



**Tab 1:**  
**Draft Minutes 8/10/18 HCH**  
**Commission Meeting**

**Alameda County Health Care for the Homeless Commission**  
**Thursday, August 9 2018, 3:00-4:00pm**  
**SPECIAL TELECONFERENCE MEETING DRAFT MINUTES**

HCH Commissioners Present

boona Cheema  
 Laura Guzman (phone)  
 Lois Bailey Lindsey  
 Claudia Young  
 Lynette Lee  
 Michelle Schneidermann, MD

Absent:

Fr. Rigo Caloca-Rivas  
 Samuel Weeks DDS

County Staff/Partners Present:

Heather MacDonald-Fine, AHS  
 David Modersbach HCH  
 Lucy Kasdin HCH  
 Omar Rascon HCH

Item	Discussion/ Recommendations	Action
A. CALL TO ORDER 1. Welcome & Introductions 2. Adopt agenda	boona cheema  chair HCH Commission  Meeting brought to order and agenda accepted	
B. CLOSED SESSION	No Closed Session.	
C. PUBLIC COMMENT**	No public comment	
D. CONSENT AGENDA  Review and Approve Minutes 7/20/18 HCH Commission meeting	Minutes of 7/20/18 HCH Commission Meeting were reviewed and approved by HCH Commission	<b>Motion:</b> Lois Bailey Lindsey; second, C.Young  Yea: unanimous
E. HCH Program Director Report	Deferred	
E. BOARD ORIENTATION	Deferred	
F. REGULAR AGENDA  1. Presentation of HCH Program 2019 Budget Period Renewal Submission for review and approval of HCH Commission.  <b>Action Item: Approve Submission of 2019 ACHCH Budget Period Renewal</b>	HCH Grants Manager David Modersbach provided an overview of the next year budget, and recap of items discussed during the July 20, 2018 meeting. Plan regarding the number of patients we would like to serve, financial forecast, contracts, and other information that form our proposed budget plan. Our budget includes the addition of four (4) positions that the program is going to fill.  Question: what is the recruitment process for the positions? – Deputy Director provided an update of the recruitment process.  <ul style="list-style-type: none"> <li>• HCPA I: Theresa Ramirez will start in early September.</li> <li>• Behavioral Health – up to 6 weeks</li> <li>• Social Worker – Interviews are scheduled for early-mid September.</li> <li>• CHOW – List should be published by end of September</li> </ul>	

<p>2. Consumer/Community Input – Report from HCH Consumer/Community Advisory Board</p> <p>3. Board Executive Committee report</p>	<p>Question: how will the auditors feel about not having a program director?</p> <ul style="list-style-type: none"> <li>• Lucy Kasdin clarified that the health center does have an Interim Director, Dr. Jeffrey Seal.</li> <li>• David Modersbach provided Commission an overview of the selection, hiring and evaluation process of the program director – the commission is in a position to provide oversight on director position.</li> </ul> <p>Question: how should we explain the slight decline in patients served?</p> <ul style="list-style-type: none"> <li>• David Modersbach explained that a goal that the HCH program is achieving is to provide more comprehensive, quality-driven care for patients, with a deeper-touch. That combines with a refocusing on intensive substance abuse services and a move away from “light touch” substance use engagement from the past to slightly reduce total HCH patients. .</li> </ul> <p>Motion to Approve BPR 2019 (Laura Guzman, seconded by Michelle) – all approved.</p> <p>No HCH CCAB report</p> <p>Item: Reoccurring meeting with Boona, Lynnette, Jeffrey, David, and Luella to create agenda for HCH Commission meetings, which will initiate on Monday September 10, and regularly take place 2 Monday’s before the HCH Commission meeting.</p>	<p><b>Motion:</b> L.Guzman; second, M.Schneidermann</p> <p><b>Yea:</b> unanimous</p>
<p>G. OTHER ITEMS</p> <p>1. HCH Commission Discussions/Questions to prepare for 8/14/2018 HRSA Operational Site Visit</p> <p>a. Entrance Conference 8/14/18 9:00am-10:30am</p> <p>b. Board HRSA Luncheon 8/15/18 noon</p> <p>c. Exit Conference 8/16/18 10:30am</p>	<p>Reviewing and preparing for the OSV: There was a discussion regarding the highlights of HCHP – one item to highlight is the CCAB’s role in shaping consumer experience and providing guidance from the perspective of the patient. Focusing on what is important to the patient is a great talking point because of the work they are currently doing to measure patient experience.</p> <p>Other highlights: Street Medicine and Street Psychiatry are very innovative outreach strategies that should also be emphasized, and their collaboration with the Trust Health Center – Trust provides a great narrative on what patients need in addition to medical services; for instance, case management, re-entry assessments, disability paperwork support, judicial support and advocacy, etc.</p> <p>David Modersbach provided an overview of previous HRSA visits, and how our program has changed since then.</p> <p>Question: Contract renegotiation and compliance management – what is the commission’s role when renegotiating? Commission Chair provided an explanation on the commission’s role when renegotiating directly with the provider, but they provide input and feedback to HCHP to ensure that there is a corrective action plan. HCHP informs the commission about contractual issues, and Commission assists with the development of action plans and</p>	

