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

Co-Applicant Board Meeting Agenda

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

May 11th, 2023, 10:00am - 12:00pm

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

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

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

C. ACTION TO SET THE AGENDA & CONSENT AGENDA	Robert Anderson	10:05am
1. Approve meeting minutes from April 13, 2023, Board Meeting		Tab 1
2. Contracts and MOUs update		Tab 2
3. Budget and Finance Report		Tab 3
4. Quality Improvement/Quality Assurance update		Tab 4
5. HCH/FH Director's Report		Tab 5

D. COMMUNITY ANNOUNCEMENTS / GUEST SPEAKER		
Communications and Announcements are brief items from members of the Board regarding upcoming events in the community and correspondence that they have received. They are informational in nature and no action will be taken on these items at this meeting. A total of five minutes is allotted to this item. If there are additional communications and announcements, the Chairperson may choose to defer them to a second agenda item added at the end of the Board Meeting.		
1. Community updates	Board members	10:10am
2. Best Practices for Engaging the Chronically Homeless	Susan Manheimer, Chief Police (Retired)	10:15am

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) 573-2640 in order to make reasonable arrangements to ensure accessibility to this meeting and the materials related to it. The HCH/FH Co-Applicant Board meeting documents are posted at least 72 hours prior to the meeting and are accessible online at: http://www.smchealth.org/smmc-hfhfh-board

3. A Collaborative Approach to Assessing Homeless Mortality in San Mateo County	Karen Pfister, Office of Epidemiology and Evaluation Public Health, Policy, and Planning	10:45am

E. BUSINESS AGENDA			
1. Request for the board to approve a letter supporting AB 920	Suzanne Moore	11:10am	Tab 6
2. Request for the board to approve a letter opposing SB 31	Suzanne Moore	11:15am	Tab 6

F. REPORTING & DISCUSSION AGENDA			
1. UDS-2022 Annual Federal Report Review	Gozel Kulieva	11:20 am	
2. Min-West Farmworker Health conference debrief	Alejandra Alvarado	11:40 am	
3. National Conference for Agricultural Worker Health debrief	Silvia Campos & Amanda Hing Hernandez	11:50 am	

G. ADJOURNMENT	12:00pm
Future meeting: **June 8th, 2023, 10am-12pm at Half Moon Bay Library** **Address: 620 Correas St, Half Moon Bay, CA 94019**	

*Instructions for Public Comment During Meeting

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

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

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) 573-2640 in order to make reasonable arrangements to ensure accessibility to this meeting and the materials related to it. The HCH/FH Co-Applicant Board meeting documents are posted at least 72 hours prior to the meeting and are accessible online at: http://www.smchealth.org/smmc-hfhfh-board

TAB 1

Meeting Minutes

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

HEALTH CARE FOR THE HOMELESS/FARMWORKER HEALTH PROGRAM (HCH/FH)
Co-Applicant Board Meeting Minutes

April 13th, 2023 10 am – 12 pm

Co-Applicant Board Members Present	County Staff Present	Members of the Public	Absent Board Members/Staff
Robert Anderson, Chair Victoria Sanchez De Alba, Vice Chair Gabe Garcia Brian Greenberg Janet Schmidt Judith Guerrero Steve Carey Steve Kraft Suzanne Moore Tayischa Deldridge Jim Beaumont, HCH/FH Program Director (Ex-Officio)	Alejandra Alvarado Amanda Hing Hernandez Frank Trinh Gozel Kulieva Irene Pasma Lauren Carroll Meron Asfaw		Francine Serafin Dickson Tony Serrano

A. Call to order & roll call	Robert Anderson called the meeting to order at 10:03 am and did a roll call.	
B. Public comment	None	
C. Action to set the agenda and consent agenda	1. Approve meeting minutes from February 9, 2023, Board Meeting 2. Contracts and MOUs update 3. Budget and Finance Report. 4. Quality Improvement/Quality Assurance update	**Request to approve the Consent Agenda was** MOVED by Susanne Moore and SECONDED by Steve Kraft. APPROVED by all Board members present.

D. Community announcements / Guest speaker	**Susanne Moore** Suzanne brought to the Board's attention a pending California legislations that impacts the homeless population. **AB 920** would add housing status as a measure of homelessness to the list of protected categories under California's anti-discrimination statute in order to prevent against the routine discrimination of people who are unhoused. **SB 31** prohibits a person from sitting, lying, sleeping, or storing, using, maintaining, or placing personal property upon any street, sidewalk, or other public right-of-way within 1000 feet of a (defined) sensitive area; also provides that a violation of the prohibition may be charged as a misdemeanor or an infraction, at the discretion of the prosecutor; imposes criminal penalties for a violation of these provisions. Susanne addressed the counsel and the Board if they would like to write letters of support. County attorney counseled that in order for the letter to come from the Co-Applicant Board, the Board will have to approve it. Susanne offered to write a draft letter. Staff and Board will revisit the topic during May meeting. **Robert Anderson** Provided an update on farmworker housing. Robert discussed attending a presentation in San Francisco on how climate change affects farmworkers. **Victoria Sanchez De Alba** Updated the Board on the upcoming summit hosted by the Farmworkers Committee of San Mateo County. The event will take place on Saturday May 20th 1-3 pm at the Boys and Girls Club in Half Moon Bay, at the Coast side event center, and all members of the public are invited. The summit will expand on the May 2022 meeting and address issues related to: Access to clean water, Housing, and Health. Victoria mentioned about the ABC channel 7 news on farmworkers. Staff will share the link for ABC channel 7 news on behind the scenes of arms in San Mateo county **Brian Greenberg**	**The board will review the draft letter in next meeting in May.**

	Provided an update on the Navigation Center, and the ribbon cutting ceremony. Brian offered to do a tour for the board on a separate date. **Judith Guerrero** Coastside Hope is hosting an open house on April 21, 3 pm-4 pm. Judith invited everyone to attend the open house and meet staff and board. Staff will share the flyer for Coastside Hope's open house with the Board. **Janet Schmidt** Janet recommended an insightful article on poverty in American. Staff will share the link to the article with the Board via email.	
E. Business Agenda 1. **Request to approve board members to attend the 2023 National Healthcare for the Homeless conference in Baltimore, MD**	**Jim Beaumont** Requested Board approval, per Board policy, to send two Board members to the upcoming National Healthcare for the Homeless Council conference in Baltimore. A few county and out of county partners who will also attend different conferences for Homeless and Farmworker. **Gabe Garcia** Gabe mentioned an article during the UoP Dental School discussion. Staff will share the article with the board.	**MOVED** by Susanne Moore, **SECONDED** by Gabe Garcia, **APPROVED** by all members.
2. **Request for the Board to approve our contracting with University of Pacific for Dental Services at the Navigation Center**	**Jim Beaumont** Requested to approve development of a contract with University of Pacific for dental services at the Navigation Center. The funding from these services will come from the following sources: Health Plan of San Mateo committed $125, 000 in startup funds Sequoia Hospital district made a financial commitment Kaiser Permanente – HCHFH is currently pursuing funding	**MOVED** by Steve Kraft, **SECONDED** by Janet Schmidt, **APPROVED** by all members.

	There is a potential that the HCHFH program will use some grant money for the dental services.	
F. Reporting and Discussion Agenda **1. 2023 Western Forum for Migrant and Community Conference Overview**	**Tayischa Deldridge** Tayischa attended the 2023 Western Forum for Migrant Community Conference and shared her experience. She shared about the Social Determinants of Health for Farmworkers. She shared what she learned from the different sessions she attended in the conference.	
2. Strategic Plan: Review 2022 Progress Against Targets and Plan for Next Cycle	**Jim Beaumont** He gave an overview of the goal of the strategic plan and informed the board that the aim of planning for the next cycle is to tweak the strategic plan so the program can bridge the gap. He also provided an overview of what HCH/FH staff can work on and how HCH/FH can spend its grant money. **Meron Asfaw** She provided a presentation on the current contracts and MOUs of HCH/FH, highlighting the various services they provide to both the homeless and farmworker populations.. **Irene Pasma** She gave an overview of the strategic planning process and guided the board through the target priorities 1, 2, and 3. She explained the discussion topics for the three breakout sessions, which focused on increasing homeless and farmworker patient utilization of SMMC & BHRS services (SP1), decreasing barriers for homeless and farmworker patients to access healthcare (SP2), and supporting healthcare providers serving homeless and farmworker patients (SP3). During the breakout sessions, the group discussed the following questions: 1. Is there an activity missing that you would have expected to be listed or realized should be added to address your group's strategic priority? 2. Do you have comments about progress against the goals?	

	3. Can you think of a stakeholder or agency we should consult with for this strategic priority? For any ideas related to strategic planning, board members were encouraged to email staff at ipasma@smcgov.org.	
G. Adjournment	Meeting was adjourned by Robert Anderson at 12:01pm. Future meeting: May 12th, 2023, 10am-12pm 455 County Center, Redwood City, CA 94063 (Room 101)	

Social Determinants of Health in the National Agricultural Workers Survey

Andrew Padovani, JBS International
Kimberly Prado, JBS International
Western Stream Forum
February 2023

Disclaimer: The views are solely those of the presenters

Outline

Provide an overview of Recent changes in farmworkers':

- living and working conditions
- earnings
- health care access
- assistance programs use

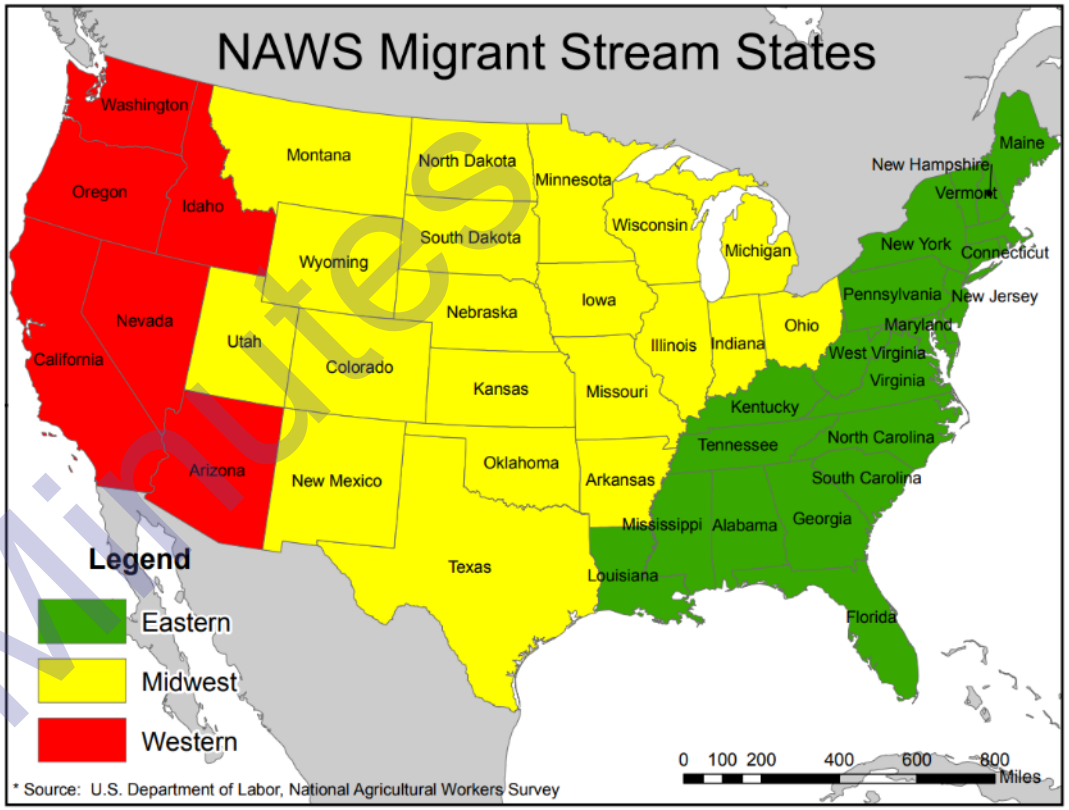
The National Agricultural Workers Survey (NAWS)

What is in the NAWS?

- National survey of crop workers
  - Began in Federal Fiscal Year 1989
- Random sample of 1,500–3,000 workers every year
- Interview workers at US farms
- Reliable source of information on crop worker demographics, employment, and health
- Limited regional coverage
  - state-level data (California)

NAWS Migrant Stream Regions

- Note that Western Stream crop workers are an increasing share of all crop workers, they went from 55% in fiscal years 2015-2016 to 62% in fiscal years 2019-2020.



Who is in the NAWS Sample?

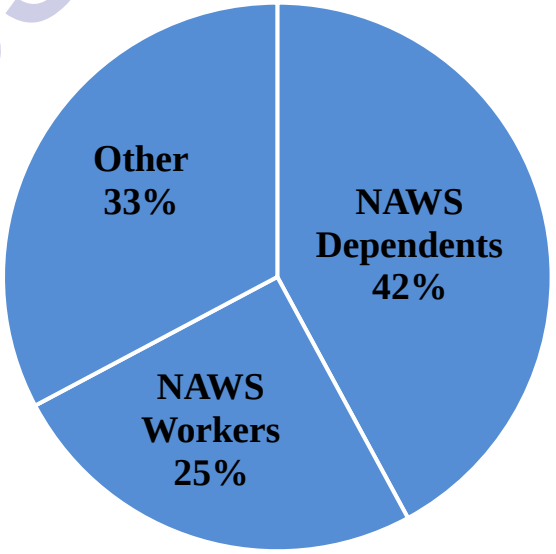
Includes:

- Workers 14 years of age and older
- Currently employed
- US Farms
- Performing eligible crop tasks
- Family members of the above groups

Does not include:

- H-2A workers
- Livestock workers
- Workers no longer in the crop labor force

Percent of 330(g)[1] Migratory and Seasonal Agricultural Worker Population NAWS 2018–2020



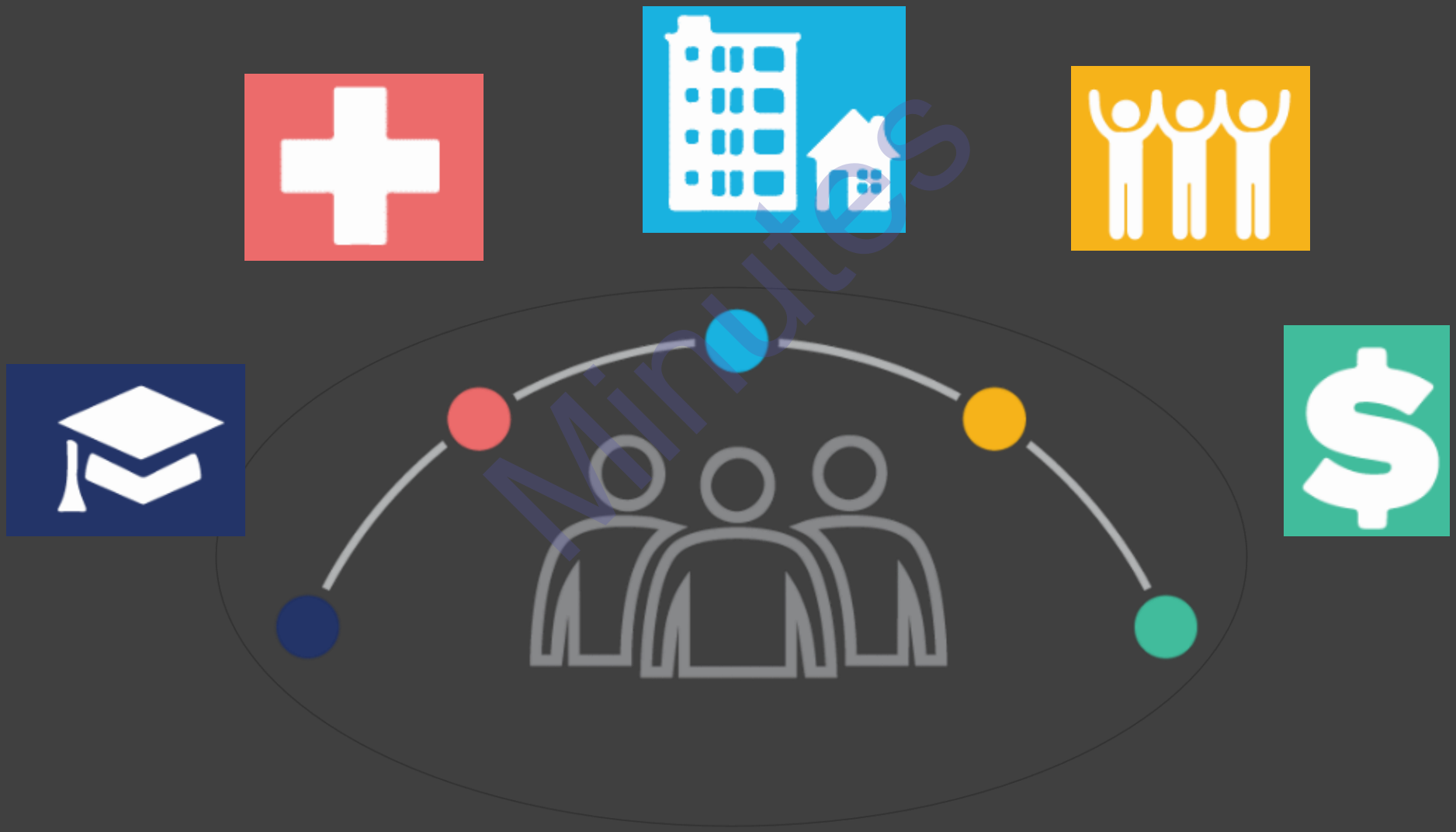
Calculations based on LSC and DOL/ETA population estimates

[1]Definition of population of Migratory and Seasonal Agricultural Worker as described in Section 330(g) of the Public Health Service Act from HRSA. Can be accessed at https://bphc.hrsa.gov/programrequirements/compliancemanual/glossary.html

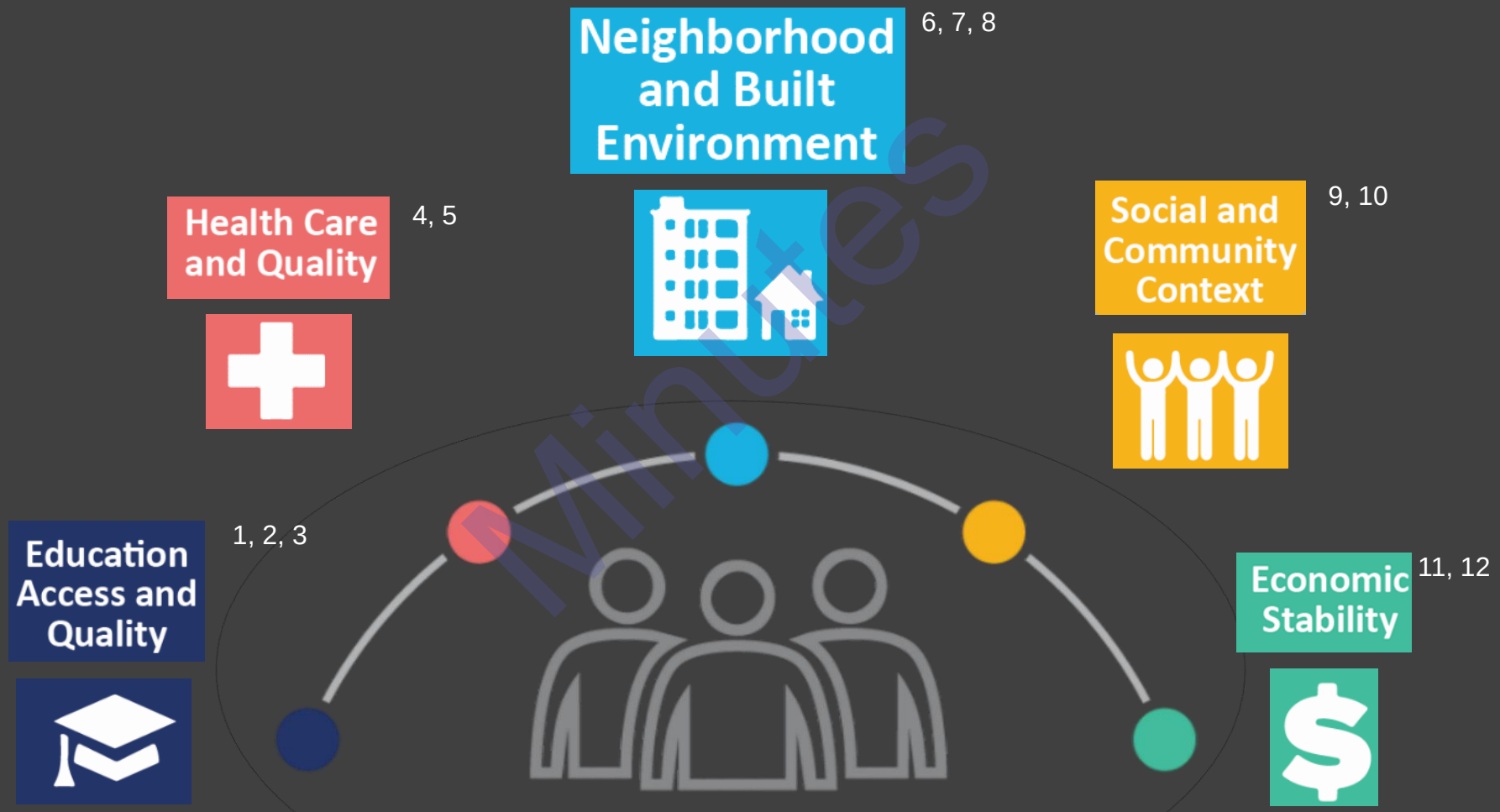
What data does NAWS collect?

- Demographics of Worker and household members
- Wages, benefits, and other income
- Work history – last 12 months
- Experience and job tenure
- Use of social service programs
- Legal status
- Health care access and utilization, lifetime health history
- Supplemental questions to meet other (non-DOL) information needs
  - Example: Migrant and Seasonal Head Start

Social Determinants of Health (SDOH)



Social Determinants of Health (SDOH)



Farmworker SDOH

Educational attainment among farmworkers is low (many attaining 8th grade or less) [13]

- Impacts health and safety [14-15] and children's educational disparities. [16, 17]

Farmworkers' health care access is impacted by ethnicity, citizenship, labor, and housing. [18]

- Less preventive medicine screening and insurance [19] despite ailments [13]
- Barriers to health care [20]
- Adverse health outcomes [21-25]

Farmworker housing can impact health. [27]

- Social capital, community, environment, healthy behaviors [26]

Social context in working conditions and living conditions influence health by employment, housing, ethnicity, and citizenship.

- Duties, privileges, stress, and exposures differ among workers and members of the community [18, 28-32]

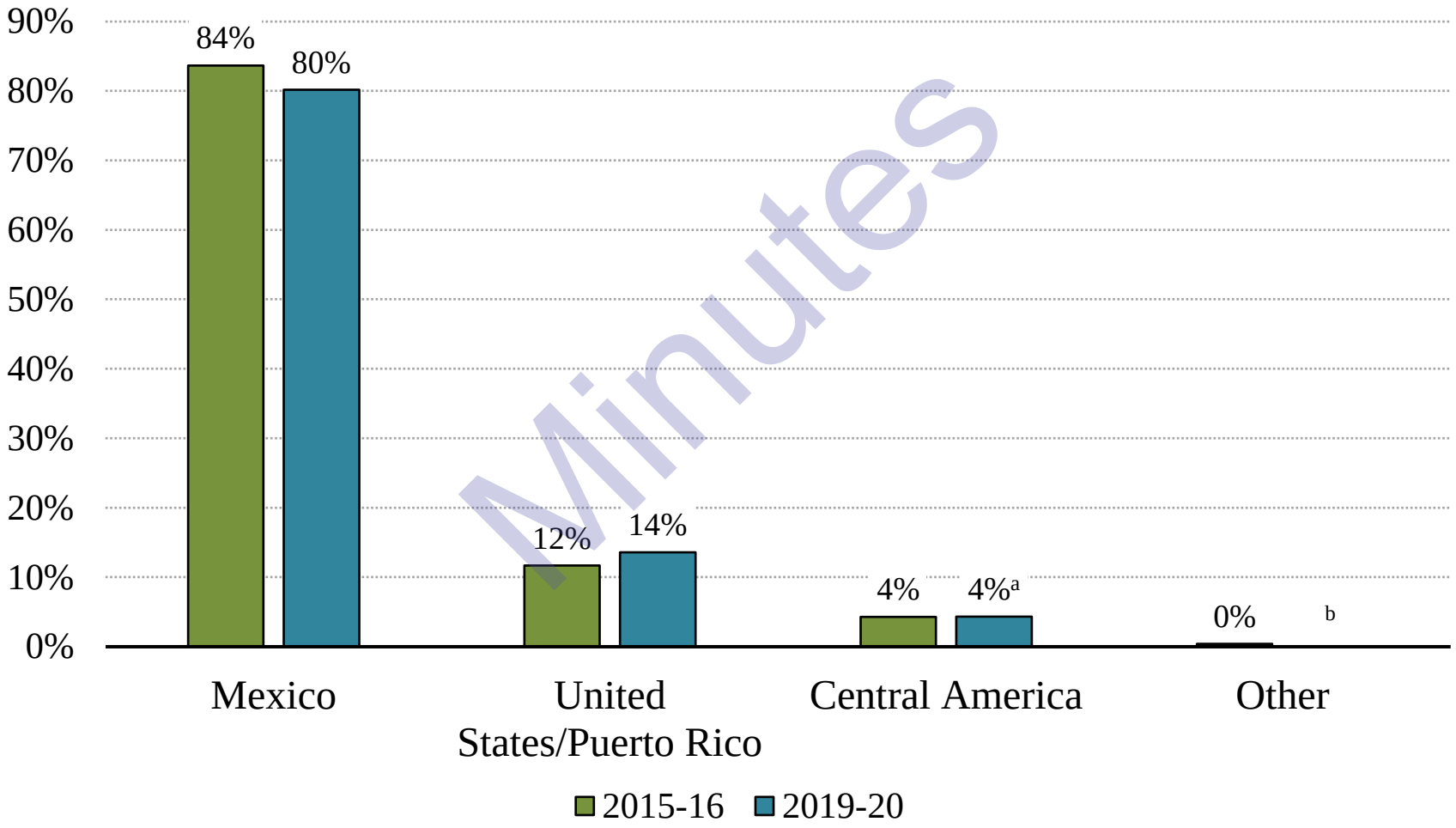
Many farmworker total family incomes fall near, at, or below poverty level. [18]

- Leads to food insecurity [33] and economic stability [34-36]

Farmworker Demographics

Farmworker Place of Birth

In the Western stream, 4 in 5 farmworkers were born in Mexico.

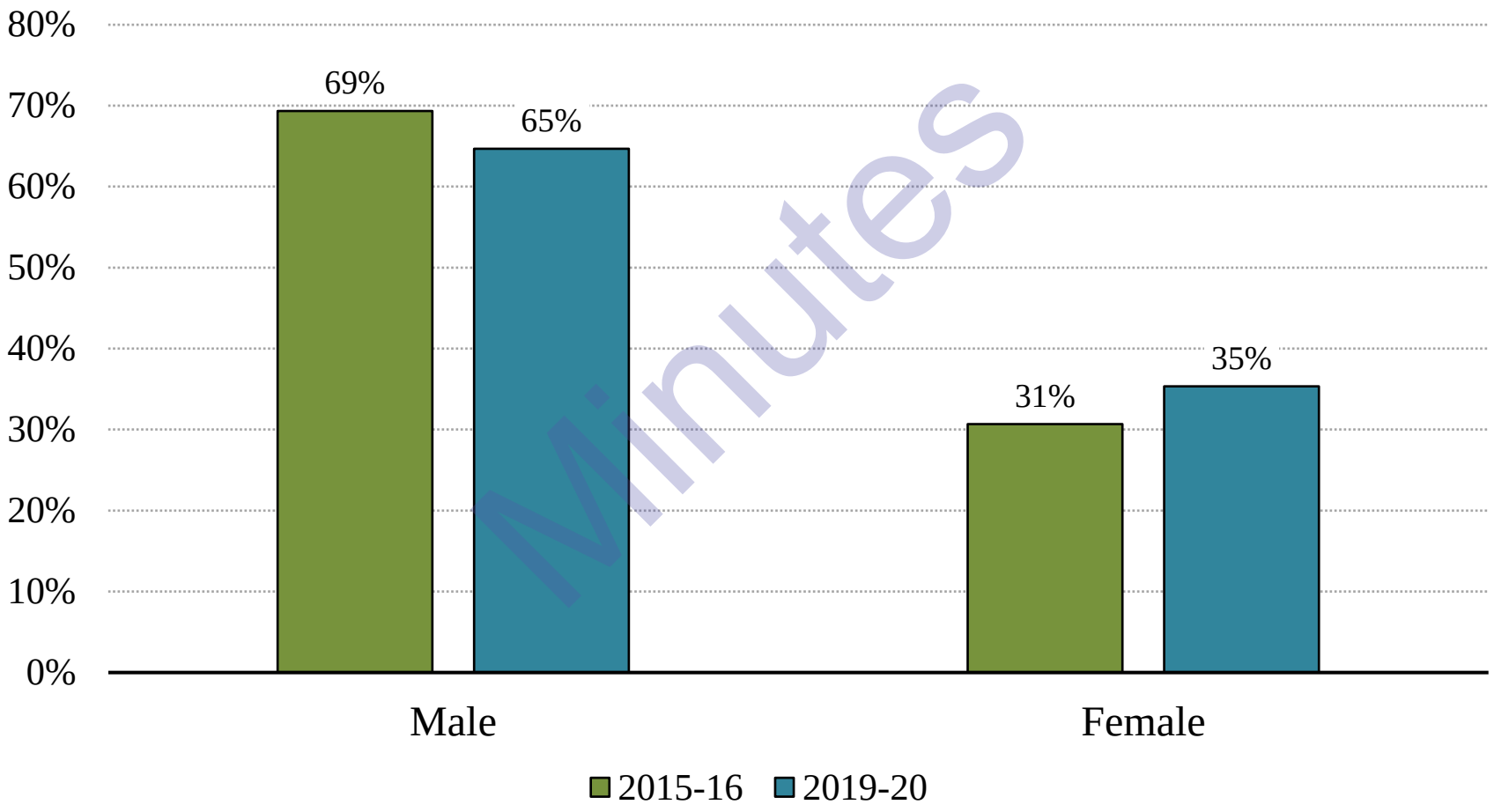


[a] Estimates have relative standard errors between 31% and 50% and should be interpreted with caution.

