic areas and travel**	**Susceptible race/ethnicity**	**Immunity assessment:**
Hepatitis A	Laboratory workers working with HAV or HAV infected animals	Men who have sex with men (MSM) and drug users	Anticipate close personal contact with international adoptee from a country of high or intermediate endemicity during the first 60 days after arrival of the adoptee.	Those residing in, originating from, or traveling to highly endemic areas *	N/A	Immunize those with no serologic evidence of past infection.
Hepatitis B	Healthcare workers, public safety workers exposed to blood or potentially infectious body fluids, staff of institutions for persons with developmental disabilities or correctional facilities, ESRD or chronic hemodialysis facilities	Men who have sex with men, injection drug users, those with more than 1 sex partner in 6 months, or persons seeking STD treatment	Household contacts and sex partners of those infected with HBV, STD and HIV testing facilities, clients of institutions for persons with developmental disabilities, those incarcerated in correctional facilities, those in drug treatment facilities, or facilities targeting MSM, persons participating in end stage renal disease programs or hemodialysis, patients receiving assisted blood glucose monitoring in long term care facilities	Those residing in, originating from, or traveling to highly endemic areas (HBsAg prevalence >=2%)*	See endemic areas and travel	Prevaccination testing to determine past infection is recommended for all foreign-born persons born in Africa, Asia, the Pacific Islands, and other regions with high endemicity of HBV infection (HBsAg prevalence of >8%); for household, sex, and needle-sharing contacts of HBsAg-positive persons; and for HIV-infected persons, injection-drug users, incarcerated persons, MSM; and persons born in countries with intermediate levels of endemic HBV infection [HBsAg prevalence of 2%--7%]. Prevaccination testing can be done with a single test (anti-HBc) or with a panel of tests (e.g., HBsAg and anti-HBs). **Using serologic testing to assess immunity from vaccination in persons with unknown or uncertain vaccination status can be problematic.**
Human Papilloma Virus	N/A	Women up to age 26. Men who have sex with men or immunocompromised men up to age 26. All other men up to age 21 (but may offer vaccine to those aged 22-26 years). May administer to patients with genital warts, abnormal PAP or positive HPV DNA test, which provides protection against infection with HPV vaccine types not already acquired	N/A	N/A	N/A	N/A
Meningococcal	One dose for laboratory workers who work with meningococcus. Revaccination in 5 years is recommended for continued occupational exposure	N/A	One dose for first year college students up to age 21 years living in dormitories (if they have not received a dose on or after their 16th birthday), military recruits, persons at risk during an outbreak attributable to vaccine serogroup	One dose for those residing in, originating from, or traveling to highly endemic areas	N/A	N/A

	Table 2: Risk factor and immunity assessment [a,b,c]					
Vaccine	**Occupational**	**Behavioral**	**High risk contacts and facilities**	**Endemic areas and travel**	**Susceptible race/ethnicity**	**Immunity assessment:**
MMR	2 doses needed for healthcare workers (28 days apart). Unvaccinated health-care personnel born before 1957 who lack laboratory evidence of measles, mumps, and/or rubella immunity should be vaccinated with 2 doses of MMR vaccine at the appropriate interval for measles and mumps or 1 dose of MMR vaccine for rubella.	N/A	2 doses needed for college students, women of childbearing age without evidence of immunity	2 doses needed for those traveling internationally	N/A	1) Born before 1957 **(this criteria not used in healthcare workers)** 2) Received >1 dose MMR 3) Laboratory evidence of immunity to all 3 diseases. **Physician diagnosed disease no longer considered evidence of immunity** 4) Persons vaccinated before 1979 with either killed mumps vaccine or mumps vaccine of unknown type who are at high risk for mumps infection should be considered for revaccination with 2 doses of MMR vaccine. 5) Persons vaccinated from 1963 to 1967 with killed measles vaccine or measles vaccine of unknown type should be revaccinated with 2 doses of MMR vaccine 6) All women of childbearing age should have rubella immunity determined by serology.
Pneumovax (PPSV 23)	N/A	Cigarette smoking	Patients 65 years and older; residents of nursing homes and long-term care facilities. Give single dose 8 weeks after PCV 13 for persons 19 years or older with co-existing immunocompromising conditions, including renal disease, CSF leaks and cochlear implants.	Routine use of PPSV vaccine is not recommended for American Indians/Alaska Natives or other persons younger than 65 years unless they have underlying medical conditions.	N/A	N/A
PCV 13	N/A	N/A	Give single dose 8 weeks before PPSV 23 for persons 19 years or older with co-existing immunocompromising conditions, including renal failure, CSF leaks, and cochlear implants. For patients who have received PPSV 23 first, give PCV 13 1 or more years after PPSV dose.	N/A	N/A	N/A
Td/Tdap	Healthcare workers	N/A	For Tdap: Give to all adults who have not previously received Tdap, one dose during each pregnancy	N/A	N/A	Adults with uncertain or incomplete history of primary vaccination with tetanus and diphtheria toxoid-containing vaccines should complete a primary vaccination series: First 2 doses at least 4 weeks apart, and third dose 6-12 mos after the second; Tdap can substitute for Td for one dose. For incompletely vaccinated adults, administer remaining doses of Td if Tdap already given.
Varicella	Healthcare workers, teachers, childcare employees, and staff of institutional and correctional settings, and military personnel with no evidence of immunity to varicella	N/A	College students; residents of institutional settings or correctional facilities; adolescents and adults living with children, household contacts of immunocompromised people, nonpregnant women of childbearing age with no evidence of varicella immunity	Those traveling internationally	N/A	1) Born in US before 1980 **(this criterion not used in healthcare workers and pregnant women)** 2) Received 2 doses at least 4 wks apart 3) History of varicella disease or herpes zoster diagnosed by healthcare provider 4) Laboratory evidence of immunity
Zoster	N/A	N/A	N/A	N/A	N/A	N/A

*Hepatitis A and B Hyperendemic areas:
List of countries available at wwwn.cdc.gov/travel/contentdiseases.asp

Recommended Adult Immunization Schedule—United States - 2014

Note: These recommendations must be read with the footnotes that follow containing number of doses, intervals between doses, and other important information.

Figure 1. Recommended adult immunization schedule, by vaccine and age group[1]

VACCINE ▼ / AGE GROUP ►	19-21 years	22-26 years	27-49 years	50-59 years	60-64 years	≥ 65 years
Influenza [2,*]	1 dose annually					
Tetanus, diphtheria, pertussis (Td/Tdap) [3,*]	Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs					
Varicella [4,*]	2 doses					
Human papillomavirus (HPV) Female [5,*]	3 doses					
Human papillomavirus (HPV) Male [5,*]	3 doses					
Zoster [6]					1 dose	
Measles, mumps, rubella (MMR) [7,*]	1 or 2 doses					
Pneumococcal 13-valent conjugate (PCV13) [8,*]	1 dose					
Pneumococcal polysaccharide (PPSV23) [9,10]	1 or 2 doses					1 dose
Meningococcal [11,*]	1 or more doses					
Hepatitis A [12,*]	2 doses					
Hepatitis B [13,*]	3 doses					
Haemophilus influenzae type b (Hib) [14,*]	1 or 3 doses					

*Covered by the Vaccine Injury Compensation Program

- For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection; zoster vaccine recommended regardless of prior episode of zoster
- Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indication)
- No recommendation

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at www.vaers.hhs.gov or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at www.hrsa.gov/vaccinecompensation or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005; telephone, 202-357-6400.

Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination is also available at www.cdc.gov/vaccines or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 8:00 a.m. - 8:00 p.m. Eastern Time, Monday - Friday, excluding holidays.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), American College of Obstetricians and Gynecologists (ACOG) and American College of Nurse-Midwives (ACNM).

Figure 2. Vaccines that might be indicated for adults based on medical and other indications[1]

VACCINE ▼ / INDICATION ►	Pregnancy	Immuno-compromising conditions (excluding human immunodeficiency virus [HIV])[4,6,7,8,15]	HIV infection CD4+ T lymphocyte count [4,6,7,8,15]: < 200 cells/μL	HIV infection CD4+ T lymphocyte count [4,6,7,8,15]: ≥ 200 cells/μL	Men who have sex with men (MSM)	Kidney failure, end-stage renal disease, receipt of hemodialysis	Heart disease, chronic lung disease, chronic alcoholism	Asplenia (including elective splenectomy and persistent complement component deficiencies) [8,14]	Chronic liver disease	Diabetes	Healthcare personnel
Influenza [2,*]	1 dose IIV annually				1 dose IIV or LAIV annually	1 dose IIV annually					1 dose IIV or LAIV annually
Tetanus, diphtheria, pertussis (Td/Tdap) [3,*]	1 dose Tdap each pregnancy	Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs									
Varicella [4,*]	Contraindicated			2 doses							
Human papillomavirus (HPV) Female [5,*]		3 doses through age 26 yrs				3 doses through age 26 yrs					
Human papillomavirus (HPV) Male [5,*]		3 doses through age 26 yrs				3 doses through age 21 yrs					
Zoster [6]	Contraindicated			1 dose							
Measles, mumps, rubella (MMR) [7,*]	Contraindicated			1 or 2 doses							
Pneumococcal 13-valent conjugate (PCV13) [8,*]		1 dose									
Pneumococcal polysaccharide (PPSV23) [9,10]		1 or 2 doses									
Meningococcal [11,*]		1 or more doses									
Hepatitis A [12,*]		2 doses									
Hepatitis B [13,*]		3 doses									
Haemophilus influenzae type b (Hib) [14,*]		post-HSCT recipients only		1 or 3 doses							

*Covered by the Vaccine Injury Compensation Program

- For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection; zoster vaccine recommended regardless of prior episode of zoster
- Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)
- No recommendation

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Centers for Disease Control and Prevention

These schedules indicate the recommended age groups and medical indications for which administration of currently licensed vaccines is commonly indicated for adults ages 19 years and older, as of February 1, 2014. For all vaccines being recommended on the Adult Immunization Schedule: a vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are issued during the year, consult the manufacturers' package inserts and the complete statements from the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/hcp/acip-recs/index.html). Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

Footnotes
Recommended Immunization Schedule for Adults Aged 19 Years or Older: United States, 2014

1. **Additional information**
   - Additional guidance for the use of the vaccines described in this supplement is available at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
   - Information on vaccination recommendations when vaccination status is unknown and other general immunization information can be found in the General Recommendations on Immunization at www.cdc.gov/mmwr/preview/mmwrhtml/rr6002a1.htm.
   - Information on travel vaccine requirements and recommendations (e.g., for hepatitis A and B, meningococcal, and other vaccines) is available at http://wwwnc.cdc.gov/travel/destinations/list.
   - Additional information and resources regarding vaccination of pregnant women can be found at http://www.cdc.gov/vaccines/adults/rec-vac/pregnant.html.
2. **Influenza vaccination**
   - Annual vaccination against influenza is recommended for all persons aged 6 months or older.
   - Persons aged 6 months or older, including pregnant women and persons with hives-only allergy to eggs, can receive the inactivated influenza vaccine (IIV). An age-appropriate IIV formulation should be used.
   - Adults aged 18 to 49 years can receive the recombinant influenza vaccine (RIV) (FluBlok). RIV does not contain any egg protein.
   - Healthy, nonpregnant persons aged 2 to 49 years without high-risk medical conditions can receive either intranasally administered live, attenuated influenza vaccine (LAIV) (FluMist), or IIV. Health care personnel who care for severely immunocompromised persons (i.e., those who require care in a protected environment) should receive IIV or RIV rather than LAIV.
   - The intramuscularly or intradermally administered IIV are options for adults aged 18 to 64 years.
   - Adults aged 65 years or older can receive the standard-dose IIV or the high-dose IIV (Fluzone High-Dose).
3. **Tetanus, diphtheria, and acellular pertussis (Td/Tdap) vaccination**
   - Administer 1 dose of Tdap vaccine to pregnant women during each pregnancy (preferred during 27 to 36 weeks' gestation) regardless of interval since prior Td or Tdap vaccination.
   - Persons aged 11 years or older who have not received Tdap vaccine or for whom vaccine status is unknown should receive a dose of Tdap followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter. Tdap can be administered regardless of interval since the most recent tetanus or diphtheria-toxoid containing vaccine.
   - Adults with an unknown or incomplete history of completing a 3-dose primary vaccination series with Td-containing vaccines should begin or complete a primary vaccination series including a Tdap dose.
   - For unvaccinated adults, administer the first 2 doses at least 4 weeks apart and the third dose 6 to 12 months after the second.
   - For incompletely vaccinated (i.e., less than 3 doses) adults, administer remaining doses.
   - Refer to the ACIP statement for recommendations for administering Td/Tdap as prophylaxis in wound management (see footnote 1).
4. **Varicella vaccination**
   - All adults without evidence of immunity to varicella (as defined below) should receive 2 doses of single-antigen varicella vaccine or a second dose if they have received only 1 dose.
   - Vaccination should be emphasized for those who have close contact with persons at high risk for severe disease (e.g., health care personnel and family contacts of persons with immunocompromising conditions) or are at high risk for exposure or transmission (e.g., teachers; child care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers).
   - Pregnant women should be assessed for evidence of varicella immunity. Women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of pregnancy and before discharge from the health care facility. The second dose should be administered 4 to 8 weeks after the first dose.
   - Evidence of immunity to varicella in adults includes any of the following:
     — documentation of 2 doses of varicella vaccine at least 4 weeks apart;
     —U.S.-born before 1980, except health care personnel and pregnant women;
     — history of varicella based on diagnosis or verification of varicella disease by a health care provider;
     — history of herpes zoster based on diagnosis or verification of herpes zoster disease by a health care provider; or
     — laboratory evidence of immunity or laboratory confirmation of disease.
5. **Human papillomavirus (HPV) vaccination**
   - Two vaccines are licensed for use in females, bivalent HPV vaccine (HPV2) and quadrivalent HPV vaccine (HPV4), and one HPV vaccine for use in males (HPV4).
   - For females, either HPV4 or HPV2 is recommended in a 3-dose series for routine vaccination at age 11 or 12 years and for those aged 13 through 26 years, if not previously vaccinated.
   - For males, HPV4 is recommended in a 3-dose series for routine vaccination at age 11 or 12 years and for those aged 13 through 21 years, if not previously vaccinated. Males aged 22 through 26 years may be vaccinated.
5. **Human papillomavirus (HPV) vaccination (cont'd)**
   - HPV4 is recommended for men who have sex with men through age 26 years for those who did not get any or all doses when they were younger.
   - Vaccination is recommended for immunocompromised persons (including those with HIV infection) through age 26 years for those who did not get any or all doses when they were younger.
   - A complete series for either HPV4 or HPV2 consists of 3 doses. The second dose should be administered 4 to 8 weeks (minimum interval of 4 weeks) after the first dose; the third dose should be administered 24 weeks after the first dose and 16 weeks after the second dose (minimum interval of at least 12 weeks).
   - HPV vaccines are not recommended for use in pregnant women. However, pregnancy testing is not needed before vaccination. If a woman is found to be pregnant after initiating the vaccination series, no intervention is needed; the remainder of the 3-dose series should be delayed until completion of pregnancy.
6. **Zoster vaccination**
   - A single dose of zoster vaccine is recommended for adults aged 60 years or older regardless of whether they report a prior episode of herpes zoster. Although the vaccine is licensed by the U.S. Food and Drug Administration for use among and can be administered to persons aged 50 years or older, ACIP recommends that vaccination begin at age 60 years.
   - Persons aged 60 years or older with chronic medical conditions may be vaccinated unless their condition constitutes a contraindication, such as pregnancy or severe immunodeficiency.
7. **Measles, mumps, rubella (MMR) vaccination**
   - Adults born before 1957 are generally considered immune to measles and mumps. All adults born in 1957 or later should have documentation of 1 or more doses of MMR vaccine unless they have a medical contraindication to the vaccine or laboratory evidence of immunity to each of the three diseases. Documentation of provider-diagnosed disease is not considered acceptable evidence of immunity for measles, mumps, or rubella.

   Measles component:
   - A routine second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who:
     — are students in postsecondary educational institutions;
     — work in a health care facility; or
     — plan to travel internationally.
   - Persons who received inactivated (killed) measles vaccine or measles vaccine of unknown type during 1963–1967 should be revaccinated with 2 doses of MMR vaccine.

   Mumps component:
   - A routine second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who:
     — are students in a postsecondary educational institution;
     — work in a health care facility; or
     — plan to travel internationally.
   - Persons vaccinated before 1979 with either killed mumps vaccine or mumps vaccine of unknown type who are at high risk for mumps infection (e.g., persons who are working in a health care facility) should be considered for revaccination with 2 doses of MMR vaccine.

   Rubella component:
   - For women of childbearing age, regardless of birth year, rubella immunity should be determined. If there is no evidence of immunity, women who are not pregnant should be vaccinated. Pregnant women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from the health care facility.

   Health care personnel born before 1957:
   - For unvaccinated health care personnel born before 1957 who lack laboratory evidence of measles, mumps, and/or rubella immunity or laboratory confirmation of disease, health care facilities should consider vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval for measles and mumps or 1 dose of MMR vaccine for rubella.
8. **Pneumococcal conjugate (PCV13) vaccination**
   - Adults aged 19 years or older with immunocompromising conditions (including chronic renal failure and nephrotic syndrome), functional or anatomic asplenia, cerebrospinal fluid leaks, or cochlear implants who have not previously received PCV13 or PPSV23 should receive a single dose of PCV13 followed by a dose of PPSV23 at least 8 weeks later.
   - Adults aged 19 years or older with the aforementioned conditions who have previously received 1 or more doses of PPSV23 should receive a dose of PCV13 one or more years after the last PPSV23 dose was received. For adults who require additional doses of PPSV23, the first such dose should be given no sooner than 8 weeks after PCV13 and at least 5 years after the most recent dose of PPSV23.
   - When indicated, PCV13 should be administered to patients who are uncertain of their vaccination status history and have no record of previous vaccination.
   - Although PCV13 is licensed by the U.S. Food and Drug Administration for use among and can be administered to persons aged 50 years or older, ACIP recommends PCV13 for adults aged 19 years or older with the specific medical conditions noted above.

9. Pneumococcal polysaccharide (PPSV23) vaccination

- When PCV13 is also indicated, PCV13 should be given first (see footnote 8).
- Vaccinate all persons with the following indications:
  - all adults aged 65 years or older;
  - adults younger than 65 years with chronic lung disease (including chronic obstructive pulmonary disease, emphysema, and asthma), chronic cardiovascular diseases, diabetes mellitus, chronic renal failure, nephrotic syndrome, chronic liver disease (including cirrhosis), alcoholism, cochlear implants, cerebrospinal fluid leaks, immunocompromising conditions, and functional or anatomic asplenia (e.g., sickle cell disease and other hemoglobinopathies, congenital or acquired asplenia, splenic dysfunction, or splenectomy [if elective splenectomy is planned, vaccinate at least 2 weeks before surgery]);
  - residents of nursing homes or long-term care facilities; and
  - adults who smoke cigarettes.
- Persons with immunocompromising conditions and other selected conditions are recommended to receive PCV13 and PPSV23 vaccines. See footnote 8 for information on timing of PCV13 and PPSV23 vaccinations.
- Persons with asymptomatic or symptomatic HIV infection should be vaccinated as soon as possible after their diagnosis.
- When cancer chemotherapy or other immunosuppressive therapy is being considered, the interval between vaccination and initiation of immunosuppressive therapy should be at least 2 weeks. Vaccination during chemotherapy or radiation therapy should be avoided.
- Routine use of PPSV23 vaccine is not recommended for American Indians/Alaska Natives or other persons younger than 65 years unless they have underlying medical conditions that are PPSV23 indications. However, public health authorities may consider recommending PPSV23 for American Indians/Alaska Natives who are living in areas where the risk for invasive pneumococcal disease is increased.
- When indicated, PPSV23 vaccine should be administered to patients who are uncertain of their vaccination status and have no record of vaccination.

10. Revaccination with PPSV23

- One-time revaccination 5 years after the first dose of PPSV23 is recommended for persons aged 19 through 64 years with chronic renal failure or nephrotic syndrome, functional or anatomic asplenia (e.g., sickle cell disease or splenectomy), or immunocompromising conditions.
- Persons who received 1 or 2 doses of PPSV23 before age 65 years for any indication should receive another dose of the vaccine at age 65 years or later if at least 5 years have passed since their previous dose.
- No further doses of PPSV23 are needed for persons vaccinated with PPSV23 at or after age 65 years.

11. Meningococcal vaccination

- Administer 2 doses of quadrivalent meningococcal conjugate vaccine (MenACWY [Menactra, Menveo]) at least 2 months apart to adults of all ages with functional asplenia or persistent complement component deficiencies. HIV infection is not an indication for routine vaccination with MenACWY. If an HIV-infected person of any age is vaccinated, 2 doses of MenACWY should be administered at least 2 months apart.
- Administer a single dose of meningococcal vaccine to microbiologists routinely exposed to isolates of *Neisseria meningitidis*, military recruits, persons at risk during an outbreak attributable to a vaccine serogroup, and persons who travel to or live in countries in which meningococcal disease is hyperendemic or epidemic.
- First-year college students up through age 21 years who are living in residence halls should be vaccinated if they have not received a dose on or after their 16th birthday.
- MenACWY is preferred for adults with any of the preceding indications who are aged 55 years or younger as well as for adults aged 56 years or older who a) were vaccinated previously with MenACWY and are recommended for revaccination, or b) for whom multiple doses are anticipated. Meningococcal polysaccharide vaccine (MPSV4 [Menomune]) is preferred for adults aged 56 years or older who have not received MenACWY previously and who require a single dose only (e.g., travelers).
- Revaccination with MenACWY every 5 years is recommended for adults previously vaccinated with MenACWY or MPSV4 who remain at increased risk for infection (e.g., adults with anatomic or functional asplenia, persistent complement component deficiencies, or microbiologists).

12. Hepatitis A vaccination

- Vaccinate any person seeking protection from hepatitis A virus (HAV) infection and persons with any of the following indications:
  - men who have sex with men and persons who use injection or non-injection illicit drugs;
  - persons working with HAV-infected primates or with HAV in a research laboratory setting;
  - persons with chronic liver disease and persons who receive clotting factor concentrates;
  - persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A; and

12. Hepatitis A vaccination (cont'd)

  - unvaccinated persons who anticipate close personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity. (See footnote 1 for more information on travel recommendations.) The first dose of the 2-dose hepatitis A vaccine series should be administered as soon as adoption is planned, ideally 2 or more weeks before the arrival of the adoptee.
- Single-antigen vaccine formulations should be administered in a 2-dose schedule at either 0 and 6 to 12 months (Havrix), or 0 and 6 to 18 months (Vaqta). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose schedule may be used, administered on days 0, 7, and 21 to 30 followed by a booster dose at month 12.

13. Hepatitis B vaccination

- Vaccinate persons with any of the following indications and any person seeking protection from hepatitis B virus (HBV) infection:
  - sexually active persons who are not in a long-term, mutually monogamous relationship (e.g., persons with more than 1 sex partner during the previous 6 months); persons seeking evaluation or treatment for a sexually transmitted disease (STD); current or recent injection drug users; and men who have sex with men;
  - health care personnel and public safety workers who are potentially exposed to blood or other infectious body fluids;
  - persons with diabetes who are younger than age 60 years as soon as feasible after diagnosis; persons with diabetes who are age 60 years or older at the discretion of the treating clinician based on the likelihood of acquiring HBV infection, including the risk posed by an increased need for assisted blood glucose monitoring in long-term care facilities, the likelihood of experiencing chronic sequelae if infected with HBV, and the likelihood of immune response to vaccination;
  - persons with end-stage renal disease, including patients receiving hemodialysis, persons with HIV infection, and persons with chronic liver disease;
  - household contacts and sex partners of hepatitis B surface antigen–positive persons, clients and staff members of institutions for persons with developmental disabilities, and international travelers to countries with high or intermediate prevalence of chronic HBV infection; and
  - all adults in the following settings: STD treatment facilities, HIV testing and treatment facilities, facilities providing drug abuse treatment and prevention services, health care settings targeting services to injection drug users or men who have sex with men, correctional facilities, end-stage renal disease programs and facilities for chronic hemodialysis patients, and institutions and nonresidential day care facilities for persons with developmental disabilities.
- Administer missing doses to complete a 3-dose series of hepatitis B vaccine to those persons not vaccinated or not completely vaccinated. The second dose should be administered 1 month after the first dose; the third dose should be given at least 2 months after the second dose (and at least 4 months after the first dose). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, give 3 doses at 0, 1, and 6 months; alternatively, a 4-dose Twinrix schedule, administered on days 0, 7, and 21 to 30 followed by a booster dose at month 12 may be used.
- Adult patients receiving hemodialysis or with other immunocompromising conditions should receive 1 dose of 40 mcg/mL (Recombivax HB) administered on a 3-dose schedule at 0, 1, and 6 months or 2 doses of 20 mcg/mL (Engerix-B) administered simultaneously on a 4-dose schedule at 0, 1, 2, and 6 months.

14. *Haemophilus influenzae type b* (Hib) vaccination

- One dose of Hib vaccine should be administered to persons who have functional or anatomic asplenia or sickle cell disease or are undergoing elective splenectomy if they have not previously received Hib vaccine. Hib vaccination 14 or more days before splenectomy is suggested.
- Recipients of a hematopoietic stem cell transplant should be vaccinated with a 3-dose regimen 6 to 12 months after a successful transplant, regardless of vaccination history; at least 4 weeks should separate doses.
- Hib vaccine is not recommended for adults with HIV infection since their risk for Hib infection is low.

15. Immunocompromising conditions

- Inactivated vaccines generally are acceptable (e.g., pneumococcal, meningococcal, and inactivated influenza vaccine) and live vaccines generally are avoided in persons with immune deficiencies or immunocompromising conditions. Information on specific conditions is available at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

Important Notes About Specific Vaccines

Vaccine	Important Notes
Hepatitis A	• Single-antigen vaccine formulations should be administered in a 2-dose schedule at either 0 and 6–12 months (Havrix), or 0 and 6–18 months (Vaqta). • If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose schedule may be used, administered on days 0, 7, and 21–30, followed by a booster dose at month 12.
Hepatitis B	• Give vaccine at 0, 1-2 months, and 4-6 months • Minimum 1 month interval between 1st and 2nd dose, 2 months between 2nd and 3rd dose, and 4 months between 1st and 3rd dose. • For immunocompromised adults and those receiving dialysis: recommended dosage is 1 dose of 40ug/mL of Recombivax HB® administered on a 3 dose schedule (0, 1, and 6 months) or two doses of 20 ug/mL of Engerix-B ® administered on a 4 dose schedule at 0,1,2, and 6 months. • If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose schedule may be used, administered on days 0, 7, and 21–30, followed by a booster dose at month 12.
Human Papilloma Virus	• Give bivalent or quadrivalent vaccine to adult women up to age 26, if not previously vaccinated. Females infected with one or more vaccine HPV types before vaccination would be protected against disease caused by the other HPV types. **SMMC has Quadrivalent vaccine only.** • Give quadrivalent vaccine to adult males up to age 21, if not previously vaccinated. May give vaccine to men aged 22-26 who are HIV negative and not MSM. • May give quadrivalent vaccine to adult males up to 26 years of age who have risk factor of MSM, if not previously vaccinated. • Give at 0, 2 months, 6 months • Minimum of 1-2 months (4-8 weeks) between the 1st and 2nd dose and at least 6 months (24 weeks) between the 1st and 3rd doses. • Do not give during pregnancy. If woman is found to be pregnant after first dose, delay the remainder of the 3 dose series until completion of pregnancy. • Vaccination is recommended for immunocompromised persons (including those with HIV infection) through age 26 years for those who did not get any or all doses when they were younger.
Seasonal Influenza	• Annual vaccination against influenza is recommended for all persons aged 6 months or older • Use preservative free vaccine for pregnant women • Persons aged 6 months or older, including pregnant women and persons with hives-only allergy to eggs, can receive the inactivated influenza vaccine (IIV) that is an age-appropriate formulation. • Adults aged 18-49 years can receive the recombinant influenza vaccine (RIV), which does not contain any egg protein. • Healthy, nonpregnant adults up to age 49 years without high-risk medical conditions can receive either intranasally administered live, attenuated influenza vaccine (LAIV) (FluMist), or inactivated influenza vaccine (IIV). • Healthcare personnel who care for severely immunocompromised persons (i.e. those who require care in a protected environment) should receive IIV or RIV rather than LAIV. • Adults aged 65 years and older can receive standard or high dose IIV • Intramuscular or intradermal IIV are options for adults aged 18-64 years
Meningo-coccal	• MenACWY (Menactra, Menveo) is preferred for adults with any of the preceding indications who are aged 55 years and younger or adults aged 56 years or older who were vaccinated previously with MenACWY and are recommended for revaccination or for whom multiple doses are anticipated. • Meningococcal polysaccharide vaccine (MPSV4--Menomune) is preferred for adults aged 56 years and older who have not received MenACWY previously and who require a single dose only (i.e. travelers). • Administer 2 doses of meningococcal conjugate vaccine quadrivalent (MenACWY) at least 2 months apart to adults with functional asplenia, persistent complement component deficiencies, or HIV. • Revaccination with MenACWY every 5 years is recommended for adults previously vaccinated with MenACWY or MPSV4 who remain at increased risk for infection (e.g., adults with anatomic or functional asplenia or persistent complement component deficiencies or microbiologists).
MMR	• Assess for immunity to MMR (see Table 2, page 4). Note that healthcare provider- diagnosed disease is no longer considered acceptable evidence for immunity for MMR. • MMR #2 is given minimum of 28 days after MMR#1 • A second dose of MMR vaccine, administered 4 weeks after the first dose, is recommended for adults who: 1) are students in postsecondary educational institutions; 2) work in a healthcare facility; 3) plan to travel internationally • Persons who have been vaccinated previously with killed measles vaccine or with an unknown type of measles vaccine during 1963-1967 should receive 2 doses of vaccine. • Persons vaccinated before 1979 with either killed mumps vaccine or mumps vaccine of unknown type who are at high risk for mumps infection (e.g., persons who are working in a health-care facility) should be considered for revaccination with 2 doses of MMR vaccine. • For women of childbearing age, regardless of birth year, rubella immunity should be determined. If there is no evidence of immunity, women who are not pregnant should be vaccinated. • Healthcare personnel born before 1957 who lack laboratory evidence of immunity to measles, mumps, and/or rubella should receive 2 doses of MMR vaccine 28 days apart. Healthcare personnel who lack laboratory evidence of immunity to rubella should receive one dose of MMR vaccine. • Do not vaccinate women who are pregnant or may become pregnant within 4 weeks of receiving the vaccine • Pregnant women without evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from healthcare facility.
PPSV23	• When PCV 13 is also indicated, PCV 13 should be given first. Persons with immunocompromising conditions, renal failure,

Vaccine	Important Notes
	nephrotic syndrome, CSF leaks or cochlear implants should receive both PCV 13 and PPSV 23. • Vaccinate all adults 65 years or older • Vaccine adults younger than 65 years with chronic lung disease, chronic cardiovascular diseases, diabetes mellitus, chronic renal failure, nephrotic syndrome, chronic liver disease, alcoholism, cochlear implants, CSF leaks, immunocompromising conditions, and functional or anatomic asplenia, residents of nursing homes or long-term care facilities, and adults who smoke cigarettes. • Persons with symptomatic or asymptomatic HIV infection should be vaccinated as soon as possible after their diagnosis • **Repeat vaccination 5 years later in those aged <65 y at time of first vaccine**, and in those with HIV, congenital immunodeficiency, hematological malignancy, generalized malignancy, history of organ transplantation, chronic renal failure, nephrotic syndrome, functional or anatomic asplenia, or if using immunosuppressive drugs • Persons who received 1 or 2 doses of PPSV23 before age 65 years for any indication should receive another dose of the vaccine at age 65 years or later if at least 5 years have passed since their previous dose. • When cancer chemotherapy or other immunosuppressive therapy is being considered, the interval between vaccination and initiation of immunosuppressive therapy should be at least 2 weeks. • Vaccination during chemotherapy or radiation therapy should be avoided. • No further doses of PPSV 23 are needed for persons vaccinated with PPSV at or after age 65 years.
PCV 13	• Adults aged **19 years or older with immunocompromising conditions (including chronic renal failure and nephrotic syndrome), functional or anatomic asplenia, CSF leaks or cochlear implants**, and who have not previously received PCV13 or PPSV23 should receive a single dose of PCV13 followed by a dose of PPSV23 at least 8 weeks later. • Adults aged 19 years or older with the aforementioned conditions who have previously received one or more doses of PPSV23 should receive a dose of PCV13 one or more years after the last PPSV23 dose was received. • For adults who require additional doses of PPSV23, the first such dose should be given no sooner than 8 weeks after PCV13 and at least 5 years since the most recent dose of PPSV23. • When indicated, PCV 13 should be administered to patients who are uncertain of their vaccination status history and have no record of previous vaccination.
Td/Tdap	• Administer Tdap to all other adults who have not previously received Tdap or for whom vaccine status is unknown. Tdap can be administered regardless of interval since the most recent tetanus or diphtheria-toxoid containing vaccine. Tdap dose should be followed by Td booster doses every 10 years thereafter. • Administer one dose of Tdap vaccine to pregnant women during each pregnancy (preferred during 27–36 weeks' gestation), regardless of number of years since prior Td or Tdap vaccination. • Adults with an unknown or incomplete history of completing a 3-dose primary vaccination series with Td-containing vaccines should begin or complete a primary vaccination series including a Tdap dose. • For unvaccinated adults, administer the first 2 doses at least 4 weeks apart and the third dose 6–12 months after the second. • For incompletely vaccinated (i.e., less than 3 doses) adults, administer remaining doses.
Varicella	• All adults without evidence of immunity to varicella should receive 2 doses of single-antigen varicella vaccine or a second dose if they have received only 1 dose. • Assess for immunity to varicella (see Table 2, page 5) • Dose 2 should be given 4-8 weeks after dose 1 • Do not vaccinate women who are pregnant; administer upon completion or termination of pregnancy or before discharge from healthcare facility
Zoster	• Give one dose only to those aged >60 years and older regardless of whether they report a prior episode of herpes zoster. • Although the vaccine is licensed by the Food and Drug Administration (FDA) for use among and can be administered to persons aged 50 years and older, ACIP recommends that vaccination begins at age 60 years. • Persons aged 60 years and older with chronic medical conditions may be vaccinated unless their condition constitutes a contraindication, such as pregnancy or severe immunodeficiency

NOTE: If the second or third dose is late, it is not necessary to restart the series

SMMC Pharmacy Adult Vaccine Formulary

Vaccine	Availability
Hepatitis A	Available; clinics will stock
Hepatitis B	Available; clinics will stock
Combination Hepatitis A/B vaccine (Twinrix)	Available; clinics will stock
Human Papilloma Virus	Available for women; those ≥19 years must pay unless their insurance covers it.
Influenza	Available; clinics will stock
Meningococcal	Not available for adults aged≥19 years
MMR	Available; clinics will stock
Pneumococcal polysaccharide	Available; clinics will stock
PCV 13	Available; clinics will stock
Rabies	Available; clinics will stock
Td	Available; clinics will stock
Tdap (Adacel)	Available; clinics will stock
Varicella	Will not be routinely stocked in clinics for adult use. Clinic must furnish evidence of negative varicella titer and order vaccine in advance.
Zoster	Available; patients without Medicare Part D or covering insurance must pay for vaccine.

Adult Immunization Eligibility with Vaccines Distributed by the California Department of Public Health Immunization Branch

Vaccine	Risk/Age appropriate usage
Hepatitis B	• Available only for adult (aged ≥19 years) household or sexual contacts of HBsAg positive pregnant woman • Fully insured children and adults are not eligible to receive state vaccine
Human Papilloma Virus	• Not currently available for adults aged≥19 years • Fully insured children and adults are not eligible to receive state vaccine
Influenza	• VFC vaccine can be provided to insured children and adults in outbreak situations only when the local Health Officer, in consultation with CDPH, decides that vaccination is indicated as part of outbreak control. • Flu vaccine from the state (with the exception of that provided specifically by the VFC [317] program) can be given to all, regardless of insurance status.
MMR	• 1st Dose – Adults who have not been immunized against MMR • 2nd dose in adults 19 years and older and born in 1957 or later **ONLY** if they are: 1) College/university students; 2) Health care workers • Fully insured children and adults are not eligible to receive state vaccine
IPV (Polio)	• Only for ACIP recommended high risk situations
Td	• Available for adults ≥19 years of age only when Tdap is not indicated • Fully insured children and adults are not eligible to receive state vaccine
Tdap	• Available for adults ≥ 19 years of age • Fully insured children and adults are not eligible to receive state vaccine
Varicella	Not available for adults aged≥19 years
Zoster	Not available

Adult Sites, Routes, Dose, Needle Size, and Number of Doses

Vaccine	Site	Route	Dose	Needle Size	Number of Doses
Hepatitis A	Deltoid	Intramuscular	1 mL	1-1.5″ 23-25 gauge	2 doses (0 and 6-18 mos)
Hepatitis B	Deltoid	Intramuscular	1 mL	1-1.5″ 23-25 gauge	3 doses (0, 1-2 mos, 4-6 mos)
Combination Hepatitis A and B	Deltoid	Intramuscular	1 mL	1-1.5″ 23-25 gauge	3 doses (0,1, and 6 mos) Alternate dosing (0, 7d, and 21-30 d, and 12 mos)
Human Papilloma Virus	Deltoid	Intramuscular	.5 mL	1-1.5″ 23-25 gauge	3 doses (0, 2 mos, 6 mos) in adult women and men 19-26 years
Influenza (Inactivated)	Deltoid	Intramuscular	.5 mL	1-1.5″ 23-25 gauge	1 dose annually
Influenza (LAIV)	Nose	Intranasal	0.1 mL each nostril	N/A	1 dose annually
Meningococcal	Deltoid	Intramuscular	.5 mL	1-1.5″ 23-25 gauge	1 or more doses
MMR	Outer aspect of upper arm	Subcutaneous	.5 mL	5/8″ 23-25 gauge	1-2 doses if born before 1957 1 dose if born after 1957 (except healthcare workers)
Pneumococcal polysaccharide (PPSV 23 and PCV 13)	Deltoid	Intramuscular	.5 mL	1-1.5″ 23-25 gauge	If indicated, give 1 dose of PCV 13 8 weeks before PPSV 23 vaccine. If PPSV23 given first, give PCV 13 one or more years after PPSV23. For PPSV 23, give 1-2 doses if first dose given before 65 years and if vaccine was given >5 years previously for 1 dose if first dose given after 65 years
Td	Deltoid	Intramuscular	.5 mL	1-1.5″ 23-25 gauge	1 dose every 10 years across all ages
Tdap	Deltoid	Intramuscular	.5 mL	1-1.5″ 23-25 gauge	1 dose in place of Td in all adults and 1 dose for each pregnancy
Varicella	Outer aspect of upper arm	Subcutaneous	.5 mL	5/8″ 23-25 gauge	2 doses (0 and 4-8 wks)
Zoster	Outer aspect of upper arm	Subcutaneous	.5 mL	5/8″ 23-25 gauge	1 dose for those aged ≥60

Notes: Do not use buttocks. SQ injections mistakenly given IM do not need to be repeated

Hepatitis A (HAV) Vaccine

Standing Orders for Administering Hepatitis A Vaccine to Adults at all San Mateo County Health System Clinics

Purpose: To reduce morbidity and mortality from the hepatitis A virus (HAV) by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

Policy: Under these Guidelines, eligible nurses, pharmacists, supervised medical assistants and supervised nursing students may vaccinate patients who meet the criteria below.

