SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

AGENDA

TOPIC: **Healthcare for the Homeless/Farmworker Health Program Strategic Planning Subcommittee Meeting**

DATE: October 30th, 2023

TIME: 11:00am-1:00pm

PLACE: County Building Room 101, RWC Address: 455 County Center, Redwood City, CA 94063

Item	Time
1. Welcome	11:00am
2. Tab 1: Approve Meeting Minutes:	11:05am
3. Tab 2: Review and Discuss Draft 2024-2027 HCH/FH Strategic Plan ***Attached**: Draft 2024-2027 HCH/FH Strategic Plan* • Review this document with the lens of: 1) are the main themes and achievements captured? 2) Should any term/concept be added to the glossary? 3) Is anything fundamentally missing? 4) **Most importantly, will this document help you as Board Members and staff make decisions/prioritize what projects you want to take on/fund?** If not, what can be added to it to make it so?	11:10am-12:30pm
4. **Business Agenda**: Vote to approve bringing Strategic Plan to the November HCH/FH Board	12:30 pm
5. **Adjourn**	1:00pm

FUTURE MEETING DATE: TBD

Tab 1

Meeting Minutes

Healthcare for the Homeless/Farmworker Health Program

July 2023 Strategic Planning Subcommittee Meeting Minutes

Attendees:

1. **Board Members:**
    1. Robert Anderson
    2. Gabe Garcia
    3. Judith Guerrero
    4. Janet Schmidt
    5. Suzanne Moore
    6. Steven Kraft
2. **Staff**
    1. Irene Pasma

Minutes:

Staff walked the Board through the attached slide deck and received input from the Board on the contents. It was discussed the Subcommittee would reconvene in September and invite stakeholders who gave input into the strategic plan though this plan had to be modified and delayed due to HCH/FH Staff changes.

