Board of Directors
**COMMUNITY HEALTH INVESTMENT COMMITTEE MEETING**
Monday, August 1, 2022
Zoom Teleconference
Minutes

**1. Call to Order**
Meeting was called to order at 5:35 pm. Chair Galligan presided. Present: Rick Navarro, John Delaney, Linda Wolin, Nancy Bush, Henry Sanchez, and Karen Bettucchi. Absent: Mary Lund

**2. New Business**

**A.** Minutes: Rick Navarro moved to approve the minutes from November 29, 2021 meeting and Henry Sanchez seconded the motion. Motion passed unanimously.

**B.** Reviewed and discussed the FY'22 Community Health Investment Fund which included the:
1. The Community Grants Program
2. Healthcare Workforce Tuition Assistance Program.
3. Committee voted and approved the Discretionary Fund Events & Sponsorships

**C.** Community Health Investment Proposal

**D.** Discussed the following items related to the 2022 – 2023 Grant Cycle Grant Cycle:
1. Community Health Investment Committee Charge
2. Community Grants Program Policy
3. Funding Focus Areas
   - Healthy Aging - socialization and connectivity
   - Mental Health - prevention services and programs
   - Preventive Health – screenings and healthy living
4. Community Grants Program Budget
5. LOI process – LOI's will be submitted to grants@peninsulahealthcaredistrict.org, and screened by Management. LOI's and recommendations will be reviewed by Community Health Investment Committee at its meeting on October 3, 2022.
6. Committee Meeting Schedule & Work Plan

**E.** Current Committee Bios were requested for PHCD's new website.

Meeting adjourned at 6:30 pm

**D.** Adjournment

Respectively written and submitted by:

_____
Ann Evanilla-Wasson
Director of Community Engagement

| Page | Organization Name & Program Title | Requested Amount | Prior year Request | Q2 report | Focus | Program Description | Notes/Rec |
|---|---|---|---|---|---|---|---|
| 5 | AbilityPath<br>Adult Day Program - Pathways to Health & Wellness | $50,000 | $50,000 | x | PH | Support to expand Adult Day Program curriculum as well as senior-specific programing to address preventive health topics. | Yes |
| 9 | AnewVista Community Services<br>Building Tech Champions | $50,000 | 0 | N/A | HA | Support virtual and in-person classes for seniors on technology skills, wellbeing, physical health, independe | ? - Yes |
| 13 | Bay Area Community Health Advisory Council<br>Community Mammogram Program | $30,000 | $30,000 | x | PH | Funds to maintain and expand Community Mamogram Program by supporting a Community Outreach Professional, fliers, educational workshops, and sponsorships at culturally relevant educational opportunities. | Yes |
| 15 | Belmont-Redwood Shores Rotary<br>Medical Equipment Loan Program | $15,000 | 0 | N/A | PH | Support to clean, store and distribute durable medical equipment. | No |
| 18 | Boys & Girls Clubs of the Peninsula<br>Mental health and athletics at San Mateo Park | $25,000 | $25,000 | x | MH & PH | Support for mental health and athletics at San Mateo Park Elementary School. | Yes |
| 21 | Breathe California of the Bay Area<br>Breath California | $25,000 | $15,000 | x | PH | Support to maintain COVID prevention in hi-risk population. | No - weak LOI |
| 23 | Call Primrose<br>Food Pantry Program | $20,000 | $15,000 | x | ALL | Support to maintain grocery pantry program which provides access to free healthy food. | Yes - pick ONE focus area |
| 25 | Caminar<br>Medication Assistance Program | $50,000 | $50,000 | x | | Support to maintain medical and behavioral health services for clients, including psycho-education, wellness assessments, linkages to care, and improving protective factors. | Yes |
| 27 | CASA of San Mateo County | $30,000 | $25,000 | ? | MH | To fund the screening and training of adult volunteers who monitor and advocate for the mental health needs of children in foster care or juvinale justice system. | ? - Q2 general operating sup |
| 29 | Catholic Charities<br>Adult Day Services San Mateo County | $50,000 | 45,000 | x | HA | Support for virtual and on-site adult day programming for frail seniors and adults with disabilities and/or di | Yes |
| 31 | City of Millbrae's Recreation Department<br>Monthly Senior Birthday Luncheon Program | $4,080 | 0 | N/A | HA | Support birhday lunches for senior living in Millbrae. | No |
| 35 | Edgewood Center<br>Edgewood Center's HealthyKin | $40,000 per year for 2 years | $35,000 | x | All | Support to maintain trauma-informed, culturally responsive services, navigation and referrals for Kinship families to enable caregivers to offer permanent care to youth and keep them out of the foster care system. | Yes - pick ONE focus |
| 33 | First 5 San Mateo County<br>Help Me Grow San Mateo County | $60,000 each yr for 2 years | $50,000 | x | MH & PH | Support to maintain program which provides education and resources on healthy child develpment to health care providers, families and the community. | Yes - pick ONE focus |
| 37 | Foster City Village, Inc.<br>Inspiring Aging | $20,000 | 0 | N/A | All | Support for maintain and expand 55+ …… | ? - MH most viable focus |
| 41 | Fresh Approach<br>VeggieRx for Seniors | $45,000 | 0 | N/A | HA | Support to provide nutrition classes and visits to farmers markets for food insecure adults 65+ in San Mate | Yes - partner for outcome |
| 41 | Friends for Youth<br>Mentoring Servies | $25,000 | $25,000 | x | MH | Support to maintain youth-led SEL classes and provide one-on-one adult mentoring for students in the San Mateo/Foster City School District. | Yes |
| 50 | Healthier Kids Foundation<br>HearingFirst | $30,000 | $30,000 | x | PH | Support to maintain hearing screen and referal program for students in San Bruno Park Elementary School | Yes |
| 52 | IEP Collaborative, Inc.<br>Special Education Advice and Counsel Program | $44,602 per year for 2 yrs | $26,000 | x | MH | Support to maintain legal counsel for students/families eligible for special education services - Individuals with Disabilities Education Act – IEPs or 504s - to access educational supports, mental health, and other therapies. | Yes |
| 54 | Innovate Public Schools<br>Mental Health in Education Project | $75,000 | 0 | N/A | MH | Support to lift up parent voices to broade acces to mental health services | No - advocacy outside our |
| 56 | Jewish Family and Children's Services (JFCS)<br>Center for Dementia Care@ JFCS' Seniors at Home | $30,000 | $20,000 | x | HA | Support to maintain direct services to individuals with dementia and provide in-home respite for family caregivers. | Yes - ? social & connectivity |
| 58 | Justice At Last, Inc.<br>Empowerment Through Health and Wellness | $30,000 per year for 2 years | $24,000 | x | MH | Support to providee crisis stabilization and access to mental health services for survivors of human traffick | Yes |
| 60 | Kara<br>Bereavement Support, Grief Education, & Crisis Response | $25,000 annually for 2 yrs | $20,000 | x | MH | Support to maintain mental health of bereaved community through crisis response to schools, peer-based support groups and grief-related therapy for families and/or individuals. | Yes |
| 62 | Latino Commission on Alcohol & Drug Abuse Services of San Mateo County - Entre Familia Outpatient Services | $20,000 | $20,000 | x | MH | Support to maintain virtual counseling and group sessions on relapse prevention and healthy coping skills in San Bruno area. | Yes |
| 64 | LifeMoves<br>BehavioralMoves | $30,000 | $30,000 | x | MH | Support to maintain behavioral health screening and on-site services at First-Step for Families shelter in San | Yes |
| 66 | Lucile Packard Foundation for Children's Health<br>Stanford Children's Health Teen Van | $467,439 for 2 years | $175,000 | x | All | Support to maintain two visits per month to San Mateo Union High Schools to provide medical, mental and nutrition care. | Impact Partner |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 69 | Mission Hospice and Home Care<br>Charitable Care at Mission House | $175,000 | $165,000 | x | HA | Support to maintain charitable hospice services to PHCD residents at RWC Hospice House and in-home services. | Impact Partner |
| 72 | National Center for Equine Facilitated Therapy<br>Equine-Assisted Mental Health & Resilience Program | $20,000 | $25,000 | x | MH | Support to provide mental health services and resiliency skills to youth. | Yes |
| 74 | NEMS Behavioral Health Integration Program<br>Behavioral Health Integration Program | $60,000 | 0 | N/A | MH | Support bevavioral health services, referrals, linkages for the most vulnerable and underserved families in San Mateo County and launch new outreach activities. | ? - stats too low, transportation |
| 76 | Ombudsman Services of San Mateo County, Inc<br>Long Term Care Ombudsman Program | $80,000 | $70,000 | x | HA | Support to maintain Long Term Ombudsman Program and expand program to include Memory & Me and the Friendly Visitor Program. | Yes - adjust funding <$60K |
| 78 | One Life Counseling<br>Free and Low-Fee Mental Health Counseling | $50,000 | $10K/$50K | x | MH | Support to provide access to mental health counseling for low-income youth, families, and individuals within PHCD. | Yes |
| 80 | One Step Beyond, Inc.<br>OSBI CA Recreation – Health and Fitness | $10,000 | 0 | N/A | PH | Support to maintain recreation health and fitness program for adults with intellectual disabilities. | Yes |
| 82 | Pathways Home Health & Hospice<br>Pathways Bereavement Program | $10,000 | 0 | N/A | MH | Support to maintain and existing breavement services to individuals coping with the loss of a loved one, inc. screening for depression, isoltion, anxiety and other behavioral health concerns. | Yes |
| 84 | Peninsula Bridge<br>Mental Health Wellness Program | $35,000 per year for 2 yrs | $35,000 | X | MH | Support to maintain and expand counseling services for students and parents/caregive workshops. | Yes |
| 86 | Peninsula Family Service<br>Older Adult Peer Counseling Program | $60,000 | $45,000 | x | HA | Support to maintain and expand peer counseling and group support to community member 55+. | Yes |
| 87 | Peninsula Family<br>Community Health Initiative | $60,000 per year for 2 years | $45,000 | x | HA & PH | Support to launch community movement exercise classes in San Mateo and San Bruno as well as maintain Diabetic Prevention Program and HEAL workshops. | Yes |
| 91 | Peninsula Jewish Community Center<br>Pink Power and Fit @ the PJCC | $15,000 | $10,000 | x | PH | Support of on-site, virtual and community-based exercise program for post-operative breast cancer survivors to improve strength and well-being. | Yes |
| 93 | Peninsula Volunteers, Inc.<br>Adult Day Services at Rosener House | $50,000 | $40,000 | x | HA | Funds to subsidize attendance at adult day health services for seniors with low income. | No - combine w/ SI Scholarship |
| 95 | Peninsula Voilunteers, Inc.<br>Meals on Wheels for San Mateo County | $60,000 per year for 2 years | $75,000 | x | HA | Support to maintain weekly home delivered meals for 30 home-bound seniors. | Yes |
| 97 | Rebuilding Together Peninsula<br>Safe at Home | $45,000 per year for 2 yrs | $30,000 | x | HA | Support to expand home safety/health repairs for low income homowners, majority are elderly, persons of color and/or people with disabilitieswho wish to safely age in place. | ? - will fund 10 homes |
| 99 | Samaritan House<br>Free Clinic of San Mateo | $350,000 | $305,000 | x | All | Support to maintain access to a medical home - providing diabetes care, a food pharmacy, vaccines, mental health and dental hygiene care for residents. | Impact Partner |
| 101 | San Bruno Park District<br>Wellness Coordinator Position | $75,000 | $75,000 | x | MH&PH | Support to maintain a Wellness Coordinator who facilitates mental and preventive health activities/programing for 5 San Bruno Park School District students, staff and families. | Yes |
| 103 | San Mateo County Health Foundation<br>Food Boxes for Food Insecure Families | $21,455 | 0 | N/A | PH | Expand distribution of perishable groceries by puchasing a walk-in refrigeration unit to store food boxes at the San Mateo Medical Center. | ? - frig to store food boxes |
| 105 | San Mateo Police Activities League<br>Family Support, Education & Mental Wellness Program | $60,000 per year for 2 years | $30,000 | x | MH | Support to expand mental health curriculum and therapy services at all 3 San Mateo/Foster City High Schoo | Yes |
| 107 | San Mateo Union High School District<br>Attend Leadership Development Training | $60,000 | 0 | N/A | MH | Support leadership development through intensive program at the Hudson Institute for SMUHSD Mental Health and Wellness Administrators and Specila Education Administrators. | No- outside focus areas |
| 110 | Second Harvest of Silicon Valley<br>Alleviate Hunger | $50,000 | $50,000 | x | PH | Support to provide free-of-cost nutritious food to low-income families and individuals in Burlingame, Foster City, Millbrae, San Bruno and San Mateo | Yes |
| 112 | StarVista<br>Youth Mental Health & Substance Use Prevention Prg | $60,000 | $25K/$25K | x | MH | Support to maintain and ensure access to crisis intervention, suicide prevention, and substance abuse prevention/intervention for youth and for the wider community to learn about available resources. | Yes |
| 114 | Via Heart Project | $55,470 | 0 | N/A | PH | Support to purchase 9 AEDs, conduct 10 CPR/AED traing classes and 1 youth heart screening. | previously |
| 116 | Villages of San Mateo County<br>Healthy Seniors at Home | $20,000 | $10,000 | x | HA | Support for services such as safe homes, Lyft, medical alert devices for seniors with low income. | Yes |
| 118 | Vista Center for the Blind and Visually Impaired<br>Vision Loss Rehabilitation Program | $46,284 | $30,000 | x | ALL | Maintain and expand staffing for vision loss program. | No - outside focus area |
| 120 | WomenSV<br>Survivor Support Program | $30,000 per year for 2 years | $30,000 | X | MH | Support to maintainmental health services for Survivor Support Program. | yes |

Peninsula HEALTH CARE DISTRICT
Building a Healthier Community

Letter of Interest
Screening Criteria

1. Organization's name
2. Serves PHCD residents
3. Addresses one Focus Area
    - Healthy Aging - socialization & connectivity
    - Mental Health - prevention services & programs
    - Preventive Health – screenings & healthy living
4. Clear, strong program description and associated activities
5. Request within range - $10-60K
6. How funds will be used
7. Total budget - involves leverage additional funding to support the program
8. Location program will take place; is office within PHCD
9. Demographics of community to be served
10. Address health disparities
11. Projected number of people to be served with this funding request
12. Percentage of the projected number reside in PHCD
13. Outcome measures
14. Q2 submitted on time

abilitypath

September 8, 2022

**RE: Letter of Intent**

Dear Community Health Investment Committee,

Thank you for your ongoing partnership and support of the services we provide to individuals with special needs and developmental disabilities. We are submitting for considering our Letter of Intent for AbilityPath's Pathways to Health and Wellness for the Adult Day Program-North.

Our curriculum will focus on activities that promote healthy lifestyles and overall well-being for adults and seniors. Individuals served will participate in developing or enhancing personal healthy habits to help them achieve their desired quality of life, while also helping to prevent health risks.

Your support helps create a world in which people of all abilities are fully accepted, respected, and included. If you have any questions, please contact Anne-Marie Hong, Grants Manager, at 650-250-7130 or ahong@abilitypath.org.

With gratitude,

Bryan Neider

Bryan Neider
CEO

1. **Organization's name:** AbilityPath
2. **Program title:** Adult Day Program – Pathways to Health and Wellness
3. **Priority funding area:** Preventive Health
4. **Program description & activities:** Funding will help expand the Adult Day Program's Pathways curriculum as well as to ramp up senior-specific programming to address preventive health topics. Pathways to Health and Wellness, which currently utilizes recreational, occupational and music therapies, plans and adapts activities and curriculum to meet the evolving needs of the individuals we serve, especially as a result of the Covid-19 pandemic. Health and wellness curriculum is designed to help prevent risk factors that lead to poor health, diminished quality of life and (often early) onset of health conditions. Pathways' programming keeps the mind and body active through engaged social relationships, shared, hands-on learning experiences, and skill-building while improving an individual's overall physical and emotional well-being and quality of life. We promote healthy aging, disease prevention, dental health, and mental health through tailored program activities as follows:
    a. Hands-on classes and instruction
        i. Nutrition, meal prep, & healthy cooking classes
        ii. Personal care & daily living skills classes
        iii. Self-advocacy & healthy relationships classes
        iv. Three-week Snack Busters Challenge
            1. Last year's three-week nutrition challenge encouraged water consumption over soda, making a healthy snack and taking photos of it, and trying a new food and creating a meme of it
    b. Health and Wellness education and community engagement
        i. Community-based exercise, fitness & health education classes
        ii. Accessing senior centers & utilizing senior-specific resources
        iii. Learning to return to active, in-person lifestyles, routines, and social lives that were paused due to the pandemic
    c. Psychological Support
        i. Psychology interns to provide support in focused mental health capacity
            1. As a result of Covid, addressing isolation, loss of 2+ years, loss of friendships & routines
        ii. Interns to assess needs for support throughout regular activities and provide guidance and suggestions to individuals and support staff

    Re-establishing these elements into participants' everyday lives will promote cognitive well-being and ultimately will allow individuals to fight off detrimental effects of aging and avoid serious or early on set of conditions such as obesity, diabetes, and/or dementia.
5. **Requested amount:** $50,000
6. **How funds will be used:** Funds will be used to purchase program supplies, which will include food and supplies for cooking, nutrition and wellness classes, admission fees to utilize community kitchens and attend fitness classes, and materials for activities. Funds will also cover a portion of the budgeted salary expenses for program management.
7. **Total Budget: $**1,865,804 (breakdown of revenue + expenses included on last page)

8. **Will requested funds will launch, maintain or expand this program:** Funding will expand this program.
9. **Location of program:** This program primarily takes place in the community, introducing and utilizing community resources, partners, and locations as natural supports. Additional classes and instruction are offered virtually as well as in-person at AbilityPath's campuses in Burlingame and Daly City.
10. **Demographics of community to be served:** Our Adult Day Program-North serves individuals with intellectual and/or developmental disabilities. These individuals are low- to very-low income, 41% female and 59% male. Individuals are over the age of 18 – 27% are over the age of 50, 47% are ages 30-49, and 26% are ages 20-29. At least 12 ethnicities and 25 different diagnoses are represented.
11. **How program will address health disparities:** Traditional health education and wellness activities are often not accessible to adults with developmental disabilities due to transportation, communication, and other barriers. Our day program will address any health disparities present by working with an individual's support team to ensure access to needed resources such as but not limited to translation services, self-advocacy, communication accommodations, transportation, mobility devices or equipment. AbilityPath utilizes occupational and recreational therapists to assess modifications needed for an individual to be successful and happy in program and will make recommendations to the support team if support outside of program is also needed.
12. **Projected number of people to be served with this funding request:** 150
13. **Percentage of the projected number residing in PHCD:** 82%
14. **Measurement tools used to track impact:** We utilize several assessment tools to document the hopes/dreams/goals and abilities/needs of an individual. These tools are: Positive Personal Profile, Pathways Activities Support Scale (PASS), Quality of Life survey, and Pictorial Interest Survey. We initially collect this information to know an individual's interest in daily activities and inform the service delivery; we then update it as the individual's goals or needs change, or at least annually. This allows us to provide person-centered and individualized service. We track & report on goal achievement on a semi-annual basis in an Individual Service Plan for each individual. We request completion of an annual Participant Satisfaction Survey and an annual Family/Caregiver Satisfaction Survey.
15. **History with PHCD:** PHCD has been a valued partner of AbilityPath for more than 10 years. What began as an event sponsorship relationship in 2007 grew to six generous grant awards. In 2020, PHCD partnered with AbilityPath to establish the first cooperative living homes in San Mateo County for adults with developmental disabilities. PHCD support has improved the health and well-being of residents with special needs and developmental disabilities by funding the following projects: speech screenings for preschoolers to identify delays as early as possible; support services for families of children with special needs; health education for adults with developmental disabilities; and piloting an initiative to increase developmental screenings in the medical home.
16. **Contact:** Anne-Marie Hong, Grants Manager, 650-250-7130 or ahong@abilitypath.org

**AbilityPath**

**Day Program-North Budget FY23**

| | |
|---|---|
| Revenue | |
| Regional Center & DOR | 3,068,433 |
| Enterprise Business Revenue | 165,000 |
| **Total Revenue** | **3,233,433** |
| Expense | |
| Salary & Wages | 1,257,211 |
| Employee Benefits | 420,251 |
| Direct Expenses | |
| Medical Fees | 1,230 |
| Other Contract Fee Payments | 21,240 |
| Program Supplies | 58,012 |
| Operating Expenses | 1,020 |
| Vehicles and Transportation | 70,430 |
| Mileage & Parking | 4,565 |
| Other Special Events | 159 |
| Total Direct Expenses | 156,656 |
| Total Expense | 1,834,118 |
| 8010 Depreciation | 31,687 |
| **Total Expenses** | **1,865,804** |

AnewVista Community Services

September 5, 2022

Peninsula Health District Grant Committee

**Focus Area**: Healthy Aging Grant
**Organization**: AnewVista Community Services
**Program Name**: Building Tech Champions
**Priority Funding Area**: Expansion to Peninsula Health District
**Requested Amount**: $50,000
**2022 Current Budget** $170,000

AnewVista Community Services builds technology champions from our aging adults.

We achieve this by building confidence through education, peer support, and access to the experts. Our classes are both in person across different facilities and on zoom creating a hybrid community. We have been providing classes on the Peninsula since 2019. As the pandemic started, we seamlessly moved to virtual as we had already been testing scalability and remote teachings. We increased from once every 2 weeks on site to three times a week virtually. We discovered that the growth in learning increased exponentially. This also forced us to create content that currently exceeds 150 topics.

Our programs focus includes:

- Fear Reduction: fear of scams, looking uneducated, of breaking their systems, and inconveniencing their family or others.
- Providing a safe environment: consistent workshops, building community, easy and regular access to experts.
- Local in-person or remote technical support specialized for senior's unique needs.
- Solving technical problems in the user's homes provides a better understanding of how they use their devices (computers, smart phones, smart homes, security systems, banking, health systems, entertainment…) and their behavioral approach to technology.

Spanning over 150 topics covering everything digital in the home and class pace and approach are specifically tailored to allow seniors to learn at their own pace. We are the only group that also provides a safety net for follow-up questions in class, e-mail, remote and in-home support.

We receive a continuous feedback loop to our solutions and lessons and experience how participants utilize their technology in their homes.

AnewVista currently teaches classes in English and Spanish and provides free tech tip cards in English, Spanish and simplified Chinese.

We also conduct special projects in conjunction with other organizations such as the Ombudsman Services of San Mateo County where we have provided tablets to low income assisted living facilities. This program was especially important during the active pandemic and future programs may include measuring activity and engagement improvement for those actively using the tablets for memory and memory care, active waking hours and more.

**Outcomes from 2021:**

- 100% are moderately more confident or extremely more confident in their use of technology
- 97% of students feel much more aware or extremely more aware of digital / technical offerings
- 96% of students are more confident in their ability to get products and services in their home by using technical tools
- 89% of students have improved their Cybersecurity practices
- **0% of students have experienced monetary loss from being hacked or scammed**

**Qualitative Outcomes**

- 94% indicate Improved social interactions
- 95% of our active participants teach or mentor their friends or family on technology
- 86% of students state an improved emotional health

**Outcomes support the notion of**

- Independence – getting goods and services how they want and when they want, the ability to seek help, rides, medicines, shopping – safely and securely
- Self-determination through understanding of technology and without fear
- Productivity by using technology without frustration or fear
- Connectedness to others both through our community and being armed with the ability to reach out to others virtually and digitally
- Physical health: through online health programs and health apps and wearables
- Emotional Wellbeing by belonging and the ability to join other common interest groups.

One of the funders is Sequoia Health district and our focus has been in the mid-peninsula. We currently are engaged or have been engaged with communities and facilities in the Peninsula Health district including the Daly City Senior Center, Burlingame, and Jewish Family services and wish to re-engage but are currently resource constrained thus are seeking funding from the Peninsula Health District to expand further north.

AnewVista Community Services Inc would appreciate the opportunity to submit a grant proposal.

Sincerely

Eric Gee

Executive Director/founder
ericgee@anewvistacs.org
c: 650-995-4002
o: 650-300-0688

**From:** Eric Gee
**To:** ann.wasson@peninsulahealthcaredistrict.org
**Subject:** Re: Peninsula Health Care District Letter of Intent
**Date:** Thursday, September 22, 2022 4:27:13 PM



Hi Ann,

I wanted to follow up my voicemail in writing:

Currently we serve about 1500 people across the Peninsula but primarily focused on the Sequoia Health District, Palo Alto and San Jose.

We have spillover to residents in the Peninsula Health District probably about 15% of the total.

The way we win our fans is to visit local centers of trust, distributing tech tip cards and peer recommendations.

We have already started giving classes in Foster City at both Atria and the PJCC and will be doing classes later this month with the Jewish Family Services group where they report that most of the residents are in the northern peninsula area. We also have conducted classes at the pride center in San Mateo and would look forward to conducting additional classes.

I would expect in the first year our Peninsula Health District population would be around 200-300 residents and grow from there. We have a very strong retention rate exceeding 95%

I will call in the am to answer any additional questions you may have.

Thank you.

On Wed, Sep 7, 2022 at 4:04 PM Eric Gee <ericgee@anewvistacs.org> wrote:

> Dear Grant Committee,
>
> Please see the attached Letter of Interest. We look forward to submitting a full proposal.
>
> Thank you in advance for your time and consideration.
>
> --
> Eric Gee
> Founder / Executive Director
> e: ericgee@anewvistacs.org
> c: 650-995-4002
>
> AnewVista Community Services www.AnewVistacs.org
> Anewvista Inc www.AnewVista.com

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-Eric Gee
Founder
c:650-995-4002
e: ericgee@anewvistacs.org

BAY AREA
Community Health
Advisory Council

September 7, 2022

To: Ann Wasson, M.S., Director Community Engagement
Peninsula Health Care District

From: Lisa M. Tealer, Executive Director
Bay Area Community Health Advisory Council

Re: Letter of Intent for Peninsula Health Care District Community Grant Program

The Bay Area Community Health Advisory Council (BACHAC), a fiscally sponsored organization of Community Initiatives, is submitting a letter of intent for the Peninsula Health Care District Community grant program to support their Community Mammogram Program (https://www.bachac.org/community-mammogram-program). The Community Mammogram Program (CMP) is BACHAC's longest running community health outreach program. For over 24 years, this program has provided free mammograms to uninsured women in San Mateo County. The strategic success factors of this program are:

- Engage with women via a trusted member and organization from the community
- Ensure access to this vital health screening tool
- Inform the community on health educational opportunities, specifically focus on breast health and breast cancer
- Partner with a healthcare organization that can provide the mammograms and the medical expertise
- Secure funds to compensate community health outreach professionals, develop and produce culturally relevant materials, offer and support workshops and/or educational platforms focused on breast health and breast cancer.

In order to employ these success factors, community health outreach professionals from the community are needed to build trust, increase community awareness of this screening tool, educate community members about breast health and assist them with navigating the health system. BACHAC is requesting $30,000 from a budget total of $485,000 to continue the community outreach efforts that have made this program a success. These funds will be used to provide compensation for Community Health Outreach Professionals, training and their support materials (fliers, etc.), stipend for speakers for workshops, digitally marketing and sponsorships on culturally relevant educational opportunities (examples include, the Breast Cancer & African Americans

BAY AREA
Community Health
Advisory Council

Conference in August, BACHAC's Wellness Where You Are Session in October). These funds will be used to maintain and expand BACHAC's Community Mammogram Program. These mammograms will be conducted at the Women's Health Center located at Mills Peninsula Medical Center in the City of San Mateo. Demographics of the women who have historically utilized this program are 80-90% Latina or a person of color, over 40 years of age within underserved communities in several of PHCD's priority areas of San Mateo, Millbrae, Burlingame, SSF, Daly City. BACHAC estimates 300+ women will utilize this program with 80-90% within PHCD's priority areas. This program attempts to minimize the barriers to mammogram screenings that create health disparities and ultimately negative health outcomes especially in underserved and often communities of color. Tracking data is provided directly from Sutter Heath's Mills Peninsula Medical Center and includes basic demographic data (race & age) as well as geographic information (i.e. zip codes)

BACHAC is grateful for the on-going support from PHCD for over 3 years for the CMP and pandemic relief. In addition PHCD and BACHAC, have partnered to offer community COVID vaccine clinics and are continuing to work together on COVID-19 messaging to prepare the community for another surge during the winter. PHCD is a member of Umoja Health San Mateo County that was formed in November 2021 to address the critical needs of underserved communities in the northern part of San Mateo county during the pandemic (www.umojahealth.org/san-mateo) This model of collaboration will continue beyond the pandemic to address other health disparities in the community. BACHAC leads this collaborative model with biweekly meetings, providing a community focused forum for discussion, connecting other Umoja Health partners to serve the health needs of unserved communities in San Mateo county.

For more details and/or questions about the program, please contact Lisa M.Tealer, Executive Director, BACHAC, via email ltealer@bachac.org and/or by phone at 650-888-4065.

Respectfully submitted,

Lisa M. Tealer, Executive Director

Bay Area Community Health Advisory Council

www.bachac.org

To: Peninsula Health Care District
Re: Letter of Intent
Date: August 26, 2022

# LETTER OF INTENT

1. Organization's name:

Belmont-Redwood Shores Rotary

2. Program Title:

Medical Equipment Loan Program (MELP)

3. Pritority Funding Area request will address:

Our program distributes durable medical equipment (such as wheel chairs, rollators, walkers, and the like), which have been recycled from previous users to new ones. The program provides such equipment at no cost to those who may need it, and additionally keeps such useful medical equipment from needlessly going into local area landfills.

4. Program description and the associated activities:

Our project is based on a similar program in Pasadena, California, the Convalescent Aid Society, which has distributed durable medical equipment at no cost to recipients for over 100 years (see *Welcome to Convalescent Aid Society (godaddysites.com)*).

With financial assistance from the Belmont-Redwood Shores and San Carlos Rotary Clubs, and volunteers from both clubs, we began this project several months ago and have:

- Created a call-in phone system for receiving and distributing equipment
- Located a storage area (at a cost of $550/month) for approximately 150 pieces of equipment, an amount which continues to rise steadily
- Created a system of marking and photographing each piece of equipment that is loaned out
- Sanitized and repaired all equipment loaned to users
- Joined in a partnership arrangement with Villages of San Mateo County, a 501(c)(3) charitable organization with the mission of helping others age in place and live independently
- On Saturday, June 5, held a "grand opening" in San Carlos, at which time our Rotary organizers and the Mayor of San Carlos, Ms. Sara McDowell, engaged in an official ribbon cutting and celebration of our project

5. Requested amount

$15,000

6. How funds will be used

- Cleaning supplies for cleaning of donated medical equipment
- Payment of storage fees to Public Storage where cleaned equipment is stored and distributed to new users
- Payment to an independent contractor for creation of MELP website and data program

7. Total annual budget

$35,000

8. Will requested funds launch, maintain or expand this program

Requested funds will allow us to maintain the program and expand it by increasing our storage space at Public Storage or some other facility. Our proposed data program will make possible data search and entry by customers, as well as provide more data for use by our volunteers.

9. Location program will take place

The storage facility where equipment is stored and distributed is: Public Storage, 2250 S. Delaware St., San Mateo, 94403. We presently rent two units for equipment storage. Distribution of equipment is made each Saturday at this location from 10 am to 12 pm.

10. Demographics of community to be served

To date our customers have been older individuals and injured individuals who have need for a durable medical equipment and cannot afford it. Customers are from a variety of mid-Peninsula cities, with no discrimination as to location, and include Millbrae, San Mateo, Foster City, as well as other local cities.

11. How program will address health disparities

Our program provides durable medical equipment for those who need it free of charge and without satisfying a needs-based test. We do request that when the customer has finished using the equipment that it be returned to us to again to be recycled as described above.

