SOCIAL POLICY RESEARCH ASSOCIATES

Evaluation of the Solano Coalition for Better Health's Health Access Work Plan: 2008-2009 Report

Final Report
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Health access issues, particularly those concerned with low-income and vulnerable populations, have long been a priority for the Solano Coalition for Better Health (SCBH) and its Health Access Committee. In December 2007, the Solano Coalition for Better Health approved a new three-year (2008-2011) Strategic Plan for Health Access. Based on this strategic plan, SCBH then created a three-year work plan with concrete activities and measurable goals and sub-goals. The activities of this workplan are being executed by SCBH, its Health Access Committee, and the four work groups that operate under the committee's authority: Enroll and Retain, Behavioral Integration, Oral Health, and Frequent User. In this report, we present the workplan's goals and sub-goals organized by work group for July 2008 through June 2009 and assess the extent to which they have been achieved.

Enroll & Retain Case Study #1

AM, a six-year-old Hispanic girl, was in extreme pain with swelling and discoloration at her gum line. Because her family lacked health insurance, she had not received treatment for her condition. After hearing about the SKIP program, the family set up a meeting with a SKIP representative to apply for health insurance. During this meeting, the family informed the representative of the child's condition. The SKIP representative then helped make a doctor's appointment at the Solano County Dental Clinic for AM to be treated for her dental pain. This appointment was kept by the family and the child was treated. The family also successfully enrolled in Healthy Families so AM can receive care as needed.

Enroll and Retain Work Group

The Enroll and Retain Work Group aims to increase the percentage of Solano County residents who are consistently enrolled in a health insurance plan or other program. The work group provides oversight to Healthy Kids Solano (HKS) and the Solano Kids Insurance Program (SKIP), the primary interventions related to the work group's goals. HKS is the local children health insurance program for Solano County children below 300% of the Federal Poverty guideline, and who are ineligible for state sponsored insurance such as no cost Medi-Cal or Healthy Families. SKIP assists children and their families with enrollment and retention in publicly-funded health care programs. The 100% School Campaign Strategy, which works in partnership with all seven school districts in the county to identify uninsured children in each school and enroll them in health care

programs has produced a 'best practice' model and successful strategy for the SKIP program. Below we summarize the results relating to three of the work group's major goals for 2008-2009.

Goal 1: Enroll and retain all eligible children and adults in an available public or other subsidized plan or health program.

Sub-goal: Provide application assistance to 2,500 clients to enroll in available public/private health insurance program for which they are eligible.

Results

- Falling slightly short of the 2,500-client goal, 2,362 people received application assistance from SKIP and enrolled in an insurance plan during the reporting period (7/08-6/09).
  - The main reason the annual enrollment goal was not reached was because the number of SKIP Health Access Specialists was reduced from seven to five during the reporting period.

Sub-goal: Students at 100% (57) of elementary schools and their siblings have health insurance.

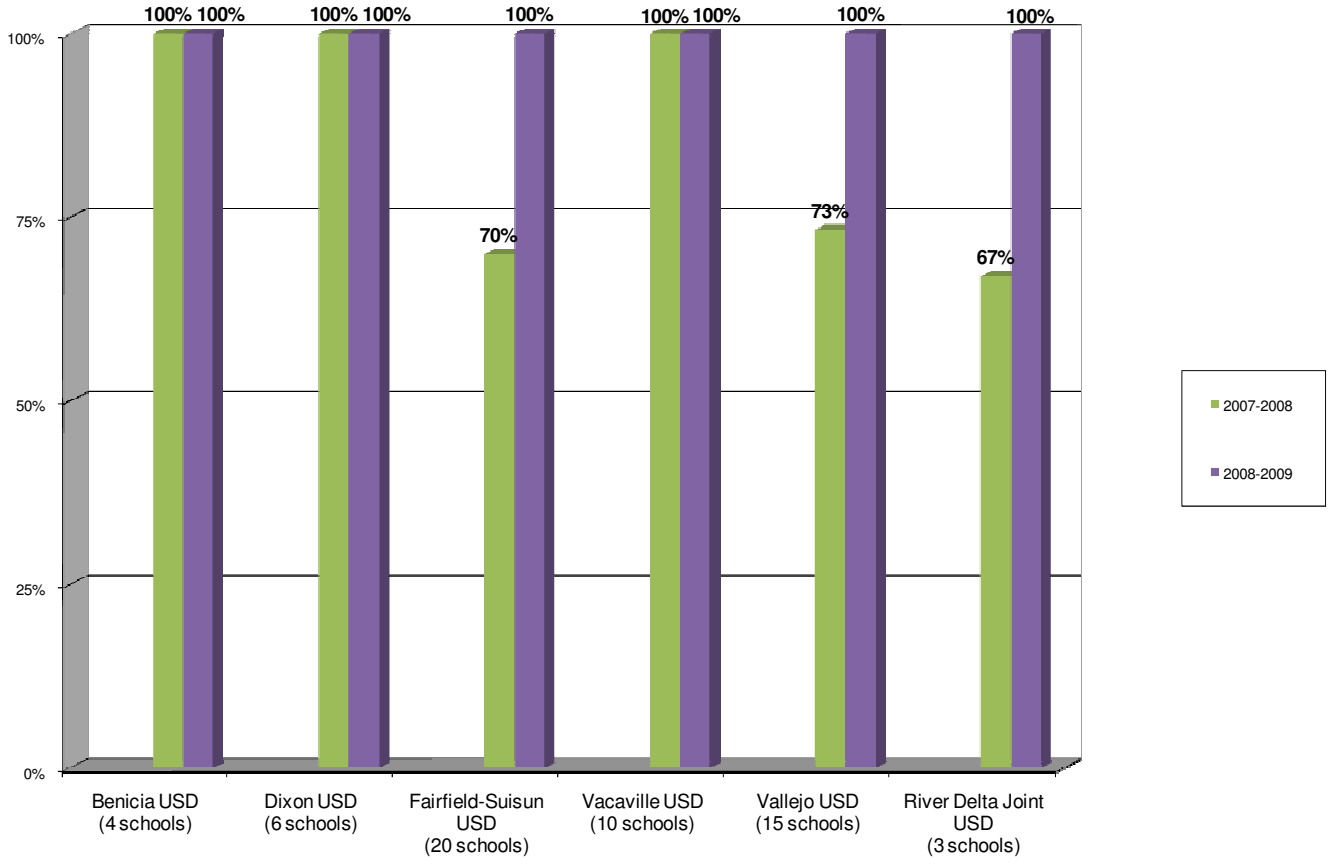
Results

- Reaching its goal, SKIP staff ensured that students and their siblings at 100% (57) of Solano County public elementary schools were covered by health insurance.
  - This represented a 10 school (21%) increase from June 2008.
  - New districts to achieve 100% enrollment rates included Fairfield-Suisun Unified and Vallejo Unified, the county's two largest.
    - The new elementary schools in these districts that obtained 100% enrollment rates included: B. Gail Wilson, Cordelia Hills, David Weir, Laurel Creek, Oakbrook, Rolling Hills, Dan Mini, Wardlaw, Federal Terrace, and Highland.

