SAFETY NET CLINIC COALITION OF SANTA CRUZ COUNTY

October 2010

Report to the Community: 2020 Vision for a Safety Net System of Care

The result of a two-year collaborative planning process, this Report documents the Safety Net Clinic Coalition's 2020 Vision for a Safety Net System of Care, including the means to achieve it. The subsequent action plan affirms the Coalition's commitment to ensuring a healthy community for all residents, particularly in the context of national health reform.

Safety Net Clinic Coalition of Santa Cruz County

REPORT TO THE COMMUNITY

EXECUTIVE SUMMARY

Safety net clinics play a vital role in our local health care system by providing services to people regardless of their ability to pay. From school-based clinics to full-service primary care, the eight members of the Safety Net Clinic Coalition of Santa Cruz County (SNCC) collectively provided 250,000 patient visits to local residents in 2009.

Given the economic downturn and California's on-going budget crisis, it is particularly challenging for clinics to keep pace with the complex health care needs of their patients. However, in a forward-looking effort, clinic leaders (with input from their boards of directors) convened to assess the new opportunities afforded by local, state, and national reforms. Through two day-long retreats and numerous subsequent meetings, clinic leaders developed consensus on a 2020 Vision for a Safety Net System of Care designed to take advantage of pending reforms and to help build capacity to serve growing needs.

This Report to the Community documents that vision, which prioritizes quality primary care and prevention as well as a whole person orientation that is coordinated and integrated across all elements of the health care system. Toward that end, clinic leaders selected five goals to work toward, both individually and in partnership with each other:

1. Launch a collaborative Quality Improvement process within SNCC;
2. Develop Patient Centered Medical Homes;
3. Increase access to urgent care and same-day services;
4. Expand capacity to provide and coordinate medically, socially, and behaviorally complex care; and
5. Organize collaborative approaches to increasing geographic access.

SNCC's vision affirms its commitment to ensuring a healthy community for all residents. SNCC's goals are designed to prepare the clinics to expand primary care services to thousands of individuals newly covered by national health reform in 2014. The evidence shows that communities with strong primary care systems have better quality health care with lower costs. Such is the vision that will guide the collective action of the Safety Net Clinic Coalition of Santa Cruz County in the months and years ahead.

Safety Net Clinic Coalition of Santa Cruz County l October 2010

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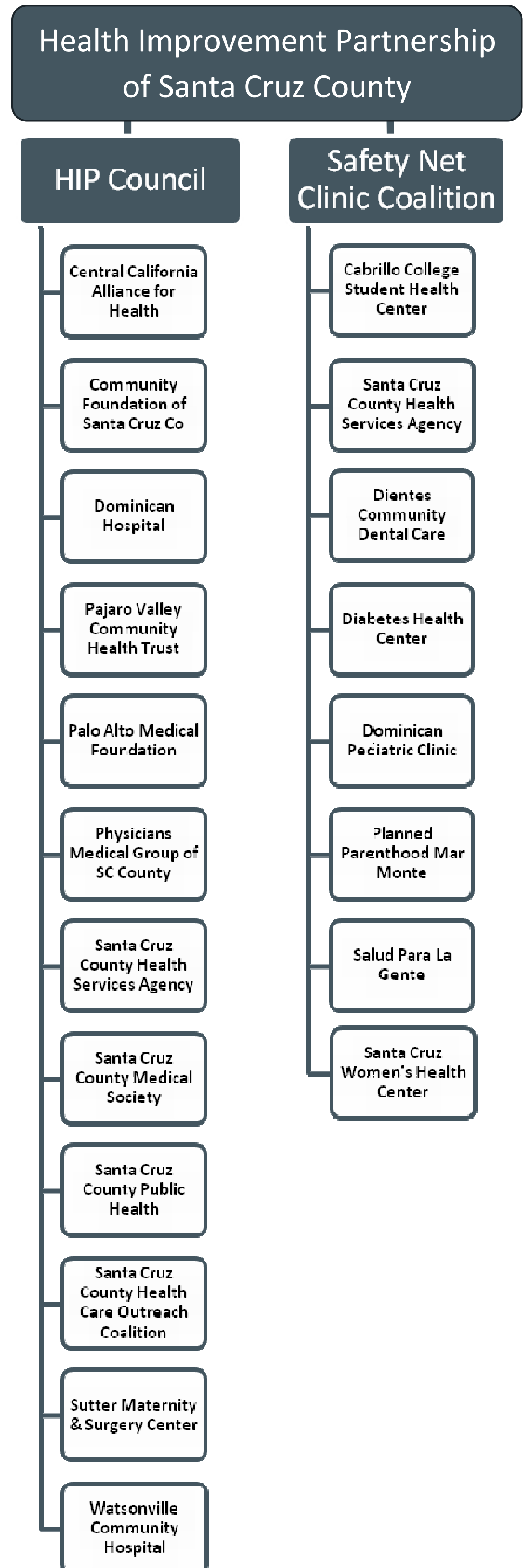

The first half of this report provides an overview of the Health Improvement Partnership and its Safety Net Clinic Coalition. It describes new opportunities posed by national health reform, the State's Coverage Initiative, and the Central California Alliance for Health's incentive programs. The second half of the report responds with a 2020 Vision for a Safety Net System of Care and the action steps Clinics will take to achieving it.