[b] Estimates are suppressed because number of responses is less than 4 or relative standard errors for the estimates are greater than 50%.

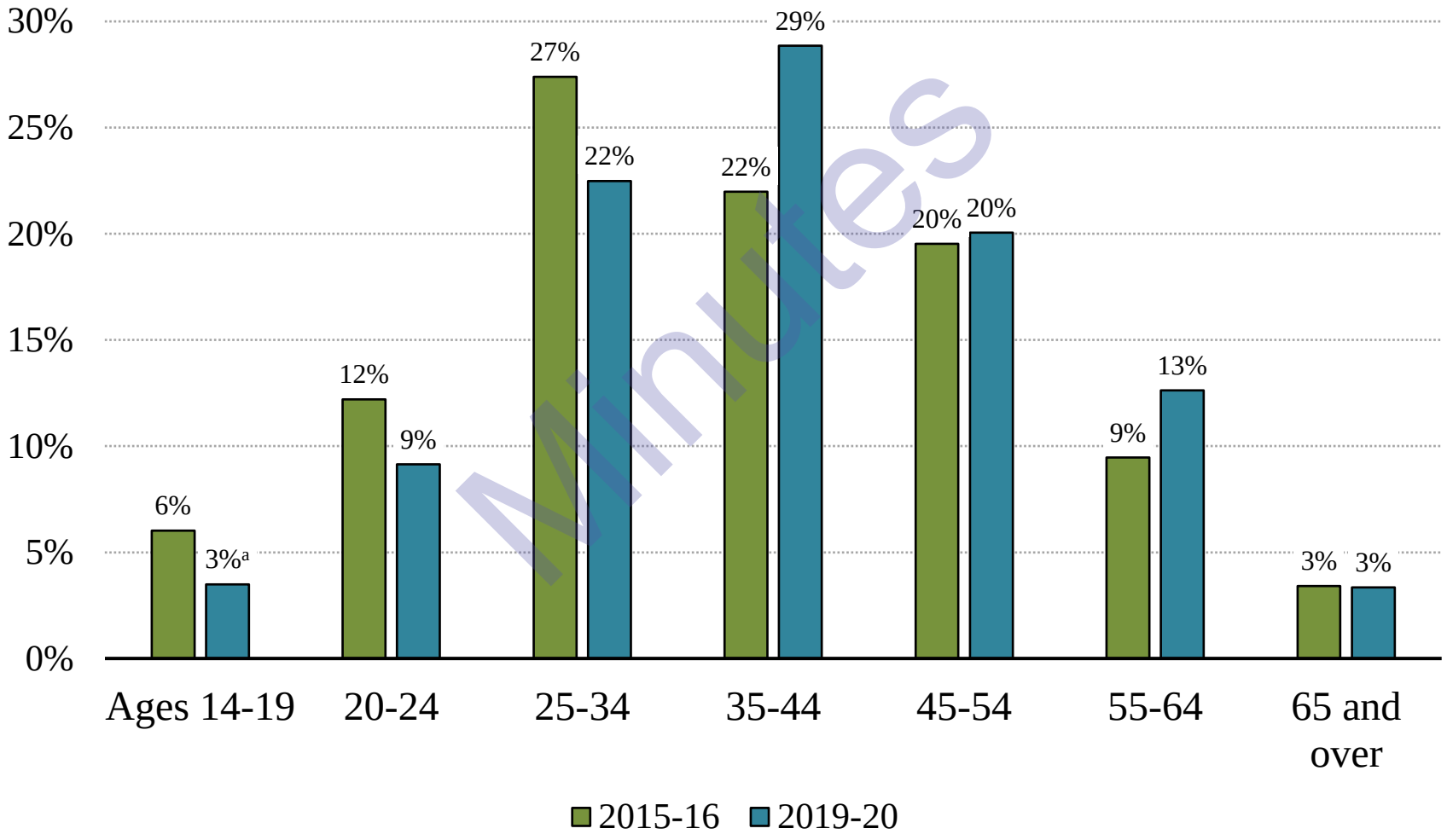
Most Farmworkers Are Male

In the Western stream, two-thirds of farmworkers are men.



Distribution of Farmworker Age

Western stream farmworkers are aging, with about 7-in-10 over age 35.



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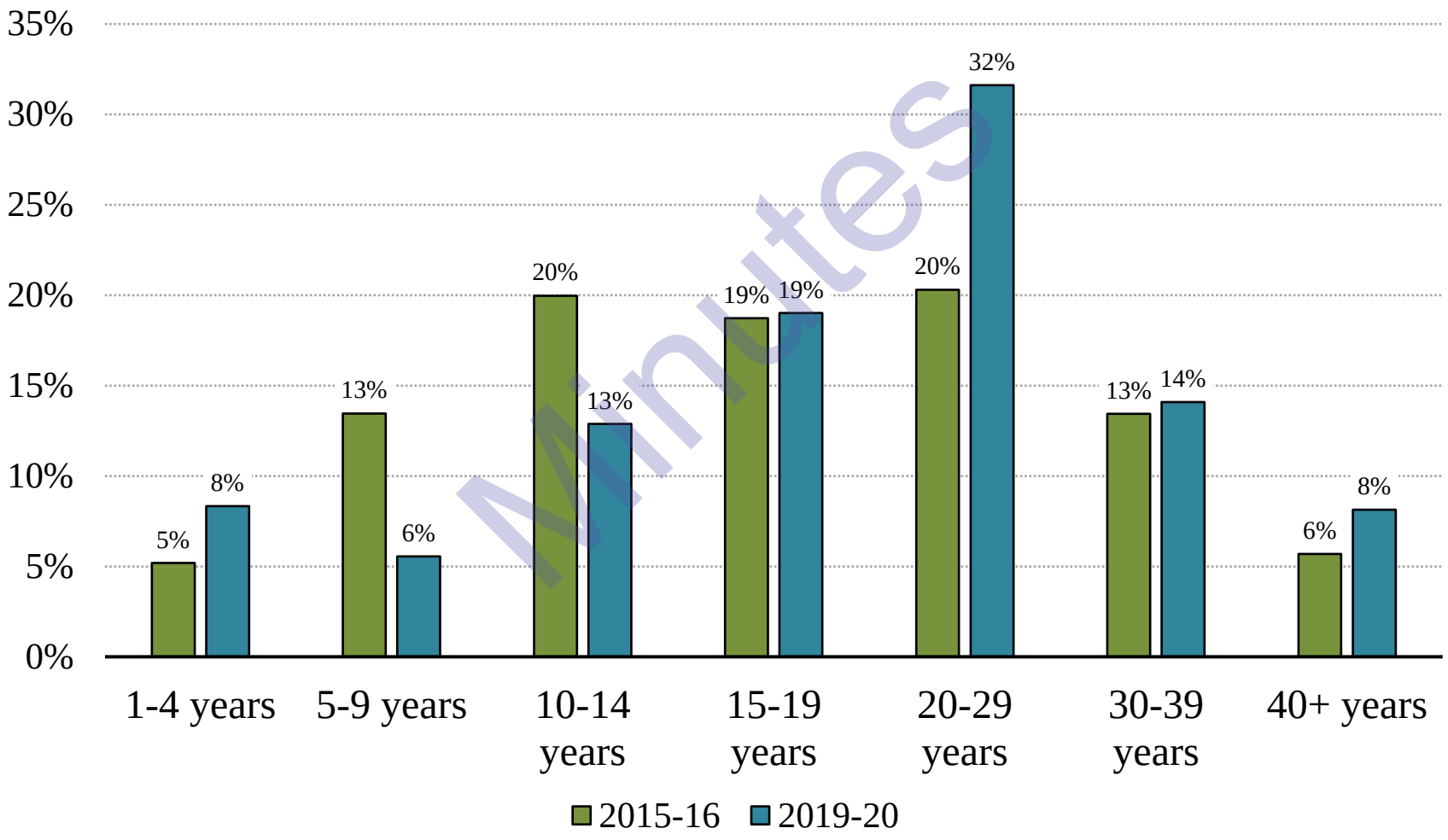
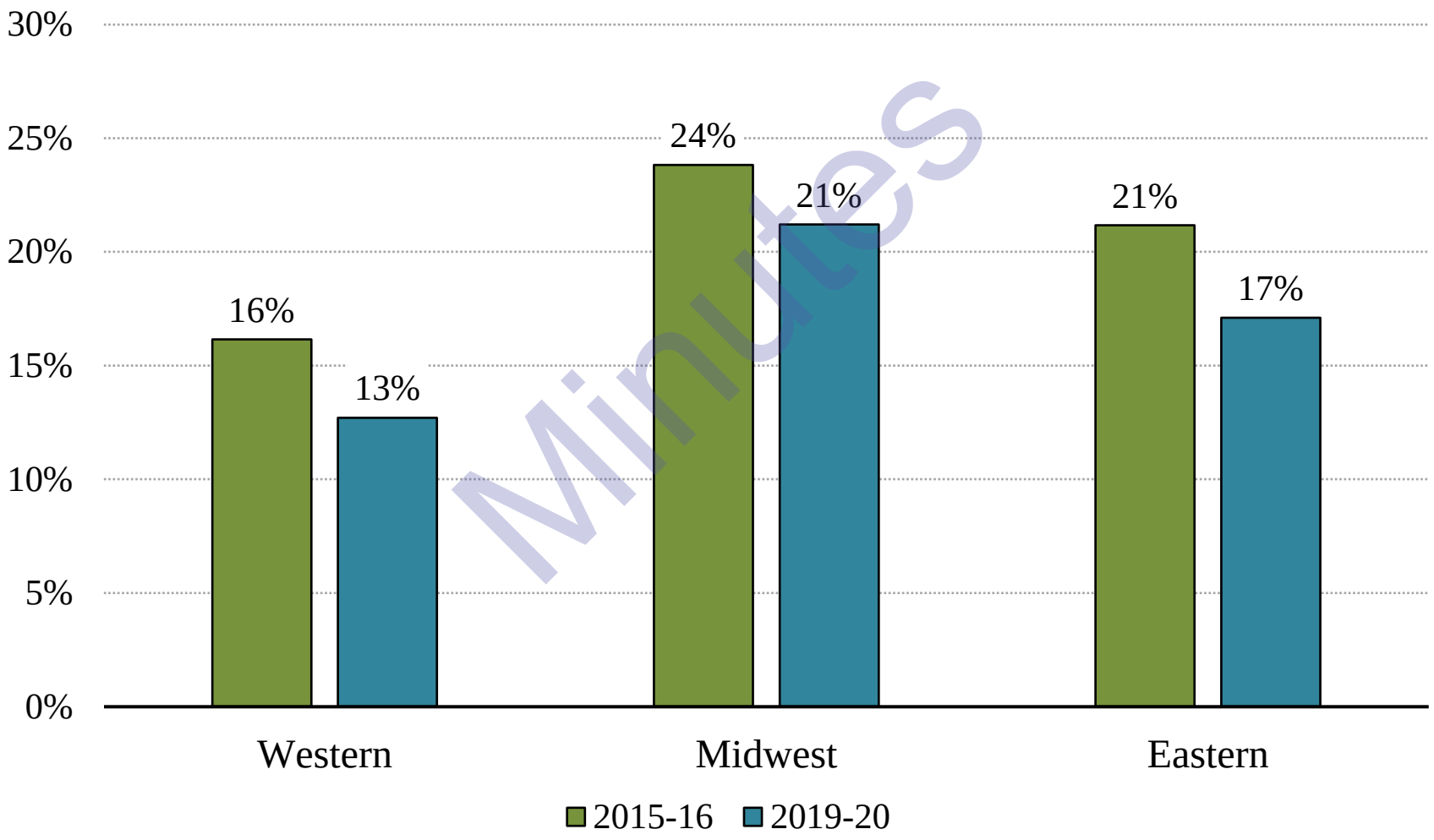
Years Since First Arrival in the U.S.

About half of farmworkers in the Western stream have been in the U.S. over 20 years.



Migrant Farmworker Share by Stream

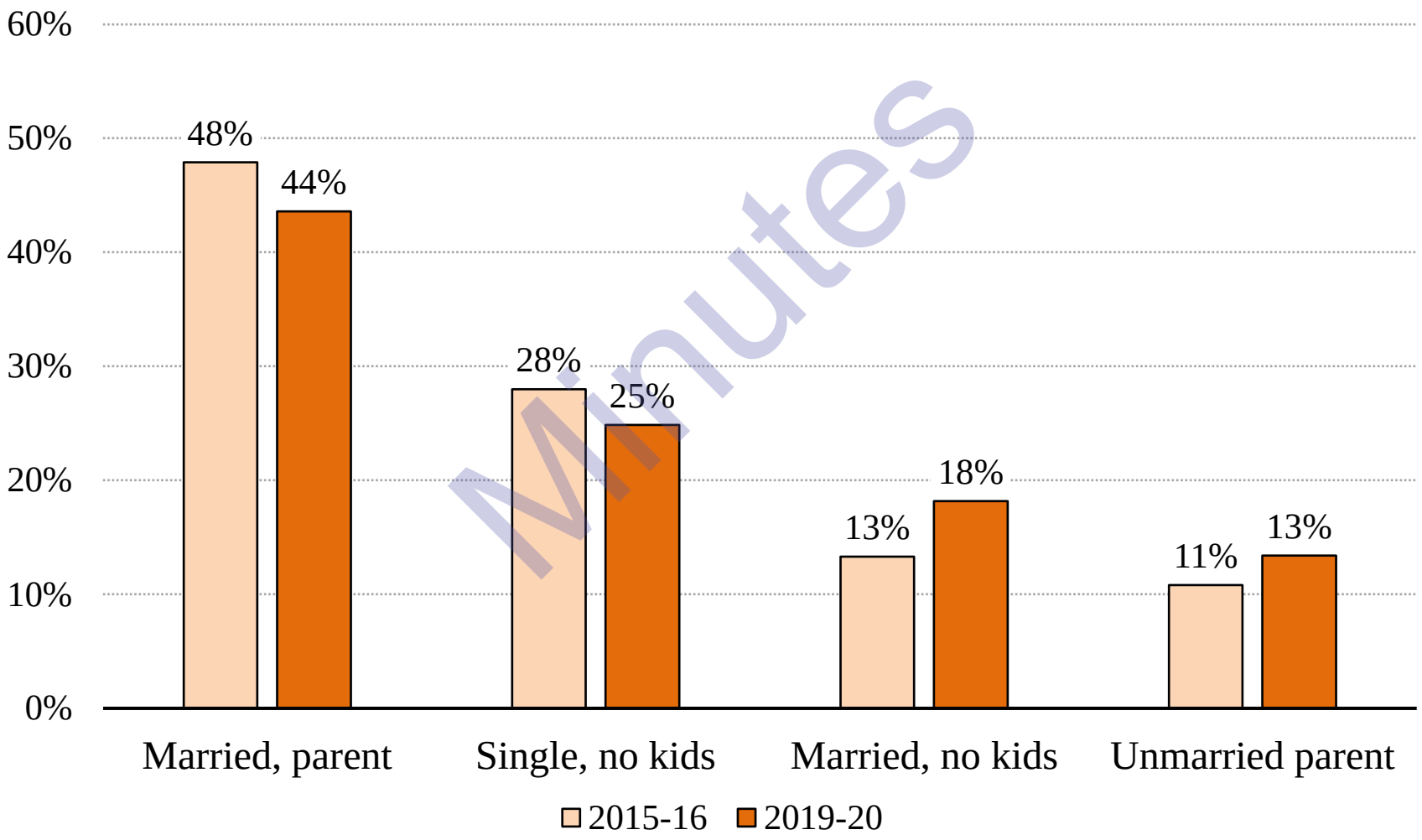
One-in-Seven farmworkers are migrants in the Western Stream, fewer than the national average.



Farmworker Family and Households

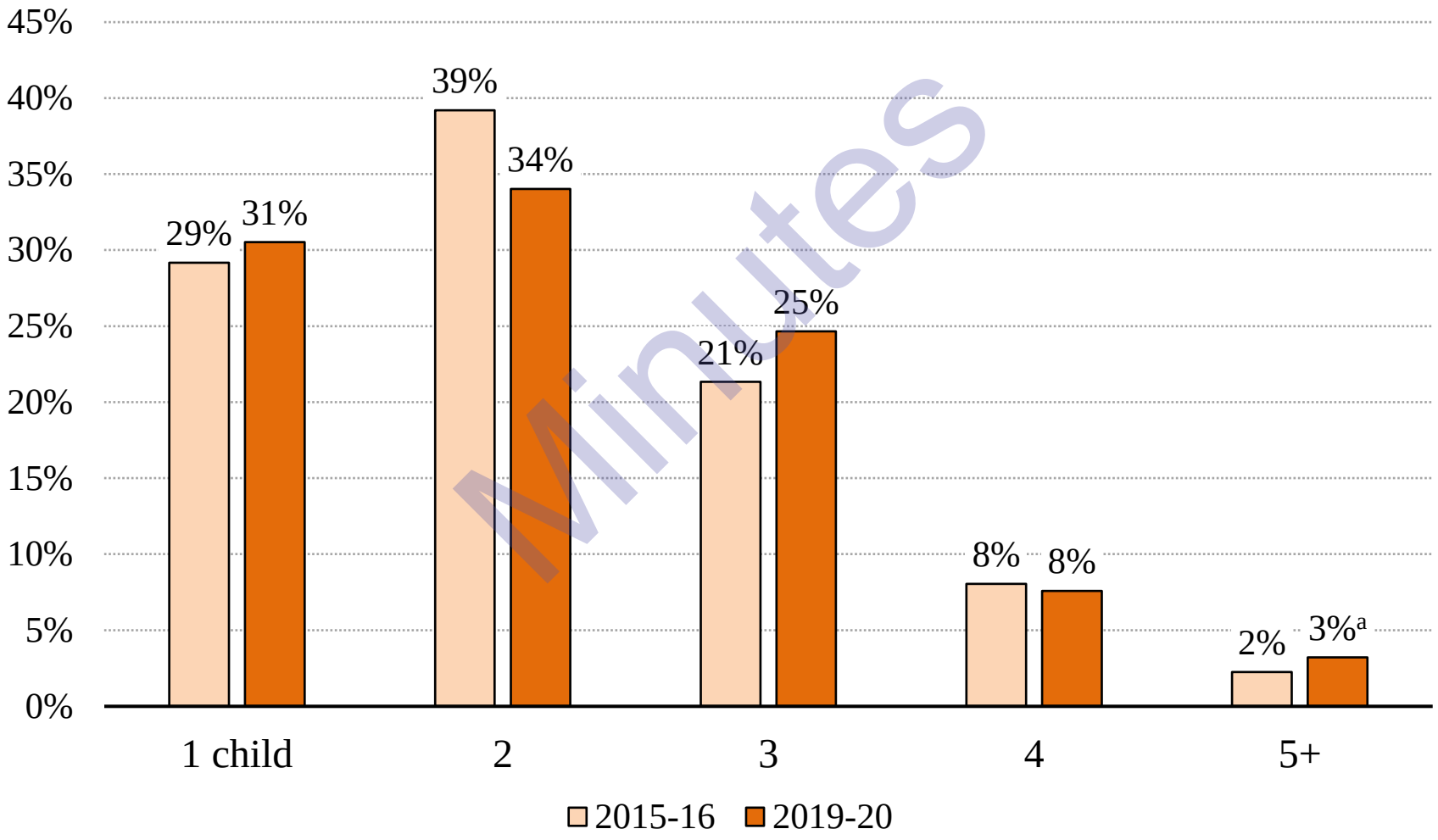
Marital and Parental Status

About half of farmworkers in the Western stream are married or a parent.



Number of Minors Living at Home

About two-thirds of Farmworkers in the Western stream have one or two kids at home.



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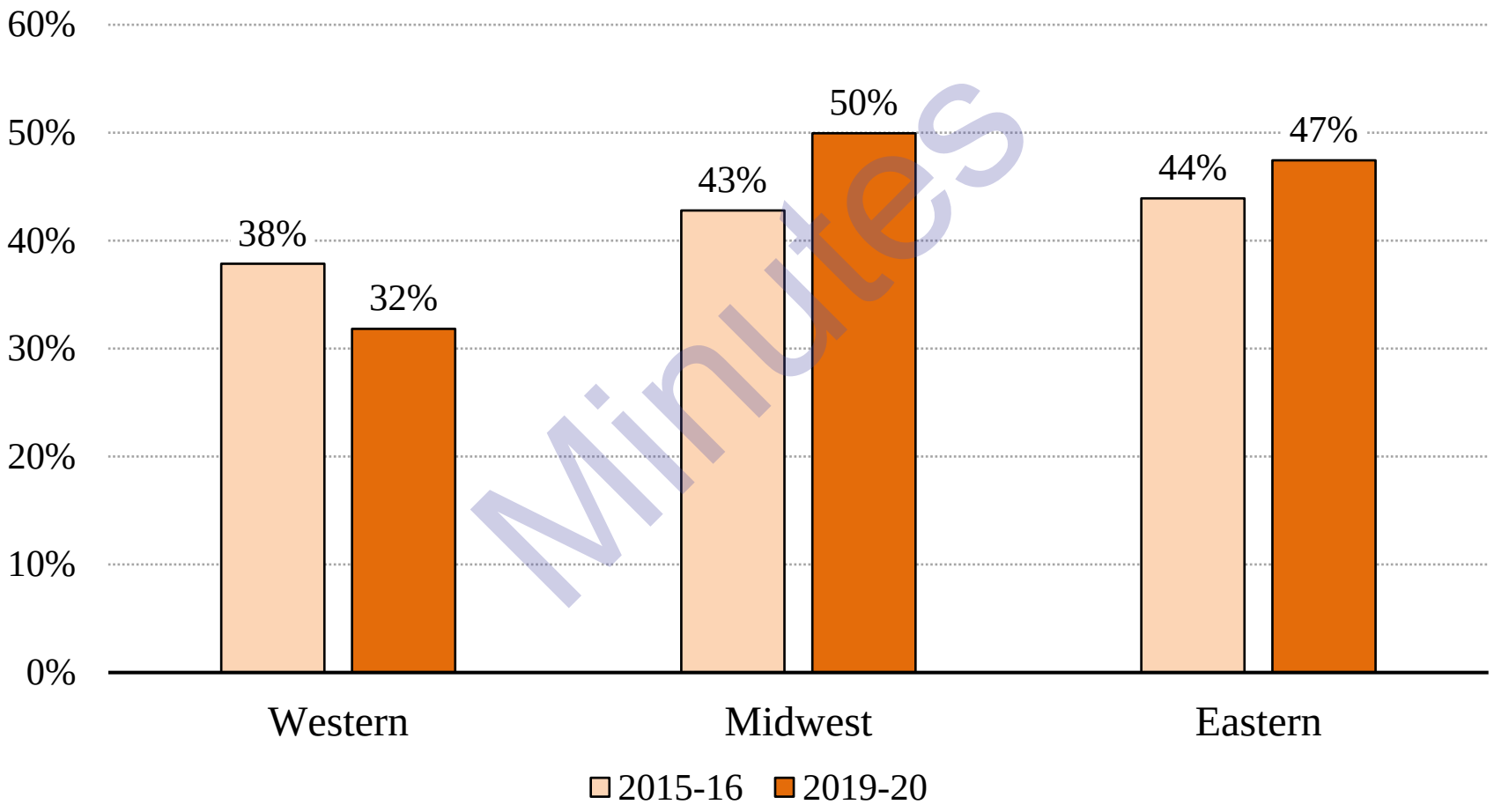
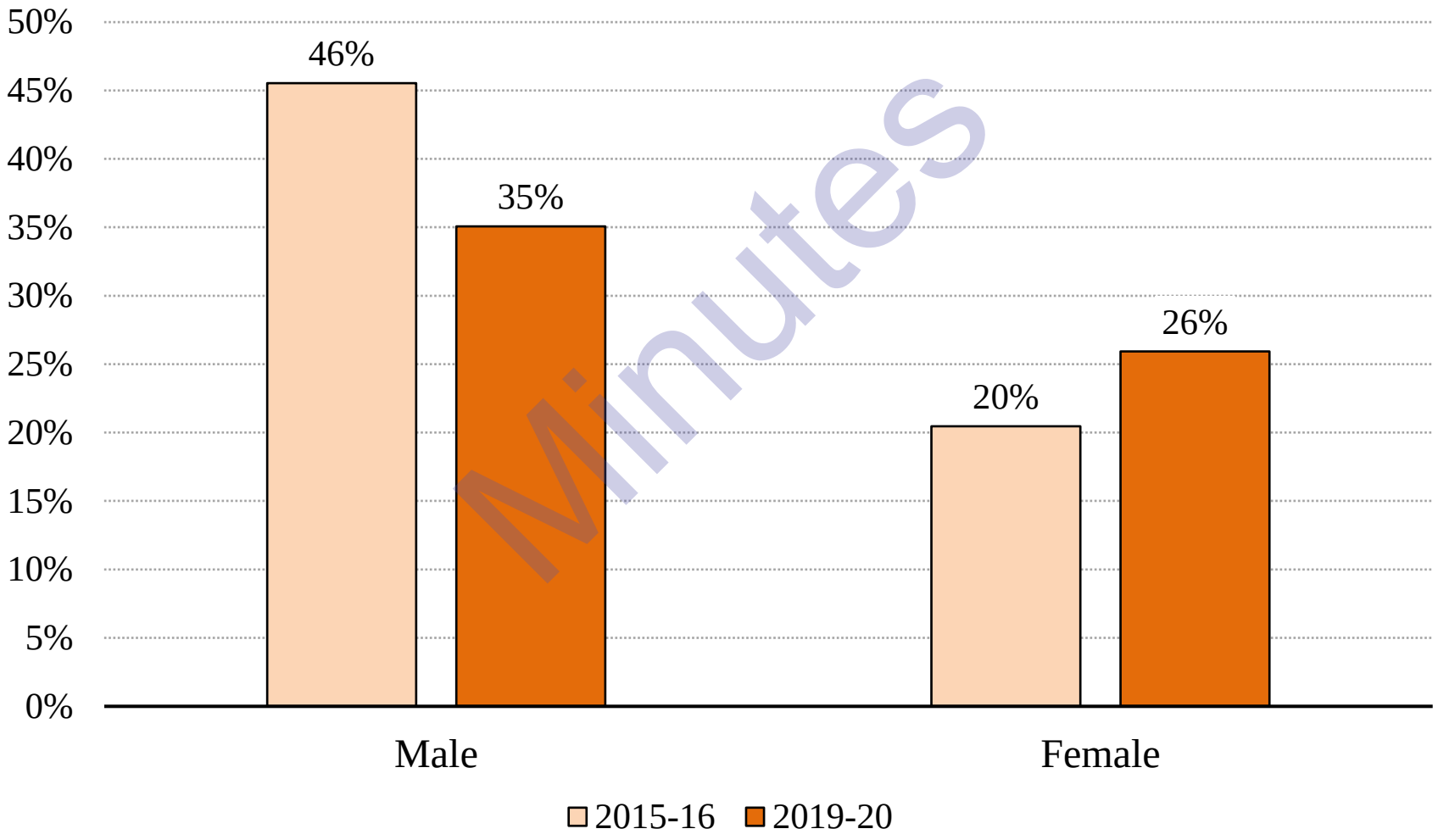
Farmworkers Unaccompanied by Their Family

One-in-three Western stream Farmworkers are unaccompanied by their families.



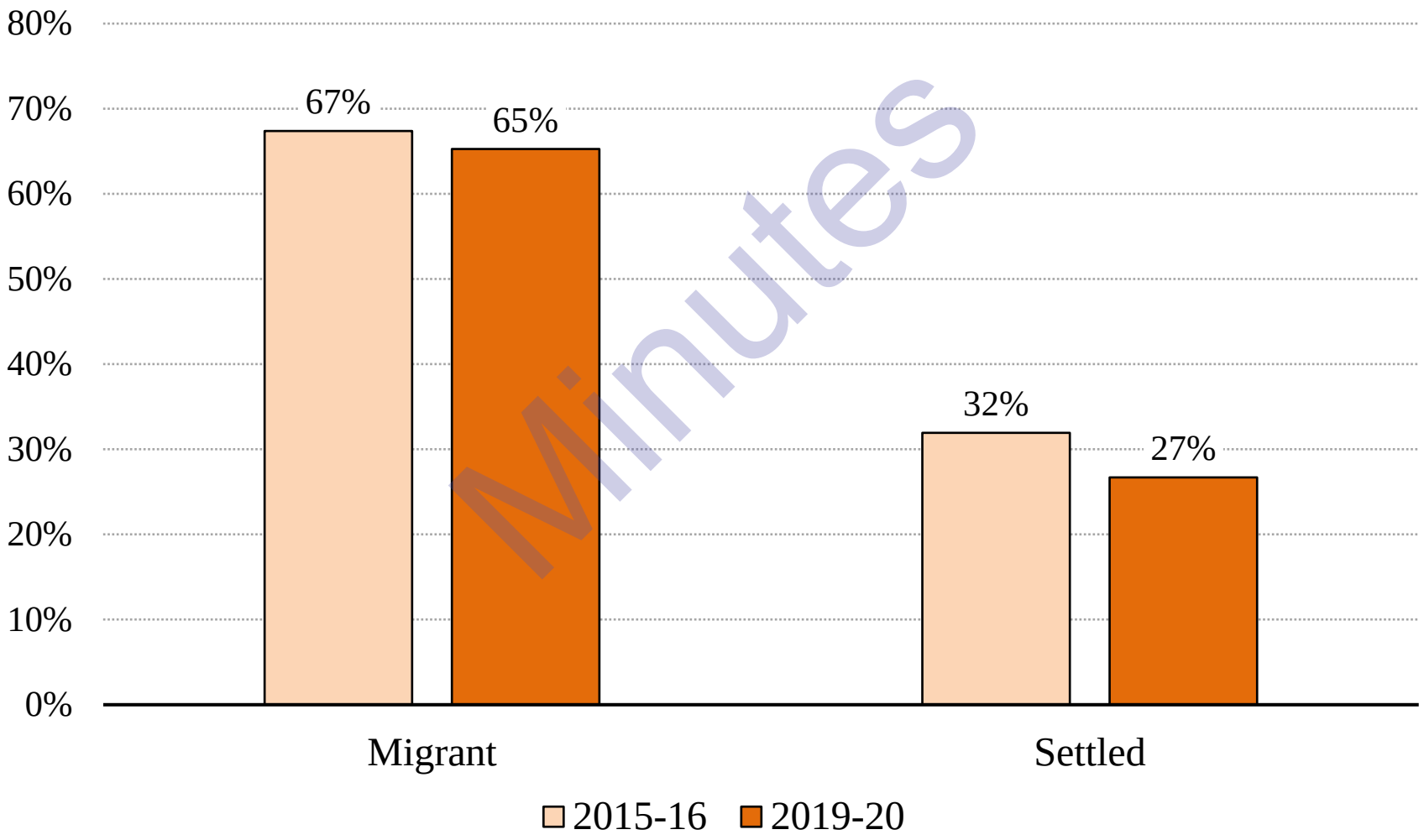
Unaccompanied by Gender

Male farmworkers are unaccompanied more often than women.