Enroll & Retain Case Study #2

OM, an eleven-year-old Hispanic boy, needed to have staples removed from his head, but had not because his family lacked health insurance. After finding out about his problem, a school nurse made a doctor's appointment for OM and referred his family to SKIP for a health insurance appointment. Due to SKIP's help, OM is now covered by the Kaiser Child Health Plan so he is able to receive ongoing care as needed.

Exhibit I: Percentage of Schools with 100% Enrollment Rates by District[1][2]



Goal 2: Increase awareness of available health insurance options for kids through participation at community events, providing orientations and utilization of media.

Sub-goal: Produce ongoing media hits related to health insurance and the uninsured. Media hits are defined as SCBH-generated publicity such as letters to the editor, opinion columns, newsletters, and interviews in print, radio and television.

Results

- SCBH produced a substantial number of media hits during 2008-2009.[3]

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[1] The River Delta Joint Unified School District covers counties other than Solano County. The Coalition is only accountable for the three district's schools within Solano County.

[2] Although Travis Unified School District is located on the Travis Air Force Base in Solano County, the district's nurses do their own screening and referring of uninsured children and SKIP representatives are not involved. Consequently, this district is excluded.

[3] For a list of media hits by month as well as examples of article titles, see Appendix A.

- First quarter (7/08-9/08): 31 media hits focused primarily on the budget impasse in Sacramento and its adverse impact on county residents.
- Second quarter (10/08-12/08): 19 media hits focused on specific health conditions such as diabetes, obesity, and lung cancer.
- Third quarter (1/09-3/09): 57 media hits highlighted health care reform, the plight of the uninsured and the impact of the future budget cuts.
- Fourth quarter (3/09-6/09): 67 media hits focused on the aftermath of the special election, medical coverage for children, and the impact of the recession on small non-profit agencies.

Sub-goal: SCBH participates in at least 25 events/orientations/presentations.

Results

- The work group successfully met this goal as SCBH and SKIP staff participated in more than 75 events in the 2008-2009 reporting period.
  - These events included *Back to School Night*, day care events, health fairs, and foreclosure events throughout Solano County.

Goal 3: Assure easy access for residents to Medi-Cal eligibility staff through effective coordination with county and community clinics, hospitals and community-based organizations.

Sub-goal: SKIP staff meets with Medi-Cal eligibility staff quarterly.

Results

- The workgroup successfully attained its goal of having SKIP staff meet with Medi-Cal eligibility staff quarterly between July 2008-June 2009.

Goal 4: Maintain health coverage for Solano County children who do not qualify for Medi-Cal or Healthy Families

Sub-goal: Raise $1.4 million in funds necessary to support 1,000 kids in the Healthy Kids Solano (HKS) program through grant solicitation and support from Solano Magazine's fundraiser.

Results

- SBCH and its partners succeeded in raising $1.4 million for the HKS Program.
  - Major funding came from the Master Tobacco Settlement, the Solano Golf Classic and grants from Solano First Five, the Blue Shield Foundation, and The California Endowment.

Behavioral Health Integration Work Group

In a climate of reduced public mental health resources, particularly for those who are not seriously and persistently mentally ill, there remains a major gap in services. The Behavioral Health Integration Work Group works to lessen this gap by facilitating access to behavioral health services for some of Solano County's more vulnerable populations. The primary ongoing activity related to this goal has been providing on-site Behavioral Health Consultant (BHC) services at primary care clinic sites in the county that serve a high proportion of Medi-Cal clients. These BHC services complement the work of clinic primary care physicians for patients who have co-existing medical and behavioral health issues. This allows for a more comprehensive approach to patient care and improves the chances of patients accessing behavioral health services. Below we summarize the results relating to the work group's goal for 2008-2009.

Behavioral Health Integration Case Study #1

JD, a seventy-year-old Pacific Islander woman with Type II Diabetes, came into see her PCP for a follow-up for her diabetes treatment with her daughter. Prior to this visit, over the previous few months, JD had been increasingly depressed and less and less motivated to manage her diabetes. She had also missed several appointments.

During her appointment, JD's PCP referred her to a behaviorist through a "warm handoff." The PCP invited the behaviorist into the exam room where the behaviorist introduced JD to available behavioral health services, and gathered information about JD's depressive symptoms, living situation and current stressors. The behaviorist learned that JD, who had moved from Tonga to live with her daughter 10 years ago, was struggling with feelings of sadness about the fact that two of her four sisters had recently become very ill with cancer. She also reported having no interest in activities that she used to enjoy and feeling like life was not worth living.

After this warm handoff, JD was scheduled for a second appointment with the behaviorist. When JD and her daughter returned for this second appointment, she and the behaviorist had a candid discussion about her symptoms, depression and diabetes management. The behaviorist helped JD and her daughter identify activities that JD had enjoyed such as Bingo and walks and got them to agree to a goal of doing those activities regularly. The behaviorist also worked with JD on ways that she could obtain support for achieving these goals as well as how to overcome potential obstacles.

Goal 1: Train and support primary care and prenatal providers to screen, identify, assess, treat and refer for behavioral health conditions.

Results

During the 2008-2009 reporting period, a behaviorist was available at five primary care clinic sites that serve a high proportion of Medi-Cal clients: the Solano County Clinics in Fairfield and Vallejo, La Clinica's Vallejo facility, and the two Community Medical Center (CMC) clinics in Vacaville and Dixon. These behaviorists provided a range of services, including conducting training for primary care physicians (PCPs) on such issues as depression, anxiety, substance abuse, and medication compliance and acting as a liaison between PCPs and the county mental health department to facilitate access to necessary care by PCP patients. Behaviorists also provided direct services to patients by conducting immediate assessments and intervention, on-going treatment, and referrals for patients who could not be treated in a primary care clinic setting.

Often PCPs used the "warm handoff" method for referring patients to services from a behaviorist. To do this, PCPs would invite a behaviorist into the exam room and introduce the patient. Frequently, PCPs would then leave the behaviorist and the patient alone together so the behaviorist could get to know the patient and provide whatever immediate services were possible (please see Behavioral Health Integration case study No. 1 for a more detailed illustration of a warm handoff). Following the referral, PCPs would either continue to provide services to clients or refer them to other providers.