THE HEALTH IMPROVEMENT PARTNERSHIP OF SANTA CRUZ COUNTY

The Health Improvement Partnership (HIP) is a non-profit coalition of public and private health care organizations dedicated to increasing access to care and building a stronger local delivery system. In an industry dominated by fragmentation and competition, HIP provides a common voice for health care improvement on behalf of the community and serves as an incubator for effective solutions.

Incorporated in 2005, HIP initially focused on specific projects such as Healthy Kids[1] (an enrollment and coverage program) and Make Your Wishes Known (a partnership with Hospice Santa Cruz to promote advance directives). In the run up to state – and later, national – health reform, HIP led public information efforts to explain the local implications of reform through its newspaper columns and community policy forums.

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[1] www.schealthykids.org

Today, HIP's activities increasingly focus on systems improvement, including reducing costs, and improving quality and population health. HIP is also playing a greater role in care coordination. Its Health Navigator Pilot, launched in 2009, provides hands-on help to low-income, uninsured, recently hospitalized patients. The Navigator coordinates medical care, including enrollment in Medi-Cal or County benefits if the individual is eligible, assistance with discharge medications, linking to a regular source of primary care, and help accessing shelter or other social services.

In 2009, Santa Cruz County's Safety Net Clinics provided 250,000 patient visits, a 10% increase from 2008.

Another example of HIP's systems approach is its Baby Gateway program which not only enrolls eligible newborns into Medi-Cal coverage before they leave the hospital, but also assigns them to a primary care provider, and provides mothers with important well-baby care, including orientation to a book called, "What to Do if Your Child Gets Sick." Early data indicate that the combination of these interventions is reducing inappropriate emergency room use.

The Safety Net Clinic Coalition

Recognizing that strong safety net clinics are integral to a high-performing system, HIP is committed to supporting the Safety Net Clinic Coalition (SNCC), a subset of clinic organizations that work together to address the challenges unique to their patients and operations. Collectively, the clinics provide 250,000 patient visits a year to low-income residents.[2]

SNCC is composed of eight distinct organizations that provide an array of services to diverse patient populations: a student health center; a diabetes education program; a dental clinic with school-based outreach programs; a hospital-based pediatric clinic; reproductive services clinics with primary care; a women's clinic with integrative medicine; a comprehensive migrant health clinic with school-based clinics; and county clinics that focus on the homeless. Together, the clinics play a vital role in our local health care system by serving low-income individuals regardless of their ability to pay, including uninsured, under-insured, and publicly insured patients. The clinics deliver linguistically and culturally competent care on an in-patient basis, and they also offer community outreach and education programs.

Safety Net Patient Profile 2009

68% earn less than 100% FPL
46% are uninsured
37% are Medi-Cal covered
70% of adults are female
23% are farm workers
64% are Hispanic
38% are under age 19
42% are 20-44 years
4% are 65 or older

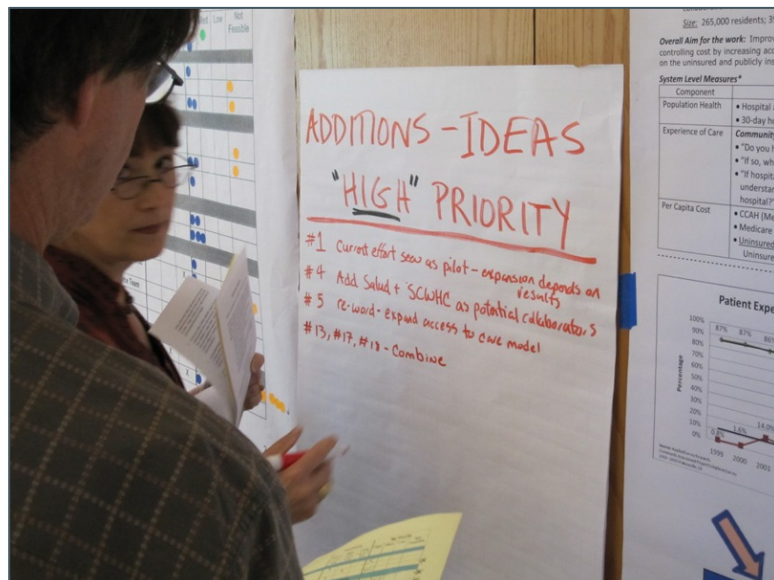
[2] Safety Net Clinic Coalition data survey, 2009.

