



**TOPIC:** HCH/FH Program QI/QA Subcommittee  
**DATE:** July 13<sup>th</sup>, 2023  
**TIME:** 12:30pm-2:00pm  
**PLACE:** Venus Room- Department of Housing 264 Harbor Blvd., Bldg. A Belmont, CA 94002

Item	Time
1. Welcome	12:30pm
2. Approve Meeting Minutes:	12:35 pm
3. Program Updates	12:40 pm
1. Q1 2023 Tables- Performance Measures	1:00 pm
1. 2022 UDS Breakdown Tables	1:15 pm
2. QI/QA Plan Amendment	1:30 pm
3. Looking ahead: 2023	1:45 pm
4. <b>Adjourn</b>	2:00 pm

**FUTURE MEETING DATES:** TBD

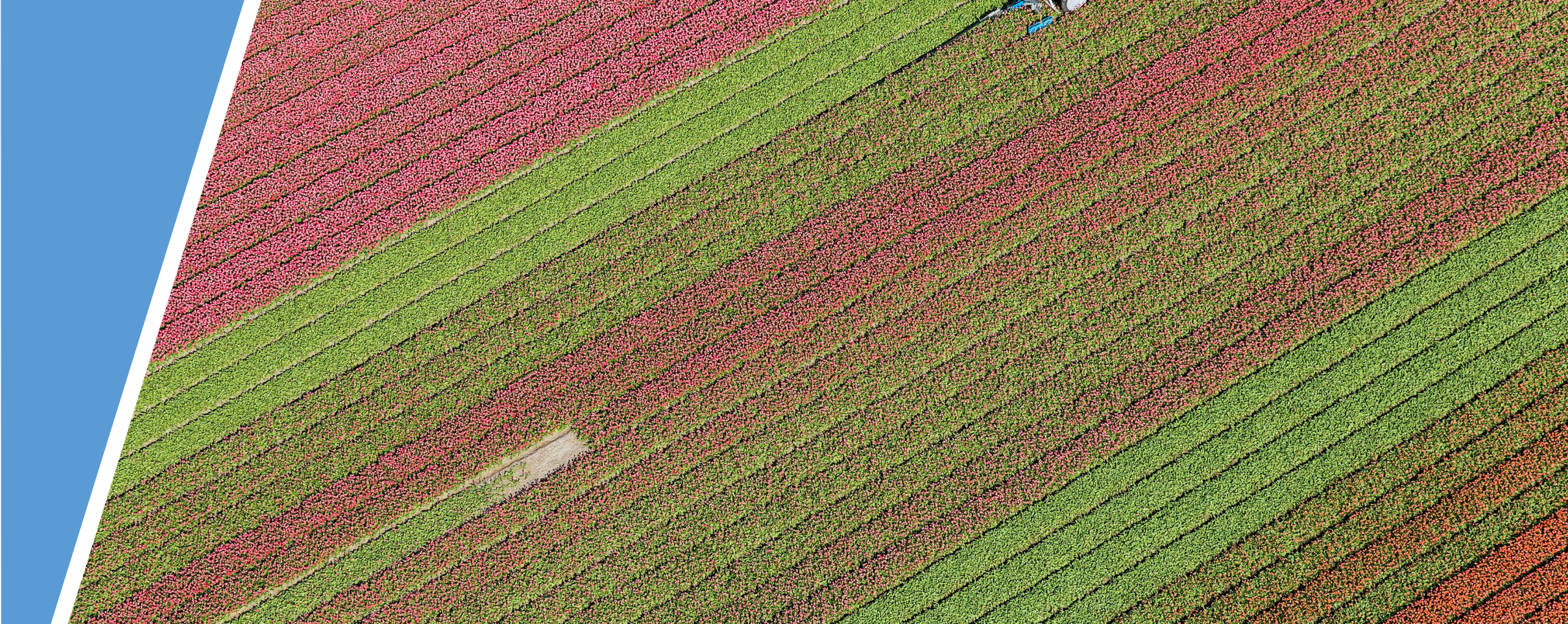
**HCH/FH Program QI Committee**

Thursday April 13<sup>th</sup>, 2023; 12:30-2:00 PM at County Building Room 101, RWC Address:  
 455 County Center, Redwood City, CA 94063