Procedure:

1) Identify adults in need of hepatitis A vaccination based on the following criteria:
   - Any adult who wants to be protected against Hepatitis A
   - anticipated travel to country with intermediate or high endemicity for hepatitis A (i.e., all countries except the United States, Canada, Japan, Australia, New Zealand, and Western Europe)
   - men who have sex with men
   - users of illicit drugs (injecting and non-injecting)
   - diagnosis of chronic liver disease, including Hepatitis B and C
   - diagnosis of a clotting-factor disorder, such as hemophilia
   - anticipated close personal contact with an international adoptee from a country of high or intermediate endemicity during the first 60 days after the arrival of the adoptee in the United States
   - employment in a research laboratory requiring work with HAV or HAV-infected primates
   - an unvaccinated adult age 40 years or younger with recent possible exposure to HAV (e.g., within previous two weeks) *(Note: Adults older than age 40 years who have an indication for vaccination can and should receive both IG and vaccine.)*

2) Screen all patients for contraindications and precautions to hepatitis A vaccine:
   - **Contraindications:** a history of a serious reaction after a previous dose of hepatitis A vaccine or to a hepatitis A vaccine component. For a list of vaccine components, go to http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf
   - **Precautions:** a moderate or severe acute illness with or without fever

3) Provide all patients with a copy of the most current federal Hepatitis A Vaccine Information Statement (VIS). Document in the patient's medical record the publication date of the VIS and the date it was given to the patient. Provide non-English speaking patients with a copy of the VIS in their native language, if available; these can be found at www.immunize.org/vis.

4) For patients less than 19 years of age, administer 0.5 mL pediatric hepatitis A vaccine and for patients 19 years of age and older, administer 1.0 mL adult hepatitis A vaccine. Give vaccine IM (23–25g, 1–1.5" needle) in the deltoid muscle.

5) Provide a subsequent dose of hepatitis A vaccine to complete each patient's 2-dose schedule by observing a minimum interval of 6 months between the first and second doses. If the second dose is late, the series does not need to be restarted.

6) To document each patient's vaccine administration information: see *Pediatric, Adolescent, and Adult Immunization Procedures* under #4.

7) .For management of Medical Emergencies, see *Pediatric, Adolescent, and Adult Immunization Procedures* under #5.

8) Report all adverse reactions to hepatitis A vaccine to the federal Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or by calling (800) 822-7967. VAERS report forms are available at www.vaers.hhs.gov.

Hepatitis B (HBV) Vaccine

Standing Orders for Administering Hepatitis B Vaccine to Adults at all San Mateo County Health System Clinics

Purpose: To reduce morbidity and mortality from hepatitis B virus (HBV) infection by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

Policy: Under these Guidelines, eligible nurses, pharmacists, supervised medical assistants and supervised nursing students may vaccinate patients who meet the criteria below.

Procedure:

1) Identify adults with no or unknown history of prior receipt of a complete series of hepatitis B vaccine who are in need of hepatitis B vaccination based on the following criteria*:
   a) Persons younger than 19 years with no or unknown history of prior receipt of a complete series of hepatitis B vaccine
   b) Persons 19 years or older meeting any of the following criteria:
      - patient with end-stage renal disease, including patients receiving hemodialysis
      - patient with HIV infection
      - patient with chronic liver disease
      - Sexually active and not in a long-term, mutually monogamous relationship (i.e., more than 1 sex partner during the previous 6 months)
      - Under evaluation or treatment for a sexually transmitted infection (STI)
      - Men who have sex with men
      - current or recent injection drug user
      - at occupational risk of infection through exposure to blood or blood-contaminated body fluid (e.g., health care worker, public safety worker, trainee in a health professional or allied health school)
      - sex partner or household member of a person who is chronically infected with HBV (including an HBsAg-positive adopted child)
      - client or staff of an institution for the developmentally disabled
      - receiving clotting-factor concentrate
      - planned travel to a country with high or intermediate prevalence of chronic HBV infection (a list of countries is available at www.cdc.gov/travel/diseases.htm)
      - housed in or seen for care in a setting in which a high proportion of persons have risk factors for HBV infection (e.g., STD treatment facilities, correctional facilities, institutions for developmentally disabled persons)
   c) Age 19 through 59 years with diabetes mellitus
   d) Age 60 years or older with diabetes mellitus, at the discretion of the treating clinician
   e) Any person who wants to be protected from HBV infection and lacks a specific risk factor

2) Screen all patients for contraindications and precautions to hepatitis B vaccine:
   a) **Contraindications:** a history of a serious reaction (e.g., anaphylaxis) after a previous dose of hepatitis B vaccine or to a hepatitis B vaccine component. For a list of vaccine components, go to http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf
   b) **Precautions:** a moderate or severe acute illness with or without fever

3) Provide all patients with a copy of the most current federal Hepatitis B Vaccine Information Statement (VIS). Document in the patient's medical record, the publication date of the VIS and the date it was given to the patient. Provide non-English speakers with the VIS in their native language, if available and preferred; these can be found at www.immunize.org/vis.

4) Administer hepatitis B vaccine intramuscularly (23–25g, 1–1½" needle) in the deltoid muscle. For persons age 20 years or older, give 1.0 mL dosage; for persons age 19 years or younger, give 0.5 mL dosage.

5) Provide subsequent doses of hepatitis B vaccine to complete each patient's 3-dose schedule by observing a minimum interval of 4 weeks between the first and second doses, 8 weeks between the second and third doses, and at least 4 months between the first and third doses. If the second or third dose is late, the series does not need to be restarted. For healthcare personnel who are non-responders, see "Hepatitis B and Healthcare Personnel" at www.immunize.org/catg.d/p2109.pdf.

6) To document each patient's vaccine administration information: see *Pediatric, Adolescent, and Adult Immunization Procedures* under #4.

7) For management of Medical Emergencies, see *Pediatric, Adolescent, and Adult Immunization Procedures* under #5.

8) Report all adverse reactions to hepatitis B vaccine to the federal Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or by calling (800) 822-7967. VAERS report forms are available at www.vaers.hhs.gov.

*For persons born in Asia, the Pacific Islands, Africa, or other countries identified as having high rates of HBV infection (see MMWR 2005;54 [No. RR-16]:25), ensure that they have also been tested for hepatitis B surface antigen (HBsAg) to find out if they are chronically infected. If test is performed on same visit, administer hepatitis B vaccine after the blood draw. Do not delay initiating hepatitis B vaccination while waiting for test results. If patient is found to be HBsAg-positive, appropriate medical follow-up should be provided; no further doses of hepatitis B vaccine are indicated.

HPV Vaccine

Standing Orders for Administering Human Papilloma Virus (HPV4-Gardasil) Vaccine to Adults at all San Mateo County Health System Clinics

Purpose: To reduce morbidity and mortality from human papilloma virus (HPV) infection by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

Policy: Under these Guidelines, eligible nurses, pharmacists, supervised medical assistants and supervised nursing students may vaccinate patients who meet the criteria below.

Procedure:

1) Identify adults in need of vaccination against human papillomavirus (HPV) based on the following criteria:
   a) Female, age 26 years or younger
   b) Male, 21 years or younger.
   c) Male, age 22 through 26 years meeting any of the following conditions:
      i. Immunocompromised as a result of infection (including HIV), disease, or medications
      ii. Has sex with other males
      iii. Wants to be vaccinated and lacks any of the above criteria
2) Screen all patients for contraindications and precautions to HPV4 (Gardasil) vaccine:
   a) **Contraindications:** a history of a serious reaction after a previous dose of HPV vaccine or to a HPV vaccine component (e.g., yeast for quadrivalent HPV vaccine [HPV4: Gardasil, Merck]. For a complete list of vaccine components, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.
   b) **Precautions:**
      - a moderate or severe acute illness with or without fever
      - pregnancy; delay vaccination until completion of pregnancy.
3) Provide all patients with a copy of the most current federal HPV Vaccine Information Statement (VIS). In the patient's medical record, document the publication date of the VIS and the date it was given to the patient. Provide non-English speaking patients with a copy of the VIS in their native language, if available; these can be found at www.immunize.org/vis.
4) Provide HPV4 vaccine in a 3-dose schedule at 0, 2, and 6 calendar months. Administer 0.5 mL HPV vaccine intramuscularly (23–25g, 1–1½" needle) in the deltoid muscle; the anterolateral thigh muscle may be used if deltoid is inadequate.
5) For adults who have not received HPV vaccine at the intervals specified in #4, administer subsequent doses of HPV vaccine to complete each patient's 3-dose schedule by observing a minimum interval of 4 weeks between the first and second doses, 12 weeks between the second and third dose, and at least 24 weeks between the first and third doses.
   a) Men age 27 years and older who meet the criteria of 1.c.i. or 1.c.ii. above and women age 27 years and older who have received at least 1 dose before their 27th birthday should complete the 3-dose series as soon as feasible.
   b) Men age 22 years and older who have received at least 1 dose before their 22nd birthday should also complete the 3-dose series as soon as feasible.
6) To document each patient's vaccine administration information: see *Pediatric, Adolescent, and Adult Immunization Procedures* under #4.
7) For management of Medical Emergencies, see *Pediatric, Adolescent, and Adult Immunization* Procedures under #5.
8) Report all adverse reactions to HPV vaccine to the federal Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or by calling (800) 822-7967. VAERS report forms are available at www.vaers.hhs.gov.

Seasonal Influenza Vaccine

Standing Orders for Administering Seasonal Influenza Vaccine to Adults at all San Mateo County Health System Clinics

Purpose: To reduce morbidity and mortality from influenza by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

Policy: Under these Guidelines, eligible nurses, pharmacists, supervised medical assistants and supervised nursing students may vaccinate patients who meet the criteria below.

Procedure:

1) Identify adults with no history of influenza vaccination for the current influenza disease season.*

2) Screen all patients for contraindications and precautions to influenza vaccine:
   a. **Contraindications:** serious systemic or anaphylactic reaction to a prior dose of vaccine or to any of its components. For a list of vaccine components, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf. Do not give live attenuated influenza vaccine (LAIV; nasal spray) to any person who has a history of either an anaphylactic or non-anaphylactic allergy to eggs; who is pregnant, is age 50 years or older, or who has chronic pulmonary (including asthma), cardiovascular (excluding hypertension), renal, hepatic, neurologic/neuromuscular, hemotologic, or metabolic (including diabetes) disorders; immunosuppression, including that caused by medications or HIV.
   b. **Precautions:** moderate or severe acute illness with or without fever; history of Guillain Barré syndrome within 6 weeks of a previous influenza vaccination; for LAIV only, close contact with an immunosuppressed person when the person requires protective isolation, receipt of influenza antivirals (e.g., amantadine, rimantadine, zanamivir, or oseltamivir) within the previous 48 hours or possibility of use within 14 days after vaccination.
   c. **Other considerations:** an egg-free recombinant hemagglutinin influenza vaccine (RIV) may be used for people ages 18-49 years with egg allergies of any severity. People who experience onset of hives only after ingesting eggs may also receive inactivated influenza vaccine (IIV) with the following additional safety measures: 1) administration by a healthcare provider familiar with the potential manifestations of egg allergy and 2) observation for 30 minutes after receipt of the vaccine for signs of a reaction.

3) Provide all patients with a copy of the most current federal influenza Vaccine Information Statement (VIS). Document in the patient's medical record, the publication date of the VIS and the date it was given to the patient. Provide non-English speaking patients with a copy of the VIS in their native language, if available and preferred; these can be found at www.immunize.org/vis.

4) Administer influenza vaccine as follows: a) For adults of all ages, give 0.5 mL of injectable inactivated influenza vaccine (IIV-IM) intramuscularly (22–25g, 1–1½" needle) in the deltoid muscle. (Note: A 5/8" needle may be used for adults weighing less than 130 lbs [<60 kg] for injection in the deltoid muscle only if the subcutaneous tissue is not bunched and the injection is made at a 90 degree angle.) b) For healthy adults younger than age 50 years, give 0.2 mL of intranasal LAIV; 0.1 mL is sprayed into each nostril while the patient is in an upright position, c) For adults aged 18 through 64 years, give 0.1 mL IIV-ID intradermally by inserting the needle of the microinjection system at a 90 degree angle in the deltoid muscle. d) For adults aged 65 years or older, give 0.5 mL of high dose IIV-IM intramuscularly (22-25g, 1-1.5"needle) in the deltoid muscle. **Pregnant women will only receive preservative free influenza vaccine in accordance to California Code, Section 124172).**

5) To document each patient's vaccine administration information see *Pediatric, Adolescent, and Adult Immunization Procedures at San Mateo Health System Clinics* under #4.

6) For management of Medical Emergencies, see *Pediatric, Adolescent, and Adult Immunization Procedures* under #5.

7) Report all adverse reactions to influenza vaccine to the federal Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or by calling (800) 822-7967. VAERS report forms are available at www.vaers.hhs.gov.

**If there is a vaccine shortage, prioritize vaccine supplies by identifying adults in need of influenza vaccination based on meeting any of the following criteria:*

a. *Age 50 years or older*
b. *Having any of the following conditions:*
   - *chronic disorder of the pulmonary or cardiovascular system, including asthma*
   - *chronic metabolic disease (e.g., diabetes mellitus), renal dysfunction, hemoglobinopathy, or immunosuppression (e.g., caused by medications, HIV) that has required regular medical follow-up or hospitalization during the preceding year.*
   - *any condition that compromises respiratory function or the handling of respiratory secretions or that can increase the risk of aspiration (e.g., cognitive dysfunction, spinal cord injury, seizure disorder or other neuromuscular disorder)*
   - *will be pregnant during the influenza season*
c. *Residence in a nursing home or other chronic-care facility that houses persons of any age who have chronic medical conditions*
d. *In an occupation or living situation that puts one in proximity to persons at high risk, including*
   - *a healthcare worker, caregiver, or household member in contact with person(s) at high risk of developing complications from influenza*
   - *a household contact or out-of-home caretaker of a child 0–23 months of age*
e. *Wish to reduce the likelihood of becoming ill with influenza*

MMR Vaccine

Standing Orders for Administering Measles, Mumps, & Rubella Vaccine to Adults at all San Mateo County Health System Clinics

Purpose: To reduce morbidity and mortality from measles, mumps, and rubella by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

Policy: Under these Guidelines, eligible nurses, pharmacists, supervised medical assistants and supervised nursing students may vaccinate patients who meet the criteria below.

Procedure:

1) Identify adults in need of initial vaccination against measles, mumps, or rubella who were: (a) born in 1957 or later with no history of receipt of live, measles-, mumps-, and/or rubella-containing vaccine given at 12 months of age or older or no other acceptable evidence of immunity (e.g., laboratory evidence); (b) are women of any age planning to become pregnant and who do not have evidence of immunity; or (c) are healthcare workers born before 1957 without evidence of immunity.
2) Identify adults in need of a second dose of measles, mumps, and rubella (MMR) vaccine who (a) were born in 1957 or later and are planning to travel internationally, or are students in a college, university, technical or vocational school or (b) are healthcare workers born before 1957 at potential risk of infection from a current mumps outbreak.
3) Screen all patients for contraindications and precautions to MMRvaccine:
   a. **Contraindications:**
      - a history of a serious reaction (e.g., anaphylaxis) after a previous dose of MMR vaccine or an MMR vaccine component. For a list of vaccine components, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf
      - pregnant now or may become pregnant within 1 month
      - known severe immunodeficiency; hematologic and solid tumors; congenital immunodeficiency; receiving long-term immunosuppressive therapy, or severely immunocompromised from HIV infection, including CD4+ T-lymphocyte count of less than 200 cells per µL.)
   b. **Precautions:**
      - recent (<11 months) receipt of antibody-containing blood product (specific interval depends on product). ***Refer to "Intervals between antibody-containing products and vaccines that contain measles or varicella" on page 30.***
      - history of thrombocytopenia or thrombocytopenic purpura
      - moderate or severe acute illness with or without fever
4) Provide all patients with a copy of the most current federal MMR Vaccine Information Statement (VIS). Document in the patient's medical record, the publication date of the VIS and the date it was given to the patient. Provide non-English speaking patients with a copy of the VIS in their native language, if available and preferred; these can be found at www.immunize.org/vis.

5) Administer 0.5 mL MMR vaccine SC (23–25g, 5/8" needle) in the posterolateral section of the upper arm.
6) For adults in need of a second dose of MMR, observe a minimum interval of 4 weeks between the first and second doses. If the second dose is late, the series does not need to be restarted.
7) To document each patient's vaccine administration information: see *Pediatric, Adolescent, and Adult Immunization Procedures* under #4.
8) For management of Medical Emergencies, see *Pediatric, Adolescent, and Adult Immunization Procedures* under #5.
9) Report all adverse reactions to MMR vaccine to the federal Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or by calling (800) 822-7967. VAERS report forms are available at www.vaers.hhs.gov.

Meningococcal Vaccine

Standing Orders for Administering Meningococcal Vaccine to Adults at all San Mateo County Health System Clinics

Purpose: To reduce morbidity and mortality from meningococcal disease by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

Policy: Under these Guidelines, eligible nurses, pharmacists, supervised medical assistants and supervised nursing students may vaccinate patients who meet the criteria below.

Procedure

1. Identify adults in need of vaccination against meningococcal disease based on any of the following criteria:
    a. First-year college student, age 19 through 21 years, living in residence hall, and lacking documentation of receipt of quadrivalent meningococcal conjugate vaccine (MCV4) at age 16 years or older.
    b. anticipated travel to a country in the "meningitis belt" of sub-Saharan Africa or other location of epidemic meningococcal disease, particularly if contact with the local population will be prolonged
    c. anticipated travel to Mecca, Saudi Arabia, for the annual Hajj
    d. Diagnosis of anatomic or functional asplenia, including sickle-cell disease
    e. Diagnosis of persistent complement component deficiency (an immune system disorder)
    f. Employment as a microbiologist with routine exposure to isolates of *N. meningitidis*
    g. military recruits
    h. History of receiving either MCV4 or meningococcal polysaccharide vaccine (MPSV4: Menomune [sanofi]) at least 5 years earlier and having continued risk for infection (e.g., living in or recurrent travel to epidemic disease areas).

2. Screen all patients for contraindications and precautions to meningococcal vaccine:
    a. **Contraindications**: a history of a serious allergic reaction (e.g., anaphylaxis) after a previous dose of meningococcal vaccine or to a meningococcal vaccine component. For a list of vaccine components, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.
    b. **Precautions:** moderate or severe acute illness with or without fever

3. Provide all patients with a copy of the most current federal Vaccine Information Statement (VIS). Document in the patient's medical record, the publication date of the VIS and the date it was given to the patient. Provide non-English speaking patients with a copy of the VIS in their native language, if available and preferred; these can be found at www.immunize.org/vis.

4. For adults ages 55 years and younger, administer 0.5 mL MCV4 via the intramuscular route (23–25g, 1–1½" needle) in the deltoid muscle. If the person has a permanent contraindication or precaution to MCV4, or if MCV4 is unavailable and immediate protection is needed, MPSV4 is an acceptable alternative, although it must be given subcutaneously. For these adults age 56 years and older who have not received MCV4 previously and anticipate needing only 1 dose, administer 0.5 mL MPSV4 via the subcutaneous route (23–25g, 5/8" needle) in the posterolateral fat of the upper arm. For adults age 56 years and older who have received MCV4 previously or anticipate needing multiple doses (e.g. 1.b. through 1.3 above), administer MCV4.

5. Schedule additional vaccination as follows:
    a. For adults ages 55 years and younger who are either identified above in 1.c. or 1.d., or who have HIV infection AND meet any of the criteria in 1. above, give 2 doses of MCV4, 2 months apart.
    b. For adults who remain at high risk (e.g., categories 1.b. through 1.e. above), give 1 dose every 5 years.

6. To document each patient's vaccine administration information: see *Pediatric, Adolescent, and Adult Immunization Procedures* under #4.

7. For management of Medical Emergencies, see *Pediatric, Adolescent, and Adult Immunization Procedures* under #5.

8. Report all adverse reactions to meningococcal vaccine to the federal Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or by calling (800) 822-7967. VAERS report forms are available at www.vaers.hhs.gov.

Pneumococcal Polysaccharide Vaccine

Standing Orders for Administering Pneumococcal Polysaccharide Vaccine (PPSV 23 and PCV 13) to Adults at all San Mateo County Health System Clinics

Purpose: To reduce morbidity and mortality from pneumococcal disease by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

Policy: Under these Guidelines, eligible nurses, pharmacists, supervised medical assistants and supervised nursing students may vaccinate patients who meet the criteria below.

Procedure

1. Identify adults in need of vaccination with pneumococcal polysaccharide vaccine (PPSV 23) based on the following criteria:
   a. Age 65 years or older with no or unknown history of prior receipt of PPSV
   b. Age 18–64 years with no or unknown history of prior receipt of PPSV and any of the following conditions:
      i) cigarette smoker
      ii) chronic cardiovascular disease (e.g., congestive heart failure, cardiomyopathies)
      iii) chronic pulmonary disease (e.g., chronic obstructive pulmonary disease, emphysema, asthma)
      iv) diabetes, alcoholism, chronic liver disease (cirrhosis)
      *v) candidate for or recipient of a cochlear implant; cerebrospinal fluid leaks***
      *vi) functional or anatomic asplenia (e.g., sickle cell disease, splenectomy)***
      *vii) immunocompromising condition (e.g., HIV infection, congenital immunodeficiency, hematologic and solid tumors)***
      *viii) immunosuppressive therapy (e.g., alkylating agents, antimetabolites, long-term systemic corticosteroids, radiation therapy)***
      *ix) organ or bone marrow transplantation***
      *x) chronic renal failure or nephrotic syndrome***

2. Identify adults in need of a second and final dose of PPSV 23 if five or more years have elapsed since the previous PPSV 23 dose and the patient meets one of the following criteria:
   a. Age 65 years or older and received prior PPSV 23 vaccination before age 65 years
   b. Age 64 years or younger and at highest risk for serious pneumococcal infection or likely to have a rapid decline in pneumococcal antibody levels (i.e. categories 1.vi. to 1.x. above)

3. **Identify adults age 19 years and older in need of vaccination with pneumococcal conjugate vaccine (PCV13) who are at highest risk for serious pneumococcal infection or likely to have a rapid decline in pneumococcal antibody levels (i.e., categories 1.v.–1.x. above, which are italicized).

4. Screen all patients for contraindications and precautions to pneumococcal vaccine.

   a. **Contraindications:** a history of a serious reaction (e.g., anaphylaxis) after a previous dose of PPSV or PCV or to a vaccine component. For a list of vaccine components, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.
   b. **Precautions:** a moderate or severe acute illness with or without fever

5. Provide all patients with a copy of the most current federal Vaccine Information Statement (VIS). Document in the patient's medical record, the publication date of the VIS and the date it was given to the patient. Provide non-English speaking patients with a copy of the VIS in their native language, if available and preferred; these can be found at www.immunize.org/vis.

6. Administer vaccine as follows:
   a. For adults identified in 1. and 2. above, administer 0.5 mL PPSV23 vaccine either intramuscularly (23–25g, 1–1½" needle) in the deltoid muscle or subcutaneously (23–25g, 5/8" needle) in the posterolateral fat of the upper arm.

b. For adults identified in 3. Above (or categories 1.v.–1.x. above, which are italicized), administer 0.5 mL PCV13 intramuscularly (23–25g, 1–1½" needle) in the deltoid muscle. For adults previously vaccinated with PPSV, give PCV13 at least 12 months following PPSV. If not previously vaccinated with PPSV, give PCV13 first, followed by PPSV23 in 8 weeks.

7. To document each patient's vaccine administration information: see *Pediatric, Adolescent, and Adult Immunization Procedures* under #4.

8. For management of Medical Emergencies, see *Pediatric, Adolescent, and Adult Immunization Procedures* under #5.

9. Report all adverse reactions to pneumococcal vaccine to the federal Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or by calling (800) 822-7967. VAERS report forms are available at www.vaers.hhs.gov.

Td/Tdap Vaccine

Standing Orders for Administering Tetanus-Diphtheria Toxoids & Pertussis Vaccine (Td/Tdap) to Adults at all San Mateo County Health System Clinics

Purpose: To reduce morbidity and mortality from tetanus and diphtheria by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

Policy: Under these Guidelines, eligible nurses, pharmacists, supervised medical assistants and supervised nursing students may vaccinate patients who meet the criteria below.

Procedure:

1) Identify adults in need of vaccination against tetanus, diphtheria, and pertussis based on the following criteria:
   a) lack of documentation of receiving a dose of pertussis-containing vaccine (i.e., Tdap) as an adolescent or adult
   b) currently pregnant and no documentation of Tdap given during current pregnancy
   c) lack of documentation of receiving at least 3 doses of tetanus- and diphtheria-containing toxoids
   d) completion of a 3-dose primary series of tetanus-, and diphtheria-containing toxoids with no documentation of receiving a booster dose within the previous 10 years
   e) recent deep and dirty wound (e.g., contaminated with dirt, feces, saliva) and lack of evidence of tetanus toxoid-containing vaccine in the previous 5 years
2) Screen all patients for contraindications and precautions to tetanus and diphtheria (Td) toxoid, and if applicable, pertussis vaccine (Tdap):
   a) **Contraindications:**
      - a history of a serious reaction (e.g., anaphylaxis) after a previous dose of Td or a Td or Tdap component. For a list of vaccine components, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.
      - for Tdap only, a history of encephalopathy within 7 days following Tdap/DTP/DTaP not attributable to another identifiable cause
   b) **Precautions:**
      - history of Guillain-Barre syndrome within 6 weeks of previous dose of tetanus toxoid-containing vaccine
      - history of an arthus-type hypersensitivity reaction after a previous dose of tetanus or diphtheria toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus toxoid-containing vaccine
      - moderate or severe acute illness with or without fever
      - for Tdap only, progressive or unstable neurologic disorder, uncontrolled seizures or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized
3) Provide all patients with a copy of the most current federal Vaccine Information Statement (VIS). Document in the patient's medical record, the publication date of the VIS and the date it was given to the patient. Provide non-English speaking patients with a copy of the VIS in their native language, if available and preferred; these can be found at www.immunize.org/vis.

4) Administer 0.5 mL Td or Tdap vaccine IM (23–25g, 1–1/2" needle) in the deltoid muscle.

5) Provide subsequent doses of Tdap or Td to adults as follows:
   a. to complete the primary 3-dose schedule: observe a minimum interval of 4 weeks between the first and second doses, and 6 months between the second and third doses.
   b. to boost with Tdap or Td after after primary schedule is complete: prioritize use of Tdap if not previously given (Note: there is no need to observe a minimum interval between Td and the subsequent Tdap) ; if Tdap was already administered, boost with Td routinely every 10 years.*
   c. for pregnant women, administer Tdap during each pregnancy (preferably during 27 through 36 weeks' gestation), regardless of number of years since prior Td or Tdap vaccination.

6) To document each patient's vaccine administration information: see *Pediatric, Adolescent, and Adult Immunization Procedures* under #4.

7) For management of Medical Emergencies, see *Pediatric, Adolescent, and Adult Immunization Procedures* under #5.

8) Report all adverse reactions to Td and Tdap vaccine to the federal Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or by calling (800) 822-7967. VAERS report forms are available at www.vaers.hhs.gov.

Varicella Vaccine

Standing Orders for Administering Varicella (Chickenpox) Vaccine to Adults at all San Mateo County Health System Clinics

Purpose: To reduce morbidity and mortality from varicella (chickenpox) by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

Policy: Under these Guidelines, eligible nurses, pharmacists, supervised medical assistants and supervised nursing students may vaccinate patients who meet the criteria below.

Procedure:

1. Identify adults in need of varicella (chickenpox) vaccination who (a) were born in the U.S. in 1980 or later or (b) are a healthcare worker or non-U.S.-born person, and who also meet any of the following criteria:
   - lack documentation of 2 doses of varicella vaccine
   - lack a history of varicella based on diagnosis or verification of varicella by a healthcare provider
   - lack a history of herpes zoster based diagnosis or verification of zoster by a healthcare provider
   - lack laboratory evidence of immunity or laboratory confirmation of disease

   Note: Because HIV-infected adults are at increased risk of severe disease from varicella, vaccination may be considered (2 doses,given 3 months apart) for HIV-infected adults and adolescents with CD4+ T-lymphocytes count >200 cells/μL.

2. Screen all patients for contraindications and precautions to varicella vaccine:
   a. Contraindications:
   - a history of a serious reaction (e.g., anaphylaxis) after a previous dose of varicella vaccine or to a varicella vaccine component. For a list of vaccine components, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.
   - pregnant now or may become pregnant within 1 month (pregnant women should be vaccinated upon completion or termination of pregnancy)
   - having any malignant condition, including blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems
   - receiving high-dose systemic immunosuppressive therapy (e.g., two weeks or more of daily recipt of 20 mg or more [or 2 mg/kg body weight or more] of prednisone or equivalent)
   - an adult or adolescent with CD4+ T-lymphocytes count <200 cells/μL
   - family history of congenital or hereditary immunodeficiency in first-degree relatives (e.g., parents, siblings) unless the immune competence of the potential vaccine recipient has been clinically substantiated or verified by a laboratory

   b. Precautions:
   - recent (<11 months) receipt of antibody-containing blood product (specific interval depends on product). Refer to "Intervals between antibody-containing products and vaccines that contain measles or varicella" on page 30.
   - receipt of specific antivirals (i.e. acyclovir, famcyclovir, or valacyclovir) 24 hours before vaccination; avoid use of the antiviral drugs for 14 days after vaccination.
   - moderate or severe acute illness with or without fever

3. Provide all patients with a copy of the most current federal Varicella Vaccine Information Statement (VIS). Document in the patient's medical record, the publication date of the VIS and the date it was given to the patient. Provide non-English speaking patients with a copy of the VIS in their native language, if available and preferred; these can be found at www.immunize.org/vis.

4. Administer 0.5 mL varicella vaccine SC (23–25g, 5/8" needle) in the posterolateral section of the upper arm. If indicated, administer a second dose 4–8 weeks after the first dose. If the second dose is late, the series does not need to be restarted.

Varicella Vaccine

Standing Orders for Administering Varicella (Chickenpox) Vaccine to Adults at all San Mateo County Health System Clinics

5. Varicella vaccine must be stored frozen. Reconstitute and administer varicella vaccine immediately after removing it from the freezer.
6. To document each patient's vaccine administration information: see *Pediatric, Adolescent, and Adult Immunization Procedures* under #4.

7. For management of Medical Emergencies, see *Pediatric, Adolescent, and Adult Immunization Procedures* under #5.

8. Report all adverse reactions to varicella vaccine to the federal Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or (800) 822-7967. VAERS report forms are available at www.vaers.hhs.gov.

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Zoster (Shingles) Vaccine
Standing Orders for Administering Zoster (Shingles) Vaccine to Adults at all San Mateo County Health System Clinics

Purpose: To reduce morbidity and mortality from zoster (shingles) by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

Policy: Under these Guidelines, eligible nurses, pharmacists, supervised medical assistants and supervised nursing students may vaccinate patients who meet the criteria below.

Procedure:

1. Identify adults who are age 60 years or older with no history of prior receipt of zoster vaccine

2. Screen all patients for contraindications and precautions to zoster vaccine:
   - **a. Contraindications:**
     - a history of a severe allergic reaction (e.g., anaphylaxis) to a vaccine component, including gelatin and neomycin. For a list of vaccine components, go to http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf
     - primary or acquired immunodeficiency, including
       - leukemia, lymphomas, or other malignant neoplasms affecting the bone marrow or lymphatic system
       - AIDS or other clinical manifestations of HIV, including persons with CD4+ T-lymphocyte values <200 per mm3 or <15% of total lymphocytes
       - current immunosuppressive therapy, including high-dose corticosteroids (>20 mg/day of prednisone or equivalent) lasting two or more weeks
       - clinical or laboratory evidence of other unspecified cellular immunodeficiency
       - receipt of or history of hematopoietic stem cell transplantation
       - current receipt of recombinant human immune mediators and immune modulators, especially the antitumor necrosis factor agents adalimumab, infliximab, and etanercept
     - pregnancy or possibility of pregnancy within 4 weeks of receiving vaccine

   - **b. Precautions:**
     - moderate or severe acute illness with or without fever
     - receipt of specific antivirals (i.e. acyclovir, famcyclovir, or valacyclovir) 24 hours before vaccination; avoid use of the antiviral drugs for 14 days after vaccination.

3. Provide all patients with a copy of the most current federal Shingles Vaccine Information Statement (VIS). Document in the patient's medical record, the publication date of the VIS and the date it was given to the patient. Provide non-English speaking patients with a copy of the VIS in their native language, if available and preferred; these can be found at www.immunize.org/vis.

4. Administer approximately 0.65 mL of reconstituted zoster vaccine SC (23–25g, 5/8" needle) in the posterolateral section of the upper arm. Zoster vaccine must be stored frozen. Reconstitute and administer zoster vaccine immediately after removing it from the freezer. DO NOT transport zoster vaccine from a pharmacy to another office where it will be administered.

5. To document each patient's vaccine administration information: see *Pediatric, Adolescent, and Adult Immunization Procedures* under #4.

6. For management of Medical Emergencies, see *Pediatric, Adolescent, and Adult Immunization Procedures* under #5.

7. Report all adverse reactions to herpes zoster vaccine to the federal Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or (800) 822-7967. VAERS report forms are available at www.vaers.hhs.gov

Intervals between antibody-containing products and vaccines that contain measles or varicella

Product/indication	Dose, including mg immunoglobulin G (IgG)/ kg body weight*	Recommended interval before measles or varicella-containing vaccine administration (months)
Respiratory syncytial virus immune globulin (IG) monoclonal antibody (Synagis™)†	15 mg/kg intramuscularly (IM)	None
Tetanus IG	250 units (10 mg IgG/kg) IM	3
Hepatitis A IG		
Contact prophylaxis	0.02 mL/kg (3.3 mg IgG/kg) IM	3
International travel	0.06 mL/kg (10 mg IgG/kg) IM	3
Hepatitis B IG	0.06 mL/kg (10 mg IgG/kg) IM	3
Rabies IG	20 IU/kg (22 mg IgG/kg) IM	4
Measles prophylaxis IG		
Standard (i.e., nonimmunocompromised) contact	0.25 mL/kg (40 mg IgG/kg) IM	5
Immunocompromised contact	0.50 mL/kg (80 mg IgG/kg) IM	6
Blood transfusion		
Red blood cells (RBCs), washed	10 mL/kg negligible IgG/kg intravenously (IV)	None
RBCs, adenine-saline added	10 mL/kg (10 mg IgG/kg) IV	3
Packed RBCs (hematocrit 65%)§	10 mL/kg (60 mg IgG/kg) IV	6
Whole blood (hematocrit 35%–50%)§	10 mL/kg (80–100 mg IgG/kg) IV	6
Plasma/platelet products	10 mL/kg (160 mg IgG/kg) IV	7
Cytomegalovirus intravenous immune globulin (IGIV)	150 mg/kg maximum	6
IGIV		
Replacement therapy for immune deficiencies¶	300–400 mg/kg IV¶	8
Immune thrombocytopenic purpura	400 mg/kg IV	8
Postexposure varicella prophylaxis**	400 mg/kg IV	8
Immune thrombocytopenic purpura	1000 mg/kg IV	10
Kawasaki disease	2 g/kg IV	11

* This table is not intended for determining the correct indications and dosages for using antibody-containing products. Unvaccinated persons might not be fully protected against measles during the entire recommended interval, and additional doses of immune globulin or measles vaccine might be indicated after measles exposure. Concentrations of measles antibody in an immune globulin preparation can vary by manufacturer's lot. Rates of antibody clearance after receipt of an immune globulin preparation also might vary. Recommended intervals are extrapolated from an estimated half-life of 30 days for passively acquired antibody and an observed interference with the immune response to measles vaccine for 5 months after a dose of 80 mg IgG/kg.

† Contains antibody only to respiratory syncytial virus

§ Assumes a serum IgG concentration of 16 mg/mL.

¶ Measles and varicella vaccinations are recommended for children with asymptomatic or mildly symptomatic human immunodeficiency virus (HIV) infection but are contraindicated for persons with severe immunosuppression from HIV or any other immunosuppressive disorder.

