HEALTH CARE FOR THE HOMELESS/FARMWORKER HEALTH PROGRAM

Co-Applicant Board Strategic Planning Subcommittee Meeting Agenda
Room 101, 455 County Center, Redwood City, 94063
July 24th 2023, 3-5pm

A. CALL TO ORDER AND ROLL CALL	Robert Anderson	3:00pm
B. PUBLIC COMMENT	Robert Anderson	3:05pm

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

B. DISCUSSION	Irene Pasma	3:10pm

1. Strategic Plan Roadmap Overview	3:10pm-3:30pm
2. Needs Assessment Recommendations	3:30pm-4:00pm
BREAK	4:00pm-4:10pm
3. Strategic Plan Stakeholder Meetings Overview	4:10pm-4:30pm
4. Planning for September/October Subcommittee Meeting	4:30pm-4:55pm

C. ADJOURNMENT	4:55pm

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

-

HCH/FH Board Strategic Planning Subcommittee Meeting

July 24, 2023

Room 101, 455 County Center

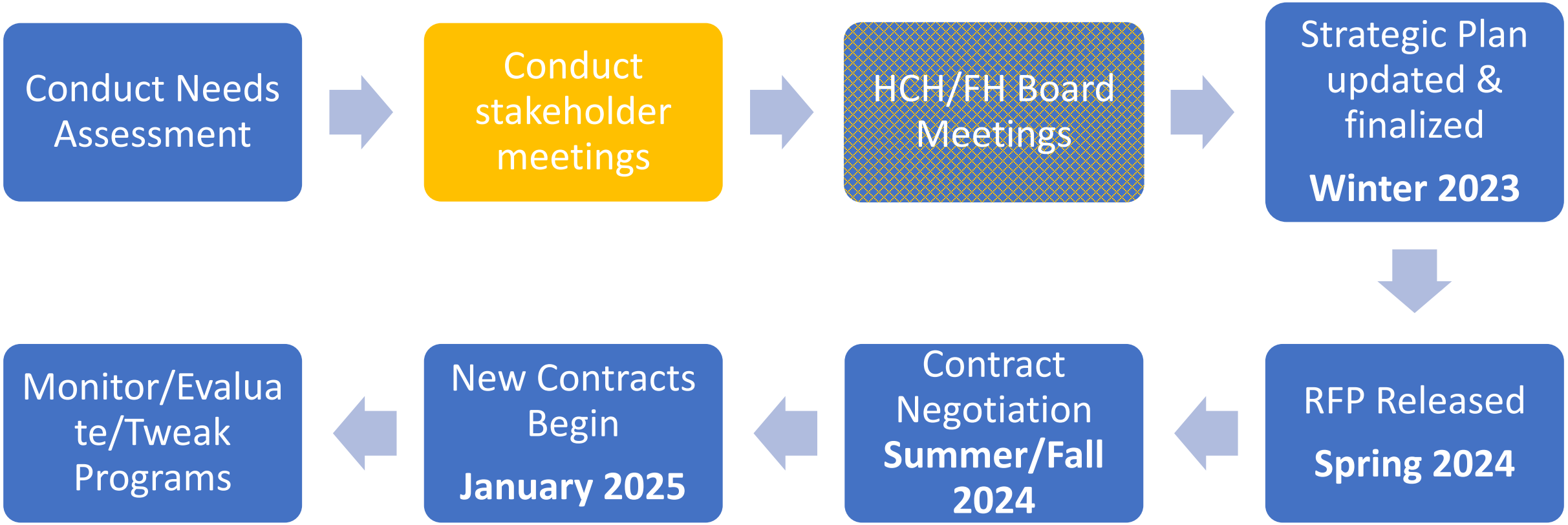
Redwood City, CA

2020-2023 HCH/FH Strategic Plan - link

Agenda

- Review strategic planning timeline
- Needs Assessment Update & Potential Recommendations
- Strategic Plan Stakeholder Conversations
- What we know now
- Next steps

Program Strategic Planning Process



Needs Assessment

Survey Distribution

Care Team

- Summer 2022
- Online survey
- Email invitation
  - Advisors and department managers
  - Medical Staffing Office (licensed independent practitioners)
- Hospital newsletter (SMMC Heartbeat)

Patients

- Winter 2022/2023
- In person: HCH/FH clinics and community partners
- Online: via text to H/FW Patient Master List
- English and Spanish
- Age 18+
- $10 gift card