The Challenges Facing Safety Net Clinics

While the safety net clinics play a vital role in providing health care to low-income residents, they currently face financial and operational challenges to serving a high need patient population.

First, the clinics face a growing demand for services by patients with complex health care needs. These needs include chronic conditions that require intensive treatment and case management, in addition to psychosocial issues requiring behavioral health, housing, or other social services.

At the same time, the majority of SNCC patients are at poverty level, and so they typically access treatment episodically because they cannot afford on-going care. Two-thirds of safety net clinic patients have incomes below 100% of the Federal Poverty Level (FPL) – about $10,000 annually for an individual. According to a recent report by the UCLA Center for Health Policy Research, 22% of Santa Cruz County residents – 53,000 people – were uninsured for all or part of 2009.[3] Our local 2009 Community Assessment Project telephone survey found that 47% of our County's Latino respondents were uninsured.[4]



The economic crisis – and resulting loss of employer-based health coverage – has further exacerbated the need for comprehensive primary care, including oral health, mental health and substance abuse services. County unemployment hit a record high of 15% in 2010 and over 25% in Watsonville, compared to 12% in California and 11% across the nation.[5]

Reimbursement that does not always cover the cost of care is another challenge. Medi-Cal is currently the largest safety net clinic payer source, covering 37% of all patients.[6] Fortunately, Salud Para La Gente and the County Health Services clinics are Federally Qualified Health Centers (FQHC), which means they receive an enhanced, cost-based form of Medi-Cal reimbursement. In turn, FQHC status helps subsidize the cost of uncompensated services to the clinics' uninsured patients who make only modest, sliding fee payments. Dientes and Women's Health Center also receive FQHC reimbursement through a contract with the County to serve homeless patients. On the other hand, most SNCC members receive straight (non-FQHC) Medi-Cal reimbursement which typically does not cover all costs associated with the care they provide.

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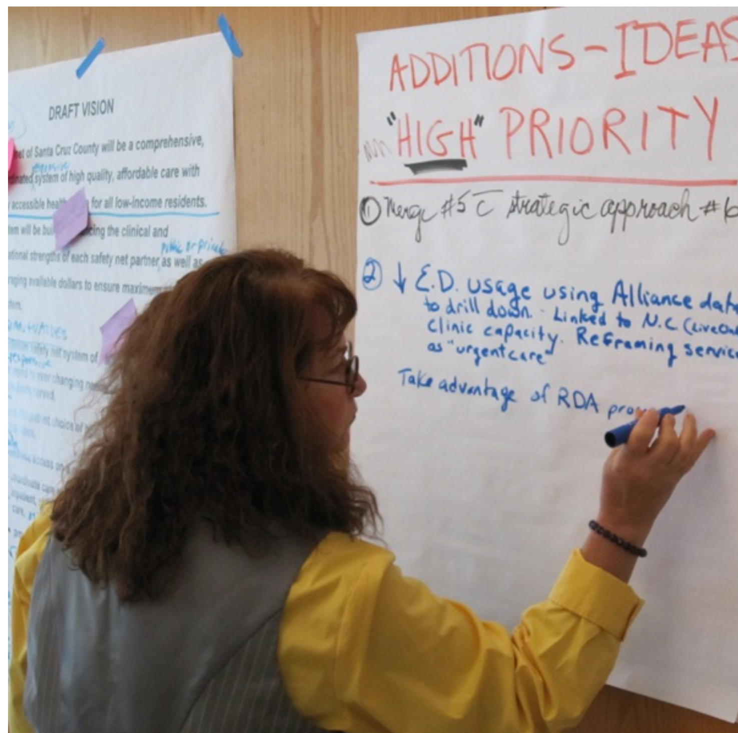
[3] Lavarreda, Shana Alex, et al, "California's Uninsured by County," *UCLA Center for Health Policy Research*, August 2010.
[4] Applied Survey Research, "2009 Comprehensive Report," C*ommunity Assessment Project,* United Way of Santa Cruz County, 2009.
[5] *Santa Cruz County Sentinel,* March 10, 2010.
[6] SNCC data survey, 2009.

In 2009, California eliminated adult Medi-Cal dental benefits. This change is a major loss to Medi-Cal patients, who typically have significant dental needs but also to Dientes and Salud Para La Gente, which lost a critical source of revenue to help sustain services to low-income adults.

Other payer sources provide important reimbursement to both FQHCs and non-FQHCs, but unfortunately many of these have suffered reductions due to State budget cuts and are continually under threat of further erosion. These include FamPACT and the Children's Health and Disability Program (CHDP) for teens and children respectively, and the Breast and Cervical Cancer Control Program for women. California's budget has eliminated the Expanded Access to Primary Care Program, a critical source of clinic funding to provide primary care to the uninsured.