12. Projected number of people to be served with this funding request

In the first ten months of our operation we have loaned out approximately 210 pieces of equipment. We anticipate a 50% increase in this coming year, which would therefore indicate we will have 378 loans of equipment in the coming year.

13. Percentage of the projected number resides in PHCD

Almost all of the pieces of equipment that we have loaned for the past ten months of our operation have been in the areas described in Sec. 10 above and we anticipate that will be true going forward into the next year.

14. Measurement tools used to track impact

In order to track our equipment usage, we catalog each piece of equipment which is donated to us and is catalogued, numbered, and photographed. When it is distributed the customer indicates his or her name and a contact method. When the item is returned by the customer the catalog-sanitizing-storage procedure is repeated.

15. Organization's history with PHCD

MELP has no history with PHCD as it was created approximately 10 months ago.

16. Contact name, email and phone number

***Bill Dawson***
Past President
Belmont-Redwood Shores Rotary
billdaws@comcast.net
650-533-5669

BOYS & GIRLS CLUBS
OF THE PENINSULA

September 8, 2022

Ann Evanilla-Wasson, Director of Community Engagement
Peninsula Health Care District
1819 Trousdale Drive
Burlingame, CA 94010

Dear Ann and the District Board,

Thank you for the Peninsula Health Care District's support of pressing health needs in the community. Over the last decade, you have generously supported Mid-Peninsula Boys & Girls Club's health programs for students from low-income neighborhoods on the Peninsula. We are thrilled to share that Mid-Peninsula Boys & Girls Club has merged with Boys & Girls Clubs of the Peninsula to bring more resources like mental health support and high-quality athletics to Peninsula students.

**Boys & Girls Clubs of the Peninsula (BGCP) requests a $25,000 grant to support our programs that promote mental health and physical activity at San Mateo Park Elementary School. These programs fall under Peninsula Health Care District's focus areas of Mental Health and Preventative Health.**

## BGCP Overview

Driven by our vision that all youth should grow up to lead fulfilling lives fueled by their passions, talents, and a love of learning, BGCP empowers the youth in our community with equitable access to social, academic, and career opportunities to thrive. Students benefit from deep academic support, engaging enrichment, and rigorous college and post-secondary support. We also address critical health and wellness needs with daily hot meals, social and emotional learning integrated into all programs, family engagement, and on-site mental health services.

Boys & Girls Clubs of the Peninsula is now the largest expanded learning youth developer in San Mateo County. This fall, we will serve more than 3,500 students at 24 sites from Daly City to East Palo Alto.

## Program Description

San Mateo Park Elementary School is one of BGCP's newest sites, with programs having just launched in August 2022 at the start of the school year. The San Mateo-Foster City School District selected San Mateo Park as a BGCP school site due to its high need for services. Nearly 70% of students come from socio-economically disadvantaged backgrounds, with many living in the North Central neighborhood of San Mateo, and over 47% are English Learners. While these youth share the same potential and aspirations as their peers in the more affluent surrounding communities, many have limited access to healthy food, mental health support, enriching summer camps, sports leagues, and other supports that promote academic, mental, and physical well-being.

BOYS & GIRLS CLUBS
OF THE PENINSULA

In its inaugural year, this program will engage 120 students (32% of the school population) in programs that promote mental health and physical activity—addressing Peninsula Health Care District's identified community needs of Mental Health and Preventative Health—in addition to rigorous academic and enrichment support.

**Sports and Fitness:** Physical activity has become even more important to get kids to move around after being sedentary during distance learning. Our robust athletics program will offer exposure to fundamentals of different sports like basketball and soccer, while building healthy habits and mindsets. In addition, we will also have competitive, high-quality sports leagues that are offered completely free to BGCP students.

**Mental Health:** We know nurturing our students' mental health is equally as important as championing their physical health. It's an essential foundation for our youth to thrive. Youth, especially BGCP students, are feeling increased stress, anxiety, and depression as a result of the pandemic and demand for our mental health services is at an all-time high. To address mental health, BGCP will:

- Provide training on trauma informed care to all direct service staff and integrate the components of trauma informed care (safe environment, strong relationships, and teaching emotional regulation) into all programming
- Partner with organizations like Child Mind Institute and Children's Health Council to offer Trauma Treatment Groups to our elementary-aged students and provide resources to caregivers

To evaluate our programs, BGCP collects data on student perception through classroom observations and student surveys. This allows BGCP to continually measure and refine the impact of our programs over time and support the success of BGCP students.

## Partnership

With Peninsula Health Care District's support, we will successfully launch our first year of programs at San Mateo Park. A $25,000 grant would directly support our San Mateo Park staff who will deliver our athletics and mental health programs, while helping to lay a foundation for BGCP's presence in the San Mateo community. The total budget for our San Mateo Park programs is $661,000.

Boys & Girls Clubs of the Peninsula is grateful for your consideration of this request and hope we will be invited to submit a full proposal. We are happy to answer any follow-up questions you may have.

Sincerely,

Kathryn Yee, Head of Development & Marketing
kyee@bgcp.org | 650-763-6024

BOYS & GIRLS CLUBS
OF THE PENINSULA

**Additional Information for Boys & Girls Clubs of the Peninsula's LOI**

San Mateo Park, one of Boys & Girls Clubs of the Peninsula's newest sites, opened in August 2022. BGCP programming is located directly at San Mateo Park, so students just walk to BGCP classrooms after school to participate. Currently, 126 students are enrolled in our programs, surpassing our goal of 120 students for our inaugural year.

| Grade | Count |
|---|---|
| K | 13 |
| 1 | 29 |
| 2 | 25 |
| 3 | 24 |
| 4 | 16 |
| 5 | 19 |
| **Total** | **126** |

| Age | Count |
|---|---|
| 5 | 11 |
| 6 | 28 |
| 7 | 24 |
| 8 | 23 |
| 9 | 18 |
| 10 | 15 |
| 11 | **3** |
| Unknown | 4 |
| **Total** | **126** |

**A $25,000 grant from Peninsula Health Care District would directly support our sports and physical fitness programming at San Mateo Park Elementary School.**

Physical activity has become even more important to get kids to move around after being sedentary during distance learning. We will improve fitness and physical activity for BGCP students by:

- Providing ample recess time, fitness enrichment, and exposure to fundamentals of different sports like basketball and soccer
- Building healthy habits, mindsets, and skills such as resilience, collaboration, conflict resolution, and leadership that are impactful in every part of our students' lives
- Offering opportunities to engage in sports camps and high quality, competitive sports leagues

Our athletics enrichment activities complement BGCP's other offerings, while also building community by bringing together students and families around sports. All physical activity and fitness programs are offered completely free to BGCP students.

To evaluate the programs, BGCP will regularly administer surveys to collect data on student perceptions. The survey will include questions regarding topics such as enjoyment in the program and sense of belonging, respect, and care. These surveys will supplement classroom observation data as well as student attendance and participation data.

The grant would directly support the staff who deliver our fitness and sports programs as well as any material and equipment needed at San Mateo Park. The total budget of our San Mateo Park site is $661,000.

**Letter of Intent**
**To: Peninsula Health Care District**
**From: Breathe California of the Bay Area, Golden Gate and Central Coast**
**Date: September 8, 2022**

Breathe California of the Bay Area, Golden Gate and Central Coast (1) seeks $25,000 (5) to maintain its COVID Prevention in High-Risk Populations (2) program in the PHCD area (8). The program will address the PHCD focus/priority funding area of Preventive Health (3).

Program Description and Activities (4): Breathe California, PHCD's only local respiratory health agency, will continue to offer lung health service that prevent the onset of COVID and other serious lung disease in the high-risk populations who are most vulnerable. Through this grant, we will increase services to PHCD's residents through a community lung health education program that focuses on four strategies: A. Provision of COVID information and education targeting seniors, who are the most vulnerable population, along with other health education on topics such as COPD and health screening services; B. Tobacco use prevention education, emphasizing e-cigarette/vaping prevention education for youth, parents, and young adults, and offering cessation assistance, due to increased risks from COVID for tobacco/vape users, as well as the threat of addiction, cancer; COPD, and heart disease. C. Asthma education for all ages, targeting disadvantaged populations with health disparities and offering home visits and environmental assessments, to provide comprehensive prevention services for this population at high risk of COVID and its most severe impacts; and D. Mass media, social media, and direct outreach to promote vaccinations for COVID, influenza, and pneumonia. Services are delivered by staff health educators, health education interns, and volunteer physicians, nurses, and respiratory therapists.

The $25,000 in PHCD funds will be used to support project-specific staffing, provide project-specific travel to deliver services, pay for communications about project services and to promote vaccinations, and pay costs for project printing, supplies and educational materials. Other agency funding resources will be used to provide a total project budget of $40,000 (7).

Services will be offered throughout San Mateo County and will be concentrated in the PHCD area of San Bruno, Millbrae, Burlingame, Hillsborough, San Mateo, Foster City, South San Francisco (9). Breathe California will seek to serve the communities within those cities that have health inequities. Demographic groups will include low-income students and parents, vulnerable seniors, MediCal patients, recent immigrants, those with language barriers, and those with environmental justice issues (10).

Because lung disease disproportionately impacts lower socioeconomic communities and communities of color, Breathe California has evolved into an agency that primarily targets those communities for service. We deliver programs to those communities free of charge, in locations where they already gather, in many languages and collaborate

***Note: Numbers in parenthesis align with the LOI questions asked in the instructions.

with partners from within those communities to reach at-risk individuals. We have established relationships, many decades-long, with ethnic-serving agencies, faith-based groups, and civic organizations that allow us to reach target groups and to provide assistance with linguistic and cultural competence. (11) Breathe California also works with County Health Departments, major health care providers, schools, senior service providers, Medical/Medicare plans, parent programs, and local colleges and universities to reach populations with inequities and to ensure that its services are coordinated and non-duplicative. We are part of tobacco control coalitions, asthma coalitions, and senior collaboratives that seek to coordinate the resources and programs, available in the Counties of its service area, contributing to efforts to create efficient systems of service delivery. These efforts allow us to maximize impact, conserve resources, and stay abreast of best practices and research-based programs in our areas of service.

The projected number of people to be served directly with this funding request is 1,000, with another 10,000 served through media (12). Approximately 90% of projected residents will reside in the PHCD (13).

Breathe California uses a variety of measurement tools to track the impact of its services: service logs, sign-in sheets, evaluation surveys, pre and post- tests, satisfaction surveys, pre and post-intervention observation reports, and school reports. For media reach evaluation we track number of subscribers, number of viewers, number receiving mailings, and circulation estimates (14).

Breathe California of the Bay Area, Golden Gate, and Central Coast has enjoyed the support of Peninsula Health Care District for approximately eight years; PHCD has supported many of the agency's priority initiatives to fight local lung health threats, including the most recent COVID projects (15).

Margo Sidener, MS, CHES, will be the contact for the grant; she is the agency's CEO. Her email is margo@lungsrus.org, and her phone number is 316-689-2629.

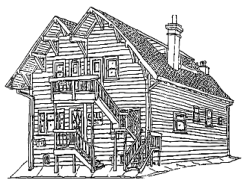
***Note: Numbers in parenthesis align with the LOI questions asked in the instructions.

CALL PRIMROSE

139 Primrose Road
Burlingame, CA 94010

650-342-2255
650-275-7655 Fax





Tax ID 47-2131340

**TO:** Peninsula Health Care District
**From:** Terri Boesch, Executive Director, CALL Primrose
**RE:** Funding LOI for CALL Primrose Community Pantry Program
**DATE:** September 2st, 2022

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Call Primrose operates a year-round food pantry program, providing free, healthy groceries to low-income individuals and families along the mid-peninsula cities of Brisbane, through San Carlos. We strive to be an effective contributor towards the elimination of hunger and food insecurity within our County. We believe that our program addresses all three of the current funding priority areas of PHCD, as access to adequate healthy and nutritious food is fundamental to all areas of physical and mental health. CALL Primrose will use the following strategies to address each of the priority areas of PHCD with our services

**Healthy Aging** – We are working with local recreation and community centers to ensure that materials introducing our free grocery services are available to those who visit, targeting seniors in particular.

**Mental Health** – We work with caseworkers from Caminar, MHA and other Behavioral health organizations and centers of influence to provide access to our services to those who are struggling emotionally and mentally. Adequate access to nutritious food is critical to every aspect of one's health.

**Preventative Health** – We will continue to offer our clients healthy and nutritious options, including fruits and vegetables and proteins which support healthy eating habits that will contribute positively to good health.

CALL Primrose is respectfully requesting funding in the amount of **$20,000** which is roughly 3.5% of our total FY 2022 budget of **$521,000**. If granted, this funding will be used maintain our existing grocery pantry program, specifically to assist us in purchasing the necessary items needed to supplement food donations received from our partner organizations.

CALL Primrose operates out of a facility on Primrose Road in downtown Burlingame, and our reach covers much of San Mateo County. One Hundred percent of the clients served by CALL Primrose qualify as low income or very low-income households. Thirty seven percent of these households reside in the City of San Mateo, another 27% reside in Millbrae/San Bruno, 12% reside in SSF and 22% reside in Burlingame/ Hillsborough/ Foster City. Two percent are unhoused.

**Approximate race/ethnicity is as follows:**

- **Hispanic- 48%**
- **Asian – 27%**
- **White – 20%**
- **African American – 4%**

**Other – 1%**

CALL Primrose will continue to addresses health disparities by providing access to free healthy groceries to all who are in need, and through the continuation of our current process which enables health care providers, caseworkers and/or other family members to pick up on behalf of clients who are unable to make it to our center due to health issues.

**It is estimated that CALL Primrose will serve 3,000 people with this funding, with 95 % of these individuals residing within PHCD.**

We will be measuring our impact through the monthly tracking of the number of unduplicated households served, the number of total households served, the number of individuals served as well as age and ethnicity of those served. In addition, we will track the number of new households served each month as a measurement of the success of our outreach efforts.

CALL Primrose has been fortunate to have worked with PHCD since 2020, and has received funds in support of our mission in 2020, 2021 and 2022. We are extremely grateful!

We thank you in advance for your consideration. Please feel free to contact our Executive Director, at the number or email address below, should you require further information.

**CALL Primrose**
Community Pantry Program
Contact - **Terri Boesch, Executive Director**
Email - tboesch@callprimrose.org
Telephone - (650) 342-2255 Xt101

Peninsula Health Care District – Caminar Letter of Interest

1. Organization's name: Caminar
2. Program title: Medication Assistance Program (MAP)
3. Priority Funding Area request will address: Mental Health
4. Program description and the associated activities:

Caminar's Medication Assistance Program, MAP, is designed to meet clients where they are, providing in-home and remote medication guidance to those living with mild to moderate mental illness and co-occurring physical conditions. A licensed vocational nurse, LVN, travels to clients' homes to review and implement medication programs decoding the confusing process of creating and keeping a medication schedule with factors such as morning and evening medications, medications required to be taken with food, and so on. This support can make the difference between independent living and a more supervised and expensive living situation. This program is especially needed during COVID-19 when clients are isolated in their homes. In addition, required medication supervision may be an aspect of their living situation; MAP can meet that requirement. MAP supports whole-person care, mental health, physical health, and healthy aging and keeps individuals in their homes with the dignity of independent living.

5. Requested amount: $50,000
6. How funds will be used
7. Total budget: $102,994
8. Will requested funds will launch, maintain or expand this program: Maintain
9. Location program will take place:

MAP currently serves clients in San Mateo County and throughout the Peninsula Healthcare District, with plans to expand to Santa Clara and Solano Counties in FY23.

10. Demographics of community to be served

Caminar was created and continues to support the mental, economic, and social well-being of low-income households, people of color, people with disabilities, and those who identify as LGBTQIA+ in the District. Our unique population served within those impacted by systemic inequities are those living with co-occurring conditions. Caminar has committed the past 58 years to build healthy and safe environments with science-based clinical care, and offerings have changed and been added based on community feedback. The clients we serve directly reflect the demographic diversity of the District.

Over 95% of clients in San Mateo live below the federal poverty line, all clients are living with mental illness, and most have a co-occurring diagnosis. Of our District clients, 51% identify as male, 42% female, 1% transgender and 1% intersex, 54% identify as BIPOC, over 26% identify as homeless upon enrollment, over 5% are non-English speakers, and 17% identify as part of the LGBTQIA+ community. Caminar's

relationship with the community is held and strengthened by our diverse and lived experience staff and, importantly, our trauma-informed approach to care.

11. How program will address health disparities

MAP was created to fill an identified gap; clients who are on the brink of institutionalization of some kind and for whom medication assistance could maintain their independence. All MAP clients have a diagnosed mental illness and are living below the poverty line; receiving medication assistance can prevent mental and physical health decline and stabilize participants to the point of being able to maintain employment and/or housing. Ongoing in-home medication assistance is not offered to those released from various institutional settings.

12. Projected number of people to be served with this funding request: 25

13. Percentage of the projected number resides in PHCD: 100%

14. Measurement tools used to track impact

As a county contractor and organization dedicated to providing excellent care, Caminar has extensive quality assessment staff and tools. Each program receives clinical oversight from Dr. Mark Ritchie, M.D., Chief Medical Officer, and Khizer Subhani, BSN, R.N., PHN, Director of Nursing, and quality oversight by Ann Rawley, Ph.D., Director of Quality Improvement. A licensed psychologist for 25 years, Dr. Rawley supports strength-based, person-centered, trauma-informed services and diverse, inclusive culture. Dr. Rawley deeply understands quality needs, clinical care, and operations overseeing residential, day treatment, outpatient, and shelter-based mental health and substance use treatment programs. Proficient in quality assurance, improvement, management, organizational development/transformation, implementation science, and measurement-informed services, Dr. Rawley promotes continuous quality improvement to drive cost-effective positive outcomes, staff well-being, and community health.

Indicators of success include reduction in Emergency Department usage, achieving reintegration along with reducing recidivism rates, and clients maintaining employment and safe housing. These markers are collected from clients along with anonymous feedback and suggestions for improvements and are reviewed by staff and the Board's committee on quality.

15. Organization's history with PHCD:

PHCD has generously contributed to Caminar since 2011; supporting programs focused on client wellness and wrap-around supports needed for optimal quality of life. This is the second year of requesting support for MAP from PHCD. Contributions to date total $510,750.

16. Contact name, email and phone number:

Katie Saunders | ksaunders@caminar.org | (650) 513-8767

CASA
Court Appointed Special Advocates
FOR CHILDREN
CASA OF SAN MATEO COUNTY

**CASA of San Mateo County Letter of Interest to Peninsula Health Care District**

**September 2022**

1. **Organization's Name:** CASA of San Mateo County
2. **Program title:** CASA of San Mateo County
3. **Priority funding area request will address:** Mental Health
4. **Program description and the associated activities:**

Court Appointed Special Advocates (CASA) of San Mateo County recruits, screens, trains, and assigns caring adult volunteers to serve as advocates for children in the foster care and juvenile justice systems. CASA will use the below strategies to address the mental health needs of children in the foster care and juvenile justice systems:

- Facilitate weekly 1:1 meetings between a trained adult volunteer and a child in the foster care or juvenile justice system for the duration of their time under the protection of the court.
- Conduct ongoing communications with the child's social workers, teachers, lawyers, and other individuals/organizations to identify medical and mental health needs, monitor progress, and ensure children receive appropriate mental health and medical care.
- Attend court hearings and submit reports to county judges, with the express purpose of advocating for services, placements, and other decision in the best interest of the child, including mental health services.
- Provide training to volunteers on mental health-related issues their youth may experience, including initial pre-service training and continuing education training for active volunteers.

When children enter the foster care or juvenile justice system, they experience overwhelming and chronic changes to their environment—including frequent changes in homes, schools, caregivers, and social, medical, and educational professionals assigned to their case. CASA volunteers are assigned to a single child and meet regularly with that child throughout their time under the protection of the court. They are often the only stable adult in a child's life during this time, and they play a key role in identifying the need for mental health services and advocating to social workers and judges for access to services. In addition to their advocacy work, CASAs provide stability in a child's life, working to decrease the social isolation commonly experienced among foster children. Through regular meetings, outings, and activities, CASAs aim to improve children's social skills, increase their confidence, and help them develop a sense of community and belonging that is essential to maintaining their mental health.

5. **Requested amount:** $30,000

6. **How funds will be used:** Funds will be used to screen, train, assign, and support adult volunteers who will monitor and advocate for the mental health needs of children in the foster care or juvenile justice system.

7. **Total budget:** $707,779

**8. Will requested funds will launch, maintain, or expand this program:** Funds will be used to maintain CASA of San Mateo's current program.

**9. Location program will take place:** Headquartered in Redwood City, CASA serves children whose cases fall under the jurisdiction of San Mateo County courts.

**10. Demographics of community to be served:** CASA serves children and young adults from ages 0-21. In the fiscal year 2021-2022, the demographics of the community served were as follows: 38% male, 62% female, 37% Hispanic/Latino, 10% Asian/Pacific Islander, 10% white, 4% African American, 1% Native American, and 32% other/unknown race or ethnicity.

**11. How program will address health disparities:** Children who have been significantly abused and neglected are disproportionately more likely to suffer from medical, vision, and dental conditions, poor mental health, development delays, and behavioral disorders. Mental health diagnoses, such as PTSD, ADHD, attachment disorders, depression, anxiety, and eating disorders are unfortunately common in this population. Despite this increased level of need, medical and mental health services for children in the foster care or juvenile justice system are often limited and sporadic. Because children are frequently moved from placement to placement and experience a revolving door of professionals, medical records are often lost or non-existent, resulting in undiagnosed or misdiagnosed conditions. CASA volunteers address these disparities through regular communication with their assigned child and other professionals and caregivers in the child's life. CASAs bridge potential gaps in health care by identifying medical, dental, vision, mental health, and behavioral needs; monitoring children's preventative health care, including doctors' appointments and immunizations; and coordinating logistics necessary for children to receive medical and mental health services. Additionally, CASAs encourage mental resilience through regular positive interactions. Among older youth in foster care, mentoring has been associated with fewer depressive symptoms, lower levels of stress, higher life satisfaction, and lower reports of suicidal ideation.[1]

**12. Projected number of people to be served with this funding request:** 57 children or youth

**13. Percentage of the projected number resides in PHCD:** 100%

**14. Measurement tools used to track impact:** In order to measure, track, and ensure program effectiveness, CASA volunteers submit monthly reports detailing: 1) number of hours and activities spent with their assigned child, 2) advocacy and support goals, 3) communications with other professionals, 4) medical/mental/vision/dental health status, concerns, and needs, 5) placement changes, 6) visitations, 7) educational updates, 8) enrichment activities, and 9) challenges, successes, and/or other concerns. Additionally, CASA staff collect a variety of data, including demographics, number of children served, court history, court hearing dates, family information, placements, monthly CASA volunteer hours, educational activities, professionals involved with the child's life, and CASA volunteer demographic information.

**15. Organization's history with PHCD:** CASA is honors to have partnered with PHCD to improve medical and mental health outcomes for vulnerable children since 2017.

**16. Contact name, email and phone number:** Leila Watkins, Director of Development, leila@casaofsanmateo.org, 650-449-7371

[1] https://www.socialworktoday.com/archive/070714p10.shtml

**PHCD LOI 2022-2023**
**SUMMARY INFORMATION**

1. **Organization name ***

Catholic Charities CYO of the Archdiocese of San Francisco

2. **Program title ***

Adult Day Services San Mateo County

3. **Priority Funding Area request will address**

Healthy aging – socialization and connectivity

4. **Program Description and the associated activities**

Catholic Charities Adult Day Services San Mateo County (ADS SMC) is a licensed Adult Day Program that provides a safe, therapeutic and caring environment for frail seniors and adults with disabilities, most of whom have been diagnosed with some type of dementia. Open Monday-Friday, serving San Mateo County residents. Prior to the pandemic, our center served up to 24 participants/day (45 annually). Our home-like community environment is particularly effective for seniors with hard-to-manage forms of dementia who have struggled within more institutional settings. ADS SMC helps participants maintain their independence as long as possible, and offers assistance as needed. We offer recreational and social activities, a nourishing hot lunch and assistance with transportation, with the goal of avoiding unnecessary hospitalizations and improving or maintaining mental and physical health.

1. Provide case management to 38-45 seniors and adults with disabilities
2. Provide 5 hours per day of recreational, social and cognitive activities for seniors and adults with disabilities.
3. Provide information and referral over the phone to community members who call (average of 25-30 callers per month)
4. Offer respite, support groups, and educational sessions to caregivers.
5. Satisfaction Survey results from clients and caregivers who report an Increased Quality of Life due to the services they received at the Adult Day Services Program.

5. **Requested amount***

$50,000

6. **How funds will be used**

Funds from the Peninsula Health Care District will help support ongoing operating expenses associated with sustaining ADS SMC at a level that allows us to continue to support our seniors with a hybrid model of onsite and virtual programming. This funding will also allow us to continue to make individual wellness calls to ensure our clients' mental and physical wellbeing and recognize and/or prevent health issues before they arise. While our advancement team is finding creative and innovative ways to raise funds, the reality is that every other nonprofit is in the same boat and funds are limited.

7. **Total budget**

$522,988

8. **Will requested funds launch, maintain or expand this program**

Maintain an existing program.

9. **Location program will take place**

Catholic Charities Adult Day Services San Mateo County, 787 Walnut Street, San Carlos, CA 94070

**10. Demographics of community to be served**

Clients' ages range from 64-98. Approximately 42 percent of clients are over the age of 85. Our clients are of various ethnicities and socioeconomic backgrounds.

**11. How program will address health disparities**

Our program is premised on the following Theory of Change: If we provide our seniors who suffer from cognitive and/or physical impairment with opportunities for daily activities then they will optimize their physical, emotional and cognitive health, remain living active in the community and increase their quality of life.

The key services required to achieve our Theory of Changes include the following: provision of respite care support, education and support to family caregivers. Then, the caregivers will benefit from reduced stress levels, an improved ability to care for their loved one, keep loved ones home longer, and both the senior and caregiver will maintain their own highest level of independence, good health and improved quality of life.

**12. Projected number of people to be served with this request**

- 38-45 seniors and adults with disabilities will be served.
- 65-80 family caregivers will attend monthly virtual or in-person caregiver support group.
- 200-250 individuals from the community will be provided information and referral over the phone.

**13. Percentage of the projected number resides in the PHCD**

33% - 40%

**14. Measurement tools used to track impact**

Catholic Charities uses a comprehensive, agency-wide database to track, measure and record client demographics, statistics and client measure-of-success outcomes. In addition, ADS SMC uses a variety of tools to collect metrics and assess the outcomes of our program. Daily attendance sheets track units of service. We use caregiver surveys to track the impact of our program on caregivers' physical and mental health, stress levels and whether or not the caregivers themselves see improvements in the participants' physical and mental health. Additional tools include focus groups, employee engagement surveys, client satisfaction surveys, functional assessments, mood & engagement assessments and mini mental exams in regular intervals.

**15. Organization's history with PHCD**

Catholic Charities' relationship with PHCD goes back 25+ years.

**16. Contact name, email and phone number**

Katharina Mack, grants@catholiccharitiessf.org, 415-963-2254

To whom it may concern,

The City of Millbrae's Recreation Department would like to express interest in receiving funds from the Peninsula Healthcare District for our monthly Senior Birthday Luncheon program.

The funding will subsidize the price of the monthly luncheon held to celebrate the birthdays of the seniors in our community. This monthly lunch has been a long tradition for the seniors in Millbrae. It allows older adults in the community to come together for a time of celebration, eat food, socialize, and play Bingo! We use the following three things allow us to create a time for seniors with the goal of healthy aging through connection and socialization; 1. Providing a program and space for celebration (birthdays), 2. Providing an affordable meal outside of the home, 3. Providing exciting activities such as Bingo (this builds more enthusiasm and boosts participation numbers).

The requested amount is $4,080 which would cover 12 months of this program. ($2,880 to subsidize meals, $1,200 for additional activities and decorations).

Previously, the food for this Senior Birthday Luncheon was provided by another entity, but they no longer can continue that contribution. The cost to us per meal is $10. However, we are hoping to only charge $6 for Seniors to keep it affordable (pre-pandemic we charged $5). We also traditionally have given free lunch to those who's birthdays land in that month. Therefore, we need a portion of the food cost to be subsidized. We also would love to update our bingo equipment and add monthly themed decorations as well. The total budget for this program is $8,400 annually. As mentioned, we are looking for $4,080 to be funded.

This program was stopped due to Covid19. If we receive funds from the PHCD, it will help us relaunch the program and maintain it through the year. We are also hoping to expand from 40 seniors to 60 seniors per lunch. We will be looking for funding for this program annually. The monthly Senior Birthday Lunch will take place at our new Millbrae Recreation Center in the beautiful large banquet space, the Great Hall!

The City of Millbrae's senior population makes up 19.7% of the city according to the 2020 Census. The Asian community makes up 45.9% of Millbrae. The senior population and Asian community are two of the important communities we serve through our senior recreation programs.

We know that connecting and socialization are two of the biggest needs for our older adult communities. Through the Covid19 pandemic, many seniors experienced isolation and were not able to connect with others. Through providing a monthly birthday lunch for seniors in our community, we are addressing both needs. For the coming year, we expect to serve 40-60 Seniors per month with this program. We expect 100% of those using this program to reside in the PHCD.

We track this program by looking at the monthly demand. If we see an increase in participation, then we know that this program is serving the community well and meeting the intent of the program (connection and socialization).

The City of Millbrae's Recreation Department has received funds in the past from the Peninsula Healthcare District. PHCD provided $50,000 of funding to continue Millbrae's senior and youth programs after loss of facilities and equipment when our recreation facility was destroyed by a fire in July 2016. Other PHCD support included helping to fund Millbrae's outdoor fitness court and new equipment for the new Millbrae Recreation Center.

Thank you in advance for your consideration. Please let me know if there is further information you would like for us to share.