** The investigational product VariZIG, similar to licensed VZIG, is a purified human immune globulin preparation made from plasma containing high levels of anti-varicella antibodies (immunoglobulin class G [IgG]). When indicated, health-care providers should make every effort to obtain and administer VariZIG. In situations in which administration of VariZIG does not appear possible within 96 hours of exposure, administration of immune globulin intravenous (IGIV) should be considered as an alternative. IGIV also should be administered within 96 hours of exposure. Although licensed IGIV preparations are known to contain anti-varicella antibody titers, the titer of any specific lot of IGIV that might be available is uncertain because IGIV is not routinely tested for antivaricella antibodies. The recommended IGIV dose for postexposure prophylaxis of varicella is 400 mg/kg, administered once. For pregnant women who cannot receive VariZIG within 96 hours of exposure, clinicians can choose either to administer IGIV or closely monitor the women for signs and symptoms of varicella and institute treatment with acyclovir if illness occurs. (**Source:** CDC. A new product for postexposure prophylaxis available under an investigational new drug application expanded access protocol. MMWR 2006;55:209–10).

Screening Questions and Corresponding Vaccines

If the answer is "yes" to any of these questions, further evaluation by a nurse or physician may be necessary to determine whether to proceed with immunization

1) Are you sick today?

2) Have you ever had a serious reaction after receiving a vaccine?

3) Do you have allergies to any medications or vaccines?

4) Do you have allergies to any foods or other items?
    a. Yeast: (Hepatitis B, HPV, Meningococcal)
    b. Gelatin: (MMR, Varicella, Zoster)
    c. Eggs: (Influenza)

5) Do you have cancer, leukemia, AIDS, or any other immune system problem? (MMR, Varicella, Zoster)

6) Do you take cortisone, prednisone, other steroids, anticancer drugs, drugs like Remicade® or Enbrel®, or have you had radiation treatments? (MMR, Varicella, Zoster)

7) Have you had Guillain-Barre Syndrome? (Meningococal [MCV4 only], Tdap, Td, Influenza)

8) Have you ever had seizures, prolonged coma, decreased level of consciousness, or a worsening brain or nerve problems? (Td, Tdap)

9) Have you had a blood transfusion or received immune globulin in the last year? (MMR, Varicella, Zoster)

10) Are you currently pregnant? (HPV, MMR, Varicella, Zoster)

11) Are you likely to get pregnant in the next 4 weeks? (HPV, MMR, Varicella, Zoster)

12) Have you received any vaccinations in the last 4 weeks? Which vaccines?

13) Do you have a condition where you bleed easily or have low platelets? (IM injections)

Pediatric and Adolescent Immunization Guidelines Through Age 18

Recommended Schedule

San Mateo County Health System

Revised April 2011

San Mateo County Health System
Immunization Guidelines
Through Age 18

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Routine On-Time Schedule

➢ Include the Hep B #1 received at birth in registry. If infant did not receive Hep B #1 at birth, give either at initial visit or use 2-4-6 month schedule.
➢ Individual vaccines in parentheses can be given in place of combination vaccines; if individual vaccines are given at 15 months instead of Pentacel, IPV #4 should not be given.
➢Note that children with certain medical conditions may need additional vaccines (such as MCV4 or PPSV) or may have contraindications to live vaccines – consult the CDC schedules and other resources.

Age **Usual age** (early / late administration)	Immunization(s)
Birth	**Hep B** #1
(6 wks-) **2 months**	**Pentacel** #1 *(DTaP, IPV, Hib)*, **Hep B** #1 or #2, **PCV** #1, **RV** #1
(3½ -) **4 months**	**Pentacel** #2 *(DTaP, IPV, Hib)*, **PCV** #2, **RV** #2, **Hep B** #2 if not previously given
(5½ -) **6 months**	**Pentacel** #3 *(DTaP, IPV, Hib)*, **Hep B** #3 if 24 wks old, **PCV** #3, **RV** #3 (needed only if RotaTeq was used for any prior dose)
(7-) **9 months**	**Hep B** #3 if pt. was < 24 wks at previous visit
12 (-15) **months**	**MMR** #1, **VZV** #1, **PCV** #4,
15 (-18) **months**	**Pentacel** #4 *(DTaP,IPV, Hib)*, **Hep A** #1
2 years	**Hep A** #2
4 – 6 years	**Kinrix** *(DTaP, IPV)*, **MMR** #2, **VZV** #2
11 – 12 years	**MCV4** #1, **Tdap** **HPV** #1, then **HPV** #2 in 1- 2 mos, **HPV** #3 6 mos after **HPV** #1
13 – 18 years	**MCV4** #2 at 16 years

Influenza vaccine notes:

- During flu season, seasonal flu vaccine should be given to children 6 months through18 years of age.
- Two doses of seasonal flu vaccine, 4 weeks apart, are needed for children 6 months through 8 years of age who are receiving the vaccine for the first time, or who were vaccinated for the first time during the previous year but only received 1 dose.

Catch-up Schedules

Late, started at 4-11 months:

Minimum interval after prior visit *or Age*	Immunizations
	(If Hep B #1 was given at birth, include in registry)
First visit	**Pentacel** #1 *(DTaP, IPV, Hib),* **Hep B** #1 or #2, **PCV** #1
4 wks. later	**Pentacel** #2 *(DTaP, IPV, Hib),* **Hep B** #2 if still needed, **PCV** #2
4 wks. later	**Pentacel** #3 *(DTaP, IPV, Hib),* **PCV** #3, ***Hep B** #3 if at least 24 weeks old and 8 wks after **Hep B** #2*
8 wks. later	**Hep B** #3 if still needed
12 – 15 months	**MMR** #1, **VZV** #1, **Hep A** #1, **PCV** #4 (at least 8 wks after PCV13 #3)
15 –18 months	**Pentacel** #4 *(or DTaP, Hib)* at least six months after **DTaP** #3
2 years	**Hep A** #2 (at least 6 months after Hep A #1)
4 – 6 years	**Kinrix** *(DTaP, IPV),* **MMR** #2, **VZV** #2
11 – 12 years	**MCV4** #1, **Tdap** **HPV** #1, then **HPV** #2 in 1- 2 mos, **HPV** #3 6 mos after **HPV** #1
13-18 years	**MCV4** #2 at 16 years

If PCV 13 started between 7–11 months, only 3 doses are needed ***with at least one dose after 12 mos.***
If Hib started between 7-11 months, only 3 doses are needed ***with at least one dose after 15 mos.***

Late, started at 12 months – 23 months:

Minimum interval after prior visit *or Age*	Immunizations
First visit	**Pentacel** #1 *(DTaP, IPV, Hib),* **Hep B** #1, **PCV** #1, **MMR** #1, **VZV** #1
4 wks. later	**DTaP** #2, **IPV** #2, **Hep B** #2, **Hep A** #1
4 wks. later	**Pentacel** #2 *(DTaP, IPV, Hib)* (Hib #2 not needed if first dose given after 15 mos.) **PCV** #2
6 mos. Later	**DTaP** #4, **Hep B** #3, **Hep A** #2
4 - 6 years	**Kinrix** (*DTaP, IPV),* **MMR** #2, **VZV** #2
11 – 12 years	**MCV4** #1, **Tdap** **HPV** #1, then **HPV** #2 in 1- 2 mos, **HPV** #3 6 mos after **HPV** #1
13-18 years	**MCV4** #2 at 16 years

If Hib started at ≥15 months of age, only 1 dose is needed.

Influenza vaccine notes:

- During flu season, seasonal flu vaccine should be given to children 6 months through18 years of age.
- Two doses of seasonal flu vaccine, 4 weeks apart, are needed for children 6 months through 8 years of age who are receiving the vaccine for the first time, or who were vaccinated for the first time during the previous year but only received 1 dose.

Catch-up Schedules

Late, started at 24 months - 4 years and 11 months:

Minimum interval after prior visit *or Age*	Immunization(s)
First visit	**Pentacel** *(DTaP, IPV, Hib)*, **PCV**, **Hep B** #1, **Hep A** #1, **MMR** #1, **VZV** #1
4 wks. later	**DTaP** #2, **IPV** #2, **Hep B** #2
4 wks. later	**DTaP** #3, **IPV** #3
6 mos. later	**DTaP** #4, **Hep B** #3, **Hep A** #2
4 - 6 years	**Kinrix** *(DTaP, IPV)* (not needed if **DTaP** #4 and **IPV** #3 received after 4th birthday), **MMR** #2, **VZV** #2
11 – 12 years	**MCV4** #1, **Tdap** **HPV** #1, then **HPV** #2 in 1- 2 mos, **HPV** #3 6 mos after **HPV** #1
13-18 years	**MCV4** #2 at 16 years

Late, started at 5 - 6 years of age:

Minimum interval after prior visit *or Age*	Immunization(s)
First visit	**DTaP** #1, **IPV** #1, **Hep B** #1, **MMR** #1, **VZV** #1, **Hep A** #1
4 wks. later	**DTaP** #2, **IPV** #2, **Hep B** #2, **MMR** #2 (if now ≥7 yrs, use Td or Tdap instead of DTaP) *
12 wks. later	**DTaP** #3, **IPV** #3, **Hep B** #3, **VZV** #2 (" ") *
6 mos. later	**DTaP** #4, **Hep A** #2 (" ") *
11 - 12 years	**MCV4** #1, **Tdap** **HPV** #1, then **HPV** #2 in 1- 2 mos, **HPV** #3 6 mos after **HPV** #1
13-18 years	**MCV4** #2 at 16 years

* Tdap should be substituted for a single dose of Td in the catch-up series for children aged 7 through 10 years: use Td for other doses

Influenza vaccine notes:

- During flu season, seasonal flu vaccine should be given to children 6 months through18 years of age.
- Two doses of seasonal flu vaccine, 4 weeks apart, are needed for children 6 months through 8 years of age who are receiving the vaccine for the first time, or who were vaccinated for the first time during the previous year but only received 1 dose.

Catch-up Schedules

Late, started 7 - 10 years of age:

Minimum interval after prior visit *or Age*	Immunization(s)
First visit	**Tdap**, **IPV** #1, **Hep B** #1, **MMR** #1, **VZV** #1, **Hep A** #1
4 wks. later	**Td** #2, **IPV** #2, **Hep B** #2, **MMR** #2
6 mos. later	**Td** #3, **IPV** #3, **Hep B** #3, **VZV** #2, **Hep A** #2
11 – 12 years	**MCV4** #1, **Tdap** **HPV** #1, then **HPV** #2 in 1- 2 mos, **HPV** #3 6 mos after **HPV** #1
13-18 years	**MCV4** #2 at 16 years

Late, started 11 - 12 years of age:

Minimum interval after prior dose	Immunization(s)
First visit	**Tdap**, **IPV** #1, **Hep B** #1, **MMR** #1, **VZV** #1, **Hep A** #1, **MCV4** #1, **HPV** #1
4 wks. later	**Td**, **IPV** #2, **Hep B** #2, **MMR** #2; **HPV** #2
6 mos. later	**Td**, **IPV** #3, **Hep B** #3, **Hep A** #2, **VZV** #2 **HPV** #3
13-18 years	**MCV4** #2 at 16 years

Late, started 13 - 18 years of age:

Minimum interval after prior dose	Immunization(s)
First visit	**Tdap**, **IPV** #1, **Hep B** #1, **MMR** #1, **VZV** #1, **Hep A** #1, **MCV4** #1, **HPV** #1
4 wks. later	**Td**, **IPV** #2, **Hep B** #2, **MMR** #2, **VZV** #2, **HPV** #2
6 mos. later	**Td**, **IPV** #3, **Hep B** #3, **Hep A** #2, **HPV** #3
13-18 years	**MCV4** #2 at 16 – 18 yrs. for those who received #1 at age 13 – 15 yrs.

Influenza vaccine notes:

- During flu season, seasonal flu vaccine should be given to children 6 months through18 years of age.
- Two doses of seasonal flu vaccine, 4 weeks apart, are needed for children 6 months through 8 years of age who are receiving the vaccine for the first time, or who were vaccinated for the first time during the previous year but only received 1 dose.

Vaccine	Important Notes (See CDC catch-up IZ schedule for minimum ages, intervals and children with underlying medical conditions)
DT Pediatric	- Give when pertussis vaccine is contraindicated through age 6 yrs
DTaP	- Give through age 6 yrs. - DTaP #4 can be given at 12 mos of age, if 6 mos since DTaP #3 and child is not likely to return at age 15-18 months - 5th dose not needed if 4th dose given on/after 4th birthday
Hepatitis A	- Do not give before first birthday - 2nd dose must be at least 6 months after 1st dose
Hepatitis B	- Infants born to HBsAg positive mother: give 0.5ml HBIG and Hepatitis B #1 within 12 hours of birth - Hep B #1 recommended for all infants at birth - Hep B #2 at 1-2 months of age, at least 4 weeks after Hep B #1 - Hep B #3 at least 16 wks after Hep B #1 & at least 8 wks after Hep B #2, but not before 24 wks of age
Hib	- If starting at 2-6 months = 4 doses; starting at 7-11 mo = 3 doses; starting at 12-14 mo = 2 doses; starting at 15-59 mo = 1 dose - At least one dose must be given on or after 15 months - If reconstituting, must use diluent which is in the box with the vaccine - Hiberix may only be used for the 4th dose at 15 mos through 4 years -PedvaxHib 3 dose series at 2, 4 and 12-15 months of age
HPV	- SMCo recommends immunizing both females and males. Per ACIP: recommended for females routinely at 11-12 year old visit, may be given at 9 years of age, Gardasil as permissive recommendation for males. Catch up recommended for 13-18 year olds. - 3 dose series - usual schedule: HPV #2 one to two months after HPV #1, and HPV #3 six months after HPV #1 - Accelerated schedule: 4 weeks between HPV #1 and HPV #2, minimum 12 weeks between HPV #2 and HPV #3, at least 24 weeks between HPV #1 and HPV #3 - May be offered to males 9 through 26 years (use Gardasil only) - Gardasil - females and males; Cervarix - females only
Influenza– TIV (inactivated vaccine, injection)	- Routine for 6 mo – 18 year olds during flu season - Use only preservative-free vaccine under 3 years of age and for pregnant women - 2 doses administered 4 weeks apart for children <9 years of age if receiving vaccine for the first time or only one prior dose
Influenza – LAIV (live attenuated vaccine, nasal spray)	- Use beginning age 2 for healthy children (no asthma or other chronic medical problem, not immunocompromised, not pregnant) - Do not give if another live vaccine (MMR or Varicella) has been given in the previous 4 weeks - 0 .1 mL in each nostril - 2 doses administered 1 month apart for children < 9 years of age if receiving the vaccine for first time or only one prior dose - Give same day as other live virus vaccines or wait 4 weeks
IPV	- IPV #4 can be omitted if IPV #3 was given on or after 4th birthday dose - 4 or more doses given at any age meet school entry requirements, but one does is recommended after 4th birthday - If ≥ 18 years of age, not recommended, but ok to give
Kinrix (DTaP , IPV)	- For use as booster dose at 4-6 years of age - DtaP #5, IPV #4 - Not for primary series
Meningococcal Conjugate (MCV4)	- Routine use at age 11-12, booster at age 16. If initial dose at 13 – 15, booster at age 16-18. If initial dose at ≥ 16 yrs, need one dose only. - Also for high-risk children, age 2-10, who have not received meniugococcal vaccine before or received MPSV5 ≥ 5 yrs previously. See CDC schedule for details. - Menveo requires reconstitution; use diluent in package; use lot number on side of box - Minimum interval between dose #1 and dose #2 is 8 weeks
MMR	- Do not give before 1st birthday - MMR #2 is routinely given at age 4-6; minimum of 28 days (4 weeks) after MMR #1 - Give same day as other live virus vaccines or wait 4 weeks
Pediarix (DTaP, IPV, Hep B)	- Use when these components are needed. See notes for each component - Approved for 3-dose primary series, *not booster*, 6 weeks through 6 years of age
Pentacel (DTaP, IPV, Hib)	- Use when these components are needed. See notes for each component - Approved for use 6 weeks through 4 years of age
Pneumococcal Conjugate (PCV)	- PCV13 now replaces PCV7 - If starting at 2-6 mos =4 doses; starting at 7-11 mos=3 doses; starting at 12-23 mos = 2 doses; starting at 24-59 mos= 1 dose - At least one dose must be given on or after 1st birthday - Give one dose of PCV13 to under age 5 years (under 6 years, if high risk) even if completed PCV7 series.
Pneumococcal Polysaccharide	- Give one time to high risk children 2 years of age and older
Rotavirus (RV) (oral)	- Series is 3 doses using RotaTeq or 2 doses using Rotarix, usually at 2, 4, (& 6) mos of age, with at least 4 week interval - 3 doses needed if Rotarix and Rotateq used interchangeably - Give first dose after 6 wks (or no later than 14 wks 6 days), last dose before 8 months
Td	- Do not give before 7th birthday - Booster recommended every 10 yrs after Tdap
Tdap	- Routine use as booster at age 11 or later as catch-up dose - Use one dose Tdap at age 7 – 10 if primary series was incomplete or unknown, followed by Td to complete series as needed. In view of current pertussis edpidemic, CDPH recommends use of either Boostrix or Adacel starting at age 7 - No minimum interval required between Td and Tdap.
Varicella	- Do not give before 1st birthday or if child has history of chickenpox - Routine age for #2 is 4-6 years - If 1-12 years of age, give VZV #2 at least 3 months after VZV #1; if ≥ 13 years of age, give VZV #2 at least 4 weeks after VZV #1 - Give same day as other live virus vaccines or wait 4 weeks

TB skin testing (TST) and Immunizations
* TST can be given before or same day as MMR. If not given together, wait 30 days after MMR to place TST.
* No timing restrictions between varicella and TST.

Timing Intervals
* All immunizations may be given simultaneously at different sites, i.e. 1 inch apart in each thigh or upper arm.
* No need to restart vaccine series, regardless of the time lapsed between doses.
* Vaccine doses given sooner than 4 days before minimum intervals should be repeated.
* Live virus vaccine: If varicella, FluMist and MMR are not administered on the same day, interval between administration should be at least 4 weeks (28 days).

Eligibility for Immunization with Vaccines Distributed by the California Department of Public Health, Immunization Branch Effective January 2011

Vaccine	Risk/Age Appropriate Usage
DTaP/DT	• Under 7 years of age
DTaP/IPV (Kinrix)	• 4 years through 6 years of age
DTaP/IPV/Hep B (Pediarix)	• 6 weeks through 6 years of age
DTaP/IPV/Hib (Pentacel)	• 6 weeks through 4 years of age
Hepatitis A	• 1 year through 18 years of age
Hepatitis B	• Birth through 18 years of age
Hib	• Under 5 years of age • Older children with high risk conditions
Hiberix	• 15 months through 4 years of age
HPV	• 9 through 18 years of age
Influenza (inactivated)	• 60 years of age and older • Adults with high risk conditions • 6 months through 18 years of age • Household contacts of infants under six months of age
Influenza (live attenuated, FluMist)	• 2 years through 49 years of age, healthy and not pregnant
IPV	• Through 18 years of age • Adults 19 years and others in high risk situations, e.g. travel, hospital staff
Meningococcal Conjugate	• 11 years through 18 years of age • High risk 2 years through 10 years of age
MMR 1st dose	• 1 year of age and older
MMR 2nd dose	• 13 months through 18 years of age • Adults 19 years and older and born in 1957 or later only if they are college/university students or health care workers
Pneumococcal Conjugate	• Under 5 years of age • 5-18 years with high risk conditions
Rotavirus	• 6 weeks to 32 weeks (8 months) of age
Td	• 7 years of age and older
Tdap	• 7 years of age and older
Varicella	• 1 year through 18 years with no history of disease or vaccine

USE VFC VACCINES FOR VFC ELIGIBLE PATIENTS, BIRTH THROUGH 18 YEARS ONLY.

SITES, ROUTES, AND DOSAGES

Vaccine/Skin Test	Site	Route	Dosage
DTaP	Anterolateral thigh (infant/toddler) Deltoid (child)	Intramuscular	0.5mL
DTaP/IPV/Hep B (Pediarix)	Anterolateral thigh (infant/toddler) Deltoid (child)	Intramuscular	0.5mL
DTaP/IPV/Hib (Pentacel)	Anterolateral thigh (infant/toddler) Deltoid (child)	Intramuscular	0.5mL
DTaP/IPV (Kinrix)	Deltoid	Intramuscular	0.5mL
Hepatitis A	Anterolateral thigh (infant/toddler) Deltoid (adult/child)	Intramuscular	0.5mL
Hepatitis B	Anterolateral thigh (infant/toddler) Deltoid (adult/child)	Intramuscular	0.5mL
Hib	Anterolateral thigh (infant/toddler) Deltoid (child)	Intramuscular	0.5mL (may need to be reconstituted - use diluent in box with vaccine)
Hiberix	Anterolateral thigh (infant/toddler) Deltoid (child)	Intramuscular	0.5mL (may need to be reconstituted - use diluent in box with vaccine)
HPV	Deltoid	Intramuscular	0.5mL
Influenza (Inactivated)	Anterolateral thigh (infant/toddler) Deltoid (child/adult)	Intramuscular	0.25mL (6 mos- 35 mos) 0.5mL (3 yrs and older)
Influenza (Live)	Nose	Intranasal spray	0.2mL (.1mL in each nostril)
IPV	Fatty area of thigh or outer aspect of upper arm Anterolateral thigh (infant/toddler) Deltoid (child/adult)	Subcutaneous or Intramuscular	0.5mL 0.5mL
Meningococcal Conjugate	Deltoid	Intramuscular	0.5mL (may need to be reconstituded)
MMR	Fatty area of thigh or outer aspect of upper arm	Subcutaneous	0.5mL (reconstituted)
Pneumococcal Conjugate	Anterolateral thigh (infant/toddler) Deltoid (child)	Intramuscular	0.5mL
Pneumococcal Polysaccharide	Deltoid Outer aspect of upper arm	Intramuscular or Subcutaneous	0.5mL
Rotavirus	Mouth	Oral	2 mL (RotaTeq) 1 mL (Rotarix)
TST	Volar surface of forearm	Intradermal	0.1mL
Td	Deltoid	Intramuscular	0.5mL
Tdap	Deltoid	Intramuscular	0.5mL
Varicella	Fatty area of thigh or outer aspect of upper arm	Subcutaneous	0.5mL (reconstituted)

NEEDLE SIZES

Intramuscular	1" for infants and children 1" - 1 ½' for teenagers /adults	#23 - #25 gauge
Subcutaneous	5/8"	#23 / #25 gauge
Intradermal	½"	#25 / #27 gauge

SCREENING QUESTIONS AND CORRESPONDING VACCINES

If answer is "yes" to any of these questions, further evaluation by nurse and / or physician may be necessary to determine whether to proceed with the immunization(s).

1. Is your child sick today? (All)

2. Did your child have any problems after his/her previous immunizations? (All)

3. Has your child ever had seizures? (DTaP, Tdap)

4. Has your child been treated for cancer, AIDS, leukemia? (MMR, Varicella, Rotavirus, FluMist)

5. Has your child had Guillain-Barrē Syndrome? (MCV)

6. Is your child taking either cortisone, prednisone pills or prednisone liquid? (MMR, Varicella, Rotavirus, FluMist)

7. Does your child have severe allergies to any medications? (streptomycin: IPV, neomycin: MMR/IPV/Varicella)

8. Does your child have severe allergies?
   Yeast: Hep B, HPV
   Gelatin: MMR, and Varicella
   Eggs: Seasonal flu,
   Latex: (refer to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf)

9. Does your child have chronic gastrointestinal (stomach) disease (or history of intussusception)? (Rotavirus)

10. Has your child had a blood transfusion or received immune globulin in the last year? (MMR, Varicella, Rotavirus, FluMist)

11. Is your daughter likely to become pregnant in the next three months? (MMR, Varicella, FluMist)

12. Is your daughter pregnant? (HPV, MMR, Varicella, FluMist)
13. Does your child have asthma? (FluMist)

14. Is your child taking aspirin for a medical coudition? (FluMist)

15. Has your child received a measles (MMR) or chickenpox (Varicella) vaccine within the last 4 weeks? (FluMist)

APPENDIX:

2011 CDC Recommended Immunization Schedule for Persons Aged 0-6 Years

2011 CDC Recommended Immunization Schedule for Persons Aged 7-18 Years

2011 CDC Catch-Up Immunization Schedule for Persons Aged 4 Months thru 18 Years Who Start Late or Who Are More Than 1 Month Behind

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2011

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼ Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B[1]	HepB	HepB			HepB						
Rotavirus[2]			RV	RV	RV[2]						
Diphtheria, Tetanus, Pertussis[3]			DTaP	DTaP	DTaP	see footnote[3]	DTaP				DTaP
Haemophilus influenzae type b[4]			Hib	Hib	Hib[4]	Hib					
Pneumococcal[5]			PCV	PCV	PCV	PCV				PPSV	
Inactivated Poliovirus[6]			IPV	IPV	IPV						IPV
Influenza[7]					Influenza (Yearly)						
Measles, Mumps, Rubella[8]						MMR		see footnote[8]			MMR
Varicella[9]						Varicella		see footnote[9]			Varicella
Hepatitis A[10]						HepA (2 doses)				HepA Series	
Meningococcal[11]										MCV4	

Range of recommended ages for all children

Range of recommended ages for certain high-risk groups

This schedule includes recommendations in effect as of December 21, 2010. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: **http://www.cdc.gov/vaccines/pubs/acip-list.htm**. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at **http://www.vaers.hhs.gov** or by telephone, **800-822-7967**.

1. **Hepatitis B vaccine (HepB).** (Minimum age: birth)
   At birth:
   - Administer monovalent HepB to all newborns before hospital discharge.
   - If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
   - If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if HBsAg-positive, administer HBIG (no later than age 1 week).

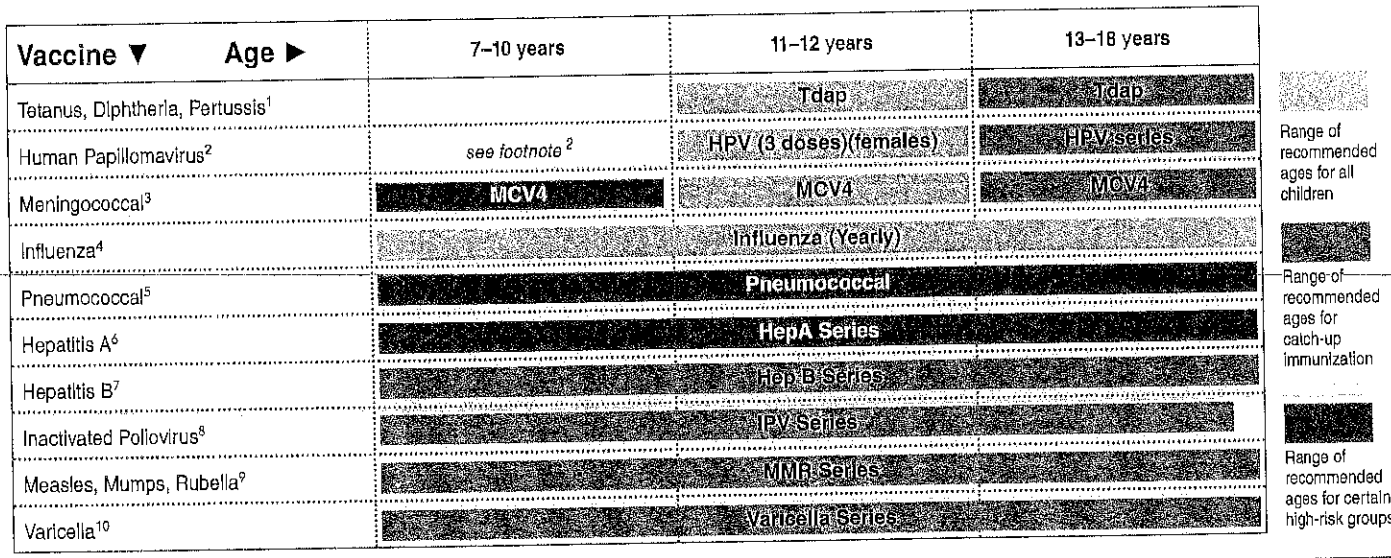
   Doses following the birth dose:
   - The second dose should be administered at age 1 or 2 months. Monovalent HepB should be used for doses administered before age 6 weeks.
   - Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg 1 to 2 months after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).
   - Administration of 4 doses of HepB to infants is permissible when a combination vaccine containing HepB is administered after the birth dose.
   - Infants who did not receive a birth dose should receive 3 doses of HepB on a schedule of 0, 1, and 6 months.
   - The final (3rd or 4th) dose in the HepB series should be administered no earlier than age 24 weeks.
2. **Rotavirus vaccine (RV).** (Minimum age: 6 weeks)
   - Administer the first dose at age 6 through 14 weeks (maximum age: 14 weeks 6 days). Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
   - The maximum age for the final dose in the series is 8 months 0 days
   - If Rotarix is administered at ages 2 and 4 months, a dose at 6 months is not indicated.
3. **Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).** (Minimum age: 6 weeks)
   - The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
4. ***Haemophilus influenzae* type b conjugate vaccine (Hib).** (Minimum age: 6 weeks)
   - If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
   - Hiberix should not be used for doses at ages 2, 4, or 6 months for the primary series but can be used as the final dose in children aged 12 months through 4 years.
5. **Pneumococcal vaccine.** (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])
   - PCV is recommended for all children aged younger than 5 years. Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
   - A PCV series begun with 7-valent PCV (PCV7) should be completed with 13-valent PCV (PCV13).
   - A single supplemental dose of PCV13 is recommended for all children aged 14 through 59 months who have received an age-appropriate series of PCV7.
   - A single supplemental dose of PCV13 is recommended for all children aged 60 through 71 months with underlying medical conditions who have received an age-appropriate series of PCV7.
   - The supplemental dose of PCV13 should be administered at least 8 weeks after the previous dose of PCV7. See *MMWR* 2010;59(No. RR-11).
   - Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant.
6. **Inactivated poliovirus vaccine (IPV).** (Minimum age: 6 weeks)
   - If 4 or more doses are administered prior to age 4 years an additional dose should be administered at age 4 through 6 years.
   - The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
7. **Influenza vaccine (seasonal).** (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])
   - For healthy children aged 2 years and older (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used, except LAIV should not be given to children aged 2 through 4 years who have had wheezing in the past 12 months.
   - Administer 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
   - Children aged 6 months through 8 years who received no doses of monovalent 2009 H1N1 vaccine should receive 2 doses of 2010–2011 seasonal influenza vaccine. See *MMWR* 2010;59(No. RR-8):33–34.
8. **Measles, mumps, and rubella vaccine (MMR).** (Minimum age: 12 months)
   - The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
9. **Varicella vaccine.** (Minimum age: 12 months)
   - The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
   - For children aged 12 months through 12 years the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
10. **Hepatitis A vaccine (HepA).** (Minimum age: 12 months)
    - Administer 2 doses at least 6 months apart.
    - HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.
11. **Meningococcal conjugate vaccine, quadrivalent (MCV4).** (Minimum age: 2 years)
    - Administer 2 doses of MCV4 at least 8 weeks apart to children aged 2 through 10 years with persistent complement component deficiency and anatomic or functional asplenia, and 1 dose every 5 years thereafter.
    - Persons with human immunodeficiency virus (HIV) infection who are vaccinated with MCV4 should receive 2 doses at least 8 weeks apart.
    - Administer 1 dose of MCV4 to children aged 2 through 10 years who travel to countries with highly endemic or epidemic disease and during outbreaks caused by a vaccine serogroup.
    - Administer MCV4 to children at continued risk for meningococcal disease who were previously vaccinated with MCV4 or meningococcal polysaccharide vaccine after 3 years if the first dose was administered at age 2 through 6 years.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the Advisory Committee on Immunization Practices (**http://www.cdc.gov/vaccines/recs/acip**), the American Academy of Pediatrics (**http://www.aap.org**), and the American Academy of Family Physicians (**http://www.aafp.org**).

Department of Health and Human Services • Centers for Disease Control and Prevention

Recommended Immunization Schedule for Persons Aged 7 Through 18 Years—United States • 2011

For those who fall behind or start late, see the schedule below and the catch-up schedule



This schedule includes recommendations in effect as of December 21, 2010. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: **http://www.cdc.gov/vaccines/pubs/acip-list.htm.** Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at **http://www.vaers.hhs.gov** or by telephone, **800-822-7967.**

1. **Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).** (Minimum age: 10 years for Boostrix and 11 years for Adacel))
   - Persons aged 11 through 18 years who have not received Tdap should receive a dose followed by Td booster doses every 10 years thereafter.
   - Persons aged 7 through 10 years who are not fully immunized against pertussis (including those never vaccinated or with unknown pertussis vaccination status) should receive a single dose of Tdap. Refer to the catch-up schedule if additional doses of tetanus and diphtheria toxoid–containing vaccine are needed.
   - Tdap can be administered regardless of the interval since the last tetanus and diphtheria toxoid–containing vaccine.
2. **Human papillomavirus vaccine (HPV).** (Minimum age: 9 years)
   - Quadrivalent HPV vaccine (HPV4) or bivalent HPV vaccine (HPV2) is recommended for the prevention of cervical precancers and cancers in females.
   - HPV4 is recommended for prevention of cervical precancers, cancers, and genital warts in females.
   - HPV4 may be administered in a 3-dose series to males aged 9 through 18 years to reduce their likelihood of genital warts.
   - Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
3. **Meningococcal conjugate vaccine, quadrivalent (MCV4).** (Minimum age: 2 years)
   - Administer MCV4 at age 11 through 12 years with a booster dose at age 16 years.
   - Administer 1 dose at age 13 through 18 years if not previously vaccinated.
   - Persons who received their first dose at age 13 through 15 years should receive a booster dose at age 16 through 18 years.
   - Administer 1 dose to previously unvaccinated college freshmen living in a dormitory.
   - Administer 2 doses at least 8 weeks apart to children aged 2 through 10 years with persistent complement component deficiency and anatomic or functional asplenia, and 1 dose every 5 years thereafter.
   - Persons with HIV infection who are vaccinated with MCV4 should receive 2 doses at least 8 weeks apart.
   - Administer 1 dose of MCV4 to children aged 2 through 10 years who travel to countries with highly endemic or epidemic disease and during outbreaks caused by a vaccine serogroup.
   - Administer MCV4 to children at continued risk for meningococcal disease who were previously vaccinated with MCV4 or meningococcal polysaccharide vaccine after 3 years (if first dose administered at age 2 through 6 years) or after 5 years (if first dose administered at age 7 years or older).
4. **Influenza vaccine (seasonal).**
   - For healthy nonpregnant persons aged 7 through 18 years (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used.
   - Administer 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
   - Children 6 months through 8 years of age who received no doses of monovalent 2009 H1N1 vaccine should receive 2 doses of 2010-2011 seasonal influenza vaccine. See *MMWR* 2010;59(No. RR-8):33–34.
5. **Pneumococcal vaccines.**
   - A single dose of 13-valent pneumococcal conjugate vaccine (PCV13) may be administered to children aged 6 through 18 years who have functional or anatomic asplenia, HIV infection or other immunocompromising condition, cochlear implant or CSF leak. See *MMWR* 2010;59(No. RR-11).
   - The dose of PCV13 should be administered at least 8 weeks after the previous dose of PCV7.
   - Administer pneumococcal polysaccharide vaccine at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition.
6. **Hepatitis A vaccine (HepA).**
   - Administer 2 doses at least 6 months apart.
   - HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, or who are at increased risk for infection, or for whom immunity against hepatitis A is desired.
7. **Hepatitis B vaccine (HepB).**
   - Administer the 3-dose series to those not previously vaccinated. For those with incomplete vaccination, follow the catch-up schedule.
   - A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.
8. **Inactivated poliovirus vaccine (IPV).**
   - The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
   - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
9. **Measles, mumps, and rubella vaccine (MMR).**
   - The minimum interval between the 2 doses of MMR is 4 weeks.
10. **Varicella vaccine.**
    - For persons aged 7 through 18 years without evidence of immunity (see *MMWR* 2007;56[No. RR-4]), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
    - For persons aged 7 through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
    - For persons aged 13 years and older, the minimum interval between doses is 4 weeks.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the Advisory Committee on Immunization Practices (**http://www.cdc.gov/vaccines/recs/acip**), the American Academy of Pediatrics (**http://www.aap.org**), and the American Academy of Family Physicians (**http://www.aafp.org**).
Department of Health and Human Services • Centers for Disease Control and Prevention

Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind—United States • 2011

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
PERSONS AGED 4 MONTHS THROUGH 6 YEARS					
Hepatitis B[1]	Birth	4 weeks	8 weeks (and at least 16 weeks after first dose)		
Rotavirus[2]	6 wks	4 weeks	4 weeks[2]		
Diphtheria, Tetanus, Pertussis[3]	6 wks	4 weeks	4 weeks	6 months	6 months[3]
Haemophilus influenzae type b[4]	6 wks	4 weeks if first dose administered at younger than age 12 months; 8 weeks (as final dose) if first dose administered at age 12–14 months; No further doses needed if first dose administered at age 15 months or older	4 weeks[4] if current age is younger than 12 months; 8 weeks (as final dose)[4] if current age is 12 months or older and first dose administered at younger than age 12 months and second dose administered at younger than 15 months; No further doses needed if previous dose administered at age 15 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months	
Pneumococcal[5]	6 wks	4 weeks if first dose administered at younger than age 12 months; 8 weeks (as final dose for healthy children) if first dose administered at age 12 months or older or current age 24 through 59 months; No further doses needed for healthy children if first dose administered at age 24 months or older	4 weeks if current age is younger than 12 months; 8 weeks (as final dose for healthy children) if current age is 12 months or older; No further doses needed for healthy children if previous dose administered at age 24 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age	
Inactivated Poliovirus[6]	6 wks	4 weeks	4 weeks	6 months[6]	
Measles, Mumps, Rubella[7]	12 mos	4 weeks			
Varicella[8]	12 mos	3 months			
Hepatitis A[9]	12 mos	6 months			
PERSONS AGED 7 THROUGH 18 YEARS					
Tetanus, Diphtheria/ Tetanus, Diphtheria, Pertussis[10]	7 yrs[10]	4 weeks	4 weeks if first dose administered at younger than age 12 months; 6 months if first dose administered at 12 months or older	6 months if first dose administered at younger than age 12 months	
Human Papillomavirus[11]	9 yrs	Routine dosing intervals are recommended (females)[11]			
Hepatitis A[9]	12 mos	6 months			
Hepatitis B[1]	Birth	4 weeks	8 weeks (and at least 16 weeks after first dose)		
Inactivated Poliovirus[6]	6 wks	4 weeks	4 weeks[6]	6 months[6]	
Measles, Mumps, Rubella[7]	12 mos	4 weeks			
Varicella[8]	12 mos	3 months if person is younger than age 13 years; 4 weeks if person is aged 13 years or older			

1. **Hepatitis B vaccine (HepB).**
   - Administer the 3-dose series to those not previously vaccinated.
   - The minimum age for the third dose of HepB is 24 weeks.
   - A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.
2. **Rotavirus vaccine (RV).**
   - The maximum age for the first dose is 14 weeks 6 days. Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
   - The maximum age for the final dose in the series is 8 months 0 days.
   - If Rotarix was administered for the first and second doses, a third dose is not indicated.
3. **Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).**
   - The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.
4. ***Haemophilus influenzae* type b conjugate vaccine (Hib).**
   - 1 dose of Hib vaccine should be considered for unvaccinated persons aged 5 years or older who have sickle cell disease, leukemia, or HIV infection, or who have had a splenectomy.
   - If the first 2 doses were PRP-OMP (PedvaxHIB or Comvax), and administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
   - If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a final dose at age 12 through 15 months.
5. **Pneumococcal vaccine.**
   - Administer 1 dose of 13-valent pneumococcal conjugate vaccine (PCV13) to all healthy children aged 24 through 59 months with any incomplete PCV schedule (PCV7 or PCV13).
   - For children aged 24 through 71 months with underlying medical conditions, administer 1 dose of PCV13 if 3 doses of PCV were received previously or administer 2 doses of PCV13 at least 8 weeks apart if fewer than 3 doses of PCV were received previously.
   - A single dose of PCV13 is recommended for certain children with underlying medical conditions through 18 years of age. See age-specific schedules for details.
   - Administer pneumococcal polysaccharide vaccine (PPSV) to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant, at least 8 weeks after the last dose of PCV. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition. See *MMWR* 2010;59(No. RR-11).
6. **Inactivated poliovirus vaccine (IPV).**
   - The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
   - A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months following the previous dose.
   - In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
7. **Measles, mumps, and rubella vaccine (MMR).**
   - Administer the second dose routinely at age 4 through 6 years. The minimum interval between the 2 doses of MMR is 4 weeks.
8. **Varicella vaccine.**
   - Administer the second dose routinely at age 4 through 6 years.
   - If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
9. **Hepatitis A vaccine (HepA).**
   - HepA is recommended for children aged older than age 23 months who live in areas where vaccination programs target older children, or who are at increased risk for infection, or for whom immunity against hepatitis A is desired.
10. **Tetanus and diphtheria toxoids (Td) and tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).**
    - Doses of DTaP are counted as part of the Td/Tdap series.
    - Tdap should be substituted for a single dose of Td in the catch-up series for children aged 7 through 10 years or as a booster for children aged 11 through 18 years; use Td for other doses.
11. **Human papillomavirus vaccine (HPV).**
    - Administer the series to females at age 13 through 18 years if not previously vaccinated or have not completed the vaccine series.
    - Quadrivalent HPV vaccine (HPV4) may be administered in a 3-dose series to males aged 9 through 18 years to reduce their likelihood of genital warts.
    - Use recommended routine dosing intervals for series catch-up (i.e., the second and third doses should be administered at 1 to 2 and 6 months after the first dose). The minimum interval between the first and second doses is 4 weeks. The minimum interval between the second and third doses is 12 weeks, and the third dose should be administered at least 24 weeks after the first dose.