In addition to revenue constraints, clinics face other on-going challenges. A 2008 survey of the clinics showed that their priority challenges included crowded facilities, difficulty recruiting providers due to Santa Cruz County's high cost-of-living, and the financial and operational challenges of implementing electronic information systems.[7]



[7] SNCC data survey, 2008.

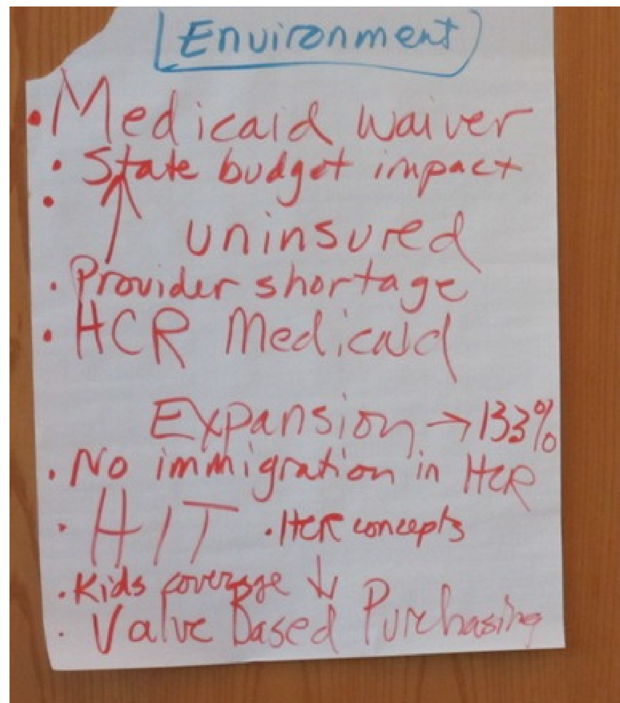
Safety Net Clinic Snapshot	
Cabrillo College Student Health Center	Provides services to Cabrillo college students, including treatment for minor injuries and illnesses, monitoring of some chronic conditions, immunizations, physicals, and testing for pregnancy, HIV/AIDS, tuberculosis and other conditions. Personal counseling services are available on a short-term basis. SHS makes referrals to community agencies and other local resources to help with more serious or chronic medical problems.
County Health Services Agency	Serves over 11,000 patients via three clinics: Emeline Clinic and Homeless Persons Health Project in North County, and the Crestview Clinic in Watsonville. Provides primary care, urgent care, family planning, pediatric, mental health and other services.
Diabetes Health Center	Works to prevent and reduce the incidence of complications associated with diabetes by providing culturally competent Diabetes Prevention and Self Management Education and Medical Nutrition Therapy to about 1,000 Pajaro Valley area residents. Partners with safety net clinics and other providers for referral and follow-up care.
Dientes Community Dental Care	Full service, stand-alone dental clinic providing comprehensive services to over 6,400 individual patients at its mid-county location. Also manages a Children's Dental Outreach Program at eight elementary schools throughout the County, as well as outreach education at community health fairs and events.
Dominican Pediatric Clinic	Serving nearly 1,500 patients, provides well-child visits, sick visits, consultative evaluations, immunizations, lab, and X-ray services, with a focus on special needs infants. The clinic partners with Stanford's Lucile Packard Children's Hospital pediatric specialists who provide subspecialty care at the clinic's facilities on a regularly scheduled basis.
Planned Parenthood Mar Monte	Provides over 41,000 patient visits annually at two clinics in Watsonville and downtown Santa Cruz. Services include a range of high quality, affordable reproductive and general health services, pregnancy testing, STD screening and treatment, cancer screening, pediatrics, adult primary health care, and transgender services. PPMM also conducts extensive health education outreach services to area schools and other organizations. In addition, PPMM provides local pregnant and parenting teens with weekly support and education through our "Teen Success" program.
Salud Para La Gente	Provides a coordinated network of high quality, comprehensive, primary care health care services (including medical, dental, vision, and elder day) to over 23,000 individual patients (including some residents of Monterey and San Benito counties). Salud operates four clinic sites, an adult day health center and seven school-based medical and dental clinics at elementary and middle schools in the Pajaro Valley.
Santa Cruz Women's Health Center	Provides affordable and quality primary care services (as well as perinatal education and counseling, mental health counseling, health education, and integrative medicine) to nearly 5,000 women and children; additionally runs a promotora program that deploys community health workers at outreach and screening events throughout the community.

Looking Ahead: New Opportunities

The good news is that national health reform, the state Coverage Initiative, and the Central California Alliance for Health's enhanced provider payment incentives offer new opportunities to address the current challenges.