Approved by SMMC Clinical Standards Committee & Solutions IRB

2022 SMMC Homeless & Farmworker Visit Data

Needs Assessment Locations	# PEH visits	Percentage of Visits Homeless	# Farmworker Visits	Percentage Visits by Farmworkers
39th Ave	5658	27%	620	12%
Street/Field/Mobile	3549	17%	550	11%
Fair Oaks	2399	12%	139	3%
Primary Care SMMC (ICC)	2043	10%	97	2%
Mobile Dental Clinic	1345	7%	24	0%
Daly City Clinic	1138	6%	36	1%
Mental Health Primary Care	933	5%	78	2%
Adolescent Clinics	1322	6%	1	0%
Ron Robinson Senior Care	1045	5%	22	0%
South San Francisco	591	3%	12	0%
Coastside Clinic	583	3%	2999	59%
Sonrisas	N/A	N/A	307	6%
Total	**20,651**		**5,065**	

Potential Needs Assessment Recommendations to SMMC Leadership – Care Team Survey

1. **Supporting Staff:** Comfort providing services among MD/NP/PA providers is something SMMC could further assess to understand how to best support its providers in serving complex patients.
2. **Community Resources & Referrals**: SMMC should include robust community services referral pathways capability into EPIC to support and empower roles across care teams to make community referrals and address patients' numerous social determinants of health needs. In the interim, for HCH/FH to support clinic teams with information whenever possible.
3. **Community Resources & Referrals** It is recommended HCH/FH and SMMC continue supporting care teams with training and knowledge-sharing about existing behavioral health resources available in San Mateo County
4. **Connection to Case Managers**: It is recommended SMMC make it feasible and easy for community (i.e. LifeMoves) and county (i.e. Bridges to Wellness) case managers to access Epic and interface with SMMC's care teams. In the interim, it is recommended HCH/FH work closely with care teams to help them connect with patient's community case managers whenever possible.
5. **Supporting Staff:** It is recommended that SMMC continue its numerous efforts to make front line staff feel appreciated and that HCH/FH continue to partner with SMMC on opportunities to fund wellness initiatives.

Potential Needs Assessment Recommendations to SMMC Leadership – Patient Survey

1. **Social Determinants of Health**: It is recommended HCH/FH and SMMC continue its SDOH and Epic work to ensure addressing SDOH needs is embedded in clinic work flows due to its integral importance in a patient's health outcomes.
2. **Health coverage**: HCH/FH will continue closely monitoring insurance status of both patient populations and working with the Health Coverage Unit and community partners to ensure clients get signed up and remain signed up to insurance.
3. **Patient Education:** HCH/FH and SMMC can consider ways to better understand patient's attitudes and beliefs about preventative care and provide education on its importance. HCH/FH and SMMC should take patient responses into the health classes they're interested in into consideration when thinking about patient-facing education/outreach.
4. **Access to care**: It is recommended HCH/FH continue working with SMMC and County Health in identifying ways to reduce barriers for both populations in accessing oral health care in San Mateo County.
5. **Tele-Health:** It is recommended that HCH/FH and SMMC continue asking patient's ability to connect with care teams in their preferred manner and understanding what the clinic team can do to fill technology gaps where they exist.

Strategic Plan

Stakeholder Meetings **(put check marks for meetings that have occurred)**

Health	County	Community
✓Public Health, Policy & Planning	❑Center on Homelessness	✓Farmworker Affairs Coalition
✓San Mateo Medical Center	✓Dept. of Agriculture	❑Behavioral Health Comm.
✓Behavioral Health & Recovery Services	✓Health Plan of San Mateo	✓Continuum of Care
✓Health Coverage Unit	❑Department of Housing	✓LifeMoves*
❑Aging & Adult	✓LEAG (lived experience)	❑Puente*
✓Admin		❑Abode*
		❑ALAS*
		❑El Centro*

*External Contract

Contracts & MOUs

Service Category	Contract/MOU	Contract/MOU Information	Services
Enabling services (care coordination)	LifeMoves	Enabling services 50% of available funding to support programs	• Medical Care Coordination • Care coordination for newly housed
	Abode		
	ALAS		• On-farm health education • Medical Care Coordination
	Puente		
Primary care services	PHPP Street/Field/ Mobile Clinic	Clinical services represent the other 50% of available funding to support program and do not go out for bid.	• Primary healthcare for H/FW • Alcohol and Other Drugs
Behavioral Health services	Behavioral Health & Recovery Services (BHRS)		• Behavioral Care Coordination (HCH) • In-field support (HEAL) • Substance Use Disorder case management (El Centro)
Dental services	Saturday dental clinic		• Once a month Saturday dental clinic at Coastside clinic • Dental services once a week at La Honda (Puente)
	Sonrisas		

Current Strategic Plan Priorities and Associated Activities

Increase homeless & farmworker patient utilization of SMMC & BHRS Services	• Care coordination contracts (Puente, ALAS, LifeMoves, Abode) • BHRS MOU (HCH) • Saturday dental clinic and Sonrisas MOU/Contract
Decrease barriers for homeless and farmworker patients to access health care	• Bringing services to where people are located: PHPP and BHRS (El Centro and HEAL) MOUs
Support health care providers serving homeless and farmworker patients	• Staff collaboration/partnership with SMMC
Decrease health disparities among people experiencing homelessness & farmworker patients	• Clinical services coordinator work in analyzing data and working with departments to see where modifications can be made
Meet and Exceed all HRSA Compliance Requirements	• UDS, SAC, Needs Assessment, Strategic Planning etc.