**Present:** Suzanne Moore, Amanda Hing-Hernandez, Janet Schmidt, Gabe Garcia, Victoria Sanchez de Alba, Frank Trinh, Irene Pasma, Alejandra Alvarado

ITEM	DISCUSSION/RECOMMENDATION	ACTION
	Meeting began at 12:30 PM	
Approve Meeting Minutes		Suzanne approved, Gabe second
Program Updates: 1. ACTIVATE Pilot 2. Telehealth at Maple Street 3. Homeless Death Data Event 4. Hypertension Pilot 5.	1. ACTIVATE Pilot: Previously discussed with SMMC Materials Management about possibility of developing a MOU with Mitre <ul style="list-style-type: none"> <li>• With MOU requirement, the process to develop agreement would take approx. 2 months</li> <li>• Additional time needed to develop MOU might conflict with grant funding timeframe, exploring other opportunities</li> </ul> 2. Telehealth at Maple Street: Equipment being re-allocated from Maple Street Shelter to Navigation Center <ul style="list-style-type: none"> <li>• Once transition of equipment is complete, we will work on process of equipment implementation for patients</li> </ul> 3. Homeless Mortality Data: HCH/FH collaborating with Public Health Epidemiology to accurately collect county homeless mortality data <ul style="list-style-type: none"> <li>• County data retrieval from previous 10 years in collaboration with HSA using HMIS data</li> <li>• Additional data collected- length of homelessness, where they lived when they passed, etc.</li> <li>• Public Health Epidemiology’s working relationship with the coroner’s office and Health IT</li> </ul> Final report likely to be completed around the Fall (Q3)           4. Hypertension Pilot: BP Cuffs have been distributed; follow-up conducted with SMMC team to assess status of patients <ul style="list-style-type: none"> <li>• Health disparities among Black/African American population evaluated via chart reviews</li> <li>• Goal: construct holistic approach to care and preventative screening, targeting patients at younger age</li> <li>• Identify PEH and farmworker individuals to track blood pressure and other metrics</li> </ul>	
UDS Performance measures	Alejandra presented on the 2022 UDS performance measures, reporting how our program did for our selected outcome measures <ul style="list-style-type: none"> <li>• UDS: Uniform Data System</li> <li>• Preparation for the UDS submission begins months in advance and consists of several parts divided amongst the staff.</li> </ul>	

	<ul style="list-style-type: none"> <li>• Of the 20+ QI metrics reported in the UDS, our program has selected eight that we can prioritize and track throughout the year to aid in improvement. These were the outcome measures reviewed during this meeting.</li> <li>• UDS Criteria were provided for each of the outcome measures to better assess values; definitions were reviewed, UDS results assessed and values compared from 2021 UDS results to 2022 UDS results.</li> </ul>	
QI/QA subcommittee meeting schedule	Reviewed preferences for QI/QA committee meetings with the committee members. Discussion occurred regarding location preferences and frequency of meetings. Members concluded their preference is to meet after board meetings and quarterly, whenever possible.	
Looking ahead 2023	<p>Discussion regarding future meeting topics and upcoming events:</p> <ul style="list-style-type: none"> <li>• Current administrative building is getting torn down, office relocation in April 2023</li> <li>• Collect committee members general availability to plan for time/location of future meetings</li> <li>• New project initiatives <ul style="list-style-type: none"> <li>• Pap-test update- waiting for FDA approval</li> <li>• HMB library update- BP cuff installation initiative</li> <li>• AMI Phones- contract renewal</li> </ul> </li> <li>• HCH/FH committee member goals, vision, limitations <ul style="list-style-type: none"> <li>• What goals are you excited for the HCH/FH program to accomplish this year?</li> <li>• What aspects are you looking for the HCH/FH program to focus on? <ul style="list-style-type: none"> <li>• Are there any limitations that concern you?</li> <li>• Any additional visions or questions?</li> </ul> </li> </ul> </li> </ul>	
<b>Future meeting dates</b>	<b>TBD</b>	
<u>FOLLOW UP- ACTION ITEM</u>		