<p>3. Items for upcoming agendas 4. Housekeeping</p>	<p>highlight follow-ups to shape future contracts when renegotiation is in motion.</p> <p>Items to send to Commission:</p> <ul style="list-style-type: none"> <li>• Bright Research PxEx Packet</li> <li>• 2017 UDS report Dashboard</li> <li>• HRSA Checklist</li> <li>• HCH Contract Monitoring process</li> <li>• HCH Commission Recruitment docs</li> <li>• Hiring a Project Director talking points</li> </ul> <p>Meeting Adjourned 3:49pm moved by Lynette second Claudia unanimous</p>	
<p>H. ADJOURNMENT</p>		

# **Tab 2: HCH Director's Report**



September 21, 2018

TO: Alameda County Health Care for the Homeless Commission

FROM: Jeffrey Seal, MD; Interim Director and Medical Director

SUBJECT: Director's Report

Program activity update since the 08/2018 HCH Commission meeting and HRSA Operational Site Visit:

1. Strategic Plan

HCH has largely finished its strategic plan and accompanying implementation schedule. We plan to present it to HCSA leadership next week, and we will plan to present it in final form to the Commission on the upcoming meeting.

2. Personnel

Theresa Ramirez, our new HCPA I, started on 9/10/18. She brings vast experience in public systems and quality work, and she will be in charge our quality program in addition to other significant roles. We are excited to have her join our team. We continue to pursue the hiring of several other key positions, such as direct services manager, and will continue to update you.

Regarding the HCH director position, a plan has been developed. We are working with HCSA leadership on finalizing the details, and the latest an initial proposal would be received is the October commission meeting. We plan to discuss more in the commission meeting, and at this point the request of agency leadership is that the commission would give consideration to the process by which it would accept or reject a proposal, as well as the evaluation.

3. StreetHealth

The HCH StreetHealth team continues to develop its model and provide robust services to encampments in downtown Oakland. The HCH program has just been awarded expansion funding by HRSA for expansion of the StreetHealth Team (\$121,500 ongoing funding, \$175,000 one-time only funding).

4. Quality

- a. After the feedback from **OSV**, we are giving increased consideration to appropriate quality dashboards for the commission, as well as planning for more regular review of metrics with the commission.
- b. We received approximately \$50K in **QI Achievement Award** from HRSA, and we are currently planning to split this between a dental consultant, who will help us develop a long term strategy toward dental services in the county, and outreach trainings.
- c. **Quality Committee:** As previously noted, Bright Research Group has worked with our consumer advisory board to develop a consumer experience survey that is culturally appropriate for individuals experiencing homelessness, and we think it will have system and possibly national impact. We will now enter into a period when this survey is piloted in our different contracts with BRG.
- d. **Street outreach medicine symposium:** BRG is working with HCH to host a street medicine symposium at the end of this month. The meeting will include CBOs and street outreach providers, and the goal will be to share and agree upon best practices to inform our community's outreach medicine practice moving forward.
- e. **Contracts:** We have continued to actively restructure our contracts by incorporating results-based accountability to improve quality and clarify expectations. We recently purchased RBA
  - i. Our mobile dentals services contract (OnSite) has come to a hard stop per county contract regulations, so we have recently started the process for a new RFP.
  - ii. Our RBA metrics for Tri-City street outreach medicine have been finalized, and the contract will begin this month.

## 5. Data Systems

No updates from last director's report. We are continuing the process to update our database.

## 6. Operational Site Visit

Please see attached summary.

## 7. Medical Respite

HCH, along with leadership from HCSA, LifeLong, and Alameda Point Collaborative, visited the site that will be developed for medical respite and permanent supportive housing over the next few years. APC is still early in its development process for the project, and we have established ourselves as excited partners, though, roles are still to be determined.

Sincerely,

A handwritten signature in black ink, appearing to read 'J Seal'.

Jeffrey Seal, MD  
Interim Director and Medical Director  
Alameda County Health Care for the Homeless  
Jeffrey.Seal@acgov.org  
510-891-8920

## Tab 4

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# Alameda Senior Housing and Medical Respite Center



## Alameda Point Collaborative

**Doug Biggs**

**Executive Director**

Alameda Point Collaborative

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**Bonnie Wolf**

**Project Director**

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## PROJECT VISION

The Alameda Point Collaborative (APC) has initiated the development of the Alameda Senior Housing and Medical Respite Center (Center). The project will co-locate: Senior Permanent Supportive Housing, Medical Respite, and a Primary Care Clinic to benefit medically vulnerable adults in Alameda County. The 3.6 acre campus, next to Crown Memorial State Beach's Crab Cove in Alameda, is an optimal healing environment for individuals recovering from homelessness and complex health conditions.

Established in 1999, APC is recognized for creating successful permanent supportive housing communities for homeless families in Alameda County, achieving a 95% retention rate for its 500 residents. APC's wraparound services include: case management; job training and social enterprises; community gardening/food security; children and youth programs; and community leadership initiatives.