Behavioral Health Integration Case Study #2

SM, is a forty-two-year-old white woman with substance abuse issues and disabling anxiety, which prevented her from working or attending school. Because of her inability to work, she was at risk of becoming homeless. After a visit to the Solano County Clinic in Fairfield, she was referred to a behaviorist who taught her ways to manage her anxiety and helped to change her anxiety medication to a non-addictive alternative. The behaviorist also referred her to Narcotics Anonymous, the Christian Help Center, and the Special Services Center at Solano College for support in staying clean. As a result of this assistance, SM is now working part-time and attending college classes.

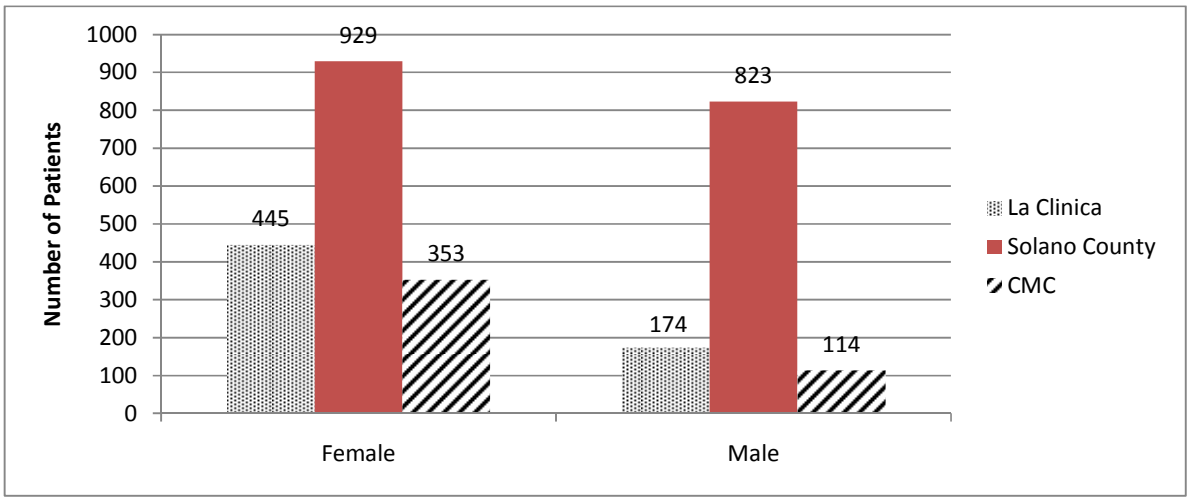
Number and Description of Clients Served by Behaviorists

- Behaviorists at the five clinics served a total of 2,897 clients between July 2008 and June 2009.[4] Sixty percent of these clients (1,754) were served by the Solano County clinics in Fairfield and Vallejo, 21% (619) were served by La Clinica in Vallejo, and 19 % (567) were served by CMC's clinics in Vacaville and Dixon.[5]
- All five clinics served more female clients than male clients. La Clinica and the CMC clinics served substantially more females (72% and 76% female, respectively) whereas the Solano County clinics served only slightly more females than males (53% female) (please see Exhibit II).

[4] This section includes information on the 2,840 clients for whom we have descriptive data. This data covers the full reporting period with the following exceptions: 1) Complete data for the first quarter (7/08-9/08) is unavailable due to a lack of staff to collect it and the fact that a more comprehensive data collection instrument was not developed and implemented by the Health Access Coordinator until later. 2) July, 2008 data is not available for the two CMC clinics.

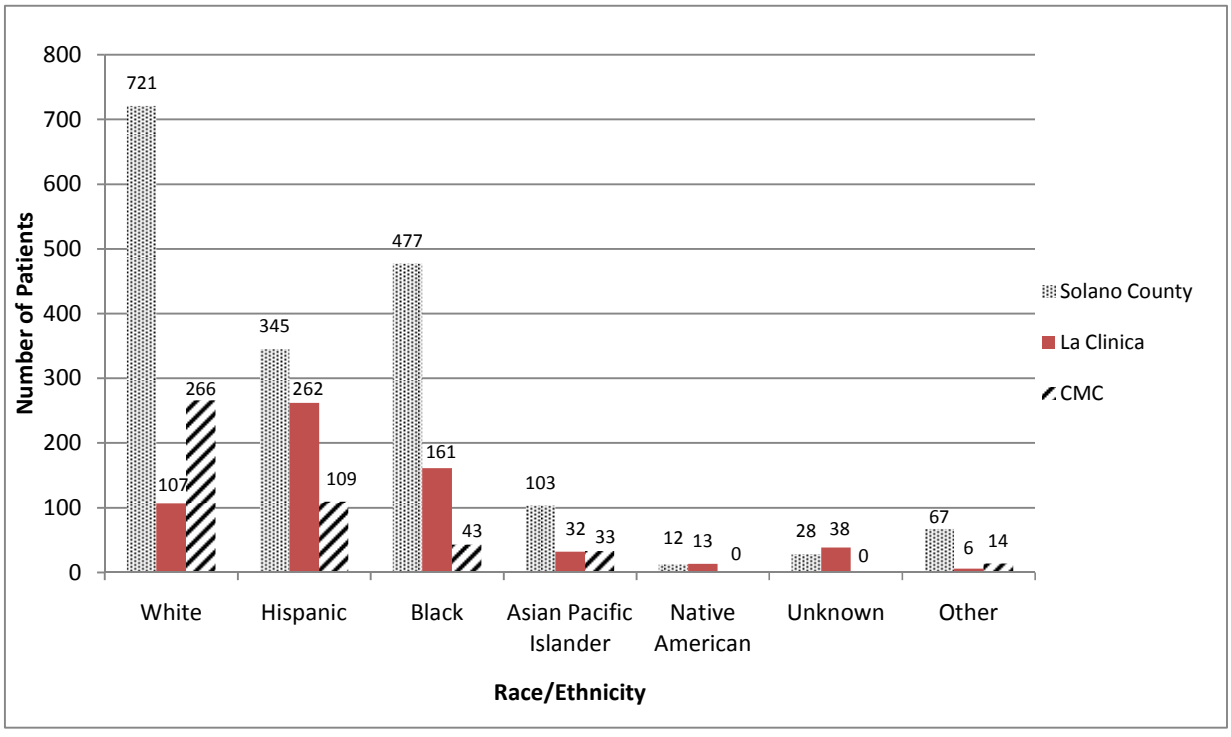
[5] The CMC Vacaville clinic served 337 and the CMC Dixon clinic served 230.