Contact: Hannah Moran, Recreation Services Manager, hmoran@ci.millbrae.ca.us, 650-259-2478

Best, Hannah Moran

Recreation Services Manager, City of Millbrae

**PHCD 2023 LOI: Help Me Grow San Mateo County**

1. Organization's name: *First 5 San Mateo County*
2. Program title: *Help Me Grow San Mateo County*
3. Priority Funding Area request will address: *1) Preventive Health, and 2) Mental Health*
4. Program description and the associated activities (see *EXAMPLE*):
   *Help Me Grow (HMG) is a national model, designed to help communities leverage existing resources to provide information on child development, link families to community-based services, identify vulnerable children, and empower families to support their children's healthy development through the implementation of* ***Four Core Components****:*
   • ***Child Health Provider Outreach*** *supports community-based pediatricians by enhancing their developmental promotion and early detection activities for all children and families.*
   • ***Family and Community Outreach*** *promotes the HMG system, facilitates provider networking, and bolsters children's healthy development by supporting families.*
   • ***Centralized Access Point or (CAP)*** *typically takes the form of a call center or virtual hub that serves as the "go-to" place for family members, health care providers, and others seeking information, support, and referrals for children and early development.*
   • ***Data Collection and Analysis*** *ensures ongoing capacity for continuous system improvement.*
   *Help Me Grow San Mateo County (HMG SMC) launched in 2018 with partial funding from PHCD and has been fully operational with all four components since June 2019.*
   *Primary Activities*
   *With PHCD funding, HMG SMC will support the following activities within the District:*
   a. *Family and Community Outreach: Augmentation of HMG CAP staff time (staffed by AbilityPath) to conduct outreach activities to promote the use of the HMG SMC system and to validate and destigmatize developmental questions and concerns*
   b. *Child Health Care Provider Outreach: Dedicated time for Stanford Children's Health staff to build relationships, encourage screening and promote utilization of the HMG system in pediatric clinics*
   c. *Centralized Access Point: Knowledgeable, multilingual staff will provide direct support for families contacting CAP with questions/concerns about child development or needing resources*
5. Requested amount: *$60,000 each year for 2 years totaling $120,000*
6. How funds will be used:
   *The grant funds from PHCD will be used to support the implementation of the Core Components of HMG within the District boundaries as noted above in the Primary Activities Section under #4. This funding helps to support a targeted, holistic approach for families and providers within the District.*
7. Total budget: *The HMG SMC budget is $1,053,000 based on FY 2021-22 expenditures.*
8. Will requested funds launch, maintain or expand this program: *Maintain existing program*
9. Location program will take place*:*
   *Most of the services delivered, including family and community outreach, and support via the HMG CAP, are provided virtually by phone, email, and text. Much of the health provider outreach is done in clinic, meeting them at their convenience.*
10. Demographics of community to be served:
    *Help Me Grow SMC offers families and providers serving young children universal access to developmental professionals that can support families by connecting them to resources that will help*

*their child thrive. HMG supports pediatricians to implement developmental screening systems in their practices and also supports parents to complete the tool and to determine appropriate next steps. All families of and providers serving young children ages 0-5 (and the children themselves) residing in PHCD boundaries are the intended targets of this project.*

**11**. How program will address health disparities:
*The Help Me Grow system aims to reduce health disparities for children with developmental or behavioral concerns given that an estimated 16% of all American children experience developmental or behavioral problems. Early identification and treatment of developmental concerns helps children to reach their full potential and can help prevent more costly and less effective intervention later in life. In SMC, early data show that 4,000 children ages 0-5 are not receiving the early intervention services they should presumably qualify for. Low income children are diagnosed with special needs significantly later than higher income children. For example, nationally, the average age for autism diagnosis is four, but six years old for low income white children, eight years old for black children, and nine years of age for Latinx children.*

**12**. Projected number of people to be served with this funding request:
*At the highest level, this grant aims to serve 200 families via the CAP, offer technical assistance and support to pediatric providers at one new clinic setting and two ongoing sites serving PHCD children, and outreach to 250 families and community-based provides about HMG SMC and the importance of developmental screening.*

**13**. Percentage of the projected number that resides in PHCD:
*100% of the people served with PHCD funding will reside or serve those who reside in PHCD. We project that approximately one quarter of all of those served by HMG SMC reside or provide services to those who reside in the district, although this request for funding is less than 6% of the overall annual program budget.*

**14**. Measurement tools used to track impact:
*The main tools utilized by HMG SMC to track impact is the CAP database, affectionately referred to as ALICE. Launched last year, ALICE is a customized case management database that tracks referral sources in to HMG, screening results, referrals from HMG to other services and supports, and a host of other information including demographics. ALICE enables staff to pull and sort data in real time to help HMG assess and fine-tune service delivery with a lens toward continuous quality improvement.*

**15**. Organization's history with PHCD:

a. *2018: Help Me Grow San Mateo County, $25,000 (6-month term)*
b. *2020: Help Me Grow San Mateo County, $35,000*
c. *2021: Help Me Grow San Mateo County, $50,000*
d. *2022: Help Me Grow San Mateo County, $50,000*

**16**. Contact name, email and phone number:

***Contact Name:*** *Emily Roberts, MSW/ MPH* ***Email****: eroberts@smcgov.org*
***Title:*** *Strategic Initiatives Project Manager* ***Cell:*** *415-572-0585*

**Edgewood Center's Letter of Intent 2023- PHCD Community Grant**

Edgewood Center's **HealthyKin** is the only program of its kind in San Mateo County, providing access to physical and mental health services at no cost to kinship caregivers (and their families) who heroically step up to care for children unable to live with biological parents. HealthyKin addresses all three Priority Funding Areas – Healthy Aging, Mental Health, and Preventative Health through the following activities:

1.) **Healthy Aging:** Edgewood's Healthy Kin provides weekly support groups and workshops through Our Kinship Day of Learning (KDL). The KDL events touch on various topics relevant to and often requested by the kinship community including Health Talk with our Community Health Nurse and our New Paths Psycho-Education group that focuses on the understanding the root cause of our behaviors providing the opportunity to develop new parenting skills that can alleviate or change one's approach in dealing with stress and trauma. Most Kinship caregivers are grandparents suddenly raising children within a different cultural era and at an advanced age than their previous parenting experience. This involves support adjusting and adapting to the significant changes to their health and wellness status while parenting children at this stage of life; HealthyKin supports their physical and mental health while building community with peers sharing the kinship experience.
2.) **Mental Health:** At the core of HealthyKin we are providing individual and family counseling to caregivers and kinship youth as well as parenting education and coping skills as preventative support in reducing stress and conflict.
3.) **Preventative Health**: Community Health Nursing is providing nursing case management and health assessments, consultation, and chronic disease self-management workshops to all HealthyKin Kinship families.

HealthyKin Serves kinship caregivers who assume full parental responsibilities otherwise provided by biological parents and reside in the following zip codes: **94402**; **94403; 94010**; **94030**; 94066; and 94080. Significant relevant demographic information among our caregivers includes: 37% are Latinx; 25% are Black; and 76% are on Medi-Cal. Among youth: 68% are on Medi-Cal; 25% have a currently or formerly incarcerated biological parent; and 80% have guardianships not appointed by the court. Edgewood HealthyKin supports health equity by providing services to communities and clients wanting a better future than what has historically been available due to low myriad of circumstances, socioeconomic status, and systemic racism.

Edgewood HealthyKin requests PHCD Community Grant funding in the amount of forty thousand dollars a year for two years, a total investment of eighty thousand dollars through 2024. Although not finalized the 2023 operating budget for HealthyKin is currently established at $250,000 **to provide the full continuum of program services to one hundred (100) kinship clients – forty-five percent (45%) of those current clients reside within the PHCD.** This budget is flat for Fiscal year 2023 and 2024, with a potential increase if we reach our post pandemic client and staff recruitment goals. The requested funding will support in **maintaining the services** already being provided to the residents of the Peninsula Health Care District. If funded the grant award will support financial planning and stability over two fiscal years by defraying partial staff salary costs for the Community Health Nurse, Kinship Clinical Supervisor, and Program Director to serve District residents as a subset of San Mateo County residents, as

well as production and distributions of materials and supplies to support District-based client health outcomes and new client recruitment.

Staff supported by the grant deliver direct services to clients, services that are critically needed for this vulnerable population, such as nursing assessments, treatment planning, case management, chronic disease self-management, nutrition and wellness workshops, counseling services and psycho-education workshops to support caregivers' capacity to continue providing compassionate care to their kinship children and youth, while also **supporting the health needs of the entire family, helping build healthier communities.**

HealthyKin provides access to basic health services – physical, mental directly (dental through referrals) – with a focus on health disparities and health equity by helping level the health care playing field for low-income elderly caregivers and their children/youth. It does this through a suite of coordinated services that provide kinship families with access to resources not available in their communities: free access to a community health nurse to assess their health and create and track a treatment plan that includes strategic referrals to other providers as part of an integrated care plan. HealthyKin ensures clients have access to the basic health resources enjoyed by more affluent District residents.

The program also fosters greater social capital by empowering historically disenfranchised populations with knowledge and understanding of the health care system and how to navigate and utilize it. HealthyKin offers targeted prevention to reduce adverse health outcomes through our health education workshops and individual health counseling and case management led by our community health nurse and kinship resource specialist, who provides peer support, helping increase seniors' confidence and engagement with the health system so they can act independently -- with greater self-efficacy and improved quality of life -- as they complete the program and graduate.

Program evaluation is paramount at Edgewood to demonstrate our competency in achieving measurable improvements in the health status however, the measurement tools description would require its own page of the LOI -We use a combination of survey instruments and evidence-based evaluation tools to measure the program's outcomes including a comprehensive health screening tool that is aligned with Joint Commission standards. The Joint Commission is the gold standard for accrediting hospitals and health care agencies. Every year we reach our projected outcomes, which include 80% of caregivers reporting improved/maintained normal vital signs, improved confidence in accessing preventive care, and improved medication compliance. We also meet the objectives of 75% of caregivers reporting significant improvement on health outcomes, decreased emergency room visits, and increased knowledge of their health

PHCD and Edgewood have been working together to improve health outcomes for kinship caregivers and families in the region by supporting our San Mateo County Kinship Support Network's HealthyKin Program for eight years, including: $20,000 in 2012; $50,000 in 2013; $30,000 in 2014; $35,000 in 2015; $10,000 each in 2016 and 2017; $25,000 in 2018; and $35,000 in 2019, 2020, 2021, 2022, and hope to continue the partnership in 2023 and 2024.

Sincerely,
Jenifer Reeve, Foundation Relations Director
jenr@edgewood.org //415-629-9897

Foster City Village
BUILDING DYNAMIC COMMUNITY FOR OLDER ADULTS



September 7, 2022

Peninsula Health Care District
1819 Trousdale
Burlingame, CA 94010
Attn: Ann Wasson

Dear Ann:

Attached please find the Letter of Interest from Foster City Village, Inc. for year 2023. We are pleased to offer an all-encompassing program, INSIRED AGING, which touches each focus area of the District.

A personal thank you as well for assisting me to find prior records and grants from FCV and PHCD as the "newby" here.

Please contact me if anything is missing or you have questions. We look forward to hearing from you after review of this proposal.

Best regards,

*Pennie Lundberg*

Pennie Lundberg, Development Consultant
Foster City Village, Inc.
650/483-6815
penniellundberg@gmail.com

**TO: PENINSULA HEALTH CARE DISTRICT DATE: SEPTEMBER 7, 2022**
**FROM: FOSTER CITY VILLAGE, INC.**
**RE: LETTER OF INTENT FOR 2023 GRANT SUBMISSION – "INSPIRED LIVING"**

Thank you for allowing Foster City Village (FCV) to submit this Letter of Interest. We appreciate your long history of support and feel the programs we have outlined below fulfill our mutual commitment to health equity in all three areas you have highlighted for support in 2023. Our goal is for our community and FCV members to age in their own homes as healthy and happy as possible.

1) **Organization Name**: Foster City Village, Inc.
2) **Program Title: INSPIRED AGING**
3) **Priority Funding Areas**: All areas – Healthy Living, Mental Health and Preventative Health. Each one of the Foster City Village programs described below address three areas of service.

"Foster City Village" (FCV) is part of a national organization called Village to Village, whose mission all over the country is to assist seniors. At FCV, we provide services and programs to make sure our residents have access to appointments, eat healthy, live in a safe home, keep active and socialize with peers.

4) **Program Description and Associated Activities:**

**PHCD Area of Focus #1: Healthy Living** - This program is two-pronged and based on **nutrition** – providing healthy meals, classes on cooking for one, healthy restaurant choices, shopping with coupons and more. We plan to continue working with local restaurants to provide fully cooked, frozen meals for those with special needs, we inform our members of food distribution from Second Harvest Food distribution (twice monthly) and deliver Meals on Wheels to qualifying members and non-members. We assess each members' individual food needs, so every level of involvement will differ. Rides are available to every on-site event if requested.

The second prong in the **Healthy Living** area is **physical fitness** to the extent each member is able. We offer general exercise and Yoga classes, as well as fitness routines that address specific needs of aging seniors. Classes are on a fixed schedule online. We plan to resume in-person classes in 2023.

**PHCD Focus Area #2 – Mental Health – Socialization and Connectivity**. Over the past 2-3 years with not only the normal isolation that seniors may feel as they age, perhaps lose driving privileges, becoming less active due to health challenges, friends and family aging too, the Pandemic exaggerated those situations to the point where some members became vulnerable, very isolated and in need of help more than ever. Rather than shutting down some of our programs as some nonprofits were forced to do, we actually experienced a higher level of need and received a significant increase in requests for service.

FCV continues to offer a variety of events for our members to socialize and engage – The Learning Hour, Board Game Competitions, Walks, Concerts, Speaker Series, and presentations from museum experts on topics of interest. These are already well attended but our goal is to encourage more to attend. Transportation is available if requested. We invite experts from PHCD to come and speak with our members anytime!

In 2021 we established the **"WE CARE" – Socialization, Not Isolation** program, a very specialized and individualized program for each member. In addition to all the services available in other areas of focus, this program provided one-to-one calls or visits twice or more per month by a vetted Foster City Village volunteer. (We attempt to "match" a volunteer to each member so the same person calls or visits each time to establish a relationship). We visit members at their home to read together, watch TV, cook a meal together, help with a project, go out to lunch together or do something the member may wish to do out in the community. At the same time we assess what additional basic needs they may have to remain engaged with the community and healthy (state of their home and yard, hygiene, personality/physical changes, ability to do every-day chores, mobility). Concerns are brought to the Director of the WE CARE program for follow

up. We have decided to extend the program into 2023. In 2022 we made 392 calls and visits. In many cases this was the ONLY outside contact the member received. We have received accolades from dozens of family members thanking us for giving them peace of mind about their loved ones' aging process.

**PHCD Area of Focus #3: Preventive Health – Healthy Living, Screenings –** FCV offers a key element to seniors to maintain their health regimen by providing **EASY, DEPENDABLE ACCESS** to attend appointments to meet their health needs. Many seniors may be uncomfortable going to an appointment alone, don't have anyone in their sphere to go with them, can no longer drive or are unsure of their driving, are actually ill or don't want to ask for help. Our volunteers provide rides to and from doctor appointments, dental, lab, chemo and radiation, and other necessary appointments. This offers our members peace of mind that they can make appointments and have dependable, caring transportation to and from their location. Our rides are not limited to just San Mateo and Foster City – we offer transportation throughout the Peninsula.

5) **Requested Amount:** $20,000
6) **How Funds Will be Used**:

**Focus Area #1 – Healthy Living and Physical Fitness** - Partial funding from PHCD's grant would go toward working with our local restaurants for discounted donated meals, fees for local experts to hold these physical fitness classes.

**For the second prong of Healthy Living, mental health, the "WE CARE" Program,** funding will support additional training for our volunteers, identification badges and T-shirts for volunteers so they are easily recognizable to our members and expenses that volunteers may incur (gas, cost of lunches, etc.) while spending time with our members.

**Lastly, funds for Focus Area #3, preventive health**, will be used primarily for reimbursement of gas expenses and parking fees for volunteer drivers.

**Remaining funds** will be used toward the hiring of a part-time Program Director, who will oversee these programs and activities for quality assurance, maximum attendance, surveying, training of volunteers and other tasks.

7) **Total Budget** – Organization $234,000; Program $61,000
8) **Will requested funds launch, maintain or expand this program?** Maintain and Expand
9) **Location Program Will Take Place:** Foster City Community Center, Library, local parks and other outdoor facilities, individuals' homes and online.
10) **Demographics of community served –**We serve all older adults and do not discriminate based on age,

gender, sexual orientation, race, identity or disability. The only exception we make are those individuals who are non-ambulatory and those with dementia because our volunteers lack the necessary expertise and equipment needed, and we lack the necessary insurance coverage. In general, the 94404 zip code area of Foster City and parts of San Mateo is 44% white, 47% Asian, 8% Latino, 5% mixed race and 2.5% African American. We serve 3 of the 6 largest demographic groups living in poverty in our service area: Females 65-74 (15% of members), Females 75+ (54% of our members) and Males 75+ (15% of our members). Our fee-assisted members have increased from 7% to 13% of our member base in the past year alone.

11) **How Program will address health disparities** – People assume that Foster City residents fall into affluent or semi-affluent income levels. There are approximately 950 households in Foster City (almost 1/3 of the entire population) with at least one household member over 55. Approximately half of our member households consist of just one senior living alone. Many of these aging citizens may live in a lovely home but are struggling to live on a fixed income and remain in their home each month. It is particularly difficult in recent times due to gas and food price increases.

We are proud to serve three low-income senior housing communities in Foster City and San Mateo: Edgewater Isle, Metro Center and Alma Point Senior Housing. These seniors are at the lowest level of income stability. They will sometimes avoid critical appointments and/or care, many do not drive, are isolated, and may not be able to eat healthier meals based on income. Foster City Village invites any

resident of these communities a membership through our “Silver Scholarship” program. No one will be turned away because of inability to pay the membership dues.

Through our programs available for anyone 55+ in the 94404 zip area, we feel we are serving seniors with a wide range of disparities – including health maintenance, income, and areas of need.

**12) Projected number of people to be served with this funding request:** Varies per program. Estimate is a minimum of 400 persons, members + hundreds of non-members have become involved with various programs and activities of their choosing.

**13) Percentage of the projected number resides in PHCD – 35%**

**14) Measurement tools used to track impact –** Programs are tracked by number of participants, outcomes and satisfaction from initial projections and surveying and community reach based on a mix of actual participation and secondary market data.

**15) Organization’s history with PHCD:**

We are grateful to have received support from PHCD in 2019, 2020, and 2021. We did not receive a grant in 2022. Grant amounts have varied from $10,000 to $20,000.

**Contact Name, Email, Phone Number** - Pennie Lundberg, Development Consultant representing Foster City Village, 650/483-6815, penniellundberg@gmail.com

Making Healthy Food More Accessible
in the San Francisco Bay Area

5060 Commercial Circle, Ste. C, Concord, CA 94520
(925) 771-2990 | **freshapproach.org** | programs@freshapproach.org

**Organization's name:** Fresh Approach

**Program title:** VeggieRx for Seniors - Connecting through nutrition education and healthy food access.

**Priority Funding Area request will address:** Healthy Aging - socialization and connectivity

**Program description and the associated activities:** Fresh Approach will use three strategies to achieve improved *Healthy Aging*:

1. Group-setting nutrition classes. Fresh Approach will engage two cohorts of participants in online VeggieRx nutrition and cooking workshops (one in English and one in Spanish). Classes are evidence-based that cover the fundamentals of a nourishing diet for the mind and body, basic cooking, and strategies to manage limited resources and food access. Curricula are built to align with trauma-informed practices and are appropriate for the targeted age, cultural identifications, and languages. Class participants receive "prescription" vouchers to spend on produce at local farmers' markets.

2. Healthy Food Events at Senior Centers (or other community centers). Fresh Approach will promote healthy eating and connectedness by hosting activities that raise awareness and enthusiasm for local produce among seniors (such as fruit and vegetable bingo and cultural awareness crafting sessions focused on food). Samples of local produce will be offered during these gatherings.

3. Tours of the San Mateo Farmers' Market. VeggieRx participants will be invited to participate in tours of the farmers' market facilitated by the Fresh Approach team. During the tour, activities like local foods trivia games will give seniors a chance to further explore fresh and seasonal produce.

Classes will be hosted online (with the option to participate via phone calls) by Fresh Approach nutrition bilingual staff. Participants will receive VeggieRx vouchers ($10/participant/week of the program) to spend on fruit and vegetables at participating local farmers' markets. The vouchers work as strong incentives for low-income individuals to begin to shop at their local farmers' market and learn more about other financial incentives (including CalFresh/SNAP and Senior Farmers' Market Nutrition Program) that can be used to purchase fruit and vegetables, creating lasting impacts after this project ends. The events at the Senior Centers and the farmers' market tours will allow seniors who feel comfortable with participating in in-person events to come together with their peers and learn about the local food system and share their personal nutrition stories and backgrounds.

**Requested amount:** $45,000

**How funds will be used:** Funds will be used to coordinate and host VeggieRx classes, and in-person events, and to support the costs for VeggieRx Vouchers (value and administration).

**Total budget:** $67,413

**Will requested funds will launch, maintain or expand this program:** Expand the program

Fresh Approach
Making Healthy Food More Accessible
in the San Francisco Bay Area

5060 Commercial Circle, Ste. C, Concord, CA 94520
(925) 771-2990 | **freshapproach.org** | programs@freshapproach.org

**Location:** San Mateo (Senior Center and Farmers' Market) and San Bruno (Senior Center).

**Demographics of community to be served:** This program serves food insecure adults age 65 and older living with or at risk for diet-affected health conditions within the PHCD's boundaries. Eligibility is determined by anonymous surveys that include food insecurity levels, consumption of fruit and vegetables, and self-reported health conditions. According to the 2022 Senior Report from the United Health Foundation, 12.1% of California adults age 65 and older experience food insecurity; 8.3% of adult seniors reported consuming two or more fruits and three or more vegetables daily. 26.1% of seniors reported a body mass index of 30.0 or higher. 9.8% of seniors reported being told by a health professional that they have diabetes.

**How the program will address health disparities:** Older adults were hit particularly hard by the economic and public health crisis caused by COVID-19. Long-existing and stark racial and ethnic disparities in food insecurity rates among Black and Latinx older adults worsened[1]. Food insecurity has a harmful impact on the health and well-being of older adults, as associated with poorer health outcomes, longer hospital stays, and increased mortality[2]. Older adults have confronted increased social isolation as a result of social distancing policies. Despite positive attributes of existing nutrition assistance programs, including CalFresh, their standard benefits are often inadequate and limit the program's ability to do even more to improve food security, health, and well-being (some COVID-related initiatives recently sunsetted due to the end of federal funding). Existing research has shown that nutrition education, paired with nutrition vouchers would have important positive health impacts for participants. The proposed program would support health and well-being among older adults and promote socializing. The increased awareness built by this project around farmers' markets, CalFresh use, and other financial incentives will also show ripple and lasting effects after this program ends.

**Projected number of people to be served with this funding request:** 80

**Percentage of the projected number resides in PHCD:** 99%

**Measurement tools used to track impact:** The proposed program will measure its performance by administering pre- and post-surveys to all class participants. The number of participants enrolled and engaged in the program, as well as the rate of vouchers spent at the farmers' markets will be used to determine the reach and scale of the program. Changes in the consumption of fruit and vegetables, and shopping behaviors will determine the impact.

**Organization's history with PHCD** PHCD first funded Fresh Approach in the 2016-2017 grant cycle for $75,000. PHCD funded Fresh Approach again in the 2017-2018 grant cycle ($57,500); in the 2018-2019 grant cycle ($50,000); in the 2019-2020 grant cycle ($50,000) and in the 2020-21 grant cycle ($45,000).

**Contact name, email and phone number** Koy Hardy koyhardy@freshapproach.org 925.771.2990

[1] Hunger, Poverty, and Health During COVID-19 SPOTLIGHT: Older Adults Food Research and Action Center May 2021
[2] Spitzer, A. K-L, Shenk, M. P. R., & Mabli, J. G. (2020). Food Insecurity is Directly Associated with the Use of Health Services for Adverse Health Events among Older Adults. J Nutr. 150(12):3152-3160.

Fresh Approach

Making Healthy Food More Accessible
in the San Francisco Bay Area

5060 Commercial Circle, Ste. C, Concord, CA 94520
(925) 771-2990 | **freshapproach.org** | programs@freshapproach.org

**Organization's Name**
Friends for Youth
**Program title**
Mentoring Services
**Priority Funding Area request will address**
Mental Health - prevention services and programs

**Total budget**
$1,104,500
**Requested amount**
$25,000
**Contact name, email and phone number**
Cecilia Chu, Executive Director
cecilia@friendsforyouth.org
650-368-4464

**Program Description**

Friends for Youth (FFY) provides quality mentoring relationships for underserved youth who need support most, with the goal of empowering them to be mentally and behaviorally healthy, emotionally secure, and equipped with resiliency-building skills. Since 1979, we've matched over 3,000 youth with a caring adult mentor in our flagship 1-to-1 Program, with over 90% completing the full one-year program (33-67% for similar programs). Since 2016, we've provided school-based group mentoring to address rising dropout rates for low-income, BIPOC students. We also lead a collaborative of ten nonprofits (Whole Health for Youth) that provides holistic, wraparound services for local marginalized communities, while working to decrease duplicative services, share best practices, and improve efficacy. FFY has helped mentees improve their social-emotional and mental health, ultimately changing the course of their lives.

Friends for Youth Mentoring Services will use three strategies to achieve improved youth mental health:

1. Youth-Led Social Emotional Learning Curriculum including topics like boundaries, code-switching, identity and intersectionality, self-care and healthy coping strategies;
2. 30 weeks of school-based group mentoring sessions with school administration support led by a youth professional and facilitator; and
3. 1-to-1 Mentoring Sessions and case management for families

All strategies are evidence-based with mental health and social work research. Friends for Youth is very data driven, and has worked extensively with MENTOR National and Drew DeMarie of MENTOR Colorado to develop new outcome evaluations with alumni youth. Our proprietary social-emotional learning based curriculum follows the Casel Core Competencies Framework and has been developed for and by our youth themselves. Group Mentoring Sessions are currently provided at seven schools in the Redwood City School District and Sequoia High School in the Sequoia Union High School District. Youth are referred to our program by teachers and school administrators if they have low attendance, failing grades and/or behavioral issues. Our group session facilitators have on average 7 years of youth development experience and prioritize putting our mentees and their needs first. We want to provide safe spaces for the 10-15% of students who are struggling most in their school systems. We understand that their health, particularly their mental health, must come before we can even begin to talk about academics and success in life. For youth who are not ready for Group Mentoring, we will refer and serve

them in our 1-to-1 Mentoring Program. FFY also has an MOU with the San Mateo Foster City School district and 31% of our 1-to-1 referrals now come from these zip codes.

Funds will expand both our 1-to-1 and Group Mentoring Programs. We have long standing relationships with the Edgewood Center for Children and Families, San Mateo County Behavioral Health, and the YMCA in South San Francisco who refer youth to our 1-to-1 Mentoring Program. We hope to further develop these relationships to address the increasing mental health needs and gaps in services. StarVista is a supporting partner in our Whole Health for Youth Collaborative and regularly refers students to us from PHCD zip codes.

We hope to pilot group programs and expand to South San Francisco and San Mateo Foster City Schools. In South San Francisco, we are in talks with Alta Loma Middle School and Parkway Heights Middle School, as well as South City High School. In San Mateo, we are in talks with Borel Middle School, Sunnybrae Elementary and San Mateo High School.

**Demographics of community to be served**

Youth are referred to our program by youth-serving professionals due to struggles with social, emotional, and behavioral health. Our mentees are predominantly of Latinx (72.9%) background. 7.1% are Black. 7.1% are multi-racial. 4.4% are Asian Pacific Islander. 0.5% are Native American. 17% identify as LGBTQIA+, 5% are non-binary. 100% are low-income, 85% of them very low income. The median household income in the Bay Area is $192,000 annually; under $117,400 is considered low-income. 11% of our families make less than $10,000 annually. 41% of our households make $10,000-$24,999. 33% of households make $25,000 to $49,999. 8% make $50,000 to $74,999. 5% of our households make $75,000-$99,999. Less than 3% make more than $100,000 annually. 52.7% come from single-parent family structures. Most of our youth live in families with domestic dysfunction and are exposed to violence, physical and emotional abuse, substance abuse, and gang pressure. Around 20% have or have had an incarcerated parent. About 10% are foster youth or kinship and 10% have experienced homelessness. 40% have been subject to or are perpetrators of bullying. One in three young people will reach adulthood without a mentor of any kind - including natural mentors (e.g. parents/guardians/teachers). The numbers are higher among underserved communities. The combination of both racial and fiscal inequalities create adverse conditions for our clients, making them incredibly vulnerable.

According to GreatSchools.org, 82% of students at Parkway Heights are Latinx, 65% are low-income and 31% are learning English. At Alta Loma Middle, 46% of students are Latinx, 10% are Asian and 33% are low-income. At South City High School, 57% are Latinx and 44% of students are low-income and underserved. 42% of students at San Mateo High School are Latinx, and 36% are low-income. 45% of students at Borel Middle at Latinx, 36% low-income.

**How program will address health disparities**

The findings in the 2022 Community Health Needs Assessment demonstrate mental health as among the top health needs in San Mateo County, and there is a great demand for mentoring in addressing the

rising rates of depression, anxiety, trauma, and grief among today's youth. The pandemic has exacerbated prior socio-economic stressors and lowered access to wellness activities, resources, and positive relationships. California Healthy Kids Survey data shows a steady decline in youth connectivity, from elementary school to high school, particularly among the marginalized groups we serve, as behavioral health needs (like chronic absenteeism, school suspension, and probation) simultaneously increase. Not only do these experiences and systemic barriers cause psychological stress, but they also restrict access to quality care and opportunities.

Our 43 years of field research, supported by our Outcome Evaluation, demonstrates that quality youth mentoring is associated with positive outcomes in social-emotional development (higher self-esteem, better relationships with adults and peers), behavioral health (avoiding drugs/alcohol/juvenile justice issues, bullying), and academic performance (truancy, connection to school and adults, dropout indicators, achievement) (Dubois, et al, 2011). Mentoring and intrapersonal skill development are proven to decrease depressive symptoms (MENTOR, Role of Risk 2013). The value of a mentor and supportive adults in a child's life is cited in the 2021 Surgeon General's Mental Health Advisory as an action that can help youth build resiliency and address emerging mental health challenges. Each of our school partners has identified a significant need for mentoring programs as a Tier 2 Positive Behavior Intervention Support (PPIS). Mentors are changing lives and crossing racial and economic bridges to support young people.

**Projected number of people to be served with this funding request**

10 students and their families in a pilot group program in a South San Francisco Middle School
20 mentees and their families in our 1-to-1 Mentoring Program
Projected 120 total number of individuals served with this funding request

**Percentage of the projected number resides in PHCD**

18% of our current youth and alumni mentees reside in Peninsula Healthcare District bounds, we project for an increase to 20% because of our 2021 MOU with San Mateo Foster City School District and recent influx of referrals.

**Measurement tools used to track impact**

1-to-1 Pre Survey
1-to-1 Post Survey
Group Pre Survey
Group Post Survey
Google Data Studio for Evaluations
Salesforce Demographic Data

**Organization's history with PHCD**

Friends for Youth has enjoyed a long partnership with PCHD serving youth within the PHCD local communities, with most recent funding received in:

2022 – $25,000
2021 – $25,000
2020 – $20,000
2019 – $15,000
2018 – no funding
2017 – $15,000
2016 – $10,000
2008 for $15,000

**From:** Cecilia Chu
**To:** grants@peninsulahealthcaredistrict.org
**Subject:** Re: Friends for Youth Community Grants Application
**Date:** Wednesday, September 21, 2022 11:20:06 AM



Hi there Peninsula Healthcare --

I wanted to send some updates as well as more statistics about the zip codes that we are serving:

| PHCD Zip Codes | 1-to-1 Families | Group Mentoring |
|---|---|---|
| 94010 | 7 | |
| 94011 | | |
| 94030 | 2 | Mills High |
| 94066 | 7 | |
| 94401 | 48 | San Mateo High |
| 94402 | 8 | Sunnybrae Elementary<br>Borel Middle |
| 94403 | 13 | |
| 94404 | 5 | |
| 94497 | | |
| PHCD | 90 (18%) | |
| Total | 494 | |

We are in talks with expanding our Group Mentoring Program to Mills High School, San Mateo High School, Sunnybrae Elementary and Borel Middle School. I project that we will serve another 20 new mentees, 80 individuals in your zip codes for our 1-to-1 Program and 10 new students. 40 individuals in a pilot Group Mentoring Program for a total projected impact of **120+ new individuals in your zip codes**.

I hope this helps!

In community,
Cecilia

On Thu, Sep 8, 2022 at 4:04 PM Cecilia Chu <cecilia@friendsforyouth.org> wrote:

> Hello,
>
> I have attached our Application in both Word and PDF formats. Thank you so much for your past support and consideration for this cycle.
>
> In Community,
> Cecilia
>
> 
> ***Friends for Youth's 100% BIPOC team***
> --
> **Cecilia Chu, MSW (she/they)**
> Executive Director
> **meet with me**
> **IG** @friendsforyouth
> **FB** https://www.facebook.com/mentoring

--
**Cecilia Chu, MSW (she/they)**
Executive Director
**meet with me**
**IG** @friendsforyouth
**FB** https://www.facebook.com/mentoring

Healthier Kids Foundation
4040 Moorpark Avenue, Suite 100
San Jose, CA 95117
Phone: 408.564.5114
Fax: 408.326.2711
www.hkidsf.org

August 21, 2022

Healthier Kids Foundation would like to request $30,000 of Peninsula Health Care District funding to hearing screen over 1,000 children in San Bruno Park School District in pre-school, TK, K, 2nd, fifth, and eighth grades for the school year of FY 22-23. This program is called HearingFirst and fulfills the priority funding area of Preventive Health – screenings and healthy living.