Information about reporting reactions after immunization is available online at **http://www.vaers.hhs.gov** or by telephone, **800-822-7967**. Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for immunization, is available from the National Center for Immunization and Respiratory Diseases at **http://www.cdc.gov/vaccines** or telephone, **800-CDC-INFO** (800-232-4636).

Department of Health and Human Services • Centers for Disease Control and Prevention

These Pediatric and Adolescent Immunization Guidelines Through Age 18 are approved for use by San Mateo County Health System staff. In addition, administration of immunizations using other timing that complies with the current "Recommended Immunization Schedules for Persons 0-18 Years of Age" published by the Advisory Council on Immunization Practices of the Centers for Disease Control and Prevention is also approved.

Janet Chaikind, MD
Medical Director of Pediatrics and Adolescent Medicine
San Mateo Medical Center

4/29/11
Date

Scott Morrow, MD
San Mateo County Health Officer

4/18/11
Date

San Mateo Medical Center Primary Care recommends the use of USPTF evidence based primary screening prevention recommendations..

Section 1: Preventive Services Recommended by the USPSTF			
The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians discuss these preventive services with eligible patients and offer them as a priority. All these services have received an “A” or a “B” (recommended) grade from the Task Force. Refer to the endnotes for each recommendation for population-specific clinical considerations. For definitions of all grades used by the USPSTF refer to the full listings of all USPSTF recommendations for adults and recommendations children at http://www.uspreventiveservicestaskforce.org. The widget tool can also be found at:			
Recommendation	**Adults**		**Special Populations**
	Men	**Women**	**Pregnant Women**
Abdominal Aortic Aneurysm, Screening[1]	√		
Alcohol Misuse Screening and Behavioral Counseling	√	√	√
Aspirin for the Prevention of Cardiovascular Disease[2]	√	√	
Bacteriuria, Screening[3]			√
BRCA-Related Cancer in Women, Screening[4]		√	
Breast Cancer, Preventive Medications[5]		√	
Breast Cancer, Screening[6]		√	
Breastfeeding, Counseling[7]		√	√
Cervical Cancer, Screening[8]		√	
Chlamydial Infection, Screening[9]		√	√
Colorectal Cancer, Screening[10]	√	√	
Depression in Adults, Screening[11]	√	√	
Diabetes Mellitus, Screening[12]	√	√	
Falls in Older Adults, Counseling, Preventive Medication, and Other Interventions[13]	√	√	

Recommendation	Adults		Special Populations
	Men	Women	Pregnant Women
Folic Acid Supplementation to Prevent Neural Tube Defects, Preventive Medication[14]		√	
Gestational Diabetes Mellitus, Screening[15]			√
Gonorrhea, Screening[16]		√	
Hepatitis B Virus Infection in Pregnant Women, Screening[17]			√
Hepatitis C Virus Infection in Adults, Screening[18]	√	√	√
High Blood Pressure in Adults, Screening	√	√	
HIV Infection, Screening[19]	√	√	√
Intimate Partner Violence and Elderly Abuse, Screening[20]		√	
Iron Deficiency Anemia, Screening[21]			√
Lipid Disorders in Adults, Screening[22]	√	√	
Lung Cancer, Screening[23]	√	√	
Obesity in Adults, Screening[24]	√	√	
Osteoporosis, Screening[25]		√	

Section 1: Preventive Services Recommended by the USPSTF *(continued)*			
Recommendation	**Adults**		**Special Populations**
	Men	**Women**	**Pregnant Women**
Sexually Transmitted Infections, Counseling[26]	√	√	
Skin Cancer, Counseling[27]	√	√	√
Syphilis Infection (Pregnant Women), Screening			√
Tobacco Use in Adults, Counseling and Interventions[28]	√	√	√

[1]One-time screening by ultrasonography in men aged 65 to 75 who have ever smoked.

[2]When the potential harm of an increase in gastrointestinal hemorrhage is outweighed by a potential benefit of a reduction in myocardial infarctions (men aged 45-79 years) or in ischemic strokes (women aged 55-79 years).

[3]Pregnant women at 12-16 weeks gestation or at first prenatal visit, if later.

[4]Refer women whose family history is associated with an increased risk for deleterious mutations in BRCA*1 or BRCA 2 genes for genetic counseling and evaluation for BRCA testing.*

[5]Engage in shared, informed decisionmaking and offer to prescribe risk-reducing medications, if appropriate, to women aged ≥35 years without prior breast cancer diagnosis who are at increased risk.

[6]Biennial screening mammography for women aged 50 to 74 years. Note: The Department of Health and Human Services, in implementing the Affordable Care Act, follows the 2002 USPSTF recommendation for screening mammography, with or without clinical breast examination, every 1-2 years for women aged 40 and older.

[7]Interventions during pregnancy and after birth to promote and support breastfeeding.

[8]Screen with cytology every 3 years (women ages 21 to 65) or co-test (cytology/HPV testing) every 5 years (women ages 30-65).

[9]Sexually active women 24 and younger and other asymptomatic women at increased risk for infection. Asymptomatic pregnant women 24 and younger and others at increased risk.

[10]Adults aged 50-75 using fecal occult blood testing, sigmoidoscopy, or colonoscopy.

[11]When staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and followup.

[12]Asymptomatic adults with sustained blood pressure greater than 135/80 mg Hg.

[13]Provide intervention (exercise or physical therapy and/or vitamin D supplementation) to community-dwelling adults ≥65 years at increased risk for falls.

[14]All women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.

[15]Asymptomatic pregnant women after 24 weeks of gestation.

[16]Sexually active women, including pregnant women 25 and younger, or at increased risk for infection.

[17]Screen at first prenatal visit.

[18]Persons at high risk for infection and adults born between 1945 and 1965.

[19]All adolescents and adults ages 15 to 65 years and others who are at increased risk for HIV infection and all pregnant women.

[20]Asymptomatic women of childbearing age; provide or refer women who screen positive to intervention services.

[21]Routine screening in asymptomatic pregnant women.

[22]Men aged 20-35 and women over age 20 who are at increased risk for coronary heart disease; all men aged 35 and older.

[23]Asymptomatic adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit smoking within the past 15 years.

[24]Patients with a body mass index of 30 kg/m2 or higher should be offered or referred to intensive, multicomponent behavioral interventions.

[25]Women aged 65 years and older and women under age 65 whose 10-year fracture risk is equal to or greater than that of a 65-year-old white woman without additional risk factors.

[26]All sexually active adolescents and adults at increased risk for STIs.

[27]Children, adolescents, and young adults aged 10 to 24 years.

[28]Ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco; provide augmented, pregnancy-tailored counseling for those pregnant women who smoke.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in *Bright Futures* guidelines (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	**Prenatal**[2]	**Newborn**[3]	**3-5 d**[4]	**By 1 mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**	**12 mo**	**15 mo**	**18 mo**	**24 mo**	**30 mo**	**3 y**	**4 y**	**5 y**	**6 y**	**7 y**	**8 y**	**9 y**	**10 y**	**11 y**	**12 y**	**13 y**	**14 y**	**15 y**	**16 y**	**17 y**	**18 y**	**19 y**	**20 y**	**21 y**
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision		★	★	★	★	★	★	★	★	★	★	★	★	●[7]	●	●	●	★	●	★	●	★	●	★	★	●	★	★	●	★	★	★
Hearing		●[8]	★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	★	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																																
Developmental Screening[9]								●			●		●																			
Autism Screening[10]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment[11]																					★	★	★	★	★	★	★	★	★	★	★	★
Depression Screening[12]																					●	●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[14]																																
Newborn Blood Screening[15]		←—	●	—→																												
Critical Congenital Heart Defect Screening[16]		●																														
Immunization[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[18]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead Screening[19]							★	★	● or ★[20]		★	● or ★[20]		★	★	★	★																
Tuberculosis Testing[21]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Screening[22]												★			★		★		★	←—	●	—→	★	★	★	★	★	★	←—	●	—→		
STI/HIV Screening[23]																						★	★	★	★	★	←—	●	—→	★	★	★	★
Cervical Dysplasia Screening[24]																																●
ORAL HEALTH[25]							★	★	● or ★		● or ★	● or ★	● or ★	●			●															
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per the 2009 AAP statement "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Every infant should have a newborn evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in the 2012 AAP statement "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborn infants discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per the 2010 AAP statement "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per the 2007 AAP statement "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. If the patient is uncooperative, rescreen within 6 months, per the 2007 AAP statement "Eye Examination in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/111/4/902.abstract).
8. All newborns should be screened, per the AAP statement "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. See 2006 AAP statement "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
10. Screening should occur per the 2007 AAP statement "Identification and Evaluation of Children with Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
11. A recommended screening tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
12. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
13. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See 2011 AAP statement "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
14. These may be modified, depending on entry point into schedule and individual need.
15. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf), establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.
16. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).
17. Schedules, per the AAP Committee on Infectious Diseases, are available at: http://aapredbook.aappublications.org/site/resources/izschedules.xhtml. Every visit should be an opportunity to update and complete a child's immunizations.
18. See 2010 AAP statement "Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children (0-3 Years of Age)" (http://pediatrics.aappublications.org/content/126/5/1040.full).
19. For children at risk of lead exposure, see the 2012 CDC Advisory Committee on Childhood Lead Poisoning Prevention statement "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
20. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
21. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
22. See AAP-endorsed 2011 guidelines from the National Heart Blood and Lung Institute, "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
23. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the *AAP Red Book: Report of the Committee on Infectious Diseases*. Additionally, all adolescents should be screened for HIV according to the AAP statement (http://pediatrics.aappublications.org/content/128/5/1023.full) once between the ages of 16 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
24. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
25. Refer to a dental home, if available. If not available, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf). If primary water source is deficient in fluoride, consider oral fluoride supplementation. For those at high risk, consider application of fluoride varnish for caries prevention. See 2008 AAP statement "Preventive Oral Health Intervention for Pediatricians" (http://pediatrics.aappublications.org/content/122/6/1387.full) and 2009 AAP statement "Oral Health Risk Assessment Timing and Establishment of the Dental Home" (http://pediatrics.aappublications.org/content/111/5/1113.full).

KEY ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ←— ● —→ = range during which a service may be provided

Summary of changes made to the
2014 Bright Futures/AAP Recommendations for Preventive Pediatric Health Care

(Periodicity Schedule)

Changes to Developmental/Behavioral Assessment

- **Alcohol and Drug Use Assessment**- Information regarding a recommended screening tool (CRAFFT) was added.
- **Depression**- Screening for depression at ages 11 through 21 has been added, along with suggested screening tools.

Changes to Procedures

- **Dyslipidemia screening**- An additional screening between 9 and 11 years of age has been added. The reference has been updated to the AAP-endorsed National Heart Blood and Lung Institute policy (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
- **Hematocrit or hemoglobin**- A risk assessment has been added at 15 and 30 months. The reference has been updated to the current AAP policy (http://pediatrics.aappublications.org/content/126/5/1040.full).
- **STI/HIV screening**- A screen for HIV has been added between 16 and 18 years. Information on screening adolescents for HIV has been added in the footnotes. STI screening now references recommendations made in the AAP Red Book. This category was previously titled "STI Screening."
- **Cervical dysplasia**- Adolescents should no longer be routinely screened for cervical dysplasia until age 21. Indications for pelvic exams prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
- **Critical Congenital Heart Disease-** Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement, "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).

For several recommendations, the AAP Policy has been updated since 2007 but there have been no changes in the timing of recommendations on the Periodicity Schedule. These include:

- Footnote 2- The Prenatal Visit (2009): http://pediatrics.aappublications.org/content/124/4/1227.full
- Footnote 4- Breastfeeding and the Use of Human Milk (2012): http://pediatrics.aappublications.org/content/129/3/e827.full and Hospital Stay for Healthy Term Newborns (2010): http://pediatrics.aappublications.org/content/125/2/405.full
- Footnote 8- Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs (2007): http://pediatrics.aappublications.org/content/120/4/898.full
- Footnote 10- Identification and Evaluation of Children with Autism Spectrum Disorders (2007): http://pediatrics.aappublications.org/content/120/5/1183.full
- Footnote 17- Immunization Schedules (2014): http://aapredbook.aappublications.org/site/resources/IZSchedule0-6yrs.pdf, http://aapredbook.aappublications.org/site/resources/IZSchedule7-18yrs.pdf, and http://aapredbook.aappublications.org/site/resources/IZScheduleCatchup.pdf
- Footnote 19- CDC Advisory Committee on Childhood Lead Poisoning Prevention statement "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (2012): http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf
- Footnote 22- AAP-endorsed guideline "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (2011): http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm
- Footnote 25- Preventive Oral Health Intervention for Pediatricians (2008): http://pediatrics.aappublications.org/content/122/6/1387.full and Oral Health Risk Assessment Timing and Establishment of the Dental Home (2009): http://pediatrics.aappublications.org/content/111/5/1113.full. Additional information from the policies regarding fluoride supplementation and fluoride varnish has been added to the footnote.

New references were added for several footnotes, also with no change to recommendations in the Periodicity Schedule:

- Footnote 5- Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report (2007): http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full
- Footnote 13- Use of Chaperones During the Physical Examination of the Pediatric Patient (2011): http://pediatrics.aappublications.org/content/127/5/991.full
- Footnote 15- The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf), establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.

For consistency, the title of "Tuberculin Test" has been changed to "Tuberculosis Testing." The title of "Newborn Metabolic/Hemoglobin Screening" has been changed to "Newborn Blood Screening."

San Mateo Medical Center
A County System of Healthcare

San Mateo Medical Center Primary Care Smoking Cessation Guidelines

Clinic teams and providers identify (initially and annually) all patients (of any age) who use tobacco products and note this use in the member's medical record. For pediatric patients, parents who use tobacco products are identified.
This is completed as part of the rooming process at every visit and is documented in structured data fields in the EHR.
The rooming process includes standard questions and an offer of counseling and referral for every individual who indicates they are a current smoker.
Referrals can be placed to Breathe California and/or patients can be referred to 1-800-No-Butts telephone resource line.

Excerpted from 2008 HHS "Treating Tobacco Use and Dependence" Important points to remember in the care of patients who are smoking:

1. Tobacco dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit. Effective treatments exist, however, that can significantly increase rates of long-term abstinence.
2. It is essential that providers and clinical teams consistently identify and document tobacco use status and treat every tobacco user seen in our health care settings.
3. Tobacco dependence treatments are effective across a broad range of populations. Providers and clinic teams should encourage every patient willing to make a quit attempt to use the counseling treatments available over the phone or in person.
4. Brief tobacco dependence treatment is effective.
5. Individual, group, and telephone counseling are effective, and their effectiveness increases with treatment intensity.
6. Numerous effective medications are available for tobacco dependence,and clinicians should encourage their use by all patients attempting to quit smoking—except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents).
    - Seven first-line medications (5 nicotine and 2 non-nicotine) reliably increase long-term smoking abstinence rates:
        - Bupropion SR
        - Nicotine gum
        - Nicotine inhaler
        - Nicotine lozenge
        - Nicotine nasal spray
        - Nicotine patch
        - Varenicline
7. Counseling and medication are effective when used by themselves for treating tobacco dependence. The combination of counseling and medication, however, is more effective than either alone.
8. Telephone quitline counseling is effective with diverse populations and has broad reach. Therefore, both clinicians and health care delivery systems should ensure patient access to quitlines and promote quitline use.
9. If a tobacco user currently is unwilling to make a quit attempt, providers should continue to use motivational treatments so as to increase future quit attempts.
10. Tobacco dependence treatments are both clinically effective and highly cost-effective relative to interventions for other clinical disorders.

In addition to this clinical teams and providers will assist patients to complete an Individual Comprehensive Health Assessment, which includes The Staying Healthy Assessment (SHA). Each age-appropriate SHA questionnaire asks about smoking status and/or exposure to tobacco smoke

San Mateo Medical Center Vancomycin Dosing Guidelines

Vancomycin is a tricyclic glycopeptide antibiotic that exhibits bactericidal activity by preventing the synthesis and assembly of a growing bacterial cell wall, altering the permeability of the bacterial cytoplasmic membrane, and selectively inhibiting bacterial RNA synthesis. Vancomycin is considered to be a concentration-independent, or time-dependent, killer of bacteria.

1. **Determine creatinine clearance and dose**
   a. Determine the dose with total body weight (TBW)
   b. Calculate creatinine clearance with the Cockcroft-Gault equation using an ideal body weight (IBW) or an adjusted body weight (ABW) if the patient is obese (TBW >20% over IBW)

$$\text{CrCL (mL/min)} = \frac{(140-\text{age}) \times \text{IBW}}{\text{SCr} \times 72} \quad (\times 0.85 \text{ for females})$$

IBW (male) = 50 kg + (2.3 x height in inches >60 inches)
IBW (female) = 45 kg + (2.3 x height in inches >60 inches)
ABW (kg) = IBW + 0.4(TBW – IBW)

2. **Initial Empiric Dosing**
   a. **Maintenance Dose:**

Creatinine Clearance (mL/min)	Dose & Frequency Total body weight (TBW)	Timing Trough Level (when clinically indicated)
>50	15-20 mg/kg Q8-12H	Before 4th or 5th dose
30-49	15-20 mg/kg Q12-24H	Before 3rd or 4th dose
15-29	10-15 mg/kg Q24H	Before 3rd dose
<15	10-15 mg/kg Q24-48H	Q24H – before 3rd dose Q48H – before 2nd dose
Hemodialysis	Load: 20-25 mg/kg x 1 Maintenance: 10-15 mg/kg when post-dialysis levels <15 mg/L or <20 mg/L in severe infections (i.e. meningitis, pneumonia)	Pre-dialysis – Assumes that HD is high flux and removes ~30% of vancomycin per 3 hour session
CRRT (continuous renal replacement therapy)	Load: 20-25 mg/kg x 1 Maintenance: 10-15 mg/kg Q24H	Before 3rd or 4th dose

*Round dose to 250 mg, 500 mg, 750 mg, 1 GM, 1.25 GM, 1.5 GM, 1.75 GM, or 2 GM (max dose)

   b. **Loading Dose:** Dependent upon the clinical situation, a loading dose can be used to facilitate rapid attainment of target trough serum vancomycin concentration.
      i. Normal renal function: Consider a loading dose of **25-30 mg/kg** (max 2 GM) for severe infections and ICU patients
      ii. Renal insufficiency: Use a lower loading dose of **15-20 mg/kg**

Patient Weight	Recommended Loading Dose	Infusion Rate
25 – 35 kg	750 mg x 1	60 minutes
36 – 45 kg	1,000 mg x 1	60 minutes
46 – 55 kg	1,250 mg x 1	90 minutes
56 – 65 kg	1,500 mg x 1	90 minutes
66 – 75 kg	1,750 mg x 1	120 minutes
≥ 76 kg	2,000 mg x 1	120 minutes

Central line only: Up to 1000 mg in 100 mL of compatible diluent
Peripheral line: 500 mg in at least 100 mL of compatible diluent

Red man syndrome may occur if the infusion is too rapid. It is not an allergic reaction, but may be characterized by hypotension and/or a maculopapular rash appearing on the face, neck, trunk, and/or upper extremities. If this should occur, slow the infusion rate to over 1.5 to 2 hours

Prepared by A.Sajuthi, Pharm.D., SMMC Pharmacy, January 2015

3. Therapeutic Drug Monitoring

a. Goal trough levels

Goal Trough (mcg/mL)	Indication
10-15	cellulitis, skin/soft tissue infections
15-20	pneumonia, bacteremia, endocarditis, osteomyelitis

*Recommend trough levels >10 mcg/mL to avoid microbial resistance

b. Clinical situations to obtain serum concentrations

i. Serious or life-threatening infections
ii. Patients with rapidly changing renal function
iii. Concomitant administration of nephrotoxic medication (i.e. aminoglycosides, amphotericin B)
iv. Patients on intermittent or continuous dialysis
v. Patients requiring higher than usual doses of vancomycin (>20 mg/kg/dose)
vi. Altered volume of distribution (i.e. morbidly obese patients)
vii. Treating organisms with higher MICs
viii. When SCr acutely rises, hold dose and draw level. Restart therapy when level <15-20 mcg/mL
ix. Patients receiving prolonged course of therapy (>3-5 days of therapy)
x. For prolonged course of therapy in patients with stable renal function and clinical status, once weekly monitoring is reasonable
xi. **NOTE:** Schedule trough levels to be drawn during day shift (08:00-17:00) if possible. This may require drawing the trough prior to a different dose such as the 3rd or 5th dose rather than the 4th.

c. Dose adjustments

i. **Goal Trough 10-15 mcg/mL**

Serum Trough	Dosage Adjustment	Alternative
<10 mcg/mL and interval greater than Q12H	**Decrease interval** by 12H increments (e.g. if Q36H, change to Q24H; if Q24H, change to Q12H, level will approximately double)	**Increase dose** by 25-50%
<10 mcg/mL and on Q12H	**Decrease interval** to Q8H	**Increase dose** by 25-50%
10-15 mcg/mL	**No change (desired level)**	
>15 mcg/mL	**Increase interval** by 12H increment (e.g. if Q12H, change to Q24H; level will be approximately halved)	**Decrease dose** by 25-50%

*If adjusting by dose, round to closest 250 mg increment

ii. **Goal Trough 15-20 mcg/mL**

Serum Trough	Dosage Adjustment	Alternative
<15 mcg/mL and interval greater than Q12H	**Decrease interval** by 12H increments (e.g. if Q36H, change to Q24H; if Q24H, change to Q12H, level will approximately double)	**Increase dose** by 25-50%
<15 mcg/mL and on Q12H	**Decrease interval** to Q8H	**Increase dose** by 25-50%
15-20 mcg/mL	**No change (desired level)**	
>20 mcg/mL	**Increase interval** by 12H increment (e.g. if Q12H, change to Q24H; level will be approximately halved)	**Decrease dose** by 25-50%

*If adjusting by dose, round to closest 250 mg increment

Trough >25 mcg/mL

1. View as an indicator for one or more of the following clinical events
   a. Potential undocumented error in either the administration of the vancomycin or the timing of the blood draw
   b. Potential error in the process of taking the blood sample (e.g. blood drawn through the IV line that vancomycin was administered through without proper flushing of the IV line prior to the blood draw)
   c. Significant real PK alterations
   d. Sign of renal dysfunction that has not yet manifested via an increase in SCr
2. If the unexpectedly high trough concentration is determined to be "real":
   a. Discontinue active order for vancomycin
   b. Discuss need to continue therapy
3. Consider scheduling a follow up "random" vancomycin serum concentration
   a. Don't order any sooner than 24 hours after the previously-obtained blood draw
   b. Subsequent "random" blood draws should NOT be ordered any more frequently than once daily
   c. Consider re-starting therapy at a lower dose when serum levels are <15 mcg/mL.

iii. **Hemodialysis**

1. Troughs are drawn 1 hour prior to each hemodialysis session
2. Administer each dose of vancomycin (if indicated based on trough level) AFTER hemodialysis session is complete
3. **Goal Trough 10-15 mcg/mL**

Serum Trough	Dosage Adjustment
<10 mcg/mL	**Increase dose by 250 mg**
10-15 mcg/mL	**No change (desired level)**
15-20 mcg/mL	**Decrease dose by 250 mg**
>20 mcg/mL	**Hold vancomycin dose**

4. **Goal Trough 15-20 mcg/mL**

Serum Trough	Dosage Adjustment
<10 mcg/mL	**Increase dose by 500 mg**
10-15 mcg/mL	**Increase dose by 250 mg**
15-20 mcg/mL	**No change (desired level)**
20-25 mcg/mL	**Decrease dose by 250 mg**
>25 mcg/mL	**Hold vancomycin dose**

TAB 2
Program Calendar
(Consent Agenda)

Health Care for the Homeless & Farmworker Health (HCH/FH) Program
2015 Calendar (*Revised September 2015*)

EVENT	DATE	NOTES
• Board Meeting (September 10, 2015 from 9:00 a.m. to 11:00 a.m.) • TA with HRSA for various (September 22, 23 & 24) @ SMMC • Issuance of RFP for 2016 Services • Hiring of Management Analyst • Expanded Services Grant Awards • 2015 OSV Grant Conditions expected	September	Board meeting at Fair Oaks Clinic-RWC
• Board Meeting (October 8, 2015 from 9:00 a.m. to 11:00 a.m.) • Nominations for Chair & Vice-Chair • International Street Medicine Symposium: Oct 14-17, San Jose	October	Board meeting at SMMC- San Mateo
• Board Meeting (November 12, 2015 from 9:00 a.m. to 11:00 a.m.) • Election of Chair & Vice-Chair • Annual Evaluation & Review of Program Director • Review/Approval of RFP proposals • Contracting , prepare for BOS (as required)	November	Board meeting at Coastside Clinic-HMB
• Board Meeting (December 10, 2015 from 9:00 a.m. to 11:00 a.m.) • BOS approval of contracts (as required) • Grant Year Budget Approval	December	

Conference calendar	
2016 Western Forum for Migrant and Community Health	Feb 23-25, 2016; Portland,OR
National Health Care for the Homeless Council National Conference	May 31- June 3,2016; Portland. OR

TAB 3
Consumer Input

2015 SAN MATEO COUNTY HOMELESS CENSUS AND SURVEY

FINAL REPORT

July 2015

Prepared by the San Mateo County Human Services Agency, Center on Homelessness
Data Analysis by Kate Bristol Consulting and Philliber Research Associates

2015 San Mateo County Homeless Census And Survey

TABLE OF CONTENTS

I. PURPOSE

The purpose of the 2015 Homeless Census and Survey ("the Census and Survey") is to gather and analyze information to help the community understand homelessness in San Mateo County. This data forms the basis for effective planning to solve this complex and long-standing problem. The San Mateo County Human Services Agency's Center on Homelessness and the San Mateo County Continuum of Care (CoC) Steering Committee were responsible for overseeing this data collection effort, with assistance from a broad group of community partners, including non-profit social service providers, city and town governments, and homeless and formerly homeless individuals.

The Census and Survey was designed to meet two related sets of data needs. The first is the requirement of the U.S. Department of Housing and Urban Development (HUD) that communities applying for McKinney-Vento Homelessness Assistance funds (also known as Continuum of Care or "CoC" funds) must conduct a point-in-time count of homeless people a minimum of every two years. These counts are required to take place in the last ten days of January. The Census and Survey was conducted in January 2015to meet this HUD requirement. The previous HUD-mandated count was conducted in January 2013.

The second set of data needs that the Census and Survey is designed to meet are those outlined in "Housing Our People Effectively (HOPE): Ending Homelessness in San Mateo County" (the "HOPE Plan.") This Plan is the result of a year-long process that began in 2005 and incorporated the experiences and expertise of over 200 stakeholders, including members of the business, nonprofit and government sectors. The HOPE Plan lays out concrete strategies designed to end homelessness in our community within 10 years. Plan implementation is overseen by the HOPE Inter Agency Council (IAC). The bi-annual Census and Survey provides data the IAC and the community needs to guide the implementation of the HOPE Plan, by collecting and analyzing a wealth of additional information beyond what is required by HUD. This data allows for a more complete understanding of who is homeless, why they are homeless, and what they need to end their homelessness, and helps ensure that the interventions undertaken through HOPE are targeted to achieve the best possible results.

II. METHODOLOGY

The 2015 Census and Survey consisted of two main components:

1. The Homeless Census ("the census"), a point-in-time count of homeless persons living on the streets, in vehicles, homeless shelters, transitional housing and institutional settings (jails, hospitals, substance abuse treatment programs) on the night of January 22, 2015.

2. The Homeless Survey ("the survey"), consisting of interviews with a representative sample of 239 unsheltered homeless people conducted over a two-week period between January 26 and February 9, 2015. Homeless people who were interviewed were asked to respond to a questionnaire designed to elicit demographic information (e.g. age, gender, disabilities, veteran status), as well as information about how long and how many times they have been homeless, and their use of benefits and services.

The Census and Survey used the definition of homelessness established in the federal McKinney-Vento Homeless Assistance Act as the basis for determining who to include and exclude:

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) or those who are "couch surfing" (i.e. those who "float" from location to location).

Additional details about the methodology used in the Census and Survey may be found in Appendix 1.

III. FINDINGS

A. Homeless Census

The sections below provide a summary of key findings from the 2015 Homeless Census. Complete Census data may be found in Appendix 2.

1. Number of Homeless People

The 2015 Census determined that there were **1,772 homeless people in San Mateo County on the night of January 22, 2015** comprised of:

- 775 unsheltered homeless people (living on streets, in vehicles, in homeless encampments) and,
- 997 sheltered homeless people (in emergency shelters, transitional housing, motel voucher programs, residential treatment, jails, and hospitals).

2. Number of Homeless Households

The 1,772 homeless people counted comprised **1,387 households** as follows**:**

- 1,240 "adults only" households, i.e. without dependent children (89%);
- 147 family" households, i.e., with dependent children (11%)

The chart below summarizes the types of locations where homeless people were counted, broken down by household types: adult-only households and family households.

Table 1: Homeless Count by Location and Household Type						
Location	**Adult Only House-holds**	**People in Adult Only House-holds**	**Family House-holds**	**People in Family House-holds**	**Total House-holds**	**Total People**
Unsheltered Count						
Streets	327	331	0	0	327	331
Cars	92	98	18	59	110	157
RVs	89	95	17	56	106	151
Encampments	136	136	0	0	136	136
Subtotal Unsheltered	**644**	**660**	**35**	**115**	**679**	**775**
Shelter Count						
Emergency Shelters	152	152	12	35	164	187
Motel Voucher Programs	0	0	22	67	22	67
Transitional Housing	155	155	78	299	233	454
Institutions	289	289	0	0	289	289
Subtotal Sheltered	**596**	**596**	**112**	**401**	**708**	**997**
TOTAL	**1,240**	**1,256**	**147**	**516**	**1,387**	**1,772**

3. Comparison of Year to Year Results

a. Summary of Changes

The table below shows the count totals from 2009 through 2015.

Table 2: Homeless Count 2009 Through 2015						
Location	**2009**	**2011**	**2013**	**2015**	**Net Change (2013 to 2015)**	**% Change (2013 to 2015)**
Street Count						
People Observed on Streets	422	466	353	331	-22	-6%
People in Cars	96	126	231	157	-74	-32%
People in RVs	170	246	392	151	-241	-61%
People in Encampments	115	324	323	136	-187	-58%
Subtotal Street Count	**803**	**1,162**	**1,299**	**775**	**-524**	**-40%**
Shelter Count						
People in Emergency Shelters	267	215	243	187	-56	-23%
People in Motel Voucher Programs	74	43	29	67	38	131%
People in Transitional Housing	403	441	431	454	23	5%
People in Institutions	249	288	279	289	10	4%
Subtotal Shelter Count	**993**	**987**	**982**	**997**	**15**	**2%**
TOTAL HOMELESS PEOPLE	**1,796**	**2,149**	**2,281**	**1,772**	**-509**	**-24%**

b. Analysis of Changes

Unsheltered Homeless People

As illustrated in the chart above, there was a 40% decrease in the number of unsheltered people in 2015 compared to 2013. The number of people observed on the street dropped by 6%, while the number of people in cars, RVs and encampments went down substantially, by 32%, 61% and 58% respectively. This is the first time in the past four counts that the number of unsheltered people has gone down.

There were several factors that contributed to the decrease in the unsheltered count:

- Enumerators observed fewer homeless people on the street compared to 2013, including zero families with children;
- Enumerators counted fewer cars, vans and RVs with sleeping occupants than in 2013;
- Based on responses to interviews with a representative sample of unsheltered homeless people (see Section III.B, Homeless Survey), there were fewer people per vehicle and encampment than in 2013.

It should be noted that counting certain types of vehicles, particularly RVs, is an inexact process. People sleeping in cars can generally be assumed to be homeless, since cars are not designed as living spaces. RVs, however, are designed to be lived in and provide adequate living facilities provided there are electrical and sewer hookups or facilities available nearby. In 2013, enumerators counted a number of RVs that were parked on private property (e.g. in driveways of homes) whose occupants likely were not truly homeless. In 2015, enumerators were instructed to only count RVs parked on public property that had sleeping occupants and did not appear to be connected to services. This tightening of the criteria for counting RVs likely led to some of the reduction in the number that were counted. See Appendix 1, Methodology, for a further discussion of the challenges of counting homeless people living in RVs.

Sheltered Homeless People

The sheltered count increased in comparison to 2013, though only by a factor of 2%. The total number of sheltered people went up from 982 in 2013 to 997 in 2015. Given that the inventory of available shelter and transitional housing beds has changed relatively little in the past two years, this increase is likely due to fluctuations in bed utilization rate.

Total Number of Homeless People

Overall, the 2015 homeless count of 1,772 total people represented a 24% decrease compared to 2013. This was largely a result of the decrease in homeless people observed in vehicles and encampments, as discussed above. This decrease reversed a trend of counts that have been going up consistently since 2009.

Homeless Families With Children

The percentage of households with children versus those without children went up slightly from 2013 to 2015. In 2015, 89% of households were either single individuals or couples without children and 11% were households with children. In 2013, this split was 90% adult households and 10% families with children.

As in prior years, the enumerators counted very few unsheltered homeless families with children. Of the 147 family households counted in 2015, 112 (76%) were living in shelters and 35 (24%) were in cars or RVs. There were no families with children observed on the street. The very low numbers of unsheltered homeless families reflects the County's ongoing commitment to preventing family homelessness and its investment in programs targeting families with children, such as the Motel Voucher Program, Inclement Weather Voucher Program, and homelessness prevention programs operated by the Core Service Agency Network. It is also notable that all the unsheltered families counted were living in vehicles, none were observed living outdoors or in encampments.

The 2015 data on homeless families is consistent with the experience of San Mateo County service providers who observe that homeless families with children rarely live on the streets and are much more likely to reside in shelters or cars. Many families with children also live in places that do not meet the HUD standard of homelessness (i.e. they are living temporarily with friends or families) yet they are very precariously housed. See the section on "Hidden Homelessness," below for more details.

See Appendix 2 for additional data on household composition of sheltered and unsheltered people.

4. Geographic Breakdown

a. 2015 Distribution of Homeless People by City

The following table summarizes the geographic distribution of the homeless people who were counted in the 2015 Census. Note that data is collected according to Census Tract, rather than by jurisdiction. Since some Census Tracks span multiple jurisdictions, data for some jurisdictions may include people in neighboring areas. For example, data for Half Moon Bay may include some individuals counted outside the city boundaries.