Exhibit II: Gender of Clients Served by Provider, 7/08-6/09



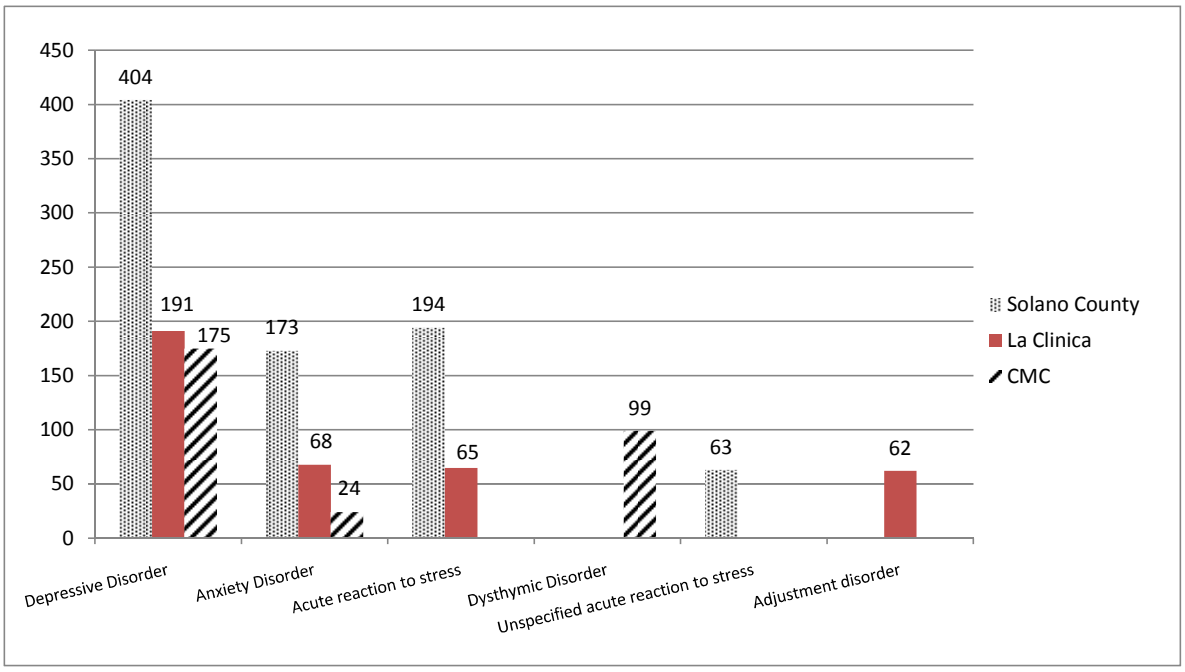
- Thirty-nine percent (1,094) of clients served by the behavioral integration program were white, followed by 25% (716) Hispanic, and 24% (681) Black.
  - Proportionately, La Clinica served far fewer white clients and far more Hispanic clients compared to the Solano County and CMC clinics (please see Exhibit III).

Exhibit III: Race/Ethnicity of Clients Served, 7/08-6/09



- The vast majority of clients suffered from depression with Depressive Disorder, the most common diagnosis overall and at each of the clinics (please see Exhibit IV). In total, 27% (768) of clients served by the behavioral integration program suffered from Depressive Disorder.
  - The next two most common diagnoses among clients served by the behavioral integration program were anxiety disorder (9%) and acute reaction to stress (9%). Both of these were the next two most common diagnoses at the Solano County clinics and La Clinica. However, at the CMC clinics, Dysthymic Disorder,[6] was the second most common diagnosis, followed by Bipolar Disorder.
- Most clients served by both La Clinica and CMC were between 21 and 60 years old (please see Exhibit V). La Clinica served approximately the same number of clients in the 21-30, 31-40, 41-50, and 51-60 age groups; the CMC clinics experienced a considerable drop of clients aged 31-40.

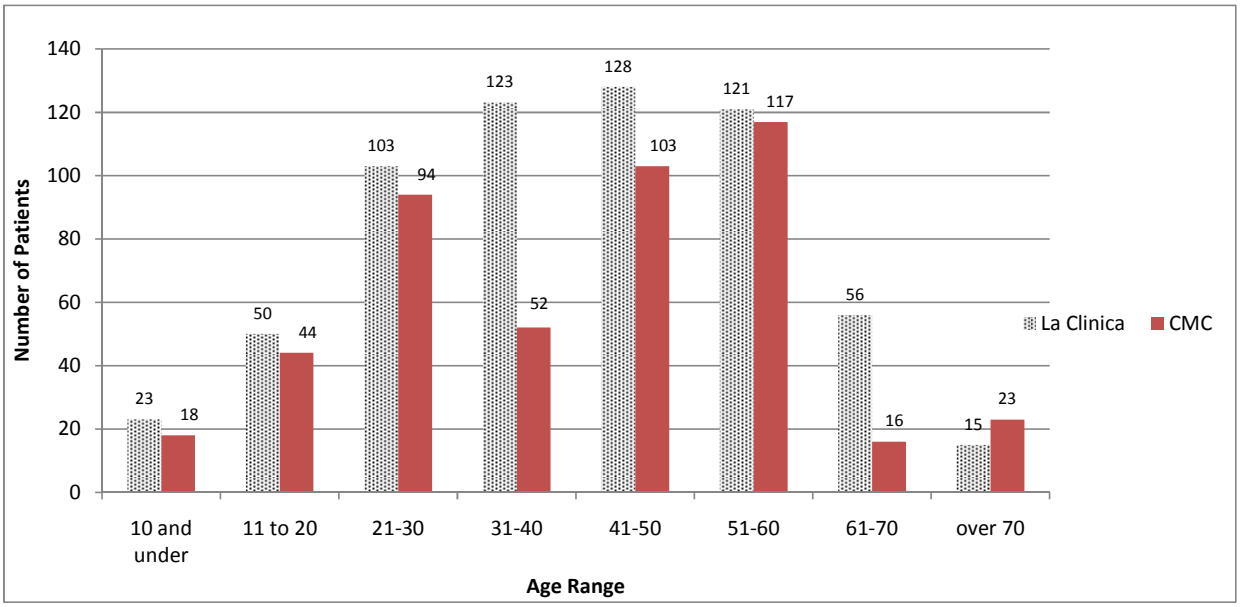
Exhibit IV: Six Most Common Client Diagnoses among Behaviorist Patients by Provider, 7/08-6/09[7]



[6] Dysthymia is a chronic type of depression in which a person's moods are regularly low. However, it is not as extreme as other types of depression.

[7] The clinics used slightly different diagnosis labeling/coding systems. The diagnoses presented in this graph represent the six most common within the clinics. In total, there were 16 different diagnoses that occurred 10 or more times.