HearingFirst is designed to detect hearing issues in children and provide appropriate prevention early. Healthier Kids Foundation uses OAE screening devices in preschools, charter schools, and public schools, to screen children 6 months old to 18 years old, for undetected hearing issues. Approximately 4-6% will show some type of hearing issue or referral. Last school year had a lower referral rate than previous years and our hypothesis was that masking and distancing helped children stay healthy. We imagine that as the world returns to normal that screening referrals will again rise.

For the children that receive a referral, we return 6 weeks later and re-screen. Often issues from viruses or flu have gone away and hearing returns. For those that receive a referral again, efforts occur to assist the child in seeing their pediatrician and then an audiologist if needed.

Parent Advocates contact the parents of those children whose screening result has identified a hearing issue and assists them with using their child's insurance to receive appropriate follow up care and treatment.

The hearing equipment used allows hearing issues to arise without using verbal cues, thus allowing small children or children with special needs to benefit also from the screening.

The requested amount continues to be $30,000 as it has been for the last 4 years and even though costs continue to rise, we try to improve our costs through efficiency. Funds are used to plan and send screeners to sites, utilize Salesforce and our equipment to screen and store all data, allocate referral results to parent advocates and allow them to assist parents in accessing the care they need. All case management and results are stored in Salesforce. The funds will allow us to continue to maintain our program, screen, and assist parents in accessing care for their children utilizing the child's own health insurance.

Screenings and follow-up will occur in all San Bruno Park School District pre-school and school sites. Here is an example from last year.

Screening dates: Wed 16, Thursday 17 and Friday 18 to screen all San Bruno sites. No school on Monday Feb 21st .

| | District | Site | Screenings | Expected # (PK, TK, K, G2, G5, and G8) | Screening Time (Please double check and update if needed) | HKF will provide | |
|---|---|---|---|---|---|---|---|
| 1 | SBPSD | Parkside Intermediate School | Hearing | | 8 AM- 2 PM | 3 screeners | 6 screeners for this day |
| 2 | SBPSD | John Muir Elementary School | Hearing | | 8 AM- 1:30 PM | 3 screeners | |
| 3 | SBPSD | Rollingwood Preschool | Hearing | AM # and PM # | 8:30 AM - 9:30 AM | 1 screener | 8 screeners for this day |
| 4 | SBPSD | Rollingwood Elementary School | Hearing | | 8:30 AM - 12:30 PM | 3 screeners | |
| 5 | SBPSD | Allen Elementary School | Hearing | | 8:30 AM - 12:30 PM | 3 screeners | |
| 6 | SBPSD | Allen Preschool AM and PM | Hearing | AM # and PM # | 9:30 AM - 10:30 AM, 12 PM - 1PM | 1 screener | |
| 7 | SBPSD | Belle Air Preschool | Hearing | AM # and PM # | 8:30 AM - 11:30 AM | 1 screener | 7 screeners for this day |
| 8 | SBPSD | Belle Air Elementary School | Hearing | | 8:30 AM - 11:30 AM | 3 screeners | |
| 9 | SBPSD | Portola Elementary School | Hearing | | 8:30 AM - 12:30 PM | 3 screeners | |

San Bruno Park Elementary is 15.4% White, 1.4% Black, 25.5% Asian or Asian/Pacific Islander, 41.5% Hispanic/Latino, 0.2% American Indian or Alaska Native, and 5.1% Native Hawaiian or other Pacific Islander. There are 39,885 residents in 6.4 miles or about 6K people per square mile.

Some of the most critical, yet often overlooked, fundamentals of pediatric health are proper hearing screenings—the first line of defense for early detection and treatment for several physical and developmental conditions. Common issues—such as hearing loss can develop in infants or young children, often without any obvious symptoms. If these problems are diagnosed early, they can be treated with a high rate of success, often using non-invasive techniques. 1000 children will be screened in the school district, and this is 5% of all hearing screenings completed by Healthier Kids Foundation each year. All funding from Peninsula Health Care District will be used for the effort in this district.

Healthier Kids Foundation has a unique method to ensuring that clients are residents. We use San Bruno Park School District's State School ID's, School ID's, and addresses of students including zip codes. Healthier Kids Foundation tracks all data through a Salesforce Data Base; all demographic data, preferred language, parent contact information, and case management steps are collected and are transferred by the district in a confidential system to Healthier Kids Foundation and saved in Salesforce.

Healthier Kids Foundation has hearing screened/individualized care management in partnership with Peninsula Health Care District for four years now.

Kathleen King, CEO Healthier Kids Foundation, kathleen@hkidsf.org, 408-605-5251

IEP COLLABORATIVE, INC.

PROVIDING SPECIAL EDUCATION LEGAL SERVICES

1. **Organization's name:** IEP Collaborative, Inc.

2. **Program title:** Special Education Advice and Counsel Program (SEAC Program) (formerly titled Special Education Collaborative Advocacy Consultation Clinic).

3. **Priority funding area request will address**: Mental Health (youth ages 2.5-21 & families)

4. **Program description and the associated activities**: IEP Collaborative, Inc. will implement its SEAC Program to achieve access to equitable education-related mental health and other therapies for students with disabilities and minimize student and family stress associated with the special education (SpEd) plan process by:
1. Providing free legal advice and counsel from attorneys who specialize in current SpEd law, including Pandemic-impact related changes and updates; and
2. Offering our free collaborative legal services at special education team meetings when appropriate.
Our services are California State Bar vetted as qualified legal aid and are free to students with disabilities or suspected disabilities irrespective of income status. Attorneys provide free legal advice regarding students' rights under the Individuals with Disabilities Education Act (IDEA) – IEPs, and Rehabilitation Act -504s. Attorneys experienced on both sides of SpEd (parents and a former teacher) staff our program, which empowers students and families to participate as legally-informed members of education teams to secure equitable access to evaluation, education, mental health and other therapies. Students and families referred by community partners or independently seeking assistance are required to complete intake forms stating their residence address and identify the school they attend. In cases in which a client already has an IEP or 504 Plan, the address and school information is confirmed against intake paperwork. We review address information against the PHCD Special District Map available on www.csda.net. PHCD funds will be used to maintain and increase program hours implementing strategies in the PHCD.

5. **Requested amount:** $44,602.00/year. We are interested in consideration for 2-year funding.

6. **How funds will be used:** The proposal supports $44,602 in program expenses, including, 504.9 attorney hours/33 support staff hours ($26,995), PHCD's 25.8% share of direct program expenses ($12,978 e.g., insurance, professional services, rent, etc.) & $4629 in indirect payroll tax costs (10.38% of request).

7. **Total budget:** $165,679.00

8. **Will requested funds launch, maintain or expand this program**: Funds will increase direct legal service hours in 2023 by 104.9 to support 504.9 total PHCD funded hours.

9. **Location program will take place**: Client services remain mostly virtual, which enhances program accessibility for families.

**10. Demographics of community to be served**: 100% of clients are students with disabilities or suspected disabilities. Although free irrespective of income, at least 68% of San Mateo County (SMC) families self-reporting on intake in 2022 are at or below the low-income threshold on 2022 HUD tables for SMC. Since 2021, 56.25% of all reporting clients self-identify as people of color; and 17.64% are families headed by caregivers aged 55 or over.

**11. How program will address health disparities:** It addresses the disproportionate lack of education and therapeutic access confronting historically disenfranchised communities (see demographics above). We mitigate this by supporting productive collaboration with schools to allow access to education, therapeutic interventions, and protection against deprivation of educational benefit. Our services are also language-accessible, due to our relationship with Language Circle, which provides interpretation and has translated our client forms into multiple languages. Further, our Staff Attorney is Spanish-bilingual

**12. Projected number of people to be served with this funding request**: We will serve at least 33 PHCD students with this funding. Assuming a 3 persons/household, this supports at least 99 PHCD residents' substantive and procedural SpEd rights.

**13. Percentage of the projected number resides in PHCD:** 25.8%

**14. Measurement tools used to track impact:** Metric tools for tracking goals 1,2,3,4 specified below: Survey Monkey report on intake forms (required) and post service survey.
Metrics tools for tracking goal 5: Survey Monkey report on input from post consultation survey.
Goal 1: 100% of students and families reporting disconnection to appropriately implemented SpEd on intake will report connection to services post consultation, including education, mental health, behavioral support services, ABA, OT, PT, and ST as appropriate for the given client.
Goal 2: 100% of students reporting temperament challenges on intake will experience improved temperament as a result of connection to services that were absent or not accessed based on parent/caregiver observations pre and post consultation/receipt of IEP/504 services.
Goal 3:100% of students and families will gain confidence navigating SpEd based on student/parent/caregiver (as appropriate) self-reporting pre and post consultation /receipt of IEP/504 services.
Goal 4: 100% Students and families will report engaging in more collaborative SpEd Meetings after consultation, including during current virtual IEP meeting protocols.
Goal 5: 100% of families will report that their matter did not require the filing of a legal complaint for resolution.

**15. Organization's history with PHCD**: 3 generous PHCD grants (6/2020 COVID relief grant ($10,000); 2021 ($22,000); 2022 ($26,000)) have supported over 900 attorney hours securing access to services and empowering students with disabilities in the district from June 2020. We are grateful for this partnership.

**16. Contact name, email and phone number:** Krista J Martinelli, Executive Director/Managing Attorney • 650-218-7244 • kmartinelli@iepcollaborative.org

Innovate Public Schools

Innovate Public Schools respectfully requests that Peninsula Health Care District consider the following request for $75,000 in funding to support our work lifting parent voices to broaden access to mental health services within the education system in San Mateo County (project name: San Mateo Mental Health in Education). This project is expected to serve 50-100 parents and reach more than 250 students in San Mateo County, with a concentrated impact focused in San Bruno, and South East South San Francisco; representing more than 75% of the participants of this program.

Innovate's San Mateo Mental Health in Education project will be designed with parent voices at the center of our work. The program will begin by engaging community organizations, neighborhood associations, educators, officials, and other groups to outreach to underrepresented parents. As our organizing team engages those parents, we will work to build trust-based relationships – grounded in their preferred language and located wherever is most convenient to them. Upon building meaningful connections, our team will best be able to discuss mental health needs within the community and what offerings are missing from mental health services in the education system today. As underrepresented parents outline their needs for mental health systems, our organizers will work with them to build skills to advocate within the education system to prioritize these services and commit funding to ensure every child will have access to the mental health services they need. In summary, over the course of the coming year, the project will: (1) Innovate's staff will outreach across San Mateo County, with a concentrated effort in San Bruno and SE So. San Francisco to reach 50+ parents from families typically underserved in the area. (2) Innovate team members, upon building trusting relationships, will convene parent advocacy groups. (3) Parents will design an agenda for advocating within the education system to get more mental health support access for every child.

Approximately 30% of San Bruno residents and another 30% identify as AAPI. These are the families that Innovate will particularly focus on reaching, as they are commonly the most underrepresented in public affairs. Even before the COVID-19 pandemic, California's public school system was failing Black and Latino students, low-income students, English learners, and students with special needs and learning differences. Fewer than half of Black and Latinx students were on grade-level in English and math and huge numbers of students weren't graduating high school eligible for college. The pandemic and school closures have dramatically accelerated these inequities, reaching beyond the quality of schools and also including the digital divide and lack of access to high-quality out-of-school and enrichment programs, especially mental health support services. We know that the inequity in education and pandemic will exacerbate the need for

mental health support for our students and their families. School remains one of the most critical ways to introduce these services into the lives of those who need it most. Now more than ever, it is essential our schools offer equitable access to mental health services and education.

Innovate utilizes a variety of tools for data tracking and reporting on our outcomes. For this project, we will measure parent engagement (attendance sheets, surveys) over time and also action taken (meetings, campaigns, outcome of the action/policy changes/funding commitments). All of this will be tracked over the course of the year via our database. The total budget for this project will be $250,000 for the year. The requested funding of $75,000 represents a portion of the total budget for the project. These funds will enable us to expand current programming in San Mateo County to take on this specific project. Although Innovate Public Schools has not been funded by Peninsula Health Care District, our CEO Michelle Vilchez has worked with the foundation over her 25 year tenure in the community. We believe her familiarity with the foundation will prove instrumental to the success of a mutually beneficial partnership for all.

For contact about this request, please feel free to reach out to:

Emily Jonas, VP of External Affairs
ejonas@innovateschools.org
415-680-8649

Michelle Vilchez, CEO
mvilchez@innovateschools.org
650-533-9144

# Jewish Family and Children's Services
OF SAN FRANCISCO, THE PENINSULA, MARIN AND SONOMA COUNTIES

**LETTER OF INTENT TO THE PENINSULA HEALTH CARE DISTRICT**

**Date:** September 8, 2022

**Organization's Name:** Jewish Family and Children's Services (JFCS)

**Program Title:** Center for Dementia Care (a program of JFCS' Seniors at Home) **Priority Funding Area:** Healthy Aging

**Program Description and Associated Activities:**
JFCS' Center for Dementia Care promotes the health and quality of life of older adults living with dementia through early detection, intervention, and reduced stigma, enabling them to remain in their homes and communities for as long as safely possible. We employ four primary strategies:

1. Comprehensive biopsychosocial assessments and individual consultations to measure mental and physical health, Activities of Daily Living (ADL), and living situations and risks, and to create individual care plans.
2. Individualized care management (help navigating medical appointments, assistance with medication, behavioral interventions, home safety support, connecting clients to other JFCS services such as nutritional assistance and opportunities for social engagement, connecting clients to community resources for additional support, etc.)
3. Giving families tools to understand and respond to changes in mood/behavior associated with dementia—the most common stressor for family caregivers—and individual support/education about advanced directives and long-term planning for their loved one.
4. In-home respite care, when appropriate, which includes personal care, homemaking, and companionship services

Our Dementia Care team is comprised of social workers/care managers (https://seniorsathome.jfcs.org/care-managers/), trained caregivers, and a neurologist. They work together to provided coordinated support and collaborate with clients and their families/caregivers to design and implement customized care plans to support quality of life and honor the unique identity of every client with dignity and compassion.

**Requested Amount:** $30,000 **Total Budget:** $505,900

**How Funds Will be Used:** Continued funding from the Peninsula Health Care District will help us deliver a comprehensive array of dementia care services to 70 individuals living in the District. Funds will also support in-home respite for family caregivers. Allocation of PHCD subsidies will prioritize individuals with low-income and/or limited (or no) support networks.

*Continued from page one*

**Will requested funds will launch, maintain or expand this program?** Funds will maintain our program.

**Location Program Will take Place:** Services take place in clients' homes.

**Demographics of Community to be Served:**
JFCS' dementia care clients are aged 60 to 100 and live in the Bay Area; 95% are low-income. We have approximately 120 clients living on the Peninsula, including 60% within the Peninsula Health Care District. JFCS serves people of all faiths and backgrounds. Clients are eligible for PHCD -subsidized services if they meet several conditions, including living in the District and having a cognitive impairment or caring for someone with cognitive impairment. We also consider clients' finances, their existing support system, and their unique caregiving/caretaking situation. PHCD funds are prioritized for low- and moderate-income clients and those who do not have a robust support system (e.g., no nearby family).

**How Program Addressed Health Disparities:** We address equity by prioritizing low-income clients when checking eligibility; outreach to underserved communities (e.g., connecting with community partners for referrals, multi-lingual fliers about our services in shopping bags at grocery stores in low-income areas); providing our individualized services on a sliding scale; and offering scholarships for home care. Our Dementia Care staff takes a client-centered approach, developing individualized care plans in collaboration with clients and/or family caregivers and taking their cultural and individual beliefs, values, and traditions into consideration. We provide ongoing caregiver training in cultural humility and Diversity, Equity, and Inclusion. We also proactively recruit, train, and retain a diverse, multilingual home care staff.

**Projected number of people to be served with this funding request:** 70 (approximately 55 seniors and 15 family caregivers)

**Percentage of the Projected Number Resides in PHCD:** 70

**Measurement Tools Used to Track Impact**: JFCS uses Evolv as its database to track client data such as demographics, number of clients served, and hours of service per client, the number of clients and families using the full allocation of hours in respite or home care services, etc. Pre- and post-service surveys measure changes in quality of life and access to healthcare and/or services as well as satisfaction with services received. Client services and clinical information, including access to services, are tracked through the SAH electronic health record, AlayaCare, and professional JFCS staff perform the pre- and post-measures.

**Organization's History with PHCD:** JFCS has a long history of partnering with Peninsula District Health Care District to support healthy aging in the District. Our first grant from PHDC was in 2008; we greatly appreciate your longtime and committed support. Together, we've helped hundreds of older adults live safer, more fulfilling lives with greater independence and dignity.

**Contact Name, Email, Phone Number:** Leah Tarlen, Director of Individual Giving, LeahT@jfcs.org; 415-449-1220

JUSTICE AT LAST

September 8, 2022
Peninsula Health Care District
Community Grants Program
Re: Letter of Interest (LOI) for Grant Cycle 2022-2023

To the grantmaking committee,

It is with great excitement that Justice At Last submits this letter of interest for our Empowerment Through Health and Wellness program. We are honored to have been a recipient of the Peninsula Health Care District Community Grants Program for the 2020, 2021, and 2022 years. This generous support has assisted us in providing essential health services to survivors of human trafficking in the identified communities.

Justice At Last is requesting $60,000 for two years from Peninsula Health Care District to support and enhance our direct service provision of mental health and medical services for survivors of human trafficking.

If you have any questions regarding our proposal or services, please contact Rose Mukhar, Executive Director of Justice At Last at rose@justiceatlast.org or by calling 650-995-4893.

Thank you for your consideration,

Rose Mukhar
Executive Director, Justice At Last

1. Organization's name: Justice At Last, Inc.
2. Program title: Empowerment Through Health and Wellness
3. Priority Funding Area request will address: Mental Health and Preventative Health

4. Program description and the associated activities

Justice At Last will use the following strategies to improve the health and wellness for survivors of human trafficking:

- Direct support services to survivors in order to address crisis stabilization
- Preventative measures and awareness to support health and wellness of survivors
- Safety Planning for holistic trauma-informed support
- Increasing access to and inclusion of necessary mental health and medical support services

This program will focus on empowering trafficking survivors of all ages to improve their mental and physical health needs by increasing access to emergency crisis counseling and mental and physical health professionals. All strategies will be implemented by Justice At Last client advocates when working with survivors who are receiving legal services and representation through Justice At Last.

5. Requested amount: $60,000 for two years

6. How funds will be used: All proposed funding will be used to provide direct services to survivors of human trafficking to improve their mental and physical health and increase access to professional services that are essential in healing from their past experiences.

7. Total Budget

| | Year One | Year Two | Total Budget |
|---|---|---|---|
| Direct Support Services and Crisis Stabilization | $20,000 | $20,000 | $40,000 |
| Mental Health Support and Preventative Services | $10,000 | $10,000 | $20,000 |

8. Will requested funds launch, maintain or expand this program: This program will be expanded from the previous year, with a new addition of medical service assistance.

9. Location program will take place: Justice At Last is a mobile legal clinic and we meet our clients where they already receive trusted services. This relieves survivors from the need to provide their own transportation or to visit a law office setting that might not feel safe and welcoming. We are headquartered in San Mateo County because there is no other legal service provider exclusively serving trafficking survivors within the Peninsula. Our office is located in Redwood City, purposefully next to the courthouse, however we are regularly out in the Peninsula Health Care District neighborhoods. Currently our San Mateo County clients reside in Millbrae, Redwood City, San Mateo, and South San Francisco and we would be serving trafficking survivors who reside in 94010, 94030, 94066, 94080, 94401, 94402, 94403, and 94404.

10. Demographics of community to be served: Justice At Last provides human trafficking survivors with free legal services regardless of their age, sex, gender identity, abilities and equity needs, nationality or type of trafficking. The population we serve within the Peninsula Health Care District are primarily Filipino women and men above the age of 25 where there is limited English proficiency. A number of our clients are also above the age of 65 who are monolingual (primarily either Tagalog or Visayan speaking) and we have bilingual staff and or provide interpretative support services to all clients served.

11. How the program will address health disparities: Client advocates will be responsible for providing critical emergency crisis management and trauma-informed support services to survivors of human trafficking, which has shown to greatly improve the stabilization of a survivor's mental health status. Additionally, client advocates will provide on-going preventative measures such as safety planning while working in tandem with staff attorneys to ensure survivors receive holistic, trauma-informed support.

12. Projected number of people to be served with this funding request: 90 total; 45 each year

13. Percentage of the projected number resides in PHCD: 100%

14. Measurement tools used to track impact: Justice At Last tracks all data using a custom AirTable database, which was built to ensure different metrics are being tracked for each client we serve. This database is used to complete reporting and compliance checks for granting purposes and to measure the impact each of our programs have on combatting human trafficking in the San Francisco Bay Area.

**Organization:** Kara
**Program Title:** Bereavement Support, Grief Education, and Crisis Response
**Priority Funding Area Request Will Address:** Mental Health Prevention Services

**Program Description and the Associated Activities:**

**Need:** While death and dying are a part of the cycle of life, the reality of experiencing a death has significant implications for the social, health and economic well-being of families. According to a recent report, *Bereavement Facts & Figures*, bereaved parents, siblings, children, and spouses are at risk for premature death, as well as other negative health, social, and economic outcomes as a result of their loss (Evermore, 2020). COVID-19 has also led to a large increase in mortality, leaving many grieving the sudden loss of family members. The COVID-19 bereavement multiplier estimates that for every COVID-19 death, approximately nine surviving Americans are impacted - losing a grandparent, parent, sibling, spouse, or child (Verdery et. al., 2020). In San Mateo and Santa Clara County alone, this impacts nearly 29,000 residents. Children are particularly vulnerable. In the five primary counties of the Bay Area, 1 in 21 children will experience the death of a parent or sibling by age 18 (62,670), and 1 in 11 will by age 25, more than double - 172,460, (CBEM, 2021). While 1 in 10 African American children will experience the death of a parent or sibling by age 18 (9.4%) and 1 in 6 will be age 25 (17.1% or 33,000). Children who lose a parent have a significant increased risk of attempting suicide, and compared to their non-bereaved peers, they experience "lower self-esteem, reduced resilience, lower grades and more school failures, heightened risk of depression, suicide, and premature death due to any cause, drug abuse, violent crime involvement, youth delinquency, and a greater number of, and more severe, psychiatric difficulties," (Evermore, 2020).

**Program Goals:** Kara seeks to support the mental health of the bereaved community through program specific goals as follows:

- Provide the healing space, connections (i.e., community), and tools grieving individuals and families need to move along their unique loss journey through peer-based support and grief-related therapy.
- Proactively equip schools and organizations with the knowledge and skills to support their members in the event of a future death through grief education and training.
- Mitigate disabling effects of grief and trauma by providing crisis response to schools and organizations after a death.

**Activities:** Kara will provide an array of bereavement support services through our five integrated programs (Adult Services, Youth & Family Services, Spanish Services, Community Outreach Services, and Therapy Services). Key activities include: peer grief support (individual and groups), grief-related therapy, crisis response, grief training, school-based grief support groups, grief camp (Camp Kara) for children and teens, and community support events (Candlelight Service, Day of Dead Celebration, WalknRun, Holidays Workshop).

**Requested Amount:** $25,000 (annually for 2 years)

**How Funds Will Be Used:** The grant would be used to fund staffing and program costs associated with our key programs noted above to provide aforementioned services.

**Total Budget:** $1,250,000 (this amount reflects the programs component of our agency budget).

**Will Requested Funds Launch, Maintain or Expand This Program:** Maintain program.

**Location Program Will Take Place:** Kara has offices in Palo Alto and San Mateo, provides services at select partner sites, and crisis response and grief training services on location.

**How Program Will Address Health Disparities and Demographics of Community:**
While loss does not discriminate based on class, ethnicity or privilege, grief is compounded by the experiences of poverty, racism, xenophobia, homophobia and other forms of structural discrimination and marginalization (Harris, Darcy, and Tashel Bordere. Handbook of Social Justice in Loss and Grief, 2016). For the past six years, Kara has established strategic directives to increase accessibility of our grief services to particularly vulnerable populations. Specifically, through our Spanish Services and Journeys programs, we make targeted efforts to support low-income individuals, people of color, and mono-lingual Spanish (or limited English) speakers, who have significant barriers to accessing grief services. Through the Journeys Program, we partner with Redwood City School District, serving a student population that is 89% Latinx, 63% receiving free or reduced-priced meals and 58% English language learners or dual language learners. Last year our Spanish Services Program supported over 500 individuals.

Designed to be accessible, Kara's peer support services are provided free of charge, in English and Spanish, and at various locations primarily in Santa Clara and San Mateo Counties. Peer support, therapy, crisis response and grief trainings are also offered online via telehealth for individuals, families or organizations that need remote services, whether due to vulnerable health conditions or accessibility issues. In addition, we often partner with community organizations already serving vulnerable populations and provide services onsite. Over the past four years, 50% of our peer support clients have been low-income and 49% people of color.

**Projected Number of People to Be Served with This Funding Request:** In 2023 we expect to serve 4,500 for our entire agency, with approximately 325 from the PHCD. With a total agency program budget of $1.25M, the averaged per client expense is $277. This equates to $90K apportioned to district residents. *A grant of $25K would therefore support 90 people from the Peninsula Healthcare District* (or 27% of the overall service cost for district residents)

**Percentage of The Projected Number Resides In PHCD:** In 2023 we expect to serve around 325 PHCD residents. This is 7% of our total service expectation (4,500).

**Measurement Tools used to Track Impact:** Pre- and post-client surveys, closing surveys

**Organization's History with PHCD:** We received our first grant from PHCD last year in 2021.

**Contact Name, Email and Phone Number:** Jim Santucci, Executive Director, jims@kara-grief.org, 650-313-2497

1. Organization's name

   Latino Commission on Alcohol and Drug Abuse Services of San Mateo County

2. Program title

   Entre Familia Outpatient Services

3. Priority Funding Area request will address

   Mental Health - prevention services and programs

4. Program description and the associated activities.

Entre Familia Outpatient Services will use two strategies to achieve improved mental health of people in our substance use disorder treatment facilities in San Bruno.

1. Individual mental health counseling to adult clients for relapse prevention, minimizing triggers, and for sustaining wellness

2. Group Presentations regarding Psycho-education, addressing mental health challenges and teaching healthy coping skills.

All strategies are hybrid virtual and facility-based services. A contracted LCSW offers one-on-one counseling to adult clients who express the need for help to their Substance Use Disorder Counselor.

Group Presentations are monthly, led by a contracted LCSW who uses evidence-based practices and is supported by 2 Mental Health Counselors who are on staff.

PHCD funds will be used to maintain programing strategies and provide more individual counseling sessions by expanding hours of an existing contracted LCSW.

5. Requested amount

   $20,000

6. How funds will be used

   150 Hours for additional LCSW private counseling sessions and added Hours for Intake Coordinator working with LCSW to develop a treatment plan for each client.

7. Total budget

   $657,000

8. Will requested funds will launch, maintain or expand this program

   Maintain

9. Location program will take place

   Virtual (via Microsoft Teams)

TLC Outpatient Facility, 1001 Sneath Lane, San Bruno

Casa Maria Recovery Home, 508 7th Ave. San Bruno

10. Demographics of community to be served

    Men and women 18-64, low income (Drug Medi-Cal clients), 70% Latino/Hispanic

11. How program will address health disparities

    Provide access to mental health services to a primarily Spanish-speaking population who have never received mental health counseling. We also use a cultural model that helps clients relate to an awareness and understanding of one's connection to one's genealogy, to one's cultural origin, customs, beliefs, and socialization.

12. Projected number of people to be served with this funding request

    120

13. Percentage of the projected number resides in PHCD

    80%

14. Measurement tools used to track impact

    California Outcome Measurement System (CalOMS), a statewide data collection and management system contributes to the improvement of treatment services for substance abuse to comprehensively measure program outcomes using performance and outcomes.

    Case Notes

15. Organization's history with PHCD

    10 years, since 2013 PHCD has funded the mental health therapy of our substance abuse clients at out San Bruno facilities.

16. Contact name, email and phone number

    Doren Martin

    doren.martin@thelatinocommission.org

    650-457-4043

LifeMoves



**LifeMoves – Letter of Intent for Peninsula Health Care District**

1. Organization's name: LifeMoves

2. Program title: BehavioralMoves

3. Priority Funding Area request will address: Mental Health

4. Program description and the associated activities: The primary objectives of the LifeMoves BehavioralMoves Program are (1) to screen our homeless clients for behavioral health issues, (2) to provide on-site support for clients' trauma and other behavioral health issues, and (3) to train a new cohort of psychology students each year in issues connected to homelessness, especially trauma. PHCD funds will be used to support these objectives at our First Step for Families shelter in San Mateo. We recognize that good behavioral health is essential for our clients to return to stable housing and sustain long-term self-sufficiency; to support these goals, we offer free, on-site, no-barrier behavioral health services specifically designed to meet the unique needs of homeless adults and children and to eliminate disparities in access to behavioral healthcare.

5. Requested amount: $30,000

6. How funds will be used: Funds will be used to support personnel expenses, program expenses, and allocated indirect costs.

Staffing for this program includes a Director of Behavioral Health, who leads the program and supervises the practicum students, and an Associate Director of Behavioral Health, who assists with program management and supervision. We also plan to budget for 0.15 FTE of the Senior Director of Clinical Services, who oversees the BehavioralMoves program, and 0.06 FTE of a Compliance position, who collects and evaluates participant data and outcomes.

In terms of program expenses, the practicum students (interns) who provide the direct client services receive stipends of approximately $300/month. Program supplies will also include materials for trainings and for specialized therapy services. Indirect costs will cover administrative functions such as HR, Finance, and Development department costs.

7. Total budget: $1,091,738

8. Will requested funds will launch, maintain or expand this program: The requested funds will maintain our existing program.

181 Constitution Drive
Menlo Park, CA 94025

650.685.5880
www.lifemoves.org

LifeMoves



9. Location program will take place: First Step for Families shelter, 325 Villa Terrace, San Mateo, CA 94401

10. Demographics of community to be served: In fiscal year 2022-23 to date, our clients at First Step for Families identify as white (57%); Black (19%); native Hawaiian or Pacific Islander (12%); multiple races (7%); American Indian (4%); and Asian (1%). 59% are of Hispanic ethnicity. 31% of clients self-reported one or more disabling conditions, and 56% were minor children.

11. How program will address health disparities: While most of our clients are on Medi-Cal (or a similar program), and therefore are eligible for mental health services from County-sponsored agencies, those programs typically have very long waiting lists, and services often do not become available during the relatively short time that clients remain in our shelters. In addition, traveling to and keeping appointments at other locations are logistical hurdles that prove to be significant barriers to homeless families in crisis, particularly during pandemic restrictions. By providing our behavioral health services on-site when possible, and through a quick referral process with clients' existing case managers, we have eliminated virtually all barriers to clients being able to access these services.

12. Projected number of people to be served with this funding request:
250 individuals

13. Percentage of the projected number resides in PHCD: 100%

14. Measurement tools used to track impact: The numbers of clients served, and hours of therapy provided, will be recorded in our customized Salesforce database. The qualitative impacts on clients and practicum students will be assessed through online surveys.

15. Organization's history with PHCD: We have previously received the following grants to support our BehavioralMoves program at First Step for Families:

2018 - $15,000
2019 - $15,000
2020 - $25,000
2021 - $25,000
2022 - $30,000

16. Contact name, email and phone number: Katherine Finnigan, Vice President of Institutional Giving (kfinnigan@lifemoves.org; 650-685-5880)

Thank you for your consideration, and we look forward to hearing from you soon.

181 Constitution Drive
Menlo Park, CA 94025

650.685.5880
www.lifemoves.org

1. **Organization's name:** Lucile Packard Foundation for Children's Health on behalf of Lucile Packard Children's Hospital Stanford

2. **Program title:** Stanford Children's Health Teen Van at schools in the Peninsula Health Care District for the 2023-24 and 2024-25 school years.