National Health Care Reform

The Affordable Care Act (ACA) authorizes many insurance reforms, not least of which is the expansion of Medicaid to all individuals on the basis of income up to 133% Federal Poverty Level. The Central California Alliance for Health estimates that in 2014 there will be 8,400 residents newly eligible for Medi-Cal. Such an expansion poses both benefits and challenges to the safety net clinics. On the one hand, clinics will see a significant increase in the number of insured, compensated care patients, a potential boon to financial operations. On the other hand, it is expected that the newly eligible Medicaid patient will have greater health care needs including significant chronic conditions, due to pent up demand for services they've had to ignore in the past due to cost. Moreover, the safety net clinics can expect competition from private providers (who in Santa Cruz County currently serve 51% of Medi-Cal patients) for these newly insured individuals.



ACA also includes major new funding for FQHCs, including expanding the number of FQHC-designated organizations locally; establishing new sites, expanding facilities and making other capital improvements for current FQHCs; increasing the FQHC provider workforce; and boosting Medicare reimbursement to FQHCs through an improved cost-based formula similar to Medicaid.

ACA includes funding for Community-Based Collaborative Care Networks and other innovations of care that might provide new funds for both HIP and SNCC to lead the coordination and integration of care for patients across the provider spectrum. This effort includes expanding HIP's Health Navigator pilot.

Finally, ACA also includes funding for public health and prevention as well as to address social and economic barriers to good health (access to healthy foods, safe walkable communities and more) through new Community Transformation Grants.

California Medi-Cal Waiver and Coverage Initiative

Medicaid waivers from the federal government grant states permission to experiment with their Medicaid programs to make them more efficient and effective. California is seeking to renew its 1115 Medi-Cal Waiver to more effectively serve high needs/high cost patients such as the elderly and disabled. The Coverage Initiative (CI) – a funding opportunity embedded within the Waiver – provides funding for Counties to expand coverage to the uninsured. The CI is envisioned as a bridge to the ACA's Medicaid expansion in 2014. It aims to improve the health of uninsured individuals now (linking them to comprehensive care and getting a jumpstart on managing chronic conditions), thereby reducing the state's share of Medi-Cal costs to cover them in 2014. Critically, the CI also promotes the Patient Centered Medical Home delivery model. The CI's goals mirror SNCC's goals very closely, focusing on the whole patient, providing a team approach to primary care, and offering coordination with other health care providers and social services. Santa Cruz County Health Services Agency is developing its CI proposal to the State in conjunction with the Safety Net Clinic Coalition. While certain benefits requirements are still being set at the State and Federal levels, the CI is seen as a unique interim step to ACA implementation.

Central California Alliance for Health: Quality and Care-Based Incentives

The Central California Alliance for Health (Alliance), our County's Medi-Cal Managed Care plan, continues to offer clinics a valuable revenue opportunity through its payment incentive programs that reward providers for specific quality of care indicators in three main areas:

- Preventive care (childhood immunizations, mammography, cervical cancer screening, well child check-ups, etc);
- Care of chronic conditions (diabetes, asthma); and
- Appropriate use of the emergency room

As a result, many clinics will qualify for enhanced bonus payments due to the high quality of care they provide, which in turn helps to compensate for other under-reimbursed services. In 2009, the Alliance distributed $10.9 million in primary care incentive payments to Santa Cruz and Monterey County providers.

> **What is a Patient Centered Medical Home?**
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> . . . a team-based model of primary care led be a personal physician who provides continuous, coordinated care throughout a patient's lifetime and across all elements of the health care system. [A PCMH] facilitates partnerships between patients, physicians, and the patient's family to ensure access to comprehensive preventive, acute, chronic, and end-of-life care. [8]

In 2011, the Alliance will begin phasing in its new Care-Based Incentive (CBI) program that reinforces the practice elements of the patient centered medical home, and includes additional rewards for reducing preventable hospitalizations. These rewards respond to the goals of ACA and the CI by echoing the Agency for Health Care Research and Quality's conclusion that "good outpatient care can potentially prevent the need for hospitalization, [and] early intervention can prevent complications or more severe disease."[9]

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[8] Patient Centered Primary Care Collaborative, http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home

[9] *Prevention Quality Indicators Overview.* AHRQ Quality Indicators. July 2004. Agency for Healthcare Research and Quality, Rockville, MD. http://www.qualityindicators.ahrq.gov/pqi_overview.htm.

The Alliance's CBI program reinforces important patient-centered outcomes that improve health and reduce pain and suffering. For providers, CBI scores can prompt a significant payment incentive to help build capacity and increase their primary care effectiveness. For policy makers, a reduction in preventable hospitalizations has the potential to reduce health care spending.

2020 VISION

SNCC's vision and goals respond to the challenges and opportunities described above by transforming and strengthening primary care in order to improve quality, increase revenue, and build capacity.