The project will renovate four existing buildings for supportive housing serving homeless adults ages 55 years and older. The project will also construct a two-story Medical Respite facility, Primary Care Clinic, and Resource Center. The architectural design for the five buildings will incorporate trauma-informed, state-of-the-art and age-friendly design principles.

The Center will be comprised the following program elements:

Center Program	Units/Service	Characteristics of Homeless Persons Served
Senior Permanent Supportive Housing	80-90 units	Alameda County residents ages 55+ with complex medical conditions
Medical Respite	50 beds	Alameda County residents ages 18+ upon discharge from East Bay hospitals or identified as in need of recuperative care
Primary Care Clinic	On-site clinical services	Alameda County residents who are Medical Respite patients, Senior Housing residents and Resource Center clients
Resource Center	Drop in center	City of Alameda residents who are homeless or at-risk of homelessness

The Center will address the unique needs of highly vulnerable individuals, with an emphasis of serving medically frail, older and homeless adults in Alameda County. The Center will enable participants to live in a dignified community; access high-quality medical and behavioral healthcare; and reduce their risk of dying alone on our streets.

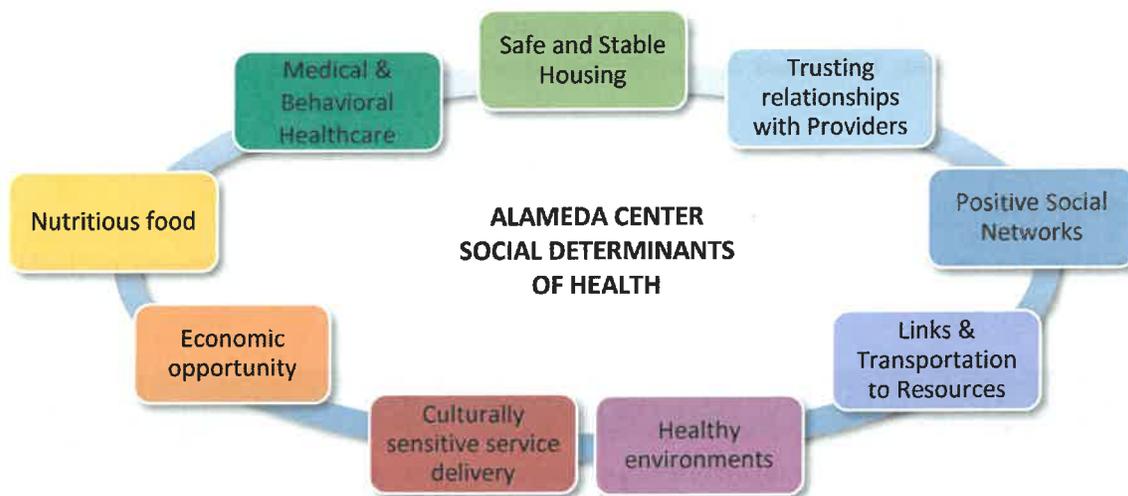
APC is confident that the Center will provide significant cost savings to our local health care systems, based on existing studies which show that Medical Respite and Permanent Supportive Housing have reduced preventable hospital readmissions, hospital inpatient days, and emergency department use.

## ACCOMPLISHMENTS TO DATE

- In December, 2017, APC’s application for a no-fee conveyance of 3.6 acres, 72,049 SF of federal surplus property to develop the Center was approved by the Department of Health and Human Services (HHS).
- In May, 2018, the project’s federally mandated Environmental Assessment for HHS found no significant environmental impact for the proposed project.
- In June, 2018, APC selected Mercy Housing, a leading Bay Area supportive housing developer, as the project’s Development Partner to raise the requisite capital funding and co-develop the Center.
- Currently, APC is in process of obtaining site control of five buildings and 3.6 acres of land for immediate use. This fall, HHS anticipates property transfer to APC upon City of Alameda zoning changes.
- Since the initial project planning, the City of Alameda staff, City Manager and City Council members have expressed strong support for the project, including dedicating funding and staff time.
- Since the start of project planning, Alameda County has proven to be a deeply engaged project partner has prioritized the project to strengthen their service delivery for vulnerable populations.
- The Alameda County Board of Supervisors approved significant pre-development funding for the Center at their recent August 7, 2018 meeting. Alameda County is considering different options for on-going services and operational support for the project.

The Center is organized around the following six strategies:

1. **Target Key Social Determinants of Health** that profoundly influence the health and well-being for highly vulnerable and older homeless individuals with complex health conditions:



2. **Develop Cross-Sector Partnerships** with health care providers, managed care organizations, governmental agencies, consumers and nonprofit organizations to:
  - Eliminate gaps in the current system of care for medically complex and older adults in Alameda County.
  - Convene an Advisory Committee to engage a collaborative learning process, develop a best practice service model, and inform Center operations.

### **3. Integrate Housing, Health Care and Supportive Services.**

- Co-locate permanent supportive housing, medical respite, primary care, and supportive services to deliver high-quality and multidisciplinary care.