3. **Priority Funding Area request will address:** mental health and preventive health

4. **Program description and the associated activities**: Adolescents and young adults are some of the most medically underserved populations in the Bay Area. The Teen Van has served nearly 5,000 patients over 16,000 visits since 1996. For many patients, it is their single point of healthcare access, with a return visit rate of around 75%. It is estimated that every dollar invested in the Van leads to a savings of $10 because of its success in prevention and early treatment. The Van's consistent presence in PHCD provides reliable, ongoing care for adolescents with complex health needs. The staff builds trust within this typically slow-to-trust population by spending dedicated time with each patient, keeping a reliable schedule, and meeting patients where they are. Most patients have multiple health-related problems, including mental health issues, and require ongoing care. Each new patient receives a full physical, a mental health assessment, consultation with a clinical social worker, and, when possible, a nutritional assessment. During this uncertain time of the coronavirus pandemic, we anticipate that some combination of ongoing COVID testing for underserved youth and their families and community vaccination efforts (for both flu and COVID) will continue to be needed.

5. **Requested amount:** $467,439 (two-year commitment)

6. **How funds will be used:** Funds will be used for salaries for the driver, clinic assistant, medical assistant, nurse practitioner, social worker, dietitian, assistant manager, and medical director. Funds will also be used for **medical supplies** (including PPE, minor medical equipment, condoms, HIV test kits), **purchased services** (including lab processing at Stanford Hospital), **maintenance of needed medical equipment** (vaccine refrigerators and thermometers, microscopes, point-of care testing devices), **non-medical supplies** (including office and administrative supplies, lab and patient labels, and educational materials for health education groups), **pharmaceuticals** (including prescription and over-the-counter medications, psychiatric medications, contraceptives, and immunizations), **vehicle maintenance** (including repairs and maintenance of the Van and its equipment, electricity when charging, and gas), and **food for patients** (both for nutrition classes and for those experiencing food insecurity).

7. **Total budget:** see attached

8. **Will requested funds will launch, maintain or expand this program:** Funds will maintain the Van's two visits per month to schools in the district.

9. **Location program will take place:** Capuchino High School, Peninsula High School, San Mateo High School, Hillsdale High School, and other sites as necessary (including Abbott Middle School).

10. **Demographics of community to be served:** The community that uses the Teen Van's services includes underserved patients aged 12 to 25 with no health insurance, those who are under-insured, and those who are experiencing homeless. The Van also provides COVID-19 testing and vaccines for all ages, regardless on insurance.

Ethnicity demographics: Latino, 79%; White/Caucasian, 14%; Asian, 3%; African American, 2%; Pacific Islander, 1%; other/mixed: 1%; Native American, 0%

Gender demographics: Female, 48%; Male, 52%

11. **How program will address health disparities:** Adolescents and young adults are some of the most medically underserved populations in the Bay Area. According to kidsdata.org, 22.1% of children ages 6-18 who live in San Mateo County are uninsured or rely on public insurance. Kidsdata.org also reports that the homeless youth population in San Mateo County, 33.8% are in grades 6-12. The Teen Van program specifically targets the most underserved youth in the Peninsula Health Care District, addresses their immediate and ongoing health care needs, and actively works to connect them with longer-term, community based traditional sources of health care when appropriate to the individual patient's circumstances.

12. **Projected number of people to be served with this funding request:** 235 per year

13. **Percentage of the projected number resides in PHCD:** 100%

14. **Measurement tools used to track impact:** The Teen Van uses a psychosocial interview tool called the HEADSSSSS Assessment (Home – Education and Employment – Activities – Drugs – Sexuality – Suicide/Depression– Safety – Spirituality – Strengths) during the comprehensive medical visit. In addition, our team has developed a new secure, online health needs questionnaire that incorporates screening tools for mental health needs (PHQ9 for depression, GAD7 for anxiety), as well as for physical and emotional safety, housing security, food security, and health-related risk behaviors. The Teen Van also has an additional chart for tracking vaccine completion. All tools are industry standards.

15. **Organization's history with PHCD:** PHCD has generously supported the Van's visits to the district since 2019.

16. **Contact name, email and phone number:**
Jasan Zimmerman, Director of Foundation Relations
jasan.zimmerman@lpfch.org
650-736-2927

| Two days per month in PHCD | 2023-24 | 2024-25 |
|---|---|---|
| **Staffing** | | |
| Driver | $12,558 | $12,934 |
| Clinic Assistant | $5,710 | $5,882 |
| Medical Assistant | $11,841 | $12,196 |
| Nurse Practitioner | $30,451 | $31,669 |
| Social worker | $26,623 | $27,422 |
| Dietitian | $26,253 | $27,040 |
| Assistant Manager | $26,821 | $27,626 |
| MD Salary | $34,070 | $35,433 |
| | | |
| **Supplies** | | |
| Medical Supplies | $7,416 | $7,638 |
| Non-medical supplies | $3,708 | $3,819 |
| Pharmacy | $37,080 | $38,192 |
| Maintenance | $7,416 | $7,638 |
| | | |
| **Total per year** | **$229,948** | **$237,491** |

**Two-year commitment** **$467,439**

MISSION HOSPICE & HOME CARE



September 8, 2022

Ann Evanilla-Wasson
Director of Community Engagement
Peninsula Health Care District
1819 Trousdale Drive
Burlingame, CA 94010
ann.wasson@peninsulahealthcaredistrict.org

Dear Ann,

I am pleased to enclose a Letter of Inquiry for funding by the Peninsula Health Care District in support of Mission House, the only hospice house on the peninsula.

The long-time partnership of the District has been critical for this program, which has become an essential resource for patients, families, and healthcare providers throughout the region. Funding from PHCD has meant that we can provide compassionate comfort care to people without insurance or ability to pay.

We look forward to hearing from you about next steps.

Sincerely yours,

Marsha Eddleman
Development Director
meddleman@missionhospice.org

# Letter of Inquiry | Peninsula Health Care District | 2022-23 grant period

## Request from Mission Hospice & Home Care | Funding for Charitable Care at Mission House

September 8, 2022

**Priority funding area**: Healthy aging – socialization and connectivity

**Program description and activities:**
Mission House helps people make the very most of their lives up until the very end. Our hospice house is a peaceful, homelike environment for patients at the end of life who need intensive, round-the-clock symptom management that cannot be provided at home. While each patient's needs are unique, patients typically stay in the hospice house a few weeks to a few months.

The hospice house is tailored for end-of-life care, allowing us to provide excellent care for patients at the end of life who would otherwise require hospitalization. With just six private rooms, each with an en-suite bathroom and door to the back patio and gardens, Mission House gives families the opportunity to spend time together when it matters most. Family members are always welcome to visit and stay.

Patients are cared for by experienced hospice nurses, home health aides, hospice physicians, social workers, spiritual counselors, and volunteers. The staff designs a personalized care plan especially for each patient. Medical staff at the house are expert in hospice symptom management; our professional social workers and spiritual counselors provide opportunities for people to reflect, socialize, and talk about what matters most to them.

Our volunteers, who have completed 26 hours of training, provide extra connection and support for patients and families. Together, our team offers compassion, dignity, and comfort to people in their last weeks of life.

At our hospice house, we provide:

1. Around-the-clock professional hospice care and symptom management for patients at the hospice house;
2. Case management to each of these patients;
3. Wrap-around support for all Mission House family members, including spiritual support, psycho-social counseling, practical assistance, and bereavement services;
4. Volunteer visits to support patients and families by visiting, singing, reading, looking through photos, or simply sitting by the bedside so a patient is not alone.

**Requested amount: $175,000**

**How funds will be used:**
Mission Hospice is committed to providing access to compassionate end-of-life care for all patients, regardless of their insurance coverage or ability to pay. While the cost of medical care in the house is covered by Medicare and most private insurance, room and board are privately paid – and out of reach for some families. We offer a sliding scale to accommodate those patients.

Funding for charitable care supports patients not covered by insurance, or when insurance does not cover the actual cost of delivering care. Charitable care allows us to admit patients regardless of their ability to pay.

**Total budget:** The costs of operating the house and providing care are budgeted to total **$1,668,507** in the 2022-23FY. This does **not include** clinical outreach and education, support for DME, fundraising, and other administrative costs.

**The requested funds will maintain the program**. This funding supports an ongoing need to offer compassionate end-of-life care for those who are unable to stay in their own homes.

**Location and demographics of community to be served:**
Centrally located in Redwood City off Woodside Road, Mission House serves patients from throughout the Peninsula and South Bay and beyond. In 2021, patients in the house ranged in age from 26 to 105. We expect the demographics for 2022-23 to be similar.

**Addressing health disparities:**
Uninsured patients, who may be more likely to suffer chronic disease due to lack of care, need the care and support we provide – and are least able to pay. Financial support from the community means that patients and families have access to the hospice house regardless of their socio-economic status.

**Number of people to be served:**
In the first six months of 2022, we cared for 72 patients at Mission House. We also provided spiritual, emotional, and grief support to the loved ones of all these patients. We anticipate caring for approximately 190 patients in 2022-23. Our goal is to always have five of the six rooms full, for a total of 1,825 patient-days over the year.

**Percentage of the projected number residing in PHCD:**
Based on admissions in past years, we estimate approximately 26% of Mission House patients lived in PHCD, so we expect to serve approximately 50 District residents in 2022-23.

**Tools for measuring and tracking impact:**
Our electronic medical record (EMR) system documents data for each patient including name, age, primary diagnosis, length of stay, as well as notes from our care team. The EMR also tracks the work of our social workers, spiritual counselors, and bereavement team to ensure that we are offering these services to all patients and families.

It is also our goal to provide quality care, which we measure though CAHPS surveys. Our goal is to have 95% of patients' families rate our care at 9 or above (on a scale of 10), and for 95% of families to recommend Mission Hospice as a place for exceptional care.

**Our organization's history with PHCD:**
Peninsula Health Care District has been an invaluable partner for Mission House, providing a grant for the hospice house every year since December 2015.

**Contact name, email and phone number:**
Marsha Eddleman, Director of Development, 650.532.2550
meddleman@missionhospice.org

**Organization's name:**
National Center for Equine Facilitated Therapy (NCEFT)

**Program title:**
NCEFT's Equine-Assisted Mental Health & Resilience Programs for PHCD residents.

**Priority Funding Area request will address:**
Mental Health

**Program description and the associated activities:**
NCEFT's Mental Health & Resilience programs combine the knowledge of human psychology with the understanding of horse behavior and the restorative properties of nature to facilitate a unique, experiential learning and healing process for participants. Sessions are conducted by licensed mental health professionals and include an equine expert and peer mentor. NCEFT uses evidenced-based activities that allow participants to build resilience, develop a positive and healthy sense of self, and feel empowered to improve their quality of life.

These programs are purposefully designed for either individuals or small groups (versus larger groups). Small groups allow our therapists to provide in-depth attention to each participant, leading to a more effective healing experience. As well, participants feel more comfortable in small groups to express themselves, be vulnerable, and bond with other participants. Combined, this approach results in a deep-impact, enriching outcome for our clientele.

Specific activities in each program are uniquely designed for the target population and age group of the participants and have been proven to reduce depression, anxiety, and other symptoms of PTSD, strengthen social and emotional well-being, increase self-awareness, and build self-confidence. Age-appropriate activities include, but are not limited to mindfulness exercises, meditation, arts & crafts, journaling, sharing perspectives with other workshop participants, bonding with and caring for horses, experiencing a world outside the home or school by engaging with nature and experiencing the benefits of being outdoors, and cultivating relationships with other program participants. NCEFT creates its programs to support the needs of our community (i.e., the growing youth mental health crisis). Current programming focuses on children and adolescents with mental health conditions, such as anxiety, depression, eating disorders, social isolation, ADHD, and learning disabilities; adults with cancer or other chronic illnesses; and US military veterans and first responders with PTSD.

NCEFT's Mental Health & Resilience Programs were featured on ABC 7's morning news on August 11, 2022. To watch this short interview, please visit: tinyurl.com/nceftabc7news

To watch highlights of NCEFT's Mental Health Workshops, including an interview with a Strides Workshop participant, please visit: vimeo.com/522917627

**Requested amount:**
$20,000 (exclusively funds PHCD residents).

**How funds will be used:**
A grant from PHCD will enable NCEFT to provide its much-needed Mental Health & Resilience programs for its clientele residing in the PHCD by underwriting these direct program-related expenses.

**Total budget:**
$30,182 (for PHCD residents). Remaining $10,182 will come from other individual/foundation sources.

**Will requested funds will launch, maintain, or expand this program:**
Maintain and expand.

**Location program will take place:**
NCEFT's property at 880 Runnymede Road, Woodside, CA.

**Demographics of community to be served:**
Youth and adolescents with mental health conditions, such as anxiety, depression, eating disorders, social isolation, ADHD, and learning disabilities; adults with cancer or other chronic illnesses; US military veterans experiencing PTSD resulting from the effects of service; and first responders experiencing PTSD caused by occupational trauma.

**How program will address health disparities:**
NCEFT offers services to all, regardless of race, ethnicity, gender, religion, sexual orientation, gender identity, gender expression, economic status, and other diverse backgrounds. We provide financial aid to all who qualify as one of our core goals is to never turn away an individual who is unable to afford services. We automatically provide our services free of charge to veterans and first responders. NCEFT expects to provide financial assistance to over 50% of its Mental Health & Resilience clientele.

**Projected number of people to be served with this funding request:**
NCEFT projects to serve 30 individuals who reside in the PHCD. NCEFT draws clients from all over the Bay Area, and historically, 15% of our client census reside in the PHCD boundaries.

**Percentage of the projected number resides in PHCD:**
100%

**Measurement tools used to track impact:**
NCEFT uses industry standard assessment tools such as the PHQ-9 rating scale for depression and the GAD-7 rating scale for anxiety; we collect pre-and- post program questionnaires to measure progress against identified program goals; and we also monitor participant attendance as regular attendance can be an indicator of participant satisfaction. We also use surveys to collect feedback and use these results to measure success and to continue to improve our programs.

**Organization's history with PHCD:**
NCEFT received grants from PHCD in 2020, 2021, and 2022 and a COVID-19 Relief Grant in 2020.

**Contact name, email, and phone number:**
Cherie Hammer, Development Director, development@nceft.org, Mobile: 650-219-7917

NEMS NORTH EAST MEDICAL SERVICES 東北醫療中心
a california health+ center

September 7, 2022

Ann Evanilla-Wasson, Director of Community Engagement
Peninsula Health Care District
1819 Trousdale Drive
Burlingame, CA 94010

Re: LOI for North East Medical Services (NEMS) Behavioral Health Integration Program

Dear Ms. Evanilla-Wasson,

North East Medical Services (NEMS) is respectfully requesting $60,000 to support our Behavioral Health Integration Program (BHIP), which provides behavioral health services, referrals, and linkage for the most vulnerable and underserved families residing in northern San Mateo County. We believe this program aligns well with PHCD's focus on Mental Health.

NEMS is one of the largest Federally Qualified Health Centers (FQHC) targeting the medically underserved, low-income, and uninsured/underinsured population of the San Francisco Bay Area. NEMS specializes in serving limited English proficient, immigrant, and low-income individuals/families. In 2021, NEMS launched the BHIP to improve patients' physical and mental health outcomes using an integrative, collaborative care model comprising of primary care and behavioral health care teams. The program provides depression screening (ages 12+) and alcohol screening (ages 14+), support for initiating and engaging with county-based treatment programs, and follow-up services at our primary care clinics. In 2021, NEMS provided behavioral health services to over 200 San Mateo County patients through more than 460 encounters at our 211 Eastmoor Clinic in Daly City.

As part of this program, we developed a new role at the clinic called Behavioral Health Linkage Workers (BHLW) who serve as integrated care "champions." The new BHLWs strengthened our collaborative care team by providing warm hand-offs and facilitating and tracking referrals to specialty care, social services, and community-based resources. Currently, the BHLW team is comprised of five (5) staff working across five clinics, who can speak English, Spanish, Cantonese, Mandarin, and Taishanese, languages that reflect the majority of patients we serve.

The target population for this project includes new and existing immigrants, limited English proficient speakers, and low-income individuals/families, specifically those of Asian or Hispanic backgrounds living in northern San Mateo County, including PHCD residents. At our 211 Eastmoor Clinic in Daly City, we serve predominantly low-income BIPOC immigrants. Nearly 80% of patients are Asian, 3% are Hispanic, and 67% of patients report being best served in a non-English language. Additionally, 57% of patients are 200% or below the Federal Poverty Level, 67% have Medicaid/Medi-Cal coverage, and 13% have Medicare. In 2020, the most

common racial/ethnic groups living below the poverty line were White (32%), Hispanic (28%) and Asian (17%) (U.S. Census Bureau). According to San Mateo County Health (SMCH) Behavioral Health & Recovery Services (BHRS) Mental Health Services Act (MHSA) Innovation Project Plan, young adults (ages 18-25) have the highest prevalence of mental illness, but have a lower rate of accessing treatment than adults. San Mateo County's 2019 Community Health and Needs Assessment (CHNA) identified behavioral health and well-being as one of the county's top five health issue areas. One in ten (11%) reported a history of mental or emotional problems, with the highest rate among young adults under age 40 (17%). One in four (26%) have experienced symptoms of chronic depression; the rate is increased among Blacks (37%) and Hispanics (34%). Across the County, one-third (32%) have sought professional help for a mental or emotional problem; however, those less likely to use mental health services include Asians (20%), seniors 65+ years (24%), and men (26%).

Language accessibility and cultural sensitivity are essential elements for treating mental and physical health disorders. NEMS BHIP addresses these health disparities by providing linguistically and culturally appropriate behavioral health services including depression screening, alcohol screening, and follow-up services for adolescents and adults. Behavioral health services, screenings and care coordination are available virtually through telehealth, including by video or phone visits. We ensure that nearly all providers, medical assistants, nurses, and support staff can speak English and at least one Asian language including Cantonese, Mandarin, other Chinese dialects, Vietnamese, or Tagalog. Additionally, the BHLW at 211 Eastmoor Clinic is bilingual in English and Spanish. As a FQHC, no one is denied services due to their inability to pay. NEMS offers a Sliding Fee Discount Program for eligible patients.

With PHCD's generous grant of $60,000, NEMS aims to support behavioral health services, referrals, and linkage for the most vulnerable and underserved families residing in San Mateo County. Funds will be used to support partial salaries for two (2) existing bilingual BHLWs (English/Spanish and English/Chinese), as well as launch new outreach activities at community events (e.g., health fairs, career fairs, cultural events, etc.) to promote BHIP services and reduce mental health stigma throughout the County. NEMS uses NextGen Electronic Health Records system to manage patient records. We will track the impact of this grant by the number of referrals to BHLWs and number of people reached at outreach events. The goal of this project is to reach 250 individuals, where an estimated 22% (55 individuals) reside within the PHCD.

Thank you for your consideration of this request. If you have any questions or would like additional information, please reach out to me at Pearl.Lee@nems.org or (415) 352-5037.

Sincerely,

Pearl Lee
Grants Manager

OMBUDSMAN
ADVOCATES FOR QUALITY OF LIFE IN RESIDENTIAL CARE

**Ombudsman Services of San Mateo County Letter of Intent**

**1. Organization's name**

Ombudsman Services of San Mateo County, Inc

**2. Program title**

Long Term Care Ombudsman Program

**3. Priority Funding Area request will address**

Healthy Aging - Socialization & Connectivity

**4. Program description and the associated activities**

Social isolation can lead older residents into depression. Just knowing that someone else cares about them can improve their outlook on life.

"We've seen that isolation has had significant impact on residents in long-term care facilities," shares Vicki Elting, Assistant State Long-Term Care Ombudsman, with the Washington State Long-Term Care Ombudsmen Program. "Isolation is tragic to the psyche, depression rates are up. Some have shared that they no longer want to live."

We know Ombudsmen visits to facilities mean a lot to residents, but the pandemic has made OSSMC truly understand how vital that human connection is to residents.

Ombudsmen are a vital component of long term care services. They provide a voice for vulnerable residents who may feel overwhelmed, fearful or ashamed to communicate problems of abuse and neglect, be it physical, sexual, emotional, verbal or financial.

Ombudsmen make unannounced visits and talk to residents to get a true sense of how things are in the long-term care community. They work with staff to suggest creative ways residents can socialize and communicate. OSSMC also provides consultations/education to LTC staff, and hold events to educate the public on topics of LTC.

Activities include:

- ❑ Consultation to facilities - 6-7 in-service trainings to143 staff within 12 months
- ❑ Consultation to individuals - 297 within 12 months
- ❑ Resolve 90% of all cases to the satisfaction of the residents or designated representative resulting in a marked improved quality of life and care for every resident served.
- ❑ Facility Coverage - 89% for Board and Care; Nursing Home coverage or Skilled Nursing Facility - 100% - within 12 months
- ❑ Community Education events - conduct 41 within 12 months
- ❑ Music & Me Program - Participants receives a personalized playlist of 40-60 songs, downloaded to an MP3 player. We will provide in-service training to facility staff including instructions on using the device, storage and best practice.
- ❑ Friendly Visitor Program - the program's volunteer will develop a relationship that provides social contact and a meaningful connection.

**5. Requested amount**

$80,000

**6. How funds will be used**

PHCD funding will be allocated toward OSSMC's Long Term Care Ombudsman Program - to assure the protection of 5,073 LTC residents in the PHCD service area through advocacy, direct intervention, education; and the Memory & Me and Friendly Visitor programs.

**7. Total budget**

$1,086,548

**8. Will requested funds will launch, maintain or expand this program**

Funding from PHCD will maintain our Long Term Care Ombudsman Program and expand program offerings with the Memory & Me and Friendly Visitor programs.

**9. Location program will take place**

OSSMC services seven cities within the PHCD which include: Burlingame, Foster City, Hillsborough, Millbrae, San Bruno, San Mateo and South San Francisco.

**10. Demographics of community to be served**

The demographics of the nursing home population have undergone significant changes in the past decade. Changes in the ethnic and cultural composition of our society are reflected in the increasingly diverse populations in LTC facilities. No longer is there a "typical" nursing home resident.

The current San Mateo County population in over 60 age group is 137,584, representing the following ethnicities: White 61.2%; African-American 3.1%; 2 or More Races 2.0%; Hispanic/Latino 12%; Asian 21.6%; Other Race 2.5%.

**11. How program will address health disparities**

Because many people of color have fewer financial resources, they have fewer choices in LTC facilities. LTCs are expensive and inaccessible to seniors with lower incomes. Part of the Ombudsman's facility monitoring activities includes recognizing/addressing any health disparities.

**12. Projected number of people to be served with this funding request**

5,073

**13. Percentage of the projected number resides in PHCD**

100%

**14. Measurement tools used to track impact**

OSSMC's data entry and reporting system, Ombudsman Data Integration Network (ODIN), provides fields which document any incidents and actions taken on behalf of residents; what services were provided to residents, staff and administrators; the number of facilities; residents served and; Community education events given.

For the newer programs, we will have regular check-ins at specified intervals: one month and six months with participating residents and staff to make sure they are benefitting from the services – particularly as care support, in addition to simple enjoyment. Anecdotes are collected from care givers and administrators about how the program is being utilized.

**15. Organization's history with PHCD**

OSSMC has a longstanding partnership with PHCD starting in 2011 when we received our first grant through 2021 with the exception of 2017 where we were unable to apply.

**16. Contact name, email and phone number**

Bernadette Mellott MPA, Executive Director
650-780-5702
berniemellott@ossmc.org

**Peninsula Health Care District LOI – One Life Counseling Center**

**1. Organization:** One Life Counseling Center **2. Program title:** Free and Low-Fee Mental Health Counseling

**3. Priority Funding Area request will address:** Mental Health - prevention services and programs

**4. Program description and the associated activities:** One Life Counseling Center's Free and Low-Fee Mental Health Counseling program will use three strategies to improve the mental health of PHCD residents:

1. Learn each client's cultural and linguistic needs, schedules, income, and specific mental health needs at intake and connect them with an appropriate therapist and low-fee payment plan.
2. Provide culturally and linguistically competent individual counseling services to children, families, and individuals who are in mental health crises and cannot afford therapy.
3. Connect clients to additional services to provide a continuum of care for basic needs

All of the clients served in this program are economically disadvantaged, and nearly all have acute mental health needs that are not otherwise being addressed due to the inability to pay for services, inaccessible scheduling, and/or language or cultural barriers. This program eliminates these barriers and ensures that clients are able to receive professional mental health counseling. The program subsidizes the costs of mental healthcare, allowing clients to pay what they can afford.

When a new client reaches out directly to One Life or is referred, we respond within 24 hours, knowing that they are likely in crisis and need immediate support. We provide an assessment over the phone and connect them to a therapist who best fits their needs, ensuring that each client receives an appointment within one week of reaching out. Each therapist begins counseling by providing the client with an Adverse Childhood Experiences (ACE) questionnaire to help the therapist further understand and address the client's needs.

The Low-Fee Counseling program is delivered via One Life's diverse team of over 95 mental health therapists. Each therapist is in the process of completing, or has completed, a master's degree in mental health counseling. Our therapists live in the community, are bilingual and bicultural, and have similar life experiences as our clients. In total, they provide therapy in 8 different languages and over 10 mental health treatment modalities that address over 30 issue areas including trauma, depression, anxiety, substance use disorder, domestic violence, and suicide ideation.

On average, each client served through the Low-Fee Mental Health Counseling program receives 10 free or low-cost mental health therapy sessions. Clients with greater needs continue to receive therapy as needed through the program. Each client is also connected to a Peer Advocate who helps them identify other needs, such as food insecurity, housing, transportation, or medical care. The Peer Advocate then works with our network of over 50 providers and connects the client to the appropriate supports.

One Life is the only service provider in the community that provides free and low-fee, high-quality, culturally and linguistically competent therapy to anyone in need within a week of them reaching out—with appointments offered on evenings and weekends as well as weekdays.

**5. Requested amount:** $50,000 **6. How funds will be used:** The requested funds will be used to pay for additional therapy hours to meet the high demand for accessible mental health counseling services for low-income youth, families, and individuals within the PHCD. In addition to serving at least 50 new PHCD residents with the requested grant support, the funds will also serve Undocumented Unaccompanied Minors (UUM) seeking asylum. Through the resettlement process, many UUMs experience polytrauma and require mental health counseling.

Our highly trained therapists provide ongoing counseling support for each child, family, and adult we serve. We help them learn healthy coping skills, as well as build their strengths and resiliency long-term so they are able to achieve life dreams and goals including pursuing their educational and career aspirations. We will also use some funding to advertise our counseling services within low-income PHCD neighborhoods, including those with high percentages of immigrant residents, to insure we are reaching residents with high mental health care needs and who may not know how to access support.

**7. Total budget:** $695,000 **8. Will requested funds will launch, maintain or expand this program:** Expand

**9. Location program will take place:** The program takes place at One Life Counseling Center's counseling offices:

1303 San Carlos Ave
San Carlos, CA 94070

525 Veterans Blvd
Redwood City, CA 94063

749 Brewster
Redwood City, CA 94063

961 Laurel Street, Suites 203-205
San Carlos, CA 94070

1001 Laurel Street
San Carlos, CA 94070

1033 Laurel St , Suite B and C
San Carlos, CA 94070

1350 Cherry St.
San Carlos, CA 94070

1720 Marco Polo Way
Burlingame, CA 94010

**10. Demographics of community to be served:** The program provides free/low-cost culturally and linguistically competent counseling to low-income children--including Undocumented, Unaccompanied Minors (UMMs), families, and individuals, at least 80% of whom are Latinx.

**11. How program will address health disparities:** There is a significant health disparity for low-income, Spanish-speaking children, families, and individuals in PHCD. San Mateo County's mental health therapy services program to serve low-income residents with mental health therapy, Access and Care for Everyone (ACE), does not have resources for Spanish-speaking therapists, even though Census Bureau Data reflects that over 140,000 San Mateo County residents speak Spanish at home. Additionally, according to the 2022 Sequoia Hospital Community Health Needs Assessment and 2021 Report, San Mateo County is trending downward and failing to meet benchmarks in behavioral health and emotional well-being, particularly for low-income and Latinx populations.

One Life is the only service provider in the community that provides free and low-fee, high-quality, culturally and linguistically competent therapy to anyone in need within a week of them reaching out—with appointments offered on evenings, weekends, and weekdays. This radical accessibility addresses the health disparities experienced by low-income individuals whose primary language is Spanish and/or work multiple jobs or atypical hours.

**12. Projected number of people to be served with this funding request:** 200 unduplicated individuals

**13. Percentage of the projected number resides in PHCD:** 100%

**14. Measurement tools used to track impact:** Each client is provided with an anonymous post-program survey with six questions asking about their experience, and space to write in additional feedback.

**15. Organization's history with PHCD:** One Life Counseling Center has partnered with Peninsula Health Care District since 2018 through our Free/Low-Fee Mental Health Counseling Program and our Music and Memory Program. PHCD's loyal support over the past four years has allowed us to serve over 1,000 PHCD residents in need of mental health support.

**16. Contact:** Executive Director Suzanne Hughes; suzie@onelifecounselingservices.com; 415-860-1475

## Peninsula Healthcare LOI – One Step Beyond Disability Services

1. Organization's name

One Step Beyond, Inc.

2. Program title

OSBI CA Recreation – Health and Fitness

3. Priority Funding Area request will address

Preventative Health

4. Program description and the associated activities

Since 2003, One Step Beyond, Inc. (OSBI) has provided comprehensive and person-centered programs to adults who have an Intellectual Disability in Arizona, then expanded to the California Bay Area in 2016. The mission of OSBI is "to provide dynamic, responsive programs that engage the goals, talents, and interests of individuals with intellectual disability and empower them to achieve their dreams of optimal independence, enriching social networks, and effective participation in our community." Programs focus on training in employment and life skills preparation, access to recreational and cultural opportunities, and advocacy for people who have disabilities and their families.

Research shows that lack of physical activity increases the risk of many medical problems including heart disease, diabetes, obesity, and poor bone quality. Specifically, studies have demonstrated that persons who have an intellectual disability, when compared to the rest of the population, have decreased cardiovascular fitness and strength. OSBI's Recreation Health & Fitness Programs, target these risk factors, by providing participants individualized training schedules, nutrition plans, and monthly meetings with a fitness and nutritional coach. Support from the Peninsula Health Care District will allow OSBI to continue delivering its Recreation Health & Fitness Programs to adults who have intellectual disabilities in San Mateo County who chose to be apart of OSBI for our programming. OSBI has 19 years of experience delivering programming and services to over 500 people with disabilities annually. OSBI's metrics have demonstrated that 70% or more of its program participants show an increase in positive outcomes. Programmatic success of OSBI's Recreation Health & Fitness programming is attributed to the use of industry-leading evidence-based practices and certified staff to support the needs of individuals who have disabilities.

5. Requested amount

$10,000

6. How funds will be used

Funding is needed to contract certified fitness instructors to facilitate fitness and wellness activities throughout the year for participants in OSBI's Recreation Health & Fitness Programs. Contracted instructors deliver programming in a safe, inclusive and secure environment that promotes equitable access to health and wellness activities, regardless of disabilities.

7. Total budget

$40,000

8. Will requested funds will launch, maintain, or expand this program

Funding from the Peninsula Health Care District will allow OSBI to maintain its Recreation Health & Fitness Programs for adults who have intellectual disabilities.

9. Location program will take place

Belmont, CA – Up the Middle Fitness Center

10. Demographics of community to be served

Adults between the ages of 18-25, with disabilities living in the project geographical area. Also, 95% of OSBI members receive basic government assistance and thus have income limitations.
17% Asian or Pacific Islander
19% Latino or Hispanic
3% Black of African American
61% Caucasian or white
55% female
45% male

11. How program will address health disparities

Providing equitable access to health prevention services and programming to individuals who have disabilities is a core value within OSBI, which is currently not being met or accomplished to its fullest potential in the area. OSBI's Recreation Health & Fitness Programs, will increase preventative health services and programming access, while decreasing equity gaps to an already marginalized group.