Table 3: Geographic Distribution of Sheltered and Unsheltered Homeless People

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
TOTAL	**775**	**997**	**1,772**

b. Unsheltered Homeless Population By City Compared to General Population

The table below provides an analysis of the total number of unsheltered people[1] counted in each jurisdiction compared to the total population of people in each jurisdiction.

Table 4: Unsheltered Homeless People Compared to Total Population

City	General Population*	% of General Population	Unsheltered Homeless Population	% of Unsheltered Homeless Population
Airport	NA	NA	1	0.13%
Atherton	7,159	0.96%	1	0.13%
Belmont	26,731	3.58%	11	1.42%
Brisbane	4,443	0.59%	21	2.71%
Burlingame	29,892	4.00%	7	0.90%
Colma	1,492	0.20%	3	0.39%
Daly City	104,739	14.01%	32	4.13%
East Palo Alto	29,143	3.90%	95	12.26%
Foster City	32,377	4.33%	0	0.00%
Half Moon Bay	12,013	1.61%	84	10.84%
Hillsborough	11,273	1.51%	0	0.00%
Menlo Park	33,071	4.42%	27	3.48%
Millbrae	22,424	3.00%	8	1.03%
Pacifica	38,606	5.17%	63	8.13%
Portola Valley	4,518	0.60%	0	0.00%
Redwood City	80,872	10.82%	223	28.77%
San Bruno	42,443	5.68%	8	1.03%
San Carlos	29,387	3.93%	20	2.58%
San Mateo	101,128	13.53%	82	10.58%
South San Francisco	66,174	8.85%	55	7.10%
Unincorporated	64,007	8.56%	32	4.13%
Woodside	5,481	0.73%	2	0.26%
TOTAL	**747,373**	**100.00%**	**775**	**100.00%**

As indicated in this chart, several cities have a higher percentage of the unsheltered homeless population than their share of the general population. These include: Brisbane, East Palo Alto, Half Moon Bay, Pacifica and Redwood City. Similar results were found in prior counts. The

[1] Note that this data does not include sheltered homeless people (those living in emergency shelters, transitional housing, etc.). The inclusion of the sheltered homeless people would skew the data towards those jurisdictions with the largest numbers of shelters and transitional housing programs.

higher numbers of homeless people in certain jurisdictions tends to correlate with higher poverty levels in those communities.

c. Comparison of 2009 to 2015 Data By City

The table below shows the unsheltered population in each jurisdiction over the past four counts (2009 through 2015). The final columns show the net and percent change between 2013 and 2015. For most jurisdictions the count went down, which is consistent with the reduction in unsheltered homelessness community-wide.

Table 5: 2009 Through 2015 Counts by Jurisdiction

City	2009 Count	2011 Count	2013 Count	2015 Count	Net Change (2013-2015)	Percent Change (2013-2015)
Airport	4	9	5	1	-4	-80%
Atherton	0	1	0	1	1	NA
Belmont	5	1	43	11	-32	-74%
Brisbane	1	0	34	21	-13	-38%
Burlingame	8	3	13	7	-6	-46%
Colma	0	1	7	3	-4	-57%
Daly City	49	44	27	32	5	20%
East Palo Alto	204	385	119	95	-24	-20%
Foster City	0	0	7	0	-7	-100%
Half Moon Bay	19	41	114	84	-30	-26%
Hillsborough	0	0	0	0	0	0%
Menlo Park	25	72	16	27	11	71%
Millbrae	1	1	21	8	-13	-61%
Pacifica	16	95	150	63	-87	-58%
Portola Valley	3	16	2	0	-2	-100%
Redwood City	220	233	307	223	-84	-27%
San Bruno	34	14	99	8	-91	-92%
San Carlos	11	9	10	20	10	100%
San Mateo	99	68	103	82	-21	-21%
South San Francisco	7	122	172	55	-117	-68%
Unincorporated	95	47	46	32	-14	-30%
Woodside	2	0	7	2	-5	-69%
Scattered Sites	0	0	0	0	0	NA
TOTAL	**803**	**1,162**	**1,299**	**775**	**-524**	**-40%**

As the table illustrates, certain jurisdictions have experienced significant fluctuations in the numbers of homeless people over the past four bi-annual counts. This may reflect the mobility of the homeless population within the County and the limitations of point in time counts.

5. "Hidden" Homelessness

While many of the homeless people in San Mateo County are either residing in shelters or visible on the streets or in vehicles, there are also many homeless people in places that are not easily accessible to enumerators. These "hidden" homeless populations include individuals who live in structures not meant for human habitation, such as storage sheds, unconverted garages, shacks, bus stations, etc. These individuals fall under HUD's official definition of homelessness, but they typically are not found during homeless counts because they are not visible on the streets.

Additionally, there are substantial numbers of people who stay temporarily in the homes of friends or family but who lack their own permanent housing. People who shelter temporarily with friends or family are not considered officially homeless according to HUD definitions of homelessness, but rather as "unstably housed," or "at-risk of homelessness." In the HOPE Plan, people who stay temporarily with family and friends are categorized as "at-risk" of homelessness. However, these individuals often self-identify as homeless and many homeless service providers and advocates believe they should be included in official homeless counts.

In 2009 and 2011 the Center on Homelessness conducted a "Hidden Homeless Study" to attempt to further analyze the number of people who are missed during the one night census. The 2011 study revealed that an estimated 9% of homeless people seeking services from providers during the three days following the count were probably missed because they lived in places that would not be visible (e.g. sheds, garages, on private property, etc.). The study further found a substantial number of people who were living temporarily with family and friends who considered themselves to be homeless even though they would not meet the HUD definition. These households were more likely to be families with children, confirming the anecdotal evidence from service providers that homeless families are more likely than single adults to stay temporarily in the homes of family members or friends.

There was no Hidden Homeless Study conducted in 2015. A description of the methodology for the 2011 Hidden Homeless Study may be found in the 2011 Census and Survey Report.

B. Homeless Survey

For the 2015 Homeless Survey, volunteers conducted interviews with a representative sample of 239 unsheltered homeless people using a brief interview questionnaire. Given the difficulty of locating unsheltered homeless families with children during the regular survey time frame (only two households with children were interviewed in the homeless survey), a separate over-sampling survey of homeless families was conducted in the month following the count. The

data gathered during this survey provides some additional demographic information about unsheltered homeless families.

The sections below provide a summary of key findings from the Homeless Survey, as well data on sheltered homeless people from the County's HMIS system where available and relevant. Complete Homeless Survey data may be found in Appendix 3.

1. Demographic Data

The results of the 2015 unsheltered homeless survey indicated that the typical unsheltered homeless person in San Mateo County is a single man with at least one disability. The homeless count found that 85% of unsheltered people on the night of the count were single adults. Among the people surveyed, 75% were men, and 43% had at least one disability. The most commonly cited disabilities were alcohol or drug problems (26%), mental illness (24%), chronic health problems (15%), and physical disability (13%).

Rates of disability were lower in the 2015 survey than in the 2013 survey, but this is likely due to significant changes in how questions were asked. The 2015 survey used a set of questions suggested by HUD which asked not only if respondents had a particular health or behavioral health condition but also whether the condition interfered with their ability to be employed or stay in stable housing. This resulted in fewer people indicating they had a disability than in previous surveys, which did not ask about how their condition affected their ability to function.

The population of sheltered homeless people looks somewhat different than the unsheltered population. While this population is still predominantly single and male, there is a greater representation of families. Of the homeless people living in shelters, transitional housing and institutional settings, 40% are in families with children, compared to only 15% of the people who are unsheltered. Sheltered individuals were 56% male and 44% female. Levels of disability are also somewhat lower among the sheltered population compared to the unsheltered population: only 22% reported having a mental illness and 23% chronic substance use.

The Ethnicity of the homeless population (including both sheltered and unsheltered people) was 32% Latino or Hispanic and 68% non-Hispanic. When asked to identify their Race, 53% indicated they were White, 21% Black or African-American, 4% Asian, 11% American Indian/Native American, 9% Native Hawaiian/Pacific Islander, and 3% were of multiple races.[2] This data reveals that some groups are over- or under-represented among homeless people in San Mateo County. African Americans represent only 3% of the total County population, yet are 21% of the homeless population. Many of the African Americans in San Mateo County live in the south county communities of East Palo Alto and Redwood City, which, as noted earlier,

[2] In accordance with federal requirements, Ethnicity and Race are considered separate categories for the purpose of the homeless count. People are asked to identify their Ethnicity as either Hispanic or Non-Hispanic, and are given six options to select from for Race (White, Black, Native American, Pacific Islander, Asian, Multiple Races). Some people who indicate their Ethnicity is Hispanic do not feel any of these Race categories are applicable, but since there is no "other" option, they have to be counted under one of these six categories. In the most recent survey, some Latino respondents selected "Native American" as their Race.

have a disproportional number of homeless people. Latinos are only 25% of the County population, but 32% of the homeless population.

Of the unsheltered homeless people counted, 13% were Veterans (having either served in the U.S. Armed Forces and/or in the National Guard or as Reservists). The proportion of unsheltered homeless veterans counted has remained relatively steady over the past two counts (13% in 2011 and 11% in 2013). Among the sheltered people counted in the HMIS system, 19% were veterans. This was a slight decrease from 2013 when 24% of sheltered homeless people were veterans.

Many unsheltered homeless people in San Mateo County have been homeless repeatedly and/or for long periods of time. The survey found that 35% were "chronically" homeless, meaning that they were disabled and had been homeless for longer than 12 months or for 4 times in the past 3 years. This represented a major decrease from 2013, when 65% of those surveyed met the definition of chronic homelessness. This decrease is likely due to the overall reduction in number of disabled people counted, which is discussed above. Since the questions relating to disability changed, fewer people in the survey indicated they had a disabling condition, and therefore fewer people met the definition of chronic homelessness.

The typical homeless person has strong connections to San Mateo County. Of those who responded to the survey, 75% reported that that they were living in San Mateo County at the time they became homeless and 57% indicated that their hometown was in San Mateo County.

2. Service Utilization

In addition to providing demographic data, the survey also provided critical data about the services that unsheltered homeless people need. Given their high rates of disability, it was not surprising that the survey found high rates of service use among unsheltered homeless people. Of those surveyed, 79% indicated they had accessed free meals, 40% transportation assistance, 33% health services and 23% mental health services. However, while 43% of people indicated they had some sort of disability, only 29% were receiving SSI or SSDI. Of those who indicated they had a mental illness, only 38% indicated they were receiving mental health services.

The survey also documented that homeless people tend to be frequent users of emergency services, which are not only very expensive but also are not highly effective in helping them become more stable. Of those surveyed, 33% reported that the main place they receive medical care is the emergency room and another 14% indicated they received no medical care at all. Of those who indicated they had a chronic medical condition, only 32% indicated they were accessing health services.

Criminal justice system involvement was prevalent among those surveyed, with 21% indicating they were on probation or parole or both. This was an increase compared to 2013 when 14% indicated reported being on probation or parole, but a decrease compared to the 27% found in 2011. The survey also found that involvement with the foster care system increased slightly

from 10% in 2013 to 11% in 2015. Of those surveyed who had been in foster care, 15% indicated they had been in foster care in San Mateo County.

In the 2015 survey, 28% of respondents indicated they had been a victim of domestic violence, a significant increase from 2013 when only 16% said they had experienced domestic violence.

IV. IMPLICATIONS FOR SYSTEMS IMPROVEMENT

Planners, policymakers and service providers have a wealth of data available from the homeless surveys of the past four bi-annual counts (2009 through 2015) as they work to expand and improve the system of housing and services for homeless people. The following are some strategies and approaches that have been and will continue to be included in local efforts to prevent and reduce homelessness.

- Addressing the lack of housing affordability by continuing to create supportive and affordable housing for homeless people;
- Designing and implementing housing retention programs to help those at-risk of homelessness keep their housing with appropriate services and supports;
- Continuing to implement specialized outreach to homeless veterans and linking them to available housing resources, particularly the VASH permanent housing program and SSVF prevention and rapid re-housing programs;
- Working with the systems of care whose clients have very high levels of homelessness, particularly the alcohol and drug treatment, mental health, criminal justice and foster care systems, to develop strategies for meeting the housing and service needs of these populations;
- Coordinating with the health systems to ensure that all homeless single adults are able to access the health care available since the expansion of Medi-Cal through the Affordable Care Act;
- Embracing joint planning between the County and local jurisdictions to meet the housing and service needs of homeless people;
- Exploring non-traditional housing options for utilization or development such as shared housing and residential care facilities for populations with specialized needs, such as older adults;
- Continuing to operate the Homeless Outreach Team (HOT) program. HOT services include intensive outreach to and engagement with chronically homeless people and help connect them to permanent supportive housing. This program helps reduce the incidence of chronic homelessness.

This report may be downloaded at http://hsa.smcgov.org/center-homelessness.

APPENDIX 1: METHODOLOGY

A. Overview

1. Project Team

The San Mateo County 2015 Homeless Census and Survey (the "Census and Survey") was conducted in January and February 2015. The San Mateo County Human Services Agency's Center on Homelessness staff were responsible for project planning and implementation. The Center on Homelessness contracted with Kate Bristol Consulting (KBC) and Philliber Research Associates (PRA) for assistance with developing the project methodology, analysis of the data and preparation of the final report.

2. Census and Survey Components

The Census and Survey consisted of two main components:

- Homeless Census ("the census"), a point-in-time count of homeless persons living on the streets, in vehicles, homeless shelters, transitional housing and institutional settings on January 22, 2015, and,

- Homeless Survey ("the survey"), consisting of interviews with a representative sample of 239 unsheltered homeless people conducted over a two-week period between January 26 and February 9, 2015. Homeless people who were interviewed were asked to respond to a questionnaire designed to elicit demographic information (e.g. age, gender, disabilities, veteran status), as well as information about how long and how many times they have been homeless, and their use of benefits and services.

The methodology for each of these components is detailed in the sections that follow.

3. Definition of Homelessness

The Census and Survey used the definition of homelessness established by the U.S. Department of Housing and Urban Development (HUD) in the federal McKinney-Vento Homeless Assistance Act as the basis for determining who to include and exclude:

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) or those who are "couch surfing" (i.e. those who "float" from location to location).

B. Homeless Census Methodology

The Homeless Census consisted of two parts:

1. A Street Count, in which teams of enumerators counted homeless people who were visible on the streets, in encampments or in vehicles in the early morning hours of January 22, 2015;

2. A Shelter Count, in which the organizations operating emergency shelters, transitional housing and other facilities housing homeless people reported on the numbers of individuals housed in their facilities on the night of January 22, 2015.

The complete census results are presented in Appendix 2.

1. Street Count Methodology

The Street Count was a "complete coverage" count that enumerated every homeless person visible on the streets, in encampments and in vehicles in every census tract in the county. The count was conducted by teams of volunteers who fanned out across San Mateo County in the early morning hours of January 22nd. The volunteers included staff from social service organizations, city and county departments, community members, and homeless "guides." The guides were homeless individuals with knowledge about locations where homeless people typically sleep. The homeless guides received a $10 per hour stipend for their work on the census.

The composition of the teams was also designed to maximize local knowledge -- volunteers were recruited from all over the county and team members were assigned to the census tracts with which they were most familiar. For census tracts that included state parks, park rangers served as enumerators.

Beginning three weeks prior to the count, the Center on Homelessness held trainings across the county to prepare volunteers for the count. The training included information about the purpose of the count, a review of the data collection tool and how to use it to record the numbers of people counted, and what to expect on the morning of the count.

On the morning of the count, the volunteers gathered at deployment sites at 5:00 AM for census tract assignments, maps, supplies, and a brief training review. During the enumeration, volunteers surveyed the streets, roads, highways and open spaces of their assigned tracts (either by foot, bike, or car) and recorded their results on tally sheets. Volunteers returned to their deployment sites prior to 9:00 AM. Upon their return, they turned in their census tally

forms and were debriefed by the deployment captains to ensure the integrity of the enumeration effort.

Volunteers did not make direct contact with homeless people during the census enumeration. Due to the imperative to conduct a complete count within a narrow time frame and the reluctance of many homeless people to consent to interviews, visual-only enumeration strategies were employed. The homeless people were counted and tallied according to these observed categories:

- Adult (over age 24)
- Child (under age 18)
- Age undetermined
- Female
- Male
- Gender Undetermined

Enumerators also noted the household composition of the people they observed, dividing them into single individuals or families with children under age 18.

The enumerators also counted:

- the number of vehicles (cars, vans, RVs, or campers) that appeared to have homeless people living in them, and,
- the number of homeless encampments they observed.

Due to safety concerns, enumerators did not go inside homeless encampments or look inside vehicles to separately count the people in them. In order to estimate the numbers of people in vehicles and encampments, multipliers were developed using data from the homeless survey (described in Section C, below), which asked respondents who had lived in vehicles or encampments to indicate the number of people they typically lived with and whether those people were adults or children. These multipliers were then used to estimate the numbers of people living in vehicles and encampments and their household composition. The methodology for the multiplier is discussed further below under the Homeless Survey.

2. Shelter Count Methodology

The Shelter Count component of the Homeless Census was conducted on the night of January 22nd. The Center on Homelessness compiled a comprehensive list of all facilities and programs providing short-term housing and shelter to homeless people. These facilities were divided into four categories:

- Homeless shelters
- Motel voucher programs
- Transitional housing
- Institutions (jails, hospitals, and inpatient alcohol and drug treatment programs)

The majority of programs on the list currently enter data on their clients into the County's Homeless Management Information System (HMIS). HUD requires all communities that receive federal homeless assistance funding to create and maintain an HMIS that meets specific standards. The HMIS database was used to extract data on the numbers of people in most of the emergency shelters, motel voucher programs, and transitional housing programs operating in the community. For the very small number of shelters and transitional housing programs that do not participate in the HMIS, the Center on Homelessness staff gathered data using a survey form. The jail, hospital, and AOD treatment programs do not participate in HMIS and so data from these locations was also collected using a survey.

C. Homeless Survey Methodology

For the 2015 homeless survey, volunteers conducted interviews with a representative sample of 259 unsheltered homeless people using a brief questionnaire. Over a two week period, about 40 to 50 volunteer surveyors conducted interviews with a sample of unsheltered homeless people. To collect additional demographic data on unsheltered homeless families, an "over-sampling" survey was conducted later in February and collected data from 40 vehicularly-housed families with children.

1. Training and Compensation of Survey Workers

The majority of the interviewers who conducted the survey were current or formerly homeless people. Evidence from other communities suggests that this approach is most successful, because homeless people are often more comfortable speaking candidly to another homeless person. Homeless or formerly homeless people are also more likely to know of locations where unsheltered homeless people can be found.

All interviewers received training from Center on Homelessness staff on topics including respondent eligibility (i.e. the definition of homelessness), interviewing protocol, prompting for detailed responses, and confidentiality. Homeless interviewers were paid a cash compensation for each completed survey. In addition, it was determined that survey data would be more easily collected if an incentive gift was offered to survey respondents in appreciation for their time and participation, so each respondent also received a cash incentive.

2. Sampling Methodology

Developing a sampling methodology for unsheltered homeless people can be very challenging. Given the difficulty of locating a sufficiently large number of people who were willing to be interviewed, it was not possible to develop either a truly random sampling methodology or a stratified sampling methodology. Instead, PRA developed a "convenience sample" approach, in which respondents were selected based upon their availability and willingness to participate. However, the surveys were distributed throughout the county in proportion to the results of the census. This ensured that there was appropriate representation of people from the different geographic areas of the community.

Collecting data on families with children who are unsheltered is particularly challenging. These households generally do not live outdoors or in encampments and often are missed during observation-based counts. Most often, they are living in cars or vans and thus are difficult to locate. In the past three surveys (2009, 2011 and 2013), the homeless survey found very few people who indicated they were accompanied by minor children. In an effort to better understand the population of unsheltered homeless families, and also to comply with new HUD reporting requirements relating to household types, in 2015 the Center on Homelessness conducted an additional "over-sampling" survey to collect additional surveys from unsheltered families. These additional 40 surveys were also conducted using a "convenience" sample approach and were collected by staff from non-profit agencies that work with at-risk and homeless families.

It should be noted that while the survey results are the product of a non-random survey, and therefore are not scientifically representative of the homeless population, the methodologies used in this survey have been employed in many communities and are approved by HUD as effective methods of obtaining data on the characteristics of homeless people.

3. Survey Design

The survey questions used in 2015 were different than in 2013. This year, HUD has provided a suggested set of questions designed to align with federal data reporting requirements. The Center on Homelessness adopted the suggested HUD survey format, but also added some additional questions based on local data needs. It should be noted that one result of changing the survey format is that it is more difficult to compare 2015 data with prior years. In particular, the approach to asking about disabling conditions is very different in the 2015 survey form than in the 2013 form, and yielded lower overall rates of disability among respondents. See Appendix 4 for a copy of the survey tool.

4. Data Collection and Analysis Process

During the interview process, the interviewers took care to ensure that respondents felt comfortable, regardless of their location. Respondents were encouraged to be candid in their responses and were informed that these responses would be framed as general findings, would be kept confidential, and would not be traceable to any one individual. Workers were asked to remain unbiased at all times, make no assumptions or prompts, and ask all questions but allow respondents to skip any question they did not feel comfortable answering.

Overall, the interviewers experienced excellent cooperation from respondents. This was likely influenced by the fact that many of the interviewers had previously been, or are now, fellow members of the homeless community. Another reason for interview cooperation may have been the gift of $5, which was given to respondents upon the completion of the interview.

In order to avoid potential duplication of respondents, the survey requested respondents' initials and date of birth, so that duplication could be avoided without compromising the respondents' anonymity. Upon completion of the survey effort, an extensive verification

process was conducted to eliminate potential duplicates. This process examined respondents' date of birth, initials, gender, ethnicity, length of homelessness, and consistencies in patterns of responses to other questions on the survey.

The complete results of the homeless survey as well as the over-sampling survey are presented in Appendix 3.

5. Methodology for Developing Multiplier for Vehicles

As noted above, on the night of the count enumerators were instructed not to look inside vehicles and encampments to count sleeping occupants, but rather to just note the number of vehicles and camps. During the past four homeless counts, the Center on Homelessness has used data from the homeless survey to estimate the number of people in each car, van, RV or encampment based on how respondents answered the questions about where they were living and how many people were living with them. These responses are then used to generate a multiplier that is applied to the numbers of cars, RVs and camps counted.

In 2015, the homeless survey found an unusually small number of people who indicated they were living in vehicles or camps and had minor children present. Less than 1% of the total respondents said they had one or more children. This was far lower than in the prior three counts, when typically at least 5% of those interviewed were unsheltered adults who had children with them. To ensure the 2015 count did not undercount families with children, the results from the survey were adjusted by taking 13 of the 40 family households from the "over sampling" survey and adding them to the main sample for the purpose of generating the multipliers. The number of surveys added was based on the proportion of families with children surveyed in 2013. The multipliers developed are presented in Appendix 2.

Table 2-A
Street Count Observed Totals

Location	# Cars, RVs, Camps	# of Adult Only HH	# of People in Adult Only HH	# of Family HH	# of People in Family HH	# Adults in Family HH	# Children in Family HH	Total HH	Total People
People on Street		327	331	0	0	0	0	327	331
People in Cars	110	92	98	18	59	27	32	110	157
People in RVs	106	89	95	17	56	26	30	106	151
People in Encampments	136	136	136	0	0	0	0	136	136
TOTAL		**644**	**660**	**35**	**115**	**53**	**62**	**679**	**775**

Table 2-B
Vehicle Multipliers

Location	% Adult Only HH	Multiplier # Adults	% Family HH	Multiplier # PPl in Fam	Multiplier # Adults in Fam	Multiplier # Children in Fam
Vehicles	84%	1.07	16%	3.29	1.50	1.79

Table 2-C
Shelter Count

Provider	Program	HH Only Adults	Ppl in Adult Only HH	Family HH	Ppl in Family HH	Total HH	Total PPl
Emergency Shelter							
CORA	Emergency Shelter	6	6	8	18	14	24
Home And Hope	Interfaith Hospitality Network	0	0	4	17	4	17
MHA	Spring Street Shelter	15	15	0	0	15	15
Project Wehope	WeHOPE Shelter	42	42	0	0	42	42
Samaritan House	Safe Harbor Emergency	30	30	0	0	30	30
Star Vista	Your House South	3	3	0	0	3	3
VA Menlo Park	VADOM	56	56	0	0	56	56
Subtotal Shelter		**152**	**152**	**12**	**35**	**164**	**187**
Motel Voucher Programs							
San Mateo County H.S.A.	CalWORKS Vouchers	0	0	3	10	3	10
IVSN	Motel Voucher Program	0	0	19	57	19	57
Subtotal Motel Voucher Prog		**0**	**0**	**22**	**67**	**22**	**67**
Transitional Housing							
CORA	Case De Sor Juana Ines	0	0	8	25	8	25
MHA	Spring Street Transitional Housing	7	7	0	0	7	7
Samaritan House	Safe Harbor Transitional	56	56	0	0	56	56
Service League	Hope House	6	6	0	0	6	6
IVSN	Bridges 2	2	2	3	9	5	11
IVSN	Family Crossroads	0	0	3	11	3	11
IVSN	First Step for Families	0	0	37	149	37	149
IVSN	Haven Family House	0	0	20	80	20	80
IVSN	Maple Street	68	68	0	0	68	68
IVSN	Redwood Family House	0	0	7	25	7	25
Star Vista	Day Break	6	6	0	0	6	6
VA Menlo Park	Compensated Work Therapy (CWT)	10	10	0	0	10	10
Subtotal Transitional		**155**	**155**	**78**	**299**	**233**	**454**
Institutions							
Free at Last	Free at Last AOD	35	35	0	0	35	35
Health Right 360/WRA	WRA (AOD Treatment)	24	24	0	0	24	24

Table 2-C
Shelter Count

Provider	Program	HH Only Adults	Ppl in Adult Only HH	Family HH	Ppl in Family HH	Total HH	Total PPl
Hope House	Hope House SUD	6	6	0	0	6	6
Our Common Ground	Adult OCG (AOD Treatment)	6	6	0	0	6	6
Our Common Ground	OCG DMC (AOD Treatment)	16	16	0	0	16	16
Latino Commission	Casa Aztlan	7	7	0	0	7	7
Latino Commission	Casa Maria	4	4	0	0	4	4
Latino Commission	Casa Los Hermanos	3	3	0	0	3	3
Project 90	Project 90 AOD	30	30	0	0	30	30
San Mateo County Sheriff	San Mateo County Jail	155	155	0	0	155	155
San Mateo Medical Center	Medical Center	3	3	0	0	3	3
Subtotal Institutions		**289**	**289**	**0**	**0**	**289**	**289**
TOTAL		**596**	**596**	**112**	**401**	**708**	**997**

Table 2-D
Combined Street and Shelter Count

Location	Adult Only HH	People in Adult Only HH	Family HH	People in Family HH	Total HH	Total People
Street Count						
People Observed on Streets	327	331	0	0	327	331
People in Cars	92	98	18	59	110	157
People in RVs	89	95	17	56	106	151
People in Encampments	136	136	0	0	136	136
Subtotal Street Count	**644**	**660**	**35**	**115**	**679**	**775**
Shelter Count						
People in Emergency Shelters	152	152	12	35	164	187
People in Motel Voucher Programs	0	0	22	67	22	67
People in Transitional Housing	155	155	78	299	233	454
People in Institutions	289	289	0	0	289	289
Subtotal Shelter Count	**596**	**596**	**112**	**401**	**708**	**997**
TOTAL HOMELESS PEOPLE	**1,240**	**1,256**	**147**	**516**	**1,387**	**1,772**

Table 2-E

2007 Through 2015 Combined Street and Shelter Counts

Location	2007	2009	2011	2013	2015	Net Change (2013 to 2015)	% Change (2013 to 2015)
Street Count							
People Observed on Streets	596	422	466	353	331	-22	-6%
People in Cars	498	96	126	231	157	-74	-32%
People in RVs		170	246	392	151	-241	-61%
People in Encampments		115	324	323	136	-187	-58%
Subtotal Street Count	**1,094**	**803**	**1,162**	**1,299**	**775**	**-524**	**-40%**
Shelter Count							
People in Emergency Shelters	296	267	215	243	187	-56	-23%
People in Motel Voucher Programs	107	74	43	29	67	38	131%
People in Transitional Housing	306	403	441	431	454	23	5%
People in Institutions	261	249	288	279	289	10	4%
Subtotal Shelter Count	**970**	**993**	**987**	**982**	**997**	**15**	**2%**
TOTAL HOMELESS PEOPLE	**2,064**	**1,796**	**2,149**	**2,281**	**1,772**	**-509**	**-24%**

Table 2-F
Street Count by Jurisdiction and Location Type

City	Street		Cars		RVS		Encampments		Total	
	Total HH	Total PPl	Total HH	Total PPl	Total HH	Total PPl	Total HH	Total PPl	Total HH	Total PPl
Airport	1	1	0	0	0	0	0	0	1	1
Atherton	1	1	0	0	0	0	0	0	1	1
Belmont	1	1	0	0	7	10	0	0	8	11
Brisbane	8	8	1	1	4	6	6	6	19	21
Burlingame	2	2	2	2	1	1	2	2	7	7
Colma	2	2	0	0	1	1	0	0	3	3
Daly City	12	12	4	6	2	2	12	12	30	32
East Palo Alto	30	30	17	25	17	25	15	15	79	95
Foster City	0	0	0	0	0	0	0	0	0	0
Half Moon Bay	38	38	18	26	5	7	13	13	74	84
Hillsborough	0	0	0	0	0	0	0	0	0	0
Menlo Park	25	26	0	0	0	0	1	1	26	27
Millbrae	6	6	1	1	0	0	1	1	8	8
Pacifica	10	10	18	26	7	10	17	17	52	63
Portola Valley	0	0	0	0	0	0	0	0	0	0
Redwood City	88	91	18	26	32	49	57	57	195	223
San Bruno	4	4	1	1	1	1	2	2	8	8
San Carlos	4	4	4	6	7	9	1	1	16	20
San Mateo	44	44	9	12	14	20	6	6	73	82
South San Francisco	45	45	5	7	1	1	2	2	53	55
Unincorporated Total	6	6	10	16	7	9	1	1	24	32
Coastside	0	0	7	13	7	9	0	0	14	22
Central - Highlands/Baywood	0	0	0	0	0	0	0	0	0	0
North - Broadmoor	0	0	0	0	0	0	0	0	0	0
South - N Fair Oaks, West MP	6	6	3	3	0	0	1	1	10	10
Woodside	0	0	2	2	0	0	0	0	2	2
Scattered Sites	0	0	0	0	0	0	0	0	0	0
TOTAL	327	331	110	157	106	151	136	136	679	775

Table 2-G
Street Count by Jurisdiction and Household Type

City	Adult HH	Ppl in Adult HH	Fam. HH	PPl in Fam HH	Total HH	Total PPl
Airport	1	1	0	0	1	1
Atherton	1	1	0	0	1	1
Belmont	7	8	1	3	8	11
Brisbane	18	18	1	3	19	21
Burlingame	7	7	0	0	7	7
Colma	3	3	0	0	3	3
Daly City	29	29	1	3	30	32
East Palo Alto	73	75	6	20	79	95
Foster City	0	0	0	0	0	0
Half Moon Bay	70	71	4	13	74	84
Hillsborough	0	0	0	0	0	0
Menlo Park	26	27	0	0	26	27
Millbrae	8	8	0	0	8	8
Pacifica	48	50	4	13	52	63
Portola Valley	0	0	0	0	0	0
Redwood City	186	192	9	31	195	223
San Bruno	8	8	0	0	8	8
San Carlos	14	14	2	7	16	21
San Mateo	70	72	3	10	73	82
South San Francisco	52	52	1	3	53	55
Unincorporated	21	22	3	10	24	32
Coastside	11	12	3	10	14	22
Central - Highlands/Baywood	0	0	0	0	0	0
North - Broadmoor	0	0	0	0	0	0
South - N Fair Oaks, West MP	10	10	0	0	10	10
Woodside	2	2	0	0	2	2
Scattered Sites	0	0	0	0	0	0
TOTAL	**644**	**660**	**35**	**116**	**679**	**776**

Table 2-H
Street Count by Jurisdiction: 2007 Through 2015

City	2007 Count	2009 Count	2011 Count	2013 Count	2015 Count	Net Change (2013-2015)	Percent Change (2013-2015)
Airport	16	4	9	5	1	-4	-80%
Atherton	0	0	1	0	1	1	NA
Belmont	12	5	1	43	11	-32	-74%
Brisbane	11	1	0	34	21	-13	-38%
Burlingame	20	8	3	13	7	-6	-46%
Colma	2	0	1	7	3	-4	-57%
Daly City	42	49	44	27	32	5	20%
East Palo Alto	222	204	385	119	95	-24	-20%
Foster City	14	0	0	7	0	-7	-100%
Half Moon Bay	74	19	41	114	84	-30	-26%
Hillsborough	16	0	0	0	0	0	0%
Menlo Park	52	25	72	16	27	11	71%
Millbrae	16	1	1	21	8	-13	-61%
Pacifica	7	16	95	150	63	-87	-58%
Portola Valley	13	3	16	2	0	-2	-100%
Redwood City	212	220	233	307	223	-84	-27%
San Bruno	31	34	14	99	8	-91	-92%
San Carlos	9	11	9	10	20	10	100%
San Mateo	62	99	68	103	82	-21	-21%
South San Francisco	97	7	122	172	55	-117	-68%
Unincorporated	162	95	47	46	32	-14	-30%
Woodside	4	2	0	7	2	-5	-69%
Scattered Sites	0	0	0	0	0	0	NA
TOTAL	1,094	803	1,162	1,299	775	-524	-40%

Table 2-I

Street Count by Jurisdiction Compared to General Population

City	General Population*	% of General Population	Unsheltered Homeless Population	% of Unsheltered Homeless Population
Airport	NA	NA	1	0.13%
Atherton	7,159	0.96%	1	0.13%
Belmont	26,731	3.58%	11	1.42%
Brisbane	4,443	0.59%	21	2.71%
Burlingame	29,892	4.00%	7	0.90%
Colma	1,492	0.20%	3	0.39%
Daly City	104,739	14.01%	32	4.13%
East Palo Alto	29,143	3.90%	95	12.26%
Foster City	32,377	4.33%	0	0.00%
Half Moon Bay	12,013	1.61%	84	10.84%
Hillsborough	11,273	1.51%	0	0.00%
Menlo Park	33,071	4.42%	27	3.48%
Millbrae	22,424	3.00%	8	1.03%
Pacifica	38,606	5.17%	63	8.13%
Portola Valley	4,518	0.60%	0	0.00%
Redwood City	80,872	10.82%	223	28.77%
San Bruno	42,443	5.68%	8	1.03%
San Carlos	29,387	3.93%	20	2.58%
San Mateo	101,128	13.53%	82	10.58%
South San Francisco	66,174	8.85%	55	7.10%
Unincorporated	64,007	8.56%	32	4.13%
Woodside	5,481	0.73%	2	0.26%
Scattered Sites	0	0.00%	0	0.00%
TOTAL	747,373	100.00%	775	100.00%

*US Census 2013 Population Estimate

Table 2-J
Shelter Count by Jurisdiction

Provider	Program	Program Type	Total PPl
Burlingame			
Health Right 360/WRA	WRA (AOD Treatment)	Institution	24
Subtotal Burlingame			**24**
Daly City			
IVSN	Family Crossroads	Transitional Housing	11
Subtotal Daly City			**11**
East Palo Alto			
Free at Last	Free at Last AOD	Institution	35
Our Common Ground	Adult OCG (AOD Treatment)	Institution	6
Project Wehope	WeHOPE Shelter	Emergency Shelter	42
Subtotal East Palo Alto			**83**
Menlo Park			
IVSN	Haven Family House	Transitional Housing	80
VA Menlo Park	VADOM	Emergency Shelter	56
VA Menlo Park	Compensated Work Therapy (CWT)	Transitional Housing	10
Subtotal Menlo Park			**146**
Redwood City			
Hope House	Hope House SUD	Institution	6
IVSN	Maple Street	Transitional Housing	68
IVSN	Redwood Family House	Transitional Housing	25
Latino Commission	Casa Aztlan	Institution	7
MHA	Spring Street Shelter	Emergency Shelter	15
MHA	Spring Street Transitional Housing	Transitional Housing	7
Our Common Ground	OCG DMC (AOD Treatment)	Institution	16
San Mateo County Sheriff	San Mateo County Jail	Institution	155
Service League	Hope House	Transitional Housing	6
Star Vista	Your House South	Emergency Shelter	3
Star Vista	Day Break	Transitional Housing	6
Subtotal Redwood City			**314**
San Bruno			
Latino Commission	Casa Los Hermanos	Institution	3
Subtotal San Bruno			**3**
San Mateo			
IVSN	First Step	Transitional Housing	149
Latino Commission	Casa Maria	Institution	4
Project 90	Project 90 AOD	Institution	30
San Mateo Medical Center	Medical Center	Institution	3
Subtotal San Mateo			**186**
South San Francisco			
Samaritan House	Safe Harbor Emergency	Emergency Shelter	30
Samaritan House	Safe Harbor Transitional	Transitional Housing	56

Table 2-J
Shelter Count by Jurisdiction

Provider	Program	Program Type	Total PPl
Subtotal South San Francisco			**86**
Scattered Sites			
Home And Hope	Interfaith Hospitality Network	Emergency Shelter	17
San Mateo County H.S.A.	CalWORKS Vouchers	Motel Voucher	10
IVSN	Motel Voucher Program	Motel Voucher	57
IVSN	Bridges 2	Transitional Housing	11
Subtotal Scattered Sites			**95**
Confidential			
CORA	Emergency Shelter	Emergency Shelter	24
CORA	Case De Sor Juana Ines	Transitional Housing	25
Subtotal Confidential			**49**
TOTAL			**997**

Table 2-K

Combined Street and Shelter Count by Jurisdiction

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, West MP	10	0	10
Woodside	2	0	2
Scattered Sites	0	95	95
Confidential	0	49	49
TOTAL	**775**	**997**	**1,772**

APPENDIX 3: SURVEY DATA

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Unsheltered Homeless Survey

This Appendix provides a complete breakdown of the responses of all respondents to all the questions in the Homeless Survey. In these charts, the term "frequency" refers to the number of individuals who responded. There were 239 completed surveys (including household members), but every respondent did not respond to every question, thus the frequencies do not always total 239.