Attached: July 2023 Strategic Planning Subcommittee Presentation

HCH/FH Board Strategic Planning Subcommittee Meeting

July 24, 2023

Room 101, 455 County Center

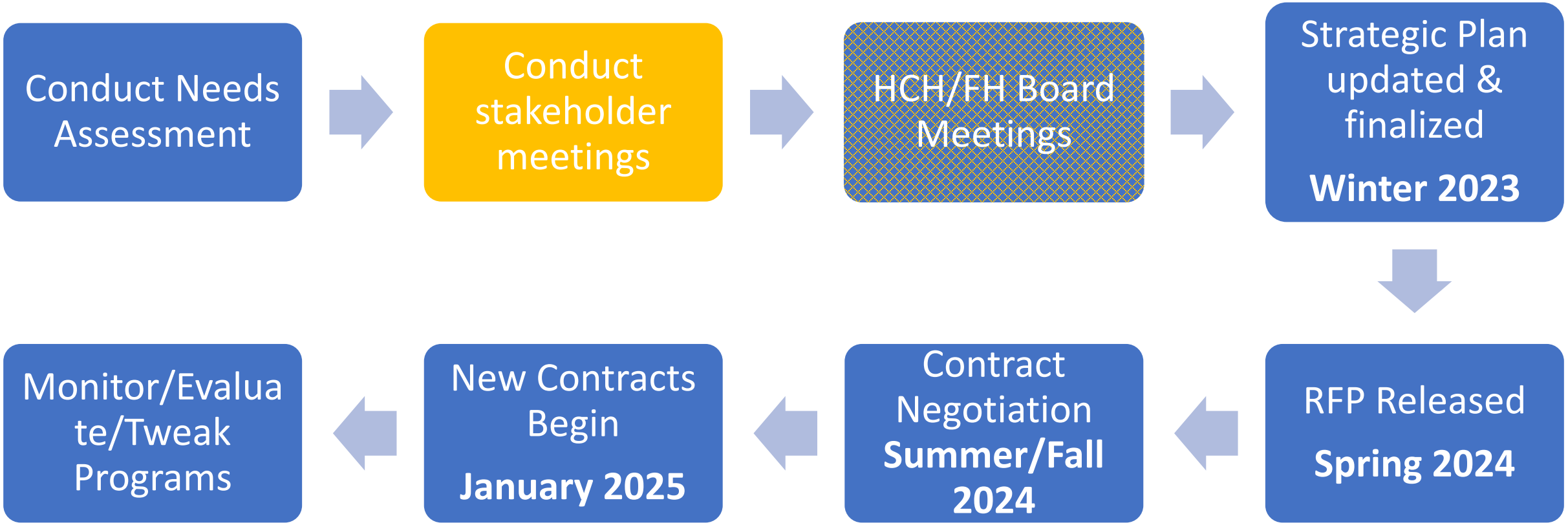
Redwood City, CA

2020-2023 HCH/FH Strategic Plan - link

Agenda

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

Program Strategic Planning Process



Needs Assessment

Survey Distribution

Care Team

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

Patients

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

Approved by SMMC Clinical Standards Committee & Solutions IRB

2022 SMMC Homeless & Farmworker Visit Data

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

Potential Needs Assessment Recommendations to SMMC Leadership – Care Team Survey

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

Potential Needs Assessment Recommendations to SMMC Leadership – Patient Survey

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

Strategic Plan

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

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

*External Contract

Contracts & MOUs

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

Current Strategic Plan Priorities and Associated Activities

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

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

Current State Thinking

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

Next Steps

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

August: Report out to Board on progress

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

Oct: Share with Board findings and final recommendations

November: Approval Strategic Plan at Board Meeting

Appendix

Additionally:

What is working well

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

Future Surveys Topics

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

Main Take Aways from Providers

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

Main take aways from Patients

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

Tab 2

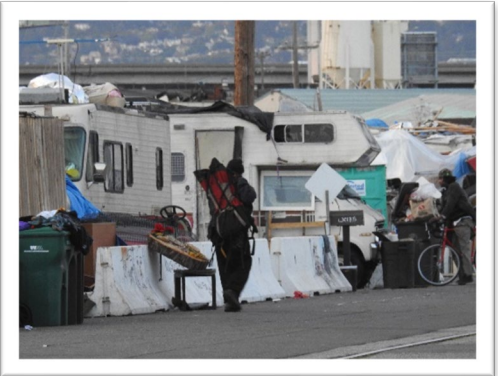
Draft 2024-2027 HCH/FH Strategic Plan

County of San Mateo

Healthcare for the Homeless/Farmworker Co-Applicant Board

Strategic Plan 2024-2027

Table of Contents



Executive Summary

Instead of Executive Summary, perhaps a letter from the chair? Strategic subcommittee?

HCH/FH Background

San Mateo County's Health Care for the Homeless/ Farmworker Health Program (HCH/FH) is a federally funded program which has delivered and coordinated health care and support services for people experiencing homelessness since 1991. In July 2010, the program expanded its scope of services to include the farmworker population and their families/dependents.

HCH/FH is funded by U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) pursuant to Sections 330(g) and 330(h) of the Public Health Service Act to support the planning for and delivery of services to medically underserved populations. It is jointly governed by an independent Co-Applicant Board, and the San Mateo County Board of Supervisors.

People in San Mateo County experiencing homelessness or who work as farmworkers (and their families) can access any San Mateo County Health touch point – San Mateo Medical Center (SMMC), satellite clinics, mobile clinics – and numerous other County and community-based organizations to receive outpatient health services regardless of insurance or documentation status. The HCH/FH Program has agreements with county and nonprofit organizations to provide these services and compliance with HRSA regulations provides SMMC with Federally Qualified Health Center status.

HRSA has a broad definition of homelessness which, in addition to people residing in shelters or on the street/in cars/RVs, includes doubling up (i.e. couch surfing) and those in transitional or permanent supportive housing. For farmworkers, both seasonal and migrant workers are included in HRSA's definition, and importantly, so are family members.

Strategic Plan Background

This strategic plan is built upon the 2020-2023 Strategic Plan (link). Over 25 stakeholder meetings were conducted by HCH/FH staff with relevant key stakeholders, publications were read such as the California Statewide Study of People Experiencing Homelessness (link) and 2023 The California Street Medicine Landscape Survey and Report (link) which helped inform both the stakeholder conversations and the recommendations staff made to the HCH/FH Board in adopting this strategic plan. The HCH/FH Strategic Planning Subcommittee met three times and the Board was updated throughout the process. Further, the 2022/2023 Needs Assessment (link) informed the strategic plan in fundamental ways by shedding light on attitudes, beliefs and values of San Mateo Medical Center clinicians and patients alike.

This plan, like its predecessor, outlines major strategic priority areas which are slightly revised from the last plan to reflect current trends and environment. Each priority area has several bucketed activities whereas more granular-level activities and implementation plans reside in program-level documents (i.e. RACI charts). The priorities outlined in this strategic plan will inform the HCH/FH Co-Applicant Board in deciding which services it will go out to RFP for in 2024 with contracts starting in 2025 and how to direct staff time.