Unaccompanied by Migrant status

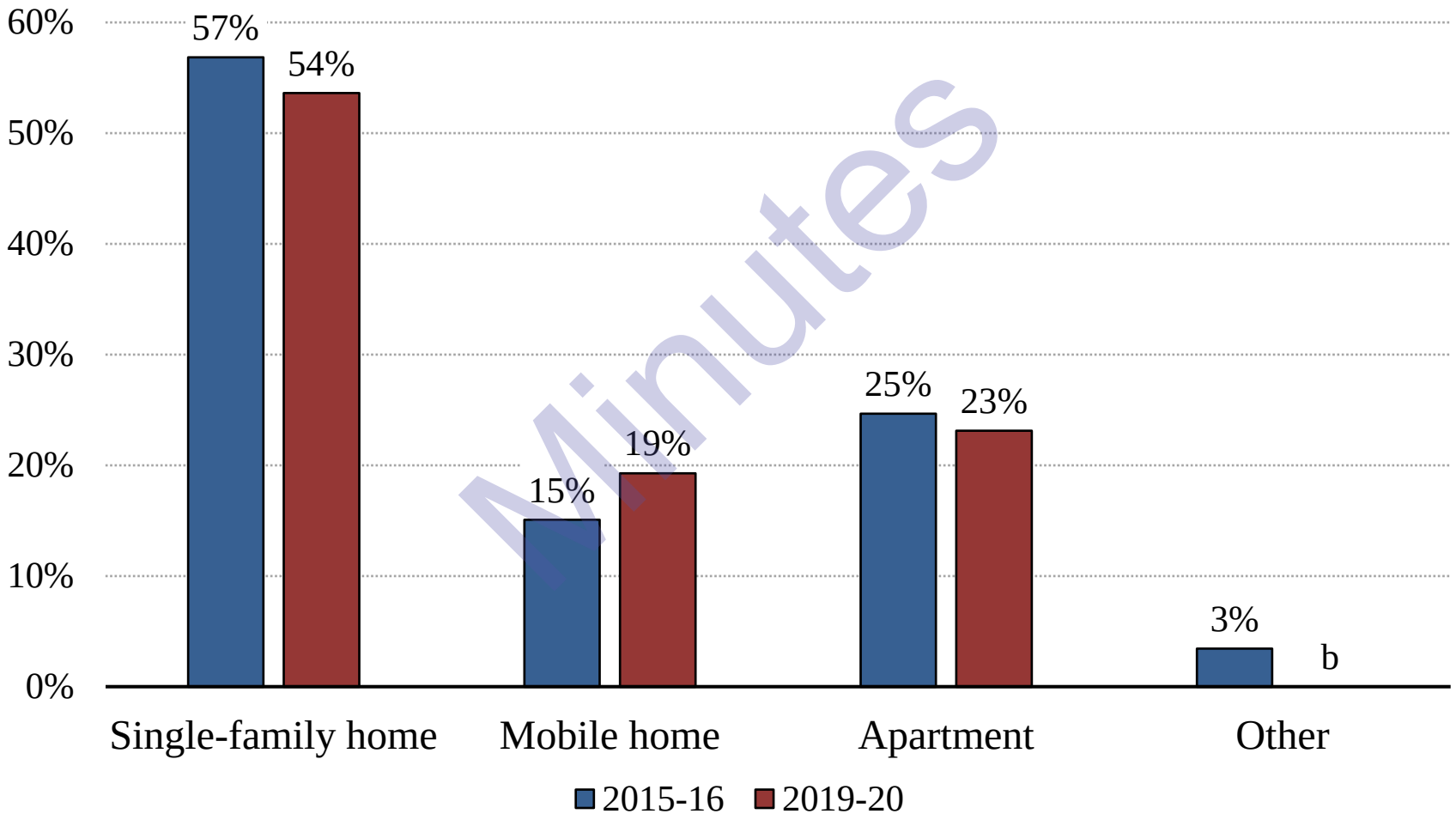
Migrants are unaccompanied by family significantly more often.



Housing and Transportation

Types of Housing used by Farmworkers

Western stream farmworkers most often live in Single-family homes.



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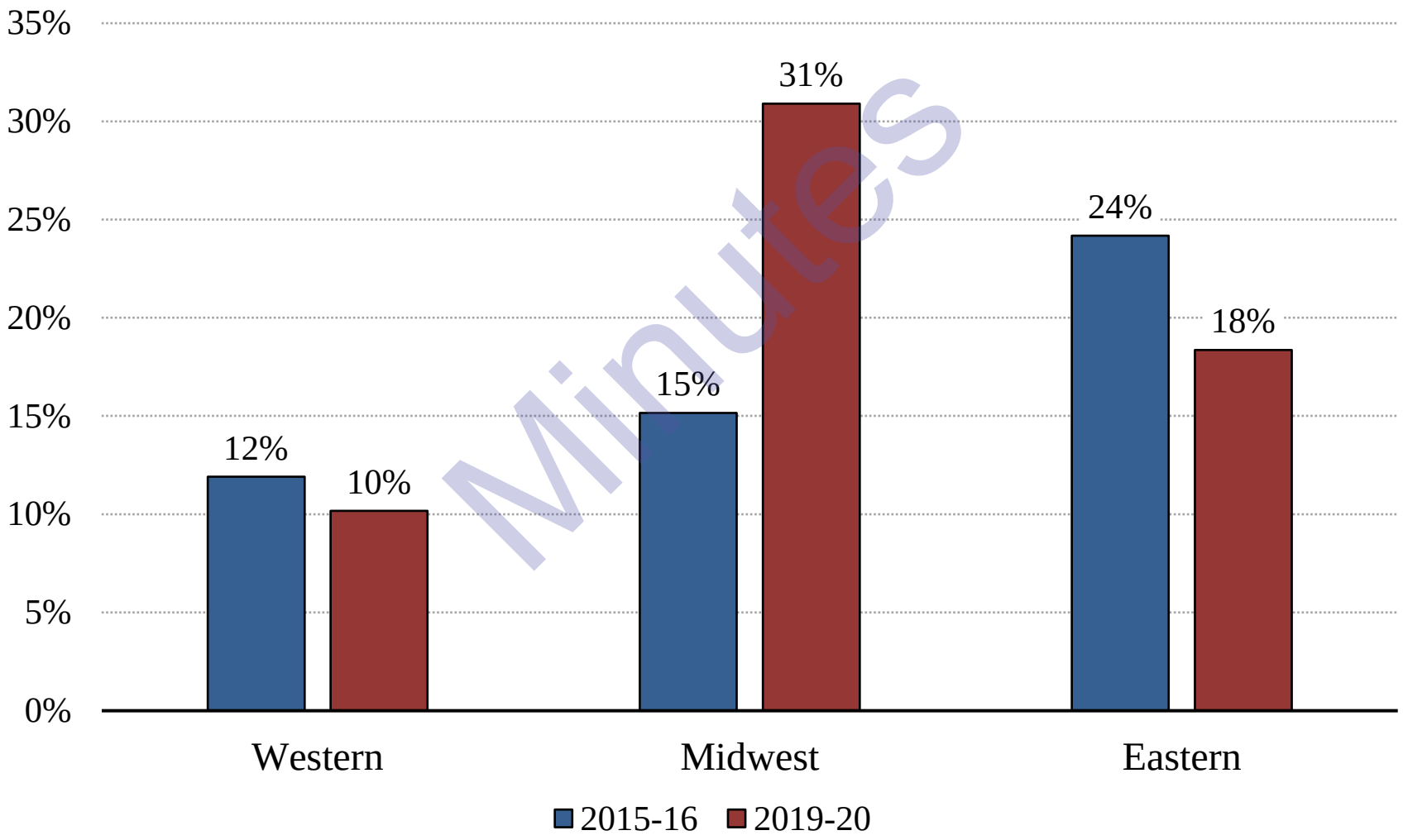
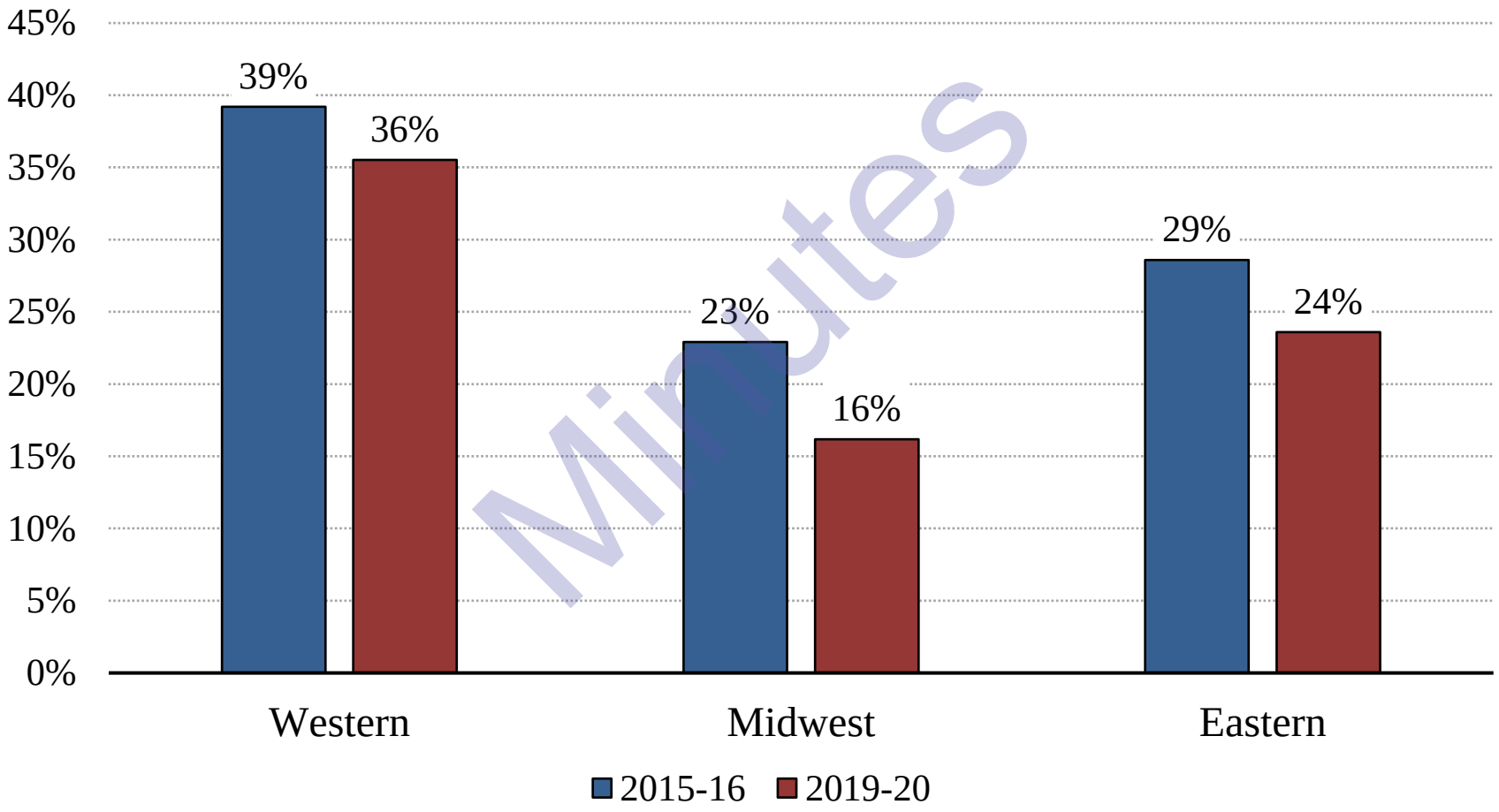
On- and Off-farm Employer-provided Housing

Western stream Farmworkers are much less likely to live in employer-provided housing.



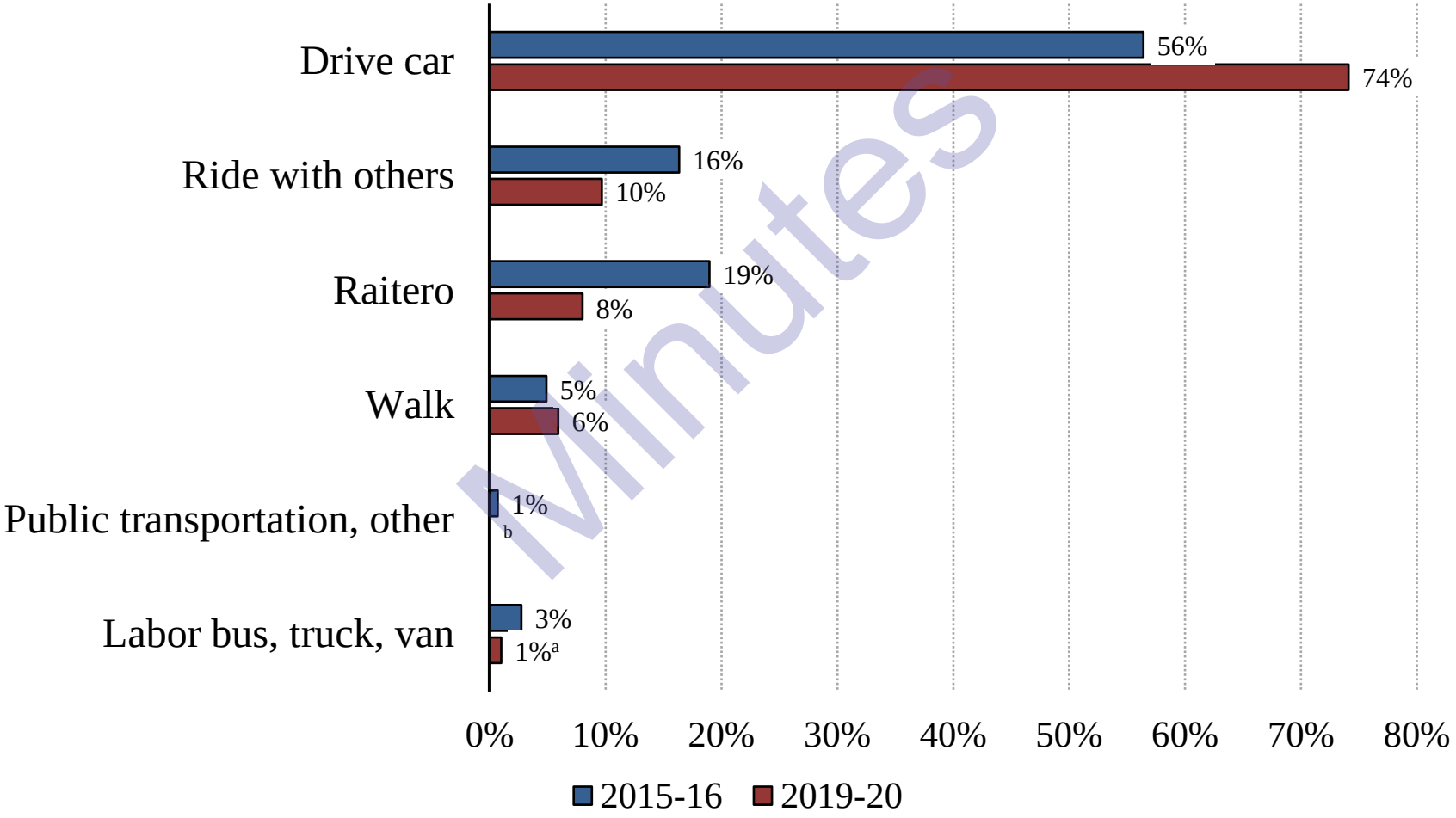
Share of farmworkers in Crowded Housing

Two-fifths of Farmworkers in the Western stream live in crowded housing.



Modes of Transportation to Work

Most Farmworkers in the Western stream drive a car or truck to work.



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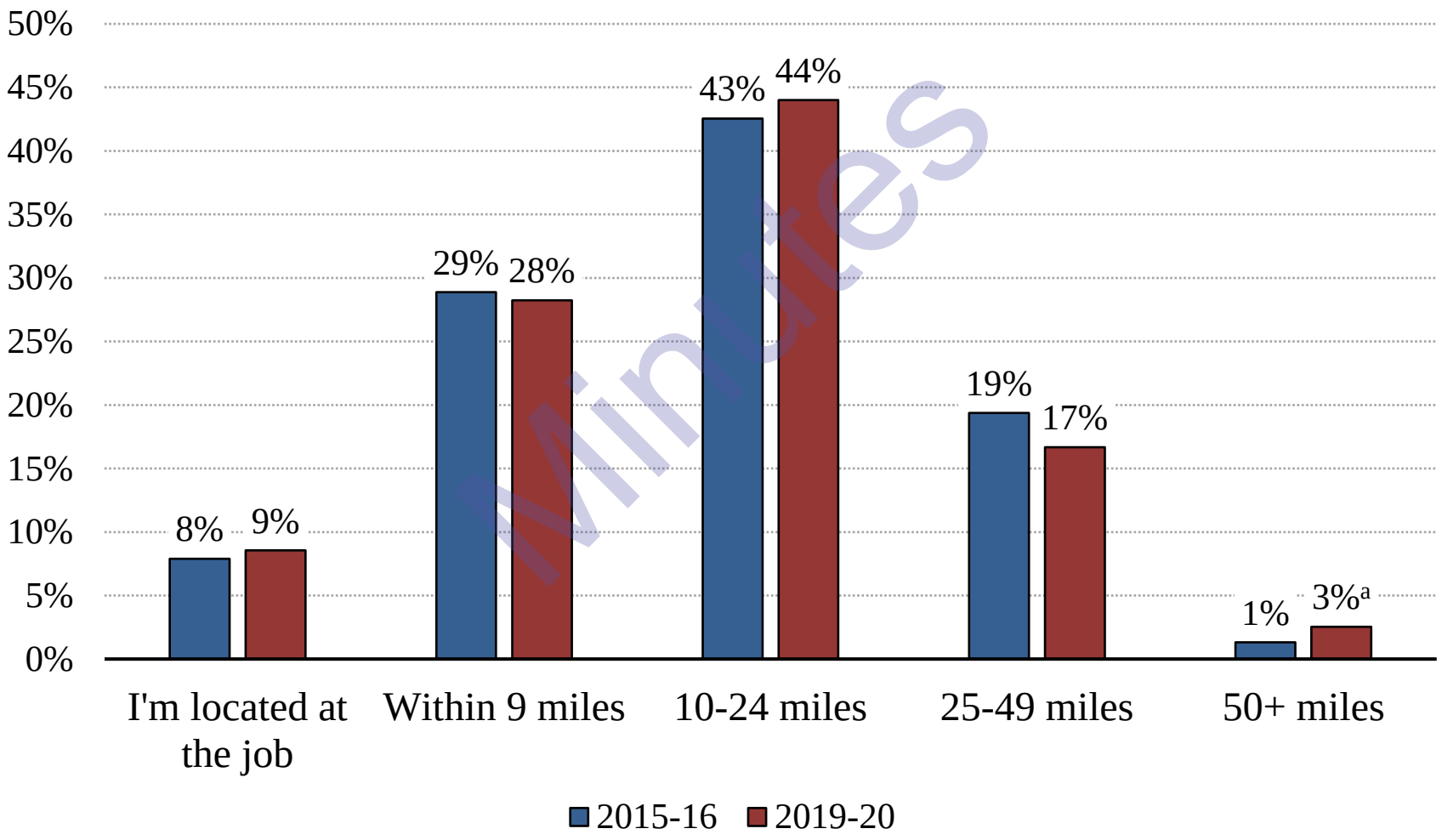
Distance Traveled to Current Job

Most Farmworkers in the Western stream traveled at least 10 miles to their current job.



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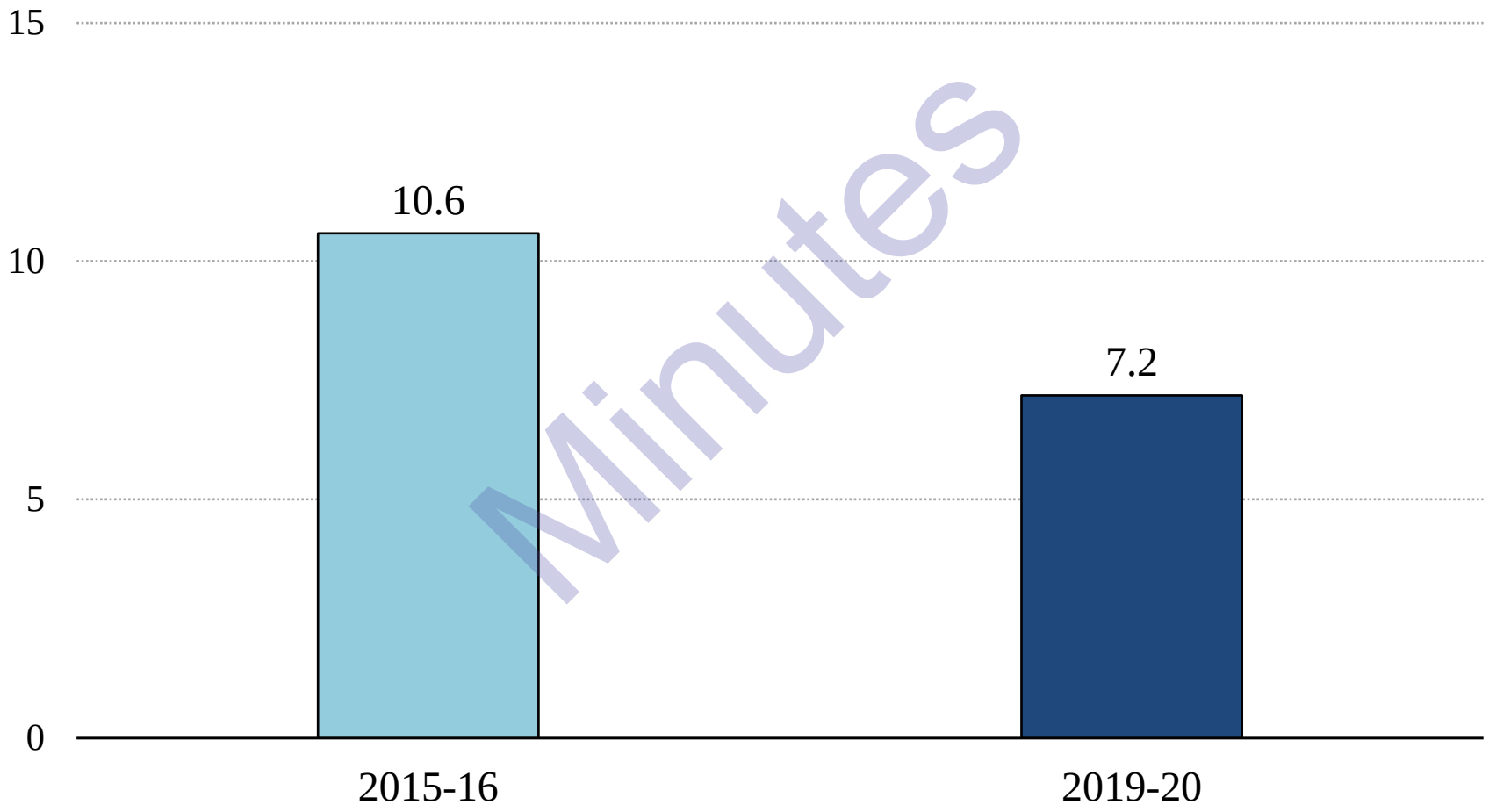
Farmworker Employment

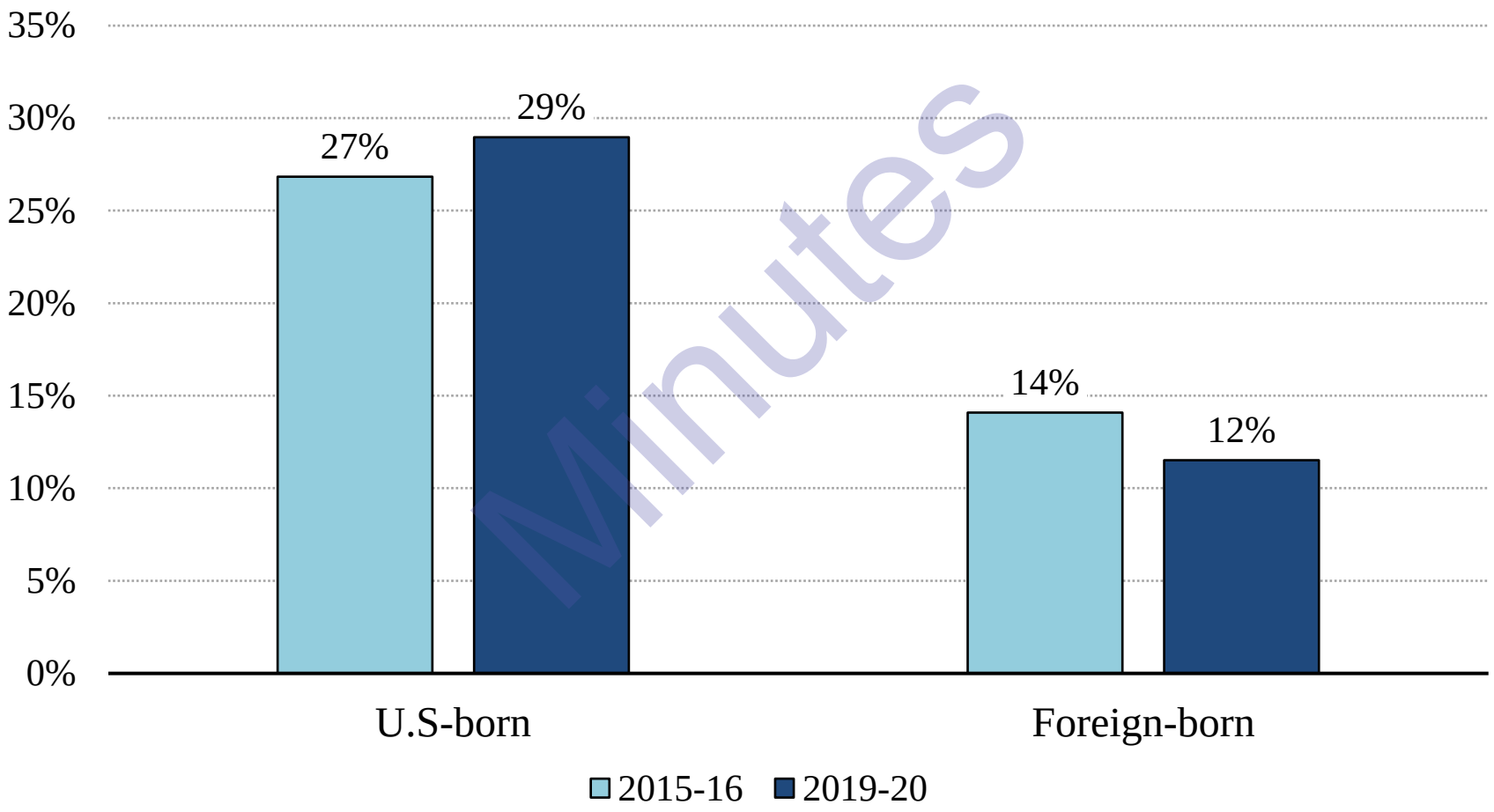
Average Non-work Weeks in the Western stream

There were 3 more work weeks on average in 2015-16 than in 2019-20.