### **4. Create Restorative and Dignified Environments.**

- Provide a physical environment that promotes serenity and well-being, in contrast to life on the streets or the typical shelter experiences. With a healing bay-front location, promote aging in place with dignity and health recovery.
- Integrate trauma-informed and age-friendly design to create a sanctuary of care. Incorporate design elements to address the needs of trauma survivors and people with physical disabilities, cognitive impairments, and serious mental illness. (For example, interior and outdoor spaces will emphasize client choice by incorporating distinct spaces for both privacy or interaction).

### **5. Provide Culturally Responsive Services.**

- Acknowledge that racial inequities shape homelessness in Alameda County and across the nation – African Americans comprise just 11% of the county’s overall population, yet account for 49% of homeless individuals in Alameda County in 2017.
- Emphasize culturally-specific services, leadership opportunities and staffing that reflects the client population.
- Provide transportation to connect residents to their families and communities of origin.

### **6. Provide Trauma-Informed Care.**

- Focus on trauma-informed care as a unifying approach, as homelessness is a traumatic experience and chronically homeless individuals commonly experience complex trauma from childhood throughout their lives.
- Infuse care with trauma-informed principles, including: promoting client safety, choice, resilience, and healing within the context of trustworthy, compassionate relationships.
- Develop trauma-shielding systems, policies and practices to prevent secondary trauma and build healthy and resilient agencies.

## **VITAL COMMUNITY NEED**

According to the 2017 Homeless Count, there is an estimated 5,629 persons experiencing homelessness in Alameda County on any given night. There is a severe shortage of supportive housing for older, homeless and frail adults as well as recuperative care beds for medically complex homeless adults in Alameda County.

Homelessness is associated with profound health inequities. Homeless individuals suffer from high rates of undiagnosed or inadequately treated chronic and acute medical conditions. These health challenges are exacerbated by heightened exposure to communicable diseases and a chronicity of traumatic incidents,

including physical and sexual assault. Barriers to health care utilization are correlated with competing survival needs (for food, shelter and safety), stigmatization and a general mistrust of the health care system. Further, homeless individuals are denied certain surgeries and treatments because providers are concerned about the patient's ability to manage recovery, side effects, and potential complications.

In spite of a higher illness burden, homeless individuals tend to substitute emergency room services for primary care, leading to worsened health and increased mortality. Homelessness complicates basic self-care and treatment for chronic diseases, such as diabetes, given a lack of nutritious food, sanitary conditions, storage for medications, or predictable routines. Without stable housing, none of the proven health care interventions that have improved the life expectancy for housed individuals show any population-based improvements.

Homeless patient hospital stays in the U.S. are 4 times longer and readmission rates are nearly 2 times as high as those of housed patients, costing approximately \$4,000 more per visit for homeless patients.<sup>1</sup> Homeless patients visit emergency rooms 6 times per year, compared to 1.6 times for persons with stable housing.<sup>2</sup>

Older adults are the fastest growing part of the homeless population nationally; an estimated 50% of all single homeless adults are ages 50 and over. According to EveryOne Home, the 3,278 homeless older adults ages 50 and over in Alameda County in 2017. Older homeless individuals face rapidly deteriorating health conditions and difficult deaths. They experience medical and geriatric conditions in their fifties that are typically seen in housed persons in their seventies and eighties. Vast numbers of older homeless people never make it to their "elder" years of 65 years or older, as homeless people die 25 years earlier compared the general population.<sup>3</sup>

Research demonstrates that older adults experiencing homelessness feel devalued and forgotten and are at risk for a myriad of adverse life experiences, compared to individuals with stable housing.<sup>4</sup> There is significant late-onset homelessness among older adults in Alameda County, in addition to stark levels of chronically homeless older adults. Dr. Margot Kushel's HOME-HOPE study, surveying 350 homeless older adults aged fifty years and older in Oakland, found that almost half of the participants became homeless after age 50 years old.<sup>5</sup> Later-onset homelessness was often precipitated by a major illness, death of a loved one, or loss of employment. Once homeless, these individuals quickly spiral into personal chaos and dramatically worsened health conditions.

## CENTER PROGRAMS

### MEDICAL RESPITE

The Center's 50-bed Medical Respite program will provide recuperative care in a short-term residential setting for homeless individuals that are too ill or frail to recover from physical illness or injury on the streets, but do not require hospitalization. Medical Respite offers a compassionate and cost-effective hospital discharge option that enables patients to resolve acute conditions and stabilize chronic conditions. Intensive case management

will support participants to connect to primary health homes, specialty care, and housing placements.

The Center will serve patients with high medical acuity in an exceptionally beautiful facility designed for clinical care. The proposed program will serve an estimated 275 patients annually with a likely average length of stay of 60 days. Referrals will be coordinated with East-Bay hospitals, managed care plans, and skilled nursing facilities.