Note that the survey included interviews only with people who were unsheltered (living on streets, in vehicles, encampments and other places not meant for human habitation).

A. Location (Street, Park, Shelter, etc.)

1. Where did you sleep last night?

Response	Frequency	Percent
Vehicle (car, van, RV, truck)	82	34.3%
Street or sidewalk	38	15.9%
Encampment/woods	28	11.7%
Bus, train station, airport	23	9.6%
Park	19	7.9%
Under bridge/overpass	11	4.6%
Abandoned building	9	3.8%
Other	29	12.1%
Total	**239**	**100.0%**

B. Household Composition

3. Are there other adults or children in your household? If yes, data was collected on household members.

Response	Number of People	Percent	Number of House-holds	Percent
Single adult (over 18)	225	94.1%	225	97.4%
Two Adults (over 18), No Children	8	3.3%	4	1.7%
Family (1 or more adults and 1 or more children under 18)	6	2.6%	2	0.9%
Total	**239**	**100.0%**	**231**	**100.0%**

C. Demographics

4. How old are you?

Response	Frequency	Percent
Under 18	2	0.8%
18 to 24	7	3.0%
25 to 64	221	93.2%
65 and older	7	3.0%
Total	**237**	**100.0**%

5. Are you male, female or transgender?

Response	Frequency	Percent
Male	179	74.9%
Female	60	25.1%
Transgender Male to Female	0	0.0%
Transgender Female to Male	0	0.0%
Total	**239**	**100.0**%

6. Are you Hispanic or Latino?

Response	Frequency	Percent
Yes	45	18.9%
No	185	77.7%
Don't Know/Refused	8	3.4%
Total	**238**	**100.0**%

7. What is your race?

Response	Frequency	Percent
White	120	51.7%
Black/African American	44	19.0%
American Indian/Alaskan Native	15	6.5%
Native Hawaiian/Pacific Islander	13	5.6%
Asian	11	4.7%
Multiple Races/Other	21	9.1%
Don't Know/Refused	8	3.4%
Total	**232**	**100.0**%

D. Veteran Status

8. Have you served in the United States Armed Forces?

Response	Frequency	Percent
Yes	31	13.0%
No	205	85.8%
Don't Know/Refused	3	1.3%
Total	**239**	**100.0%**

9. Were you ever called into active duty as a member of the National Guard or as a Reservist?

Response	Frequency	Percent
Yes	10	4.2%
No	222	93.7%
Don't Know/Refused	5	2.1%
Total	**237**	**100.0%**

Some respondents served in either the USAF or in the Guard/Reserves

Response	Frequency	Percent
Served in US Armed Forces or Guard/Reserve	32	13.4%
Did not serve in USAF or Guard/Reserve	207	86.6%
Total	**239**	**100.0%**

10. Have you ever received health care or benefits from a VA center?

Response	Frequency	Percent
Yes	22	9.4%
No	207	88.5%
Don't Know/Refused	5	2.1%
Total	**234**	**100.0%**

E. Length of Homelessness and Episodes of Homelessness

11. Is this the first time you have been homeless?

Response	Frequency	Percent
Yes	95	39.9%
No	138	58.0%
Don't Know/Refused	5	2.1%
Total	**238**	**100.0%**

12. How long have been homeless this time?

Response	Frequency	Percent
One week or less	4	1.9%
Between one week and one month	11	5.3%
One to six months	42	20.1%
Six months to one year	38	18.2%
One to two years	34	16.3%
Three to five years	48	23.0%
Five to ten years	27	12.9%
More than ten years	5	2.4%
Total	**209**	**100.0%**

13. Including this time, how many separate times have you stayed in shelters or on the streets in the past three years?

Response	Frequency	Percent
Less than 4 times	101	60.8%
4 or more times	44	26.5%
Don't know/Refused	21	12.7%
Total	**166**	**100.0%**

13a. In total, how long did you stay in shelters or on the streets for those times?

Response	Frequency	Percent
One week or less	9	7.1%
Between one week and one month	11	8.7%
One to six months	38	29.9%
Six months to one year	21	16.5%
One to two years	11	8.7%
Three to five years	22	17.3%
Five to ten years	13	10.2%
More than ten years	2	1.6%
Total	**127**	**100.0%**

F. Chronic Homelessness

A chronically homeless person is defined by HUD as a single adult with a disability who has been homeless for a period of 12 months or longer or has been homeless for four times in the past three years, or a household in which at least one adult meets that definition.

The following tables present information on the group of respondents who indicated through their responses to Questions 12, 13 and 17 that they were chronically homeless. All of these households are single adults.

Response	Frequency	Percent
Chronically Homeless	82	34.9%
Not Chronically Homeless	153	65.1%
Total	**235**	**100.0%**

G. Geographic Location and Hometown

14. Where were you living at the time you most recently became homeless?

Response	Frequency	Percent
San Mateo County	172	74.5%
Other County in California	47	20.3%
Out of State	12	5.2%
Total	231	100.0%

If in San Mateo County, what City?

Response	Frequency	Percent
Redwood City	27	19.9%
Pacifica	26	19.1%
San Mateo	21	15.4%
South San Francisco	13	9.6%
Daly City	11	8.1%
San Bruno	8	5.9%
Half Moon Bay	8	5.9%
East Palo Alto	7	5.1%
San Carlos	5	3.7%
Belmont	4	2.9%
Refused	1	.7%
Millbrae	1	.7%
La Honda	1	.7%
Foster City	1	.7%
El Granada	1	.7%
Burlingame	1	.7%
Total	**136**	**100.0%**

15. Is your hometown in San Mateo County?

Response	Frequency	Percent
Yes	132	57.4%
No	95	41.3%
Don't Know/Refused	3	1.3%
Total	230	100.0%

If yes, what City do you consider your hometown?

Response	Frequency	Percent
San Mateo	23	22.5%
Pacifica	20	19.6%
Redwood City	17	16.7%
South San Francisco	14	13.7%
Daly City	8	7.8%
East Palo Alto	7	6.9%
San Bruno	5	4.9%
Half Moon Bay	3	2.9%

Response	Frequency	Percent
San Carlos	3	2.9%
Burlingame	1	1.0%
Menlo Park	1	1.0%
Total	**102**	**100.0%**

H. Prior Residence

16. Where did you live before you became homeless this last time, were you…

Response	Frequency	Percent
Renting a home or apartment	82	36.0%
Staying with friends	43	18.9%
Living with relatives	41	18.0%
Home owned by you or your partner	14	6.1%
Motel	13	5.7%
Prison/jail	13	5.7%
In treatment center	9	3.9%
Shelter or transitional housing	3	1.3%
Foster care	1	.4%
Other	9	3.9%
Total	**228**	**100.0%**

I. Disability

17. Please tell me whether any of these situations apply to you?

Response	Yes		No		Don't Know/Refused	
	Count	%	Count	%	Count	%
a. Do you have any ongoing health problems or medical conditions?	73	30.7%	142	59.7%	23	9.7%
b. Do you have a physical disability?	97	40.9%	128	54.0%	12	5.1%
c. Do you drink alcohol?	113	47.7%	115	48.5%	9	3.8%
d. Do you use illegal drugs?	67	28.5%	153	65.1%	15	6.4%
e. Do you have a psychiatric or emotional condition?	98	41.7%	117	49.8%	20	8.5%
f. Do you have PTSD?	67	28.0%	145	60.7%	22	9.2%
g. Have you ever had a traumatic brain injury?	76	32.1%	149	62.9%	12	5.1%

17h. Do any of the situations we just discussed keep you from holding a job or living in stable housing? ***The response to this question was used to determine if the respondent has a disabling condition.***

Response	Frequency	Percent
Yes	104	43.5%
No	82	34.3%
Don't Know/Refused	18	7.5%
Question skipped	35	14.6%
Total	**239**	**100.0%**

17i. Which ones keep you from holding a job or living in stable housing? ***Response to this question was used to determine the type of disabling condition.***

Response	Frequency	Percent of all Respondents (N = 232)
Alcohol or illegal drug use	61	26.3%
Psychiatric/emotional condition	55	23.7%
Alcohol use	49	21.1%
Health issue	35	15.1%
Illegal drug use	31	13.4%
Physical Disability	29	12.5%
PTSD	16	6.9%
Brain Injury	17	7.3%
Total	**NA**	**NA**

Multiple response question

18. Have you ever received special education services for more than 6 months?

Response	Frequency	Percent
Yes	38	16.5%
No	179	77.8%
Don't Know/Refused	13	5.7%
Total	**230**	**100.0**%

19. Do you have AIDS or an HIV-related illness?

Response	Frequency	Percent
Yes	5	2.2%
No	213	91.8%
Don't Know/Refused	14	6.0%
Total	**232**	**100.0**%

20. Do you receive any disability benefits such as SSI, SSDI or Veteran's disability?

Response	Frequency	Percent
Yes	70	30.0%
No	156	67.0%
Don't Know/Refused	7	3.0%
Total	**233**	**100.0**%

J. Criminal Justice System Involvement

21. Are you currently on probation and/or parole?

Response	Frequency	Percent
Yes, probation	34	15.1%
Yes, parole	8	3.6%
Yes, both	5	2.2%
No	178	79.1%
Total	**225**	**100.0%**

K. Domestic Violence

22. Have you ever been a victim of domestic violence?

Response	Frequency	Percent
Yes	63	27.8%
No	156	68.7%
Don't Know/Refused	8	3.5%
Total	**227**	**100.0%**

L. Foster Care System Involvement

23. Were you ever in foster care?

Response	Frequency	Percent
Yes	24	10.7%
No	200	89.3%
Total	**224**	**100.0%**

23a. If yes, were you in Foster Care in San Mateo County?

Response	Frequency	Percent
Yes	9	15.0%
No	51	85.0%
Total	**60**	**100.0%**

23b. How long ago were you in Foster Care in San Mateo County?

Response	Frequency	Percent
One year or less	2	25.0%
Between 1 and 5 years ago	0	0.0%
Between 5 and 10 years ago	0	0.0%
Between 10 and 20 years ago	2	25.0%
More than 20 years ago	4	50.0%
Total	**8**	**100.0**%

M. Use of Services

24. Where do you usually get your medical care?

Response	Frequency	Percent
Emergency Room	76	33.3%
San Mateo Medical/CHOPE	48	21.1%
Don't ever go	31	13.6%
Community clinic	24	10.5%
Mobile Healthcare/van	15	6.6%
VA Hospital	11	4.8%
Ravenswood clinic	6	2.6%
Other	17	7.5%
Total	**228**	**100.0**%

25. Are you currently using any of the following services/ assistance?

Response	Frequency	Percent
Free meals	155	78.7%
Food pantry	116	58.9%
Bus passes	79	40.1%
Health services	65	33.0%
Mental health services	45	22.8%
Emergency shelter	37	18.8%
Shelter day services	22	11.2%
Transitional housing	16	8.1%
Job/vocational training	15	7.6%
Legal assistance	13	6.6%
Life skills classes	4	2.0%

Educational classes	2	1.0%
Total	**NA**	**NA**

Multiple response question

Over-Sampling Survey – Unsheltered Families with Children

To better understand the characteristics of unsheltered households with children, an "oversampling" survey was conducted. See Appendix 1, Methodology for details.

A. Household Composition

Everyone interviewed for the over-sampling survey was a household with at least one adult and one child. There were a total of 40 households interviewed consisting of 127 people (55 adults and 72 children)

Response	Frequency	Percent
Adults (age 18 and over)	55	43.3%
Children (under age 18)	72	56.7%
Total	127	100.0%

Average Household Size	
Average Number of People	3.2
Average Number of Adults	1.4
Average Number of Children	1.8

B. Location (Street, Park, Shelter, etc.)

1. Where did you sleep last night?

Response	Frequency	Percent
Vehicle (car, van, RV, truck)	124	97.6%
Other	3	2.4%
Total	**127**	**100.0%**

C. Demographics

4. How old are you?

Response	Frequency	Percent
Age 0 to 5	35	27.6%
Age 6 to 12	25	19.7%
Age 13 to 17	14	11.0%
18 to 24	11	8.7%
25 to 39	27	21.3%
40 to 49	10	7.9%
50 and older	5	3.9%
Total	**127**	**100.0%**

5. Are you male, female or transgender?

Response	Frequency	Percent
Male	47	37.0%
Female	80	63.0%
Transgender Male to Female	0	0.0%
Transgender Female to Male	0	0.0%
Total	**127**	**100.0%**

6. Are you Hispanic or Latino?

Response	Frequency	Percent
Yes	77	60.6%
No	49	38.6%
Don't Know/Refused	1	.8%
Total	**127**	**100.0%**

7. What is your race?

Response	Frequency	Percent
White	85	66.9%
Black/African American	27	21.3%
American Indian/Alaskan Native	1	.8%
Native Hawaiian/Pacific Islander	8	6.3%
Asian	6	4.7%
Total	**127**	**100.0%**

D. Veteran Status

Questions on Veteran Status were only asked of adults.

8. Have you served in the United States Armed Forces?

Response	Frequency	Percent
Yes	0	0.0%
No	53	100.0%
Don't Know/Refused	0	0.0%
Total	**53**	**100.0**%

9. Were you ever called into active duty as a member of the National Guard or as a Reservist?

Response	Frequency	Percent
Yes	0	0.0%
No	53	100.0%
Don't Know/Refused	0	0.0%
Total	**53**	**100.0**%

10. Have you ever received health care or benefits from a VA center?

Response	Frequency	Percent
Yes	0	0.0%
No	53	100.0%
Don't Know/Refused	0	0.0%
Total	**53**	**100.0**%

Sheltered Households – Demographic and Subpopulation Data

Data for the sheltered count was collected from HSA's Homeless Information Management System (HMIS). For those programs that do not enter data into HMIS, a survey was conducted to collect the needed data directly from each program. Counts were compiled for people living in four types of sheltered locations: emergency shelter, motel voucher programs, transitional housing and institutions (jails, hospitals, AOD programs). However, there was no demographic or subpopulation data collected for the 289 people living in institutions. This appendix presents demographic and subpopulation data only for the 708 people living in shelters, motel voucher programs and transitional housing

Type of Sheltered Location	Number of People	Percent
Emergency Shelter	187	26.4%
Motel Voucher Program	67	9.5%
Transitional Housing	454	64.1%
Total	**708**	**100.0%**

A. Household Composition

Household Type	Number	Percent
Households of Only Adults	302	72.1%
Households with Adults and Children	112	26.7%
Households with Only Children (Unaccompanied minors)	5	1.2%
Total	**419**	**100.0%**

Adults and Children by Household Type	Number	Percent
Adults in Adult Only Households	302	42.7%
Adults in Households with Children	163	23.0%
Children in Households With Children	238	33.6%
Unaccompanied Children (under 18)	5	0.7%
Total	**708**	**100.0%**

Adults and Children	Number	Percent
Adults	465	65.7%
Children	243	34.3%
Total	**708**	**100.0%**

Adults = age 18 and over; Children = under age 18

B. Demographics

Gender	Number	Percent
Male	307	43.4%
Female	399	56.4%
Transgender Male to Female	2	0.3%
Transgender Female to Male	0	0.0%
Total	**708**	**100.0**%

Ethnicity	Number	Percent
Non-Hispanic/Non-Latino	430	60.7%
Hispanic/Latino	278	39.3%
Total	**708**	**100.0**%
Race	**Number**	**Percent**
White	303	42.8%
Black/African American	132	18.6%
Asian	17	2.4%
American Indian/Alaskan Native	130	18.4%
Native Hawaiian/Pacific Islander	88	12.4%
Multiple Races	38	5.4%
Total	**708**	**100.0**

C. Subpopulations

The table presents the numbers and percentages of adults in each of the subpopulations listed. Children are excluded from these calculations.

Population	Number	Percent of Adults (N = 465)
Chronically Homeless Adults	83	17.8%
Veterans	89	19.1%
Chronically Homeless Veterans	51	11.0%
Adults with Serious Mental Illness	103	22.2%
Adults with Substance Use Disorder	107	23.0%
Adults with HIV/AIDS	1	0.2%
Victims of Domestic Violence (adults only)	77	16.6%

2015 San Mateo County Homeless Survey

To be completed by interviewer:
Type of Participant:

☐ Single Adult

☐ Adult Member of Family (***Be sure to complete Survey Addendum for Household Members!)***

Language Interview Conducted: ☐English ☐Spanish ☐Other:

City Neighborhood Where Interview Conducted:

Interview Date: Interviewer's Name:

To be completed by Center on Homelessness:

City Code: Form Number:

Hello, my name is _____ and I'm a volunteer for San Mateo County's Center on Homelessness. We are conducting a survey to count homeless people to provide better programs and services to them. Your participation is voluntary and your responses to these questions will not be shared with anyone outside of our team. I need to read each question all the way through. Can I have about 15 minutes of your time?

☐ No, survey refused. ☐ YES (*Begin asking questions*.)

This survey is completely confidential, but we do need to create a unique number just for you so that we don't mistakenly count you twice.

a. What are the first two letters of your first name? ___ ___
b. What is your birthdate? (mm/dd/yyyy) ___ ___ / ___ ___/ ___ ___ ___ ___

1. Where did you sleep last night? (*don't read the categories, let respondent tell you*): ☐ Street or sidewalk ☐ Vehicle (car, van RV, truck) ☐ Park ☐ Abandoned building ☐ Bus, train station, airport ☐ Under bridge/overpass ☐ Encampment/woods ☐ Other location (specify) _____ ***If any of these locations, continue on to Question 2***	2. Did another volunteer or survey worker already ask you these same questions about where you were staying last night? ☐ Yes ***(STOP. Thank person and end the interview.)*** ☐ No *(Continue to question 3.)* ☐ Don't Know/Refused (*Continue to question 3.)*
3. Are there any other adults or children in your household who were sleeping in the same location with you last night? ☐ No *(Continue to question 4)* ☐ Yes (*Let the person know you will also need to collect some data on his or her household members.* ***Be sure to complete the survey addendum for household members*** *after Question 25**)***	4. How old are you? _____ 4a. *If hesitant, ask* ***Are you…..?*** ☐ Under 18 ☐ 18-24 ☐ 25+ ☐ Don't know/Refuse to Answer
5. Are you male, female, or transgender? ☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male	6. Are you Hispanic or Latino? ☐ Yes ☐ No ☐ Don't Know/Refuse to Answer

7. What is your race? You can select one or more races. (*Please read categories.)*

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other (specify):
- ☐ Don't Know / Refuse to Answer

8. Have you ever served in the United States Armed Forces (e.g. served in full-time capacity in the Army, Navy, Air Force, Marines Corps, or Coast Guard).

☐ Yes ☐ No ☐ Don't Know/Refuse to Answer

9. Were you ever called into active duty as a member of The National Guard or as a Reservist?

☐ Yes ☐ No ☐ Don't Know/Refuse to Answer

10. Have you ever received health care or benefits from a Veterans Administration medical center?

☐ Yes ☐ No ☐ Don't Know/Refuse to Answer

11 Is this the first time you have been homeless?

☐ Yes ☐ No ☐ Don't Know/Refuse to Answer

12. How long have you been homeless <u>this time</u>? Only Include time spent staying in shelters and/or on the streets

_____ Days
_____ Weeks
_____ Months
_____ Years
_____ Don't Know/Refuse to Answer

13. (*Skip 13 and 13a if person answered Yes to 11).* Including this time, how many separate times have you stayed in shelters or on the streets in the past 3 years; that is, since January 2011? Was it 4 or more times or less than 4 times?

- ☐ Less than 4 times
- ☐ 4 or more times
- ☐ Don't Know/Refuse to Answer

13a. In total, how long did you stay in shelters or on the streets for those times? (Enter days, weeks, months, years

_____ Days
_____Weeks
_____Months
_____Years
_____Don't Know/Refuse to Answer

14. Where were you living at the time you most recently became homeless? *(Select only one)*

- ☐ San Mateo County? What city? _____
- ☐ Other county in CA? What county? _____
- ☐ Out of state? What state? _____

15. Is your hometown in San Mateo County?

- ☐ Yes? What city? _____
- ☐ No

16. Immediately before you became homeless this last time, were you (*Select only one*):

- ☐ Renting a home or apartment
- ☐ Living with relatives
- ☐ Staying with friends
- ☐ Living in a home owned by you or your partner
- ☐ Living in a motel
- ☐ In jail or prison
- ☐ In a treatment center
- ☐ In foster care
- ☐ In a shelter or transitional housing
- ☐ Other: _____

17. Please tell me whether any of these situations apply to you:

17a. Do you have any ongoing health problems or medical conditions such as diabetes, cancer, heart disease?

☐ Yes ☐ No ☐ Don't Know/Refuse to Answer

17b. Do you have a physical disability?

☐ Yes ☐ No ☐ Don't Know/Refuse to Answer

17c. Do you drink alcohol?

☐ Yes ☐ No ☐ Don't Know/Refuse to Answer

17d. Do you use illegal drugs? This includes prescription drugs that were not prescribed for you.

☐ Yes ☐ No ☐ Don't Know/Refuse to Answer

17e. Do you have psychiatric or emotional conditions such as depression or schizophrenia?
☐ Yes ☐ No ☐ Don't Know/Refuse to Answer

17f. Do you have post-traumatic stress disorder or PTSD? *(If necessary, explain that this is a condition that can occur in people who have seen or had life-threatening events such as natural disasters, serious accidents, war, or personal violence. If may cause feelings of detachment).*
☐ Yes ☐ No ☐ Don't Know/Refuse to Answer

17g. Have you ever had a traumatic injury to your brain from a bump, blow, or wound to the head?
☐ Yes ☐ No ☐ Don't Know/Refuse to Answer

17h. *(If the person has none of the above health issues, skip to question*
Do any of the situations we just discussed keep you from holding a job or living in stable housing?
☐ Yes ☐ No ☐ Don't Know/Refuse to Answer

17i. *If person answered yes to question 17h, ask 17i, if no, skip to question 18.* Which ones keep you from holding a job or living in stable housing?
☐ Alcohol use ☐ Illegal drug use
☐ Ongoing health issue ☐ PTSD
☐ Psychiatric / emotional condition ☐ Physical disability
☐ Brain injury

18. Have you ever received special education (Special Ed) services for more than 6 months?
☐ Yes ☐ No ☐ Don't Know/Refuse to Answer

19. Do you have AIDS or an HIV-related illness
☐ Yes ☐ No ☐ Don't Know/Refuse to Answer

20. Do you receive any disability benefits such as Social Security Income, Social Security Disability Income, or Veteran's Disability Benefits?
☐ Yes ☐ No ☐ Don't Know/Refuse to Answer

21. Are you currently on probation or parole?
☐ Yes, probation ☐ Yes, parole
☐ Yes, both ☐ No

22. Have you ever been a victim of domestic violence?
☐ Yes ☐ No ☐ Don't Know/Refuse to Answer

23. Were you ever in foster care?
☐ Yes ☐ No

23a. *If Yes, ask question 23. If no, skip to question 24.*
Were you in Foster Care In San Mateo County?
☐ Yes ☐ No

23b. *If Yes, ask question 23b. If no, skip to question 24.*
How long ago were you in Foster Care in San Mateo County?
Years: _____ Months: _____ Days: _____

24. Where do you usually get your medical care? *(Select only one.)*
☐ Emergency Room ☐ Mobile Healthcare Van
☐ Community Clinic ☐ San Mateo Medical/CHOPE
☐ Ravenswood Clinic ☐ Veterans Affairs Hospital/Clinic
☐ Don't ever go ☐ Other _____

25. Are you currently using any of the following services or assistance? *(Read the entire list and check all that apply.)*
☐ Emergency shelter ☐ Life skills classes ☐ Other: _____
☐ Transitional housing ☐ Shelter day services ☐ Not using services
☐ Free meals ☐ Legal assistance
☐ Food pantry ☐ Health services
☐ Bus passes ☐ Mental health services
☐ Job/vocational training ☐ Educational classes

STOP HERE! Go back and check Question 3. If the person you are interviewing has other household members go on to Question 26 and complete the entire Survey Addendum for Household Members.

If the person has no other household members, thank them for taking the survey.

Survey Addendum for Additional Household Members

Complete one column for each additional household member. Do not include the head of household (the person who replied to questions 1 to 25). Ask each person in the household the questions directly. If the person cannot answer the questions (because they are too young, are not present, or for any other reason) ask the head of household to provide the answers for them.

Questions	Person 1	Person 2	Person 3	Person 4
26. What are your initials?				
Just to confirm, you stayed at an unsheltered location with [name or initials of head of household] last night? ☐ Yes ☐ **No. *If no, STOP***. *Only collect data on household members who were with the head of household in an unsheltered location last night. If yes, continue to Question 27.*				
Questions 27 to 31 should be asked of ALL household members (adults and children).				
27. How are you related to the head of household?	☐ Child ☐ Spouse ☐ Other Family ☐ Non-Married Partner ☐ Other, Non Family _____	☐ Child ☐ Spouse ☐ Other Family ☐ Non-Married Partner ☐ Other, Non Family _____	☐ Child ☐ Spouse ☐ Other Family ☐ Non-Married Partner ☐ Other, Non Family _____	☐ Child ☐ Spouse ☐ Other Family ☐ Non-Married Partner ☐ Other, Non Family _____
28. How old are you? (Enter number)				
28a. If hesitant, ask, Are you?	☐ Under 18 ☐ 18-24 ☐ 25+ ☐ Don't know/Refuse to Answer	☐ Under 18 ☐ 18-24 ☐ 25+ ☐ Don't know/Refuse to Answer	☐ Under 18 ☐ 18-24 ☐ 25+ ☐ Don't know/Refuse to Answer	☐ Under 18 ☐ 18-24 ☐ 25+ ☐ Don't know/Refuse to Answer
29. Are you male, female, or transgender?	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male	☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male
30. Are you Hispanic or Latino?	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer
31. What is your race? You can select one or more races.	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

	☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other (specify): ☐ Don't Know / Refuse to Answer	☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other (specify): ☐ Don't Know / Refuse to Answer	☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other (specify): ☐ Don't Know / Refuse to Answer	☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other (specify): ☐ Don't Know / Refuse to Answer
Questions 32 to 43 should be asked to ADULT household members ONLY				
32. Have you ever served in the United States Armed Forces (e.g. served in full-time capacity in the Army, Navy, Air Force, Marines Corps, or Coast Guard).	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer
33. Were you ever called into active duty as a member of The National Guard or as a Reservist?	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer
34. Have you ever received health care or benefits from a Veterans Administration medical center?	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer
35. Is this the first time you have been homeless?	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer
36. How long have you been homeless <u>this time</u>? Only Include time spent staying in shelters and/or on the streets	_____ Days _____ Weeks _____ Months _____ Years _____ Don't Know/Refuse to Answer	_____ Days _____ Weeks _____ Months _____ Years _____ Don't Know/Refuse to Answer	_____ Days _____ Weeks _____ Months _____ Years _____ Don't Know/Refuse to Answer	_____ Days _____ Weeks _____ Months _____ Years _____ Don't Know/Refuse to Answer
37. *(Skip question 37 and 38 if person answered Yes to 35).* Including this time, how many separate times have you stayed in shelters or on the streets in the past 3 years, that is since January 2011? Was it 4 or more times or less than 4 times?	☐ Less than 4 times ☐ 4 or more times ☐ Don't Know/Refuse to Answer	☐ Less than 4 times ☐ 4 or more times ☐ Don't Know/Refuse to Answer	☐ Less than 4 times ☐ 4 or more times ☐ Don't Know/Refuse to Answer	☐ Less than 4 times ☐ 4 or more times ☐ Don't Know/Refuse to Answer
38. In total, how long did you stay in shelters or on the streets for those times? (Enter days, weeks, months, years	_____ Days _____ Weeks _____ Months _____ Years _____ Don't Know/Refuse to Answer	_____ Days _____ Weeks _____ Months _____ Years _____ Don't Know/Refuse to Answer	_____ Days _____ Weeks _____ Months _____ Years _____ Don't Know/Refuse to Answer	_____ Days _____ Weeks _____ Months _____ Years _____ Don't Know/Refuse to Answer

39. Please tell me whether any of these situations apply to you:				
39a. Do you have any ongoing health problems or medical conditions such as diabetes, cancer, heart disease?	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer
39b. Do you have a physical disability?	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer
39c. Do you drink alcohol?	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer
39d. Do you use illegal drugs? This includes prescription drugs that were not prescribed for you.	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer
39e. Do you have psychiatric or emotional conditions such as depression or schizophrenia?	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer
39d. Do you have post-traumatic stress disorder or PTSD? *(If necessary, explain that this is a condition that can occur in people who have seen or had life-threatening events such as natural disasters, serious accidents, war, or personal violence. If may cause feelings of detachment).*	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer
39g. Have you ever had a traumatic injury to your brain from a bump, blow, or would to the head?	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer
39h. *(If the person has none of the above health issues, skip to question 40)* Do any of these situations we just discussed keep you from holding a job or living in stable housing?	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer
39i. *If person answered yes to question 39h, ask question 39i, if no, skip to question 40* Which ones keep you from holding a job or living in stable housing?	☐ Alcohol use ☐ Illegal drug use ☐ Ongoing health issue ☐ PTSD ☐ Psychiatric / emotional condition	☐ Alcohol use ☐ Illegal drug use ☐ Ongoing health issue ☐ PTSD ☐ Psychiatric / emotional condition	☐ Alcohol use ☐ Illegal drug use ☐ Ongoing health issue ☐ PTSD ☐ Psychiatric / emotional condition	☐ Alcohol use ☐ Illegal drug use ☐ Ongoing health issue ☐ PTSD ☐ Psychiatric / emotional condition

	☐ Physical disability ☐ Brain injury	☐ Physical disability ☐ Brain injury	☐ Physical disability ☐ Brain injury	☐ Physical disability ☐ Brain injury
40. Have you ever received special education (special ed) services for more than 6 months?	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer
41. Do you have AIDS or an HIV related illness?	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer
42. Do you receive any disability benefits such as Social Security Income, Social Security Disability Income, or Veteran's disability Benefits?	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer
43. Have you ever been a victim of domestic violence?	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer	☐ Yes ☐ No ☐ Don't know/Refuse to Answer

Thank you for completing the survey!

The New York Times

Taking Note

California Heat Puts Farm Workers at Risk

12

Farm workers in California's Central Valley.
MATT BLACK FOR THE NEW YORK TIMES

By ANNA NORTH
SEPTEMBER 3, 2015

California's drought has forced cities to cut back on water and (some) farmers to let their fields go fallow. But increasingly hot, dry weather in the state may have its most dire effect on some of the people who plant and pick its crops.

According to Esther Yu-Hsi Lee at ThinkProgress, extreme summer heat in

California is putting farm workers at risk of illness and death.

The United Farm Workers union believes around 30 workers died from heat-related causes between 2005 and 2013, including one worker who was just 17 years old. California occupational health regulations require that employers provide shade when the temperature goes above 80, frequent breaks when it exceeds 95, and a water source "located as close as it is feasible to place it to the areas where employees are working."

But Ms. Lee notes that in one case, "as close as it is feasible" appears to have meant a mile away. And farm workers who are paid by how much produce they pick may not want — or be able to afford — to take a water break.

Not all farm workers necessarily know there are regulations in place to protect them, especially if they don't speak English. And many farm workers are undocumented — they may fear deportation if they report workplace violations, and they may have few options when it comes to seeking other work.

Though heat-related deaths have dropped since the state adopted the regulations, Ms. Lee writes, heat-related illnesses have not. And the problem could get worse — according to Roberto Mera of the Union of Concerned Scientists, nighttime temperatures in California's Central Valley are rising, meaning those who live and work there (including many farm workers) have less opportunity to recover from hot days. A heat wave in 2006, he writes, resulted in emergency room visits, hospitalizations and as many as 146 deaths, and Latino residents of agricultural areas were especially at risk.

In a recent op-ed at Project Syndicate, Bill Gates argued that the world's poorest farmers would face the greatest harm from climate change. He was referring primarily to farmers in the developing world, but that principle may apply in the United States, too: As climate change grows more severe, those with the least political and economic clout will be most vulnerable to its effects.

12 COMMENTS »

More In Taking Note »

Satanists, Vegans and Atheists Seek Equal Opportunity in Little Rock

Now that the Arkansas state government has approved a Ten Commandments monument at the Capitol, proposals for other monuments are flowing in.

TAB 4
Request for Board to Approve New Member Documents will be available at meeting.

TAB 5
Request for Board to Approve Re-Appointment of Board Members

Documents will be available at meeting.

TAB 6
Discussion on OSV Report

ASSESSMENT & SUMMARY

Operational Site Visit Report

On August 18, 2015, we received the Operational Site Visit (OSV) Report from the HRSA OSV conducted March 10-12 2015. The OSV Report reflects HRSA's and the site visit team's findings of compliance with the 19 Program Requirements, and also discusses a couple of Performance Measures. In general, we are pleased to have received the report in a more timely fashion than the previous OSV Report and also we find the report to not be as critical as might have been expected from the Exit Conference. Notwithstanding, we do fully expect to receive grant conditions on the failed program requirements. The following assessment is derived from our present understanding of the requirement issues as represented in the OSV, along with discussions with our consultant (who does OSVs for HRSA). This assessment is expected to change some as we gather more information from HRSA, have conference calls on the specific requirements and when grant conditions are actually issued based on the report.

Overall, the program was found to have MET seven (7) of the nineteen (19) HRSA Program Requirements. Numerically, this is an improvement from the April-May, 2013 OSV (report received in August 2014) when only five (5) requirements were found to have been met. Further, an additional four (4) requirements appear that they will require very simple efforts in order to meet the requirements. One of these is the Program Requirement for a Quality Improvement Program (requirement #8) for which we are already under a grant condition. We last submitted materials to meet this condition on August 16, 2015 and are presently awaiting HRSA's response. We believe we have adequately addressed all outstanding issues and concerns so additional action, if any, for either the current grant condition or from this 2015 OSV Report, should be minor in nature.

While none of the remaining eight (8) requirements appears that they will require substantially significant efforts to address, they all do appear that they will require at least a moderate amount of effort to bring them into compliance. Included here are two requirements for which the program is currently under grant conditions. Key Management Staff (#9) and Staffing – Credentialing & Privileging (#3) both had submissions made on August 16, 2015 to address outstanding issues or concerns on which we are awaiting HRSA's response.

While we believe we have met all of the needed elements presented to us previously for the Credentialing & Privileging (C&P), this new OSV Report had added specifically that the HCH/FH Co-Applicant Board needs to have an "agreement" with SMMC, for SMMC to perform the C&P activities. This effort – to craft an acceptable "agreement" for everyone – along with any additional items that may surface on the current grant condition (none expected), likely will necessitate a moderate amount of effort to accomplish. Likewise with the Key Management Staffing (#9) requirement where we believe we have met the current grant conditions needs, this OSV Report has specifically added the need to develop a HCH/FH specific Medical Director position description, as well as identifying the need for the

program to have additional operational staff. These efforts also look to require a moderate amount of effort to complete.

The remainder of those that appear to require **moderate** effort to come into compliance on are:

- Required & Additional Services (#2) – Collect and maintain copies of all agreements that SMMC has for services with external entities. Routinize this effort along with routine review of HCH/FH Scope Form 5A - Services.
- Scope of Services (#16) – HCH/FH Scope Form 5B – Sites has undergone modification in light of the March site visit. The OSV Report includes some new concerns to be addressed. Likely will require interactive effort with us, our consultant and HRSA to reach a final acceptable resolution.
- Billings & Collections (#13) – Determination/action required on Medicare FQHC status; development of HCH/FH Policies & Procedures in this area; work with IT and Fiscal on data and reports.
- Budget (#14) – Improve data on overall cost of services for HCH/FH patients along with the revenue generated by those services; improve reporting to the HCH/FH Co-Applicant Board for this; develop contingency spending plans.
- After Hours Coverage (#5) – while the OSV Report notes that there did exist Policy & Procedures for this, the reviewers efforts to verify were not completely successful. This will require some effort to determine exactly what HRSA will require to address sufficiently.
- Sliding Fee Discount Program (#7) – While our SFDP was approved by HRSA, the report identifies some additional areas for improvement around standard operations, policies & procedures, and data collection.

In addition to the Quality Improvement requirement already discussed above, those requirements where we believe it will likely take a fairly **minor** amount of effort to address are:

- Hospital Admitting Privileges (#6) – Reviewers had difficulty putting together policies and procedures that they could identify for meeting this requirement; they were concerned that it was overly EHR (eCW) based and not formalized. Need to identify and collect tracking and referral policies and procedures for hospital admitting and ER visits.
- Contractual Affiliation/Agreements (10) – Reviewers were unhappy that the HCH/FH Co-Applicant Board had approved extending by a year the (then) contracts with community partners, insisting that they Board needed to see and approve each contract individually. Reviewers also cited new federal requirements for: a.) determination of contractor vs sub-recipient status even though we had not done any applicable contracts since those requirements went into effect, and b.) for women and minority business recruitment in procurement (already done). Will need policy on contractor/sub-recipient status determination

and possibly on the Board's handling of contracts (since the Board will never actually be a signing party.

- Board Authority (#17) – While the report discusses the reviewers issue with language in the Co-Applicant Agreement that permits the Board of Supervisors to remove any Co-Applicant Board member, this issue was identified in the process of writing the Co-Applicant Agreement, vetted with HRSA Policy who provided language for the Co-Applicant Agreement, and accepted by HRSA when they approved the Co-Applicant Agreement in January 2015. Actual requirement need stated as the HCH/FH Board needing to approve the annual audit, which is already in the Board's Bylaws and the Board reviewed and accepted the most recent (March 31, 2015) Single Audit at its May 2015 meeting.