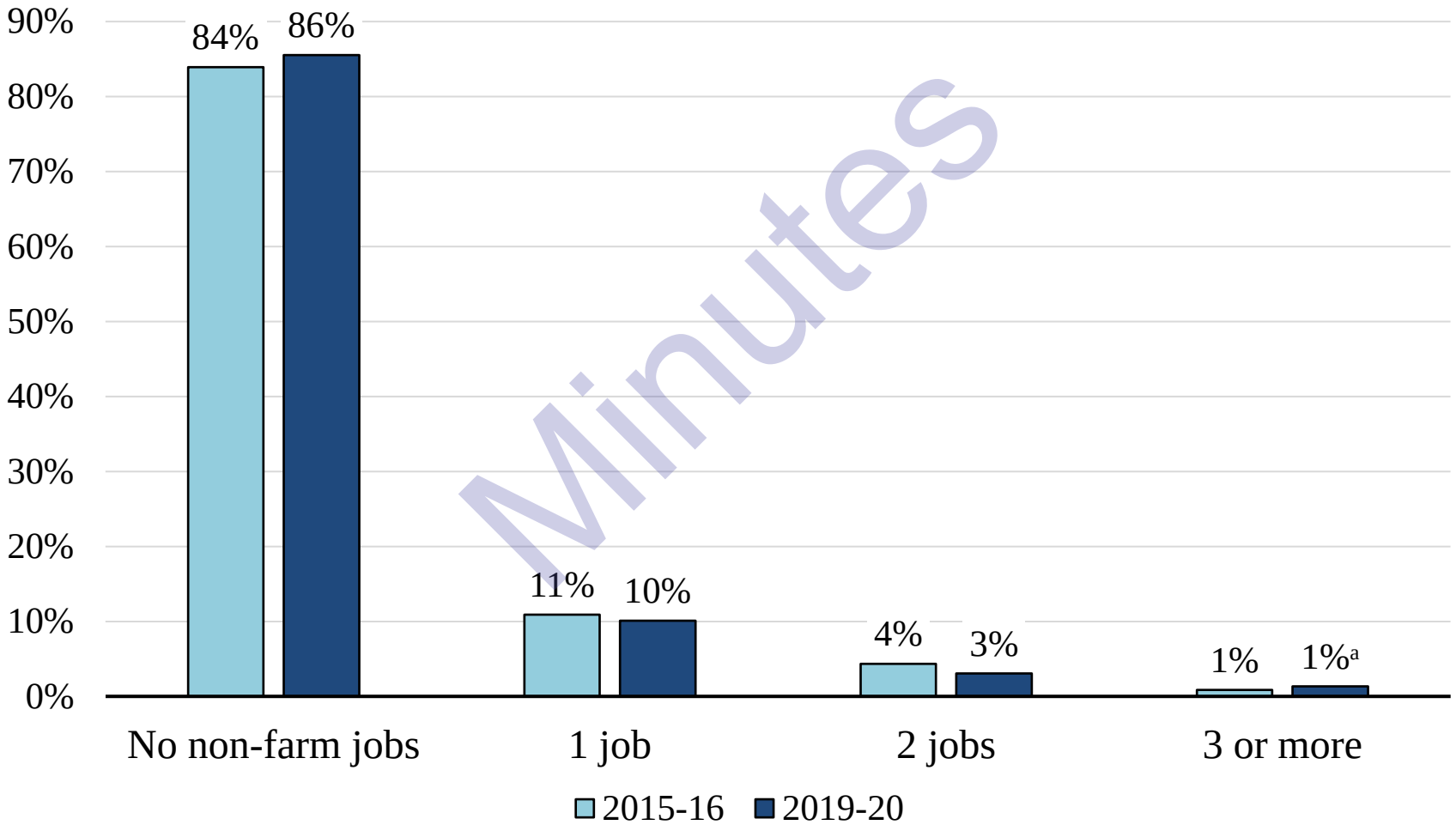
Workers with at least One Non-Crop Job Last Year

1-in-4 U.S.-born workers held non-crop jobs compared to 1-in-9 foreign born workers.



Non-Farm Jobs in the Western Stream

In the Western stream, about 15% of workers held at least one non-farm job.



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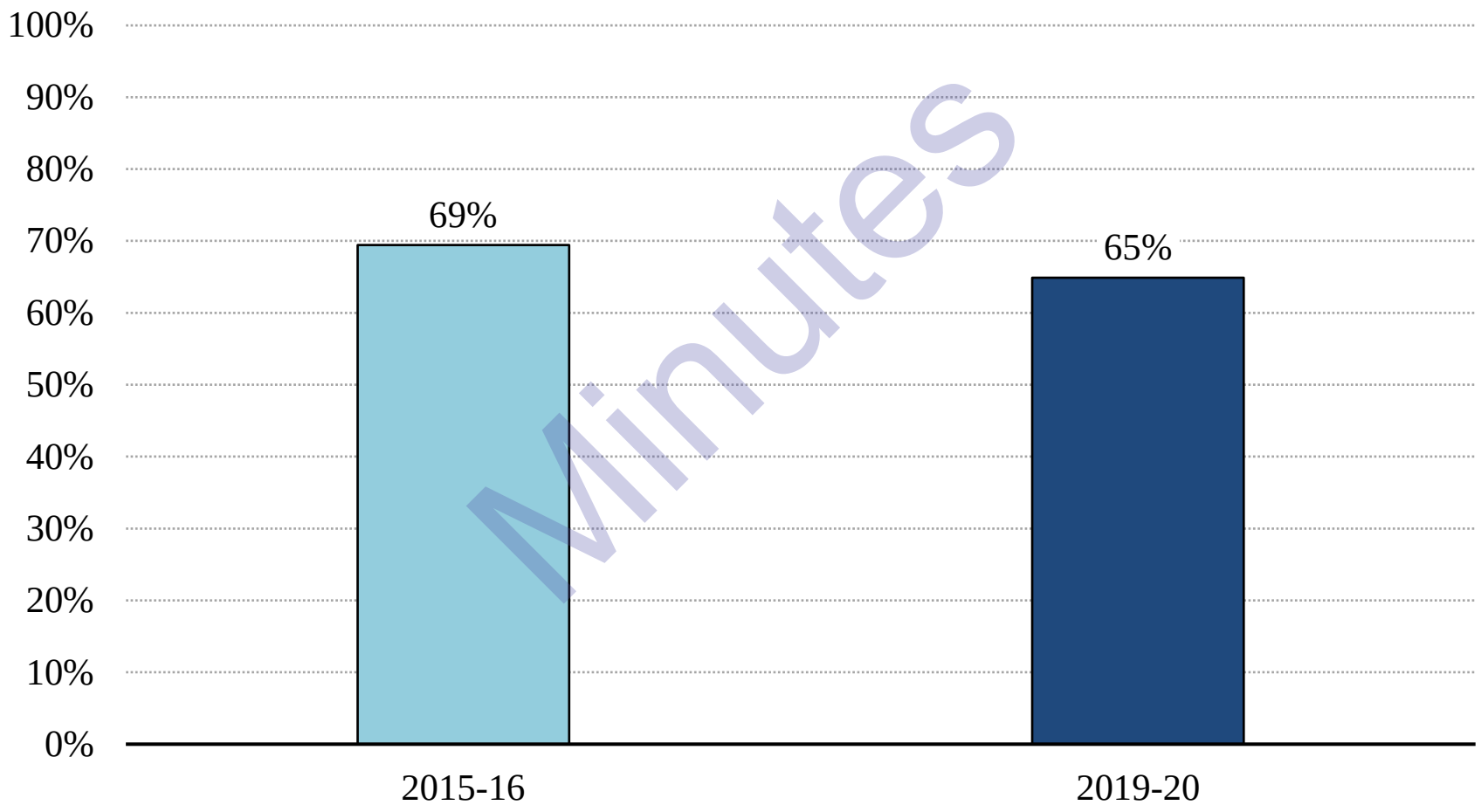
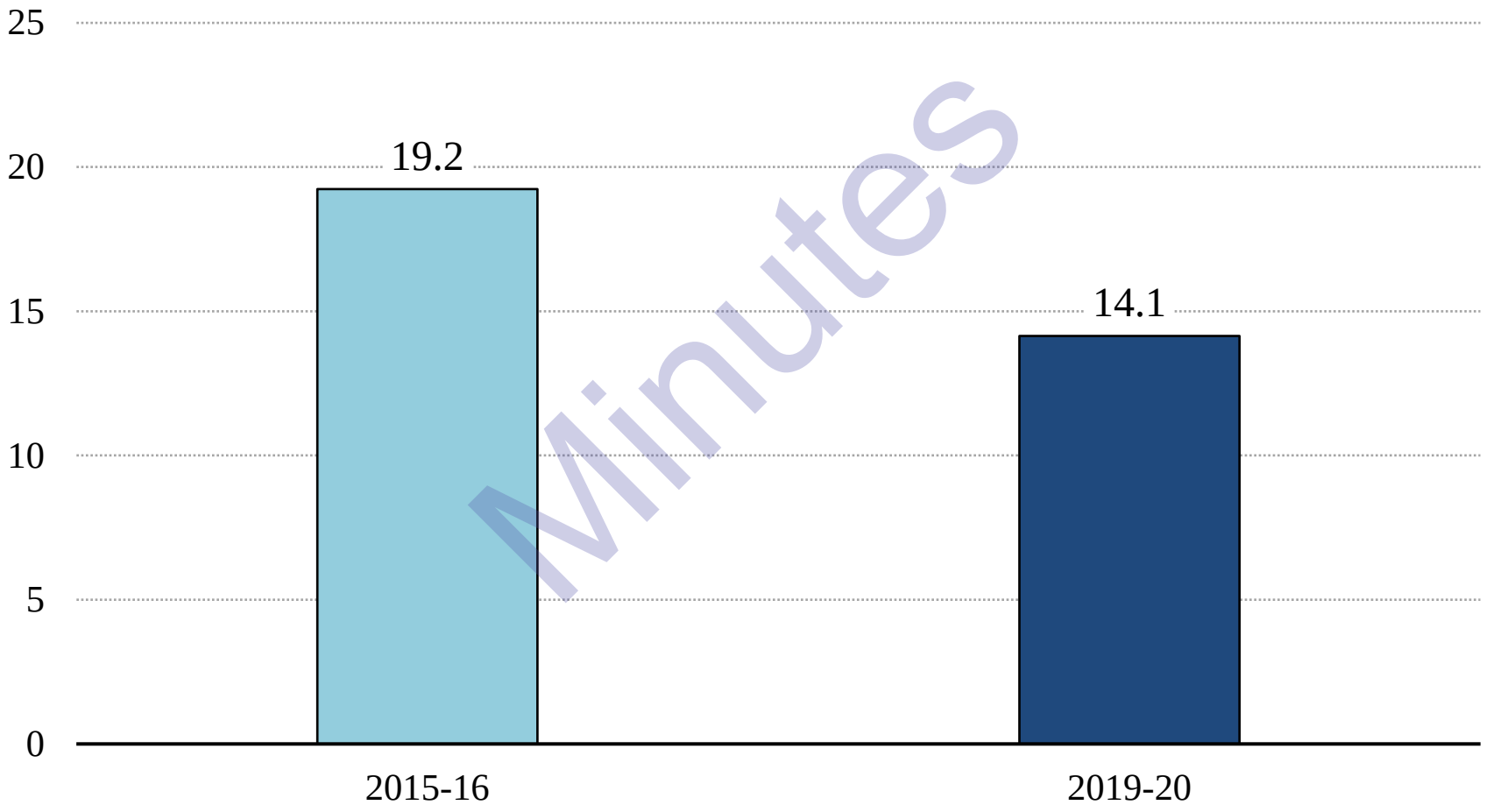
Workers Out of Work at least Once Last Year

7-in-10 workers in the Western stream they experienced at least one period without work.



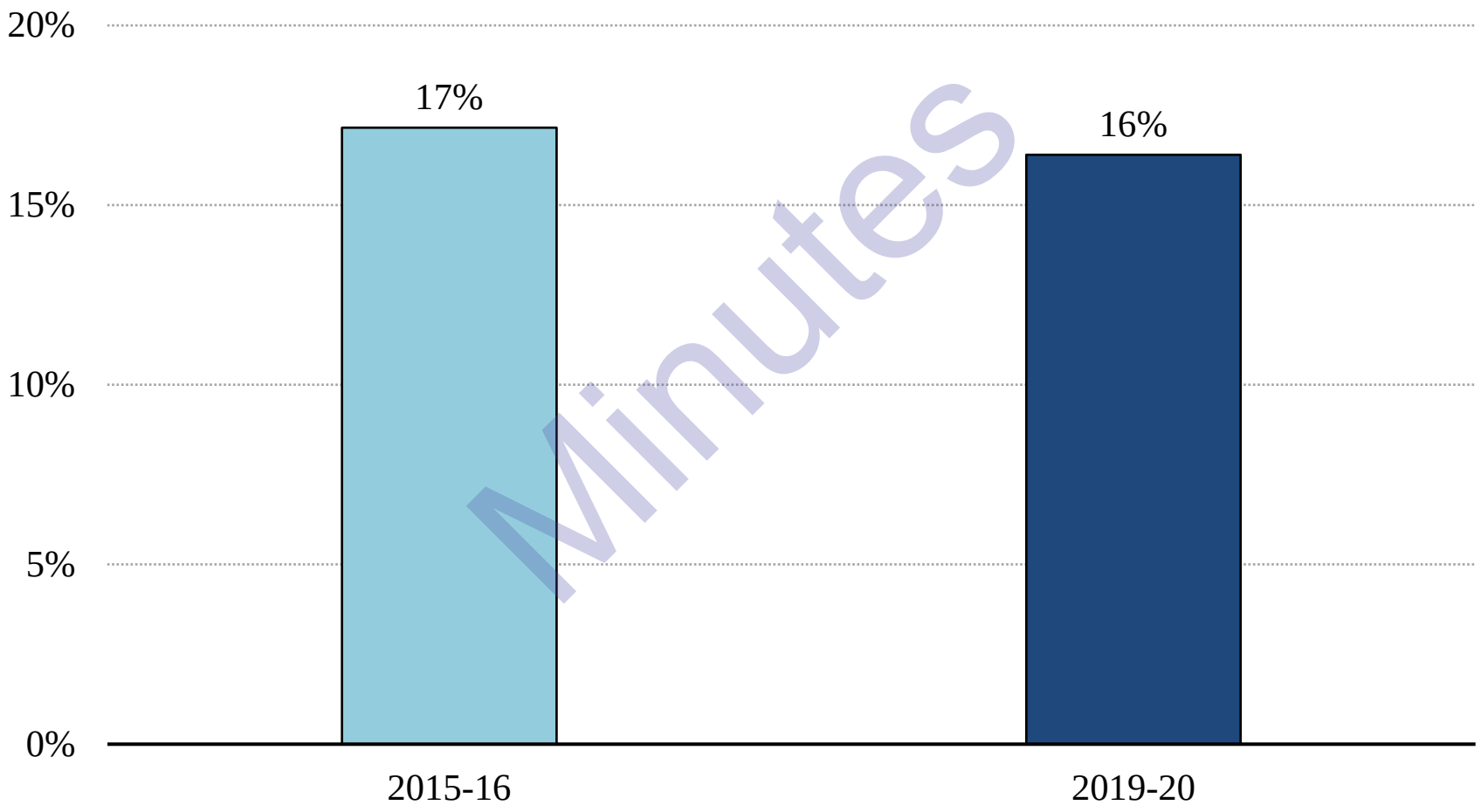
Average Weeks Out of Work

In 2019-20, farmworkers in the Western stream were out of work 5 fewer weeks.



Workers Receiving Unemployment Insurance

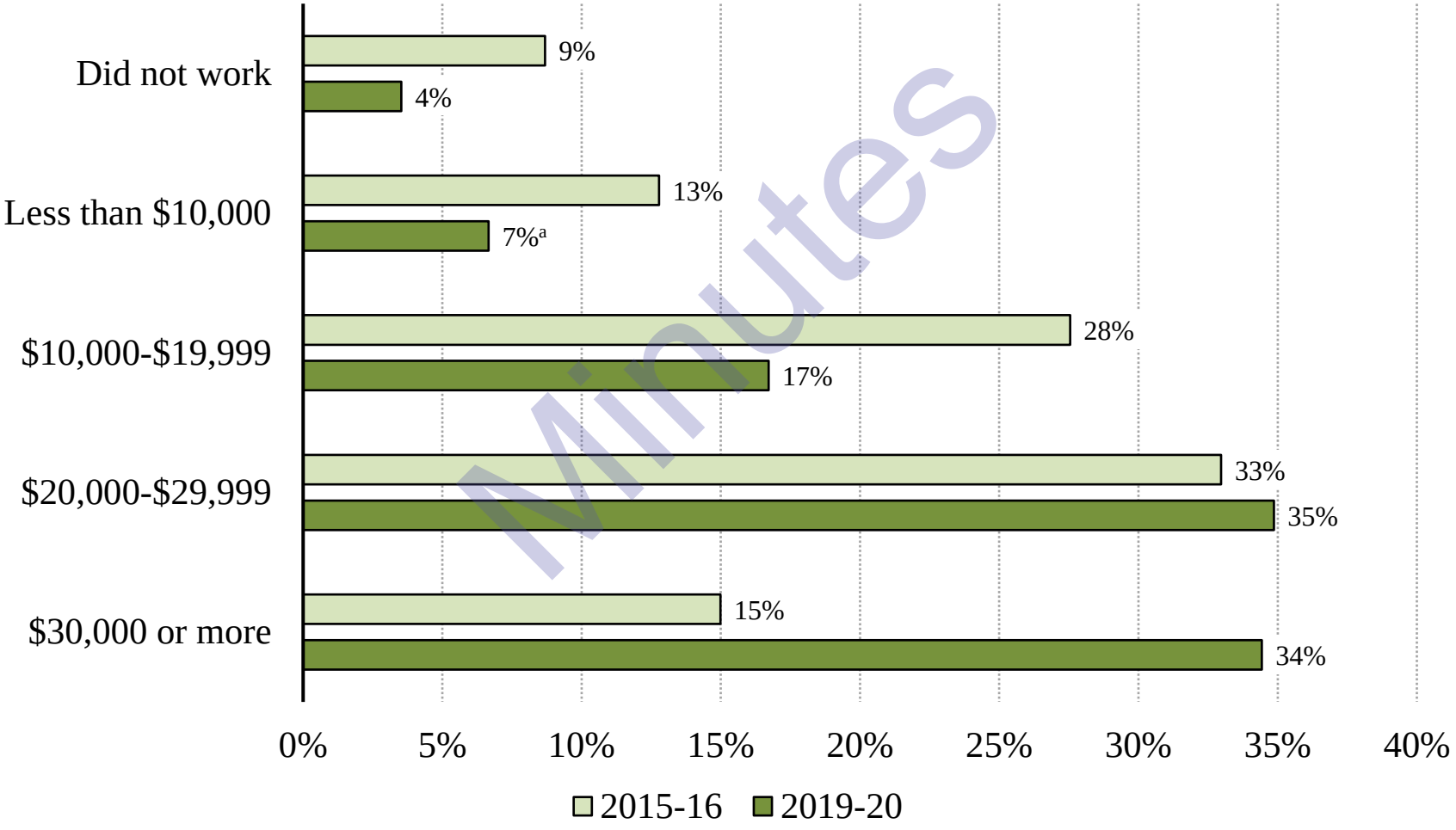
1-in-6 workers experiencing unemployment received UI in the Western stream.



Farmworker Income

Farmworker Personal Income

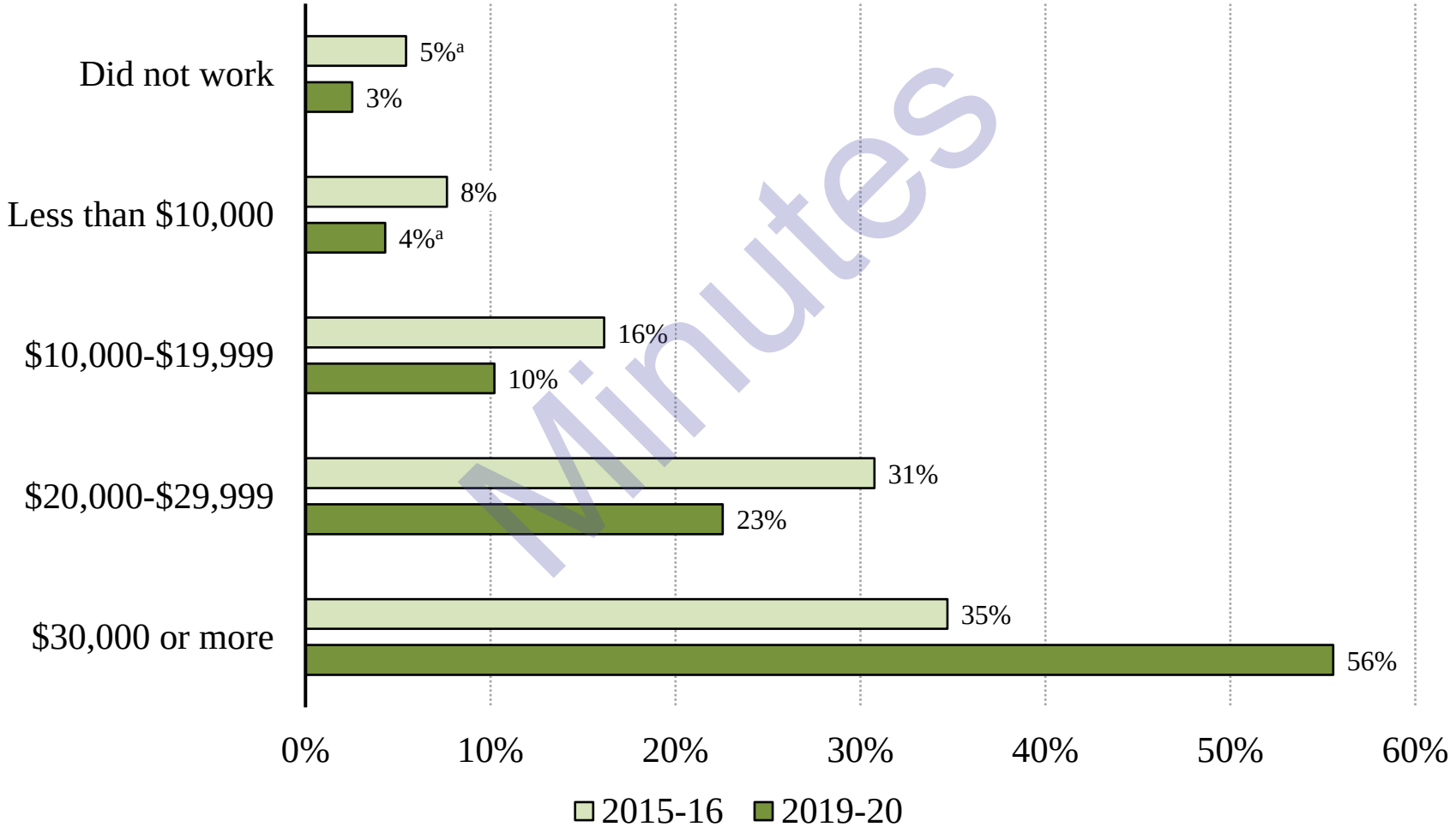
Personal income increased in the Western stream in 2019-20 compared to 2015-16.



[a] Estimates have relative standard errors between 31% and 50% and should be interpreted with caution.

Farmworker Family Income

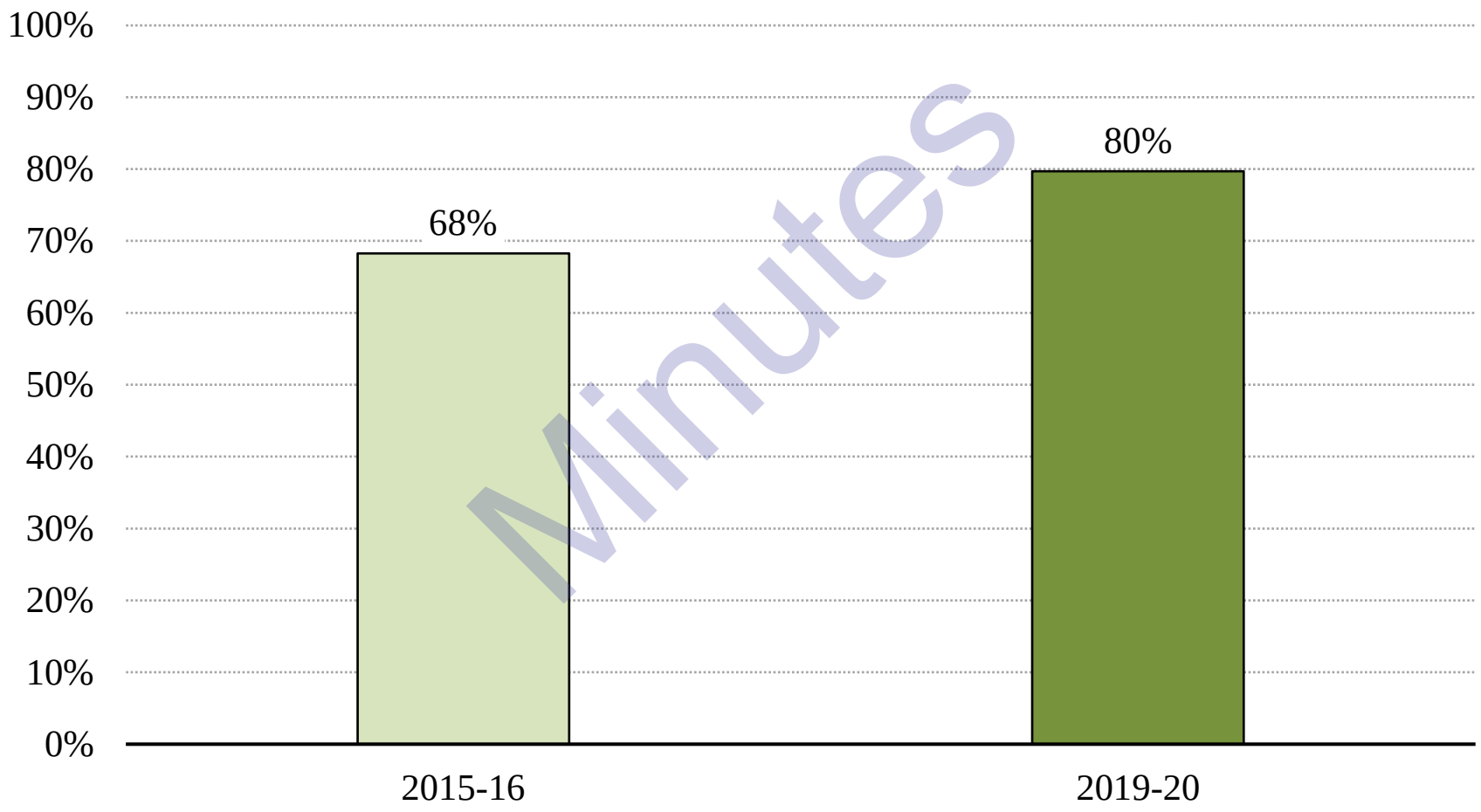
Family income also increased in 2019-20 compared to 2015-16.



[a] Estimates have relative standard errors between 31% and 50% and should be interpreted with caution.

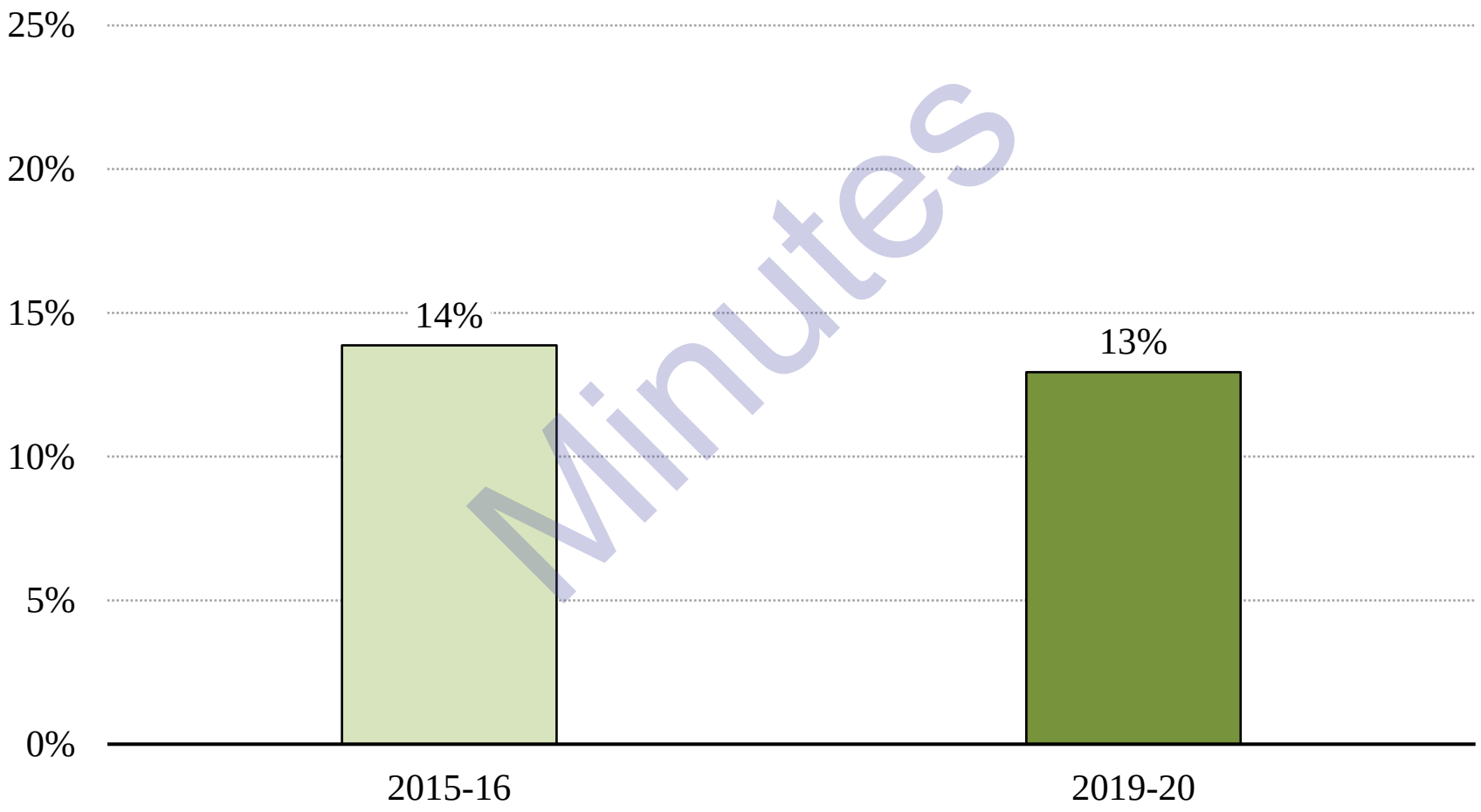
Currently Own or Buying an Asset

Farmworkers were more likely to own/plan to own an asset in 2019-20.