2020 Vision for a Safety Net System of Care

The health care safety net of Santa Cruz County will be a comprehensive, well-coordinated system of high quality, affordable care with an easily accessible medical home for all low-income residents. The system will be built by balancing the clinical and organizational strengths of each safety net partner as well as by leveraging available dollars to ensure maximum stability. The optimum safety net system of care will:

- Prioritize primary and preventive care services in order to improve quality, improve the patient experience, and reduce costs;
- Coordinate care effectively across levels of treatment-primary care, specialty care, inpatient, skilled care, and rehab;
- Provide culturally competent care;
- Build a county-wide quality improvement system to track health outcomes, and identify opportunities for improvement;
- Adopt electronic health records that will allow for connectivity to other health care and community-based organizations to promote integrated care management and effective referrals for hospital, specialty and community based care;
- Respond to ever-changing needs of the communities and residents served;
- Provide patient choice of both public and private providers; and
- Address access on a county-wide, geographic basis.

ACHIEVING THE VISION

In order to achieve their 2020 Vision, clinic leaders prioritized five goals:

1. Launch a collaborative Quality Improvement process within SNCC
2. Develop patient centered medical homes
3. Increase access to urgent care and same day services
4. Expand capacity to provide and coordinate medically, socially, and behaviorally complex care
5. Organize collaborative approaches to increasing geographic access

1. LAUNCH A COLLABORATIVE QUALITY IMPROVEMENT PROCESS WITHIN THE SAFETY NET CLINIC COALITION

Background

One of the most significant outcomes of the SNCC planning process was agreement to launch a collaborative Quality Improvement (QI) process to analyze quality data provided by the Alliance for its Medi-Cal members. Under the guidance of HIP's physician consultant, SNCC medical directors recently agreed to share specific clinical quality outcomes with each other so as to understand their own strengths and weaknesses, and to learn best practices from each other in order to improve outcomes in areas of need. This step demonstrates a heightened level of trust that has been cultivated over time within the Coalition. Furthermore, the goal of Quality Improvement goes hand-in-hand with Goal #2, advancing the Patient Centered Medical Home (PCMH). The QI strategy ensures that providers monitor metrics to evaluate improvement efforts, while the PCMH model provides the tools to help implement those improvements such as open-access scheduling, effective use of health information technology, and implementing a team-based approach to primary care.

Action Steps toward Quality Improvement

- **Share QI Data.** Continue to review and discuss quality metrics provided by the Alliance for its members who are safety net clinic patients. Where certain providers have achieved superior outcomes, best practices can be shared to guide improvement in other clinics. For issues that are common to all clinics, such as reducing preventable hospitalizations, clinics may find it more effective to work together on quality initiatives, rather than each clinic working in isolation.

- **Educate SNCC members.** In service to the QI metrics, ensure that SNCC providers, administrative leaders and staff work from a common definition of the Patient Centered Medical Home, understand how it is operationalized, and coordinate a self-assessment within individual clinics to evaluate their capacity to redesign their primary care services as a PCMH, and as measured through the QI process.

2. DEVELOP PATIENT CENTERED MEDICAL HOMES AS A WAY TO INCREASE PREVENTIVE CARE, IMPROVE QUALITY, AND INTEGRATE AND COORDINATE CRITICALLY NEEDED MENTAL HEALTH AND OTHER SERVICES.

Background

The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients and their personal providers,[10] and when appropriate, the patient's family. Hallmarks of the medical home include quality and safety, enhanced access to care, and a payment structure that appropriately reimburses for patient-centered care management work that falls outside of the face-to-face visit.

Four leading health care professional organizations representing approximately 333,000 providers, developed the following joint principles to describe the characteristics of the PCMH:[11]

- Personal provider – each patient has an ongoing relationship with a personal provider trained to provide first contact, continuous and comprehensive care.
- Provider directed medical practice – a personal provider leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- Whole person orientation – the personal provider is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This approach includes care for all stages of life, preventive services, chronic care, acute care, and end-of-life care.
- Care is coordinated and/or integrated across all elements of the health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services).
- Care is facilitated by registries, electronic tools, including electronic health records, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
- Care includes mental health, substance abuse and oral health services.

Action Steps toward Patient-Centered Medical Homes

- **Expand the Health Navigator Pilot.** Increase the number of Health Navigators in order to increase effective coordination for uninsured patients needing Medi-Cal enrollment assistance, medications

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[10] A personal provider is defined as a physician or nurse practitioner under physician supervision, supported by a team of that may include nurses, educators, case managers, and behavioral specialists.

[11] Adapted from *Joint Principles of Patient-Centered Medical Home,* American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA), March 2007

and supplies upon discharge, linkage to a regular source of primary care, and other social service referrals.

- **Increase Insurance Enrollment.** Increase enrollment for uninsured and under-insured patients to ensure that children and adults are enrolled into a full benefit program for which they are eligible (Medi-Cal, Healthy Families, Healthy Kids). Partner with the Santa Cruz County Health Care Outreach Coalition (a community-wide network of certified enrollment assisters) to increase enrollment.

- **Move toward interoperable health information technology.** Strengthen patient data sharing capabilities and electronic connectivity within individual clinics, among clinics, and with other health care organizations in the County.