Exhibit V: Age of Behaviorist Clients by Provider, 7/08-6/09[8]



Oral Health Work Group

One of the most critical, yet often overlooked, aspects of primary health is oral health care. Dental cavities are the most common childhood disease in the United States. In Solano County, the widespread incidence of oral health problems among children is further complicated by the additional challenges of few dentists accepting Denti-Cal, an insufficient supply of pediatric dentists, and large areas of the county that lack adequate oral health services for uninsured residents. The Oral Health Work Group aims to increase oral health outcomes among children through two primary interventions: 1) increasing access to oral health treatment services through care coordination, linkages to comprehensive health insurance, and a Gap Fund to pay for necessary treatment for un- and under-insured children; 2) increasing oral health prevention efforts in Solano County through a public health campaign designed to raise awareness of the importance of oral health care. Below we summarize the results relating to the work group's three goals for 2008-2009.

[8] No exact age data was provided for Solano County clinic clients, so only included La Clinica and CMC clients are included in this exhibit.

Goal 1: Assist families in paying for urgent oral health services for children and then link them to health coverage and a dental home.

Sub-goal: County Public Health will provide care coordination and urgent oral health treatment [through the Gap Fund] for a minimum of 70 kids who are uninsured or underinsured.

Results

- In 2008-2009, 98 un- and under-insured children received care coordination and urgent oral health treatment paid for by the Gap Fund, exceeding the Oral Health Work Group's goal of serving 70 children by 40% (28 children).
  - By the end of the reporting period, the Gap Fund had expended $67,460 for urgent oral health treatment, 86% of available funds (a total of $78,394 was available). Because of an expected increase in demand for urgent oral health care in 2009-2010, the work group has approved an increase in available funding for the Gap Fund to $93,000.

Oral Health Case Study

A five year old girl suffered from baby bottle tooth decay and although she had Denti-Cal, her mother had not taken her back to the dentist because she was unable to afford the sedation needed to do required dental work. Because these were baby teeth, the mother was waiting for her child's teeth to fall out. When the child's teacher noticed the decay, the child was referred to the Child Health Access Program's dental services. Through the Gap Fund, the child was able to receive the necessary sedation for a dentist to take care of the decay.

Sub-goal: At least 50% of those who received services through the Gap Fund will have identified a dental home after treatment.

Results

- Data on this goal is unavailable because the evaluation tool to track this data was not implemented during this reporting period. However, the Oral Health Workgroup has been working with the SKIP Coordinator to develop protocols for tracking this information and implementation has been projected for Fall 2009. Consequently, data to measure this goal should be available for the next evaluation report.

Sub-goal: At least 60% of those who received services through the Gap Fund will have received oral hygiene education.

Results

- One hundred percent (98) of the children who received services through the Gap Fund received oral hygiene education, exceeding the work group's goal of educating 60%.

Goal 2: Conduct a public health campaign to improve the oral health practices and use of preventative dental services for children and families.

Sub-goal: Ten thousand focus group-tested brochures will be distributed in locations where health, social, or childcare services are rendered.

Results

- The work group achieved its goal of distributing 10,000 oral health brochures at locations where health, social or childcare services are rendered.

- After feedback from community stakeholders regarding appropriate literacy levels, an oral health brochure in both English and Spanish was developed and reviewed by the Oral Health Work Group.
- Ten thousand of these oral health brochures were then distributed at 35 different venues throughout Solano County including Women, Infants, and Children (WIC) and pediatric dentist offices, social service agencies, and Planned Parenthood facilities. They were also distributed by SKIP staff at health fairs.

Sub-goal: At least 400 persons will receive one-on-one education with the use of the educational brochure from SKIP representatives and at the following locations: WIC sites, Family Resource Centers (FRCs), Child Start and School Readiness Sites, Child Health & Disability Program providers, Children's Health Access Program (CHAP) schools. A post-test will indicate that at least two new ideas will have been imparted to the recipients.

Results

- At least hundred and eighty-nine parents participated in group trainings on use of the oral health brochure during the reporting period, about half of the 400-person goal. There were several reasons why the work group missed this goal:
  - Other than two pilot trainings conducted for eight providers in the third quarter, no trainings were conducted until April, 2009.
  - Although twenty-five trainings for individuals were conducted from April to June, 2009, because of the small seating capacities of the venues, the audiences remained small.
    - These trainings were held at Family Resource Centers, School Readiness sites, Child Start Daycare Centers, and WIC programs in both English and Spanish.
  - FRCs also provided training to parents. However, because the FRCs did not provide SCBH with attendance data for those trainings, parents trained by FRCs are not included in this number. If FRCs had provided their data to SCBH, it is possible that this goal would have been attained.
- According to a post-test conducted following the trainings, all 189 training participants indicated that they had learned at least two new oral health ideas. Examples of these new ideas included the importance of drinking less soda, using toothpaste containing fluoride, and proper brushing techniques.

Goal 3: Increase the number of children receiving sealants or fluoride varnish.

Sub-goal: One thousand eligible WIC kids will receive fluoride varnish.

- As only 362 children received varnish treatment during the reporting period, the work group did not achieve this goal.

- The reason this goal was not achieved was that the pilot program providing sealants for eligible WIC kids was discontinued in 2008.

Frequent User Work Group

The Frequent User Work Group is aimed at increasing the appropriate use of health care by frequent users. Many research studies have documented the existence of a small group of adults who have very high numbers of lengthy hospital stays and frequent emergency room admissions. These "frequent users" are low-income people who typically have at least one chronic health condition, face mental health or substance abuse issues and lack access to stable housing. Despite their regular use of hospital services, most of these frequent users are not receiving effective treatment and continue to suffer from very poor health outcomes. Because of their disproportionate use of acute care services, these individuals are extremely costly to the health care system. Consequently, Solano County's commitment to ensuring access for this population to treatment is critical to the achievement of a health care system that is both more effective and financially stable. Below we summarize the results relating to the work group goals for 2008-2009.

Frequent User Case Study

JF is a 56-year-old Asian Pacific Islander man who suffered a stroke as a result of methamphetamine use. At the time of his stroke, he was technically homeless, sleeping on the couches of friends in houses were drugs were sold. Because he did not receive emergency services for at least 24 hours after his stroke, he is paralyzed on his left side. Due to the paralysis, JF has difficulty bathing, shopping, and walking more than 100 yards which has adversely impacted his quality of life.

After his stroke, JF was referred by Sutter Solano Hospital staff to the Frequent User Program. Because he has no access to transportation, one of the main duties of the Frequent User Program case manager is to transport him to medical appointments to ensure he receives necessary care. Because he often has two appointments a day in different cities, this is very labor intensive.