The Medical Respite program will provide:

- 24/7 staffing for acute and post-acute healthcare in a supportive residential setting with the provision of nutritious meals and clothing
- Access to on-site Federally Qualified Health Center (FQHC) clinicians for urgent care, follow-up care, behavioral health care, wound care, medication management, and health education
- Trauma-informed case management and daily client monitoring for emotional support as well as assistance accessing key benefits (Medicaid, SSI, food stamps), job training and other services
- Linkages to suitable housing placements and primary health home, mental health and substance abuse services

## SENIOR PERMANENT SUPPORTIVE HOUSING

The 80-90 units of Senior Permanent Supportive Housing will enable homeless individuals ages 55 years and older to “age in place” in a dignified and service-enriched community setting. The program will incorporate “assisted living” elements, including in-home supportive service and hospice care.

The Senior Housing program will provide:

- Stable, safe and affordable permanent housing units
- Access to on-site Federally Qualified Health Center (FQHC) clinicians for urgent care, follow-up care, behavioral health care, wound care, medication management, and health education
- Services to address geriatric conditions and assistance with activities of daily living
- Trauma-informed and culturally-specific case management counseling and peer recovery groups
- Recreational, wellness and community-building activities
- Complex-care coordination and transportation assistance for specialty appointments and connection with family/communities of origin
- Palliative or end-of-life care when appropriate

## PRIMARY CARE MEDICAL CLINIC

The FQHC will be staffed by primary care providers, a psychiatrist, a registered nurse, licensed clinical social workers, and case managers.

The Center’s Federally Qualified Health Center (FQHC) will provide access to:

- Primary and urgent care for clients with complex and chronic health conditions
- Behavioral health counseling, recovery groups and referrals to treatment
- Select specialty health care, such as nutrition, podiatry and wound care
- Complementary medicine to promote healing, reduce pain, alleviate stress and treat behavioral health conditions (e.g. acupuncture)
- Health education services
- Care coordination with specialists, treatment programs, and community-based organizations

## **RESOURCE CENTER**

The Resource Center will provide a safe and welcoming drop-in space for City of Alameda residents who are homeless or are at high risk of homelessness. The Resource Center will serve an estimated 100 Alameda residents annually.

The Resource Center will provide trauma-informed, no-barrier case management, peer advocacy, and intensive assistance with housing placements. Emergency supplies, such as blankets and food, will offer a vital community resource and promote engagement with participants. The Resource Center is the one Center program that will serve the City of Alameda, rather than Alameda County.

## HEALTH OUTCOMES AND COST SAVINGS

The Center's integration of Permanent Supportive Housing, Medical Respite and on-site health care will achieve major health benefits for homeless adults with complex conditions as well as reduce costs to health systems:



ALAMEDA CENTERS BENEFICIAL OUTCOMES Linking Housing, Healthcare and Supportive Services	
	<ul style="list-style-type: none"> <li>• Quality of life (physical and mental health, life satisfaction, social networks)</li> <li>• Housing stability for older homeless adults</li> <li>• Trusting and healing relationships with health providers</li> <li>• Resolution of acute conditions</li> <li>• Stabilization of chronic conditions</li> <li>• Health-promoting activities</li> <li>• Utilization of primary care</li> </ul>
	<ul style="list-style-type: none"> <li>• Exposure to infectious and traumatic incidents</li> <li>• High-risk behaviors</li> <li>• Premature and difficult deaths</li> <li>• Cycle from shelter/streets to acute care</li> <li>• Readmissions, Emergency Department utilization and length of patient stays</li> </ul>

Medical Respite care has the potential to not only reduce costs to health systems, but also keep medically fragile people off the street reduce homeless individuals cycling from the streets to emergency room visits, inpatient hospitalizations, detox stays, and other costly crisis health services.

Cost Savings Associated with Medical Respite
<ul style="list-style-type: none"> <li>• <b>Cost Savings for Individuals Residing in Medical Respite at Five Sites</b> (current federally-funded three year study):</li> <li>• 35% decline in the average hospitalization rate over a one-year period after Medical Respite participation.</li> <li>• 45% decline in the average rate of ED visits over a one-year period after program participation.<sup>6</sup></li> </ul>
<p><b>Circle the City Medical Respite, Phoenix</b> (Based on a three-year study of 309 participants of their 50-bed program):</p> <ul style="list-style-type: none"> <li>• Reduction of per-patient costs to the state Medicaid agency by an average of 58%, when comparing the 12-months before and 12-months after receiving Circle the City medical respite care.</li> <li>• 65.7% decline of ED visits per participant per month, comparing 12-months before and after medical respite care.</li> <li>• Realized annual savings of over \$4.7 million, with an average Circle the City participant cost reduction from \$2,220 monthly to \$900 monthly, based on 12-month before and 12-month after receiving Medical Respite participation.</li> <li>• 92% of participants were discharged into a housing situation other than the streets or emergency shelter system.<sup>7</sup></li> </ul>

Permanent Supportive Housing is a Housing First intervention to enable profoundly disabled and homeless individuals to rapidly gain housing stability and health recovery. Permanent Supportive Housing has proven to reduce public and health costs for residents who are homeless and frequent users of multiple health services.