Overall, we believe at this time that we will be able to address any resultant grant conditions without extreme efforts. We do have a conference call set for Thursday, August 27th with our Project Officer to initiate some discussion on the report, so we expect a little more clarity at that point in time. Again, the final reality will be when HRSA actually issues the specific grant conditions resulting from this report. We will update this assessment and summary as need be as we move forward.

Health Center Program Site Visit Report

TA Request Details

TA Request Number: TA001150

Grantee Information: **San Mateo County Health Services Agency**
222 W. 39th Avenue
San Mateo, CA

Contact: Jim Beaumont; jbeaumont@smcgov.org; (650) 573-2459

Type of Visit: Operational Site Visit

Date(s) of Visit: March 10 – 12, 2015

Consultants

Candace Chitty (**Clinical**); cjchitty@qfhc.com; (352) 468-1715
Leo Fishel (**Team Leader - Financial**); leo@fishel.org; (301) 656-7137
Lawrence Peaco (**Governance**); consultantzero@earthlink.net; (410) 313-9123

Site Visit Participants

Name	Title	Interviewed	Entrance	Exit
Jim Beaumont	Program Director	Yes	Yes	Yes
Marmi Bermudez	Program Manager Eligibility CHS	Yes	No	No
Kathryn Calafato	Controller	Yes	No	No
Nirit Eriksson	Attorney	Yes	No	No
Doris Fung	Supervisor to Payroll	Yes	No	No
Brad Lew	Financial Analysis & Planning Manager	Yes	No	No
David McGrew	CFO SMMC	Yes	No	No
Linda Nguyen	Project Coordinator	Yes	Yes	Yes

Iwhan Park	Financial Analysis & Planning Director	Yes	No	No
Ann Marie Selvestri	Dental Program Manager	Yes	No	No
Carrie Tam	Accounting Manager	Yes	No	No
Frank Trinh	Medical Director	Yes	No	Yes
Kathryn Barrientoes	Board Member	Yes	Yes	Yes
Paul Tunison	Board Member	Yes	Yes	Yes
Kerry Lobel	Vice Chair	Yes	No	No
Beth Fells	Board Member	Yes		
Brian Greenburg	Board Member	No	No	Yes
Daniel Brown	Board Member	No	No	Yes
Tayisha Deldridge	Board Member	Yes	No	Yes
Sandi Nierenberg	Board Member	No	No	Yes
Jean S. Fraser	Chief, San Mateo County Health System Services Agency	Yes	No	No
Susan Ehrlich, M.D.	CEO San Mateo Medical Center	Yes	No	No
John Thomas	COO, San Mateo, Medical Center	Yes	No	No
Naomi Yunker	Medical Staff Credentialing	Yes	No	No
Robert Stebbins	Board Chair	Yes	Yes	Yes
Tesha Fleming	Manager of Corporate Compliance and HIPPA			

Program Requirement Compliance Review Summary

Program Requirement Compliance Review	Compliance Status
1. Needs Assessment	Met
2. Required and Additional Services	Not Met
3. Staffing Requirement	Not Met
4. Accessible Hours of Operation/Locations	Met
5. After-Hours Coverage	Not Met
6. Hospital Admitting Privileges and Continuum of Care	Not Met
7. Sliding Fee Discounts	Not Met
8. Quality Improvement/Assurance Plan	Not Met
9. Key Management Staff	Not Met
10. Contractual/Affiliation Agreements	Not Met
11. Collaborative Relationships	Met
12. Financial Management and Control Policies	Met
13. Billing and Collections	Not Met
14. Budget	Not Met
15. Program Data Reporting Systems	Met
16. Scope of Project	Not Met
17. Board Authority	Not Met
18. Board Composition	Met
19. Conflict of Interest Policy	Not Met

Section 1. Need - Program Requirement #1

Program Requirement #1 - Needs Assessment

Health center demonstrates and documents the needs of its target population, updating its service area, when appropriate. (Section 330(k)(2) and (k)(3)(J) of the PHS Act)

Compliance Status: Met.

Documents reviewed onsite or in advance:

Most recent Needs Assessment(s)
Service Area Map
UDS patient origin data
Health center's list of sites with service area zip codes (Form 5B)
Other: PIN 2007-09, UDS Mapper, BPHC MUA Designation listing

Compliance Review Findings:

The Health Services Agency (HSA) grantee has prepared a written Needs Assessment including a zip code delineated service area. The needs assessment has not been updated since 2010.

UDS patient origin data by zip code is somewhat consistent with the grantee's defined service area. Several service area zip codes contain no health center patients, indicating the grantee has not updated the service area assessment.

Section 2. Services - Program Requirement #2

Program Requirement #2 - Required and Additional Services

Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals. (Section 330(a) and (h)(2) of the PHS Act)

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Health center's official Scope of Project for services (Form 5A)
Clinical Practice Protocols and/or other policies and procedures that support the delivery of

health center services
Contracts, MOAs, MOUs, etc. for services provided via formal written agreements and/or formal written referral arrangements, including general tracking and referral policies and procedures

Compliance Review Findings:

Direct Required Services: Services provided directly as outlined in Form 5A: Services, Column I, are primary care, diagnostic laboratory and radiology, coverage for emergency services, family planning, immunizations, well child care, OB/GYN, dental, pharmacy, mental health and substance abuse, case management, eligibility assistance, health education, outreach, transportation, translation, and specialty services.

Referred Services Grantee Pays: San Mateo County's Healthcare for the Homeless/Farmworker Health Program (HCH/FH) describes on Form 5A, Column II, multiple services that the grantee does not provide directly and pays for the services. Agreements for most of the services listed were not available for review during the Site Visit and accuracy of Form 5A remained undetermined. The grantee provided formal written agreements directly related to the provision of services for the homeless/farmworker population for adult and pediatric primary care, OB/GYN (mobile health van, Ravenswood Family Health Center), preventive and restorative dental (Ravenswood Family Dentistry), behavioral health (Ravenswood), and case management, eligibility assistance, health education, outreach, transportation and translation (Puente de la Costa Sur - migrant/farmworker only). The reviewed agreements do not adequately support referred services from HCH/FH to these outside organizations/providers and it is unclear how individuals seen are registered as patients of the HCH/FH Program; the process for documenting service information in the health center medical record; and how health center policies and procedures apply. Other agreements to support the remaining required and additional services were not available; therefore, documentation did not support meeting this requirement. Agreements not provided include services for laboratory and radiology, pharmacy, cardiology, and dermatology. A review of PIN 2008-01: Scope of Project, and discussion about the descriptions/definitions associated with each of the Form 5A columns was provided to grantee staff.

Referred Services Only: Referred services on Form 5A, Column III include substance abuse, case management, nutrition, and other enabling/supportive services. Formal written arrangements with these outside organizations/providers were not provided; therefore, documentation did not support meeting this requirement.

Referral Tracking and Follow-Up: Policy 1.10.F, Outside Referral Process, is in draft format and dated February 22, 2014, with a status of ready for (San Mateo Medical Center [SMMC]) Chief Nursing Officer (CNO) review. Policy language does not address procedural steps for staff to follow to track and follow-up on referrals made.

Limited English Proficiency: To meet language needs SMMC clinic staff are bilingual and provisions are made using the SMMC language line. Patient materials and/or signage in other languages and/or informing patients of these services was not provided.

If Not Met - Steps/Actions Recommended for Compliance:

The grantee must determine which patients seen for services by contracted outside organizations/providers are patients of the health center (Section 330 Program). An identification and tracking process must be created clearly outlining how patients are identified and managed between the grantee and the organization.

Formal written agreements for services provided in Form 5A, Column II, must address how the services will be documented in the health center's record and how the health center's policies and/or procedures will apply.

The grantee must obtain formal written referral arrangements for all services listed in Form 5A, Column III. These agreements must address the manner by which the referral will be made and managed, and the process for referring patients back to the center for appropriate follow-up care.

The grantee must make patients aware of health services for patients with limited English proficiency or with disabilities in documents or messages (e.g., patient materials, signage, website, etc.).

The grantee must develop and approve a Referral Tracking and Follow-up Policy and/or Procedures that address steps for staff to track and follow-up with patients and/or outside organizations/providers when referrals are made.

Section 2. Services - Program Requirement #3

Program Requirement #3 - Staffing

Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed and privileged. (Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I) of the PHS Act)

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Staffing Profile
Provider contracts, agreements, and any subrecipient arrangements related to staffing (as applicable)
Credentialing and Privileging Policies and/or Procedures
Documentation of provider licensure or certification for all licensed or certified health center practitioners
Privileging lists

Compliance Review Findings:

Core Staff: Although the grantee is in receipt of Healthcare for the Homeless and Migrant Health Section 330 grants, the grantee does not appear to apply a specific focus on homeless or migrant/farm worker health care issues. Staffing rosters presented include all providers in the SMMC network but the grantee does not have a system in place to specifically track the FTE of providers who provide care to the special populations as part of their clinical practice; therefore, the health center cannot specifically account for its provider FTEs. The size and composition of staff cannot be determined as appropriate for serving the patient population and carrying out the approved Scope of Project.

Credentialing and Privileging Policy: The grantee's Credentialing and Privileging Policy, Medical Staff Bylaws, last revised May 24, 2011, has not been approved by the co-applicant Board and is not compliant with HRSA requirements. Specifically, the policy does not address:

- Inclusion of peer review and/or performance information at each two-year reappointment;
- Inclusion of immunization status, PPD and life support training;
- Inclusion of credentialing and privileging criteria and process for other licensed/certified professionals;
- Requirement to credential contracted, volunteers, and locum tenens providers; and
- Requirement of health center co-applicant Board to privilege all Licensed Independent Practitioners or that the co-applicant board has delegated this responsibility.

Credentialing and Privileging Process: A random sample of six provider files was selected from the grantee staff roster. The roster presented for sampling was all-inclusive of SMMC's entire provider staff and listed approximately 361 providers. The review of files was completed with SMMC credentialing staff. Findings are consistent with the previous Operational Site Visit findings of April 2013: The privileging process for licensed independent practitioners (LIPs) is accomplished by the SMMC and is hospital specific. The health center was unable to provide an agreement with the hospital to perform credentialing and privileging, outlining roles and responsibilities of each party as per HRSA Credentialing and Privileging PIN 2002-22, Appendix A. Files did not demonstrate inclusion of all required credentialing and privileging criteria, specifically immunization status, PPD, life support, and summary of peer review and/or performance information every two years. There is no documentation that credentialing and privileging is approved by the co-applicant Board or that the co-applicant board has delegated this responsibility as required by PINs 2001-16 and 2002-02. The credentialing and privileging

process for other licensed or certified professionals is accomplished by the SMMC hospital staff and does not meet HRSA requirements. There is no evidence of privileging approval by supervisory evaluation. TA was provided during the file review process with SMMC credentialing staff and included review of HRSA requirements. Documents left with the grantee include a sample Credentialing Delegation Agreement and Credentialing Checklists.

If Not Met - Steps/Actions Recommended for Compliance:

The grantee must revise the Credentialing Privileging Policy to address gaps in HRSA PIN 2002-22 and PIN 2001-16. Specific gaps are documented in the findings section.

The grantee must demonstrate the hospital's credentialing and privileging process meets the requirements outlined in PIN 2002-22, Appendix A.

The grantee must secure a credentialing and privileging agreement between SMMC and the health center/Section 330 program. Please refer to PIN 2002-22. Appendix A for requirements.

The grantee must provide documentation that the co-applicant Board approved the credentialing and privileging process. Co-applicant Board minutes should list names of professional staff being credentialed and receiving clinical privileges. The co-applicant board may delegate this responsibility (via resolution or bylaws) to an appropriate individual to be implemented based on co-applicant board-approved policies and/or related operating procedures (including methods to assess compliance with these policies and/or procedures).

The grantee must provide documentation that health center appropriately credentials and privileges other licensed/certified professionals in accordance with HRSA PIN 2002-22 and PIN 2001-16;specifically, immunization status, PPD, life support, and summary of peer review and/or performance information every two years.

Section 2. Services - Program Requirement #4

Program Requirement #4 - Accessible Hours of Operation / Locations

Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served. (Section 330(k)(3)(A) of the PHS Act)

Compliance Status: Met.

Documents reviewed onsite or in advance:

Hours of operation for health center sites

Most recent Form 5B: Service Sites (*Note that the form lists only the TOTAL number of hours per week each site is open, not the specific schedule.*)

Compliance Review Findings:

The grantee provides services at times and locations that assure accessibility and meet the needs of the population served. The SMMC operates ambulatory care clinics at 222 W. 39th Avenue, San Mateo, CA. At this physical location there are separate clinical areas providing adult, senior (Ron Robinson Senior Care Center), pediatric primary care, OB/GYN, surgery, and specialty care outpatient clinics. Tours of these clinical areas were completed during the Site Visit. Hours of operation are posted on the SMMC website.

http://www.sanmateomedicalcenter.org/content/clinics.htm

Other clinics operated by SMMC are:

Coastside Health Center
225 Cabrillo Highway, Suite 4361
Half Moon Bay, CA

South San Francisco Clinic
306 Spruce Street
San Francisco, CA

Sequoia Teen Wellness Center
200 James Avenue
Redwood, CA

HCH Mobile Dental Van
222 W. 39th Avenue
San Mateo, CA

Daly City Youth Health Center
2780 Junipero Serra Blvd.
Daly City, CA

Fair Oaks Health Center
2710 Middlefield Road
Redwood City, CA

Daly City Clinic
380 90th Street
Daly City, CA

HCH Mobile Dental Van
225 West 39th Avenue,
San Mateo, CA

Additional contracted sites operated by Behavioral Health and Recovery Services of San Mateo County:

Coastside Mental Health
225 Cabrillo Highway South
Half Moon Bay, CA

Central County Mental Health Center
1950 Alameda de las Pulgas
San Mateo, CA

North County Mental Health
375 89th Street
Daly City, CA

South County Mental Health
802 Brewster Avenue
Redwood City, CA

Additional contracted sites operated by Public Health Department of San Mateo County:

Mobile Health Clinic
225 37th Avenue
San Mateo, CA

Maple Street Shelter
1580 A. Maple Street
Redwood City, CA

Edison Clinic
222 W. 39th Avenue
San Mateo, CA

Additional contract site operated by another FQHC:

South County CHC (dba Ravenswood FHC)
1798 Bay Road
East Palo Alto, CA

The grantee recently developed a Patient Satisfaction Survey that includes access and availability questions. The first administration of the survey instrument is planned in the coming month.

Section 2. Services - Program Requirement #5

Program Requirement #5 – After-Hours Coverage

Health center provides professional coverage for medical emergencies during hours when the center is closed. (Section 330(k)(3)(A) of the PHS Act and 42 CFR Part 51c.102(h)(4))

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Health center's After-Hours Coverage Policies and/or Procedures
Most recent Form 5A: Services Provided, see Coverage for Emergencies During and After Hours

Compliance Review Findings:

After Hours Coverage Procedure: SMMC policy LD.04.03.01, Scope of Services - Ambulatory Services Policy, states, "patients calling the clinics after hours are advised of night and weekend coverage/Nurse Response System by a telephone message." Policy language does not adequately address how the health center/Section 330 Program provides professional coverage for medical emergencies when the health center is closed. Staff verbalized when patients call after hours they have the option to speak with the nurse triage service. Patients are sent to the Emergency Department when on-call nurses cannot meet patients' clinical advice needs per protocol.

After-Hours Coverage Process: A test of the after-hours system was completed with unsuccessful results. The SMMC adult primary care clinic, the SMMC OB/GYN clinic, and the Coastside Health Center were called after hours. All clinics provided an after-hours message in English and Spanish. The OB/GYN and Coastside Health Center provided an option to speak with nurse triage. The SMMC adult primary care clinic after-hours message did not provide an option to speak with the nurse triage service.

Patient Materials: The grantee did not demonstrate clarity in patient materials and other sources (website or signage) regarding how to access the nurse triage line.

If Not Met - Steps/Actions Recommended for Compliance:

The grantee must develop after-hours policies and procedures that adequately address provisions for professional coverage for medical emergencies when the health center is closed.

The grantee must provide professional coverage for medical emergencies at all locations when the health center is closed.

The grantee must make patients aware of the availability of and procedures for accessing professional coverage after hours, including patients with limited English proficiency or disabilities.

Section 2. Services - Program Requirement #6

Program Requirement #6 - Hospital Admitting Privileges and Continuum of Care

Health center physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking. (Section 330(k)(3)(L) of the PHS Act)

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Other: Outside Referral Process

Compliance Review Findings:

Hospitalization Process: Physicians employed at the SMMC have admitting privileges at SMMC's public safety net hospital. SMMC hospitalists provide inpatient care.

Hospital and Emergency Department Tracking and Follow-Up: The grantee was unable to provide internal policies, systems or procedures for addressing hospital/emergency department referrals, discharge follow-up, and patient tracking.

If Not Met - Steps/Actions Recommended for Compliance: The grantee must develop and implement policies and procedures for emergency department and hospital tracking and follow-up to assure the continuity of care for hospitalized health center patients.

Section 2. Services - Program Requirement #7

Program Requirement #7 - Sliding Fee Discounts

Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. (Section 330(k)(3)(G) of the PHS Act and 42 CFR Part 51c.303(f) and (u))

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Schedule of Fees/Charges for all services in scope
Sliding Fee Discount Schedule/Schedule of Discounts (often referred to as the Sliding Fee Scale)
Policies for the Sliding Fee Discount Program
Supporting operating procedures for the Sliding Fee Discount Program
Documents/forms that support the eligibility process for the Sliding Fee Discount Program

Compliance Review Findings:

There is a Board-approved Sliding Fee Discount Schedule, Policy and Procedure. The policy is dated October 20, 2014. Eligibility is based exclusively upon income and household size but the policy does not include definitions of income or household size. Patients are notified of the sliding fee program and other coverage programs by center staff at the time they call for an appointment, arrive for an appointment, or drop in for services. Literature and signage is in both English and Spanish. Interpretation services are available free of charge, including sign language interpreters. The income documentation required is identified in the policy and includes self-declaration. Patients must reapply annually or sooner if eligibility criteria change.

There is one discount schedule for all medical and clinical services included in the Scope of Project. The schedule includes a minimum pay class and three sliding fee classes set to range between 101-138%, 139-170%, and 171-200% of FPL. The break at 138% is done to correspond with the SMMC's other discount programs. The minimum pay class is charged nothing and the other classes pay 2%, 5% and 20% of charges. Those above 200% pay full fee.

The policy does not include a provision that it will be updated annually or that it will be re-evaluated at least every three years to ensure that it is not a barrier to care. The current schedule uses the 2014 guidelines, even though the new Federal Poverty Guidelines were issued in January 2015. SMMC's other charity care programs update the guidelines each year on April 1 to correspond with Medi-Cal's practice but the Sliding Fee Discount policy is silent on this point.

There is a consolidated online application form used by eligibility units for all assistance programs for which patients are screened.

The referred care and service contracts reviewed did not include provisions ensuring that comparable discounts would be provided.

Insured patients are reportedly eligible for the Sliding Fee Program but this was not found in the written policy.

The policy provides that no patients will be denied care due to an inability to pay for services but the procedure for waiving charges has not yet been developed.

SMMC has a separate Prompt Pay Discount Program for patients who do not qualify for other programs. A 50% discount is given for those who pay within 30 days of the bill date.

If Not Met - Steps/Actions Recommended for Compliance:

The sliding fee policy must include a definition of income and household.

The policy must include provisions that it will be updated annually and that it will be re-evaluated at least every three years to ensure that it is not a barrier to care.

The policy must include a provision supporting current practice that insured patients who qualify may participate in the Sliding Fee Discount Program.

All referred care contracts must provide for discounts in accordance with a Sliding Fee Discount Schedule that meets the Section 330 Health Center program Sliding Fee Discount Schedule criteria or provides greater discounts (as long as patients at or below 200% of the FPG receive a greater discount for these services than if the Section 330 Health Center's Sliding Fee Discount Schedule were applied to the referral provider's fee schedule and patients at or below 100% of the FPG receive no charge or only a nominal fee. (refer to Program Requirement #2).

The Sliding Fee or Billing and Collection Policy, or both, must include provisions for how it will ensure no patient will be denied service based upon an inability or refusal to pay, including the waiving of charges and any other support or enforcement actions.

The prompt pay discount must be applied to all services and patients, including sliding fee patients; be supported by an analysis that shows the discount is cost beneficial or comparable to the cost of collection; or be eliminated from the program.

Any revisions to the Sliding Fee Discount Policy must be approved by the co-applicant Board and documented in the Board minutes.

Section 2. Services - Program Requirement #8

Program Requirement #8 - Quality Improvement / Assurance Plan

Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records. (Section 330(k)(3)(C) of the PHS Act, 45 CFR Part 74.25 (c)(2)-(3), and 42 CFR Part 51c.303(c)(1)-(2))

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Quality Improvement/Quality Assurance (QI/QA) Plan and related and/or supporting policies and/or procedures (e.g., incident reporting system, risk management policies, patient safety policies)
Clinical Director's job description
HIPAA-Compliant Patient Confidentiality and Medical Records Policies and/or Procedures
Clinical Care Policies and/or Procedures
Clinical Information Tracking Policies and/or Procedures

Compliance Review Findings:

Inclusion of Clinical Services and Management: The Quality Improvement Plan Policy for 2014/2015 and the HCH/FH QI Policy and Procedure documents were reviewed and approved by the co-applicant Board on February 26, 2015. These documents support inclusion of clinical services and management across the grantee's Scope of Services; however, review of QI minutes, Board minutes, and interviews with staff do not support inclusion of measures outlined in the plan.

For example, QI Plan documentation states the HCH/FH QI Committee will review data from SMMC clinics and contractors on a quarterly basis and monitor progress on utilization and Clinical Performance Measures, including utilization reports, clinical performance findings, patient and staff satisfaction, and patient and staff complaints. Contractor agreements are quite comprehensive in specifying performance metrics, yet indication of these being reported through the HCH/FH QI Committee was not found. There is no evidence that all SMMC clinics are reporting performance to the HCH/FH QI Committee. The current intended measures for this year are limited to two diabetes (homeless diagnosed with diabetes and homeless/farmworkers with A1cs in various ranges), three dental care (patients receiving dental services, patients completing Phase 1 dental treatment, percent who completed at least two appointments in the last 12 months) and one primary care access (percent patients who completed at least two appointments in the last 12 months). These measures do not fully reflect the range of services provided.

Confidentiality of Patient Records: HCH/FH uses a secure electronic health record. The grantee uses SMMC HIPAA Policies and Procedures to address privacy and security practices. Policies are appropriate and comprehensive.

Clinical Director: The Medical Director, Dr. Frank Trinh, is accountable for the QI/QA Program as per review of a Memorandum of Understanding between the San Mateo Health System (new name for HSA) and SMMC (April 4, 2014), outlining specific roles and responsibilities for the HCH/FH Program QI/QA activities.

Periodic Assessment and Continuous Quality Improvement: The grantee has been working toward meeting QI/QA grant conditions. Actions completed include development and approval of the QI/QA Plan, specific QI/QA activities outlined for the Medical Director, and convening of the health center QI Committee (February 2014). At the time of this Site Visit, one assessment of performance using chart reviews of a small sample of A1c results among patients with diabetes has been completed, but not yet reported to the QI Committee. A schedule to guide additional periodic assessments is not yet in place and peer review to monitor adherence to clinical practice guidelines has not been developed.

Clinical Policies and Procedures: Policies and procedures reviewed appear to be relevant to all SMMC ambulatory care clinics and are not approved by the co-applicant Board as required. Numerous documents reviewed were found not specifically identified as applying to the HCH/FH population and are outdated.

If Not Met - Steps/Actions Recommended for Compliance:

The grantee must include clinical services and management performance measures across the scope of services.

The grantee must conduct periodic assessments (e.g., peer review, review and analysis of Clinical Performance Measure trends and outcomes) of the appropriateness of both the utilization and quality of services and apply continuous quality improvement when negative trends are identified.

The co-applicant Board of the health center must approve all clinical policies and specifically document approvals in Board minutes.

The grantee would benefit from QI/ QA Technical Assistance. This TA should focus on expanding the scope of performance measures, developing peer review processes, data collection and reporting methods, maximizing the electronic health record, and implementing continuous quality improvement.

Section 3. Management and Finance - Program Requirement #9

Program Requirement #9 - Key Management Staff

Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior approval by HRSA of a change in the Project Director/Executive Director/CEO position is required. (Section 330(k)(3)(I) of the PHS Act, 42 CFR Part 51c.303(p), and 45 CFR Part 74.25(c)(2)-(3))

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Health center Organizational Chart
Key Management Staff position descriptions and biographical sketches
Health center's official Scope of Project for Services and Sites (Form 5A and Form 5B)

Compliance Review Findings:

The grantee has established and operates the Section 330 Health Center Program as a fully integrated program of the San Mateo Medical Center (SMMC). Hence, the Homeless/Farm Worker Program, which comprises the Health Center Program, has no separate identity. The Program Director of the Homeless/Farm Worker Program operates with in the SMMC's management matrix to obtain the resources necessary to administer, direct, organize and evaluate the program. This includes service delivery site operations, clinical management systems and processes, financial management and information systems support and reporting. The draft of the Program Director's revised job description has not been finalized pending County Board of Supervisors review and approval. (The co-applicant Board has already reviewed and approved the draft job description.) Under the draft job description, the Program Director will be a direct report to the SMMC's CEO, coordinate program management requirements through the SMMC's COO, but work more closely on a day-to-day basis with the Deputy COO. However, an operating plan that defines how the Program Director would access and obtain the necessary management infrastructure resources (e.g. staffing to manage the program) has not yet been developed.

The program has its own Medical Director, but at 0.10 FTE through a Memorandum of Agreement, the level of effort would seem insufficient to accomplish the full range of Health Center Program Medical Director tasks, duties and responsibilities, including leading the Health Center Program 361 clinical staff in the performance of duties in providing services to the in scope service/target population and oversight of Health Center Program clinical services. The Medical Director's job description contained in the grant application is inadequate because it is generic and not particularized to meet the Homeless and Farmworker Program's requirements, taking into account that it is fully integrated into the SMMC's services. Presumably, the

Homeless/Farm Worker Program matrix management operating plan could also include how the program's clinical management processes would be supported through the SMMC's clinical management infrastructure.

In summary, the requirement is not met because:

- The Program Director's job description has not been finalized and approved by the Board of Supervisors; and
-
- The program's Medical Director's job description is inadequate and the tie of the Health Center Program clinical management processes to those of the SMMC's clinical management processes has not been defined.

If Not Met - Steps/Actions Recommended for Compliance:

The grantee must ensure adequate Key Management Staff and support that meet the Health Center Program's requirements. In particular, the grantee must:

- Finalize the Project Director's job description;
- Delineate the Medical Director's tasks, duties and responsibilities, prepare a job description that reflects the delineation, and ensure that the position is adequately resourced;
- Ensure that the financial management and reporting infrastructure including management and other staff are sufficient to provide adequate support to meet the needs of the program (both the Program Director and System Chief indicated that there was inadequate staffing to support the needs of the Health Center Program).

Section 3. Management and Finance - Program Requirement #10

Program Requirement #10 - Contractual/Affiliation Agreements

> Health center exercises appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meets Health Center Program requirements. (Section 330(k)(3)(I)(ii) of the PHS Act, 42 CFR Part 51c.303(n) and (t), Section 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act, and 45 CFR Part 74.1(a)(2))

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Contract(s) or sub-award(s) (subrecipient agreements) for a substantial portion of the Health Center Project
Memorandum of Understanding (MOU)/Agreement (MOA) for a substantial portion of the Health Center Project
Procurement and/or other policies and/or procedures that support oversight of contracts or affiliations

Compliance Review Findings:

The grantee has written co-applicant Board-approved policies and operational procedures that ensure oversight over contracted services and monitoring contractor performance. As a component of the San Mateo County and the SMMC, the program must operate with the constraints of the county's procurement process and is expected not take any action contrary to the County's best interests. The program contracts reviewed do not contain provisions that limit the co-applicant Board's compliance with Program Requirements. However, the co-applicant Board's exercise of its authority may potentially be constrained. (See Program Requirement #17, Board Authority).

The requirement is not met because:

- Although the co-applicant Board approved the expenditure of funds to support the extension of service contracts, the co-applicant Board did not review and approve the actual contracts (See Program Requirement #4, Locations).
- Service agreements to carry out a portion of its Section 330 federal award, approved Scope of Project, were established as contracts rather than subrecipient agreements. However, the grantee did not appear to follow the process set forth in 45CFR 75, Section 75.351, which requires the pass through entity to make case-by-case determinations regarding whether each agreement casts the party receiving the funds as a subrecipient or contractor.
- Procurement Policies reviewed do not include the requirement to take all necessary affirmative steps to assure that minority businesses, women's business enterprises and labor surplus area firms are used when possible (45CFR75 Section 75.330).

If Not Met - Steps/Actions Recommended for Compliance:

The Governing Board must:

- Review and approve all contracts/subrecipient agreements involving the use of federal Section 330 funds and program income;
- Complete and document case-by-case determinations regarding whether a service agreement to carry out a portion of the Scope of Project is a subrecipient agreement or a contract, taking into account additional guidance HRSA may supply to support these

determinations. This applies to all contracts/agreements made after the 45CFR75 Federal Register publication date, December 19, 2014.

- Revise Procurement Policies to include the requirement to take all necessary affirmative steps to assure that minority businesses, women's business enterprises and labor surplus area firms are used when possible (45CFR75 Section 75.330).

Section 3. Management and Finance - Program Requirement #11

Program Requirement #11 - Collaborative Relationships

Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of support from existing health centers (section 330 grantees and FQHC Look-Alikes) in the service area or provides an explanation for why such letter(s) of support cannot be obtained. (Section 330(k)(3)(B) of the PHS Act and 42 CFR Part 51c.303(n))

Compliance Status: Met.

Documents reviewed onsite or in advance:

Letters of Support
Other relevant documentation of collaborative relationships

Compliance Review Findings:

The grantee establishes and maintains collaborative relationships with other area providers as set forth in the Letters of Support contained in its most recent SAC application, including from other area Health Center Programs and community service providers.

Section 3. Management and Finance - Program Requirement #12

Program Requirement #12 - Financial Management and Control Policies

Health center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability. Health center assures an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report. (Section 330(k)(3)(D) and (q) of the PHS Act and 45 CFR Parts 74.14, 74.21, and 74.26)

Compliance Status: Met.

Documents reviewed onsite or in advance:

Most recent independent financial audit and Management Letter, including audit Corrective Action Plans based on prior year audit findings, if applicable
Most recent A-133 Compliance Supplement (grantees only)
Chart of Accounts
Balance Sheet
Income Statement
Most recent Health Center Program required Financial Performance Measures/UDS Report
Most recent Income Analysis (Form 3)
Other: Audits FY 2010-2013; FFR 2014; Drawdown reports; G/L accounts for federal funds

Compliance Review Findings:

The County of San Mateo single audit reports for the four fiscal years ending June 2013 were reviewed. The most recent audit report for the year ending June 2013 was unmodified, had no material weaknesses or significant deficiencies with its compliance with federal programs, but had both material weaknesses and significant deficiencies regarding the internal control over financial reporting. Management's response and planned corrective action are incorporated in the single audit report.

The accounting system is able to fully classify operations by normal account, function, location and source of funds. It is controlling for the expenditure of federal funds in its general ledger. The capability of the SMMC finance, accounting and IT staff interviewed was good. The financial management capacity of the San Mateo Health Care for the Homeless and Farmworker Health (HCH/FH) Program is limited, as noted in requirement #9.

The written financial policies of the county and SMMC were not provided or reviewed.
The co-applicant Board has not reviewed the single audit report to see if there are findings that may affect the section 330 program (Note: The co-applicant Board plans to begin reviewing the single audit report).

Section 3. Management and Finance - Program Requirement #13

Program Requirement #13 - Billing and Collections

Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures. (Section 330(k)(3)(F) and (G) of the PHS Act)

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Most recent Income Analysis (Form 3)
Most recent Health Center Program required Financial Performance Measures/UDS Report

Compliance Review Findings:

SMMC participates in Medi-Cal and other reimbursement programs but has not enrolled and does not participate in Medicare FQHC cost based reimbursement. Nearly all of the homeless and migrant patients receive some form of financial support, despite the fact that 59% are uninsured. The CY 2013 UDS shows that 86% of medical and clinical cost was collected compared to 70% nationally, which is good and suggests that the collection efforts are acceptable.

The clinical reviewer found that new uninsured patients who phone or drop-in are referred to the eligibility unit in order to apply for assistance. This process must be completed prior to being seen by the clinician and may have significant appointment delays of week or more. If so, this could constitute a barrier to care.

The HCH/FH Program does not have written Billing and Collection Policies, but these are reportedly being developed.

If Not Met - Steps/Actions Recommended for Compliance:

The grantee must enroll with Medicare and participate in FQHC cost based reimbursement or explain why it is not in its best interest to do so.

The HCH/FH Program must review and if necessary revise its policies in order to ensure that the eligibility process does not create a barrier to care for its patient population.

The HCH/FH Program must develop written Billing and Collection Policies which identify any provisions such as separate fees, fee structure or criteria for self-declaration of income which are specific to either the homeless or farmworker populations or both.

Section 3. Management and Finance - Program Requirement #14

Program Requirement #14 - Budget

Health center has developed a budget that reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan, including the

number of patients to be served. (Section 330(k)(3)(D) and (k)(3)(I)(i) of the PHS Act and 45 CFR Part 74.25)

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Annual budget
If applicable, operating plan
Most recent Income Analysis (Form 3)
Most recent Staffing Profile
Other: Award history; Budgets for periods ending October 2014 and October 2015; UDS Reports CY 2010 - 2014; SAC application

Compliance Review Findings:

The previous OSV budget recommendation stated: "The grantee must produce a Section 330 program budget that documents the complete cost of services provided, including overhead and any applicant support." This finding remains unchanged. As shown in the table below, the total expense in the Notice of Award #13-10 issued on Jan-15, 2015 for the budget period ending (BPE) October 31, 2014, is 109% less than the total cost shown in the CY 2014 UDS. The grant budget excludes a significant amount of presumably SMMC cost and understates patient service revenue.

				Row %
	BPE Oct-2014	CY 2014 UDS	NoA less UDS	Difference/NoA
Program Income	3,674,851	6,887,072	-3,212,221	-87%
BPHC Grant	1,943,479	1,854,221	89,258	5%
Total Income	5,618,330	8,741,293	-3,122,963	-56%
Total Expense	5,618,330	11,747,650	-6,129,320	-109%
Income less Expense	0	-3,006,357	3,006,357	

The budget for Section 330 grant period ending in October is the only budget the HCH/FH Program prepares. The federal award is controlled in the general ledger by award and not by budget category or source of funds. The HCH/FH Program does not prepare monthly statements that compare the budget to current and year-to-date actual performance for either just the federal award or the total budget. It was noted that for the five years ending October 2014, the unobligated balance less anticipated carryover amounts of approximately $260k.

The expense side of the federal funds budget consists of direct salaries of HCH/FH Program staff, allocated salaries of the Fair Oak, Willow, and mobile dental staff personnel who are charged to federal funds and the associated direct costs, the HCH/FH Program's service contractor costs and other direct costs. It was noted that just over $600k of the grant are payments to county entities (Fair Oaks, Willow and the HCH Dental van) to provide services that

would presumably continue to be provided in the absence of that support. The current budget also includes another $508k of payments to county entities (not the San Mateo Medical Center under which the health center program is operated) for mobile primary care and behavioral health services for which it has MOUs. It is not determined whether these arrangements would continue in the absence of federal support.

If Not Met - Steps/Actions Recommended for Compliance:

The grantee must produce a Section 330 program budget that documents the complete cost of services provided, including overhead and any applicant support.

The grantee must prepare a monthly financial statement for management and the co-applicant Board that includes the current and year-to-date budget performance for the total budget as presented in the approved Notice of Award.

Section 3. Management and Finance - Program Requirement #15

Program Requirement #15 - Program Data Reporting Systems

Health center has systems which accurately collect and organize data for program reporting and which support management decision-making. (Section 330(k)(3)(I)(ii) of the PHS Act)

Compliance Status: Met.

Documents reviewed onsite or in advance:

Most recent UDS Report and UDS Health Center Trend Report
Most recent Clinical and Financial Performance Measures Forms
Clinical and financial information systems (e.g., EHR, practice management systems, billing systems)
Other: UDS Reports CY 2010 - 2014; Back-up for CY 2014 Report; Board minutes, November 2013 – January 2015

Compliance Review Findings:

The financial reporting systems capability of the grantee is good but the capacity of the HCH/FH Program to make use of this capability is limited, as is the adequacy of the reporting as noted in other sections of this report. The grantee's leadership is able to understand and report in an acceptable way to the co-applicant Board the information needed to make basic decisions about the program. The grantee's ability to report Needs Assessment, Strategic Plan, Clinical Performance Measures, UDS, budget performance and other data is good, but the quality and extent of the reporting could be improved as was noted during the Site Visit. Assuming the

recommendations made in the Needs Assessment, clinical, billing, budget and Board sections of this report are implemented, the program reporting will be improved.

Section 3. Management and Finance - Program Requirement #16

Program Requirement #16 - Scope of Project

Health center maintains its funded scope of project (sites, services, service area, target population, and providers), including any increases based on recent grant awards. (45 CFR Part 74.25)

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Health center's official Scope of Project for sites and services (Forms 5A, 5B, and 5C)

Compliance Review Findings:

Review of services (Form 5A) with the grantee could not determine if services as outlined in each column were accurate. Agreements and referral arrangements were not readily available to make this determination and staff were not confident in accuracy.

In review of service sites (Form 5B), the following errors were noted: Ravenswood Family Health Center is a contracted FQHC and should not be listed; the SMMC outpatient clinics with a physical address of 222 W. 39th Avenue, San Mateo, California, must be listed separately by suite number; the Coastside Health Center and Coastside Mental Health Center addresses appear to be missing suite numbers; and there appears to be a duplicate mobile van listed.