Mission & Values

Vision

- Health care services provided to homeless and/or farmworker individuals are patient centered and utilize a harm reduction model that meets patients where they are in their progress towards their goals.
- The HCH/FH Program lessens the barriers that homeless and/or farmworker individuals and their families may encounter when they try to access care.
- Health services are provided in consistent, accessible locations where people experiencing homelessness and farmworkers can receive timely care and have their immediate needs addressed in a supportive, respectful environment.
- Through its funded services and partnership with the Medical Center, the HCH/FH Program reduces the health care disparities in the homeless and farmworker populations.
- HCH/FH advocates on behalf of both populations' health needs and becomes a hub for health-related information for both San Mateo County and Community Based Organizations for these two populations.

Values

Access: Homeless and farmworker individuals and their families have full access to the continuum of health care and social services.

Dignity: Services provided are respectful, culturally competent, and treat the whole person's physical health and behavioral health.

Integrity: Homeless and farmworker individuals and their families are valued and considered a partner in making decisions regarding their health care.

Innovation: Services will continuously evolve to reflect current best practices and technological advances.

Glossary of Terms

The Strategic Plan refers to industry-specific terminology the reader might find helpful to familiarize themselves with at the start of the document.

Enabling Services: Non-clinical services that enable individuals to access health care and improve health outcomes. These include, but are not limited to: case management, care coordination, referrals, translation/interpretation, transportation, eligibility assistance, health education for individuals or families on relevant health topics, environmental health risk reduction, health literacy, and screenings, referrals, etc.

Behavioral Health and Recovery Services (BHRS): is a division within San Mateo County Health which oversees mental health, substance use disorders, outpatient treatment and other related services.

Non-conventional health settings: this is reflective of the understanding that people experiencing homelessness and farmworkers/family members are often unable to come into a typical outpatient clinic for a variety of reasons, including inability to come during regular clinic hours, lack of transportation, no health insurance/inability to pay out of pocket, or past negative experiences with the health care system. Therefore, HCH/FH strives to bring health care services to places (physically and emotionally) where people experiencing homelessness or

farmworker and their family members meet, live, or reside. This includes non-conventional health care settings such as tent encampments, shelters, safe parking programs, permanent supportive housing projects, farms, farmworker housing, and others as they arise.

Patient Population: San Mateo County's HCH/FH is a unique Federally Qualified Health Center because it focuses on two sub-populations: 1) people experiencing homelessness and 2) farmworkers and their families in San Mateo County. People experiencing homelessness includes those residing in shelter, on the street – which includes vehicularly housed - doubling up (i.e. couch surfing), permanent supportive housing, and transitional housing. Farmworkers include both seasonal and migrant workers, though due to climate, most of SMC's farmworkers are migrant (i.e. they permanently live in the county).

Public Health Policy & Planning (PHPP): is a division within San Mateo County Health which has numerous departments, including Epidemiology, Public Health Lab, and Mobile Clinics, the latter which HCH/FH works most closely with via Memorandum of Understanding and intra-departmental collaboration.

Scope of services: services provided by the San Mateo Medical Center outpatient clinics, Behavioral Health and Recovery Services regional clinics, and Public Health Policy and Planning's Mobile Clinics teams as well as those services contracted by the HCH/FH program. Note, there is overlap in those categories, i.e. HCH/FH has MOUs with BHRS and PHPP to deliver health care and enabling services.

Service Providers: HCH/FH works with a myriad of service providers. In this report, this term - unless it is further defined – encapsulates healthcare providers (i.e. physicians, nurses, social workers) as well as non-profit organizations HCH/FH contracts with (see Annual Report for full list, link).

Sub-populations: Sub-populations refer to further stratifying the two target populations by additional defining characteristics. This could mean by LGTBQ+ status, age, health condition, race/ethnicity as well as the intersectionality of these categories.

Achievements from previous Strategic Plan:

Three years have passed since the last strategic plan was finalized, during which the world dramatically changed due to the Covid-19 pandemic and San Mateo County has increased its focus on both communities. Despite the turbulent times and because of the increased focus, the HCH/FH Program was able to make strides in several noteworthy areas, and more can be found in the 2022 HCH/FH Annual Report (link):