<b>Cost Savings Associated with Permanent Supportive Housing</b>
<p><b>Per Person Cost Savings for Individuals Residing in Medical Respite and Permanent Supportive Housing in Chicago:</b></p> <ul style="list-style-type: none"> <li>• \$6,000 annually per person</li> <li>• \$9,800 annually for chronically homeless individuals</li> <li>• 23% fewer days in hospitals</li> <li>• 33% fewer ED visits</li> <li>• 42% fewer days in nursing homes.<sup>8</sup></li> </ul>
<p><b>Mission Creek PSH in San Francisco:</b> A study of 51 formerly homeless seniors shows a \$1.46 million annual cost reduction in hospital-based health care in the first year of operation.<sup>9</sup></p>
<p><b>Los Angeles County:</b> For every \$1 invested in Permanent Supportive Housing for homeless people with complex medical and behavioral issues, LA County saved \$1.20 in health and other service costs, particularly in relation to emergency services and inpatient hospital care. After one year in supportive housing, residents reduced their emergency department use by 68% and reduced inpatient hospital stays by 77%.<sup>10</sup></p>

## NEXT STEPS

APC is currently engaged in the following activities:

- Refine **project vision**
- Raise **pre-development funding**
- Develop **partnerships with healthcare providers**
- Enter into **ground-lease with HHS** to maintain the property during preconstruction up until occupancy and enter into contracts to maintain, insure and secure the property
- **Project Management:** Project planning, partnership development, and oversight for program and facility development
- Collaboratively develop **community agreements** with Alameda residents to address concerns, develop “good neighbor policies,” and build support for the project
- Meet with **effective providers of medical respite and senior supportive housing** nationally to draw upon their “lessons learned” and service model.

Next steps toward project implementation include:

- **Advisory Committee:** Convene a cross-sector collaborative learning community, with health partners, service providers, consumers and public agencies. The Advisory Committee will explore and advise strategies for homeless clients with complex medical and behavioral health conditions
- **Best Practice Service Model:** Develop an effective service model to ensure successful outcomes
- **Outcomes Evaluation:** Develop metrics and data collection system to track health benefits and cost savings

- **Architectural Design:** Recommend trauma-informed and age-friendly design that creates restorative and healing facilities, interior spaces and open spaces
- In partnership with Mercy Housing, **secure capital funding**, including Low-Income Housing Tax Credits and New Market Tax Credits, for the Senior Housing and Medical Respite, respectively
- Explore funding options to offer **intensive, layered elder services** for Senior Housing residents
- Work with Mercy Housing to select the **Architect, General Contractor** and other consultants
- Select qualified **nonprofit providers** to operate components of Center programs

The intensive project planning will enable APC, with our health, nonprofit and governmental partners, to realize the project vision for the proposed one-of-a-kind Center. The deliverables of the planning process will result in a best practice service model; trauma-informed and age-friendly architectural design recommendations; and business plan that will ensure effective and sustained Center operations.

Construction for the Alameda Senior Housing and Medical Respite will begin December 2020 and is expected to be completed by April 2022.

We affirm our shared vision to provide high-quality and comprehensive care for vulnerable individuals challenged by homelessness and complex health conditions.

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- 1 *National Health Care for the Homeless. "Medical Respite Care: Financing Approaches," June 2017.*
  - 2 *Kushel, Md, Vittinghoff, E and Hass, JS. (2001) "Factors Associated with the Health Care Utilization for Homeless Persons," JAMA 285:200-206.*
  - 3 *O'Connell II (2005). "Premature Mortality in Homeless Populations: A Review of the Literature", Nashville: National Health Care for the Homeless Council, Inc.*
  - 4 *Brown, R et al., "Health Outcomes of Obtaining Housing Among Older Homeless Adults." Am J Public Health, July 2015, 105(7), 1482-1488.*
  - 5 *Brown RT, Goodman L, Guzman D, Tieu L, Ponath C, Kushel MB (2016) Pathways to Homelessness among Older Homeless Adults: Results from the HOPE HOME Study. PLoS ONE 11 (5): e0155065. doi:10.1371/journal.pone.0155065.*
  - 6 *Shetler, D and Shepard, D. Medical Respite for People Experiencing Homelessness: Financial Impacts with Alternative Levels of Medicaid Coverage. Journal of Health Care for the Poor and Underserved, May 2018, Vol. 29, No. 2, pp. 801-813.*
  - 7 *Gonzalez, Angela. Phoenix Business Journal. "Study Shows Circle the City Medical Respite Care for the Homeless Saves Money," March 12, 2018.,*
  - 8 *Basu A, Kee R, Buchanan D, et al., "Comparative Cost Analysis of Housing and Case Management Program for Chronically Ill, Homeless Adults Compared to Usual Care," Health Services Research, February 2012, Vol. 47, No. 1; Part II, pp. 523-543.*
  - 9 *Bamberger, J. and Dobbins, S. "Long-term Effectiveness of Placing Homeless Seniors in Permanent Supportive Housing," Community Development Investment Center Working Paper Series, July 2014.*
  - 10 *Hunter, Sarah B., Melody Harvey, Brian Briscoombe, and Matthew Cefalu, "Evaluation of Housing for Health Permanent Supportive Housing Program." Santa Monica, CA: RAND Corporation, 2017. [https://www.rand.org/pubs/research\\_reports/RR1694.html](https://www.rand.org/pubs/research_reports/RR1694.html).*

## Tab 5

### Action Item:

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TO: Jennifer Clements, MPH, CPH, MCHES®  
Health Resources and Services Administration  
5600 Fishers Lane, Room 17N136A  
Rockville, MD 20857

RE: ACHCH 2018 Operational Site Visit Recap

22 August, 2018

Dear Jennifer:

We hope that you are doing well and sorry to have missed you for our 2018 HRSA Operational Site Visit, which occurred October 14-17, 2018.