SAN MATEO COUNTY HEALTH  
**SAN MATEO**  
**MEDICAL CENTER**

# QI/QA Committee Meeting Q2

Healthcare for Homeless & Farmworker Health Program

Thursday, July 13<sup>th</sup>, 2023

# Approve Meeting Minutes from 2023 Q1

---



SAN MATEO COUNTY HEALTH

**SAN MATEO  
MEDICAL CENTER**

# Agenda

- Program Updates
- Q1 2023 Tables- Performance Measures
- 2022 UDS Breakdown Tables
- QI/QA Plan Amendment
- Looking Ahead: 2023



# Program Updates

- **Half Moon Bay Library Project- BP Cuffs**

- HCH/FH program is partnering with the Half Moon Bay library to provide blood pressure kits to library patrons
- Goal: targeting library attendees who are farmworkers and people experiencing homelessness
- Proposal between HCH/FH program and Half Moon Bay library is being drafted
- Target date is to initiate the project starting in August

- **Cancer Screenings Project**

- HCH/FH program is collaborating with SMMC Population Health to evaluate detectable health disparities among farmworkers and people experiencing homelessness at SMMC
- Analysis conducted between HCH/FH patient population compared to the SMMC general patient population
- Goal: evaluate health disparities among cancer screenings/prevalence of cancer diagnosis for both patient populations



# Program Updates

- **eCW Provider Templates**

- Creating resource document for SMMC providers to distribute to people experiencing homelessness and farmworkers during their appointments
- Templates categorized by county regions: North County, Mid County, South County, Coast
- Meeting with BI to confirm template transition into SMMC EPIC rollout

- **AMI Phones Project**

- Contract renewal with AMI Strategies to continue providing phone services to people experiencing homelessness in community
- Knox Dashboard created to navigate phone usage, send notifications, reminders, track phone location, etc. to manage phone usage on staff's end
- Patients able to call and text SMMC staff, login to portal, transportation services to appointments, etc.





SAN MATEO COUNTY HEALTH  
**SAN MATEO  
MEDICAL CENTER**

# Q1 2023 Tables- Performance Measures

QI Measures of Focus	2023 Q1 PEH	2023 Q1 FW	2022 Q1 PEH	2022 Q1 FW	2021 CA 330 Programs	2021 Adjusted Quartile Ranking	2023 SMMC Performance (PCQR)
<b>Screening and Preventive Care</b>							
Cervical Cancer Screening	22%	35%	21%	35%	55.2%	1	73%
Colorectal Cancer Screening	52%	55%	42%	42%	39.9%	1	73%
Breast Cancer Screening	48%	82%	53%	80%	48.5%	1	77%
Depression Screening and Follow-up	19%	19%	16%	18%	65%	4	65%
Adult BMI Screening and Follow-up	45%	48%	38%	42%	58.1%	4	85%
<b>Chronic Disease Management</b>							
Hypertension	45%	45%	39%	44%	56.9%	3	75%
Diabetes A1c >9%	11%	20%	53%	52%	35.1%	1	N/A
<b>Maternal Health</b>							
Prenatal Care 1st Trimester					77.1%	3	N/A



# Areas of Improvement

Last Clinic Visit	# Patients No BMI Collected
PRC - Public Health Redwood City	97
PSM - Public Health San Mateo	64
PSF - Public Health So San Francisco	44
PSB - Public Health San Bruno	12
COA - Coastside Adult	9
PLS - Plastic Surgery Clinic	7
PCC - Primary Care Clinic	6
CAR - Cardiology	6
SSFA - Ssfa - Adult	6
ORT - Orthopedics	6