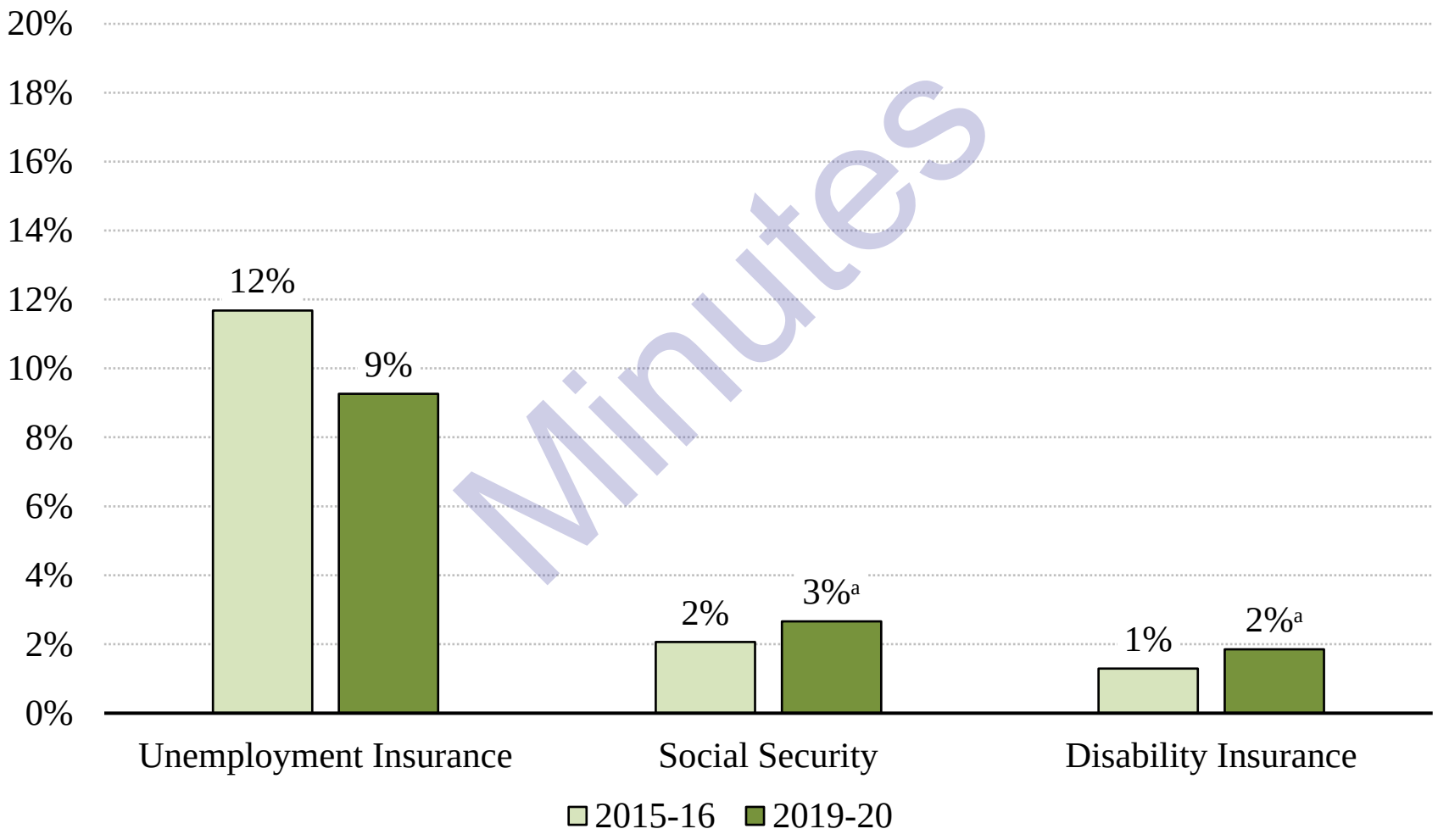
Received at least one contribution-based benefit

In the Western stream, about 1-in-8 farmworkers received a contribution-based benefit.



Contribution-based Benefits Received by Type

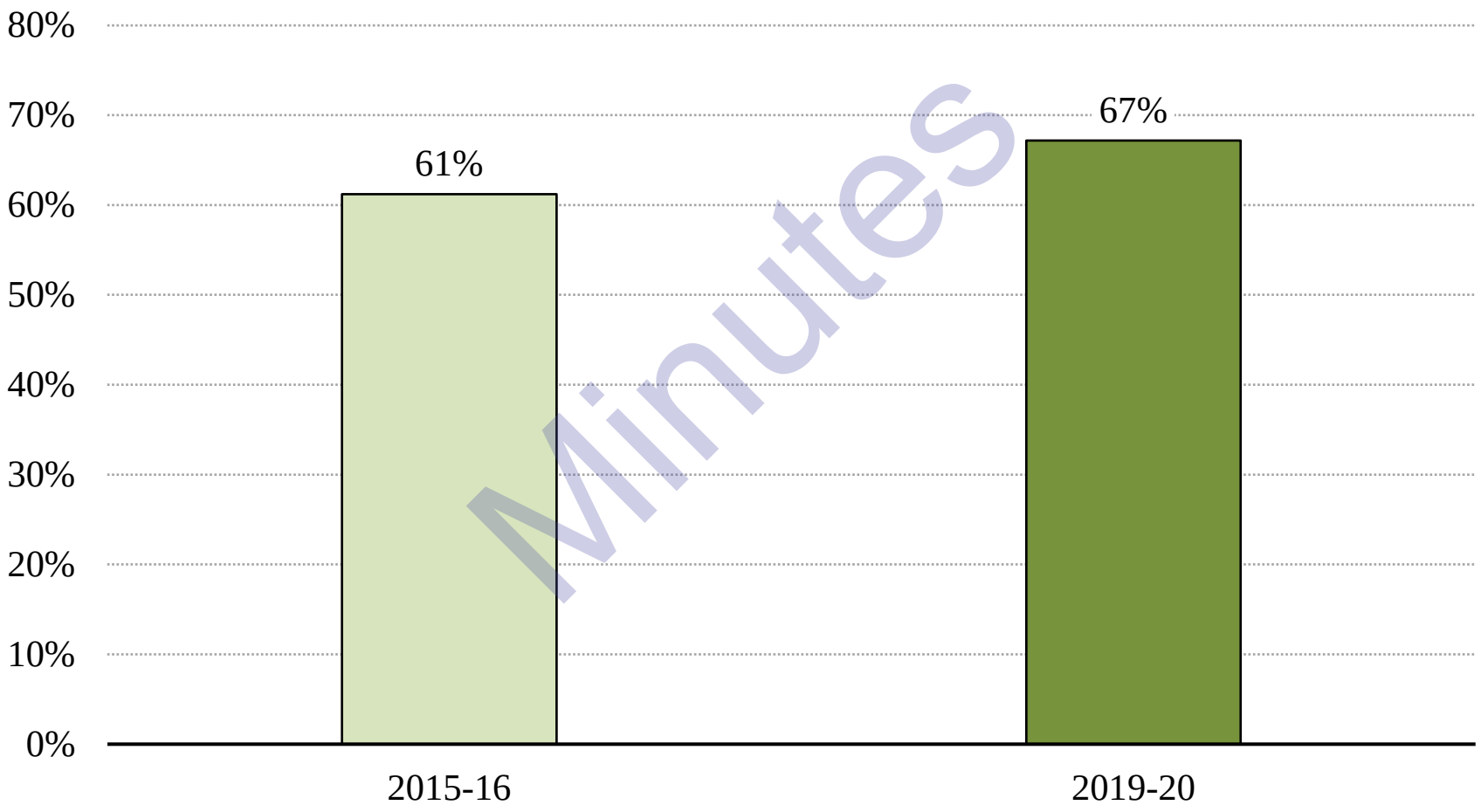
Unemployment Insurance was the contribution-based benefit received most often.



[a] Estimates have relative standard errors between 31% and 50% and should be interpreted with caution.

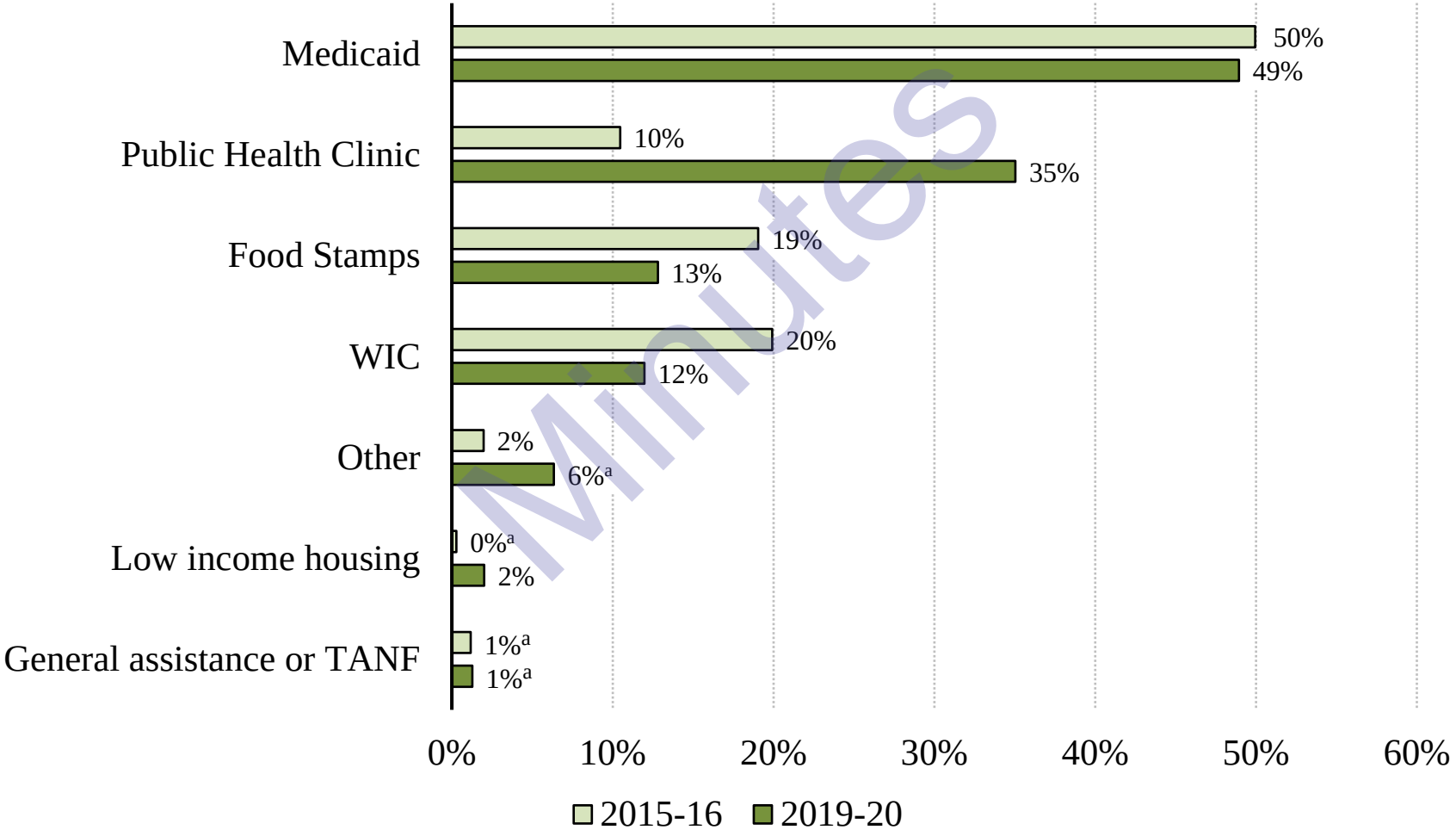
Share Receiving a Need-based Benefit

Most Western stream farmworkers receive a need-based benefit.



Need-based Benefits by Type

Farmworkers in the Western stream primarily receive benefits supporting health and nutrition.

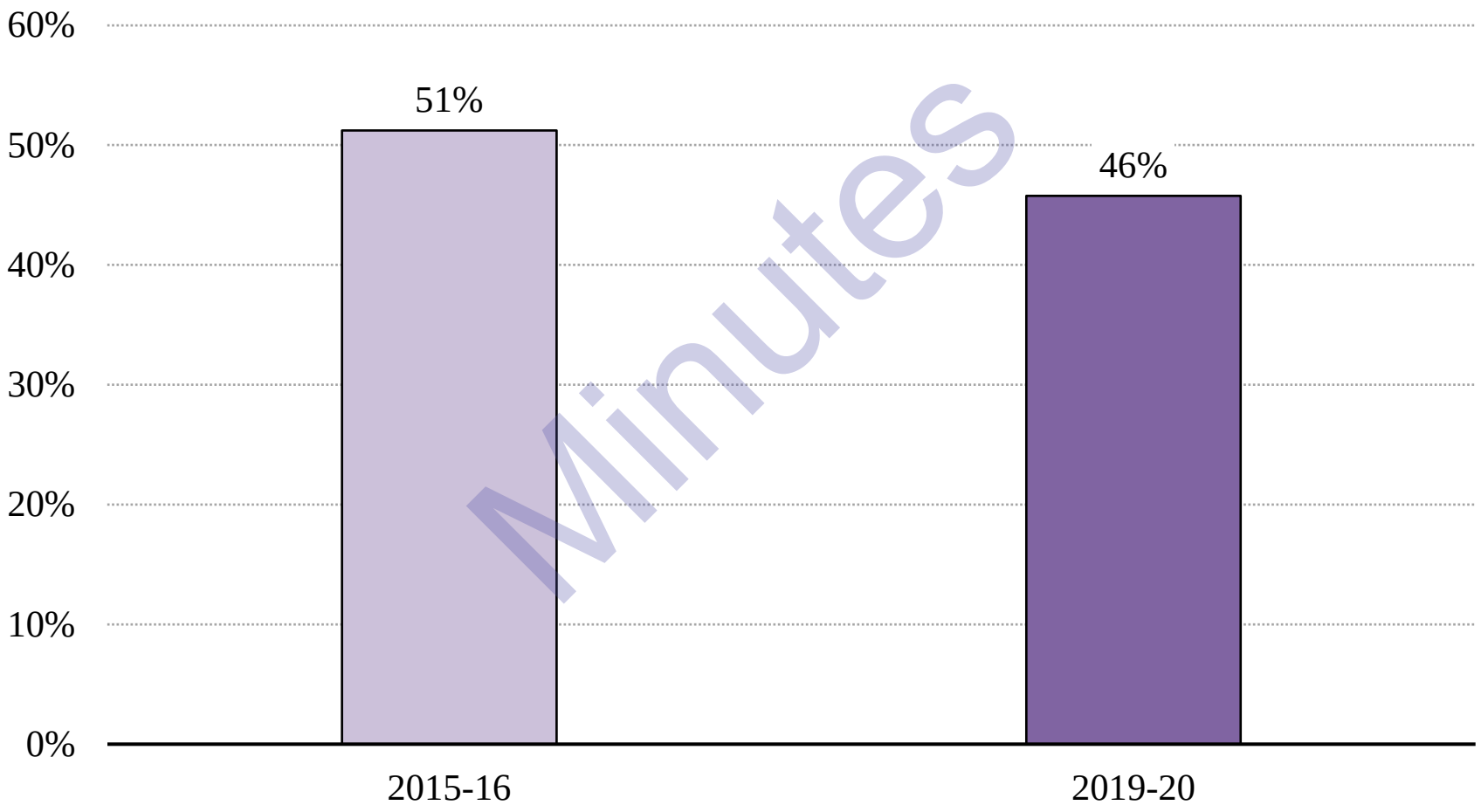


[a] Estimates have relative standard errors between 31% and 50% and should be interpreted with caution.

Health and Health Benefits

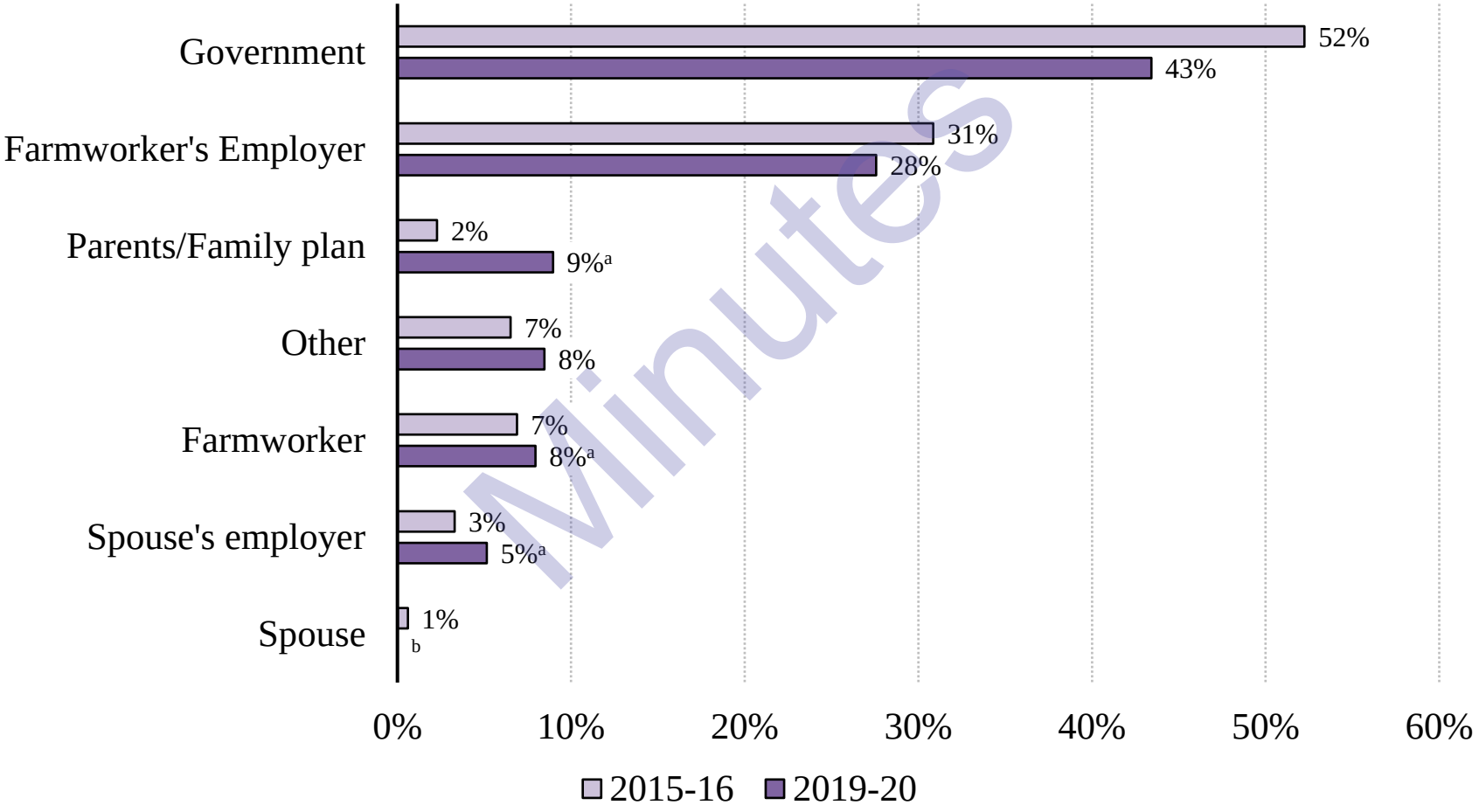
Health Insurance Among Farmworkers

About half of Farmworkers in the Western stream have health insurance.



Worker's Type of Health Insurance

Worker health insurance is most often Government or employer-provided.

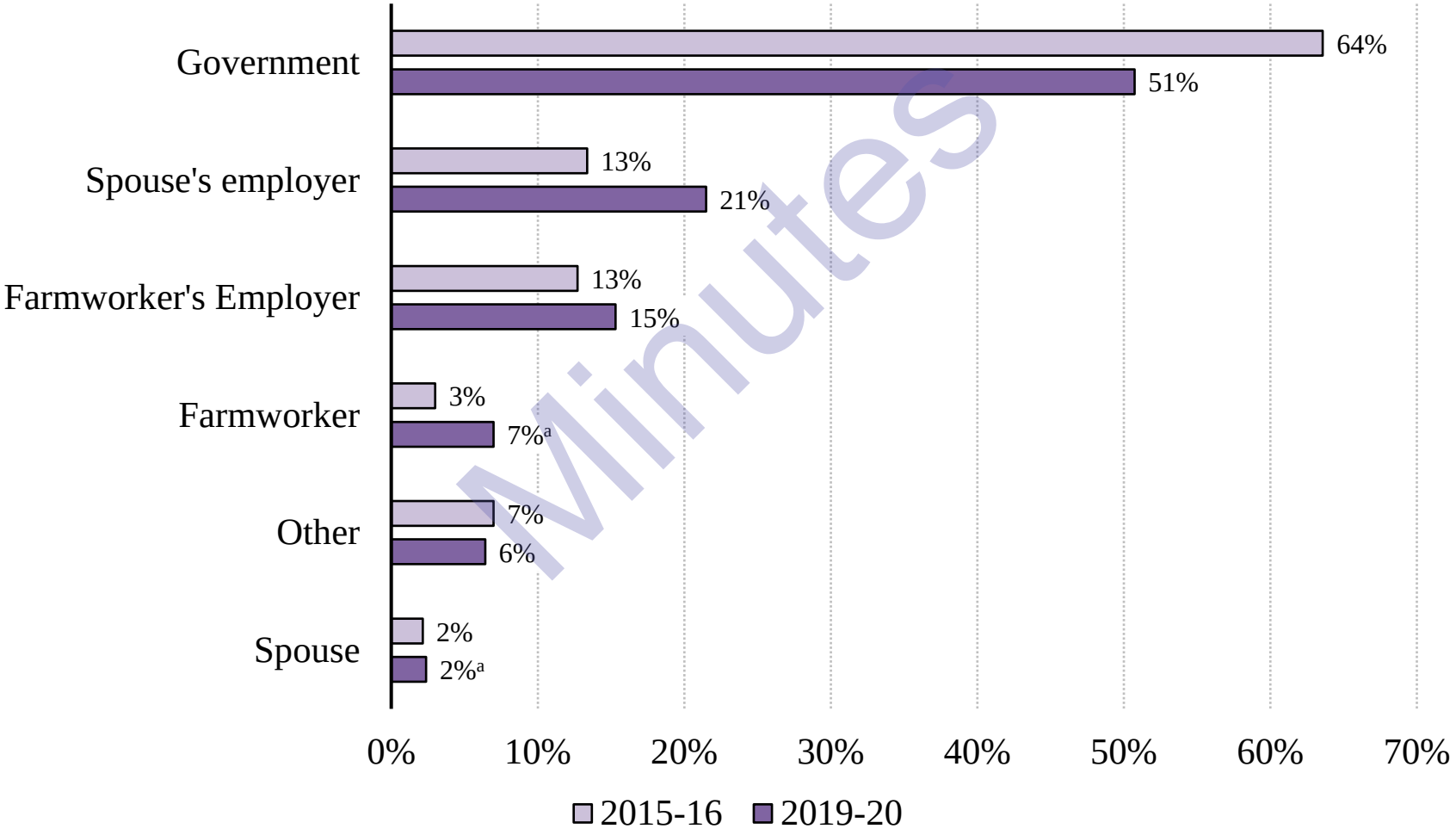


[a] Estimates have relative standard errors between 31% and 50% and should be interpreted with caution.

[b] Estimates are suppressed because number of responses is less than 4 or relative standard errors for the estimates are greater than 50%.

Spouse’s Type of Health Insurance

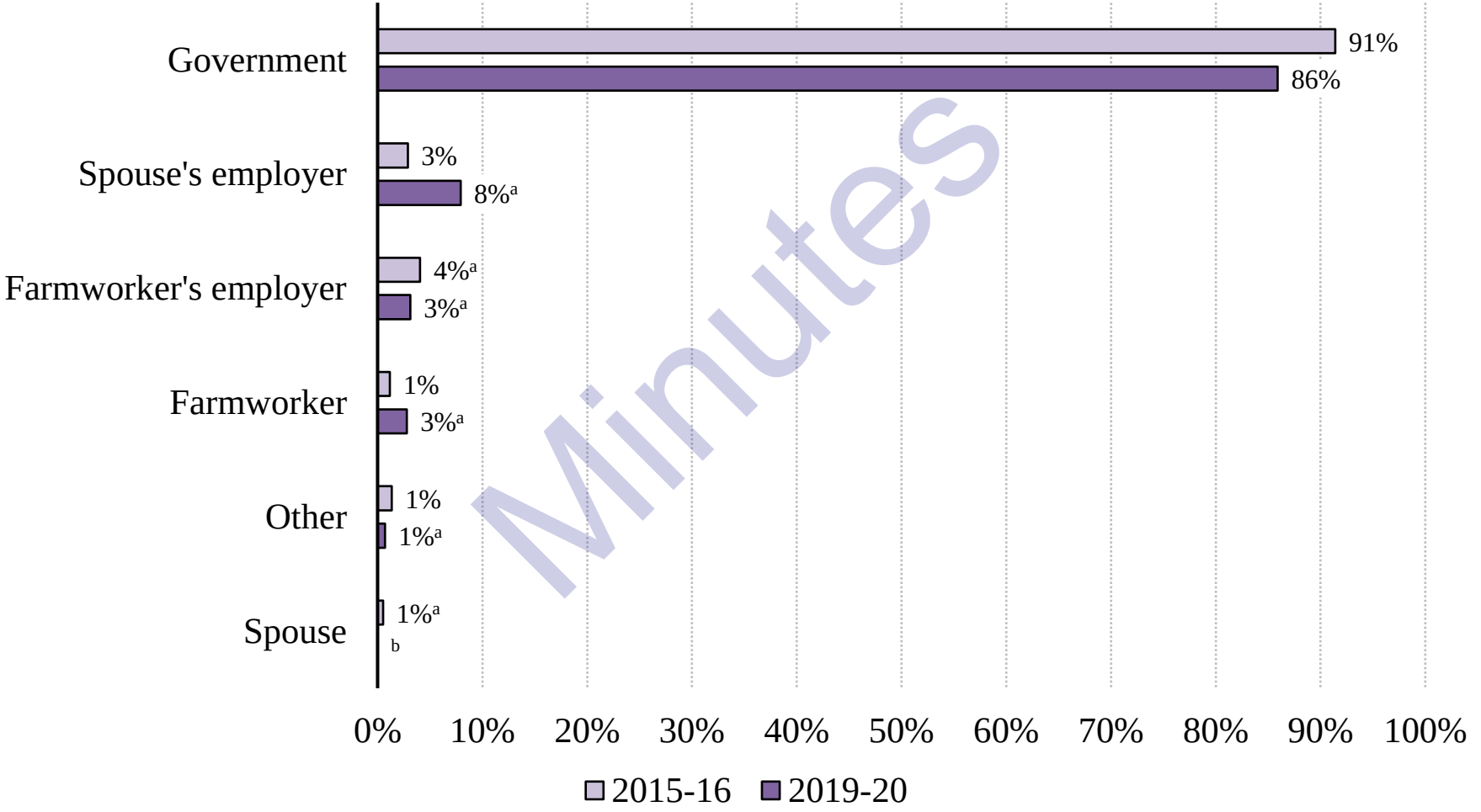
Spousal health insurance is most often Government-provided.



[a] Estimates have relative standard errors between 31% and 50% and should be interpreted with caution.

Child's Type of Health Insurance

Child Health Insurance is most often Government-provided.



[a] Estimates have relative standard errors between 31% and 50% and should be interpreted with caution.

[b] Estimates are suppressed because number of responses is less than 4 or relative standard errors for the estimates are greater than 50%.

Social Determinants of Health

Improvements:

- Crowded housing decreased 39% in 2015-2016 to 36% in 2019-2020
- Average number of farm work weeks per year and average hourly earnings increased
- Total family income below poverty decreased from 30% in 2015-2016 to 17% in 2019-2020

Social Determinants of Health

Have not changed or have worsened:

- As in fiscal years 2015-2016, the average highest grade completed among all crop workers was the 8th grade in fiscal years 2019-2020

- The share of crop workers reporting being covered by health insurance declined, from 51% in 2015-2016 to 46% in 2019-2020

The End

For more information on the NAWS:
Website
https://www.doleta.gov/naws/

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ORIGINAL PAPER

Learning the Moral Economy of Commodified Health Care: "Community Education," Failed Consumers, and the Shaping of Ethical Clinician-Citizens

Michele Rivkin-Fish

Published online: 11 May 2011

Abstract Leaders of health professional schools often support community-based education as a means of promoting emerging practitioners' awareness of health disparities and commitment to serving the poor. Yet, most programs do not teach about the causes of health disparities, raising questions regarding what social and political lessons students learn from these experiences. This article examines the ways in which community-based clinical education programs help shape the subjectivities of new dentists as ethical clinician-citizens within the US commodified health care system. Drawing on ethnographic research during volunteer and required community-based programs and interviews with participants, I demonstrate three implicit logics that students learned: (1) dialectical ideologies of volunteer entitlement and recipient debt; (2) forms of justification for the often inferior care provided to "failed" consumers (patients with Medicaid or uninsured); and (3) specific forms of obligations characterizing the ethical clinician-citizen. I explore the ways these messages reflected the structured relations of both student encounters and the overarching health care system, and examine the strategies faculty supervisors undertook to challenge these messages and relations. Finally, I argue that promoting commitments to social justice in health care should not rely on cultivating altruism, but should instead be pursued through educating new practitioners about the lives of poor people, the causal relationships between poverty and poor health, and attention to the structure of health care and provider–patient interactions. This approach involves shining a critical light on America's commodified health care system as an arena based in relations of power and inequality.

Keywords Community-based health education · Volunteerism · Moral economy of US health care · Professional subjectivity · Clinical ethics

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Introduction

A few days after supervising five dental student volunteers at a mobile clinic in a rural part of her state, Dr. Natalie Osborne found herself confronted with one of the participants, who was distressed and eager to talk. "She was considering quitting participating in the volunteer clinics," Dr. Osborne recounted to me, because, in the student's words, "the patients just weren't grateful enough." She continued:

> I was surprised—Kim is a caring and good-hearted person, and at first I didn't know what to say. So I asked her to describe what exactly happened that made her feel this way. Kim told of assessing the patient's mouth and telling her she would need to have her front teeth removed. The patient left without saying "thank you," and acted rudely. I realized what had happened: eager for appreciation, Kim wasn't aware that the patient probably experienced the news she just received as devastating. I explained this to her, and told her that, in general, these patients may have had very little experience with dentists before, or even more likely, what they have had has been traumatic, painful, even terrible. They may just be relieved if we don't mess things up. And here they are, in this gymnasium, getting who knows what kind of care, with all kinds of people around, and they may be worried about what's going to happen. Expressing gratitude in these kinds of moments may not be possible. We may want their appreciation, and we often do get a thank you, but we can't expect everyone to throw their arms around us and smile and thank us. Even in private practice it doesn't always happen.

Dr. Osborne contacted me to discuss this interaction because she felt that it was related to my research interest—understanding the ways in which community-based experiences impact dental students' sense of ethics and responsibility for addressing health disparities. Although she had never heard a student articulate her reluctance to continue volunteering in quite this way, Dr. Osborne realized that Kim's reaction was probably common. She wanted to brainstorm about how best to help students adjust their expectations and more generally strengthen their commitments to the needs of the underserved.