1. **Expanding oral health programs** – oral health has consistently been identified in HCH/FH Needs Assessments as a barrier for both farmworkers and people experiencing homelessness. HCH/FH began funding a monthly Saturday Dental Clinic at Coastside Clinic, continued weekly Sonrisas services co-located at Puente, and providing some of the funding for University of Pacific at the Navigation Center (service slated to begin end of 2023/early 2024)
2. **Launching enabling services for newly housed individuals**: while HCH/FH cannot pay for housing, during the last strategic planning it became clear that newly housed individuals might lose their housing due to health-related issues. provide medical car e coordination services to individuals who have recently been housed or are preparing to move into permanent housing
3. **More health services in the field**: the Board was passionate about mirroring the Pescadero Field Medicine program in Half Moon Bay and provided seed funding to PHPP to do so. The Board also supported the re-establishment of the HEAL team by funding one position and elevating the need for more funding to MHSA which then decided to fund 2 additional positions in their strategic planning work.
4. **Deeper collaboration** with the Center on Homelessness, Department of Agriculture, Department of Housing, Health Plan of San Mateo, and all Health departments
5. **Engagement of stakeholders** and community partners in HCH/FH Board Meetings has increased significantly

Themes for the 2024-2027 Strategic Plan

In updating the strategic plan, several major themes arose which are summarized below. While not each theme is captured explicitly in a stated strategic priority or activity beneath, these are embedded in everything staff does in implementing the Board's vision for the program.

1. **A Brick and Mortar clinic is not the end goal for all**: There has been a transition from prioritizing brick and mortar clinics as final goal for all patients to – instead – bringing medical, dental, and behavioral health care in the most appropriate modality to where people. Because for some patients, making it to a physical primary care clinic will never be a possibility for a myriad of reasons, bringing services to them – both by physically meeting them where they are as well as emotionally – should be considered a success, while also partnering with SMMC to ensure clinics able to meet the needs of both populations.
2. **Behavioral health**: Like the previous strategic plan, this continues to be a large focus. For farmworkers there is a desire to better understand *how* to deliver behavioral health services – both mental health and substance use related – in a culturally competent manner; for example, acknowledging the term "behavioral health" does not resonate with the community and stigma associated with accessing health, necessitates for a more nuanced approach than for other communities. For people experiencing homelessness, the ability to monetarily incentivize individuals to participate in treatment and/or staying clean (called contingency management) is a promising model to further explore among others with BHRS colleagues. HCH/FH relatively recently appointed a Behavioral Health Medical Director to help the program navigate these complex services - the shooting in Half Moon Bay in early 2023 reminds us all the importance of addressing behavioral health.
3. **Collaboration**: HCH/FH staff and Board members are uniquely positioned as subject matter experts to promote and conduct cross-collaboration, information sharing and problem solving between Health, HSA, DOH, as well as contracted and non-contracted providers. In order to make headway in any of the priority areas listed below, this type of cross-departmental collaboration is imperative. Additionally, HCH/FH's ability to write grants to access supplemental funding – be it from HRSA or other entities such as Health Districts, Hospital Systems, Chan Zuckerberg Initiative and others – and accessing technical assistance could be an important asset to the County.
4. **Social Determinants of Health:** The Board continues to firmly believe that housing – a classic example of a social determinant of health - is healthcare. The 2022/2023 Needs Assessment elegantly showed that when patients have access to things like housing, food, employment – they rank their health higher. Finding ways to promote social determinants of health will continue to influence the Board's decision making, though not always possible to fund directly, there are numerous other ways the Board could support this.

Areas for improvement for the next strategic planning effort:

1. Continue seeking greater engagement and input from the public
2. Continue honing goal setting and monitoring
3. Better alignment with other County Needs Assessment efforts to augment HCH/FH Strategic Planning efforts

2024-2027 Strategic Priorities

The Board may choose to assign additional measurable outcomes to each area in future iterations of the Strategic Plan, which is intended to be a living document.

Goal	Measurable Outcomes
Decrease barriers to accessing health care services	Increase the number of 'touches' or 'visits' across all services (enabling, primary, behavioral, dental) and modalities (mobile and brick & mortar clinics) year over year.
Improve health outcomes	Refer to goals set forth in the HCH/FH Quality Improvement/Quality Assurance Plan
Support health care and service providers	Track number of trainings and other professional development opportunities offered annually and increase year over year*
Meet and exceed all HRSA compliance requirements	Following a HRSA site visit, have no more than 5 immediate enforcement actions. The next site visit is anticipated in 2025.
Seek innovation and expansion opportunities	Add at least one new funding source or supplemental award in the 2024-2027 cycle.

**pending external factors such as conference location/costs and ability/willingness of staff to engage in offerings*

Strategic Plan Activities

Below are high-level activities associated with each strategic priority area. More granular-level activities are listed out in separate, program-level documents to ensure priorities are met.