12. Projected number of people to be served with this funding request

35 individuals

13. Percentage of the projected number resides in PHCD

80%

14. Measurement tools used to track impact

Project Goals: Secure certified fitness and wellness instructors to facilitate health and wellness programming.

Project Outcomes: (1) Increased participation in Recreation Health & Fitness Programs, (2) Increased positive health outcomes for participants enrolled in Recreation Health & Fitness Programs, (3) Increased sense of belonging amongst program participants.

Project Measurements and Evaluation: OSBI actively monitors and measures effectiveness through a feedback and documentation process. OSBI takes a multidisciplinary approach to tracking the effectiveness of our work. The following data collection methods and evaluation metrics will be used throughout this project: (1) Program quality and participant success will be measured through surveys completed after events, participant interviews, and discussions with OSBI staff, and (2) Engagement will be measured through a feedback process and documentation from OSBI staff, parents, stakeholders, and the community. The OSBI Program Director and Board of Directors will monitor project activities through monthly quality assurance meetings, using this evaluative work to ultimately improve all programming and effectiveness.

15. Organization's history with PHCD

In 2020, our organization received a $5,000 grant to support COVID related expenses to keep residents in the peninsula healthcare district healthy as we re-opened vital businesses and services. Funds were used in a variety of ways to help support people with disability in our area to access essential services during the height of the COVID pandemic. The funds provided were vital to the success of our programs and services ability to continue to provide in-person and virtual services to our program participants during this time and helped us to purchase PPE equipment and cleaning supplies, Emergency medical kits, worksite modification materials such as plexi-glass barriers for desks and other work areas, and IT upgrades to limit the spread of COVID through shared use of equipment.

16. Contact name, email, and phone number

LeAnn Carrillo LeAnnCarrillo@osbi.org (602) 918-5132

1. **Organization's name** Pathways Home Health & Hospice
2. **Program title** Pathways Bereavement Program
3. **Priority Funding Area** Mental Health - prevention services and programs
4. **Program description and the associated activities** The Bereavement Program strives to increase the quality of life for those grieving the loss of a loved one. This is demonstrated through improved sleep, eating, socialization, and increased energy levels in our client's life. Other indicators are reduced depression, stress, anxiety, anger, and loneliness. Pathways patient families and community members at large are eligible for appropriate bereavement services. Pathways staff conduct an intake process, initial referral assessment and pre-enrollment to determine client needs and make appropriate placement. Participants are interviewed as to the type of loss, probable stage of grief, and timeframe since the loss, to ensure that the services offered are appropriate. We also evaluate whether they are emotionally ready and able to commit to the time frame required for each service. Those who are not comfortable in a group setting are offered one-on-one counseling. With a grant to serve PHCD residents we propose:

- To provide bereavement services for 50 individuals coping with the loss of a loved one, including an initial screening for depression, isolation, anxiety and other behavioral health issues.
- To conduct a combined total of 250 workshops, individual and group counseling sessions, including telephone/video counseling services, serving family members and community bereavement clients
- To honor loved ones through two community-based remembrance events, in person or virtual as appropriate and allowed.
- To provide at least 4 mailings (stages of grief pamphlets) to each hospice family member and bereavement client over 12-15 months

5. **Requested amount** $10,000

6. **How funds will be used** The mission of the Bereavement Department is to create a pathway for grievers to integrate their loss in a way that allows their heart to remain open to life. This transformation is achieved through providing compassionate, professional bereavement counseling and education that supports individuals and families in healing mind, body and spirit after a loss.
Recognizing that grief is a uniquely individual process that takes time, the Bereavement Program provides guidance and support to those who are adjusting to the loss of a loved one. In addition to support groups and one-on-one counseling, appropriate newsletters, pamphlets, and other grief materials are supplied, including specialized resources for children coping with loss. Funds will help to provide these bereavement services which are made available to everyone in the community at no charge, thanks to generous contributions from our community partners.

**7. Total budget** $198,545

8. **Will requested funds will launch, maintain or expand this program** Maintain an existing program

**9. Location program will take place** The program takes place in the community and is open to all. One-on-one counseling may take place in-person, virtually or over the phone.

**10. Demographics of community to be served** While many of Pathways clients are over the age of 65, the demographics of the program participants reflects that of the community at large. Anyone can utilize the service, however, the funds from this grant would be used to serve only those who live in the Peninsula Health Care District.

**11. How program will address health disparities** Addressing a person's mental health has a direct impact on their physical well-being and lack of illness, particularly among those who are grieving a loss. Supporting those who have suffered a loss and are grieving can help prevent unhealthy actions and preserve self-care for those of all ages from all walks of life. The Pathways Bereavement Department develops, implements and evaluates culturally tailored bereavement and grief support programs, events, presentations, resources, materials, and activities for Pathways clients AND for the community at large. Everyone grieves differently. For some, grieving is a very private process, while others reach out to a network of friends and family. While many benefit from individual counseling, others prefer participating in a support group or activities with others who are grieving – and some need both to get them through this very difficult time. Our services are provided to meet the complex and diverse needs of our grieving clients, community members and their families, particularly those who cannot otherwise afford to pay for these vital mental health services.

**12. Projected number of people to be served with this funding request: 50**

**13. Percentage of the projected number resides in PHCD: 100%**

**14. Measurement tools used to track impact** Pathways utilizes an electronic medical record system to track patient data. Program staff members also keep detailed records of workshop attendees and individual counseling clients, including addresses and contact information. Services are provided through Pathways' South San Francisco office, which is located within the District boundaries. Reporting will include the number of clients in the PHCD service area and type of service(s) received. We also evaluate effectiveness through the participant surveys.

**15. Organization's history with PHCD** Pathways enjoys a long term, ongoing relationship with Peninsula Healthcare District as a grantee and community partner. We have been funded for 6 years and value the commitment and partnership of PHCD. Our recent funding history includes Bereavement Program Funding: 2021-$10,000; 2020-$10,000; 2019-$10,000; 2018-$15,000; un/underinsured Care 2016-$15,000; Chronic Care Management 2012-$12,500

**16. Contact name, email and phone number** Karen Krueger, Executive Director of Philanthropy Karen.Krueger@commonspirit.org (408) 773-4101

Peninsula Bridge
dream • believe • achieve

**Peninsula Bridge LOI due 9/8/22**
**Mental Health Wellness Program**

1. **Peninsula Bridge**
2. **Mental Health Wellness Program**
3. Priority Funding Area: **Mental health**

4. **Program description and the associated activities**

Peninsula Bridge will use three strategies to positively impact youth in all areas of their lives, playing an active role in helping them navigate significant challenges and stay engaged in school: 1) Individualized one-on-one student counseling services (including crisis intervention); 2) Individual parent/caregiver collateral sessions to support student goals and progress; and 3) Group parent mental health education workshops. All sessions and resources are provided in English, Spanish and Portuguese by licensed LMFT counselors using evidence-based practices.

This program is offered to low-income BIPOC students ages 10-18, who attend 21 schools within the PHCD District. Two LMFT counselors (one for middle school and one for high school) work closely with students and families to reduce stress and anxiety and build protective factors. We teach adaptive coping skills including healthy habits, how to diffuse tensions at home, how to validate grief and loss, and other mindfulness techniques. Our parent workshops include topics such as how to manage the turbulent tween/teen years, internet safety and cyber bullying. PHCD funds will be used to expand the hours of existing counselors in response to student and family needs.

5. **Requested Amount**: $70,000 over 2 years ($35,000 per year)
6. **How funds will be used** - PHCD funds will be used to maintain and expand services for the 210 students and 210 parents or caregivers who reside in the district. We have increased our program budget with expanded LMFT hours during this especially challenging time.
7. **Total budget**: $391,802
8. Funds will maintain and help expand this program
9. **Location** program will take place: Student counseling sessions take place at the Peninsula Bridge offices in San Mateo and Palo Alto. Parent workshops take place in various locations in San Mateo, East Palo Alto and Menlo Park; and also virtually.

**10. Demographics** of community to be served

Peninsula Bridge students are 100% “free and reduced lunch” eligible, 90% Latinx, 4% Black, 2% White and 4% identify as Other. Our program is located in a region where income inequality is extreme. Wealthy students have a multitude of resources while low-income families struggle with basic needs.

**11. How program will address health disparities**

This program addresses two critical areas of need due to health disparities:
a) Access and Delivery: Most Peninsula Bridge students do not have access to affordable, bilingual/bicultural, quality mental health counseling through schools and

community health organizations. Also, for the majority of Latino families there are numerous barriers to utilization of mental health care due to social and economic factors, stigma, a lack of bilingual/bicultural services and other logistical, cultural, attitudinal, and systemic barriers.

b) High Rates of Anxiety, Stress and Depression: About one-third of teens and adults suffer from anxiety disorders, and low-income students experience even higher rates due to their challenging circumstances. Yet with poverty consistently linked with mental health problems and the need for care, many youth do not receive treatment because of the barriers outlined above. These barriers may also be coupled with other student stressors such as academic pressure, bullying, home life problems, fear of a family member's deportation, housing displacement and imposter syndrome that can impact a student's ability to be successful in school and life.

12. **Projected number of people to be served** with this funding request: 210
13. **Percentage of the projected number resides in PHCD**: 100%

14. **Measurement tools used to track impact**

Program success will be determined through an analysis of data generated from the combined tools outlined below, in partnership with Acknowledge Alliance.

- Customized Student Exit Survey, self-report data measuring students' experiences in counseling. This survey will measure student progress against program goals: 1) decreased anxiety and stress; 2) increased ability to make positive choices about his/her actions or life, and 3) increased ability to cope with challenging circumstances and emotions.
- Pre/post measure of students' overall functioning and mental health using Children's Global Assessment of Functioning Scale (GAF).
- Customized Workshop Exit Survey, measuring parents' perceived gains in knowledge and access to resources to support their child's mental health wellness.
- The number of workshop presentations and workshop attendees.
- The number of student counseling sessions and parent/caregiver collateral support meetings tracked on a monthly basis.

We also measure program success by student cohort retention in our program (93%), high school graduation rates (100%), and four-year college attendance rates (94%). Without mental health wellness, these successful student outcomes are not possible.

15. **Organization's history with PHCD**

Peninsula Bridge has been an annual grantee of PHCD since 2019, receiving $30K in 2019-2021, and $35K in 2022. We submit our progress reports as requested, and track participant residence to ensure zip codes are within PHCD boundaries by school district residency.

16. **Contact:** Randi Shafton, Executive Director, randi@peninsulabridge.org;
650-473-9461 office; 650-888-2761 cell

# *2023 Community Grants*
# *Letter of Inquiry*

1. **Organization's name:** Peninsula Family Service

2. **Program title:** Older Adult Peer Counseling Program

3. **Priority Funding Area request will address:** Healthy Aging - Socialization & Connectivity

4. **Program description and the associated activities:** Through our Peer Counseling program, Peninsula Family Service works to ensure no one faces the challenges of aging alone. Trained volunteer counselors offer weekly one-on-one or group support and companionship to diverse community members (aged 55+) to help manage transitions and life changes such as health and Covid concerns, mobility issues, caregiver needs, and grief. We connect participants with volunteer counselors who share similar life-experiences and perspectives. Services are offered in English, Chinese, Spanish, and Tagalog, and for participants who identify as LGBTQIA+.

   Between the shortage of mental health counselors and the stigma many older adults associate with accessing mental health care, this program fills a significant gap in the local community's continuum of care for some of our most vulnerable neighbors. Participants receive weekly in-person, Zoom, or phone visits from their peer counselor as well as the opportunity to build a community of support through group sessions.

   Our relationship-based model aligns with and complements existing resources in the community by providing referrals to a range of essential services. Peninsula Health Care District's continued support will play a vital role in responding to the ongoing mental health struggles so many older adults are experiencing.

5. **Requested amount:** $60,000

6. **How funds will be used:** Funds will be used to support and grow the number of people we can serve as we have a waiting list of 40+ adults who wish to obtain a peer counselor. To do so, we will increase outreach efforts to recruit more volunteer peer counselors who reflect the diversity of the San Mateo County older adult population.

7. **Total budget:** $679,566

8. **Will requested funds launch, maintain or expand this program:** This grant will both maintain and expand our trusted Peer Counseling program.

9. **Location program will take place:** Individual peer counseling sessions take place weekly over the phone, a zoom conference call, or in-person when comfortable. Group sessions are offered in a variety of languages in Daly City, San Mateo, Redwood City, and the Coastside cities of Pacifica and Half Moon Bay.

10. **Demographics of community to be served:** Peer Counseling currently serves 539 diverse older adults, ages 55 to 100+ years old. More than half (61%) identify as individuals of color and with primary languages including Cantonese, Chinese, English, Mandarin, Spanish, and Tagalog. Roughly 75% are female and 25% male. We also serve participants who identify as LGBTQIA+.

11. **How program will address health disparities:** Older adults in general are more prone to depression and mental health issues as they face natural life events and stressors, such as the death of a loved one, a major loss or change, medical conditions, alcohol or drug abuse, and financial issues. Unfortunately, according to the 2019 San Mateo County Community Health and Needs Assessment (CHNA), older adults 65+ years account for 24% of residents least likely to utilize mental health services. With the ongoing pandemic and related safety concerns, these issues are exacerbated and even more urgent. If left untreated, mental health challenges can escalate and have severe negative effects on other areas of health and well-being.

    Our Peer Counseling program decreases isolation, promotes positive mental health, reduces risk for out-of-home placement, and improves quality of life by providing older adults with social contacts through either group or one-on-one sessions, connection to community resources, and practical support. This program is the only peer supported program of its kind in the community and has been identified as a critical part of the County of San Mateo's Older Adults System of Care Plan.

12. **Projected number of people to be served with this funding request:** With FY21-22 funding, including your support, we served 539 program participants. An investment by Peninsula Health Care District of $60,000 this year will allow us to serve 15 more program participants for a total of 544.

13. **Percentage of the projected number resides in PHCD:** 19% (100 individuals)

14. **Measurement tools used to track impact:** Our Efforts to Outcomes (ETO) database serves as the primary measurement tool. It is used to track the number of program participants, their basic demographics, and attendance touchpoints throughout the year. We also collect annual participant feedback using surveys or focus groups. The questionnaires for both surveys and focus groups are designed to capture participant self-reported outcomes related to mental health and well-being.

15. **Organization's history with PHCD:** Peninsula Family Service is tremendously grateful for PHCD's support. Since 2014, PHCD has made generous contributions that both helped sustain and expand programs that strengthen our community by providing children, families, and older adults the support and tools to realize their full potential and lead healthy, stable lives. Last year's generous donation of $45,000 supported the Peer Counseling program during a time of increased need due to the pandemic.

16. **Contact name, email and phone:** Mary Geissler, mgeissler@pfso.org, 612.206.6626

1. **Organization's name:**
   Peninsula Family YMCA
2. **Program title:**
   Community Health Initiative
3. **Priority Funding Area request will address:**
   Healthy Aging and Preventative Health
4. **Program description and the associated activities**

Funding from the PHCD will ensure that 684 community residents can participate in programs listed below at no cost to them. We look forward to our participants experiencing a boost in regular physical activity and an increase in knowledge based around the workshop topics. We will continue to promote the YMCA's Diabetes Prevention Program and the Dementia Prevention Program while offering the following programs throughout the year:

**Community Movement Classes**: Staying active is imperative for physical and mental health in the Active Older Adult (AOA) community. With PHCD funds we will provide weekly group exercise classes led by YMCA fitness instructors that are geared toward the AOA population. The Community Movement classes we plan to offer include yoga, Pilates, dementia prevention, Dance, chair fitness, and balance focused on fall and strength training. By offering these regularly scheduled classes, participants will engage in healthy activities with friends to stay connected and build their local AOA community.

**Healthy Eating Active Living (HEAL) Workshops**: HEAL Workshops enable participants to build and live healthier lives. HEAL promotes overall well-being through 12 interactive workshops each year focused on a range of topics such as reading food labels, identifying barriers to healthy eating/physical activity, self-monitoring, and much more. These monthly 45-minute interactive workshops are hosted by YMCA certified coaches where participants ask questions, tell stories, and engage with others, all while enhancing their knowledge on the health-related topics.

**Additional Disease Prevention:** We work closely with our Y Health Initiatives team and other community partners to address disease management and prevention (e.g., type II diabetes, cardiovascular disease, dementia, etc.) through evidence-based curriculum, wellness, and nutrition coaching. Most, if not all, of programs are offered virtually, in person, and in several languages (e.g., English, Spanish, and Cantonese).

5. **Requested amount:**
   We are requesting a grant of $120,000 to be spread among 2 years ($60K annually).
6. **How funds will be used:**

Funding will be used to compensate instructors that teach the community movement classes, the coaches who lead the HEAL workshops, and the staff responsible for the community outreach and coordination of these programs.

From our previous Peninsula Health Care District grant in FY 21/22, we were able to offer HEAL workshops and engage the community in the YMCA's Diabetes Prevention Program. We found it a challenge to serve a high volume of residents in the YMCA's Diabetes Prevention program however, because it requires both qualifying for the program, and a year-long commitment. We expect to continue promoting this, and other YMCA offered programs in FY 22/23 (current year), and plan to offer the aforementioned services as free, drop-in workshops (both in-person and virtually) that participants can opt into with a shorter commitment.

**7. Total budget:**

The total program budget for 2 years of the proposed services is estimated to be $214,496 ($107,248 annually).

**8. Will requested funds will launch, maintain or expand this program?**

The funds we are requesting will be used to **launch** our offsite community movement exercise class program. These classes will be for community centers within the designated zip codes and will be provided at no cost to the centers or the participants. The funds will also **maintain** the relevant cohorts of the YMCA's Diabetes Prevention Program, as we currently have several cohorts currently running and ongoing marketing for the programs. Finally, funds will be used to aid in **expanding** our HEAL workshop program, allowing us to bring these educational health-based workshops to our community.

**9. Location program will take place:**

The programs we are proposing will take place virtually, in-person at the Peninsula Family YMCA branch in San Mateo, and at community-based centers in San Mateo County, focusing on the highlighted zip codes.

**10. Demographics of community to be served:**

Age range = 50+, and percentage of those who are Low income = 50% of participants.

**11. How the program will address health disparities:**

These programs will address health disparities by serving residents of San Mateo no matter their income, thereby removing any financial barriers to accessing to health and movement-based classes. By working closely with San Bruno Senior Center, Redwood City Veterans Memorial Senior Center and other community centers and local partners, the Peninsula YMCA will move closer towards our vision of providing equitable access to all.

**12. Projected number of people to be served with this funding request:**

We will serve 684 total participants each year: (HEAL workshops at 84 participants + Community Movement Classes at 600 participants).

**13. Percentage of the projected number resides in PHCD:** 100%

**14. Measurement tools used to track impact:**

Community movement and Health Workshops metrics:

- Attendee count
- Survey feedback after each session

**15. Organization's history with PHCD:**

In the last 5 years the Peninsula Family Y has been awarded the following: 1.) In 2022, we received $45K for our Diabetes Prevention Program and HEAL workshops; 2.) In 2021, $45K for our Community Healthy Living programs to support technology needs for virtual programming, supplies, staffing costs, and membership; 3.) In 2020, $110K for Peninsula's Step Up & Live Strong Community Health Programs, and additional funds for COVID-19 relief; 4.) In 2019, $40K for our Community Health Programs: Healthy Weight and Your Child, Diabetes Prevention Program, and Living Strong Living Well; and 5.) In 2017, an award of $25K to pilot an elementary school lunchtime wellness program at 3 local elementary schools.

**16. Contact name, email and phone number**

Theresa De Dios
Senior Executive Director, Peninsula Family Y
Tdedios@ymcasf.org, 650.294.2601

**From:** Ann Wasson
**To:** Grants
**Subject:** Fw: Diabetes Prevention Program follow up
**Date:** Wednesday, September 21, 2022 12:45:34 PM

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**From:** Theresa De Dios <TDeDios@ymcasf.org>
**Sent:** Wednesday, September 21, 2022 11:05 AM
**To:** Ann Wasson <ann.wasson@peninsulahealthcaredistrict.org>
**Subject:** Diabetes Prevention Program follow up



Hi Ann,

Here is the info- please let me know if you have any questions or need additional clarification.

We track all participants progress in a data collection platform (weight loss , activity minutes) and ask through a survey at weeks 16 and year end how they felt the program helped them to reach goals and improve lifestyle to prevent type 2 diabetes.

Thank you!

**Theresa De Dios** (she/her)
**Senior Executive Director**
**Peninsula Family Y**
1877 S Grant Street
San Mateo, CA 94402
Main:650.286.9622
Direct: 650.294.2601
Email:tdedios@ymcasf.org
https://www.ymcasf.org/locations/peninsula-family-ymca

**Organization Name:** Peninsula Jewish Community Center
**Program Title:** Pink Power @ the PJCC
**Priority Funding Area:** Preventive Health
**Requested amount:** $15,000
**Total budget:** $67,580
The requested funds would be used to maintain and expand this program
**Contact (name, email, phone number):** Nicola Burt, development@pjcc.org, 650.378.2690
**Program Location:** 800 Foster City Blvd., Foster City, CA 94404

**Program Description and Associated Activities**
Pink Power @ the PJCC is an innovative exercise program developed specifically to address and support the needs of, and enhance recovery for, post-operative breast cancer survivors using a one-to-one training program developed at the PJCC in Foster City (in person and virtual options). Pink Power provides its participants with supervision by highly trained exercise specialists, pre- and post-program fitness assessments, individualized exercise programs and instruction, therapeutic massage (which we have discontinued for the duration of the pandemic, substituting additional activities for participants or incorporating new treatment modalities), nutritional guidance, and support groups.

Pink Power @ the PJCC offers BC Fit classes through a partnership with Bay Area Cancer Connections. In February, we reached 45 people; in March, 48 people; and in April, 56 people. We will continue with a new series of four virtual BC Fit classes beginning in October 2022. We piloted two BC Fit classes in partnership with Peninsula Health & Fitness Center.

Our program focuses on improving strength and overall well-being for breast cancer survivors of all ages. Participants attain measurable health benefits, including reduced feelings of depression, improved self-confidence, higher energy, better weight control, improved sleep, decreased stress, and improvement of strength and mobility. They see improvements in these areas: (1) increased quality of life as evidenced by physical, social, emotional, and functional well-being; (2) reduction in overall fatigue; (3) reduction in body fat percentage; (4) increased range of scapular motion; and (5) reductions in lymphedema (if present) in wrist, forearm, elbow, and bicep.

Over the next year, Pink Power plans to achieve the following:

- Enable 40 participants who complete the 1:1 program to attain measurable health benefits.
- Offer weekly, in-person Healing Yoga for Cancer Patients to provide therapeutic exercise.
- Continue to offer BC (Breast Cancer) Fit classes virtually. Provide six classes within the grant period (two three-part series) and pilot additional classes for PHCD residents.
- Provide the option to work with a trainer to use new treatment modalities focusing on lymphedema and non-invasive massage, including the use of a power plate, compression sleeve, and Theragun.
- Generate 30 new program referrals from breast cancer service organizations, physicians and clinics, other medical professionals, and word-of-mouth/social networking.
- Reach 200+ participants in our annual Pink Power Month (October) through a combination of live and Zoom programming.

Tailoring each participant's program to meet her individual goals and work with her specific health circumstances and fitness level is key to the program's effectiveness. Services include the following:

- Pre- and post-program fitness assessments (approximately 60 minutes each).
- Twenty 30-minute private classes.
- Two 30-minute nutritional guidance sessions.

Funds will be used to support PHCD residents' participation in the full Pink Power program and to explore opportunities to expand BC Fit class offerings within the District.

**Demographics of Community to be Served**
We project that we will serve 40 people in the 1:1 program, at least 40% of whom will reside in PHCD. We aim to serve an additional 50 through our BC Fit classes, More than 50% of participants receive financial assistance to participate in our program. Participants range in age from 35 to 70, and come from throughout the Bay Area.

**How program will address health disparities**
Our paramount goal is to ensure health equity in all our programs. We subsidize Pink Power @ the PJCC for participants with financial need and work closely with participants to help them overcome any barriers to accessing the technology necessary for them to participate effectively in virtual programming. Subsidies for Pink Power participants include fees for an adjunct four-month PJCC membership for enrollees as well as program fees, with the subsidy level for an individual participant dependent on their financial need. 52% of Pink Power participants pay reduced or no fees, which is enabled by support from institutional funders including PHCD and individual donors. Peninsula Health Care District Community Grants supports PHCD residents to participate in the full program, which subsidizes fees for those in need.

**Measurement Tools Used to Track Impact**
Pink Power's extensive pre- and post-program participant evaluations measure and analyze the program's impact. In the post-evaluation conversation, the trainer assesses how satisfied the participant is with results in at least one if not all categories. Data from participants is also used to measure impact and make program adjustments as needed. Because the program is individualized, adjustments can be made as needed throughout the time that the participant spends in the program. In addition, we use data from the Measurements of Improvement to demonstrate and analyze overall program impact.

Pink Power uses established, validated measures such as The Functional Assessment of Cancer Therapy-General (FACT-G) and the Piper Fatigue Scale, as well as functional assessment methods. Our data demonstrate impressive results and record improvements that are made from the time of pre-evaluation to post-evaluation. As Pink Power @ the PJCC is a highly individualized program, the time between assessments ranges from 2-6 months.

**Organization's history with PHCD**
The PJCC is grateful for many years of support from PHCD. Between 2011 and 2014, PHCD provided three generous grants to support PJCC's Get Up and Go senior transportation program. Over the past six years, PHCD has provided a total of five grants to support Pink Power @ the PJCC (formerly Pink Ribbon).

1. Organization's name: Peninsula Volunteers, Inc,

2. Program title: Adult Day Services at Rosener House

3. Healthy Aging; The goal of PVI Adult Day Services at Rosener House is to assist families who are dealing with physical and cognitive limitations such as Alzheimer's disease, Parkinson's disease, post-stroke, and other chronic conditions. The program is designed to keep participants active, engaged, and independent, functioning at the highest possible level. This in turn makes care at home easier. This along with the respite for caregivers during program hours make it possible for families to remain together, lessening the likelihood of institutional placement. The Rosener House facility is unique in offering 3-6 different activities simultaneously, as we have the space and the staff to do so. It is important to offer choices to keep people independent and stimulated. The therapies, activities, and social interaction all contribute to better physical, mental, and emotional well-being and increased life satisfaction.

4. Peninsula Volunteers Adult Day Services at Rosener House is a therapeutic day activity program. The program promotes engagement and social interaction for older adults with disabilities while also providing respite for family caregivers. PVI Adult Day Services uses a holistic approach to care, with program components including therapies, health monitoring and medication management by a Registered Nurse, counseling by a Social Work Team, nutritious lunch, recreational, educational, and social activities led by professional staff, and assisted by volunteers.
Families benefit from the respite while their loved ones are participating at the PVI Adult Day Services at Rosener House, allowing them to continue working or take a break from the demands of caregiving. Families are offered weekly support group meetings, counseling, educational opportunities, and referrals to other community resources. The entire program is designed to improve the health and quality of life of the whole family.

5. Requested amount: $50,000.

6. The funds will be used to subsidize attendance in the Rosener House program for residents of the Peninsula Health Care District. Each day of attendance includes transportation to and from Rosener House via Redi Wheels paratransit, health monitoring and medication management by our Registered Nurse, occupational therapy for those who need it, music therapy for all participants, social engagement and recreational activities, nutritious hot lunch, and caregiver respite. Caregivers may attend the weekly Caregiver Support Group facilitated by our social worker. Our social workers also provide one-on-one counseling and make referrals to other services that may be needed. The full fee at Rosener House, inclusive of all services, is $120 per day, with reduced rates as low as $60 per day available based on need. The actual cost of providing the service is $130 per day per person. During this past year, 38% of PHCD residents have been paying reduced rates. An estimate of $72,000 is needed to subsidy for PHCD residents in the coming year. The PHCD Community Grant has helped to sustain these participants in the program. As the program is all-inclusive, the PHCD grant was used to support general operations through salaries of direct care staff members.

7. Total budget: For Adult Day Services at Rosener House $1,646,960.

8. The funding requested is to maintain and expand the program.

9. 500 Arbor Rd. Menlo Park, CA 94025

10. Demographics of Rosener House participants include the following: 78% have a formal diagnosis of Alzheimer's disease or related dementia, 35% have 3 or more chronic conditions; 55% are low-income; 81% are non-minority, 3% are Black, 9% are Asian/Pacific Islander, 7% are Hispanic; 47% live with their spouse, 52% are male an 48% female, 90% are 70 years old or older. The grant from PHCD will be used to serve families who reside in the District. Our intake and application process include their diagnoses and address of residence, so we are sure they live in the District.

11. Rosener House pays careful attention to local health needs assessments including Peninsula Health Care District's Strategic Plan. One of the five identified priority areas addressed the needs of aging adults with the following objectives: 1) Promote socialization and connected aging and reduce isolation and 2) Promote access to care at the right time, the right level and best way for each individual. Instead of remaining isolated at home, both participants and family caregivers benefit from the social engagement and support they experience at Rosener House. Rosener House is also known for personalized care that is exemplified in its organizational structure and values.

12. Projected number of people to be served with this funding request: 20 participants

13. Percentage of the projected number resides in PHCD: 19%

14. The annual Caregiver Satisfaction Survey, the Standardized Levels of Care Assessment, and the Individualized Care Plan are used to collect metrics. The Caregiver Survey helps to determine satisfaction and changing needs of family caregivers. The Levels of Care Assessment determines how a participant's level of functioning changes over time. The Care Plan determines changes in social, emotional and physical needs with goals and objectives. The latter two are conducted every six months.

15. Organization's history with PHCD, since 2016
    2016-2017---- $25,000
    2017-2018----$25,000
    2018-2019--- $25,000.
    2019-2020---$35,000. 2020-- COVID 19 Relief Grant--- $5,000.
    2020-2021---$ 40,000.

16. Contact name, email and phone number:
    Dao Do, ddo@1pvi.org: 650-322-0126

**Peninsula Health Care District Letter of Intent September 8, 2022**

1. Peninsula Volunteers, Inc.
2. Meals on Wheels for San Mateo County
3. Healthy Aging
4. PVI Meals on Wheels increases food security and access to nutritious food through the following services:

    1) Nutritious home-delivered meals that provide one third the daily allowance for older adults (60+) and adults with disabilities who are unable to shop and/or cook for themselves are delivered to clients as long they remain on the program.
    2) Daily wellness and safety checks and referrals to other community services assist clients live safely and independently in their own homes and alleviate their isolation.
    3) Initial assessment and quarterly reassessments ensure the services of Meals on Wheels are meeting their needs.
    4) Nutritional education further helps clients make healthy choices about food.

    Over the past year, Meals on Wheels (MOW) has served over 1,200 home-bound seniors and adults with disabilities in San Mateo County. This essential service keeps clients well-nourished and connected to the community, provides dignity and independence, and allows clients to remain in their own homes rather than needing more costly and less independent assisted living or nursing home placement. Although there is no income requirement to be in the MOW program, meal recipients are predominantly low-income; all recipients are disabled; almost half of recipients are people of color.

5. Amount requested is $60,000 per year for two years.

6. Funds from the Peninsula Health Care District will be used to help sustain and expand the Meals on Wheels service to residents of the District. So far in this year, 286 District residents have been served 25,291 home-delivered meals and received all the ancillary services. The contract with Aging and Adult Services for Older Americans Act funding reimburses at the rate of $11.00 per meal for a limited number, requiring subsidies for the remainder. Serving PHCD residents has required $126,455 in supplemental funding so far this year. This funding is required to plan, prepare, and deliver the meals. The $60,000 grant from PHCD will be used to purchase raw food and for compostable delivery containers to sustain this vital service to PHCD residents.

7. $2,741,779 is the PVI Meals on Wheels budget for one year, FY22-23.