	PHPP Street Medicine/Mobile Clinic
	SMMC Outpatient
	SMMC Specialty Care

## • Adult BMI & Follow-Up

- Clinic locations- of the patients who had a recent visit where Adult BMI was not collected
- Primary blanks seen in PHPP Mobile and Street Medicine and Outpatient care.
- Some specialty clinics may not collect Adult BMI (Ex: tele-health visits)
- Meeting with clinics that see a large part of our patient population



# Areas of Improvement

- **Adult BMI and Follow-Up (*continued*)**

- BMI patient inclusion criteria being addressed with BI team for future reports
- Data validation- evaluating to confirm that all patients included in this list are 18+ years old
- Will provide update from BI team in upcoming meeting

- **Diabetes A1c > 9%**

- Communicating with BI regarding patients included in reporting criteria for report
- Data validation- patients falling outside of Q1 date range removed, might be impacting total patients for 2023 Q1 reporting
- Will provide follow-up on BI's feedback at upcoming meeting



SAN MATEO COUNTY HEALTH  
**SAN MATEO  
MEDICAL CENTER**

# 2022 UDS Table Breakdowns

# 2022 UDS Diabetes Breakdown

Column1	# Dx of Diabetes Mellitus	# HgbA1c </- 9%	% HgbA1c </- 9%	# HgbA1c > 9%	% HgbA1c > 9%	# HgbA1c > Not Recorded	% HgbA1c > Not Recorded
<b>Grand Total: 543</b>							
<b>Total Population</b>	455	371	82%	84	18%	88	19%
<b>Male</b>	269	215	80%	54	20%	56	21%
<b>Female</b>	186	156	84%	30	16%	32	17%
<b>% Total Male</b>	59%						
<b>% Total Female</b>	41%						
<b>Total Homeless</b>	357	292	82%	65	18%	79	22%
<b>Doubling Up</b>	154	136	88%	18	12%	19	12%
<b>Shelter</b>	49	36	73%	13	27%	22	45%
<b>Transitional</b>	20	16	80%	4	20%	8	40%
<b>Other</b>	104	83	80%	21	20%	14	13%
<b>Street</b>	30	21	70%	9	30%	16	53%
<b>Homeless Male</b>	225	180	80%	45	20%	49	22%
<b>Homeless Female</b>	132	112	85%	20	15%	30	23%
<b>% Homeless Male</b>	63%						
<b>% Homeless Female</b>	37%						
Race- A (Asian)	31	27	87%	4	13%	8	26%
Race- B (Black/African American)	20	16	80%	4	20%	13	65%
Race- D (Declined)	1	1	100%	0	0%	0	0%
Race- N (American Indian/Alaska Native)	1	1	100%	0	0%	0	0%
Race- O (Other)	58	50	86%	8	14%	6	10%
Race- P (Native Hawaiian?Pacific Islander)	16	12	75%	4	25%	2	13%
Race- Q (Unknown)	24	15	63%	9	38%	7	29%
Race- W (White)	206	170	83%	36	17%	43	21%
Hispanic- Y	163	126	77%	37	23%	24	15%
Hispanic- N	158	134	85%	24	15%	47	30%
<b>Total Farmworker</b>	110	87	79%	23	21%	8	7%
<b>Migrant</b>	9	8	89%	1	11%	1	9%
<b>Seasonal</b>	101	79	78%	22	22%	7	7%
<b>Farmworker Male</b>	57	44	77%	13	23%	7	12%
<b>Farmworker Female</b>	53	43	81%	10	19%	1	2%
<b>% Farmworker Male</b>	52%						
<b>% Farmworker Female</b>	48%						
Race- A (Asian)	1	0	0%	1	100%	0	0%
Race- B (Black/African American)	0	0	0%	0	0%	0	0%
Race- D (Declined)	5	4	80%	1	20%	0	0%
Race- N (American Indian/Alaska Native)	1	1	100%	0	0%	0	0%
Race- O (Other)	23	17	74%	6	26%	2	9%
Race- P (Native Hawaiian?Pacific Islander)	1	1	100%	0	0%	0	0%
Race- Q (Unknown)	11	7	64%	4	36%	0	0%
Race- W (White)	68	57	84%	11	16%	6	9%
Hispanic- Y	96	76	79%	20	21%	8	8%
Hispanic- N	5	3	60%	2	40%	0	0%