The grantee's most recent SAC application indicates that the grantee's HCH/FH network of care includes eight fixed-site clinics, two mobile medical units and a dental mobile unit. The current co-applicant agreement states that the SMMC system operates seven FQHC health clinics and other facilities. However, the grantee's Form 5B contains many more than seven or eight fixed-site clinics (Form 5B lists a total of 19 sites, including one administrative site).

Information provided by the grantee shows that 361 providers practice at its Form 5B facilities . Although this number of providers appears to be in excess of the number necessary to provide services to the number of homeless/migrant patients (7,516) and encounters (39,179) reported in the UDS, the grantee includes these providers in its Scope of Project but only includes a subset of the providers on the Staffing Profile.

If Not Met - Steps/Actions Recommended for Compliance:

The grantee must review and confirm accuracy of Form 5A. If errors are identified, corrections must be made.

The grantee must revise Form 5B to delete Ravenswood Family Health Center as a service site, separate by suite number service site locations with the physical address of 222 W. 39th Avenue, add suite numbers to the Coastside Health Center and Coastside Mental Health Center, and delete the duplicate mobile van.

The grantee must reconcile the statements in the grant application and co-applicant agreement and its Form 5B regarding the number of fixed-site locations within its Scope of Project. Accordingly, Form 5B must be reviewed, updated and revised as appropriate. (See also Program Requirement #1 - Needs Assessment). Refer to 45 CFR Part 75, particularly section 75.351, for information on the differences between contractors and sub-recipients: http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=c12d2fe8df37f361e92a327d4209ca78&r=PART&n=pt45.1.75

The grantee could benefit from Technical Assistance in this area.

The Staffing Profile must be updated at least annually to reflect the current scope of project.

Section 4. Governance - Program Requirement #17

Program Requirement #17 - Board Authority

Health center governing Board maintains appropriate authority to oversee the operations of the center. (Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)

Compliance Status: Not Met.

Documents reviewed onsite or in advance:

Organizational/corporate bylaws
Minutes of recent Board meetings
If Applicable: Co-Applicant Agreement for public centers
Other: Resolution 069276 Resolution Specifying Standing Rules for County Boards, Commissions, and Advisory Committees, Program Director's annual performance evaluation, Board Self-Evaluation

Compliance Review Findings:

Since the last Operational Site Visit, the grantee has seated a Co-Applicant Board to govern the Health Center Program.

The co-applicant Board maintains and exercises appropriate authority to oversee program operations as set forth in the bylaws and documented in Board minutes, including approval of policies and procedures and its annual evaluation of the Program Director. The co-applicant Board maintains minutes of its meetings documenting its functioning, including major actions and decisions, and that it meets monthly. The co-applicant Board does not review the county annual audit.

The co-applicant Board also determines the selection of services, delivery locations and hours of operation consequent to its approval of the grant application. The co-applicant Board is engaged in a strategic planning process, including long-term planning, which will be the basis for evaluating the program's progress in meeting its annual and long-term goals. The Strategic Plan contains the program's Mission Statement. Minutes reflect that the co-applicant Board receives operational and clinical information.

The bylaws specify the following:

- Membership;
- Board member selection/removal process;
- Election of officers;
- Recording of minutes;
- Meeting schedule and quorum;
- Officer responsibilities, terms of office and selection/removal process;
- Process for the creation of committees;
- Conflict of interest provisions; and
- Board/program dissolution provisions.

The co-applicant Board bylaws delineate required Health Center Program authorities. But the bylaws also contain a provision, Article 9, Removal, that potentially constrains the co-applicant Board exercise of its authority. The provision asserts the county's right to remove any co-applicant Board member at any time with or without cause. It also contains language acknowledging the county's exercise of this authority would be non-compliant

If Not Met - Steps/Actions Recommended for Compliance:

The Board must review the grantee's annual single audit report as it could contain information pertinent to the Board's review and oversight of program operations and compliance with federal requirements.

Section 4. Governance - Program Requirement #18

Program Requirement #18 - Board Composition

The health center governing Board is composed of individuals, a majority of whom are being served by the center and, this majority as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. (Section 330(k)(3)(I) of the PHS Act, 42 CFR Part 51c.303(p), and 45 CFR Part 74.25(c)(2)-(3))

Compliance Status: Met.

Documents reviewed onsite or in advance:

Composition of Board of Directors/most recent Form 6A: Board Composition
Organizational/corporate bylaws

Notice of Award

Compliance Review Findings:

Based on the grant application request and according to the Notice of Award the grantee has received a waiver from the Board Composition requirements requiring a consumer majority. Nevertheless, the co-applicant Board includes several members from organizations focusing on the needs of the homeless and farm worker populations. Moreover, the co-applicant Board contains members with management, financial and clinical expertise who would be helpful to the co-applicant Board in its review and oversight of program operations. The Board is also diverse with respect to, ethnicity, race and gender. The co-applicant Board currently has nine members.

Section 4. Governance - Program Requirement #19

Program Requirement #19 - Conflict of Interest Policy

Health center bylaws or written corporate Board approved policy include provisions that prohibit conflict of interest by Board members, employees, consultants, and those who furnish goods or services to the health center. (45 CFR Part 74.42 and 42 CFR Part 51c.304(b))

Compliance Status: Met.

Documents reviewed onsite or in advance:

Corporate Bylaws

Most recent update of Conflict of Interest Policy and related procedures
Procurement Policies and/or Procedures
Other: County Ordinance

Compliance Review Findings:

The co-applicant Board bylaws and/or county ordinance include or address the following:

- Written standards of conduct governing the performance of county employees engaged in the award and administration of contracts. (Note: All program staff are county employees or contractor.)
- Prohibit county employees, Board members, or agents from participating in the selection, award, or administration of a contract supported by federal funds if a real or apparent conflict of interest would be involved. Such a conflict would arise when a county employee, Board member or agent, or any member of his or her immediate family, his or her partner, or an organization that employs or is about to employ any of the parties indicated herein, has a financial or other interest in the firm selected for an award.
- Prohibit Board members, employees, and agents of the program from soliciting or accepting gratuities, favors, or anything of monetary value from contractors, or parties to subagreements.
- Provide in the standards of conduct for disciplinary actions to be applied for violations of such standards by Board members, employees, or agents of the health center.
- The bylaws stipulate that no Board member shall be an employee shall be an employee of the San Mateo Health System or an immediate family member of an employee.
- The bylaws also stipulate that the Program Director shall be a non-voting, ex-officio member of the Board.

Section 5. Clinical and Financial Performance

Clinical Measure #1 - Percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.

Documents reviewed onsite or in advance:

UDS Trend, Comparison, and Summary Reports
Clinical and Financial Performance Measure Forms from most recent SAC/Designation Application

Clinical Performance Analysis:

Reason(s) for selecting the measure:

- Vulnerable population - Women who are homeless

- Downward trend noted
- Lack of periodic assessment for monitoring
- Wide variation in annual results
- HRSA area of focus (Healthy People 2020 Goal: 93%)

Performance measure status and trend:

2011 - 60%
2012 - 86%
2013 - 67%
Goal by End of Project Period = 70%

There was a 20 percentage point increase in results between 2011 and 2012 and a 13 percentage point decrease between 2012 and 2013. Data depicts wide variations between years that should be addressed for possible causes.

California 2013 UDS is 60.3% for all health centers, which is less than the SMC HFH/FH 2013 UDS results.

Key factors (internal and external) contributing to and/or restricting the health center's performance on the measure:

Restricting Factors:

- Challenges in abstracting information from the electronic health record;
- Resistance of homeless women in getting a PAP. Incidence of sexual trauma in this population was cited by the grantee as a barrier; and
- Loss of follow-up due to transient nature of the population.

Contributing Factors:

- Required reporting from contracted outside organizations/providers;
- PAP testing available on mobile health unit; and
- PAP testing available and promoted at primary care visits.

Health center's in-process and/or proposed action to improve performance on the measure:

The following actions are proposed:

- Conduct an analysis of performance and address actual/potential reasons for result variations. Include female patients in the analysis to gain input from their perspective.
- Include PAP testing performance in the QI/QA Plan and periodically assess for performance to goal; implement actions when needed and evaluate effectiveness.
- Implement system reminders and conduct outreach for women due for a Pap test.

Financial Measure #1 - Medical cost per medical visit

Documents reviewed onsite or in advance:

UDS Trend, Comparison, and Summary Reports
Other: UDS Reports CY 2010 - 2014; UDS National rollup reports

Financial Performance Analysis:

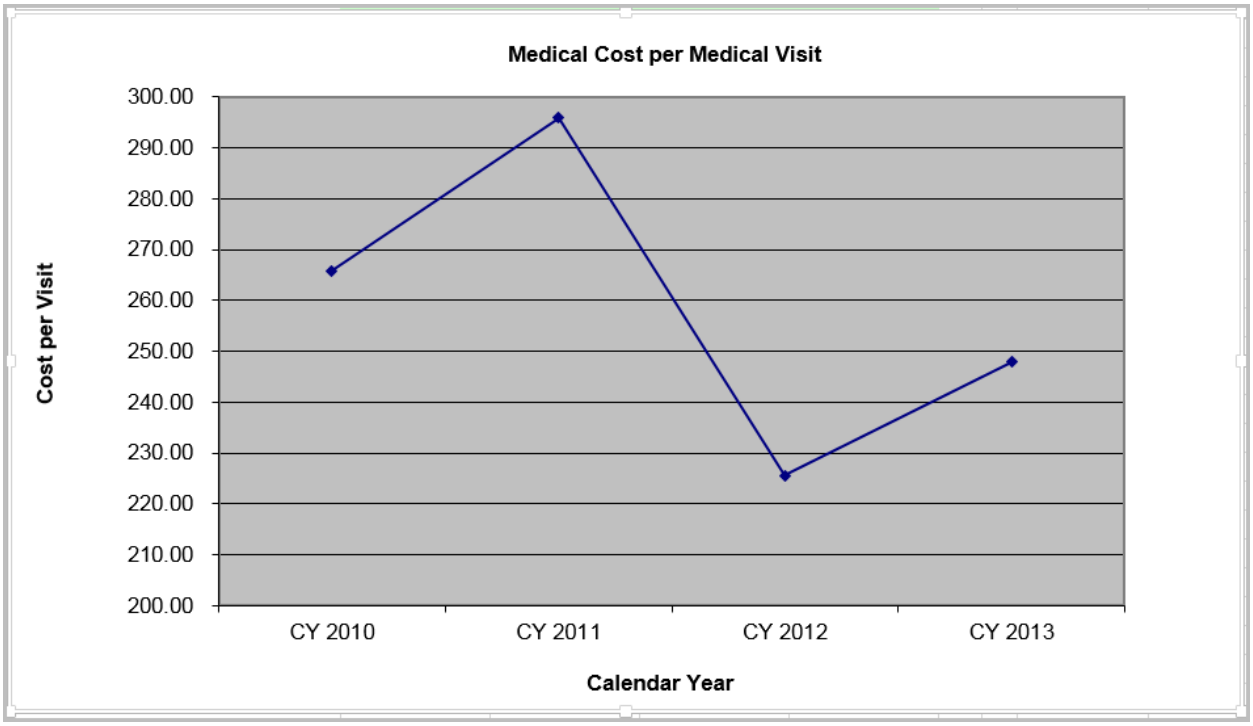
Reason(s) for selecting the measure:

Audit measures are not relevant because the grantee is a public entity and, of the two UDS financial measures, the medical cost per medical visit is the better measure of cost efficiency.

Performance measure status and trend:

The measure and four year trend is shown in the table and chart below.

	UDS	UDS	UDS	UDS
Fiscal Year	**CY 2010**	**CY 2011**	**CY 2012**	**CY 2013**
Medical Cost	2,343,349	2,829,463	3,595,292	5,494,054
Medical Visits	8,816	9,562	15,940	22,165
Cost Per Medical Visit	266	296	226	248



As shown, the medical cost per visit fell 7% over the four-year period from $266 to $248. Medical visits increased (151%), somewhat more than medical cost increased (134%) over this period. The 2013 medical cost per visit ($248) is 157% of the 2013 national average ($158), but only (109%) of the 2013 national average of the homeless only grantees ($227).

Key factors (internal and external) contributing to and/or restricting the health center's performance on the measure:

The most significant contributing factor is the number of visits seen by SMMC clinicians.

The most significant restricting factor is the cost of operations of SMMC.

Health center's in-process and/or proposed action to improve performance on the measure:

Unfortunately, the HCH/F Program has little control over the cost of operations of the SMMC Its best opportunity for improving performance on the measure is to increase the number of visits by its outreach and referral efforts. It might also improve performance by eliminating the support provided to county entities that will continue to provide the same services in the absence of that support and reprogram the funds to provide additional direct services to the target population.

Section 6. Capital and Other Grant Progress Review

Capital Grant Program(s) Reviewed:

N/A – The grantee does not have any active capital grant funding.

Section 7. Innovative/Best Practices

None noted.

TAB 7

Director's Report

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: September 10, 2015

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 activity update since the August 13, 2015 Co-Applicant Board meeting:

1. Grant Conditions

   On Thursday, August 27th, we had a phone call with our Project Officer, Kathy Ruck, which included discussion of the current grant conditions. Per that discussion, the Data Reporting Condition (Requirement #16) was reported as now being okay (however, we have yet to receive the NOA lifting the condition); the QI condition (#8) would need the re-submission of the previously submitted QI Policy (so that it was all included in the same submission 'package'); the Credentialing & Privileging condition (#3) would similarly need the C&P Policy re-submitted, in addition to another provider credentialing file; and the Key Management Staff condition (#9) for the reclassification of the HCH/FH Director's position would need to have a specific and clear timeline submitted.

   The specific Change Requests related to the issues stated above were all received and the QI and Director Position submissions completed. The C&P condition Change Request also included a request for a copy of the Medical Staff Bylaws that 'clearly demonstrates compliance with HRSA requirements or a reference document…" so they could identify where/how the requirements were being met. The deadline for this submission is September 10th.

   Based on the phone call with our PO, we expect that theses submissions should (finally) completely clear all of the grant conditions generated from our 2013 Operational Site Visit (OSV) that we received in September 2014. Just in time for…

2. Operational Site Visit (OSV) & Report

   On August 18th, just over a year from receiving the OSV Report from Our 2013 site visit, we received the OSV Report for our recent March 10 – 12 site visit.

In general, the report is not as critical as might have been expected from the Exit Conference. Notwithstanding, we do fully expect to receive grant conditions on the failed program requirements. A discussion of the report is scheduled elsewhere on the agenda and includes a copy of the report and a summary of the finding.

4. Management Analyst Position

On September 3rd we held interviews for the selected candidates for the Management Analyst position. We were pleased with the results of the interviews and are presently doing the requisite background and reference checks in preparation for making an offer. We hope to have our new staff on board prior to the October meeting of the Board.

5. Expanded Services Award Opportunity

The award announcement is expected to be made in September, but has not yet been received.

6. HRSA Technical Assistance (TA) for the Co-Applicant Board

As noted in last month's Director's Report, HRSA requested a Pre-TA presentation with the Board. This activity is scheduled elsewhere on today's agenda.

7. Seven Day Update

TAB 8
Budget/Finance Report

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: September 10, 2015

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

Based on the information available, the program has expended $1,327,481 through August 31, 2015. This represents about 71% of the current grant year and expenditures are at about 56% of the GY budget.

Based on current projections, there remains a potential unexpended balance of around $275,000 at the end of the GY (December 31, 2015). Given the known issues in appropriately and adequately addressing short term increases in expenditures, Program continues to work on a number of options that hold promise for utilizing one-time or short-term expenditures and providing longer-term or ongoing benefits.

The GY Expenditures & Projections Report thru 083115 is attached.

Attachments:
GY Expenditures & Projections Report thru 083115

Details for budget estimates	Budget	To Date (08/31/15)	Projection for GY (+~18 wks)		Projected for GY 2016	
Salaries						
Director					134,000	
Program Coordinator					87,538	
Medical Director					53,944	
Management Analyst					91,118	
new position, misc. OT, other, etc.				new	90,687	If Added
	319,778	204,533	335,000		457,287	
Benefits						
Director					75,991	
Program Coordinator					49,643	
Medical Director					30,592	
Management Analyst					51,673	
new position, misc. OT, other, etc.				new	51,429	If Added
	190,426	99,193	177,000		259,327	
Travel						
National Conferences (1500*2*2)		4,510	5,000		6,000	
Regional Conferences (600*2)		0	10,000		2,500	
Local Travel		517	1,000		800	
Taxis		1,401	2,900		4,000	
Van		1,864	2,100		2,500	
	12,833	8,292	21,000		15,800	
Supplies						
Office Supplies, misc.	5,833	7,059	9,800		10,000	
	5,833	7,059	9,800		10,000	
Contractual						
Current SMMC Clinic commitment (to 06/30)	407,713	407,713	407,713		-	
Current 2015 contracts	823,083	481,564	785,000		705,500	
Est available (for 07/01 on or otherwise)	327,705					
	1,558,501	889,277	1,192,713		705,500	
Other						
Consultants/grant writer	35,000	26,383	130,000		60,000	
IT/Telcom	15,000	5,204	10,000		12,000	
Memberships	5,000	0	5,000		5,000	
Training	2,000	100	2,000		2,000	
	66,500	31,687	147,000		79,000	
TOTALS - Base Grant	2,153,871	1,240,041	1,882,513		1,526,914	
Expanded Servcies Grant	219,724	87,450	219,724		219,724	
HCH/FH PROGRAM TOTAL	2,373,595	1,327,491	2,102,237		1,746,638	
PROJECTED AVAILABLE	BASE GRANT		271,358		282,640	

NOTE:
Former Full Annual SMMC Clinic Funding = $611,570

TAB 9
QI Committee Report

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: September 10, 2015

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

FROM: Linda Nguyen, Program Coordinator
HCH/FH Program

SUBJECT: REQUEST TO APPROVE RECOMMENDATIONS FROM QI COMMITTEE FROM HGBA1C DIABETES OUTCOME MEASURES

As part of the Quality Improvement Plan the QI Committee has been reviewing and analyzing 2014 HgbA1c Diabetes Outcome Measure reports during their last two meetings in July and August and after careful review have come up with the following recommendations for further actions.

As the HgbA1c Diabetes Outcome Measure data suggest that there is a considerable amount of "no test" occurring on the Public Health Mobile Van, because of the complexities/logistics (spinning blood and transportation to lab etc.) of drawing test/labs the committee has recommended :

1) The Program research cost/logistics of a system known as "One touch" quick test which could mitigate the issues of drawing blood in the field because of the simplified process to draw blood and obtain results. This recommendation will direct the Program's Medical Director to discuss with SMMC Ambulatory Services on logistics of such a purchase and use.

The QI Committee also made further recommendations when discussing the Expanded Services Proposal recently submitted to conduct Street/Field Medicine to:

1) Research methods to have a Pediatrician work alongside Nurse Practitioner to serve Farmworker children in the field.
2) To ensure that efforts are not duplicated in the field, have the various staff of Puente, Pescadero Clinic and Expanded Services proposal staff conduct a "Scope of Work" to describe their efforts.

This request is for the Board to approve the recommendations listed above from the QI Committee. Approval of this item requires a majority vote of the Board members present.

TAB 10
Review of Proposals for remaining funds

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: September 10, 2015

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: REVIEW PROPOSALS FOR REMAINING PROGRAM FUNDS

From the last Co-Applicant meeting (on August 3, 2015), it was reported that the Program will have remaining funds that require use before the end of calendar year. To assist the Program with ideas on use of funds, a request was put out to the Board members to turn in proposals on how best to use the funds.

Program has also solicited interest from various Community Members of San Mateo County that work with our target populations (Homeless/Farmworkers) to submit proposal of interest to attend the upcoming "International Street Medicine Symposium". Below is a chart of proposals thus far:

INTERNATIONAL STREET MEDICINE SYMPOSIUM PROPOSALS SUBMITTED			
Submitted by	**Organization**	**Staff**	**Reason**
Anita Booker	Public Health Mobile Van	4 Total : 2 NPs, Anita Booker, Frank Trinh	We will all be involved in the 'new' service line of street medicine with the new expanded services grant.
Meg Clark, Director	Home and Hope	Meg Clark (1)	I am developing an Advocacy training program for our volunteers and would love to use the connections and information that I would gain from this conference to educate the 1400 volunteers that we work with each year.
Stephen Lee	IVSN	5 total: 2 Hot Case Managers, 2 HCH Program staff, 1 Contract compliance staff (1 day)	We would like to see and understand how positions such as ours have and can work in collaboration with these teams to provide the best care possible to this community. We believe this to be important, especially in light of the upcoming expansion of services, to engage our various staff members in understanding the street medicine teams' function as our staff also each play different, key roles in the current outreach and health care processes.

Program has also received three proposals to fund supplies from InnVision, Puente and Beth Falls (on behalf of Project WeHOPE shelter) with summary below:

Submitted by	Organization	Supplies	Costs
Beth Falls	on behalf of Project WeHOPE Homeless Connect Event	homeless "kits"	
Brian Greenberg	IVSN	health care related items for homeless individuals living in streets and shelters.	$7, 901.86
Kerry Lobel	Puente	For items needed for protection from hot and cold weather as well as basic first aid items. Items for Community Health Fair.	$31, 702

Attached:

- IVSN Proposal
- Puente Proposal
- Discussion on proposal on behalf of Project WeHOPE Shelter from Beth Falls (COH)

InnVision Shelter Network

INNVISION SHELTER NETWORK
PROPOSAL FOR THE HEALTH CARE FOR THE HOMELESS/FARMWORKER HEALTH PROGRAM
AUGUST 2015

This application is in response to the availability of supplemental funding from the Health Care for the Homeless/Farmworker Health Program. Funding will provide health care related items for homeless individuals living on the street and in shelters.

ITEM	DESCRIPTION/JUSTIFICATION	QUANTITY	COST
Nitrile Gloves	For highly infectious materials	400 pairs	$48.00
Vinyl Gloves	Low infection risk	250 pairs	$20.00
Puncture Resistant Gloves	Locker Clean Out, Dorm Searches	100 pairs	$1,200.00
Sleeve covers	Used in laundry, intake and clean up	600 pairs	$22.00
PAWS – Alcohol wipes	Hygiene	10 boxes	$83.40
Purell hand sanitizer refills	Hygiene	6 cases (36 pcs. for $46.90)	$281.40
Shoe Covers	Hygiene – Cleaning up bodily fluid spills	3 boxes	$30.00
Xsorb Disinfecting absorbent powder	Cleaning up bodily fluids	5 cans	$70.00
Socks	Bunion and infection protection	1000 pairs	$1,000.00
Toilet Wipes	Hygiene	100 travel packages (24 pk of 10)	$146.88
Chapstick	Blister and cracking protection	250 sticks	$250.00
Pads	Feminine care	6000 pads	$1,500.00
Tampons	Feminine Care	6000 tampons	$1,500.00
Feminine wipes	Feminine Care	100 travel packs	$200.00
Rain Ponchos	Weather protection	100 ponchos	$100.00
Thermal Blanket	Weather protection	100 blankets	$200.00
Lotion	Skin protection	100 bottles	$100.00
Adult Diapers	Adult hygiene	50 packages	$1,000.00
First Aid Kits	Infection control	100 packs	$150.00
Total			**$7,901.86**

Date: August 25, 2015

To: Co-Applicant Board, San Mateo County Health Care for the Homeless/Farmworkers
Jim Beaumont, Director

From: Kerry Lobel

Subject:
Request for The Board to consider a proposal for the use of supplemental funding.

PROPOSAL SUMMARY
Puente is seeking $**31,702.00** to support funding for cold and hot weather protection items for farm and nursery workers and transportation to Puente second annual health health fair on October 4. 2015.

PROBLEM STATEMENT:
Farm and nursery workers face significant health consequences. Problems include infectious diseases, chemical- and pesticide-related illnesses, dermatitis, heat stress, respiratory conditions, musculoskeletal disorders and traumatic injuries, reproductive health problems, dental diseases, cancer, poor child health, inadequate preventive care, and social and mental health problems.

According to the Centers for Disease Control and Prevention, farmworkers die from heat-related illness at a rate **20 times greater** than that of the entire U.S. civilian workforce. Yet, with appropriate steps, heat-related illness is preventable and fatalities are easily avoided

- On an average day, temperatures in the fields are **8-10 degrees (F)** hotter than the reported daily high from the National Weather Service
- During peak production seasons, July and August, workers are in the fields 12 hours or more, in temperatures that frequently exceed 100 degrees
- Many workplaces do not have shaded areas for a break from the heat
- Frequently, clean drinking **water is not available**
- To protect themselves from pesticide exposure and skin cancer, farmworkers are instructed to wear long sleeves, long pants, socks, boots, hats and neck scarves— these precautions exacerbate the problem of heat
- The EPA reports that Workers Compensation claims for heat-related illness among farmworkers is the highest of any occupation
- During the cold winter months, workers may be outdoors in adverse conditions for extended periods of time.
- Problems here include local effects of non-freezing cold (chilblains, "immersion foot") causing long-term vasomotor instability. Local effects of freezing temperatures include frostbite with permanent tissue, neurovascular structures and even bone damage. Hypothermia is the manifestation of systemic effects of cold and is potentially quite serious. More than 700 people

die from hypothermia each year in the United States, and the number of injuries related to cold weather is even higher.

- Agricultural workers often come from warm climates and lack proper clothing and knowledge of cold weather conditions.
- Additionally farmworkers often perform tasks which require precise hand motions. Workers may avoid wearing proper gloves which can reduce the speed of job performance. They may feel reluctant to report the initial warning signs of frostbite or hypothermia. Job functions performed indoors are often in unheated barns or buildings. Exposure to cold weather conditions during work hours can be aggravated by inadequate housing.

PUENTE BACKGROUND

Puente is a 17-year old nonprofit, providing vital services for farm and nursery workers and their families in the rural unincorporated towns of the South Coast: Pescadero, La Honda, Loma Mar and San Gregorio. Puente's education, literacy, youth leadership, employment, behavioral health and wellness, prevention and community building efforts are the only such services offered in this far-flung region just "over the hill" from Silicon Valley, yet a world apart. The region's immigrant population faces complex challenges, compounded by the isolation that stems from living in a new rural environment, as well as language barriers and difficulties with negotiating a new cultural and social landscape. More than a third of the people of San Mateo's South Coast depend on Puente's wide array of community programs.

Most of the population served are farm and nursery workers from the rural parts of the Mexican states of Oaxaca, Guanajuato, Michoacán, and Jalisco.

Puente provides wide-ranging services including outreach; healthcare coverage enrollment, retention and navigation; transportation, translation and childcare; behavioral health services; safety net services; medical case management, and more. For 17 years, Puente's entire service model has been designed to be flexible, accessible, and comprehensive to best meet the needs of farm and nursery workers. Program staff visit nearby ranches and farms on a daily basis and the hours of our bricks and mortar offices in La Honda and Pescadero are designed to meet the needs of working individuals and their families.

THE PROGRAM

Puente proposes to provide health education to 300 participants at a community health fair scheduled for October 4, 2015. The Health Fair is a culturally appropriate outreach setting that uses effective teaching methods that respond to the cultural, educational, linguistic, literacy, health and educational needs of South Coast farmworkers and their families.

The Puente Outreach Team will provide preventive health information as well as health screenings to 250 farm and nursery workers.

Participants will receive flu vaccines, mammograms by appointment, skin screening, reproductive health information, as well as CBC and lipid panel screenings. Workshops will be offered on diabetes management, bike safety, nutrition and healthy cooking, yoga, disaster preparedness, pesticide exposure prevention, and more.

Participants will be provided with concrete tools for improving home health -- home first aid kits for minor cuts and bruises, pill box planners, forehead thermometers as well as hot weather clothing – ball

caps and water bottles. Transportation will be provided by MV Transportation for 30 farmworkers without other transportation.

Health Fair partners include Palo Alto Medical Foundation, Planned Parenthood, San Mateo County Medical Center, Red Cross, Kaiser, Stanford Hospital, HMB Library, SMC Agricultural Weights and Measures, and SMC Sheriff.

Participants will be pre and post tested and sign-in logs will be kept for each activity.

Puente staff will also distribute cold weather items at gatherings at farmworkers throughout October, November and December.

BUDGET REQUEST

Farmworker transportation	
Farmworker transportation for Health Fair on October 4, 2015 30 farm workers X $7.50 roundtrip/ MV Transportation	225.00
Home First Aid Kits	
For distribution to farm and nursery workers at health fair as well as for farmworker winter programming from October - December 500 kits X $1.45/kit	725.00
Water bottles to prevent dehydration	
For distribution to farm and nursery workers at health fair as well as for farmworker winter programming from October - December 500 water bottles X $2.66/bottle	1,330.00
Ball caps to prevent sun exposure	
For distribution to farm and nursery workers at health fair. 150 caps X 4.14/each	2,070.00
Spanish language pill box	
For distribution to farm and nursery workers at health fair as well as at Pescadero clinic appointments 300 boxes X $1.38/each	414.00

Sunscreen

For distribution to farm and nursery workers at health fair as well as for farmworker winter programming from October - December
1000 bottles X $1.76/each

1,760.00

Forehead thermometer

For distribution to farm and nursery workers at health fair as well as at Pescadero clinic appointments
250 thermometers X $4/each

1,000.00

Eye Drops

For distribution to farm and nursery workers at health fair as well as at Pescadero clinic appointments
500 X $1.25/each

625.00

Sleeping bags

For distribution at farmworker winter programming from October - December
150 sleeping bags X $35/each

5,250.00

Hoodies

For distribution at farmworker winter programing from October-December
150 farmworkers X 2 hoodies X $14.51/hoodie

4,353.00

Socks

For distribution at farmworker fall/winter programming from October - December
150 farmworkers X 6 pairs socks X $15.50/pair

13,950.00

Total Request

31,702.00

PUENTE QUOTE

8/24/2015

IMAGE	ITEM	DESCRIPTION	COLOR	IMPRINT	QTY	COST	EXT	SET UP	SUB	TAX	SHIPPING	TOTAL	
	P170	Sweatshirt - Hanes - ComfortBlend® EcoSmart® Hooded Sweatshirt	BLACK OR DARK GREEN	2 Color, Full Front	300	$13.50	$4,050.00	$0.00	$4,050.00	$303.75	WILL ADVISE	$4,353.75	$14.51
	P170	Sweatshirt - Hanes - ComfortBlend® EcoSmart® Hooded Sweatshirt	BLACK OR DARK GREEN	BLANK - NO IMPRINT	1000	$11.60	$11,600.00	$0.00	$11,600.00	$870.00	WILL ADVISE	$12,470.00	$12.47
													#DIV/0!
IMAGE	ITEM	DESCRIPTION	COLOR	IMPRINT	QTY	COST	EXT	SET UP	SUB	TAX	SHIPPING	TOTAL	#VALUE!
	SPC	CAP - Summer Mesh Cap. Poly-Foam Front Two Tone Cap Mesh Back Cap w/ Plastic Adjustable Snap Closure	KELLY / WHITE	2 COLOR IMPRINT	150	$3.25	$487.50	$90.00	$577.50	$43.31	WILL ADVISE	$620.81	$4.14
													#DIV/0!
IMAGE	ITEM	DESCRIPTION	COLOR	IMPRINT	QTY	COST	EXT	SET UP	SUB	TAX	SHIPPING	TOTAL	#VALUE!
	5283S	1.0 oz Broad Spectrum SPF 30 Sunscreen Lotion in Carabiner Tottle (PhotoImage 4 Color)	ANY	1 COLOR IMPRINT	1000	$1.59	$1,590.00	$50.00	$1,640.00	$123.00	WILL ADVISE	$1,763.00	$1.76
	5283S	1.0 oz Broad Spectrum SPF 30 Sunscreen Lotion in Carabiner Tottle (PhotoImage 4 Color)	ANY	4-COLOR PROCESS IMPRINT	1000	$1.69	$1,690.00	$50.00	$1,740.00	$130.50	WILL ADVISE	$1,870.50	$1.87
													#DIV/0!
IMAGE	ITEM	DESCRIPTION	COLOR	IMPRINT	QTY	COST	EXT	SET UP	SUB	TAX	SHIPPING	TOTAL	#VALUE!
													#DIV/0!
	5271	15 Piece Economy First Aid Kit. This kit contains: 6 Standard Size Latex Free Bandages, 4 Small Size Latex Free bandages, 1 Extra Large Bandage, 1 Moist Towelette, 1 Antiseptic Towelette, 1 Triple Antibiotic ointment and a First Aid Guide.	ANY	1 COLOR IMPRINT	500	$1.25	$625.00	$50.00	$675.00	$50.63	WILL ADVISE	$725.63	$1.45
	5271	15 Piece Economy First Aid Kit in Colorful Vinyl Pouch	ANY	BLANK - NO IMPRINT	1000	$1.07	$1,070.00	$0.00	$1,070.00	$80.25	WILL ADVISE	$1,150.25	$1.15
													#DIV/0!
													#DIV/0!

IMAGE	ITEM	DESCRIPTION	COLOR	IMPRINT	QTY	COST	EXT	SET UP	SUB	TAX	SHIPPING	TOTAL	#VALUE!
	AT603	Water Bottle - 20 Oz. Aluminum water bottle, carabiner, gift box, BPA free. 8 1/2" H x 2 7/8" Diameter	ANY	1 COLOR IMPRINT	500	$2.40	$1,200.00	$35.00	$1,235.00	$92.63	WILL ADVISE	$1,327.63	$2.66
	AT603	Water Bottle - 20 Oz. Aluminum water bottle, carabiner, gift box, BPA free. 8 1/2" H x 2 7/8" Diameter	ANY	BLANK - NO IMPRINT	1000	$2.05	$2,050.00	$0.00	$2,050.00	$153.75	WILL ADVISE	$2,203.75	$2.20
													#DIV/0!
IMAGE	ITEM	DESCRIPTION	COLOR	IMPRINT	QTY	COST	EXT	SET UP	SUB	TAX	SHIPPING	TOTAL	#VALUE!
	3564	Pill Box - Jumbo 7-Day Med Minder. Extra large capacity compartments handle multiple medications or vitamin regimens with ease	ANY	1 COLOR IMPRINT	300	$1.12	$336.00	$50.00	$386.00	$28.95	WILL ADVISE	$414.95	$1.38
	3564	Pill Box - Jumbo 7-Day Med Minder. Extra large capacity compartments handle multiple medications or vitamin regimens with ease	ANY	BLANK - NO IMPRINT	1000	$1.02	$1,020.00	$0.00	$1,020.00	$76.50	WILL ADVISE	$1,096.50	$1.10

CONTACT BEBE AT DOLPHIN GRAPHICS WITH QUESTIONS - BEBE@DGNC.COM OR CALL 888-205-2909

DISCUSSION ON PROPOSAL ON BEHALF OF PROJECT WEHOPE
FOR HOMELESS CONNECT EVENT (Beth and Linda)

Hi LN,
Could you remind me of the amount?
Also, the WeHOPE homeless connect event is this October. I'm wondering if there's anything we can do at that event? Something like a small first aid kit for homeless with some Airborne and antiseptics, maybe some tylenol? It's healthcare related and it may come in handy for them. Maybe even some boulllion cubes so they can have a hot chicken broth option if they feel ill? If this is dumb, just tell me, but if I were out there, some of that stuff would go a long way toward making me feel better.

Hi Beth,
Approximately $100,000 will be left after some of the services we already have in the works (Service Contract, data base etc).
All valid suggestions, we will prepare for the next meeting to consider. There may even be a website that sells all these "toiletries" all packaged nicely, I remember seeing at the last conference a company sold them.
Thanks!
Linda

>>> Beth Falls 8/21/2015 2:03 PM >>>
http://www.hchmd.org/pdfs/Survival%20Kit.pdf

Hi Beth,
What would be great is if you are really interested in wanting to fund supplies for the Homeless Connect to work with Project WeHOPE on a proposal for the quantity and budget, because these things will eventually have to be worked out if we will seriously be considering the project.
We also have to be careful with using funds from our budget, because they cannot be used to supplant any ongoing efforts, they must be NEW projects/supplies that would not have happened if not for these funds.
Linda

On Aug 21, 2015 3:40 PM, "Beth Falls" <bfalls@smcgov.org> wrote:
Hello Pastor Bains and Alicia,
At the Homeless Connect event coming up, do you have any street survival kits being distributed? I may have an opportunity to put in a high level proposal to the HCH/FH Board for some excess funds and I thought of you.
Or is there anything your homeless need that is healthcare related?
Let me know or give me a call.
Beth
>>> Alicia Garcia <agarcia@projectwehope.com> 8/21/2015 8:53 PM >>>

Hi Beth. We don't have any of those kits. It would be great to get some. Thank you for thinking of us.

Alicia Garcia

Linda wrote:

Heres a place with a good cause - http://www.guiltlessgiving.com/index.html

Donate Kits here!

Guiltless Giving, LLC

As seen on: CNN

Home | Catalog | Buy Now! | History | Media | Site Map



At Guiltless Giving, our inexpensive hygiene kits include everyday essentials and a useful reference card to help the homeless.

The benefit of giving a kit is... well...you know were your hard earned money is going and you're making a difference in how you give.

In each of our kits we include a reference card with toll free numbers to agencies that could assist getting those in need additional help.

You can buy our kits in small amounts and/or buy in the LARGE quantities. The choice is yours!

Help us pay it forward, one kit at a time.

Kit A

- (1) Toothbrush 30 Tuft
- (1) Toothpaste .6 oz.
- (1) Soap .5 oz.
- (1) Comb 5"
- (1) Deodorant Gel .12 oz.
- (1) Reference Card
- (1) Reseal able bag

Total: 1.69 each - minimum order of 10

Kit B - Dare to Care

- (1) Toothbrush 30 Tuft
- (1) Toothpaste .6 oz.
- (1) Soap .5 oz.
- (1) Comb 5"
- (1) Deodorant Gel .12 oz.
- (1) Shaving Cream .25 oz.
- (1) Razor – Double Edge
- (1) Reference Card
- (1) Reseal able bag

Total: 1.99 each - Minimum order of 10

Click here to see our entire Catalog!