8. Funds will be used to maintain and expand the MOW program.

9. Meals are prepared in the Little House kitchen in Menlo Park and delivered directly to each client’s home within the District.

10. Demographics of Meals on Wheels clients are as follows:
    - 71% have incomes of less than $25,000, 91% less than $50,000;
    - 98% are 60 years old and over, 40% are 85 and over, 10 individuals are over 100 years old;
    - 60% are female, 40% are male;
    - Races represented include White-43%, Asian-14%, Hispanic 11%, Native and Pacific Islander-3%, other races or unknown-21%.

11. As the sole provider of home delivered meals in the Peninsula Health Care District, PVI Meals on Wheels increases food security and alleviates the hunger of older adults and adults with disabilities through proper nutritional support. Meals follow the DASH diet, which has been proven to support the management of several chronic diseases, including high blood pressure. Hunger has a staggering impact on senior activities of daily living. Food insecurity among seniors increases disability, decreases resistance to infection, and extends hospital stays. Experts agree that risk for malnutrition is high among seniors and adults with disabilities, especially those with inadequate income to purchase food, those who are isolated, who suffer from illness and other conditions affecting independence. The San Mateo County Area Agency on Aging's Area Plan Update July 2021-June 2022 stated that 23% of all seniors had self-care concerns about preparing meals, and 48% had financial concerns regarding financial security and money to live on. Meals on Wheels alleviates these concerns. The regular check-ins which are part of the MOW program also help to lower the need to access emergency services.

12. A PHCD grant of $60,000 will fully subsidize 30 Meals on Wheels clients for one year, based on the cost of planning, preparing and delivering the meal of $16.00 and the Aging and Adult Service reimbursement rate of $11.00 per meal. However, we do expect to serve 400 residents of the District each year.

13. The PHCD grant will be used to serve only District residents. Countywide, Meals on Wheels will serve over 1,200 clients, 42% of whom reside in the District.

14. The number of meals delivered to each client is tracked, and assessments are done initially and every six months. An annual survey is conducted to determine if the MOW program is meeting the needs of the clients.

15. Since 2016, PVI Meals on Wheels has received grants from Peninsula Health Care District to provide home-delivered meals to District residents. In 2018 and 2019 grants of $50,000 was received to continue delivery of meals to residents of San Bruno through San Mateo/Foster City. In 2020, PVI Meals on Wheels received a Community Grant of $75,000, as well as a COVID Relief Grant of $45,000. In 2021, MOW received a grant of $75,000.

16. Barbara Kalt, PVI Grant Specialist; barbarak@1pvi.org; 650-207-8738

Rebuilding Together Peninsula

1. **Organization's name:** Rebuilding Together Peninsula (RTP)

**2. Program title:** Safe at Home (SAH)

**3. Priority Funding Area request will address:** Healthy Aging

**4. Program description and the associated activities:** SAH completes free critical repairs and home safety modifications for seniors wishing to age in place and reduces the risk of accidents or falls. According to the 2021 AARP survey, 77% of seniors desire to age-in-place (AARP 2021), and according to the CDC falls are the leading cause of injury for older adults. *The ability to safely age in place is directly linked to PHCD's Healthy Aging priority area, specifically the district's desire to promote socialization and connectivity. By being able to remain in their home, low-income elderly residents can remain connected to their neighbors, active in community organizations, close to their established medical providers, and more.*

SAH has three main goals: (1) Low-income, mainly elderly and BIPOC (Black, Indigenous, Persons of Color), homeowners residing on the Peninsula have access to free home repair services that enable them to live in a dry, clean, pest-free, ventilated, safe, contaminant-free, maintained, thermally controlled, accessible, and affordable home (the National Center for Healthy Housing's ten principles of healthy homes). (2) Safety and health priorities identified in each home are addressed by our expert repair technicians, skilled volunteers and/or trusted sub-contractors. (3) Participants are equipped with the knowledge and tools necessary to identify health and safety hazards.

Each year of the two year grant cycle, the SAH program will repair approximately 100 homes (unduplicated). We estimate that SAH will reach about 250 unduplicated individuals per year (each home will have 2 or 3 residents). Of those 250 residents, approximately 18 residents will be in the Peninsula Healthcare District across approximately 10 homes. Each homeowner receives 5 services over a 3 month period: (1) Homeowner submits application and it is reviewed by RTP staff. (2) Staff conduct a comprehensive Home Safety Assessment which assesses the repairs needed. (3) Staff develop a Home Safety Plan (aka scope of work) which details how the repairs will be completed. (4) Repairs and home safety modifications are completed by our experienced repair technicians and trusted subcontractors. (5) Staff review the project and collect feedback through surveys to assess the impact of our work on the homeowner.

**5. Requested amount:** $45,000 per year for two years

**6. How funds will be used:** Funds will support SAH program costs (e.g., staff, materials, supplies, etc.) in order to repair 100 homes per year, of which at least 10 per year will be in the PHCD. RTP combines PHCD with CDBG funding in order to provide homeowners with as many repairs as possible.

**7. Total budget:** Safe at Home annual budget = $949,903. RTP annual agency budget = $2,457,025

**8. Will requested funds will launch, maintain or expand this program**: The requested funds will help expand our SAH program and manage its increasing costs. RTP is requesting increased support from the PHCD from the $30,000 per year that we have been receiving to $45,000 per year. This is for two reasons: (1) the impact of inflation, particularly on construction materials, supplies and subcontractors, has skyrocketed in the post-COVID era. The San Francisco Bay Area boasts the third highest construction costs in the world (International Construction Market Survey, 2021) meaning that most elderly, low-income homeowners simply can't afford to keep their homes in good repair. And (2) RTP is expanding SAH program this year by: (a) repairing 6 additional homes in Daly City, supported in part through a "Rebuild a Block" grant from Lowe's; (b) expanding our contract with the City of Daly City (in progress) and City of San Mateo to provide construction management services to low-income homeowners that are securing home rehabilitation loans; and (c) launching a 60-unit,

mobile-home-specific repair program, which will serve as a model to provide mobile homes with health and safety repairs. Mobile homes are often ineligible for CDBG funds because they lack flood insurance. This new project was launched in partnership with the county and four foundations and is expected to serve as a model for future mobile home repair projects across the county.

**9. Location program will take place**: Safe at Home serves all of San Mateo County; PHCD funds will support costs associated with repairing homes in the zipcodes in the PHCD.

**10. Demographics of community to be served:** Of the homes served during our last fiscal year, 100% of homeowners had low, very low, or extremely low income (per HUD standards); 82% of the households had a senior living in the home; 73% of homeowners identified as a person of color, (34% Hispanic, 15% Asian, 13% Black, and 11% two or more races); and 54% of the households had a person with a disability in the home.

**11. How the program will address health disparities:** SAH provides critical health and safety repairs to low-income homeowners, the majority of whom are elderly, persons of color, and/or people with disabilities. RTP is committed to equity, emphasizing a safe and healthy home for every person. RTP's free home repair programs address two key issues of health disparities and health equity: (1) ***Gentrification and displacement jeopardizes the well-being of low-income BIPOC communities:*** Increasing housing costs in the SF Bay Area continue to drive low-income people of color out of their communities, leading to the resegregation of the region. A 2016 report from Urban Habitat, "Race, Inequality and the Resegregation of the Bay Area" describes the dramatic shift in Black populations from the inner to the outer region, and that the Bay Area lost 22,000 Black residents from 2000-2014. The report also noted that "poverty in Latino communities increased disproportionately in the outer parts of the region." Furthermore, gentrification and potential displacement is a source of stress and trauma for low-income residents (UC Berkeley 2017). Our work is fundamentally about addressing these inequities. Many of our clients have lived in their homes for generations and, as a result of our work, can live safely, age in place and remain part of the community they love. (2) ***Unhealthy Housing Conditions Disproportionately Impact the Health of Low-Income BIPOC Communities:*** No one should have to choose between basic necessities, like food or prescription medications, and a safe and healthy home. In San Mateo County, over 31% of homeowners are paying over 35% of their income on homeownership costs. The National League of Cities states that BIPOC families are more likely to reside in communities with higher concentrations of poverty and lower housing quality than their White counterparts.

**12. Projected number of people to be served with this funding request:** Our SAH program will repair 100 homes per year, reaching approximately 250 residents per year of this two year grant.

**13. Percentage of the projected number resides in PHCD:** 10%

**14. Measurement tools used to track impact**: RTP uses four tools to measure SAH's impact: (1) Homeowner Application - gathers basic demographic and income data. (2) Project Impact Checklist - developed in partnership with the Administration on Aging and the American Occupational Therapy Association. (3) Home Safety Plan/Scope of Work – developed by Rebuilding Together Peninsula. (4) Homeowner Impact and Satisfaction Survey - developed in partnership with Actionable Insights. Low-income homeowners served by RTP's home repair programs will report the following outcomes: 90% will report RTP performed quality work in their home; 90% will report feeling safer in their home since repairs were completed; 90% will believe the repairs will allow them to age in place in their home; and 90% will report being less likely to fall in their homes since repairs were completed.

**15. Organization's history with PHCD:** RTP has received 7 grants from PHCD over the last 10 years, ranging from $15,000 in 2012 to $30,000 in 2022.

**16. Contact name, email and phone number:** Joy Dickinson, Grants Consultant, 650-201-1985, development@rebuildingtogetherpeninsula.org

# *Community Grants Program Letter of Interest Form 2022-2023*

1. **Organization Name:** Samaritan House
2. **Program Name:** Samaritan House Free Clinic of San Mateo
3. **Health Priority Need:** Preventable Diseases (diabetes, colon cancer, cardiovascular health and communicable diseases, etc.)
4. **Program description/activities:** The Free Clinic of San Mateo promotes health equity, while reducing health disparities, by increasing access to a continuum of high quality, linguistically competent and culturally sensitive, primary, specialty and preventative medical, dental and mental health care for the District's medically underserved residents who suffer chronic health issues such as diabetes, heart disease and high cholesterol.

   Activities include:
   a) Access/use of medical home, including preventive care services (physical, mental, and oral with a focus on health disparities and health equity)
   b) Diabetes care (case management and medical services, health and nutrition education)
   c) Food Pharmacy program - healthful food "prescriptions" (once per week)
   d) Vaccination Clinics
   e) Mental Health Care (individual sessions)
   f) Dental hygiene care
5. **Grant amount requested:** $350,000
6. **How funds will be used:** PHCD funds will be used for core support to improve overall physical, oral, social, and mental health status; prevent disease and disability; detect and treat health conditions to improve quality of life; and increase life expectancy, while alleviating demands placed on emergency rooms for episodic primary care for the uninsured.
7. **Total program budget**: $2,199,790
8. **Intent of funding:** Maintain an existing program
9. **Program location:** Free Clinic of San Mateo, 19 West 39th Ave., San Mateo, CA 94403
10. **Constituency Demographics:** The majority of our patients earn below 250% of the federal poverty level. Our patient population consists of 85% Latinx families, with most identifying as Spanish speakers. Patients of the Free Clinic of San Mateo are uninsured and unable to afford 'out-of-pocket' healthcare costs, such as premiums, copays or deductibles of coverage even after subsidies are applied. All cope with social, financial and cultural challenges that make it difficult to access healthcare.
11. **How program will address health disparities:** The pandemic has dramatically exposed the underlying driver of health outcomes: economic inequality and unequal access to "safe" culturally sensitive care. Samaritan House provides two major benefits in that regard:

# *Community Grants Program Letter of Interest Form 2022-2023*

1) The full spectrum of attendant services to address ALL the social determinants of health;
2) A zero-fee well-integrated "medical home" combining physical, oral and mental health.

Even in the face of a global pandemic, the Free Clinic of San Mateo continues to meet its mission to provide high quality healthcare without charge to residents within the Peninsula Healthcare District who cannot qualify for medical insurance and who do not have the ability to pay for medical care.

For 30 years, Samaritan House's Free Clinic of San Mateo has served as the "safety net for the safety net providers" in Central San Mateo County. Staffed by volunteer medical providers and dentists, the Clinic provides primary care medical and dental services and mental health care, including specialty services such as diabetic care, gynecology, dermatology, neurology, orthopedics, ophthalmology, optometry, podiatry, and rheumatology - all without charge - to the working poor. Patients receive free primary medical services, including most prescription medications, labs, and x-rays. Free dental services are integrated with our medical services, as are our behavioral health services.

Providing primary and preventive care to the medically underserved and uninsured not only benefits those receiving the care, but also accrues benefits to the community at large. Keeping residents healthy improves the workforce and economy. Having a primary source of care reduces dependence on hospital emergency room visits at a considerable cost savings. Moreover, when patients do require hospitalization, the severity and complexity of their conditions is often lower because they are receiving quality care from a primary care physician.

12. **Number of clients to be served with this funding?** 1,050

13. **Percentage of clients served reside in PHCD?** 95%

14. **Measurement tools to track impact:** eClinicalWorks, Family Development Matrix, Observation Checklist, Clarity Plus, Surveys, Internal Data Reports, PHQ9/GAD7

15. **Organization history with PHCD (funding year/amount):**
    2022 - $305,000; 2021 - $260,000 (grant), $137,604 (EHR); 2020 - $250,000; 2019 - $230,000; 2018 - $250,000; 2017 - $260,000; 2016 - $240,000; 2015 - $220,000; 2014 - $220,000; 2013 - $162,000; 2012 - $220,000; 2011 - $220,000; 2010 - $180,000; 2009 - $200,000; 2008 - $200,000; 2007 - $125,000; 2006 - $100,000; 2004 - $165,000; 2003 - $100,000; 2002 - $60,000; 2001 - $140,000; 2000 - $85,000

***Contact Information***

1. Name: Dr. John Wuchenich, Associate Medical Director, Health Care Services
2. Email: jwuchenich@samaritanhousesanmateo.org
3. Phone: (650) 713-1706

**PHCD Letter of Interest - San Bruno Park School District**

1. Organization's name: San Bruno Park School District (SBPSD)
2. Program title: Wellness Coordinator Position
3. Priority Funding Areas that the request will address: Mental Health/Preventative Health
4. Program description and the associated activities:

The Wellness Coordinator facilitates mental and preventative health activities and programming for all SBPSD students, staff, and families. The 2023-2024 academic school year will mark the twelfth year that PHCD has provided this type of support to the SBPSD, yielding positive health incomes to an estimated 1400 families annually (2050 students/ 1.5 students per family). Current wellness coordinator Marie Lukehardt has been a crucial part of this effort since 2013 and will be the Wellness Coordinator for the proposed grant period.

The Wellness Coordinator will facilitate dental screenings, provided by Sonrisas Dental (Dr. Bonnie Jue), to an estimated 250 preschoolers and kindergarteners at Allen Elementary and Belle Air Elementary. Each student who is part of the screening will receive oral health education (books and short puppet presentation) that supports positive long-term dental health outcomes. The Wellness Coordinator also works with the Healthier Kids Foundation to ensure that all students in the state-mandated grades 2nd, 5th and 8th receive dental screenings.

The Wellness Coordinator will facilitate certain state-mandated vision screenings for the District. The San Bruno Lions Club will provide vision screenings to all state-mandated elementary students and 8th graders - a total of 1000 students. Students receive a passing score or referral to a vision provider as part of the screening.

The SBPSD Wellness Coordinator will work with the Healthier Kids Foundation so that students in every state-mandated-grade (K, 2nd, 5th, and 8th - as well as preschool) receive hearing screens. SBPSD partners with San Mateo County's foster youth/homeless services and YMCA Youth Services Bureau, which provides mental health intervention. Together, these student care teams are committed to meeting health and wellness needs, combatting low educational outcomes as identified by the Get Healthy San Mateo Strategic Plan, GHSM, 2015-2020.

A critical part of the Wellness Coordinator's role is ensuring District compliance practices are in order and serving as liaison between stakeholder groups. The Wellness Coordinator: assists in development of initiatives and efforts related to attendance improvement, creation of safe and welcoming school environments; implements training to school and District staff on California Education Code and District policies and procedures related to child welfare and attendance of students; monitors and tracks 504 plans for all school sites; coordinates, monitors and/or facilitates multidisciplinary intervention teams such as Student Success Team (SST), School Attendance Review Team (SART), and School Attendance Review Board (SARB) to provide support and intervention; and serves as District Homeless and Foster Youth Liaison.

5. Requested amount: $75,000

**PHCD Letter of Interest - San Bruno Park School District**

6. How will funds be used? SBPSD will pay the Wellness Coordinator personnel salary. The full-time position is part of the central District support during the academic school year.
7. Total budget $118,980

8. Will requested funds launch, maintain or expand this program? Maintain/Expand

9. Program location: At all school sites in the SBPSD, to consist of five elementary schools and one middle school and, at times, at community partner sites (i.e., San Bruno Library).

10. Demographics of the community to be served: The Student population consists of 984 female-identifying students and 1,073 male-identifying students. The racial and ethnic breakdown is as follows: Race - Hispanic or Latino - 45.9%; White - 15.99%; American Indian - 0.15%; Asian 16.77%; Pacific Islander 5.30%; Filipino 8.41%; Black 1.17%; Multi-Ethnic - 5.93%; Unknown 0.39%.

11. How the program will address health disparities: The Wellness Coordinator directly mitigates the negative impact between health and wellness service gaps translating to poverty and low educational outcomes [GHSM, 2015-2020]. She also addresses high childhood obesity/overweight rates in San Mateo County which stand at 34% and 32% for 5th and 7th graders respectively [CDPH, 2016]. Through early interventions and community proximity, the Wellness Coordinator and partners provide alternate wellness resources for the county's northern portion, with the San Mateo County Clinic at 8 miles.

12. Projected number to be served with this funding request: 2,300 students/staff/families

13. Percentage of the projected number resides in PHCD: 100%

14. Measurement tools used to track impact: The Wellness Coordinator will use a combination of tools to track impact. She will track all mental health and preventative care supported activities on an activity log. Parents and students will complete survey assessments to measure individual impact. One tool for capturing this information is the Panorama On-line platform purchased from a previous PHCD grant award.

15. Organization's history with PHCD
PHCD grant awards similar to this request: $300,000 (2011-2012), $275,000 (2012-2013), $275,000 (2014-2015), $75,000 (2015-2016), $50,000 (2016-2017), $50,000 (2017-2018), $75,000 (2019-2020), $75,000 (2020-2021) $75,000 (2021-2022), and $75,000 (2022-2023). For all grant-funding periods, SBPSD has communicated program success to PHCD staff and board members on a regular basis via written and verbal presentations as well as health and wellness event invitations. PHCD's COVID19-focused grant award (Mental Health) of $20,000 was to cover the Panorama On-line Platform and related support.

16. Contact name, email, and phone number: Marie Lukehart, mlukehart@sbpsd.k12.ca.us

**San Mateo County Health Foundation Letter of Interest**

**1. Organization's name**

San Mateo County Health Foundation

**2. Program title**

Food Boxes for Food Insecure Families

**3. Priority Funding Area request will address**

Preventive Health

**4. Program description and the associated activities**

We started the Food Boxes for Food Insecure Families Program at the beginning of the pandemic with The Samaritan House who donates food boxes to provide food insecure families a one-week supply of locally sourced eggs, veggies, fruits, and proteins. The program currently supports 240 households.

Food boxes and bags of groceries are distributed weekly. Any patient of San Mateo Medical Center is eligible to pick up a food box and bag of groceries every Monday at the Medical Center and clinics located in Daly City, South San Francisco, Redwood City, and Half Moon Bay.

We would like to expand our food box program and create a food pantry at the SMMC main campus so patients who are coming in all week for their medical appointments can conveniently and comfortably get a nutritious food supply for their families.

Currently food boxes are distributed every Monday, but unless a patient is at the hospital at the beginning of the week, chances are they wouldn't be able to get a fresh box. These boxes include produce, meat, cheese, eggs, milk, and other perishable items. Currently, staff has to remove items from boxes and try to fit them in their office refrigerator. We need a large walk-in cooler, which would allow us to keep the food boxes intact. They would keep fresh longer and be made available to patients and their families the entire week. We would be able to help more people.

**5. Requested amount**

$21,455

**6. How funds will be used**

The purpose of this request is to purchase a refrigeration unit to be placed at the hospital. The estimated cost for a 10x10 walk-in refrigeration unit (including shipping and tax) is $21,455.

**7. Total budget**

$21,455

**8. Will requested funds will launch, maintain or expand this program**

Funding from PHCD for the walk-in cooler will both maintain and expand the Food Boxes for Food Insecure Families Program.

**9. Location program will take place**

San Mateo Medical Center - 222 W. 39th Avenue; San Mateo, CA 94403

**10. Demographics of community to be served**

Despite the fact that San Mateo County is in the middle of the Bay Area and has two cities among the top five wealthiest in the country, our research has found an increasing number of food insecure families who fall in between the federal poverty line.

For a family of four, the federal poverty line is approximately $28,000 while the San Mateo County poverty line is $146,350, according to county officials. CalFresh, otherwise referred to as food stamps, requires that its users earn an income of no more than 200% of the federal poverty line (approximately $56,000). Because California has a high cost of living, the federal poverty qualifications for CalFresh seldom apply to food insecure families. San Mateo County's current FPL is 6.7%.

San Mateo Medical Center's (SMMC) patients are as diverse as the County. As a public hospital, San Mateo Medical Center serves the poor and working poor. Of our patients, 59% are Hispanic, 15% White, 5% Black, 9% Asian.

**11. How program will address health disparities**

This program addresses health disparities in our population by providing food boxes to food insecure patients/families regardless of their socio-economic or ethnic status.

**12. Projected number of people to be served with this funding request**

1500

**13. Percentage of the projected number resides in PHCD**

75%

**14. Measurement tools used to track impact**

Right now, the program is the right size for the patients that come through, which is evident by the number of boxes that get picked up each week. We serve at least this many families: 70 at the main campus, 90 in Redwood City, 50 in Daly City/SSF, and 30 in Half Moon Bay.

At this time there is no tracking mechanism in place, but as the program grows, we may institute sign-up sheets and/or survey sheets for patient families to track demographics, family size, how often they receive food, etc.

**15. Organization's history with PHCD**

PHCD gave us $40K in 2019

PHCD gave us $20K in 20/21

**16. Contact name, email and phone number**

John Jurow, CEO; jjurow@smcgov.org; 650-573-2655

**San Mateo PAL - Peninsula Health Care District Letter of Intent 2022**

1. **Organization's name:** San Mateo Police Activities League (SMPAL)

2. **Program title:** Family Support, Education, and Mental Wellness Program

3. **Priority Funding Area request will address**

Healthy Aging – socialization and connectivity
Mental Health – prevention services and programs
Preventive Health – screenings and healthy living

4. **Program description and the associated activities:** San Mateo Police Activities League's (SMPAL) Family Support, Education, and Mental Wellness Program will use four strategies to improve student mental health:

1. Identify students dealing with stress, anxiety, depression, or involvement in gangs or crimes, primarily through school teachers and staff, police officers, our PAL Counselor, and parents.
2. Provide culturally and linguistically appropriate, individualized, mental health counseling and support services for students ages 5-18 and their families.
3. Connect at-risk students to school-based support groups that provide positive peer influences, positive role models, and opportunities to help the students develop positive self-concepts, self-acceptance, and high self-esteem.
4. Provide Parent Education Nights and communication tools to increase positive parenting, family functioning, and communication skills.

The Family Support, Education, and Mental Wellness Program is a year-round endeavor in collaboration with One Life Counseling Center for students in the San Mateo/Foster City School District. It emphasizes early intervention and developing students' social, emotional, and behavioral skill sets. This program uses several strategies to improve student mental health and family wellness through Tier 1 prevention and intervention support all students, Tier 2 interventions to provide targeted support to groups of students who need additional support for their mental and behavioral health needs, and Tier 3 interventions to support individual students with high or unique mental and behavioral health needs. These free weekly services include individual and family therapy, embedded mental health programming by One Life counselors in PAL's existing student programs, school-based group counseling, and culturally and linguistically competent care coordination for kids ages 5-18 and their families. The program prioritizes underserved, at-risk, and immigrant students who exhibit signs of emerging or acute mental health challenges.

Counseling, curriculum, and therapy are designed and led by certified therapists from One Life Counseling Center. SMPAL's Program Supervisor and our Spanish-speaking Outreach Coordinator provide school outreach, coordination, and referrals.

This year, we are expanding the program to serve all three San Mateo/Foster City high schools due to increased mental health needs among teenagers after COVID, including higher levels of crime, depression, and gang activity. The program will focus on serving immigrant and at-risk students with emerging or acute mental health challenges.

PHCD funding is requested to provide the mental health curriculum, therapy, and embedded services that One Life Counseling Center delivers. PHCD funds will allow an additional 50 at-risk PHCD students and their families to receive counseling for six months, or longer when needed.

SMPAL partners with One Life Counseling Center to ensure students and their families receive high-quality, youth-centered, and culturally competent therapy services. One Life provides certified therapists on an hourly basis, the most cost-effective model for these services.

Through SMPAL's 26 years of trust and connections within San Mateo schools and the local community, along with One Life's expertise in providing youth-centered mental health support, we can offer these cost-effective, impactful, and potentially life-saving services within the Peninsula Health Care District.

**5. Requested amount:** $60,000 per year for two years

**6. How funds will be used:** Funds provided by Peninsula Health Care District will pay for the cost of therapy and screening, which will be provided by Roy Gonzalez, Associate Marriage and Family Therapist, AMFT, who works directly with SMPAL each week as our PAL Counselor, and Jennifer Bautista, Program Manager for the Newcomer & Trauma Programs. Roy and Jennifer are full-time employees of One Life Counseling Center.

Both of these roles have supported San Mateo PAL's Family Support, Education, and Mental Wellness program by providing mental health screening services through their regular involvement in our existing programs, which includes providing screening questionnaires to SMPAL students, as well as in-person observation and interactions, individual and family therapy, bilingual services in Spanish, and culturally sensitive case management, care coordination, and mental health education.

**7. Total budget:** $100,000 **8. Will requested funds will launch, maintain or expand this program:** Expand

**9. Location program will take place:** The program will take place at over a dozen locations in the PHCD in order to make student access as easy as possible. These locations include local elementary, middle, and high schools, neighborhood community centers, The San Mateo Police Department classrooms, virtual therapy, as well as home visits.

**10. Demographics of community to be served:** Marginalized children and their families in the PHCD will be served by this grant. In 2021, SMPAL served 800 unduplicated children ages 5-18. The children come from low or very low-income families (80%), are English language learners (25%), people with disabilities (10%), foster and homeless youth (4%), Latinx (55%), Asian/Pacific Islander (21%), Multi-ethnic (12%), White (9%), and Black (3%).

**11. How program will address health disparities:** The program will reduce health disparities by providing free, culturally and linguistically competent, mental health services for low-income, BIPOC, and at-risk children and their families who are in need of this support but lack the resources to access it. The program's mental health screening services also provide the early support needed to prevent serious mental health challenges that may result in ER visits, hospitalization, or cascading effects on their school and home life.

**12. Projected number of people to be served with this funding request:** 375

**13. Percentage of the projected number resides in PHCD:** 100%

**14. Measurement tools used to track impact:** (1) Patient Health Questionnaire (PHQ-9) – Utilized to determine the severity of a client's symptoms and establish a baseline; (2) Beck's Depression Inventory - Standard best practice for assessing depression; (3) Child and Adolescent Needs and Strengths (CANS) – Tool to inform decision making, including level of care, service planning, quality improvement, and outcome monitoring, and (4) Satisfaction Survey – Measures client-reported outcomes of therapy and satisfaction with the program

**15. Organization's history with PHCD:** Peninsula Health Care District has loyally supported the work of SMPAL each year since 2015, ensuring that over 1,800 marginalized children and their families in PHCD receive the mental health and wellness support they need to thrive.

**16. Contact name, email and phone number:** Lisa Tartaglia; ltartaglia@cityofsanmateo.org; 650-522-7713

# San Mateo Union High School District

**Randall Booker, Superintendent**
**Kirk Black, Ed.D., Deputy Superintendent Human Resources and Student Services**
**Yancy Hawkins, CPA, Associate Superintendent Chief Business Officer**
**Julia Kempkey, Ed.D., Assistant Superintendent of Curriculum and Instruction**


## Letter of Interest for Peninsula Health Care District Grant Funding 2022

8 September 2022

Ann Evanilla-Wasson
Peninsula Health Care District
Director of Community Engagement
1819 Trousdale Drive
Burlingame, CA 94010

Dear Ms. Evanilla-Wasson,

On behalf of San Mateo Union High School District (SMUHSD), in cross-collaboration with our Mental Health and Wellness Program and Special Education Department, we are respectfully submitting a Letter of Interest for the Peninsula Health Care District Grant for 2022. Priority funding will advance leadership development through an intensive program at Hudson Institute, a world-class executive coaching establishment in Santa Barbara, CA. Administrators of the Mental Health and Wellness Program and Special Education Department will use coaching as a professional development strategy for district and site leaders to improve wellbeing outcomes for all learners, upskill school leaders and retain top talent in public education.

The demands of the pandemic on school leaders surpassed what any educator was ever prepared to handle. Overnight, schools relandscaped teaching, assessing and serving. Educators were forced to change the scope of their work, absorbed unforeseen job demands and managed student crises well into after school hours. Profound student data emerged with a drastic spike in suicidality and self-harm rates. With the groundswell of psychological traumas sweeping our classrooms, schools often acted as triage centers. Administrators, therapists, counselors and school psychologists were overwhelmed with vicarious trauma further compromising compassion fatigue and safety in the wake of nationwide school shootings. In surveying our teams, dominant themes of feeling understaffed and distress at work emerged as strong indicators of a decline in morale. As of January 2020, a staggering net loss of 600,000 educators was reported by the U.S. Bureau Labor of Statistics. Our team began to experience employee attrition in therapists at a higher than expected rate of 15% in a span of 3 months (June- September 2022) with the vacancies now hard-to-fill. Last school year, we witnessed a 41% resignation rate of site administrators across 6 comprehensive high schools notwithstanding the retirement of our Superintendent. Subsequent pressure was exerted on management to hire and supply more resources. As leaders, we understood that staffing was part of the solution, but more importantly, accepted that new, radical change in leadership was vital to forge ahead more wholly in education.

Administrators of the Mental Health and Wellness Program and Special Education Department work closely and plan to use coaching strategies to positively influence leadership and student outcomes. The Manager of Mental Health and Associate Manager of Mental Health are licensed through the California Board of Behavioral Sciences in Marriage and Family Therapy and Social Work. The Assistant Director of Special Education is a School Psychologist and a Board Certified Behavior Analyst. Collectively, the prospective leadership coaches have school credentials in Clear Administrative Services, School Psychology, School Counseling, School Social Work, Child Welfare and Attendance with over 50 years of experience in public education. We believe our highly qualified backgrounds position us well to take on active coaching roles in our organization. Sessions will be carried out by the aforementioned managers to SMUHSD leaders across all 8 high schools in SMUHSD, starting with our respective direct reports. The PHCD funds will be used to launch and sustain coaching strategies 1-3 outlined below in a 3 phase implementation.

1. Individually coach first level leaders including Lead Mental Health Therapists (6), School Psychologists (8) and District Social Workers (3) who deliver care to students and serve on site leadership teams across San Mateo Union High School District.
2. Offer individual or small group leadership coaching sessions to site administrators (25) and district level executives as indicated.
3. Offer individual or small group leadership coaching sessions to leaders of school counseling (6-8) as indicated.