# 2022 UDS Hypertension Breakdown

Column1	Column2	Column3	Column4	Column5	Column6
<b>Total Population</b>	1159				
<b>Total # Dx of Hypertension</b>	960				
<b>Total # Hypertension Cases</b>	621				
<b>Total % Hypertension Cases</b>	65%				
<b>Total # No BP Value</b>	199				
<b>Total % No BP Value</b>	21%				
		<b>% Hypertension Cases</b>	<b>% Hypertension Cases</b>	<b>% No BP Value</b>	<b>% No BP Value</b>
<b>Total Male Population</b>	695	364	52%	127	18%
<b>Total Female Population</b>	464	257	55%	72	16%
<b>% Total Male Population</b>	60%				
<b>% Total Female Population</b>	40%				
<b>Total Homeless</b>	972	508	52%	176	18%
<b>Doubling Up</b>	407	235	58%	67	16%
<b>Shelter</b>	139	61	44%	26	19%
<b>Transitional</b>	71	38	54%	10	14%
<b>Other</b>	221	117	53%	48	22%
<b>Street</b>	134	57	43%	25	19%
<b>Homeless Male</b>	607	308	51%	116	19%
<b>Homeless Female</b>	365	200	55%	60	16%
<b>% Homeless Male</b>	62%				
<b>% Homeless Female</b>	38%				
Race-A (Asian)	100	57	57%	11	11%
Race-B (Black/African American)	80	32	40%	24	30%
Race-D (Declined)	6	2	33%	1	17%
Race-N (American Indian/Alaska Nat)	5	1	20%	1	20%
Race-O (Other)	116	69	59%	21	18%
Race-P (Native Hawaiian/Pacific Isl)	33	15	45%	10	30%
Race-Q (Unknown)	65	32	49%	9	14%
Race-W (White)	567	300	53%	99	17%
Hispanic-Y	349	203	58%	54	15%
Hispanic-N	530	263	50%	103	19%
<b>Total Farmworker</b>	195	116	59%	23	12%
<b>Migrant</b>	21	15	71%	3	14%
<b>Seasonal</b>	174	101	58%	20	11%
<b>Farmworker Male</b>	108	63	58%	13	12%
<b>Farmworker Female</b>	87	53	61%	10	11%
<b>% Farmworker Male</b>	55%				
<b>% Farmworker Female</b>	45%				
Race-A (Asian)	2	2	100%	0	0%
Race-B (Black/African American)	2	2	100%	0	0%
Race-D (Declined)	6	1	17%	2	33%
Race-N (American Indian/Alaska Nat)	2	1	50%	0	0%
Race-O (Other)	47	33	70%	5	11%
Race-P (Native Hawaiian/Pacific Isl)	0	0	0%	0	0%
Race-Q (Unknown)	19	10	53%	1	5%
Race-W (White)	117	67	57%	15	13%
Hispanic-Y	171	103	60%	21	12%
Hispanic-N	16	11	69%	2	13%



SAN MATEO COUNTY HEALTH  
**SAN MATEO  
MEDICAL CENTER**

# QI/QA Plan Amendments





# Looking Ahead: 2023

- HCH/FH preparing for UDS 2023 reporting year
- Review SMMC Patient Satisfaction Survey and Patient Grievances feedback at upcoming meeting
  - Collaborating with Patient Experience to stratify farmworkers and people experiencing homelessness data from SMMC Patient Grievances
- Finalize QI/QA Plan 2023-2024 at upcoming meeting
- Program initiative- provide trainings to SMMC internal staff and HCH/FH community partners
  - Customized trainings for individuals working directly with farmworkers and people experiencing homelessness
- Meeting with different clinics/departments to disseminate program and quarterly information