The underlying perspective motivating Dr. Osborne—that the inequities built into the U.S. health care system are a grave injustice—is a view that is shared by many deans and faculty in the country's health professional schools. Their support for student volunteering at mobile and free-standing clinics represents one of the ways these academic leaders deploy their institutional and personal resources to meet the needs of the underserved.[1] Often, medical and dental schools also have clinical requirements for community-based work, thereby ensuring that all students gain exposure to populations with limited health care options. Beyond the immediate

[1] Other efforts include recruitment of minority and rural students, curricular innovations, and extra-curricular programming. Health professional schools work with both governmental agencies and private foundations on these endeavors. Certainly, these efforts also garner legitimacy for institutions that represent themselves as serving the residents of a state or region. The dynamics between academic health professional leaders' concerns with inequalities and their institutions' political–economic interests is a question in need of further study.

contribution of providing the needed services, faculty members hope that community-based clinical experiences will influence students' developing professional commitments toward the needs of the underserved (Gelmon et al. 1998; Eyler et al. 1996; Eckenfels 1997; Seifer 1998). Advocates argue that community-based experiences will help guide students to more "altruistic" forms of practice (Jimenez et al. 2008, p. 936), and "may also make students more comfortable treating patients from diverse backgrounds" (Bailit 1999, p. 983). Some advocates implicitly recognize the potential for community engagement to backfire, resulting in compromised patient care or re-affirming negative stereotypes about poor people (Hood 2009); a few scholars have explicitly discussed the need to avoid such dangerous outcomes through the attentive structuring of students' clinical work (Buchanan and Witlen 2006). Yet the problems Dr. Osborne faced—of students becoming disinterested in underserved communities and the question of what kinds of pedagogical interventions are necessary for community-based experiences to have the desired effects—remain severely unexamined (see Strauss et al. 2010 for a recent assessment of desirable curricular developments).

This article aims to further debate on these questions. It is notable that encouraging students' commitments to the underserved is largely assumed to be a matter of cultivating in them appropriate emotions and attitudes: the literature refers to "altruism," "comfort," and "compassion," as necessary virtues, with at least some authors advocating the formalization of these virtues as "moral competencies" to be taught alongside of technical competencies (Rule and Welie 2006). Drawing on ethnographic research during community-based dental education programs and interviews with participants, I argue, in contrast to this focus, that we must recognize how clinical education in communities socializes students to position themselves in particular kinds of relationships to patients. Kim's disappointment in her patient's response and subsequent reluctance to continue volunteering were the products of expectations she had regarding the interaction: in return for the gift (unpaid work) of her time, skills, and effort, she saw herself as entitled to receive the patients' gratitude. Intuitively recognizing the problems with Kim's expectations—that they were based in a lack of awareness of both the patient's immediate circumstances and broader life experiences—Dr. Osborne strove to illuminate the possible circumstances shaping the patient's reactions, from her grief over the impending loss of her front teeth to her reasonable fears and distrust of the dental care she was receiving. She aimed, implicitly, to reposition an understanding of the patient's experiences as central for health providers' work. These are the kinds of strategies that many faculty members who are committed to the needs of poor populations undertake when working with students, but their efforts are rarely recognized or discussed as important pedagogical strategy among public health advocates at health professional schools. As quiet and often isolated efforts, usually developed outside of a broader critical analysis of the structured character of the health care system, the effects of such efforts will be limited.

This article demonstrates how the structured character of student-patient relationships in community-based education generated the kinds of expectations and emotions students would likely experience, and more generally shaped their attitudes toward work with underserved populations. In addition to volunteer

experiences, I also examine the structured relationships in required community-based educational programs, and illuminate the kinds of ethical imperatives that students came to assume from within these relations. Rather than hoping that providing services to the poor in-and-of-itself will cultivate desired attitudes of compassion and altruism, I argue the need for education into the lives of poor people, the causal relationships between poverty and poor health, and attention to the structure of provider–patient interactions as an arena where relations of power and inequality can be exacerbated or mitigated.[2] This approach involves shining a critical light well beyond the educational arena to the broader system in which it is embedded—America's commodified health care system.

The following section places this study in the context of critical studies of health professional education and governance. It then describes the specific policies that structure deficits in dental care access for the poor and the unequal outcomes in oral health that characterize populations in the U.S. Next, I outline the community-based experiences that I examined in this study and describe my research methods. Following these introductory sections, the article examines students' voluntary participation in mobile dental clinics and their required rotations in public health clinics, highlighting ethnographically the ways particular kinds of contact with the poor made particular kinds of interpretations of health disparities appear reasonable. Throughout, the article exposes how our society's cultural and institutional treatment of health care as a commodity shapes the dominant meanings associated with specific locations and modes of health care delivery, their practitioners, and clients. When students enter into "community-based" sites for clinical education, they also often learn to take up positions defined by that commodified system: ways of relating to patients and public health institutions, as well as ways of defining their sense of professional obligations in settings where health care is imperfectly commodified and the clients are considered failed consumers. The article concludes with reflections on the concerns Dr. Osborne raised—how clinical education in communities may promote students' commitments to addressing the needs of the underserved. We must teach students to recognize the ways commodified health care shapes their own and their patients' positions and their interrelations; and we must work to reshape these relations of domination to whatever extent possible.

Producing the Subjectivity of American Health Professionals

This article brings together research on the production of subjectivity among American health providers with two theoretical concerns related to the reproduction of society more broadly: analyses of the workings of symbolic power, and analyses of the technologies of citizenship deployed in governance. A long-standing body of ethnographic inquiry has detailed the processes by which students come to perform the clinical self and deploy the medical gaze (Becker 1997/1951; Fox 1957, 1998/1979;

[2] This arguments overlaps in important ways with that of Hafferty and Franks (1994) on the need to transform medical culture as a whole, not simply add on formal courses in ethics with the hope of instilling "compassion" or conveying information about how to act "ethically."

Goffman 1961; Konner 1987; Mizrahi 1986; Delvecchio-Good 1998). The focus on subject formation in dental education—itself a virtually unexamined topic—opens up a series of questions this literature has not extensively studied—namely, the ways health professional education in the U.S. is inflected by this country's health care system. Since the mainstream of American dentistry remains an arena of private practice largely unencumbered by external bureaucratic control (relative to medicine), ethnographic insights into dental education bring into relief the dynamics by which future practitioners learn to understand and practice health care as a commodified service. At stake are more than techniques of materially distributing health care through market mechanisms: what students learn are sets of assumptions regarding participants' rights, responsibilities, and entitlements, notions that define the kinds of claims they can make on each other and society at large. In other words, I see commodified health care as a type of moral economy—"consensual assumptions about reciprocal obligations" (Minkler and Cole 1997, p. 40), and health professional education as the socialization of students into that moral economy.

More specifically, the article considers how contact with poor patient populations becomes a site where young dentists apply the assumptions built into the moral economy of commodified health care to make sense of the health disparities they observe, from patients' poor health to the substandard treatments often rendered them. Aware of the systematic inequities of health care provision, faculty advocates for the underserved insisted on students' accountability to their patients, and asserted professional responsibilities to provide high quality care for all patients, regardless of their background. Yet as students encountered the realities of unequal care for the poor structured into the health care system, they translated these ethical standards into personal commitments to "educating" patients; the systemic dimensions of inequality remained conceptually bracketed out from their working evaluations of how to maintain one's professional integrity. Drawing on analyses of public service as sites where neoliberal formations of ethical citizenship emerge (Cruikshank 1999; Hyatt 2001a, b; Allahyari 2000; Shaw 2005, nd), I consider the clinic-based ethics of health care service to be an effect of broader technologies of governance that produce individual responsibility as a practice of citizenship. In vowing personally to "treat all patients equally," a student became an ethical clinician-citizen, an individualized subject (imagined to be) unencumbered by the systems that create both health disparities and broader inequalities based in race and citizenship (Harrison 1994). In these ways, students' contact with poor populations often involved their learning to perpetuate the forms of symbolic power inherent in the moral economy of commodified health care.

Scholars have also inquired into whether medical ideologies may get subverted during the initiation of novices. Examining the efforts of one school's faculty and students to transform the power relations in medicine, Davenport (2000) described participants' critiques of the objectifying medical gaze and their efforts to incorporate "witnessing" into clinic practice. Witnessing obliged providers to recognize the social, as well as physiological sources of their homeless clients' suffering by listening—"bearing witness"—to their broader life stories. Complementing this clinical work, faculty developed a systematic curriculum in which

students learned about the multi-faceted dimensions of homelessness. Davenport details the tensions participants confronted in attempting to mitigate the medical gaze, even despite deliberative interventions to do so. Her analysis offers a cautionary tale for those who hope that merely sending health professional students to work "in communities" will incline them toward long-term work with poor populations; it also presents a paradigm for restructuring community-based education to incorporate knowledge of patients' lives and attention to the power inequities that affect health in and beyond the clinic.

Indeed, in the course of this study, I met faculty and students who acknowledged, and worked to transform, their own entanglements in the power relations of health care. Their efforts were unmarked and individualized—"heroic" in the sense of being non-institutionalized and often isolated. Their perspectives suggest that encounters with underserved communities hold transformative educational potential. Students who are guided to critically assess the processes and causes of health care inequities, including the impact of historical exclusions, public policies, and the micro-level practices of practitioners, may acquire more complex understandings of the health care system and the pressures and possibilities they will confront as professionals in it. As critical analyses of service learning have explored, the deliberate creation of an encounter with "difference" for educational goals can lead students to ask profound questions regarding how the problems they encounter arose historically and what kinds of changes would be needed to resolve them. These questions, however, must be framed not as "How can we help these people?" but "why are conditions this way?" (Bickford and Reynolds 2002, p. 231). Such questions rarely arise through brief visits to communities, but from sustained relationships and insights into the systemic problems communities face (Beck 2001; Bickford and Reynolds 2002; Colligan 2000; Hyatt 2001b; Saltmarsh 1996). This article is inspired by the hope to begin a dialogue about realizing the transformative potentials of community-based clinical work.

Situating Community-Based Experiences Within the Market Place of American Dentistry

To understand what dental students learn from their community-based experiences about health disparities and their own future obligations in addressing them, it is first necessary to describe two underlying structural factors that shape students' positioning: the burden of student debt and the stratified structure of professional dentistry. In 2001, a dental graduate's average amount of debt totaled $113,000 (Haden et al. 2003, p. 573). It is likely that this debt—interpreted within a complex set of expectations regarding career aspirations and life-style standards—informs some students' sense of themselves as economically burdened if not also vulnerable. One student in my research argued that patients' assessments of them as "rich" were unfounded because they carried so much debt. This accrual of significant debt may help contextualize recent findings demonstrating that dentists construed economics as the "bottom line against which other positions had to be justified" with regard to questions of their social responsibility (Dharamsi et al. 2007, p. 1585).

Yet it bears asking what other kinds of burdens students learn to see—and whose. Students' treatment of patient populations is predicated, of course, on the existence of large numbers of people with such limited options for obtaining dental care that they accept services from supervised dental students (knowingly or not).[3] Historically and at present, the ethical code of dentists has not included the norm of universal patient acceptance,[4] and private practice dentists routinely limit their practices to patients who pay the costs they have established for their services (through direct payment or private insurance). While the economic and bureaucratic reforms of managed care dramatically restructured medicine and reduced the autonomy physicians traditionally enjoyed in private practice, American dentistry has not faced similar constraints. Very few dentists accept Medicaid, the state-funded insurance program for oral health care. Nationwide, in the mid-2000s, fewer than one in four dentists saw at least 100 Medicaid patients in a year, a decision they explained as due to low reimbursement levels, burdensome paperwork requirements, and "a low level of compliance among Medicaid patients in regard to keeping appointments and following treatment regimens" (Borchgrevink et al. 2008:1).[5] This varies widely by state: In 2000 in Ohio, for example, only 11 percent of dentists saw more than 50 Medicaid patients; focusing on California, Horton and Barker found that within a 50 mile radius around Mendota, an area with a population of approximately 800,000 people, there was a severe shortage of dentists willing to accept the state's version of Medicaid (Denti-Cal). Only five dentists accepted this insurance for children under 5 years old (Horton and Barker 2010, p. 208).[6] Low reimbursement rates are cited as a significant cause of these trends. The national average of Medicaid reimbursement rates to dentists in 2008 reached only 60.5% of the rates paid by private insurers. Each state sets its own rates, with some as low as 30–50% of the dentists' so-called retail fees.[7] Nor does Medicaid

[3] Students recounted being introduced to patients as "doctor" or as an "intern," which was vague enough that patients did not always realize they were not a licensed professional. No student ever mentioned clarifying their status to patients.

[4] Authors advocating that Universal Patient Acceptance (UPA) become a part of the ethical code of dentists have clarified what is and is not at stake in this idea, which they believe is poorly understood and rarely practiced by practitioners: "UPA does not imply an obligation to diagnose, treat, or be held accountable for abandonment, nor does it necessarily require that doctoral providers be the ones who individually meet with patients. But in tandem with that is the argument that if doctors don't really understand the nuances of Acceptance and Universal Patient Acceptance, there seems little chance they can correctly communicate the idea or expect others to responsibly carry it out for them. What needs further discussion here is the ethical basis of UPA, the potential relationship between UPA and improved access to care, and the reasons why Acceptance and UPA seem to qualify as reasonable additions to dental and other health professional codes of ethics and training curricula" (Corsino and Patthoff 2006, p. 1199). See also Peltier (2006).

[5] Borchgrevink et al. (2008). "The Effects of Medicaid Reimbursement Rates on Access to Dental Care" National Academy for State Health Policy http://nashp.org/node/670 (accessed August 25, 2010).

[6] It is also noteworthy that statistics on the number of private practice dentists who accept Medicaid patients and the numbers of patients they treat annually is hard to come by, for the trends do not appear to be systematically collected and tracked on a nationwide level. This reflects and in turn helps constitute a broader framing of much research about the problems of access to oral health care, which measures the number of patients who received treatment and emphasizes patients' "demand" for services, rather than exposing the barriers created by practicing dentists. For an illustrative example, see Guay 2004).

[7] Pewcenteronthestates.org/costofdelay NC.

reimburse for all procedures. While the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit of Medicaid requires states to provide for the relief of pain and infections, and the restoration of teeth and maintenance of dental health for persons under age 21, there are no federal requirements for states to cover any adult dental services.[8] Most state Medicaid plans cover only emergency treatments, few offer comprehensive dental services to adults, and as states struggle to balance their budgets, many Medicaid plans have cancelled the minimal coverage for adult dental care previously provided. Clearly, the market place for oral health care in the U.S. is a highly stratified arena in which the vast majority of dentists serve the relatively affluent patients—while a minority serves the indigent and those on the public plan of Medicaid.[9]

Access for this group of people is largely provided by clinics specifically devoted to public health or community dentistry. This sphere of care is structured organizationally and symbolically quite differently from private practice venues. Sometimes referred to as "community-dentistry" or "safety-net" dentistry,[10] these diverse settings include an array of clinic types, from the dental clinics of municipal public health departments to not-for-profit clinics that charge on a sliding scale and accept Medicaid insurance, to clinics under the auspices of the Indian Health Services, the prison system, etc. Dentists in community health centers and their patients are symbolically distinguished from "private practice" actors in multiple ways. Working in public health dentistry pays significantly less, carries less prestige and, in some corners, a degree of stigma, as when outsiders portray this sphere as an arena for inferior clinicians whose patients are apathetic about their oral health needs. Yet for some faculty—many of whom worked in community dentistry before entering academia—this sphere of service carried the symbolic valence of undertaking a career of social purpose. This was particularly true for clinics focusing on pediatric oral health. "Peds," pronounced "peeds," as it is colloquially known, was embraced as a socially responsible form of professionalism: inasmuch as children are not expected to be consumers, they are widely considered entitled to receive services regardless of their parents' ability or willingness to pay.[11] Advocates also valued the opportunity of teaching oral health habits to children,

[8] http://www.cms.gov/MedicaidDentalCoverage/

[9] Certainly, many people go without oral health care. The stratified character of this health care system is evident in the highly disproportionate rates of caries and edentulism (loss of teeth) among poor populations (Haden et al. 2003; Rule and Welie 2006).

[10] Although the term "safety-net" clinics is used by policy planners and the American Dental Association, one of my key informants for this project, Dr. Balun, objected to my use of the term as an umbrella category for all these types of settings. He distinguished the public health department clinics and not-for-profit clinics with which he collaborated extensively as a university faculty member, from mobile clinics and student-run volunteer clinics, insisting that the former provided continuing care to patients and established on-going relations with their community of patients. He asserted that the term "community clinics" better characterized their profile and captured their legitimacy as bona-fide health care entities that provided a defined population with stable services, whereas the term "safety-net" clinic suggested a destination of last resort without the kind of long-term commitments that the practitioners he worked with displayed.

[11] Eliasoph (1998) further elaborates on cultural assumptions about children as deserving in social service contexts.

hoping to establish disciplines that would improve health status for a life time. The provision of pediatric oral health care thus garnered a degree of respect not enjoyed by other public health venues.

Indeed, faculty and students expected adults to exhibit individual responsibility for their oral health. Although numerous environmental, political–economic, and genetic factors contribute to oral health status, they routinely cited behavioral practices as the most important causal factor. Considering routine brushing, receiving regular prophylactic care, and consuming high quality nutrition as the "rational choices" of informed individuals, they held adults (or parents of children) with severe tooth decay accountable for failing to "choose" these behavioral habits. Without insights into the complex historical, political–economic, and social systems that set patients up to have poor oral health (forces related to habitus that, admittedly, require further analysis)—discourses of individual agency erased the role of power inequalities and domination in patients' lives (see Horton and Barker 2010 for one salient case study examining these dynamics). This erasure exemplifies the systemic misrecognition of expert power (Bourdieu 1992, 1999) at the core of commodified health care.

Research Methods

I studied the knowledge students gained from working in communities by conducting participant-observation during their required and voluntary service provision, in five classes when they discussed these experiences, and by analyzing a sample ($n = 216$) of their written reports on these experiences from 1997 to 2006. I conducted semi-structured interviews with eleven students, seven clinic-based preceptors and staff, and eight faculty members involved with community-based education; most of these were taped. All fieldnotes and interviews were transcribed. Two faculty members and three students became key informants, offering me more extensive insights into their perspectives and experiences in the course of 3 years of research. Finally, I conducted a large group discussion with students and faculty on the topic of volunteering, which was taped and transcribed. All the names in this article are pseudonyms.

Structures of Domination, Ideologies of Worth, and the Volunteer Subject

Although mobile dental clinics in the United States go back as early as 1919,[12] dental advocates have worked hard to revive them over the last decade to reach some of the millions of people without regular oral health services. Through grants from private foundations and in conjunction with local professional societies and dental schools, these activists purchased large trucks and outfitted them with dozens of dental chairs, X-rays machines, and other necessary equipment that can be set up for temporary, mobile clinics. Undertaken with the support of local churches, community groups, and municipal governments, the clinics are usually set up for

[12] Harris, Ruth Roy. *Dental Science in a New Age: A History of the National Institute of Dental Research* (http://www.usc.edu/hsc/dental/images_media/mobile_clinic_factsheet.pdf).

2 days during a given weekend in large gyms or similar spaces. Since patients are treated on a first come, first serve basis, they arrive to the area where the clinic will be held the night before, sometimes waiting outside on the street all night to ensure they get a spot. With the elaborately organized assistance of hundreds of volunteers who do everything from arrange logistics, manage the crowds, serve as translators, and provide lunch and accommodations for providers, as many as 400–600 patients may get treated in a two-day clinic.

Dental students and others hoping to attend dental school in the future make significant contributions to these clinics. I attended two all-day clinics provided by an organization I call Devoted Dentists and Supporters (DDS), along with members of a dental student volunteer organization, "Students for Smiles."[13] One clinic was in an inner city area, the other in a small rural town, which opened its doors to patients from areas as far as a 5 hours drive away. With the support of the dental school, Students for Smiles recruited participants and nurtured a collective sense of camaraderie throughout these clinic events.

What they observed and helped to realize at the DDS was that people suffering from tooth aches would get some relief, but comprehensive care was not being practiced; the volunteer dentists and students realized that they were sending most patients away without addressing a fraction of their oral health needs. "Volunteering is not a health system," one dental student remarked as we ate pizza and chips donated by a local restaurant for lunch. Others were more sanguine about the event, emphasizing the "do-good" spirit of volunteerism and its rewards for all involved, as the DDS public relations representative told me:

> Some [patients] have been waiting all night. Yesterday at 10 pm, I got calls from [people in cities two and five hours away] asking if they could come. They think nothing of standing in line all night, or all day, in the rain. You should go talk with them. They're so cheerful. I'm always blown away….You've had a toothache before, right? Well, imagine having it for six months. It's so great, there are so many volunteers here, and people are showing so much support… It's just wonderful.

Indeed, I thought, imagine having a toothache for 6 months and then having to wait in line all night to get it treated. As I looked out at the crowds of people standing in line outdoors to get a number, sitting on bleachers waiting for treatment, and then finally reaching their turn to lie in one of 60 dental procedure chairs to have a tooth filled or pulled—the depiction of DDS patients as "cheerful" seemed quite a stretch. People appeared deferential and appreciative, but they were not enjoying themselves. In time I came to see his narrative as serving a purpose within the broader moral economy of commodified health care: Persons who do not pay for care (failed consumers) have few entitlements; if they become the fortunate recipients of charity, then they are expected to demonstrate their gratitude for whatever they receive, fulfilling their debt to volunteers by helping forge the sense of satisfaction that derives from helping deserving others. Portraying charity recipients as "cheerful" established them as "worthy" of this "free" care. Such

[13] All names of organizations and persons in this article are pseudonyms.

visions of debt and expectations of reciprocity in the cultural practice of volunteerism are central to the moral economy of commodified health care.

I came to understand additional aspects of this moral economy and how it structured students' engagement with poor populations from Dr. Osborne. As we stood in front of two of the sixty dental chairs at one DDS, she lamented that many students volunteered for "a chance to seek independence and not have the supervision they have at the dental school clinic. They want to try things out and see what they can do. But that's not what this is about." Dr. Osborne was worried that students' eagerness to treat patients established the wrong motivation for participation and could result in poor quality care.

Soon after she made this comment, a third-year student called Dr. Osborne over, explaining, "I'm not getting much traction here." The patient, a Latino man in his fifties, had an infected molar on the top right side. The roots had curled in and were severed from each other. After working on extracting the tooth herself for some time, Dr. Osborne called over the oral surgeon, who sectioned the molar and took out the roots one by one. Altogether, the procedure took over 45 minutes. When the treatment ended, Dr. Osborne commented with exasperation that this case exemplified the broader problem of students' over-confidence that she was confronting:

> that student wanted to go in there and had no idea of what she was going to do. She thought she'd just pull that tooth right out. It could have broken up inside the gum. We were lucky, it came out intact, but the danger is always there [that it will break off]. We need to be prepared for this. The patients who come here often have big problems—these students must have adequate supervision. We have to keep the ratio [of students: faculty] low.

In addition to what she called students' "gung-ho" willingness to try out new procedures on patients, she also confronted the flip-side of this in their reluctance to do procedures that they considered less interesting. At lunch, Dr. Osborne told the students that they would be doing cleanings for the rest of the afternoon, since that was the treatment need of the largest group of patients still waiting. The students were not pleased. One young woman rolled her eyes and said, "I don't want to do this all day." "We have to do it," replied another. "I've put in my time with cleaning," said a third. The students were disappointed because they had come to the DDS with expectations of doing "exciting" technical procedures, and instead were going to spend the rest of the afternoon doing the familiar practice of cleaning teeth.

Dr. Osborne reflected on these reactions in light of my research questions, and invited my continued observations. Throughout the 8 hours of clinic both of the 2 days it was in session, Dr. Osborne oversaw (and when needed, took over) the work of five students at a time, modeling an unflagging commitment to serving the poor through her focus and energy. Despite these efforts, she worried that the students were not getting adequate supervision and that the care they were providing may have been substandard. She identified several factors that contributed to this situation: Not enough faculty members had volunteered relative to the number of students allowed to attend, and those who were present had to supervise too many students to help them all thoroughly. Moreover, she argued, the lighting over the mobile dental chairs was poor. The instrument kits—packets of hand tools donated

by various practices and agencies—were not standardized and often contained different kinds of tools than what the dental students were learning with at school. "For restorations (fillings) to be successfully undertaken, the area of the mouth needs to be completely dry to ensure the bonding agents work; so the dentist needs to isolate the area where the filling will be done. At the dental school, we use a rubber dam that seals the tooth to create a dry environment for good quality bonding; here at the DDS, they use cotton rolls, air syringes, and try to isolate the area with gauze." All of these circumstances contributed to a situation in which students' inexperience could jeopardize the quality of care patients received, she explained. "These patients deserve the same standard of care we provide at the dental school," Dr. Osborne insisted to the students, the clinic organizers, dental school administrators, and me. Pursuing this goal required her constant vigilance supervising the students, but still seemed a remote ideal: the very structure of a one-time clinic without comprehensive care could never provide the same standards of care as the dental school did. Still, she emphasized students' individual accountability to patients and fought to neutralize their expectations for independence. Yet as I learned, such expectations stemmed from the DDS organizers themselves:

> Some of the organizers of the DDS push us to go faster, do more—they want to be able to say [for publicity's sake], "We served 1000 people" … But that's not what this should be about… If the DDS organizers want to do more patients, then let them get more [private practice dentists] out here volunteering!

Dr. Osborne protested the poor equipment, inadequate materials and supervision to the DDS organizers and dental school administrators, threatening to suspend student participation unless these issues were addressed. DDS staff and many students responded to her with hostility. Convinced that providing care to those who had no other access was a moral good in and of itself, they saw it as a threat to the entire endeavor to put the particulars of student participation under a microscope. Dr. Marshall, a founder of the DDS who dedicated his entire career to serving the poor, realized these clinics were no substitute for comprehensive care; but he felt that they were helpful in providing some desperately needed services, and bringing the plight of the underserved to public attention. When I interviewed Dr. Marshall about the DDS clinics, he provided additional insights into how student participation was structured:

> We make it fun for the kids so they want to come, not like school. I do my damnedest to make it no pressure. I let them do what they want to do—let them feel, experience themselves as practitioners. You know, we give them supervision and everything… Some students go on repeat basis. It makes a difference. I know that some have decided to take Medicaid in their private practice or work in public health departments.

As I learned in the course of fieldwork, this statement was an allusion to the fact that the DDS organizers were encouraging and supervising students in doing extractions even if they had not yet qualified academically to do so. Here was the return that volunteering at the DDS clinic promised: students who woke up at 5 am on a Saturday after an exhausting week of study, drove sometimes for 2 or 3 hours to a remote part of their state, and worked all day in the relatively rough conditions

of a MASH-style clinic, would gain enticing rewards: volunteering at this clinic would be "fun," in part because its organizers were willing to override the dental school's authority in determining students' acceptable scope of practice.

Underlying this informal exchange were cultural expectations based in the moral economy of commodified health care: that *un*paid work to help failed consumers is a virtuous act for which one is entitled to "feel good." This entitlement structured the relationship between student volunteers and patients in such a way that student desires drove the terms on which community engagement occurred. Indeed, since volunteering is framed as an individual choice, one can legitimately refuse to volunteer in the future if the engagement is not judged to be worth the time.[14] "Worthy" returns may consist of patient gratitude or new, "fun" experiences; either way, the circumstances of the patients receiving services, as well as the standard of care delivered, may get obscured. This moral economy entitled students to have their interests fulfilled without holding them responsible for understanding patients' social situations, emotional needs, or the causes of health inequities, even as it created expectations that patients would supply gratitude.

While, as mentioned above, Dr. Osborne identified the marginalization of patients' needs and experiences as an ethical dilemma inherent in student volunteering, most students interpreted volunteering quite differently.[15] To assist my study, a leader of Students for Smiles organized an open discussion at the dental school on "Why we volunteer." To my surprise, over 80 students and several faculty members came;[16] I inaugurated the session by asking participants to jot down thoughts about three questions: What are the benefits of volunteering, and what are the costs? What paradoxes or problems have you experienced in volunteering with communities? Clipping my microphone to my jacket lapel, I quickly read some of the responses I found on the first 20 or so sheets and then asked participants to elaborate on the issue I was most interested in hearing them discuss:

> Let me take a hard one, okay? Compromises of care. That's something that only one of the slips [of paper] said. But is that something that people feel that they've *seen*? Is that an issue? …[responding to some non-verbal affirmative] It is. Can you tell maybe a little about what's at stake?
>
> Tom: … you might not have access to the same materials that you have [in the dental school clinic], and similarly, you might not have access to the same

[14] Sociological studies of volunteerism have found that groups working according to the American secular volunteer paradigm feel justified in ceasing participation if participants do not find the engagement personally rewarding for themselves. This may differ for the religious service ministry paradigms, in which unpaid work can take on an obligatory form for believers.

[15] Eliasoph (1998) found that while American culture idealized volunteering as a virtuous act that nurtured community solidarity while solving social problems, it also established rigid boundaries on what could be legitimately discussed in civic contexts. "[P]ublic-spirited conversation about discouraging issues and topics that volunteers assumed to be beyond their scope," such as the sources of the problems in need of solution and whether volunteerism was the best way to address these problems, were taboo (1998, p. 47). Although political economic circumstances resulting from state cutbacks created the conditions whereby volunteer contributions were needed, volunteers systematically avoided discussing these very circumstances.

[16] I explained that the discussion was being taped for research purposes but would be kept anonymous.

supervisory resources that you have [there], and I think that, because of that, occasionally things are going to slip through the cracks.

Mark: I think that the provider is ultimately responsible, I mean I feel that they have to have their ethics at a certain level to start: *I'm* not going to deliver compromised care.

In response, I attempted to steer the conversation toward broader structural forces that might impede providers' ethical ideals from being realized:

Michele: Yeah, so there are decisions that have to be made… You have a standard… that you're taught in school as to what every patient should have, and then you're faced with … long-waiting people that all need help…And I wonder if this is more than just an issue of the individual provider's goodness or decision-making. Is there a system issue going on here?