After working with the case manager, JF became motivated enough to make all of his appointments and stay in a shelter (he was later referred to transitional housing). He also started walking daily for physical therapy and understood that continued drug use would adversely impact his health.

Goal 1: Increase the appropriate use of the health care system by frequent users.

Results

To try to increase the appropriate use of the health care system by frequent users, the Frequent User Work Group is implementing the Frequent User pilot program. In this program, frequent users[9] are referred by participating hospitals (NorthBay Medical Center, VacaValley Hospital, and Sutter Solano Medical Center) to a case manager who provides intensive case management and attempts to link those individuals to critical on-going services such as a primary

[9] According to the Frequent User Work Group notes for 10/26/07, Frequent Users are defined as individuals who are "medically compromised, have mental illness, and are homeless or in an unstable living situation."

care physician, mental health and/or substance abuse treatment, and housing and disability benefits. The aim of these linkages is to decrease those clients' inappropriate use of emergency and hospital services. Project staff are employed and supervised by the Solano county H&SS Department.

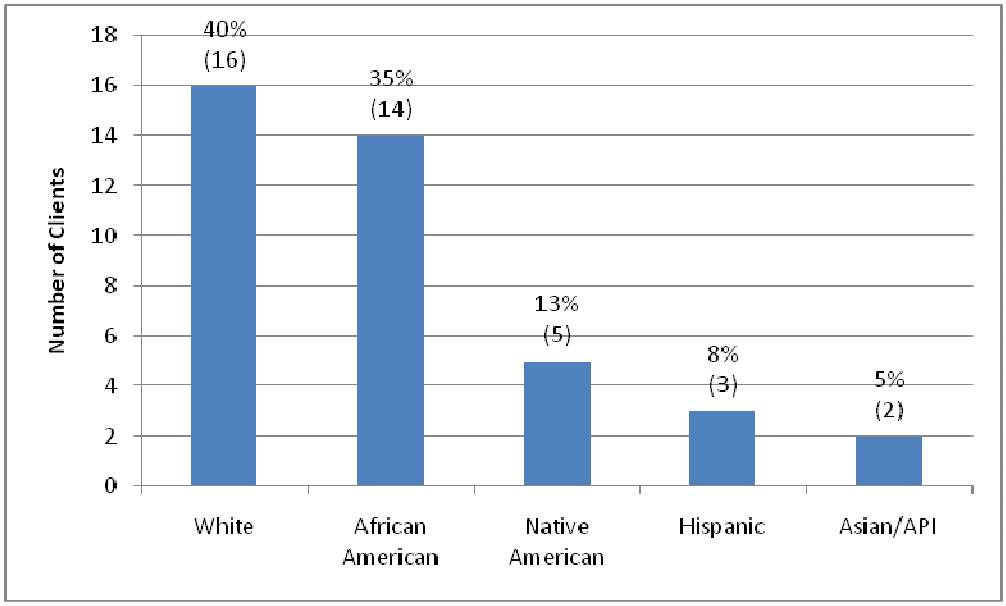
Although the pilot project originally began operation in April 2006, operations temporarily ceased in September, 2007 after the departure of the first case manager. After a partial redesign of the staffing structure, the project re-commenced in October 2008 with a Mental Health Specialist II hired by Solano County to serve as case manager.

Description of Frequent User Project Clients[10]

Between October 2008 and June 30, 2009, the Frequent User Program served 40 individuals; 31 referred from Sutter Solano Hospital, seven from North Bay Medical Center, and two from VacaValley Hospital.

- The majority (75%) of Frequent User clients were white and African American; (please see Exhibit VI).

Exhibit VI: Frequent User Client Race/Ethnicity, 7/08-6/09

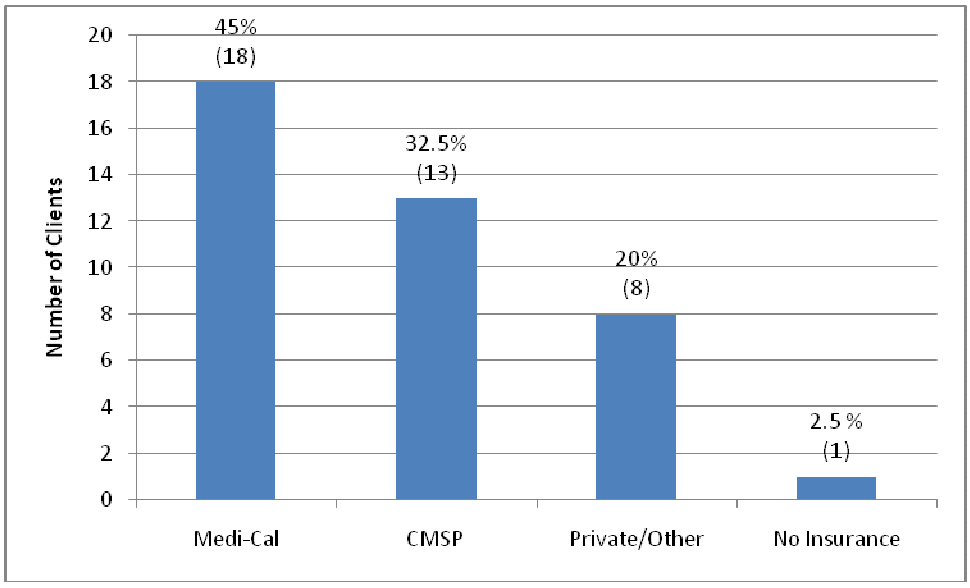


- The graph below presents the clients' insurance status upon enrollment in the program. Nearly half of all of all referred clients were covered by Medi-Cal at the time of enrollment, while another third were enrolled in the County Medical

[10] These data cover the period from October, 2008, when the new Frequent User Program case manager began work June 2009, the end of the reporting period.