2020-2023 Metrics	Lesson Learned
By EOY 2023, increase percent of people experiencing homelessness receiving mental health & AOD services by 40% from 2019 baseline.	• Metric can be set using HRSA-provided baselines • Need to reassess goal for farmworkers, might be too rigorous given current state
By EOY 2023, increase percent of farmworkers receiving mental health & AOD services by 20% from 2019 baseline	
By EOY 2023, 50% of clients receiving care coordination will have at least one brick and mortar health care visit within a 12-month period at SMMC or BHRS	• Patients connected to SM/Mobile Clinic should count toward the goal • Need to revisit if 50% is the right target
By EOY 2023, decrease the number of un-insured homeless and farmworker patients seen by HCH/FH to 5% and 10% respectively	• Rigorous Goal • Medicaid expansion impact? • Include temporal element
Following a site visit, have no more than 5 immediate enforcement actions, 2 or fewer conditions enter the 90-day phase of Progressive Action and 0 conditions enter the 30-day phase of Progressive Action	• This is an appropriate goal and will be kept for the next cycle
Program will have no more than 5% of funds remaining at the end of the current grant cycle	• This goal is likely reachable but not in the last cycle due to variety of reasons

Current State Thinking

- Better understanding and potentially funding additional farmworker behavioral health needs
- Importance of continuing to support care coordination once people are housed
- Work with HPSM to maximize HCHFH funding given ECM and Community Supports are reimbursable via Medi-Cal
- Add Navigation Center Coordination and Evaluation activities, support CES and medical bed planning
- Add Integr8 (EPIC) related activities
- Maximize FQHC benefits (loan forgiveness, FQHC sites)
- Continue supporting SMMC departments/clinics (SDOH, connection to community referrals)
- Finding ways, potentially via funding an agency, to incorporate Patient/Consumer Input

Next Steps

Now-October: complete stakeholder meetings, update activities list, and research metric-setting

August: Report out to Board on progress

September: Strategic Planning Subcommittee Meeting with invited stakeholders and members of the public

Oct: Share with Board findings and final recommendations

November: Approval Strategic Plan at Board Meeting

Appendix

Additionally:

What is working well

1. SMMC staff feel appreciated by patients
2. SMMC's efforts around interpreter services and food security are evident in care team's comfort in using interpreter services and referring patients to food security and can be used as a model for future initiatives
3. Patients feeling welcome and heard by clinic teams
4. Patients receiving information in a way that works for them [health literacy work SMMC undertook]

Future Surveys Topics

1. **Care Teams Attitudes and Beliefs**: Due to large difference in comfort levels between MD/NP/PA and the rest of the care team, develop a survey to better understand MD/NP/PA belief and attitudes about PEH and Farmworker Patients. It would be particularly important to ensure large participation from Coastside Clinic, given 60% of all SMMC farmworker patient visits occur at that clinic.
2. **Patient's access to behavioral health care:** Future surveys will be needed to better understand SMMC patients' experience in getting connected to behavioral health services.
3. **Tele-Health:** Additional questions around tele-health, i.e. asking more about cell data vs. wifi/internet and people's perceptions about what types of visits could be used for telehealth

Main Take Aways from Providers

- Majority of providers feel comfortable providing services to their farmworker and PEH patients. Regarding communication, they also feel comfortable accessing interpreter services when needed. Big gap for MD/NP/Pas.
- Most providers are aware that referrals pathways exist for benefits and insurance and food resources (e.g., CalFresh). Fewer providers are aware of referral pathways for employment assistance, financial assistance, or legal assistance [see related data in survey overlap section, below].
- While the majority of providers reported that they know how to communicate with other departments at SMMC to coordinate patient care, less than 50% reported knowing how to find out who a patient's community case manager is.
- Although less than half, many providers reported needing more information on how to refer patients to a various behavioral health services (e.g., ACCESS Call Center, Integrated Behavioral Health, detox facilities).
- More than half of providers reported that they have the skills to de-escalate a tense situation with a patient, and more than half of providers also reported their department would benefit from more de-escalation training.
- More than 75% of providers reported feeling valued by their patients for the work that they do.

Main take aways from Patients

- Access to resources addressing Social Determinants of Health seem to dictate better self-assessment of health
- Access to oral health remains the largest barrier among types of services
- Even though ~90% of respondents have health insurance, 50% indicated they had to go without a necessity (food, rent, clothes) due to cost of health
- Communication and visit preferences: most prefer communication via phone and visits in-person. Tele-health remains a complex issue to tackle for these two populations.