Chris: Well, I would say that in general, there's that mentality, you get what you pay for… in general. You know, I'm not saying I'm like that, or anybody else in here is… but that's kinda ingrained in people when they purchase anything—services, or cars—you don't pay a lot, or nothing, you don't expect a lot…

Jim: I think one of the complicated factors about volunteer activities like DDS clinics is—we're, we only have one appointment to see patients, and a lot of dental procedures require multiple appointments. So, while you might seem like you're compromising care, you're actually just completing the—you're arresting the disease, you can't actually give them a crown or anything, but you've *done* what you could, you've stabilized them. Their disease isn't going to progress… so, I think you've done a good job, you know, you could say you could do more, but you've only seen them for an hour…

If Tom partially acknowledged that unfamiliar materials can lead to substandard care, the next responses attempted in various ways to justify or minimize the impact of compromised care. Mark did so by implicitly defining the problem as a matter of individual flaws that personal decisiveness and commitment could solve; Chris rationalized the lower quality care as an understandable outcome in a "free" clinic; and Jim denied that there was compromised care because the purpose of the DDS clinic was not to provide genuine services, but only to "arrest the disease." Jim in effect argued that the framework of the MASH-like clinics entailed an entirely distinct version of dentistry, so the criteria for doing "a good job" consequently differed.[17] Only one student acknowledged the systematic compromises of care inhering in students' and patients' competing interests:

Megan: I'm a coordinator at [the volunteer student clinic], and very often we have people come into volunteer and it's their first time or their second time ever treating a patient. But they don't have any aggravation at all about sitting down and starting work on a patient, and I think that's a huge ethical issue, that we're using these people that can't afford to get care, that can't afford care

[17] This statement resonates with similar logics created by actors in the global pharmaceutical trials as described by Petryna (2009).

somewhere else, as guinea pigs. And our students look at that as… an opportunity to get experience. Well, we forget that those people are real people too, and they deserve the best care just like anybody else, people who pay for their care.

Megan's passionate appeal to patients' humanity and the value of universal equality stood out from among the many comments made during the 50 minutes session. It raised several responses, from defenses of students' professional ethics to admonishments that students should be more humble and generous, model the importance of service to younger students, and not "talk trash" about patients on the car ride home. These moral exhortations contained an incipient recognition that something was amiss, but the source of the contradiction did not get fleshed out. I believe this is because Chris' comment, "you get what you pay for"—which he at once disowned and asserted—expressed a moral economy that most participants accepted. Never refuted, this statement stood as a legitimation of the structural limitations shaping dental treatment for poor patients in the mobile clinic and beyond. It forestalled discussion of the justice of a situation where people's only access to care was a mobile clinic where only one tooth would be treated and no follow up care was planned; and it left unexplored the question of what "individual (provider) ethics" could entail in a context that so dramatically contravened standards of comprehensive practice. Participants had so internalized the moral economy of commodified health care that most did not recognize how students' engagement with poor populations often involved conflicts of interests and the potential for compromised care. Megan understood that it did. Yet her argument became a magnet for rebuttals or a springboard for solutions focused on individual students' behaviors. These moral exhortations to display altruism misrecognized that students' disregard for or resentment of patients entailed objective reflections of their positioning, a relationship that would have to be acknowledged and made into an ethical "problem" before it could be eliminated.

Required Rotations: Forming the Ethical Clinician-Citizen

Many U.S. dental schools require extramural rotations after students qualify to do restorations and extractions. They work in public health departments, not-for-profit clinics, mental hospitals, institutions for the developmentally delayed, prisons, Indian reservations, etc. Now widely considered a valuable part of students' learning, the initial establishment of these programs in the 1970s was controversial, as I learned in an interview with a founder of one of the first community-based clinical rotation programs. The idea arose as part of a national effort by the Carnegie Foundation to address the inadequate access to health care among impoverished rural and urban populations.[18] Some private practice dentists in these areas opposed the idea, fearing increased competition—despite the fact that they refused to treat uninsured and poor patients themselves. Over time proponents were able to persuade

[18] Following the Carnegie Foundation report, Congress established the AHECs, Area Health and Education Centers in 1972 (Fournier 1998).

university deans that students benefitted from exposure to a variety of clinic sites and patient populations. Dental schools embraced the relationship with community clinic sites as evidence of their institutions' commitment to public service (Caine 1975; Jacobson et al. 1999; Mofidi et al. 2003; Strauss et al. 2010). Faculty directors of these programs served as bridges between local community health clinic staff and the university, offering both moral support and student labor to public health practitioners in remote regions. They also encouraged students interested in public health focused careers, rendering these paths legitimate forms of professional practice and providing practical advice as to how to pursue such careers in the face of extensive debt and other challenges. Yet systematic pedagogical attention to the effects of brief work experiences in public health settings on students' perceptions of the poor and the problems of health disparities was not undertaken.

Alongside these explicit messages depicting community-based work as virtuous, the "hidden curriculum" also taught students how the broader dental profession assigned value to various spheres of practice and the participants in them. By the time they undertook their required rotations in public health clinics, students were well-aware of the structural and symbolic distinctions between public health and private practice dentistry. They were familiar with the pejorative concepts of the "public health mentality," and stereotyped "Medicaid clinic," images that conjured up poorly equipped, poorly skilled and cynical clinicians who supposedly worked as little as they needed to, or even engaged in unscrupulous practices.[19] They were well-versed in discourses that portrayed poor patients as unreliable, failing to show up for appointments, non-compliant, and apathetic about their oral health. They knew that private practice, by contrast, was widely considered the norm of success, where a dentist chooses his or her clientele, earns well, and enjoys autonomy.

This ideology of varying social worth typically emerged in passing, rather than being explicitly discussed. I asked preceptors in community clinics whether they addressed it directly with the students they supervised. Several described trying to counter students' assumptions that their clinics provided inferior care by modeling high quality work and respect for their patients. Dr. Davis, an African-American woman who directed a not-for-profit pediatric clinic, told me:

> Because so many patients and parents who are on Medicaid have been made to feel like second class citizens…from day one, our philosophy was that we want them to feel the same way when they're coming into our office as if they were going into any private office in the area. We did not want them to come here and feel like, "Oh this is a clinic for Medicaid patients, oh, this is a clinic for poor kids." We didn't want that stereotype or that stigma. So from the very beginning our staff has gone over and beyond and rolled out the red carpet to make parents feel good when they come here.

In stating at the outset that Medicaid recipients "have been made to feel like second class citizens," Dr. Davis alluded to entire sets of social forces that have

[19] One example as to how they supposedly did this was through deliberately restoring only the caries that were visible to the naked eye, and then taking X-rays and having to re-do them once more were diagnosed.

created barriers to patients' health. She took responsibility for the ways her institution interacted with patients, creating policies that drew on extensive knowledge about her patients' lives and ensuring that the students she supervised understood the difficulties they faced trying to access dental services: "We have to understand how hard it is to get around without a car, or to cancel appointments if you don't have a phone, and we have to work with our patients given these situations." To keep her clinic solvent, she double-booked appointments to prevent revenue losses if a patient could not come. She recorded multiple contact numbers for patients, including friends who would know how to reach them, and had her staff make several reminder calls prior to appointments. She worked with social service agencies to facilitate patients' transportation. These practical steps to help patients access dental care despite the economic barriers they faced offered a model to students of how non-profit (public) institutions can structure their work to meet their clients' specific needs—yet ironically, she described her clinic in terms that reconfirmed the symbolic dominance of private practice clinics.

Although many preceptors I met shared Dr. Davis' commitments, the moral economy of commodified health care overdetermined student learning in clinics. At the school I call the University of Dentistry, students were required to attend a 4 week public health rotation and thereafter submit a written report reflecting on the insights they gained in terms of their own developing values as a practitioner. They were also required to participate in a 2-hour oral discussion with a faculty facilitator and approximately ten peers to debrief about the community experience. In these contexts, students trained their observations on frames such as "patient management" and "treatment planning," dimensions of practice they were most interested in as they imagined their impending future. One of the issues they found striking was the dramatic differences between the practice standards they had been taught in dental school and the treatment decisions they witnessed being taken in the community clinic: whereas their faculty consistently emphasized taking all steps possible to restore decayed teeth as a matter of patient health and professional integrity, community preceptors routinely instructed them to extract potentially restorable teeth. This clash left a profound impression, with many students grappling with its causes and implications in both their written reports and class discussions. As they explained and justified it—or less often critiqued it—they also commented on the distinctions of social worth inherent in the moral economy of commodified health care.

Students understood that these trends were linked to Medicaid reimbursement policies, which covered only extractions, not fillings or root canals, for adults. The reference to Medicaid reimbursement, however, rarely led them to question the dental profession's ethics in allowing insurance policies to dictate treatment planning, or to clinicians' complicity in providing substandard care. Instead, many students accepted the substandard treatment procedures as the product of patients' own choices, a reflection of their indifference about preserving their teeth. A common trajectory of class discussions involved students bemoaning and mocking what they saw as patients' wrong-headed decisions. Many dismissed the idea that the high cost of restorative procedures was a barrier, arguing that patients found the money for items they valued. Indeed, rather than advocating for broader coverage of

dental procedures, students argued that providing dental care for free made it less valuable to patients; many insisted that clinics needed to teach patients to take responsibility for their oral health needs by not providing any treatments except emergency care without payment.[20] In the five classes I observed, these depictions of public health patients as indifferent to their health dominated the discussion; they were also a common theme in students' written reports.

Still, a minority of students were disturbed at these differences in treatment procedures, rendering them as ethical dilemmas that required resolution. My interest in these cases concerns how students and faculty conceptualized the nature of the dilemma at stake, as well as the scope of legitimate forms of redress they imagined. In one discussion, a student named Karen expressed outrage that the clinic staff refused to give narcotics to the Latino patients they served:

> The care we provided was based on insurance, not need, as it is at [the university]. Where we worked [in the community clinic] they said, "Because it's an indigent population, you don't prescribe pain medication; they're indigents and will tell all their friends, "they gave us drugs." It was very upsetting to me to see that you leave [the university] and stop providing care as well. I fought this battle for 5 weeks; I stopped taking out teeth because of it… But they didn't even teach patients correctly how to take Ibuprofen. I told them. But they were Spanish speakers and didn't understand. I watched them go home and knew they would be suffering; it was very stressful. They [clinic staff] automatically assume people who're asking for drugs are abusing them, but research shows you must give the medications when people are IN PAIN. They gave justifications, the preceptor said, "I had all my wisdom teeth out and took only Ibuprofen, so they can, too." Each patient should be treated as an individual, but they just want one type [of care] for everyone.

Karen's story highlighting an ethical breach by discriminatory staff presented a fairly uncommon example of a student considering the effects of treatment disparities on patients. The faculty facilitator, Dr. Smith, replied by distilling the lesson from this account that focused on students' need to undertake values-based decision-making in daily practice: "You're getting more questions than answers [in these rotations]. We focus on evidence-based practice at [our university]. Community rotations are introducing you to different practicing philosophies and you need to think about how you're going to undertake your professional responsibilities."

Although I knew from interviewing Dr. Smith that he saw health inequities as an important matter for dental schools to address, he defined the issue Karen raised as an apolitical matter of personal, professional decisions. Without a recognition that expertise involves the possibility of domination, or an analysis of the structured inequities that limit non-English speaking (possibly undocumented) patients' opportunities, he was unable to capture how the situation Karen described represented a systematic form of discrimination. One could imagine, by contrast,

[20] A study of North American dentists' interpretations of their "social responsibility" found that the only obligations for treatment that all dentists agreed they had was to provide relief to a person in pain (Dharamsi et al. 2007).

using this case as a springboard for discussing how social and political–economic systems that stereotype all Latino patients as "drug-users" and deprive them of indicated pain relief, contribute to these patients' reluctance to obtain oral health care, and consequently, impact their poor health outcomes.

In line with Dr. Smith's framing, most students who defined the differences in treatment procedures as ethical dilemmas conceptualized them as dilemmas for *themselves* as future clinicians. In two final ethnographic examples, I examine the main logic through which students conceptually assessed their entanglement in this systemically-produced inequity, and worked to determine a path of ethical action. Once again, the narratives students created reveal the cultural tools that the moral economy of commodified health care provided for making sense of health inequities—ideals of individual responsibility and choice inherent in the autonomous rational actor model. Time and again, students expressed commitments to their own individual ethical responsibility to "educate" patients and "give [them] choices." Patients, in turn, were understood as responsible for their own individual decisions, which were deemed reflections of their personal values and, as this student report described, their "culture" :

> The majority of the patients had rampant caries, many also had advanced periodontal disease… many… needed to have full mouth extractions, and were in the age range of 20 to 40 years. By… my second day in this clinic, I felt beaten down. I was depressed and saddened by what I was seeing, and I suppose the seeming enormity of the problem made me feel that it was hopeless…Thankfully, I recovered. The initial, overwhelming shock subsided and I came to realize that, for whatever reason, maintaining healthy teeth was not a priority for these people. For some, it was lack of knowledge and training about how to care for their teeth. Others could not afford dental treatment beyond extractions. Some simply did not care. It was evident from talking to them that they were not concerned with health issues of any kind, much less dental health. I decided that's okay. Everyone has their own set of values and priorities, and some will differ greatly from my own…
> I think this experience has helped me to broaden my horizons a bit in regard to how I view my own contribution. I can only help a person if I can give what they need. Clearly, these people did not need oral hygiene instructions and a pretty composite restoration. I hope that I will be able to offer services to a variety of people without being judgmental about the priorities and values they have. On the other hand, I must be careful not to categorize or stereotype people. Education is a large part of what we do, and I will need to know that the patient has the tools they need to make an informed decision regarding their treatment.

Shocked and upset by the severity of this population's poor health and the treatment planning that routinely occurred, this student had access to no other explanation of the situation than American folk ideas defining "culture" as individual values.[21] Seeking both to cope with her distress and adhere to general

[21] For a parallel outcome among American teachers evaluating poorly performing students, see Ladson-Billings (2006).

ethical concepts such as "value-free" objectivity in health care, she "recovered" by redefining the acceptable standards of care as matters that varied according to patients' "choices," not as professionally determined. In this students' understanding, the patients' "values" and "priorities" represented choices made by autonomous actors unhindered by competing needs, pressures, or prior experiences (such as a lifetime of not learning oral health disciplines). This student could not imagine that broader structural forces—invisible to her from her limited clinical encounter with patients—would have impacted patients' practices and decisions. Her solution, to avoid morally judging patients and provide them with education, established her as an ethical clinician-citizen—a provider who gives objective information to facilitate patients' rational decision-making and withholds judgment about the decisions they ultimately make. Responsible for offering information, this ethical clinician would not, however, need to learn about the lives and forces shaping patients' lives and decisions, or incorporate such insights into her patient "education."

The final excerpt stood out from the bulk of student reports in acknowledging the wide range of forces affecting health disparities. Nonetheless, the report typified most responses of those who sought to reconcile the ethical dilemmas they identified in community clinic treatment contexts, by emphasizing individual provider actions as the key to ensuring ethical practice:

> My… rotation was at the… Community Health Center. The patients were mostly homeless or on Medicaid and time after time I tried to encourage patients to save their teeth and my efforts went in vain. I wasn't accustomed to this, if you will, mentality. It posed a great dilemma for me as a health care provider. Up until that point I hadn't come in contact with so many people with such utter disregard to the maintenance of their dentition… I was providing care that I did not feel good about.
>
> My problems with the system are multifold. On one hand I am upset with Medicaid. Since they only pay for extractions they are sending the message that if a tooth needs any treatment (even a routine conservative restoration) then it should be extracted. Some may conclude that any treatment other than extraction is overtreatment. To me this is preposterous and absurd but unfortunately to many it is a reality. Secondly, I am disappointed in the patients for their willingness to accept this substandard care. In addition, how can practitioners allow Medicaid to dictate the treatment they render?
>
> As the weeks progressed, I unknowingly became desensitized to this environment. Extracting teeth that could otherwise be restored didn't even phase me as it once had… I even started recommending extractions!!!!
>
> On the last day of my rotation I saw a woman on Medicaid for an emergency exam in reference to tooth number 18. My diagnosis was irreversible pulpitis with acute apical periodontitis. I automatically recommended extraction and informed the patient that it was the only thing that Medicaid would pay for. The patient agreed as she could not afford anything that her insurance would not cover. I proceeded with the extraction without any further thought.
>
> On the plane ride home, I reflected on my experiences at the health center and how things had changed since my first day. Then it hit me. I had changed and

it wasn't for the better. My thoughts returned to the young, pretty woman I treated on the previous day. I had already decided what treatment was in her best interest without any input from her. I made this decision before she even sat in the chair based on the code "Caid" written on her superbill and examination of a periapical radiograph. It was that moment I realized I subconsciously had conformed to the clinic's "mentality." I allowed myself to become a product of my environment. Instead of being proactive I was reactive. I had done something that went against everything that I was ever taught. I prejudged a patient. Although what I did was acceptable in that environment, it violated my own personal code of ethics. That realization symbolized a very important lesson. I vowed to never again prejudge a patient and to treat all patients equal without regard to their socioeconomic status and the environment in which I'm placed.

This report noted the dental profession's complicity in allowing the state to determine the scope of treatment rendered. The student also came to see the profound social effects of the clinic as a cultural milieu shaping a sense of normative practice out of what otherwise the student knew was considered substandard and unethical care. Yet in conceptualizing a solution to dilemmas she outlined, the student's focus returned to maintaining her own, personal values. As a conceptual possibility, this solution entailed ignoring both the formative effects of the larger institutional context and the need for broader political–economic change that she had just mentioned! The cultural primacy of individual responsibility led this student, as others, to believe she could rely on her own personal commitment to "do the right thing," even as this assumption required her to conceptually bracket out the social, cultural, political–economic, and institutional constraints that she witnessed producing these health inequities.

Conclusion

I began this article by posing Dr. Osborne's questions of how clinical education in communities might more effectively promote students' commitments to addressing the needs of the underserved. Exploring this required understanding how and why these encounters were having unintended consequences, including reinforcing stigmatizing stereotypes of the poor. My argument revealed the ways community-based education and its outcomes reflected the broader culture and political-economy of commodified health care, a mode of distribution and knowledge I see as a moral economy. I summarize these findings here and conclude with some thoughts on how realizing the transformative potentials of community-based education would require reconceptualizing the educational process as engaging students in a systematic analysis and critique of market-based health care.

My ethnographic accounts uncovered three logics underlying community-based clinical education that worked to socialize dental students into America's commodified health care system: (1) the dialectical ideologies of volunteer entitlement and recipient debt; (2) the forms of justification for the inferior care

provided to "failed" consumers (patients with Medicaid or uninsured); and (3) the forms of obligations characterizing the ethical clinician-citizen. All of these assumptions about obligations and entitlements reflected the structure of students' relationships with underserved patients. Student volunteers were entitled to have their interests met, while poor and uninsured patients faced a range of inequities and discrimination: in various contexts, they were treated by students (sometimes without being aware that the provider was not yet a licensed dentist or had not qualified to do the given procedure); received a poorer quality of care relative to private practice as measured by materials and equipment; received substandard treatment procedures (extractions of potentially restorable teeth); received treatment for only one tooth rather than all needs; and were sometimes deprived of narcotic pain relief after extractions. Certainly, not all these conditions existed in every site where poor patients received care, and many clinics strove both to provide superb quality care and uphold their clients' dignity. My point has been to highlight the logics students learned that naturalized these inequalities and justified them when critiques arose.

Clinical education in community settings also produced the ethical clinician-citizen, one subject to engagement with the poor through voluntary or required programs that the university considered a "social good." This ethical clinician-citizen emerged in several forms. As Dr. Smith asserted, the ethical clinician-citizen is one who makes her own decisions about her professional responsibilities. Students similarly understood the ethical clinician-citizen as one who "has their ethics to a certain level from the start" so they don't "agree" to provide compromised care. Neither of these formulations recognized the impact of institutions' normative practices on individuals' likelihood of practicing their "personal" ethics, by discussing, for example, what refusing to adhere to clinic protocols that deny certain kinds of care entails when these protocols are backed up by justifications based on highly stigmatizing characterizations of patients; or whether it is feasible to expect student volunteers to refrain from procedures they have not yet qualified for—when their peers do these procedures and some clinic organizers promise to supervise them. These cases expose the limitations of constructing ethical standards as a matter of student/expert choices and discretion, an issue some academic leaders have recognized (Hafferty and Franks 1994, p. 866) but that remains difficult to dislodge.

The ethical (student) clinician-citizen was considered to have obligations to others: she or he should encourage altruism and public spiritedness among her peers, and refrain from demeaning patients to other students. Moreover, he or she should understand patients as rational, autonomous decision makers guided by their "culture" and "values," and make the effort to educate patients about their treatment options, despite broader social norms not to bother, and despite knowing that the cost of the ideal, restorative services is likely prohibitive. This "education" involves explaining the dental profession's assessment of ideal oral health procedures. It also involves respecting patients' "choices" without morally judging them—but also without understanding their background and economic or social circumstances that may shape these decisions. This narrow and universalized vision of "education," unrelated to patients' lives and struggles, can be seen as a

technology that governs providers and patients alike within commodified health care. The provider is subject to the imperative of providing this "education," and becomes an ethical clinician-citizen through the effort of facilitating patients' transformation into "informed" health care consumers. Patients are subject to the expectations that, once "informed," their decisions about their health care are considered their own, autonomously made choices; dealing with the repercussions of these choices is the patient's problem alone.

There were faculty and preceptors who worked to challenge aspects of the moral economy of commodified health care, knowing, nonetheless, that they could never fully disengage from it. Throwing her energies into these volunteer endeavors both to alleviate at least some of the oral health needs of the poor and to provide students with exposure to the gross deprivation so many endure, Dr. Osborne lived with the contradiction of knowing that a one-time mobile clinic could never meet the standards of comprehensive care that all patients should receive. Therefore, she fought for piecemeal change, standing up against the prevailing stance of her colleagues to re-structure the conditions that set volunteer students up to provide inadequate care: she fought for better-stocked instrument kits, advocated the need to ensure lower student: faculty ratios at volunteer events, and strove to prevent unqualified students from doing extractions. And in time, she saw positive changes emerge in these realms. Dr. Davis turned the notion of "failed consumer" on its head, highlighting that the system of commodified health care has made Medicaid recipients feel like "second class citizens" and taking steps to reverse that relationship. As director of a non-profit pediatric dental clinic, she instituted policies that addressed her clients' needs and taught these strategies to the students she supervised. These professionals acknowledged the workings of expert power as systemic forces that can produce or mitigate system-level inequities, and variously sought to shift students' awareness of the practical ways they and their institutions play into these processes. They did this by providing insights into their patients' lives and implicitly suggesting that the clinic as an institution is involved in either reinforcing patients' domination or helping to undo it. Through their daily practice they enacted an ideal that the privileged—dental practitioners, dental students, and dental schools—can shift the relations that reproduce inequality.

The President's Commission of the American Dental Education Association has recognized that academic dental institutions have responsibilities to address the immense inequalities in oral health within America's population (Haden et al. 2003). Their report moreover critiques the commodification of health services and asserts "the traditional model of oral and dental care, namely that of the solo practice dentist… is no longer adequate to address the nation's oral health needs" (Haden et al. 2003, p. 566). These leaders and other advocates for community-based clinical education as a way of improving the access to care problem would do well to learn from the insights and the practical strategies of Drs. Osborne, Davis, and others I met. Their work—too often individualized and isolated, unappreciated for its transformative character for both patients and providers alike—offers examples of practical and systemic challenges to the moral economy of commodified health care. Their knowledge should become one component of curricula devoted to teaching a systematic analysis of the structural inequalities inherent in market-based health care.

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1. **https://wclp.org/wp-content/uploads/2023/03/AB-920-Housing-Status-Fact-Sheet-3.02.pdf** - Support

AB 920 would add housing status as a measure of homelessness to the list of protected categories under California's anti-discrimination statute in order to prevent against the routine discrimination of people who are unhoused.

A survey conducted by the National Coalition for the Homeless (NCH) revealed that 70.4% of unhoused people self-reported facing discrimination solely based on their housing status. They are also targets of bias- motivated violence because they are unhoused. A 2018 NCH report using data from California police departments shows that unhoused people are routinely victims of assault and harassment across the state.

Adding housing status to California's anti-discrimination law advances the civil rights of people who are unfairly targeted simply because they are experiencing homelessness.

Template of letter of support

approps.committee@assembly.ca.gov

April X, 2023

The Honorable Christopher Holden, Chair
Assembly Appropriations Committee
1021 O Street, Room 8220
Sacramento, California 95814

Subject: AB 920 (Bryan): Discrimination: Housing Status - SUPPORT

Dear Chair Holden,

[ENTITY] is pleased to support AB 920 (I. Bryan). This bill would expand the list of protected categories in California's anti-discrimination law to include "housing status." This bill would expand the list of protected categories in California's anti-discrimination law to include "housing status." It would protect unhoused people from being targeted or denied access to programs and benefits by the state, or a state-funded agency, simply because they are unhoused. Further it would offer this additional sorely needed protection at no cost to the state.

[QUICK BLURB ABOUT YOUR ORGANIZATION]

Every person in California should have the right to participate fully and equally in society free from discrimination. But this right is denied to many residents simply because they are unhoused. Instead of ensuring that Californians without housing have universal access to a safe, permanent, and affordable place to live, many state and local governments continue to harass, displace, and segregate unhoused people. This disproportionately harms people of color – particularly Black communities who, because of historical and contemporary discrimination in all aspects of life, are unhoused at higher rates.

[Consider adding a story or example of how discrimination against unhoused people has played out in your experience/work/community]

AB 920 will:

- Protect the health, wellbeing, and dignity of unhoused people who are harmed and sometimes killed by discriminatory policies and initiatives;
- Affirm California's commitment to equal protection under the law and the right of all people to full and equal participation in society; and
- Shift priorities towards real solutions, including safe, affordable, and permanent housing.

AB 920 can extend these protections without a fiscal impact on the state. AB 920 adds two words -"housing status"- to Government Code Section 11135, establishing a private right of action for people who experience discrimination on the basis of their housing status under a state-funded or administered program. Because this legislation creates a private right of action, it should not have a fiscal impact on the state nor require the state to hire additional staff. Several previously enacted bills added additional protected categories under Section 11135, including AB 3035, (Committee on Judiciary) in 2002, SB 1441 (Kuehl) in 2006, and SB 559 (Padilla) in 2011. For each of those previous bills, the Appropriations Committee found negligible, absorbable, or no fiscal impact.

For these reasons, we strongly support AB 920 and urge your "Aye" vote.

Respectfully,

[SIGNATURE]

[NAME, TITLE]

2. https://legiscan.com/CA/text/SB31/id/2756302/California-2023-SB31-Amended.html - Oppose

This bill would prohibit a person from sitting, lying, sleeping, or storing, using, maintaining, or placing personal property upon any

street, sidewalk, or other public right-of-way within 1000 feet of a sensitive area, as defined. The bill would specify that a violation of this prohibition is a public nuisance that can be abated and prevented, as provided. **The bill would also provide that a violation of the prohibition may be charged as a misdemeanor or an infraction, at the discretion of the prosecutor.** The bill would prohibit a person from being found in violation of the bill's provisions unless provided notice, at least 72 hours before commencement of any enforcement action, as provided. By **imposing criminal penalties for a violation** of these provisions, this bill would impose a state-mandated local program.

All Home letter of opposition
https://www.allhomeca.org/wp-content/uploads/2023/03/SB-31-Letter-of-Opposition-All-Home-.pdf
Others in opposition (just a few listed): Western Center on law and Poverty, ACLU, Brilliant Corners, Coalition on Homelessness San Francisco, Disability Rights California, Homeless Healthcare Los Angeles, National Alliance to End Homelessness

Strategic Plan

HCH/FH Board Meeting April 13, 2023

Agenda

Overview

Reviewing Current Strategic Plan

- Progress against interim 2022 goals
- MOU & Contracts
- Activities Overview

Breakout groups: updating the strategic plan 2024-2027

Overview

- Strategic Plan informs how HCH/FH allocates staff time and spends its grant funds
- Goal is to refine/tweak this plan in this update cycle
- **What can/do HCH/FH Staff work on?** (not exhaustive)
  - Technical assistance to contractors
  - Working with clinic staff to improve health delivery
  - Working with county and nonprofit partners to understand and document gaps and make recommendations
  - HRSA Compliance (Reporting, Site Visit, Grant Renewal activities)
  - Applying for additional funding

Per our grant, 80% of the $$ is toward patients experiencing homelessness and 20% toward farmworkers and family members based population numbers.

Overview

- **What can HCH/FH spend its grant money on?**
  - Primary Care
  - Mental Health Care
  - Alcohol and Other Drug Services
  - Dental Care
  - Specialty Services (podiatry, optometry, etc.)
  - Enabling Services (scheduling, attending, transporting to medical appointments, helping people sign up for health insurance)

Upcoming projects/initiatives

1. EPIC
2. CalAIM
3. Navigation Center

Strategic Priority	Work	Outcomes
Strategic Priority 1: Increase homeless & farmworker patient utilization of SMMC & BHRS Services.	**MOU & Contracts + Staff Activities**	By EOY 2023, increase percent of people experiencing homelessness receiving mental health & AOD services by 40% from 2019 baseline.
		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
Strategic Priority 2: Decrease barriers for homeless and farmworker patients to access health care.		By EOY 2023, decrease the number of un-insured homeless and farmworker patients seen by HCH/FH to 5% and 10% respectively.
Strategic Priority 3: Support health care providers serving homeless and farmworker patients.		Outcomes are outlined in Quality Improvement/Quality Assurance Plan
Strategic Priority 4: Decrease health disparities among people experiencing homelessness & farmworker patients		
Strategic Priority 5: Meet and Exceed all HRSA Compliance Requirements		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
		Program will have no more than **5%** of funds remaining at the end of the current grant cycle

Contracts & MOUs

Service Category	Contract/MOU	Population	Services
Enabling services	LifeMoves	People experiencing homelessness	• Medical Care Coordination
	Abode		• Care coordination for newly housed
	ALAS	Farmworker & Families	• Medical Care Coordination • Health education in the farm
	Puente		
Primary care services	Street/Field & Mobile clinic	Both	• Primary healthcare for homeless and farmworker • Alcohol and Other Drugs Service (AOD)
Behavioral Health services	Behavioral Health & Recovery Services (BHRS) El-Centro	Both	• Behavioral Care Coordination (HCH) • In-field support (HEAL) • Substance Use Disorder case management
Dental services	Saturday dental clinic	Farmworker and families	• Once a month Saturday dental clinic at Coastside clinic
	Sonrisas		• Dental services once a week at Pescadero (Puente)

Activities

Contracts & MOUs + staff work

Breakout Session Instructions

	Group 1	Group 2	Group 3
Board Members	Robert	Brian	Victoria
	Tony	Judith	Gabe
	Ty	Suzanne	Janet
	Steve Carey	Steve Kraft	
Staff *Bold Name is group facilitator*	**Meron**	**Irene**	**Jim**
	Frank Trinh	Gozel	Amanda
			Alejandra
Strategic Priority	Increase homeless & farmworker patient utilization of SMMC & BHRS Services (SP1)	Decrease barriers for homeless and farmworker patients to access health care (SP2)	Support health care providers serving homeless and farmworker patients (SP3)
Discussion Questions	1. Is there an activity missing that you would have expected to be listed or realize should be added to address your group's strategic priority? 2. Do you have comments about progress against the goals? 3. Can you think of a stakeholder or agency we should consult with for this strategic priority?		