- **Incorporate behavioral health into primary care, and vice versa.** Identify evidence based models for partnerships between behavioral health and primary care clinics to address the full scope health needs of people with both behavioral and general health care conditions. Such partnerships would involve a bi-directional approach for clearly identified target populations, ensuring appropriate primary care services in behavioral health settings as well as behavioral health services in primary care settings; and

- **Identify funding to implement a PCMH system.** HIP staff will look for new funding opportunities to promote PCMH within the safety net clinics, including incorporating patient education, prevention, behavioral health, and dental services.

3. INCREASE ACCESS TO URGENT CARE AND SAME-DAY SERVICES TO REDUCE INAPPROPRIATE EMERGENCY ROOM USE AND DIRECT PATIENTS TO PRIMARY CARE.

Background

As noted above, enhanced access to primary care is a hallmark of the PCMH. This enhancement includes systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and practice staff. Dominican Hospital data show that many patients who are linked to safety net clinics are utilizing emergency department services during the day, for conditions that could be treated in the clinics. The 2009 CAP survey reported that nearly 27% of respondents said that the Emergency Department is their regular

source of care – more than twice the rate of the 2007 survey.[12]

This goal also addresses growing quality of care and cost issues for the Alliance, which seeks to reduce inappropriate emergency room use by its members. Since 2006, the Alliance has provided a financial incentive to providers to reduce their members' use of the emergency room for non-emergent, low acuity concerns that could be better treated in the office setting. This payment rewards practices to actively educate patients about appropriate emergency room use, and implement system changes, such as expanded hours, to expand primary care access.

Action Steps to Reduce Inappropriate Emergency Room Use

- **Increase same-day access** at all clinics by exploring best practices, sharing experiences among clinics and identifying technical assistance needs and resources, particularly as they relate to open-access scheduling of patients to accommodate same-day care needs;
- **Increase urgent care services** through new partnerships with hospitals and medical groups in all areas of Santa Cruz County;
- **Develop new Emergency Department diversion strategies** (e.g., expand Project Connect's successful case management model, expand the Health Navigator pilot, or explore the potential for developing resources for a collaborative mobile emergency mental health response capability).

4. EXPAND CAPACITY TO PROVIDE AND COORDINATE COMPLEX CARE, PARTICULARLY FOR THE MEDICALLY, SOCIALLY, AND PSYCHOLOGICALLY COMPLEX PATIENT.

Background

The Clinics identified patients with both medical complexity (patients with multiple chronic conditions or coexisting mental health conditions) and nonmedical complexity (language barriers, unstable home situations, and socioeconomic issues) as requiring more coordinated care. Clinics often cannot single-handedly provide the range of services these complex patients require. For example, a significant number of patients with chronic health problems have psychosocial problems that typically require the care of a mental health professional. Other complex patients include the frail elderly, those who take multiple prescription drugs, patients with progressive illness, and patients who frequently visit the emergency department. SNCC members additionally identified lack of access to cancer treatments as a continuing problem for South County residents. Adequately addressing the needs of complex patients may require new resources and partnerships with mental health providers, substance abuse treatment, and others.

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[12] *Community Assessment Project Comprehensive Report,* United Way of Santa Cruz County, 2009.

The California Healthcare Foundation reports that 7% of Medi-Cal fee for service beneficiaries account for 75% of costs, reflecting an urgent need to better manage complex care. Clinics with expanded capacity to provide and coordinate complex care are also more likely to perform well on the Alliance's chronic care indicators.

Action Steps to Expand Capacity to Provide Complex Care

- **Expand partnerships** among clinics, County Mental Health/Alcohol and Drug Services and Central California Alliance for Health to decrease barriers to mental health and substance abuse services in primary care and begin to expand the provision of integrated behavioral health services at all clinic sites including but not limited to County clinics. (See also the action steps in Goal #1, above);

- **Expand clinic participation in Access to Care programs** to improve access to specialty care and patient education;

- **Improve electronic exchange of patient information** among clinics, specialists and hospitals to support referrals and receipt of consultation/discharge reports; and

- **Remove fiscal barriers** to serving this population, for example, monitor legislation regarding Medicare Prospective Payments for existing FQHC medical sites, which would enhance funding to treat the complex needs of frail, disabled, elderly patients (SNCC's current Medicare population is relatively small, however the County clinics in particular serve a significant number of "pre-elderly" patients).

5. ORGANIZE COLLABORATIVE APPROACHES TO INCREASING ACCESS ON A GEOGRAPHIC BASIS (INCLUDING DENTAL AND MENTAL HEALTH SERVICES) FOR HIGH-NEED POPULATIONS AND NEIGHBORHOODS IN THE COUNTY.