Overall, the OSV was a positive experience and our team learned a lot. The consultants, led by Clifford Portis, along with Brittany Alosi, were able to access all requested documents. In addition, we had many successful site visits and meetings. During the Exit Conference, we were notified of three preliminary findings that would require follow-up, which we'd like to share with you as we begin our work to address them. We still have some questions regarding the best path forward, so we're looking forward to touching base with you soon and getting your guidance.

**1. Finding: Sliding Scale Fee Discount Program**

Consultants agreed that the HCH program has a good Sliding Fee Discount policy and procedure. But their preliminary finding is that the ACHCH SFDS policy should be to charge and bill patients who make >100% FPL, including "no discount" for patients >200%FPL. We discussed the reasons that ACHCH and many other HCH programs "slide to zero" throughout the FPL (HRSA OK, safety in the field, barrier to care, and tiny proportion of higher-income homeless patients (0.01% of HCH patients in 2017), and feel that the HCH program is currently in compliance.

**2. Finding: Contracts and Subawards**

As we had done in our 2015 OSV, the program had arranged site visits with subrecipient program key financial and administrative staff for review source compliance documents (A/P, ledgers, and billing/collection ledgers and reports). Because OSV consultants stated that it was the responsibility of the HCH health center to maintain key source documents on site, they chose not to carry out these fiscal/administrative site visits, and thus issued this preliminary finding.

ACHCH health center staff believes that current health center subrecipient and contractor monitoring systems and procedures are solidly in line with HRSA health center requirements.

**3. Finding: Board Authority**

This preliminary finding is most concerning: HRSA consultants stated that they believed that the HCH health center co-applicant Board (HCH Commission) arrangement did not meet Board Authority requirements.

The HCH health center Co-applicant Board was developed and approved by HRSA in a close years' long collaborative process from 2015 through 2016, so it came as a surprise when consultants stated that the HRSA-, County- and subrecipient-approved Co-Applicant Agreement is fundamentally incorrect, in their words it being a "Tri-Applicant Agreement" needing revision, and likely requiring a parallel co-applicant board within subrecipient Alameda Health System.

We really hope that upon review BPHC will not support this finding, as we understand our governance arrangements to be fully compliant with HRSA health center requirements, as it was HRSA-approved in 10/2016. The complete revision of the current arrangement spoken of by OSV consultants would certainly create an unnecessary diversion of health center resources and create a barrier to care for health center patients.

Thanks Jennifer for your close review of the findings as outlined by our OSV consultants, and your close work with HRSA/BPHC policy staff in the review of the OSV report.

We look forward to speaking with you about these preliminary findings and the OSV visit in general.

Sincerely,

Jeffrey Seal  
Interim Director/Medical Director

Lucy Kasdin  
Deputy Director

David Modersbach  
Grants Manager

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HRSA Operational Site Visit Exit Conference

8/17/2018

Present:

Clifford Portis HRSA, Kathleen Clanon HCSA, Jeffrey Seal HCH, Colleen Chawla HCSA, Kathryn Horner AHS, Jonathan Patterson HCH, Brittany Alosi HRSA, David Modersbach HCH, Lucy Kasdin HCH, Omar Rascon HCH, Lula Williams OSV, Karen OSV, Terri Moore HCH, Lynette Lee (HCHC), Lois Bailey Lindsey HCHC, James Nguyen HCSA

Program Requirement	Met/Not Met	Comments
1. Needs Assessment	MET	
2. Required and Additional Services	MET	
3. Clinical Staffing (clinical)	MET	
4. Accessible Hours of Operation/Locations	MET	
5. Coverage for Medical Emergencies During After Hours	MET	OSV made after-hours call, processed correctly.
6. Continuity of Care and Hospital Admitting	MET	
7. Sliding Fee Discount	NOT MET	Although SDFS are posted, they're not utilized, and not being done properly: Certain patients are not being charged. Any patient >100% must have a charge, even if it is small. The health center has multiple sliding fee discount schedules based on providers, and some do not charge any fees at all. This needs to be evaluated. Scale must be reviewed and made applicable to guidelines. Patient Assessment is ok, informing patients not met (b/c wrong information). Column II and III service not met b/c original problem. Evaluation of SFDS program not met.
8. QI Assurance Plan	MET	
9. Key Management Staff	MET	Reporting lines for Project Director must go directly to commission, not just HCSA
10. Contracts and Subawards	NOT MET	Monitoring of subrecipient agreement is deficient: Mechanisms for performance not met; program depends on self-attestation too much, needs to have all source documentation of subrecipient and contractors on hand, and HCH program must confirm that they are overseeing and monitoring all requirements directly. Subrecipient policy does apply to all contractors as well. Must verify all reports, data and compliance.
11. Conflict of Interest Policy	MET	
12. Collaborative Relationships	MET	
13. Financial Management and Accounting Systems	MET	Controls, documentation, draw down, documentation non grant funds, Fee Schedule, insurance, systems, procedures, billing, timely accurate 3 <sup>rd</sup> party billing; accurate patient billing not met, refusal ok, billing, ok, annual budget, non-federal/federal allocation, program monitoring all meet
14. Billing and Collections	MET	
15. Budget	MET	
16. Program Monitoring and Data Reporting Systems	MET	Not monitoring contracts and subrecipients properly but database report is met
17. Board Authority	NOT MET	Co-applicant agreement: Board is not receiving new or renewed contracts for approval. Commission required to exercise this authority within HCH health center. All contracts relating to HCH Program must be reviewed and approved by the HCH Commission