If you have ideas that you'd like to send directly to staff, please email them to Irene, ipasma@smcgov.org

Strategic Priority 1: Increase homeless & farmworker patient utilization of SMMC & BHRS Services.		
Activity	**Additional Info**	**Status**
Attach care navigator capacity to **New Patient Connection Center** to help NPCC locate, follow up, and bring patients to SMMC	We are finding NPCC does not necessarily contact LifeMoves to help find a client, but LifeMoves contacts NPCC to schedule appts. Developing this relationship between LM and NPCC has been successful.	
Attach care navigator capacity to **Mobile Clinic** to help patients seen at Mobile Clinic seek follow up/continuous care at Brick and Mortar Clinics	LifeMoves has had recent staff turn over, causing some disruption to service and partnership with Street Medicine. Staff is working closely with both LM and SM to strengthen the partnership. It does not appear Mobile Clinic leverages LifeMoves Case Managers frequently. This might not be the right model for future years. Puente continues to work closely with Field Medicine team in Pescadero.	
Attach care navigator capacity to **Street/Field Medicine** to help patients seen follow up/continuous care at Brick and Mortar Clinics		
Attach care navigator capacity to **newly housed individuals** to transition them from potentially mobile-based health services to brick and mortar/help maintain existing connection to health care services	The case manager from Abode Services is assisting individuals who have recently been housed to be connected to health care services. Since the program is new, most clients are not yet connected to SMMC and BHRS but instead are connected to different brick-and-mortar health care services. Staff is collaborating with Abode to refer clients to County health services in the future as more referrals become available.	
Work with SMMC NPCC and SMMC COO to ensure homeless patients can get slotted into a clinic visit within a reasonable time frame	MHPC opened appointment slots for LifeMoves client to help establish care much sooner than other SMMC brick-and-mortar sites. This relationship has been successful.	
Open Saturday Dental Clinic at Coastside Clinic for farmworkers and family members	In 2022, Saturday Dental Clinic saw 37 patients (1 Saturday/month) In 2022, Sonrisas Wednesday Clinic has seen 81 patients (every Wednesday)	

Strategic Priority 2: Decrease barriers for homeless and farmworker patients to access health care		
Activities	**Additional Info**	**Status**
Bring primary care to locations where **people experiencing homelessness** reside, i.e. encampments and shelters	Street Medicine has indicated they have been busier than ever and they've added another SM day. The Mobile Clinic is actively engaged in providing primary care services to people experiencing homelessness.	
Bring primary care to **farmworkers** at their employment location in San Mateo County, South and North Coast	Field Medicine has expanded to Half Moon Bay and is working closely with ALAS.	
Provide behavioral health services at locations where **people experiencing homelessness** reside, i.e. street, shelters, etc.	HEAL team clinicians have been hired and are becoming embedded in outreach teams. PHPP AOD Counselor has been very successful in the field.	
Provide mild/moderate mental health & AOD services to **people experiencing homelessness** in shelters	HEAL team clinicians have been hired and are becoming embedded in outreach teams	
Provide mild/moderate mental health& AOD services to **farmworkers**	El Centro is starting to do this work and we are working on getting data. Given progress against the target, more FW behavioral health services needed. El Centro AOD case manager is stationed at ALAS 4 times a week.	
Provide behavioral health care coordination via referral from community providers serving **people experiencing homelessness**	BHRS HCH contract is going well. BHRS HCH has been playing an integral role in connecting Healthcare in Action patients to BHRS Regional Clinics.	
HCH/FH staff works with SMMC/IT to ensure primary care/behavioral health services are provided via Tele-Health Stations	Tele-health has been put on pause on both these efforts. More information at QI/QA subcommittee.	
Develop relationships with farm owners to support services for **farmworkers.**	There has not been a lot of work reaching out to growers directly. HCH/FH works closely with Dept of Ag. HCH/FH presented to farmworkers during the annual pesticide training.	
Healthcare insurance/other benefits sign up for **people experiencing homelessness** and **farmworkers**	Close partnership with HCU, LifeMoves, Puente, and connecting ALAS to HCU to support this. However, we have not seen an increase in coverage.	
Work with BHRS IT to develop data reports from Avatar	We were able to incorporate this data into UDS 2022, but are working to automate it for the next year.	

Strategic Priority 3: Support health care providers serving homeless and farmworker patients		
Activities	**Additional Info**	**Status**
Provide training to SMMC, BHRS, PHPP, and community providers at least 2/year, including tele-health related topics (could be done via LMS module)	This work has been on hold given staff turnover. New clinical services coordinator will review training opportunities.	
Create/maintain/update LMS modules (i.e. PSA training, homeless & farmworker health topics)	Staff needs to review PSA registration work. Needs Assessment patient survey indicates many people on our master list do not self-identify as homeless or farmworker.	
Financially support SMMC, BHRS, PHPP, and community providers to attend relevant health conferences.	HCH/FH is supporting numerous partners from SMMC, BHRS, PHPP, and Board members attending conference – both for PEH and farmworkers this year.	
Partner with SMMC's Patient Experience department to conduct "Provider Appreciation" activities	On hold.	
Conduct two-way dialogue with clinic managers/providers re HCH/FH program (quarterly report, meetings, etc)	This has not happened on a consistent basis (i.e. regular meetings), but clinic providers are engaged in the Needs Assessment work and providers were asked to respond to the NA survey. Alejandra/Amanda work closely with managers on an ad-hoc basis.	
Host forums for providers within SMMC, PHPP, BHRS, and nonprofits to discuss healthcare needs of homeless and farmworker patients	This work has been on pause, however HCH/FH staff has been doing a lot of brainstorming on how these type of forums should proceed.	
Support providers via small funding requests	We are not doing small funding requests this funding cycle due to the change in how funds can be rolled over year over year.	N/A

Strategic Priority 4: Decrease health disparities among people experiencing homelessness & farmworker patients		
Activities	**Additional Info**	**Status**
Follow work outlined in the HCH/FH QI/QA Plan. In 2021, the Plan focuses on: 1. Cervical, Breast, and Colorectal Cancer Screening 2. Diabetic control 3. 1st trimester prenatal care 4. Depression screening and follow up 5. Adult BMI screening & follow up	This work is tracked by the QI/QA Subcommittee	N/A
Standardize reporting pathways between gathering and analyzing data and presenting the data to the San Mateo Medical Center to execute change	New clinical services coordinator is getting onboarded and will continue standardizing information sharing between HCH/FH and the clinic.	
Assess feasibility of capturing homeless and farmworker status in SMC County death certificates.	The Epidemiology Department has done a tremendous amount of work on this, including obtaining data from Clarity HMIS. A report is slated to be available in the summer or fall 2023.	
Education/Outreach for farmworkers and people experiencing homelessness.	ALAS promoters have started conducting education classes on Half Moon Bay farms. LifeMoves provides outreach to homeless clients. Puente provides outreach to farmworkers in Pescadero. The HEAL clinicians are conducting workshops and educational classes at Maple Street Shelter for people experiencing homelessness, and will continue these workshops at the new Navigation Center. Frank and Amanda presented at the Annual Pesticide Training for farmworkers.	

Strategic Priority 5: Meet and Exceed all HRSA Compliance Requirements		
Activities	**Additional Information**	**Status**
Ensure HRSA Site Visits are conducted to an excellent level and minimize findings	2021 Site Visit went well. No update from previous SP update.	
Have a well functioning Co-Applicant Board, with proper representation across numerous areas of subject matter expertise and robust visibility in the community, Brown Act compliant, ethics and conflict of interest	We have welcomed two new Board Members recently, one who joined in April 2022 and another who started in July 2022. Throughout the year, the Board invited guest speakers with diverse areas of extensive knowledge on farmworkers and homelessness. The Board conducted virtual meetings in compliance with the Brown Act regulations in 2022. Additionally, all Board Members completed ethics training and signed a conflict of interest policy.	
Submit UDS reports on time, answer all responses, improve year over year the processes by which data is reported.	The UDS completed for CY2022 was one of the most smooth submissions (fewest number of questions from the editor)	
Conduct Needs Assessment, update QI/QA and Strategic Plan on a regular basis	Staff is currently in the process of the Needs Assessment cycle. It should be finalized summer 2023.	
Apply for supplemental awards when appropriate.	Staff coordinates with numerous Health partners and submits supplemental funding whenever feasible.	
Right-sizing contracts throughout the year & identifying opportunities to spend down grant funds.	A lot of attention has gone into right-sizing contracts to ensure all funds are spent by the end of the grant cycle. Still, we anticipate we will have leftover funds	
Stay connected to technical assistance opportunities through HRSA.	Staff continues to monitor HRSA technical assistance opportunities and joins when appropriate.	

Strategic Priority	Outcomes	2022 interim goal	2022 Status
Strategic Priority 1: Increase homeless & farmworker patient utilization of SMMC & BHRS Services.	By EOY 2023, increase percent of people experiencing homelessness receiving mental health & AOD services by 40% from 2019 baseline.	Increase by 35% in 2021	25%
	By EOY 2023, increase percent of farmworkers receiving mental health & AOD services by 20% from 2019 baseline.	Increase by 10% in 2022	-24%
	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	40% in 2022	35%
Strategic Priority 2: Decrease barriers for homeless and farmworker patients to access health care.	By EOY 2023, decrease the number of un-insured homeless and farmworker patients seen by HCH/FH to 5% and 10% respectively.	N/A	19% 31%
Strategic Priority 3: Support health care providers serving homeless and farmworker patients.	**QI/QA Plan**		
Strategic Priority 4: Decrease health disparities among people experiencing homelessness & farmworker patients			
Strategic Priority 5: Meet and Exceed all HRSA Compliance Requirements	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	N/A	2 conditions in 2021 site visit
	Program will have no more than **5%** of funds remaining at the end of the current grant cycle	Will be measured Dec 2023	

Tab 2

Contracts and MOUs update

San Mateo Medical Center
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SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

DATE: May 11th, 2023

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

FROM: Meron Asfaw, Community Program Coordinator

SUBJECT: Contracts & MOUs Update

I am writing to provide you with a comprehensive update on the status of the contractors and MOUs associated with the HCH/FH program. As you are aware, the HCH/FH program has collaborated with several County departments and community-based organizations to offer primary care, behavioral health, enabling, and dental services to people experiencing homelessness, farmworkers, and their dependents. Please find below a detailed description of each contractor's status update for April 2023:

1. **Abode Services:** Abode Services continued outreach identifying newly housed individuals for medical care coordination. Please find below the contract's services, target, number of clients served to date (April 2023), and contract performance:

Services	Target	Number of Clients Served to Date (April 2023)	Contract Performance
Medical Care Coordination	100 clients	25 clients	25%
Helping to establish medical home			
Assisting client with scheduling and attending healthcare appointments			
Transportation			
Assisting client with completion and renewal eligibility benefits			
Providing health related resources			

2. **Ayudando Latinos a Soñar (ALAS):** ALAS's program and operational manager is in transition, and they are looking for a replacement for this role. HCH/FH staff met with ALAS promotores this month to identify any barriers and gaps in providing services to the farmworkers. The team is also working closely with the field medicine team.

3. **Public Health Policy & Planning (PHPP):** HCH/FH staff held a meeting with PHPP this month to discuss program updates. The team asked staff for the lists of farms both in Pescadero and Half Moon Bay to see how many farms are available, so they can identify the need. Staff will work on getting farms list for both areas. PHPP and LifeMoves CHOW team continued working together to support the patient in completing follow-up appointments.

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4. **Behavioral Health & Recovery Services (BHRS):** BHRS sent a quarterly report, and below is a summary of the quarterly report for the three programs under BHRS.

4.1 HCH: HCH mentioned that consistent referrals and collaborating with other partners is working well. The team mentioned that not being able to locate a client has been challenging. The team also mentioned that some clients resist accepting congregate shelters. The team ensures clients are connected to care and follows up with their appointments. Here is a summary of quarter 1 contract performance:

Contract Goal	Quarterly Report (Q1)	Contract Performance
150 unduplicated individuals annually	51 unduplicated individuals served	34% of goal achieved for unduplicated
Over 800 visits annually	286 encounters provided	36% of goal achieved for encounters
At least 85% annually of clients who receive behavioral health care coordination services	98% of clients referred to behavioral health treatment services	115% of goal achieved
At least 60% annually of clients who are referred to behavioral health treatment services	59% of clients attended at least one scheduled	98% of goal achieved
At least 60% annually of clients who receive behavioral health care coordination services will establish a medical home for primary medical care and/or behavioral health services	16 clients (31%) who received behavioral health care coordination services established a medical home	16 clients (31%) who received behavioral health care coordination services established a medical home

4.2 HEAL: The report suggests that collaborating with other service providers, such as LifeMoves, has been successful in gaining referrals and engaging in outreaches. The report also indicates that the clinician's flexibility in allowing therapists to meet clients at varying times and places is enabling HEAL clinicians to engage with clients who would not be able to engage with a clinic-based clinician. However, it was reported that very few clients have serious mental illnesses; most clients have moderate to severe Substance Abuse Disorders. The report highlights the difficulty in engaging seriously mentally ill homeless individuals who tend to lack insight and are delusional. Additionally, many clients, especially those with addiction or who lack social support, tend to delay engaging in therapeutic treatment because their basic needs are preeminent.

The emerging trends identified in the report are substance abuse-related issues, difficulty in finding employment for formerly incarcerated clients, lack of social support, and dehumanization and infantilizing by others.

Here is a summary of quarter 1 contract performance:

Contract Goal	Quarter 1 report	Contract Performance
150 unduplicated	36	24%
800 visits	88	11%

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4.3 El-Centro: El-Centro mentioned that because of the Half Moon Bay shooting, they were not able to go in farms with ALAS, and the schedule changes after the shooting. They also mentioned the challenge of reaching out to farmworkers and the difficulty in coordinating with ALAS's team. HCH/FH staff also met with El-Centro to discuss ways to reach out to the farmworker community. The staff will work on coordinating a meeting between ALAS and El-Centro. In the meantime, El-Centro will start to work with Coastside Hope. El-Centro also asked HCH/FH staff to coordinate a reserved space at Moonridge to provide substance use disorder case management. HCH/FH staff will coordinate this in the next month.

Here is a summary of quarter 1 contract performance:

Contract Goal	Quarter 1 report	Contract performance
SUD Case management for 30-35	3	10%-8.6%

5. **LifeMoves:** HCH/FH staff met with LifeMoves this month. LifeMoves is fully staffed, but still looking for an Assistance Director to oversee the team. The team mentioned that SMMC providers are not offering telehealth appointments, and there were only three telehealth visits this quarter.

6. **Puente**: Puente sent a quarterly report. According to the report, Puente's Community Development team has continued to provide health insurance assistance to farmworkers through both in-person and phone appointments. They have also established robust care coordination services for participants by utilizing Community Health Promoters and Health Associates. Moreover, two transportation options, MV Transit and Royal Ambulance, were made available for medical appointments, providing farmworkers with more opportunities to make it to their appointments on time.

   The Community Development team's efforts to provide health insurance assistance through in-person and phone appointments are successfully meeting the needs of farmworkers. Additionally, the Community Health Team's care coordination services are highly effective due to the established trust and knowledge of Community Health Promoters and Health Associates. However, it was identified that some participants are ineligible for health insurance programs due to exceeding income limits, particularly those in single-person households. This area may require additional support or education. No trends or emerging concerns were identified in the quarterly report.

   The dental waitlist has been a significant challenge, with 27 participants currently on it. However, a successful encounter was reported where a participant with an urgent toothache received prompt treatment after being referred to Coastside Dental Clinic. Due to the winter storm, the Community Development team provided financial assistance to families/individuals affected by the flooding, leading to a 2-3 week wait time for appointments with the team.

   Based on the report, it is recommended to continue monitoring the eligibility criteria for health insurance programs and explore ways to reduce wait times for dental appointments. Additionally, efforts can be made to increase awareness among farmworker individuals about available services.

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Here is a summary of quarter 1 contract performance:

Service	Target	Actual (Year to Date) Q1	Contract Performance
Care Coordination (CC)	200	65	32.5%
Health Insurance Assistance	160	52	40.6%

7. **Sonrisas:** Sonrisas is currently located at Puente, but due to space constraints, they need to move out by June. The Sonrisas team and Puente have identified a space in La Honda that has been approved by the Sonrisas dental provider. While the contract is for services in Pescadero, due to the lack of available space there, the HCH/FH team has approved the La Honda location as a temporary solution. However, the team is actively looking for a space in Pescadero. It has been communicated that no patients in this contract will be seen at the Half Moon Bay Sonrisas clinic, and clients will be referred to Coastside Dental Service if they are coming to Half Moon Bay.

8. **Saturday Dental Clinic at Coastside Clinic:** The HCH/FH staff, the Saturday dental team, and ALAS team met this month to discuss and develop strategies to decrease the Saturday dental clinic waiting list. The ALAS team will reassess the patients on the waiting list to determine their continued interest in the service. It was also noted that some farmworkers are seasonal and may lose their spot on the waiting list when they return from Mexico. To address this issue, the team has developed a plan to capture these seasonal workers. The collaboration between ALAS and the Saturday dental team is proving effective. The main priority identified in the meeting was to reduce no-shows, fill last-minute cancellations with new patients, and prioritize patients who do not qualify for medical or ACE for this service.

Tab 3

Budget and Finance Report

San Mateo Medical Center
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San Mateo, CA 94403
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SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

DATE: May 11,2023

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

Prior to including April's expenditures, totals for the first quarter were verified and updated in accordance with the actual drawdown submission for federal reimbursement. Based on those figures, there was $853,922 in grant expenditures for the first quarter.

Preliminary grant expenditures for the month total about $375,911.95. (Some routine County charges may not have been completed when the report was run.) Total grant expenditures through four months total $1.229,335. This figure outs us on track to spend at close to our original budget as planned for the year (including current year award and spend-down of some carry-over).

Our preliminary expenditure projection for the 2023 Grant Year (GY) will leave us with around $473,428 in unexpended funding when compared to our total funds for the year (base grant award plus carryover from GY 2022). This is estimated based on an expected carry-over of around $1,200,000 (currently being worked on with HRSA).

Attachment:

- GY 2022 Summary Grant Expenditure Report Through 04/30/23

COUNTY OF SAN MATEO CALIFORNIA

GRANT YEAR 2023

Details for budget estimates	Budgeted [SF-424]	*April $$*	To Date (04/30/23)	Projection for end of year		Projected for GY 2024
EXPENDITURES						
Salaries						
Director, Program Coordinator						
Management Analyst ,Medical Director						
new position, misc. OT, other, etc.						
	721,000	*60,469*	222,266	712,000		750,000
Benefits						
Director, Program Coordinator						
Management Analyst ,Medical Director						
new position, misc. OT, other, etc.						
	270,000	*25,759*	94,671	284,013		292,500
Travel						
National Conferences (2500*8)	15,000			30,500		20,000
Regional Conferences (1000*5)	5,000			7,500		7,500
Local Travel	1,500			500		1,500
Taxis	1,000		108	500		1,500
Van & vehicle usage	1,500		311	1,000		1,500
	24,000		419	40,000		32,000
Supplies						
Office Supplies, misc.	10,000			10,000		10,000
Small Funding Requests						
	10,000		0	10,000		10,000
Contractual						
2021 Contracts			27,691	27,691		
2021 MOUs		*206,250*	412,500	412,500		
Current 2022 MOUs	1,241,000	*61,908*	315,790	1,175,000		1,200,000
Current 2022 contracts	865,979	*4,800*	112,847	825,000		825,000
		7,688				
---unallocated---/other contracts						
	2,106,979		868,828	2,440,191		2,025,000
Other						
Consultants/grant writer	40,000	*6,438*	35,444	65,000		25,000
IT/Telcom	4,200		2,644	20,000		30,000
New Automation				0		-
Memberships	2,000		2,875	7,500		5,000
Training	5,000			5,000		20,000
Misc			88	1,500		1,500
	51,200		41,051	99,000		81,500
TOTAL	3,183,179	*373,312*	1,227,235	3,585,204		3,191,000
GRANT REVENUE						
Available Base Grant	2,858,632		2,858,632	2,858,632		2,858,632
Carryover	1,200,000		1,200,000	1,200,000 estimate		
Available Expanded Services Awards **						473,428 carryover
HCH/FH PROGRAM TOTAL	4,058,632		4,058,632	4,058,632		3,332,060
BALANCE	**875,453**	**Available**	**2,831,397** **Current Estimate**	**473,428** **Projected**		**141,060** based on est. grant of $2,858,632
Non-Grant Expenditures						
Salary Overage	13,750	*2,100*	8,612	35,000		40,000
Health Coverage	57,000	*7,066*	27,496	80,000		90,000
base grant prep	60,000			40,000		
food	2,500			2,500		1,500
incentives/gift cards	1,000			1,000		1,500
	134,250		36,108	158,500		133,000
TOTAL EXPENDITURES	**3,317,429**		**1,263,343**	**3,743,704**	**NEXT YEAR**	**3,324,000**

Tab 4

Quality Improvement/ Quality Assurance Updates

SAN MATEO COUNTY HEALTH
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DATE: May 11, 2023

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

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

SUBJECT: QI/QA COMMITTEE REPORT

- **HCH/FH QI Committee Meeting**
  - The HCH/FH QI Committee met in April to review the 2022 UDS results. This committee will plan to meet again in the next month or two to continue to evaluate the QI performance metrics found in the QI/QA Plan 2022-2023.
- **Homeless Mortality Data**
  - HCH/FH Program working with San Mateo County Public Health Epidemiology and homeless service providers to accurately collect County homeless mortality data. Public Health Epidemiology will be working with HSA to intersect vital statistics records with HMIS database to identify deaths in homeless individuals over the past 10 years. Public Health Epidemiology will also be accessing all County Health patient data to aid in identifying deaths in homeless persons. Public Health Epidemiology is targeting the end of 2023 to release a report on their findings. HCH/FH Program will continue to work with Public Health Epidemiology, especially as they get closer to finalizing their report.
- **2023 Clinical Quality Metrics**
  - 2023 Clinical quality metrics Q1 data should be available in May, after working with the BI team to retrieve available reports. These reports will be analyzed and the quality metrics data will be reported once analysis is finalized, likely in an upcoming meeting.

Tab 5

HCH/FH's Director Report

San Mateo Medical Center
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SAN MATEO COUNTY HEALTH
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DATE: May 11, 2023

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

FROM: Jim Beaumont Director, HCH/FH Program

SUBJECT: DIRECTOR'S REPORT & PROGRAM CALENDAR

Program activity update since the April 13, 2023, Co-Applicant Board meeting:

The HCH/FH Program continues to work with Health Administration, PHPP, LifeMoves and HiA (Healthcare in Action) in preparing for the opening of the County Homeless Navigation Center. We are also continued to work with Health Administration on assisting with the equipment needs for the Navigation Center medical and dental clinics. We continue to move forward with the contract with University of Pacific for dental services at the Navigation Center, and in accessing additional donation funding for other potential services such as Optometry, Audiology and Podiatry.

The HCH/FH Program has completed our move into the new SMMC Administration building. There are still some communication improvements in progress for the few small meetings rooms available, but the building shake out is going well. With the space limitations imposed by the move this necessitated a great reduction in the amount of stored paper files and information, so we are working through digitizing what we can

The HCH/FH Program staff is also preparing for the submission of our Service Area Competition (SAC) application this summer and interviewed potential grant writing candidates. Program is comfortable that we will be able to access the capabilities and capacity necessary to support our application efforts. Note that this is for the actual health center award that is our base grant and is obviously critical to the program.

Seven Day Update

ATTACHED:

- Program Calendar

COUNTY OF SAN MATEO CALIFORNIA

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

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2023 Calendar - County of San Mateo Health Care for the Homeless & Farmworker Health (HCH/FH) Program

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

Month	Events
January	• *HCH/FH Board's first meeting of the year* • *HCH/FH Board will vote on new time change for the board meeting*
February	• *Initial UDS Submission: February 15, 2023* • *2023 Western Forum for Migrant and Community Health, February 14-16, Long Beach, CA. https://www.nwrpca.org/events/event_details.asp?legacy=1&id=1670924*
March	• *HCH/FH Board will return to an in-person meeting. Location: SMMC Education Room 2* • *Sliding Fee Discount Scale (SFDS)-Approve*
April	• *East Coast Migrant Health Stream, Orlando FLA; sponsored by North Carolina Comm Health Center Assoc. April 5-7* • *Midwest Stream Forum on Agricultural Worker Health, Austin, TX; sponsored by National Center for Farmworker Health, April 24-26* • *SMMC Annual Audit – Approve* • *In-person meeting location: County Building Room 101* *455 County Center* *Redwood City, CA 94063*
May	• **2023 National Conference for Agricultural Worker Health, Seattle WA; sponsored by National Association of Community Health Centers (NACHC), May 2-4.** • ***National Health Care for the Homeless Conference and Policy Symposium, May 15-18, Baltimore, Maryland*** https://nhchc.org/trainings/conferences/
June	• ***Services/Locations Form 5A/5B – Approve***
July	
August	
September	
October	
November	
December	

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

Tab 6

Request for the board to approve a letter supporting AB 920 and opposing SB 31

SAN MATEO COUNTY HEALTH
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DATE: May 11th, 2023

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

FROM: Suzanne Moore

SUBJECT: SUPPORTING AB 920 AND OPPOSING HCH SB 31

The HCH/FH board has the authority to take positions on issues related to homelessness and advocate for the homeless community. With this in mind, I am providing a review of the draft letters in support of AB 920 and opposing HCH SB 31.

Our HCH/FH staff and County counsel have reviewed the draft letters and have determined that supporting AB 920 and opposing HCH SB 31 aligns with the mission of our board and directly benefits the populations we serve.

Therefore, I am requesting that the board approve the draft letters. Please note that the approval of the majority of the board is required before the letters can be sent to the respective authorities.

Attached:
AB 920 support draft letter
HCH SB 31 opposing letter

TO:

FROM:

San Mateo County Healthcare for the Homeless and Farmworkers Co-Applicant Board

RE: Support of AB 920 (I. Bryan)

DATE:

Chair _____:

San Mateo County Healthcare for the Homeless and Farmworkers Co-Applicant Board supports AB 920. We believe that this bill is consistent with the board's goal and mission to end homelessness to serve people experiencing homelessness.

The vision of Healthcare for the Homeless and Farmworkers board is to provide full access to the continuum of health care and social services in an environment that is culturally competent and treats the whole person's physical health and behavioral health. Homeless individuals and their families are valued and considered a partner in making decisions regarding their health care.

AB 920, by expanding housing status to California's anti-discrimination law, furthers the foundation necessary to best address homelessness - an environment, described by Assembly Member Bryan as "rooted in care, supportive services, compassion, affordable housing, and local innovations that build on the core needs of people who are experiencing homelessness -- while simultaneously protecting our most vulnerable neighbors from senseless discrimination that runs counter to those goals".

Our Board Members are diverse: some are currently serving the unhoused, some have formerly been unhoused, and some are concerned citizens passionate about ending homelessness. We see

the struggles and tragic losses experienced by our homeless neighbors, and we acknowledge that community fear and bias can contribute to barriers of care.

AB 920 would be an important adjunct to our efforts. Freedom from discrimination can only strengthen the work to provide health, safety, and a path to permanent housing. Homelessness is one of the greatest social issues of our generation. Please cast a yes vote to support AB 920. Thank you.

TO:

FROM:
San Mateo County Healthcare for the Homeless and Farmworkers Co-Applicant Board

RE: Opposition to SB 31 (Jones)

Chair _____,

San Mateo County Healthcare for the Homeless and Farmworkers Co-Applicant Board is in opposition to SB 31. We believe that this bill is inconsistence to our board's mission to serve people experiencing homelessness and to end homelessness

We would like to take this opportunity to share best-known practices to address healthcare for our unhoused and ultimately end homelessness. There are two important tenets that guide service for the homeless:

1. Housing First - that concept that no other aspect (health, mental health, substance use treatment, other social issues) can be adequately addressed without stable housing. If the resources to begin the path to become housed are physically out of reach for our unhoused, they cannot start the work forward.
2. Trauma-based care - many homeless have experienced past abuse and are therefore fearful and distrustful until trust is earned and gained through consistent and compassionate care.

The vision of Healthcare for the Homeless and Farmworkers Board is to provide full access to the continuum of health care and social services in an environment that is culturally competent and treats the whole person's physical health and behavioral health. Homeless individuals and their families are valued and considered a partner in making decisions regarding their health care.

This bill, by restricting the homeless from large areas of our community and charging fines for their presence, puts our unhoused

at far greater risk for harm. Outreach teams would be compromised, homeless would struggle to access services, and opportunities to build trust would be impeded.

Housing is necessary for health of the individual, the family, and the community as a whole. As a Board, we encourage our elected to commit and provide for laws and a model of care that provides a path forward for permanent housing for all. We stand with other agencies who oppose SB 31: Western Center on Law and Poverty, Brilliant Corners, Coalition on Homelessness San Francisco, Disability Rights California, Homeless Healthcare Los Angeles, National Alliance to End Homelessness. Please vote no on SB 31.