Background

While zip code shouldn't pre-determine an individual's health status, data reveal significant health care disparities that fall along geographic lines within the County. There are distinct differences between North and South County access and outcomes, and there are pockets of need in specific neighborhoods such as Live Oak. Clinic members identified this goal as a way to spur collaboration both with each other, and with community groups and other agencies. Two underserved areas are detailed below, but clinics should also consider whether their current service areas reveal gaps in access, or whether new partnerships between clinics could help expand services to other areas or patient populations.

- **Pajaro Valley** disparities are sharply defined. According to the 2009 CAP Report, rates of poverty, unemployment, the number of uninsured and level of educational attainment all point to a more disadvantaged South County population. In 2007, the CAP survey included a larger South County survey showing that South County residents suffer from multiple disparities such as decreased

regular source of healthcare, increased diabetes, increased obesity and increased reports of medical needs going unmet.

- **Live Oak**, the third largest population center in the County with 25,000 residents, is also underserved for care to low-income residents. According to the Live Oak Family Resource Center, almost 15% of children live below the federal poverty level and there is no regular, on-going health clinic. The Rotacare Clinic in Live Oak (a free clinic staffed by volunteer physicians) is open two hours per week and provides 1,000 visits annually, 60% of which were to Live Oak residents. Santa Cruz Women's Health Center provides some health screening services via its peer-to-peer promatora education program and Dientes' Children's Outreach Program serves Live Oak and Gault elementary schools.

Most of the County's undocumented residents live in the Pajaro Valley or Live Oak. Since the undocumented will not benefit from national health reform legislation, they will continue to be vulnerable to poverty, language, cultural and other barriers to care. Targeting these underserved areas will help address the health care needs of undocumented children and adults.

At the same time, clinics may also consider new partnerships to improve access to mental health and oral health services for their patients. For example, formalized referral systems between primary care clinics that don't provide dental services with those clinics that do, could ensure that patients (particularly children) receive essential dental services. As noted above, cultivating collaboration between safety net clinics and mental health providers could better integrate primary care in behavioral health settings, and vice versa.

Finally, initiatives designed to improve the quality of life within specific high-need geographic areas are an emerging area of interest among local funders, education, social services, and public safety and public health leaders. Pipeline models like the Harlem Children's Zone (HCZ)[13] are being explored within the Santa Cruz County Children's Network[14], a social service collaborative that is chaired by the County Education Superintendent. HCZ's "pipeline" model offers new ways to integrate health care services into comprehensive initiatives designed to break the cycle of generational poverty and improve education outcomes.

[13] www.hcz.org
[14] http://www.unitedwaysc.org/Childrens_Network.php

Action Steps to Increasing Access on a Geographic Basis

- **Focus on Live Oak.** Work with Live Oak community, Redevelopment Agency, schools and social service agencies to plan and implement a comprehensive primary care clinic in Live Oak which includes medical, dental, mental health and substance abuse services;
- **Focus on Pajaro Valley.** Expand services within the Pajaro Valley, including migrant health services, expanded school-based services, and/or place-based pipeline programs. (The Watsonville/Freedom area has been designated as Medically Underserved Area for primary care for low-income residents, enabling loan-forgiveness and other federal/state benefits to providers (including primary care, mental health, and dental providers) in these areas of the County;
- **Collect and utilize disparities data.** Introduce collection of Health Adjusted Life Expectancy (HALE) to report disparities in terms of quality of life rather than solely length of life. Use the data to develop strategies to reduce disparities, and to assess our progress over time.
- **Promote a place-based initiative** to develop a local Harlem Children's Zone, by integrating health, social services, and education in a pipeline model targeting high risk children (from birth through college) in high risk neighborhoods.

This Report reflects the work of the **Safety Net Clinic Coalition of Santa Cruz County,** with special thanks to:

Cabrillo College Student Health Center	Marion Brodkey RN
Santa Cruz County Health Services Agency	Rosemarie Hendrix DO
	Rama Khalsa PhD
	Gerald Landers
	Poki Namkung MD
	Renee Robinson
	Christine Sippl MPH
	Leslie Tremaine Ed.D.
	Michelle Violich MD
Dientes Community Dental Care	Will Hahn
Diabetes Health Center	Raquel Ramírez Ruiz
Dominican Pediatric Clinic	Salem Magarian MD
	Sister Michaella Siplak
Planned Parenthood Mar Monte	Cathy Bright
	Jen Hastings MD
Salud Para La Gente	José Chibrás MD
	Sara Clarenbach
	Sister Julie Hyer OP
Santa Cruz Women's Health Center	Pat Meehan MD
	Amy Peeler MPH

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Eleanor Littman RN MSN, Executive Director
Kamila Burns, Executive Assistant
Leslie Conner, Program & Policy Director
Dianna Guzman MEd, Health Navigator
Barbara Palla MD, Consulting Physician

1600 Green Hills Road, Scotts Valley, CA 95066 l 831.430.5604 l www.hipscc.org l www.schealthykids.org

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