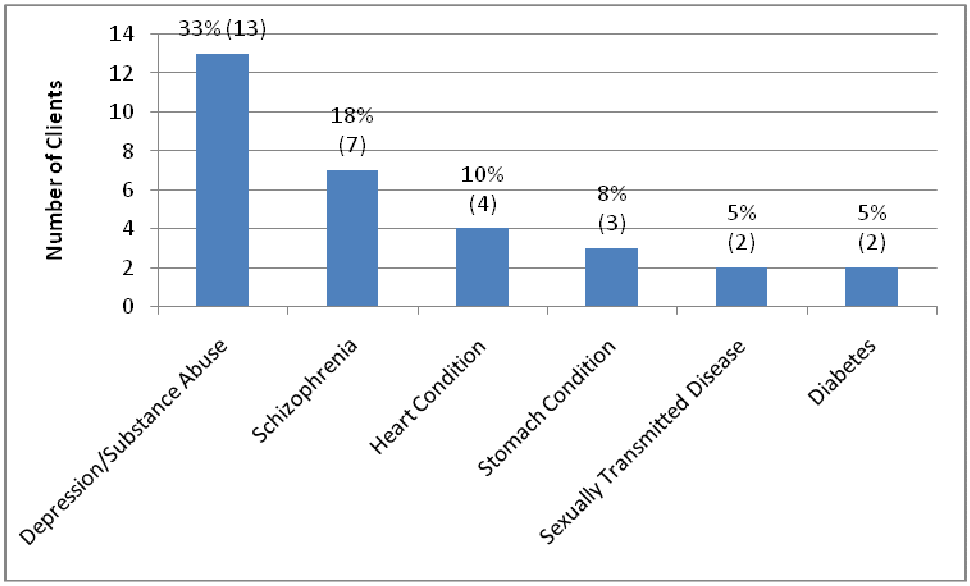
Service Program (CMSP). Only 2.5 % (1 client) had no insurance (please see Exhibit VII). This illustrates that frequent users generally do not lack insurance, but use the health care system inappropriately.

Exhibit VII: Frequent User Insurance Status, 7/08-6/09



- The most common chronic conditions suffered by clients were depression and substance abuse (33%), followed by schizophrenia (18%), heart conditions (10%), stomach conditions (8%), sexually transmitted diseases (5%), and diabetes (5%).
- Fifty-eight percent (23) of the 40 clients were identified as having a history of substance abuse issues, most commonly related to alcohol, methamphetamines, crack, cocaine, and opiates.
- The average age of the forty Frequent User clients was 48.5 years, with three clients under 30 and one over 60.

Exhibit VIII: Most Common Frequent User Primary Diagnoses, 7/08-6/09[11]



Respite Care Clients

The Frequent User Work Group also oversees the Respite Care program. This program provides a temporary bed for homeless clients who are recovering from medical treatment or illnesses but need minimal medical assistance. Participating hospitals refer these clients to the Frequent User case manager who then secures the client a bed at either the Community Action Council Respite Home (CAC) or Mission Solano. While in respite care, clients also receive counseling for any mental health and substance abuse issues, referrals to appropriate support and service providers, and assistance in locating permanent housing.

- CAC and Mission Solano served 23 clients between July 2008 and June 30, 2009. Fourteen were served by CAC and seven by Mission Solano.
  - Clients spent an average of 19.5 days in respite care. Seven clients remained for 30 days, the maximum time a client is allowed to stay, and six spent fewer than 10 days.

[11] This exhibit only includes those diagnoses which applied to more than one client.

- Among CAC clients, heart and liver problems and recovery from surgery were the most common reasons for needing respite care, followed by respiratory problems and stroke recovery.[12]
- Clients used a total of 456 bed days, 289 at CAC and 167 at Mission Solano. If respite care had not been provided, we can assume that at least some of those clients would have been in the hospital for recovery, thereby expending far greater resources.

Frequent User and Respite Care Case Study

EM, a 55-year-old African American woman with a 10 year history of cocaine use, was treated by North Bay Hospital for a stroke. She had also been diagnosed with liver cancer, Hepatitis C, and high blood pressure and was suffering from labored speech and an inability to stand or sit up for long periods. Having just been diagnosed with terminal cancer, she expressed fear and difficulty in accepting this diagnosis, and struggled with how to explain it to family members who rely on her for support. She expressed regret over her years of substance abuse and wanted time to make amends with her siblings as well.

EM was referred to the Frequent User Program for case management services, including assistance with obtaining medications, arranging transportation to doctor appointments, and applying for numerous public benefit programs, obtaining mental health services, gaining assistance from the Public Defender's Office, receiving referrals to recovery programs, and taking care of necessary drug testing.

EM was also referred to the Mission Solano shelter for two weeks and then to the Frequent User Work Group's Respite Care Program, which paid for her to stay at the CAC Respite Home for further recuperation. During her respite care, among other appointments, she had one-on-one meetings focused on life and empowerment skills. CAC respite staff also helped her to obtain pending SSI benefits.

After one week of these respite services, she called her family requesting their prayers and patience. After 30 days, her family asked her to come home and she returned. She continues to see a therapist for depression and a primary care physician for medication. She is also poised to receive in-home supportive services and a discount bus/Para transit card.

Goal 2: Educate hospital and clinic providers about resources available for frequent users.

Sub-goal: Mental Health Specialist IIs and hospital social service staff will orient hospital clinic and other Health and Social Services staff.

Results

- The Frequent User case manager (Mental Health Specialist II) provided a formal orientation for social workers from both North Bay Medical Center and VacaValley Hospital describing the Frequent User Program's goals and objectives. She also conducted an informal orientation at Sutter Hospital whose staff was already familiar with the Frequent User Program.
  - According to the Frequent User case manager, these orientations helped create a collaborative relationship between herself and hospital staff in implementing a referral system for the Frequent User program.

[12] This data was not available for Mission Solano clients.

Health Access Committee Policy Work

In addition to the activities of its work groups, the Health Access Committee, primarily through the work of SCBH, is responsible for advocating for policies and actions that increase access to health care for low income, uninsured and other vulnerable populations. Below we present how the Health Access Committee and SCBH addressed the specific work plan goals and sub-goals related to health access policy from July 2008 to June 2009.

Goal 1: Work with local policymakers to identify the impact of healthcare reform efforts on the Solano County target population.

Sub-goal: Analyze healthcare reform proposals on local coverage efforts.

Results

- SCBH-SKIP participated in the following legislative advocacy activities related to healthcare reform during the reporting period:
  - Signed coalition letter to Centers for Medicare and Medicaid Services asking for support on AB 1422, a measure designed to keep approximately 660,000 children enrolled in Healthy Families.
  - Wrote and sent letters in support of AB 1422 to state legislators.
  - Wrote and sent letters thanking state legislators who voted in favor of AB 1422.
  - Wrote and sent letters to state legislators in support of AB 1383, a measure designed to provide Medi-Cal reimbursement rate increases to California hospitals and ensure access to hospital care for low-income Californians.
  - Testified in May 2009, before California's Joint Budget Committee against cuts to the Healthy Families Program.

Sub-goal: Educate local policy makers about the impact of healthcare reform on local coverage efforts.

Results

- During the first half of the reporting period the SCBH Executive Director met with each Solano County Supervisor individually to provide information on health care issues that impact Solano County residents.

Sub-goal: Advocate for policy changes that support the local safety net.

Results

- During this reporting period, SCBH made calls to voters to explain the potential impact of proposition 1D. Had it passed, Proposition 1D would have significantly decreased First 5 funding, thereby impacting health premiums and the work of SCBH.