We are requesting the full grant amount of $60K to fund 3 leaders to become certified at Hudson Institute in Santa Barbara, CA. Hudson offers a world-class, rigorous program that fosters integration, practice, feedback and reflection. From end to end, this is a 10-month commitment. The program is administered in 3 accelerated stages: LifeForward, a 4 day prerequisite workshop, a virtual one-day coaching seminar and the coaching certification program, an 8 month intensive. Admission into the certification program is contingent upon an application review. Under the supervision of a mastery-level coach, the course is designed with the professional in mind and equips candidates with techniques ready for immediate use in their setting. Hudson focuses on 4 training areas: (1) immersion in the theory and application informing today's best practices, (2) exploration of the Use of Self as a coach, (3) emphasis on their methodology, heart of change and (4) in-depth engagement in real-time learning. The commencement of the program qualifies participants to be recognized as an International Federation Coach, the gold standard for the industry. Hudson has attracted and developed high-performing professionals from all walks of life: entrepreneurs, C-suite executives in big tech, physicians, higher education leaders. With the generous grant support from PHCD, we are optimistic to join the in-person learning in Santa Barbara, CA. Described in the table below is a timeline of the earliest possible in-person courses for our team and fees for May 2023 - March 2024.

Hudson Institute for Coaching
In-person timeline and fees

| | | |
|---|---|---|
| **LifeForward** | May 9-12, 2023 | $3795 |
| **Coaching Seminar Day** | May 19, 2023 | $395 |
| **Coaching Certification Summer 2023** | July 18- 21, 2023<br>November 14-17, 2023<br>March 19-22, 2024 | $15,500 |
| - | - | $19,690 per person |
| - | - | **$59,070 total for 3** |

The impact of leadership coaching can go wide and deep in schools. Advancing the skills of first level leaders (17), site administration (25) and school counselor department chairs (6-8) can ultimately influence the education and wellbeing of our 9,200 high schoolers and set the stage for future generations. Our students are residents of San Bruno, Millbrae, Burlingame and San Mateo. Across the Mental Health and Wellness Program and Special Education, we have over 40 therapists and school psychologists who are practitioners in prevention and instruction (social emotional lessons, drop in counseling, relevant in-service trainings), targeted interventions (group counseling, alternatives to suspension) and intensive, individualized services (crisis management, assessments, 1x1 sessions). International evidence conveys that improvements at school are less likely to occur without the presence of effective leadership. Sustainable, large-scale educational reform is a result of continuous guidance from people in positions of power.

Coaching is a teachable, observable and measurable skill. Leadership coaching in schools gives the momentum for real change to happen through empowerment, shared responsibility and compassion for practitioners at various levels. It can transform conventional supervisory relationships based on managerial advice and dependency to one of self-awareness, accountability and self-initiated action. Well-trained coaches assist in unlocking an employee's potential to maximize job performance and that person's contribution to the field. It is the role of a coach to help people identify challenges, bring their own solutions to life and make forward movement now for the betterment of the future. This is a stark contrast, but necessary balance to traditional training of mental health professionals who are skilled in investigating, diagnosing and resolving issues rooted in the past. Coaching drives people and organizations forward by establishing goals that are

specific, measurable, achievable, relevant and time-bound (SMART). Specific tools for measuring impact and outcomes will be provided by Hudson's training model and implemented by SMUHSD coaches.

In closing, SMUHSD holds a well-established partnership with PHCD. Our collaboration has brought the vision of a robust and internal wellbeing program into fruition. In 2016, we were awarded a very generous seed grant to bring on 3 Mental Health and Wellness Coordinators to lift our initiative. Since then, we have served thousands of PHCD residents: students and families. We are now serious and ready to invest in our efforts in school leaders and give them high-quality support. Coaching for educators can be rare, contracted, expensive and short-lived, often with professionals from outside of schools. Not all coaching programs are created equally and do not provide the length, depth and competitive edge Hudson Institute has to offer. This grant would afford us the ability to innovate a sustainable infrastructure for our leaders that can be invaluable at onboarding (new hires or first year administrators), continuously as a part of our own leadership development programming or acutely in challenging circumstances. Upskilling leaders can optimize talent management and retain employees in a highly competitive job market. We are confident that coaching can open up spaces for educational leaders to connect, show up and serve as their whole selves.

We look forward to submitting our full application in October 2022. I am happy to answer any questions at my contact information below. Thank you for your time and consideration.

Respectfully submitted,

Joanne Michels, LCSW, PPSC
Associate Manager of Mental Health Programs
jmichels@smuhsd.org I 415-944-0354

**Peninsula Health Care District 2023 Community Grants Program**
**Second Harvest of Silicon Valley**
**Letter of Intent**

1. Organization's name: Second Harvest of Silicon Valley

2. Program title: Alleviate hunger by providing nutritious foods to low-income residents of San Mateo, Foster City, Millbrae, San Bruno, and Burlingame

3. Priority Funding Area request will address: Preventive Health – screenings and healthy living

4. Program description and the associated activities (see *EXAMPLE*): In FY22, we served **22,396 clients/month** (52% more than 14,743 clients/month pre-pandemic) and distributed **over 9.9 million total food pounds** (209% more than 3.2 million total food pounds pre-pandemic) to residents in PHCD service areas of San Mateo, Foster City, Millbrae, San Bruno, and Burlingame. In FY23, with ongoing pandemic, inflation, increased food and fuel costs, we continue to serve more people. To meet the increased need, we will collaborate with 14 nonprofit partners in PHCD service areas - to distribute food to clients at walk-up sites, drive-thru sites, and through home deliveries. Our food distribution services provide PHCD service area residents access to nutritious foods (close to 50% fresh produce), nutrition education, CalFresh enrollments (for self-sufficiency) – all these enable residents to stay well-nourished, healthy, and lead enriched lives. A typical client receives $250 worth of free groceries every month. All clients and nonprofit partners will receive food, **free of cost**.

5. Requested amount: $50,000

6. How funds will be used: **100%** of your valuable **$50,000 grant** will be used to purchase nutritious foods that we will distribute **free of cost** to low-income clients that will participate in our various programs operating on a daily basis at **20 program sites** in San Mateo, Foster City, Millbrae, San Bruno, and Burlingame. Nearly **50%** of all food distributed *will be fresh produce*; **25%** high quality protein, and **25%** healthy whole grains. Grant funds will particularly enable to serve **100,000 meals** over next year.

7. Total budget - $6,690,047.00

8. Will requested funds will launch, maintain or expand this program: Maintain

9. Location program will take place: San Mateo, Foster City, Millbrae, San Bruno, and Burlingame

10. Demographics of community to be served: Our clients include families and individuals: working parents, children, seniors living on fixed incomes, and college students struggling to pay for their education. With ongoing COVID-19 pandemic and inflation, many people in both San Mateo and Santa Clara counties continue to seek help from Second Harvest to meet their nutritional needs and/or navigate social services for the very first time.

11. How program will address health disparities: Results from the 2021 survey of 6,000 Second Harvest client households indicate:

- 57% of respondents reported having < $100 in savings right now.
- 43% of individuals we serve are Asian; and 41% are Hispanic/Latinos.

Second Harvest's food distribution and integrated additional services (many provided in collaboration with our partner agencies) help clients to gain easy access to a wide variety of nutritious foods, which alleviates many diet-related and food insecurity related issues, improves clients' stability and enables them to maintain good health through balanced nutrition. Overall, our services better our client's health and help low-income children, families, and seniors to cope and rebuild their lives during this extraordinary COVID-19 pandemic and inflation.

12. Projected number of people to be served with this funding request: 22,000

13. Percentage of the projected number resides in PHCD: 100%

14. Measurement tools used to track impact: Each month, Second Harvest's program staff works with 14 partner agencies in abovementioned PHCD's service areas to collect monthly data to measure impact through outputs e.g. number of clients served (includes number of children, adults, and seniors served), total food pounds and fresh produce pounds distributed.

Additionally, Second Harvest staff uses MyPlate Report to track nutritional value of food distributed, measures number of clients screened for CalFresh (formerly food stamps) income eligibility, number of CalFresh applications submitted and approved for eligible clients, and client referrals to local food programs in San Mateo County.

We also conduct ongoing qualitative discussions with abovementioned partner agencies to refine and innovate our programs and operations to improve gaps in food distribution services.

In CY2023, your valuable grant will enable below program goals and outcomes in abovementioned PHCD service areas:

1) We will provide 22,000 food-insecure clients/month with 9.9 million total pounds of nutritious foods (including 50% fresh produce, 25% protein, 25% healthy grains). Of all clients served, we expect 27% (or 6,110) will be *seniors* and 27% (or 6,075) will be *children*.
2) We will serve clients through collaboration with 14 partners (community centers, churches, residences, schools, colleges) at 20 program sites.
3) We will partner with 14 medical partners who will screen and refer ~400 food-insecure medical clients for food services to provide holistic care.
4) We will pre-screen over 2,400 clients in San Mateo County and enroll at least 650 eligible clients so they can receive monthly CalFresh benefits that they can use to purchase food.

15. Organization's history with PHCD: Second Harvest has received generous support from PHCD for several years, dating back to at least 2015. Recent Grants: 2020 - $50,000 (Building A Healthier Community), and $49,500 (COVID-19 support. 2021-$50,000 (Alleviate hunger by providing nutritious foods to low-income residents in PHCD service areas). Your steadfast support and generosity have made a tremendous impact on our work to provide nutritious food to district residents, including seniors, college students, and families with children, who have benefitted from accessing nutritious foods and stayed healthy while dealing with the economic challenges due to the pandemic and inflation.

16. Contact name, email and phone number: Sunita Jethmalani, sjethmalani@shfb.org, 408-266-8866, ext. 231

**Peninsula Health Care District – Letter of Interest**
**StarVista's Youth Mental Health and Substance Use Prevention Programming FY22-23**

**1. Organization's name:** StarVista

**2. Program title:** StarVista's Youth Mental Health and Substance Use Prevention Programming

**3. Priority Funding Area request will address:** Mental Health Prevention Services & Programs

**4. Program description and the associated activities (see EXAMPLE):** Between the persisting COVID-19 pandemic and the mounting range of challenges youth face daily, growing numbers of San Mateo County youth are struggling with their mental health. San Mateo County Health Department data shows a steep increase in poor youth mental health, substance use, and primary care referrals to youth mental health clinicians. Despite these alarming trends, many youth cannot obtain the support they need amidst significant provider shortages, not knowing where to access help, and the numerous barriers that prevent access to needed services.

To address these critical needs, StarVista will provide a diverse combination of mental health and substance use services for youth through its Insights and Crisis Center programs. The specific strategies and services to be funded through this grant are below:

**CISPC's strategies** for mental health and crisis intervention:

- **Strategy 1: Educational presentations** to provide schools and community with vital knowledge and support around mental health and suicide (virtually and/or in person)
- **Strategy 2: Crisis intervention services**, including a 24/7 crisis hotline and a Youth SOS team to support youth in person
- **Strategy 3:** Virtual **youth peer support services** via an online chat room and texting line

**Insights' strategies** for youth with both mental health and substance use challenges:

- **Strategy 1:** Mental Health/Substance Abuse **Prevention and Early Intervention**, including individual and family counseling and peer group support sessions for youth
- **Strategy 2:** Mental Health/Substance Abuse **Treatment**, including case management and individual/family/group therapy rooted in evidence-based treatment models
- **Strategy 3**: Mental Health/Substance Abuse **Education**: Education to support youth through mental health topics (e.g., emotional regulation, anger management, healthy communication) and substance use topics (impacts of drug use on the adolescent brain, coping with peer pressure, effective refusal strategies, and healthy coping mechanisms)

Insights and CISPC have provided effective youth mental health and substance use services for decades with proven results. Services will be provided by a diverse team of experienced mental health clinicians and extensively trained staff and volunteers. Many youth who struggle with mental health don't know where to turn for help. PHCD's support would ensure these services continue to be available to any youth in need through the COVID-19 pandemic and beyond.

**5. Requested amount:** $60,000

**6. How funds will be used:** Funds will be used for personnel (staff salaries, benefits), operating costs (office and program supplies, rent, mileage reimbursement, trainings, etc), and a small portion of administrative costs. This will strengthen StarVista's ability to provide the above services to youth across the District and ensure PHCD youth, their families and the wider community will gain knowledge and access to vital resources and support they need.

**7. Total budget:** $3,042,323

**Peninsula Health Care District – Letter of Interest**
**StarVista's Youth Mental Health and Substance Use Prevention Programming FY22-23**

**8. Will requested funds will launch, maintain or expand this program:** Maintain

**9. Location program will take place:** Insights serves clients virtually and at its accessible in-person offices. CISPC's YSOS services take place in person wherever a youth is in crisis (e.g., home, school, community, etc), and CISPC's in-person mental health presentations happen in schools and/or accessible community settings. CISPC's hotline, teen chat and texting line take place virtually. Many services can be virtual or in-person to best meet client needs.

**10. Demographics of community to be served:** StarVista is dedicated to serving individuals of all backgrounds and demographics and strives to reach communities who have faced increased challenges/barriers (e.g., income level, immigration status, insurance). This grant specifically seeks to impact youth and the people who support them through their challenges. Our agency especially welcomes populations at higher risk of negative health outcomes and remains dedicated to reaching youth who have experienced challenges receiving services in the past.

**11. How program will address health disparities:** This project will address health disparities by 1) providing equitable, accessible services that address *and* prevent youth mental health challenges, and 2) increasing community awareness of mental health knowledge and resources. To ensure equity and minimal barriers to access, our low-to-no cost services will be provided in multiple languages virtually and in-person without requiring insurance or immigration status. Unaddressed hardships can spiral into long-lasting negative health outcomes (e.g., self-harm, homelessness, violence, and suicide), and support is vital to ensuring healthy youth outcomes.

Mental health, suicide prevention and substance use are often closely related and entwined. For example, addressing substance abuse can reduce risks of suicide and poor mental health outcomes. Conversely, improvements in mental health often result in decreased levels of substance use and suicidality. By folding mental health, crisis intervention, suicide prevention and substance use work into one collaborative project, we can comprehensively address the unique and multifaceted needs of our youth to ensure their health and ability to thrive.

**12. Projected number of people to be served with this funding request:** 2,140

**13. Percentage of the projected number resides in PHCD:** 67%

**14. Measurement tools used to track impact:** To track impact, **Insights** uses an enrollment form completed by participants during the initial intake/assessment. Insights enters client information into a secure electronic medical records system, Efforts to Outcomes, which allows secure access to the data to assess impact and complete reporting.

**CISPC** uses post-presentation and post-chat surveys, forms completed by staff during hotline calls and outcome rating scales for all client follow-up appointments to track impact. CISPC staff enter their data into their crisis-focused database, iCarol, for reporting, assessing trends, identifying program gaps and/or community needs, and determining success.

**15. Organization's history with PHCD:** PHCD has supported CISPC and Insights for over 20 years, enabling thousands in the District to receive life-changing services and build healthy, successful lives. We are grateful for the opportunity to build on our impactful partnership.

**16. Contact name, email and phone number:**

**Lauren Heminez** (she/her), Grants Manager; Grants@Star-Vista.org, 650-591-9623
**Patricia Dalao** (she/her), Grant Writer; Grants@Star-Vista.org, 650-465-3373

VIA HEART PROJECT

September 8, 2022

To the Peninsula Healthcare District Grant Committee,

We are all aware the sudden cardiac arrest is the leading killer of high school athletes, the number one cause of death on a school campus, and kills more Americans each year than breast cancer, lung cancer, prostate cancer, and AIDs *combined*. Cardiac arrest is a swift killer, often with little to no warning. The only effective treatment for cardiac arrest is providing quick access to defibrillation. We do this by placing automated external defibrillators (AEDs) and teaching CPR. We prevent cardiac arrest by screening youth for congenital heart defects, before they lead to sudden death.

Over the past six years, Via Heart Project has worked closely with Peninsula Healthcare District and dedicated much of our time and resources into making all public schools in San Mateo County Heart Safe. We have done this by placing AEDs, teaching CPR, providing maintenance solutions for the AEDs, and providing preventative heart defect screenings on the youth in our community. We have created the Peninsula Heart Safe Program, and are proud to report that ALL public k-12 schools in San Mateo County currently have AEDs on site. With your help, we have placed 115 AEDs, held over 35 training classes, and screened 1,136 youth within your boundaries. You have helped us find 19 youth within the PHCD boundaries with potentially serious heart issues that required follow up care!

We will TREAT cardiac arrest by providing nine AEDs to community locations. We will continue to increase our bystander response rates by providing CPR/AED training for up to 10 community locations. We will PREVENT cardiac arrest by providing a youth heart defect screening in 2023 to the community.

We have identified two local entities as priorities for providing early defibrillation within the community. Those entities are CORA and two of the San Mateo Community College District campuses. These locations have the foot traffic and serves a higher risk demographic that warrants having access to early defibrillation on site. CORA, San Mateo's only entity providing intimate partner abuse prevention services, has two office buildings that serve 25-50 employees as well as local families daily. The San Mateo Community College District campuses serve upwards of 25,000 students, visitors, and faculty in both daily and evening classes. Funds for this program will allow AEDs to be placed at CORA, the Skyline Campus and the College of San Mateo Campus. The demographic of the community served is widespread and includes all who visit Skyline or San Mateo College campus and all who work at or utilize CORA services.

1725 Clay Street | Suite 100 | San Francisco, CA 94109
Office: 800-284-0125 | Fax: 415-226-0675 | www.viaheartproject.org

VIA HEART PROJECT

We would also like to continue the Peninsula Youth Heart Screening Program with an event within the PCHD boundaries in 2023. We are currently working with the school districts and college district on finding the right location to host the lifesaving event that will serve up to 500 local youth between ages 12 and 25. We will work diligently with the site and community to market the screening to include all areas, schools, communities and socioeconomic groups. Most of the population served will be residents of San Mateo County, however we do not turn away youth registering to our heart screening events based on where they reside. All are welcome and included. The marketing and PR will be centered within the district boundaries.

**Program Budget**

| Item | Cost | Quantity | Total Cost |
|---|---|---|---|
| Stryker CR2 AED | $2500 | 9 | $22,500 |
| Wall Cabinet | $235 | 2 | $470 |
| CPR/AED Training Class | $1000 | 10 | $10,000 |
| Youth Heart Screening | $25,000 | 1 | $25,000 |
| | | | $55,470 |

The Peninsula Heart Safe Program will continue to treat and prevent cardiac arrest within its boundaries by expanding the program. We will do this by increasing the number of accessible AEDs, increasing the bystander response rate, and finding heart defects before they lead to cardiac arrest. Together, we will make San Mateo a Heart Safe Place to live, work, learn and play.

With Heart,

Liz Lazar
Executive Director
Via Heart Project
liz@viaheartproject.org
Mobile: 650-861-2376
Office: 800-284-0125

**1—Organization's name:** Villages of San Mateo County

**2—Program title:** Healthy Seniors at Home—Aging better in a caring "virtual village" community

**3—Priority Funding Area request will address:** Healthy Aging — Socialization and Connectivity

**4—Program description and the associated activities**

As adults age they can feel their lives are shrinking and they experience increasing isolation. Mid-Peninsula Village is a reciprocal "virtual village" community where aging adults can grow and laugh with and rely on one another in ways that improve the quality of their lives and expand their choices at all stages of aging. We enable aging adults to age better, in a connected, caring and engaged community with other seniors at the same stage of life, and with resources that make it possible for our members to continue to live independently in their homes or apartments.

At the heart of our work is *neighbors helping their neighbors*. Mid-Peninsula Village has cultivated a vibrant group of generous and caring volunteers of all ages—high school students to octogenarians— who support a range of social and educational activities for our members and services that enable our members to remain independent.

***Social Activities that encourage connection and engagement***

- *Excursions* to the Bay Area museums like the Hiller and DeYoung museums, cultural outings to the Nutcracker at Christmas, Niles Canyon train trips, and myriad other local places of interest;
- *Walks* in our beautiful parks and seashore;
- *Coffee gatherings* with topical speakers addressing healthy aging and current events, musicians, artists, and writers—all as they engage in lively conversations with the presenters and their peers.

***Volunteer led services for our members***

To support our members to continue to live independently, every month our volunteers provide 200 hours of individual support to our members who live in the PHCD district:

- *Transportation*: driving members to medical appointments, to get groceries or to do personal errands;
- *Home Improvements:* our handy people do home safety inspections and install needed equipment, fix doors and walkways and build and maintain summer gardens that our members delight in.
- *Friendly Visits:* many of our volunteers visit our members weekly just to chat and say hello.

No matter what the task, all of these services provide opportunities where mutual friendships blossom. Our members and volunteers alike describe the friendships they make as the best part of belonging to Mid-Peninsula Village.

**5—Requested amount:** $20,000

**6—How funds will be used:** We will use these PHCD grant funds in six ways – (1) Subsidizing village membership dues of low-income village members, (2) Home safety improvements, (3) Medical alert devices for our most vulnerable members, (4) Excursions and enriching social expenses, (5) Lyft rides when volunteer drivers are unavailable, and (6) Office & administrative costs.

**7—Total budget:** $260,000

**8—Will requested funds launch, maintain or expand this program**

The funds will allow us to expand both our member and volunteer base by at least 10% in 2023, and begin outreach to expand into the San Bruno and Millbrae communities. We will also increase the number and variety of social and educational programs that we offer to our members.

**9. Location program will take place**

All of our village services are delivered at the homes of our individual village members, and social events are held at various facilities in our local communities. PCHD funds will be used solely to support Village members living in San Mateo, Burlingame, Hillsborough, San Bruno and Millbrae.

**10. Demographics of community to be served.**

Currently, our Mid-Peninsula Village members (i.e. our VSMC members who reside in the PHCD district) range in age from 67 to 100 years old, with a median age of 84. Eighty percent are women and twenty percent are men.

In the upcoming year expanding both the economic and racial diversity of our members is a priority for all of the Villages of San Mateo County (VSMC). Our executive director and two influential Board members will be participating in a learning network with other Villages across the state to explore promising diversity practices. A VSMC Committee will also be created to put action steps in place to further diversify our membership base.

**11. How program will address health disparities.**

Millions of older adults across the country struggle with feelings of loneliness, isolation and a lack of regular companionship, according to the results of a University of Michigan-AARP poll of adults between the ages of 50 and 80. Indeed social isolation and loneliness is a public health epidemic with negative health impacts including shorter life expectancies, coronary heart disease, high blood pressure, stroke, dementia, depression and anxiety. And social isolation is costly, with an estimated $6.7 billion in additional Medicare spending annually.

In 2011, the Robert Wood Johnson Foundation conducted a national survey of 1000 physicians in a study, Health Care's Blind Side. Eighty five percent of physicians said unmet social needs directly lead to worse health for their patients and eighty five percent said that social needs are as important to address as medical conditions. And only twenty percent of physicians felt confident to address their patients' unmet social needs.

Villages are an antidote, creating intentional caring communities built on principles of reciprocity and supporting connections that preserve choice and self-determination. Optimal health requires more than health care – it includes social care, the kind of social care that Villages provide creating interpersonal connections and social support, and the mutual aid of caring neighbors who volunteer who provide access to resources such as transportation and home repairs and improvements.

**12. Projected number of people to be served with this funding request**: 300

**13. Percentage of the projected number resides in PHCD**

25% reside in the PHCD. However, 100% of this PHCD grant will be spent on clients residing in the PHCD. We track all services and programs provided to members by their zip code, which allows us to ensure that we use the PHCD grant funds only for village members within the PCHD district boundaries.

**14. Measurement tools used to track impact.** We track impact with six tools – (1) We tabulate the total number of individual services delivered to all of our village members using our *Run My Village* computerized database tool, (2) We conduct a quantitative survey of our village members to find out whether belonging to our village significantly improves their ability to age in place with dignity and grace in their homes, (3) We track the % of village members who renew their membership each year, which is a very concrete measure of perceived value, (4) We track the % of village members whose membership dues are subsidized by scholarships, (5) We track the growth in our total number of village members, and (6) We track the number of new volunteers trained and vetted.

**15. Organization's history with PHCD.**

PCHD has supported Mid-Peninsula Village with consecutive grants since our founding: 2015, 2016, 2017, 2018, 2019, 2020, 2021 and 2022.

**16. Contact name, email and phone number.**

Eric Hanson. Chair, Mid-Peninsula Village, Villages of San Mateo County

e_g_hanson@yahoo.com, (650) 773-7275

VISTA CENTER
for the blind and visually impaired

# Peninsula Health Care District – FY23 Letter of Intent

**LOI Submitted by: Vista Center, Palo Alto**

1. Organization's name

**Vista Center for the Blind and Visually Impaired**

2. Program title

**Vision Loss Rehabilitation Program**

3. Priority Funding Area request will address

Our Program addresses all 3 Grant Focus areas for 2023 by making it possible for seniors to learn strategies to remain independent after vision loss, to live with confidence, increase socialization and reduce isolation. Our holistic service approach promotes positive mental and physical health outcomes and avoids any need for premature institutionalization.

Healthy Aging - Socialization & Connectivity
Mental Health - Prevention Services & Programs
Preventive Health - Screening & Physical Activity

4. Program description and the associated activities (see EXAMPLE)

"Vision Loss Rehabilitation Program" supports an individual who is losing or has lost their vision by teaching them necessary skills to maintain or regain their independence; by leveraging resources, learning skills of daily living, moving safely within their home / community. Following activities promote adjustment to vision loss and quality of life:

1) Initial psychosocial need assessment to create an individual service plan
2) Individual or Group Counseling - Information & Referral, Support Group, Case management
3) Low Vision Exams
4) Vision Loss Rehabilitation instruction including Adapted Daily Living Skills (ADL), Orientation & Mobility (O&M), Assistive Technology (AT) training

Activities are delivered virtually, at the client's home in PHCD or at Vista Center Office and Clinic in Palo Alto. Program / Service staff are all highly experienced in vision loss and Certified /Credentialed in specialty. PHCD Grant of **$46,284** will fund low or no-cost services for 48 low-income seniors and adults and to expand our community outreach.

VISTA CENTER
for the blind and visually impaired

5. Requested amount – Vista Center respectfully requests FY23 program funding of **$46,284**

6. How funds will be used:

To fund Direct Costs for Personnel/Staffing and Program related Non-Personnel Expenses.

7. Total budget - $347,234

8. Will requested funds launch, maintain, or expand this program

Maintain and Expand current program.

9. Location program will take place

Vista Center main office in Palo Alto and at Client's home in San Mateo, Foster City, Hillsborough, Burlingame, Millbrae, San Bruno, Pacifica, South San Fran, SFO and other

10. Demographics of community to be served

Serving all ethnicities as are typical in this district, all genders, mostly seniors and some adults. 90% served through the grant will be low-income.

11. How program will address health disparities

Grant funding will enable us to offer **low-income participants** free visual aids and rehabilitation training (ADL / O&M) which are typically not covered by medical insurance, therefore provide affordable access to care, reduce disparities, and promote health equity.

12. Projected number of people to be served with this funding request - 48

13. Percentage of the projected number resides in PHCD - 100%

14. Measurement tools used to track impact

Measurement tools – Client Surveys and Pre and post-test administered for each activity

15. Organization's history with PHCD

- PHCD Grant funded for "Vision Loss Rehabilitation Program" in FY22 for **$30,000**
- Covid-19 related Program Grant funded in June 2020 for $17,000

16. Contact name, email, and phone number:

Poonam Malik, pmalik@vistacenter.org and 650 858 0202 (O) / 408 833 8399 (M)

**1. Organization Name:** WomenSV
**2. Program Title:** Survivor Support Program
**3. Priority Funding Area:** Mental Health- Prevention Services & Programs

**4. Program Description:** Not all abuse is physical. A perpetrator can exert control by tracking his partner's whereabouts, isolating her from extended family members and friends, cutting off access to joint finances, threatening to take the children away from her and attacking or undermining her accomplishments and capabilities. While WomenSV addresses physical and sexual violence—in fact about 35% of our survivors have experienced non-fatal strangulation--our specific area of focus is coercive control, including emotional, financial, legal and technological abuse.

Research reveals that in abusive relationships, coercive control is among the top three lethality risks, along with gun ownership and ending the relationship. Recognizing this danger, the state of California incorporated coercive control legislation into Family Code 6320 in January of 2021, acknowledging coercive control as a safety risk to domestic violence victims and making it grounds for a restraining order in family court.

WomenSV's Survivor Support Program helps victims of intimate partner violence find the means to address abuse more safely and effectively and build healthier lives for themselves and their children. The program is unique in that it supports an often-overlooked population: survivors involved with a powerful and sophisticated abuser who engages in coercive control, including emotional, financial, legal and technological abuse and other more covert tactics to control, manipulate, threaten, isolate and ultimately entrap an intimate partner.

While most domestic violence agencies are well-equipped to address physical and sexual violence, they often lack resources to serve survivors impacted by these more subtle forms of abuse. Program services include a domestic abuse helpline, one-on-one intake sessions and ongoing follow-up meetings, weekly support groups, and connections to resources (e.g., financial planning, personal counseling, private investigators, etc.). Services are provided by WomenSV's Domestic Abuse Advocates who help survivors create a customized safety plan with specific strategies to address each form of abuse they have experienced.

**5. Requested Amount:** WomenSV respectfully requests a two-year grant in the amount of $60,000 ($30,000/year)

**6. How Funds Will Be Used:** Funding from PHCD will support the salary of an additional Domestic Abuse Advocate, which will significantly shorten the amount of time women have to wait for an initial intake meeting. Advocates work directly with clients, conducting client intake interviews and providing initial and ongoing safety planning, threat assessment and follow up. Advocates support clients by accompanying them to court hearings and police stations so they do not have to face their abuser alone. In addition, Advocates co-facilitate weekly support groups and answer WomenSV's Domestic Violence Helpline.

**7. Total Budget:** $442,294

**8. Launch, Maintain or Expand Project:** Funding will be used to maintain our existing Survivor Support Program.

**9. Location of Program:** WomenSV primarily serves women from the Silicon Valley area; over 70% of our clients are from Santa Clara County (54%) and San Mateo County (17%). However, since receiving national exposure on the Megyn Kelly Today Show and Good Morning America in 2018, we have seen a steady increase in calls from around the country. Funding from PHCD will be used to support women residing in the PHCD.

**10. Demographics of Community Served:** A large percentage of the survivors WomenSV serves are living close to the poverty line and have no access to community assets, as their partners have taken total control of the community property. While on paper it may look like they are in the middle-to-upper income bracket, in reality they are often struggling to pay the rent and put food on the table. WomenSV conducts an initial intake session with each woman we serve. Based on the responses from women served last year:

- 79% either had no access or limited access to household funds
- 89% experienced financial abuse
- 95% experienced emotional abuse
- 89% experienced physical abuse
- 100% stated that they were afraid of their partner

**11. How Program Addresses Health Disparities:** The program addresses health disparities by offering long-term individual support of each survivor as opposed to short-term, crisis-only interventions that traditional DV agencies offer. At WomenSV, we establish a lasting relationship with each survivor and maintain it for as long as she chooses.

**12. Project Number of People Served With Funding:** 150

**13. Percentage of Number Residing in PCHD:** 17%

**14. Measurement Tools to Track Impact:** WomenSV uses the following tools to measure the program's impact: Client Intake Form (helps us track the types of abuse clients are experiencing and strategies to address each type); Pathway to Freedom (helps chart clients' progress towards their own desired outcome); Attack/Defense Strategy Wheel (helps clients identify the various areas of life that have come under attack and the strategies to use in response); Danger Assessment survey (administered periodically to assess current level of threat and progress towards achieving client safety); WEB (Women's Experience with Battering) Scale (administered at intake and 6-12 months later to evaluate a client's perceptions and responses to her partner's abusive behavior); Client Outcome Survey; attendance records; follow up forms; Program Tracking form

**15. Organization's History with PHCD:** WomenSV received a $20,000 grant from PHCD in 2021 and a $25,000 grant from PCHD in 2022.

**16. Contact Info:** Ruth Darlene Ruth@WomenSV.org (650)996-2200

**From:** Ruth Darlene
**To:** Ann Wasson
**Subject:** Grant numbers
**Date:** Friday, September 23, 2022 12:16:53 AM



Hi Ann
We are in the process of revising our strategic plan in order to reach more survivors. We are projecting that with this new plan we should be able to serve 220 women and 20% of them will be from San Mateo County.
We'll be talking tomorrow (Friday) at 2:00PM if all goes according to plan, but I wanted to get these numbers to you as soon as possible.
--Ruth

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**Ruth Darlene, M.A.**
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