		unless the Commission delegates that role to other party. Policy issue around Authority of Commission: Co-Applicant agreement approved before 2017 compliance manual issued. "Not a Tri-Applicant agreement:" Not sure that AHS is an appropriate partner, as a non-county entity the Co-Applicant agreement might require revision. Compliance manual defines co-applicant agreement between Entity and Co-Applicant Board, not a third party. HRSA policy might have another view of this structure. Subrecipient AHS is using Co-Applicant Board to meet HRSA HC requirements, in the opinion of OSV they may have to develop own Co-Applicant board to maintain subrecipient relationship, or become a contractor. Must review HRSA Compliance manual. HRSA policy staff will review this and respond to HCH health center.
18. Board Composition	MET	
19. Performance Analysis: Diabetes Measure	MET	All DM action steps identified.
20. 340B	MET	

These are preliminary findings, will be reviewed by HRSA Policy and double check that we're not getting dinged twice for same issue. Major two are the SFDS and Contractor/Subrecipient Monitoring, can start working to address these.

Report will go through a few layers of review, expected within 45 days. When final OSV report is issued, an NoA will be issued with conditions, and resolution will take place through EHB.

Jennifer Clements will have a phone call with us when the Report/NoA is issued.

Compliance is a big deal at HRSA these days, the faster to get these lifted the better, our SAC is next year and we want no conditions on our award for the SAC (one year project period).

Questions?

Can changes be made between now and NoA to affect findings? No once we leave, OSV consultant's findings cannot change, but HRSA/BPHC policy staff will make final decision whether to issue condition.

**Governance/Co-Applicant Board.** Brittany: Having AHS on commission creates a potential conflict. Problem is that AHS is "part" of governing body of Alameda County. They are co-governing the "Body of Record" who is HCH. Potential implication of turning AHS into a "Contract" means implications for AHS and they would lose subrecipient benefits.

Cliff – AHS could develop their own co-applicant board. How would that resolve Jennifer's issues? 1. Remove AHS from governance from current co-applicant board, and lift issue of co-applicant board. 2. Subrecipients need to be 100% compliant with HRSA requirements as they are right now, by having their own co-applicant board. AHS Co-applicant Board would have to meet 100% HRSA board requirements including consumer majority

Would this make two health centers? HCH and AHS? Brittany: No, HCH is the only grantee of record. HCH is the only organization of record, and needs to be responsible to ensure/demonstrate all AHS subrecipient compliance. Co-Applicant board needs to be separate from AHS. The overall health center/HCH and AHS can't share a co-applicant board. Needs to operate independently without conflict. Co-Applicant Board needs to approve subrecipient agreement.

Where is that Co-applicant conflict? Brittany: The HCH Commission might have to vote some day to remove AHS as a subrecipient, and being that AHS' patients and services are a substantial part of the HCH health center, that's a conflict. .

How to address this organizational conflict: Brittany: Maintain authority for oversight for health center project. No other entity or committee has authority over health center governance functions.

Question/Statement: The HCH Commission is independent, self-governing, and has authority over AHS health center operation (example hours of operation). HCH Commission governs AHS. Brittany: They need to be separate. Say HCH Commission is governing body. Needs to have oversight over health center but shouldn't have direct oversight over AHS. But

HCH program: HCH Commission does have authority over the AHS BOT regarding health center operations...

Cliff: This is based on new HRSA Health Center Compliance Manual, and even though you worked with HRSA during 2015-2016 to establish a HRSA approved governance structure, the opinion of the site visitors is that this does not meet the letter of the HRSA Health Center Compliance Manual. OSV consultants will submit their findings and recommendations to HRSA/BPHC for their review and analysis and decisions.

**Project Director:** How do we document compliance? Cliff: A revised org chart is OK. David presented a revised chart and that was approved by Cliff. Finding withdrawn.

**SFDS:** The OSV consultants are sending their findings and recommendations, as well as questions raised by the HCH Program staff to HRSA/BPHC for review and final decision.

**Thanks to all and the meeting adjourned at 11:45am**