- In May, the SKIP Director, along with representatives from 29 California Children's Health Initiative sites, gathered in Sacramento to advocate against budget cuts to the Healthy Families Program. There, among others, she met with several local elected officials such as Assembly Member Nariko Yamada, Assembly Member Noreen Evans and Senator Lois Wolk. SCBH met with 70 elected officials in total.

Goal 2: Ensure that TMSA funds continue to support the prioritized strategies within the Health Access Strategic Plan.

Results

- The Solano County Board of Supervisors decided to continue funding at $1.4 million for 2009-2010.[13]
  - Between July and December 2008, to help ensure that TMSA funds continue to support the prioritized health access strategies, the SCBH Executive Director met with each Solano County Supervisor individually to discuss the continued use of TMSA funds for health access strategies.
  - In March 2009, SBCH made its annual presentation to the Solano County Board of Supervisors on the Health Access Committee's achievements and the importance of the long-term sustainability of the coalition. The presentation highlighted programs that had the greatest impact on the community. The objective was to highlight the role of the county and the need for continued support for health access programs.

La Clinica North Vallejo

In addition to this policy work, during the 2008-2009 fiscal year, the Health Access Committee also provided funding for La Clinica's new North Vallejo clinic, representing a significant expansion of the availability of health care in community settings. The clinic, which opened November 3, 2008, is open Monday-Friday from 8:30 AM to 8:00 PM, and Saturdays from 9:00 AM to 2:00 PM. It also offers a drop-in immunization clinic on Thursdays from 11:30 AM to 2:30 PM. Services offered by the clinic include primary care, urgent after-hour care, health education, and behavioral health care.

Since its opening, the North Vallejo Clinic has rapidly become a major health care access point in the community. For example, from November 2008 to June 2009, the clinic saw 1,397 patients. These patients visited the clinic for a variety of reasons, most commonly due to acute

[13] Although funding for the 2009-2010 fiscal year was preserved, funding may be in jeopardy for 2010-2011 due to cuts at the state, county, and local level. The SCBH will follow these changes going forward.

upper respiratory infections, routine infant/child health checks, abscesses, hypertension, and diabetes. Patients were referred to the North Vallejo Clinic primarily from other La Clinica programs or sites, Sutter Solano Medical Center, or by friends and family members of existing patients.

Conclusion

Over the past year, SCBH and its health access work groups were successful in achieving 80% (12 of 15)[14] of all sub-goals identified in the Health Access Strategic Plan Work Plan. Below we present highlights from the past year.

- The Enroll and Retain Work Group achieved a major milestone by successfully enrolling all of Solano County's children attending public elementary schools and their siblings in health insurance.
- Prior to the 2008-2009 reporting period, the Behavioral Integration program experienced continuing difficulties with behaviorist staff turnover as well as with the hiring of new and replacement staff. Despite this history of staffing challenges, in the past year the work group succeeded in ensuring that a behaviorist was available at each of the five clinic sites: the Solano County Fairfield and Vallejo clinics, La Clinica's Vallejo facility, and the two Community Medical Center (CMC) clinics in Vacaville and Dixon.
- In 2008-2009, the Oral Health Work Group oversaw a major increase in the number of children served by the Gap Fund, serving 98 children with urgent oral health care. This was a substantial increase from the 2006 fiscal year, when no children received urgent oral health treatment and 2007 when only 32 children were served by the fund.
- The Frequent User Work Group successfully piloted its Respite Care program to assist frequent users recovering from illness or surgery. Although outcome data from this work is limited, anecdotal evidence suggests that the program has played a critical role in helping frequent users receive appropriate care. In addition, after a year-long hiatus, the Frequent User Program resumed operation and served 40 new clients.
- SCBH leadership's advocacy on behalf of the work groups successfully secured continued funding by the Solano County Board of Supervisors for 2009-2010.

[14] The plan actually included 16 sub-goals, but one (Oral Health Work Group Sub-goal: "At least 50% of those who received services through the GAP program will have identified a dental home after treatment") was not measureable due to a lack of data. This sub-goal was therefore excluded from this calculation.

Appendix A:
SCBH Media Articles by Month with Selected Titles, 7/08-6/09

July 2008

11 articles
- New Cancer Study Looks to Solano County – Vallejo Times Herald
- County Coalition Throws Weight Behind Challenge – Fairfield Daily Republic

August 2008

10 articles
- County's Ambition to be Big Loser – Vallejo Times Herald
- Cancer Society Looks to County for Study Participants – Fairfield Daily Republic

September 2008

10 articles
- Tournament to Benefit Kid's Health Insurance – Vacaville Reporter
- Budget Impasse Hurts Health Care – Fairfield Daily Republic

October 2008

10 articles
- Barbershops to Host Diabetes, Blood Pressure Screenings – Vallejo Times Herald
- Plenty to Gain While You Lose – Excell Magazine

November 2008
- Blood Test Helps Detect Diabetes – Fairfield Daily Republic
- Don't Be A Target for Tobacco – Vacaville Reporter

December 2008

7 articles
- New Medical Advances in Women's Health – Vallejo Times Herald
- Lung Cancer and What It Means – Fairfield Daily Republic

January 2009

16 articles
- Child Fevers – Solano Magazine
- Moderation the Key To Watching Weight – Fairfield Daily Republic
- Walk is Another Step Towards Health – Fairfield Daily Republic

February 2009

17 articles
- SKIP Can Help You Find Health Care Services – Benicia Herald
- Health Care System Worthy Investment – Fairfield Daily Republic
- Wanted: Critical Mass Conductors – Dixon Tribune

March 2009

24 articles
- The Diabetes Epidemic – Solano Magazine
- Foundation Aims Spotlight on Uninsured Americans – Benicia Herald
- Colorectal Cancer – Vallejo Times Herald
- Uninsured Week Promotes Health Care Reform – Rio Vista River News Herald

April 2009

16 articles

- Oral Health Easy to Overlook – Fairfield Daily Republic
- No Excuse for Sexual Assault – Benicia Herald
- Vote No on Prop 1D and 1E – Dixon Tribune

May 2009

42 articles

- Back Pain Isn't Just About Your Back – Fairfield Daily Republic
- Wellness Fair Set for Sunday – Vallejo Times Herald
- Propositions Have Great Cost – Fairfield Daily Republic
- Advocates for Kids Say Medical Coverage is Vital – Vallejo Times Herald

June 2009

9 articles

- Health Coalition Offers Presentation by African American Advocacy Program Benicia Herald
- Non Profits Fight to Stay Open in Crisis – Vallejo Times Herald