1. **Decrease barriers to accessing health care services**
    1. Fund and coordinate enabling services
    2. Fund and coordinate delivery of primary care, dental, and behavioral health services to non-conventional health care settings
    3. Collaborate with SMMC, BHRS, and PHPP to optimize clinic operations and reduce patient grievances
    4. Collaborate with HCU and other partners to ensure patients have and maintain insurance coverage
2. **Improve health outcomes**
    1. Follow work outlined in HCH/FH Quality Improvement/Quality Assurance Plan
    2. Provide outreach & health education to patients
    3. Identify sub-populations for additional data analysis and efforts to reduce health disparities
    4. Ensure social determinants of health are embedded in clinic and HCH/FH workflows.
3. **Support health care and service providers**
    1. Develop and provide relevant training
    2. Provide financial support for professional development and well-being initiatives
    3. Connect SMMC, BHRS, and PHPP care teams with external case managers and community resources
4. **Meet and exceed compliance requirements**
    1. Pass HRSA Site Visit audits with minimal to no findings
    2. Timely and accurate annual UDS reporting
    3. Have a well-functioning Co-Applicant Board with consumer representation
    4. Regularly monitor and evaluate financial performance of contracted services/contractors
    5. Maximize all available HRSA opportunities and relationships
5. **Seek innovation and expansion opportunities in program operations**
    1. Continuously explore and engage partnerships that align with the program goals and apply for supplemental awards when appropriate.
    2. Be active thought partners and leaders in the County's program evaluation efforts
    3. Be an active partner in the County's Epic implementation initiatives
    4. Collect data and advocate for medically fragile homeless individuals' needs
    5. Partner, engage and collaborate with relevant stakeholders to explore impacts of CalAIM and other policies on quality of care and finance

Stakeholders

Thank you to the over 40 individuals who gave their time and perspectives to forming this strategic plan as well as the members of the HCH/FH Strategic Planning Subcommittee:

1. **Anessa Farber**, San Mateo County Health
2. **Belinda Arriaga**, ALAS
3. **Clara Boyden**, San Mateo County Health
4. **Corie Schwabenland**, ALAS
5. **Corina Rodriguez**, Puente de la Costa Sur
6. **Don Orr,** San Mateo County Health
7. **Elisa Calfiore,** LifeMoves
8. Farmworker Affairs Coalition (7/14/23 meeting)
9. Farmworker Focus Group at Puente
10. **Francisco Valencia**, LifeMoves
11. **Frank Trinh**, San Mateo County Health
12. **Gabe Garcia**, HCH/FH Board Member
13. **Gale Carino**, Health Plan of San Mateo
14. **Ione Yuen**, San Mateo County Department of Agriculture/Weights & Measures
15. **Jack Nasser**, San Mateo County Health
16. **Janet Schmidt**, HCH/FH Board Member
17. **Jei Africa**, San Mateo County Health
18. **Judith Guerrero**, HCH/FH Board Member
19. **Kacie Patton**, San Mateo County Health
20. **Karen Krahn**, San Mateo County Health
21. **Kate Arsenault**, Health Plan of San Mateo
22. **Khalia Parish**, San Mateo County Human Services Agency
23. **Kique Bazan**, ALAS
24. **Koren Widdel**, San Mateo County Department of Agriculture/Weights & Measures
25. **LEAG Meeting** (6/20/23 meeting)
26. **Lody Burdick**, San Mateo County Human Services Agency
27. **Lucinda Dei Rossi**, San Mateo County Health
28. **Luis Valdivias**, El Centro
29. **Marc Meulman**, San Mateo County Health
30. **Maricela Zavala**, Puente de la Costa Sur
31. **Marmi Bermudez**, Health Coverage Unit
32. **Matthew Hayes**, San Mateo County Human Services Agency
33. **Patrick Grisham**, San Mateo County Health
34. **Peter Shih**, San Mateo County Health
35. **Rita Mancera**, Puente de la Costa Sur
36. **Robert Anderson**, HCH/FH Board Member
37. **Rose Cade**, San Mateo County Department of Housing
38. **Sandra Sencion**, ALAS
39. **Steve Kraft**, HCH/FH Board Member
40. **Suzanne Moore**, HCH/FH Board Member
41. **Tanya Beat**, LGBTQ Commission
42. **Tasha Souter**, San Mateo County Health
43. **Tejasi Khatri**, Health Plan of San Mateo
44. **Ziomara Ochoa**, San Mateo County Health