SANTA CRUZ SAFETY NET CLINIC COALITION
Meeting Summary
November 14, 2017
Facilitator: Barbara Palla

Meeting Purpose

The purpose of this meeting was to share information about local case management programs, receive feedback to shape a new workforce diversification project, and discuss the future structure of SNCC and SNCC MD.

Case Management

Six organizations briefly shared information about their efforts to implement case management programs.

- Melanie Rager, Care Management Director of Central California Alliance for Health, presented about their Intensive Case Management program. The grant program provides funding for high-volume primary care practices to add care management staff, such as licensed clinical social workers, medical social workers, addiction counselors, community health workers, housing navigators, etc. The patient eligibility requirement focuses on Medi-Cal patients who are high utilizers of the emergency department (ED) that have four ED visits or three inpatient stays within a year and at least two medical or behavioral chronic conditions. Four clinics in Santa Cruz County have received this funding: Salud Para La Gente East Beach Clinic, Santa Cruz Community Health Centers East Cliff Family Health Center, and Santa Cruz County Health Services Agency clinics at Emeline and Watsonville.
- Andrea Martinez, Fellow, and Llendl Aquino, Data Analyst, of Dignity Health, presented Passport to Health (P2H), a program to reduce unnecessary emergency department and inpatient utilization by providing more robust care at the clinic level for patients who are frequent users of Dominican Hospital. The program is a partnership between Santa Cruz Community Health Centers, Santa Cruz County Health Services Agency, and Dominican Hospital; the clinics are responsible for case management, enrollment, reporting, and data sharing, while Dominican is responsible for providing the clinics with ADT (Admission, Discharge, Transfer) reports for enrolled patients. To be enrolled in the program, a patient must have had four ED visits in the past three months or three in-patient stays in the past six months. From July 2016 to May 2017, P2H identified 370 eligible patients.
- Kelly Debaene, DVM, Epidemiologist, and Jorge Mendez, Senior Health Services Manager, of Santa Cruz County, presented Cruz to Health (C2H), a Whole Person Care Pilot Program. The program is an initiative to improve care management of Medi-Cal beneficiaries with co-occurring chronic care conditions and history of high utilization of multiple systems. C2H's primary services are those not billable to Medi-Cal. The target population must be receiving primary care at Santa Cruz County Health Services Agency clinics and must be diagnosed with a mental health or substance use disorder, along with a history of repeated and avoidable medical or psychiatric interventions and/or co-occurring chronic health conditions.
- Mark Stanford, PhD, Director of MAT Services, and Robin Oakey, Project Coordinator, of Janus of Santa Cruz, presented about Central Coast Recovery Options, a program aimed to increase access to substance use disorder treatment, reduce unmet treatment need, increase the number of buprenorphine prescribers, and reduce opioid overdose related deaths through prevention, treatment, and recovery activities. The program uses a hub and spoke model; the "hubs" are opioid treatment programs--which coordinate care through consultations, technical assistance, and bi-directional referrals--and the "spokes" are buprenorphine providers in the primary care setting. With support from the hubs, spokes provide ongoing care for patients with mild addiction, while the hubs act as subject matter experts, caring for patients with severe cases. In the first year, the Santa Cruz hub will have six spokes and the Watsonville hub will have four; in year two, Santa Cruz will expand to fifteen spokes and Watsonville to eight. In the second year, Central Coast Recovery Options is projected to serve 1840-2300 patients.
- Bill Beighe, Chief Information Officer of the Santa Cruz Health Information Organization, presented the CrossTX program. CrossTX does not provide a direct service, but rather an infrastructure for the above

programs to function. CrossTX is a care management tool that connects a patient to their entire team of care providers. The system goes beyond clinical referrals with the ability to securely share referrals with non-clinicians, such as transportation or housing providers, as needs are identified by the patient's care team. CrossTX facilitates communication between care teams and other health and social service entities and updates the care team as a patient interacts with those services.

In small groups, meeting attendees identified challenges of implementing these programs and possible solutions. Some challenges identified were the need for universal consent forms to share patient information, to engage emergency medical systems and law enforcement in these conversations, to prevent duplication of services and gaps in care, understanding how to enroll patients into these programs, and addressing the needs of undocumented people and other people without health insurance.

Workforce Diversification Project

- Shelly Barker, HIP Project Manager, presented a brief overview of a new workforce diversification project to solicit feedback from the group. HIP received a $20,000 grant from Kaiser Permanente-Northern California Region to address workforce diversification in the safety net. In this project, HIP plans to focus on the need and use of non-licensed professional staff who serve as culturally competent community representatives providing health coaching and patient navigation services. The project goals are to increase the capacity of clinics to deliver culturally competent health education, coaching, and patient navigation services through recruitment, training, and retention of community health workers, health coaches, and patient navigators. HIP plans to achieve these goals by increasing knowledge of SNCC member administrators and medical directors on hiring and retaining culturally competent staff; hiring community health workers, health coaches, and patient navigators at SNCC member clinics; reflecting diversity goals of the organization; and ensuring that patient education materials and tools used by health coaches and patient navigators are culturally appropriate and effective.

SNCC/SNCC MD 2018 Discussion

- Until now, SNCC and SNCC Medical Directors have had different templates for meeting times. HIP is proposing a re-structuring of meeting schedules for 2018, wherein SNCC and SNCC MD will convene as individual groups and a combined group in alternating quarters. The proposed topics for 2018 are as follows:
    - Workforce Diversity (employee retention, recruitment, etc)
    - Joy at Work
    - Care Team development/building empathy on teams
    - Case Management
    - Quality Improvement Systems and Program Development
    - CBI and UDS measures: quality care improvement
    - Information and Data Sharing
    - Behavioral Health Integration
    - Medication Assisted Treatment and SafeRx
    - Oral Health integration and access expansion
    - Social Determinants of Health