Santa Barbara County
Public Health Department

Health Care Centers

Annual Report

2024

Clinic Executive Director and Community Health Center Board President's Message

Honorable Board of Supervisors of Santa Barbara County and our Community:

As Deputy Director of Clinical Care, Primary Care & Family Health Division for our County, I serve as the Health Center's Executive Director. Our Board President, Cynthia Guerrero and I continue to work towards making the clinics accessible to our community while fulfilling our mission to "turn no one away, regardless of their ability to pay".

As we wrap up 2024, we wanted to take a moment to reflect on the successes and challenges our health centers have faced, and to express our gratitude for your continued support and strategic guidance. This year has been transformative in many ways and has reinforced our commitment to delivering exceptional healthcare to our community.

Our centers have experienced significant progress since the end of the COVID pandemic response. We have successfully implemented enhanced care management services, which have expanded our reach and improved patient access to care. Our team has also focused on enriching the quality of our care through professional development and training initiatives, ensuring that our staff remains at the forefront of medical advancements and patient care techniques. In addition, we have hired new providers and clinicians allowing us to serve more Medi-Cal patients than ever before.

The introduction of community health programs has been another milestone, targeting preventative care and health education, which not only improve patient outcomes but also foster a stronger, healthier community. These programs have been well-received, and we look forward to expanding them in the coming year.

We have also faced challenges, particularly those caused by increasing costs that have outpaced revenues which impact our ability to manage the increased demand for services. Addressing these issues will be crucial as we move forward, and we are confident that we will find innovative solutions to ensure the sustainability and growth of our clinics.

Looking ahead, we aim to further integrate advanced technologies into our practice such as telepsychiatry as we continue building partnerships that align with our mission of comprehensive patient care. Our Health Center Board, the Department's Leadership Team, and our dedicated staff are working to achieve these goals together.

Thank you once again for your continuous support and partnership. We are excited about what we will achieve in the coming year and look forward to our continued collaboration.

Best regards,

Dana B. Gamble
PCFH Deputy Director

Cynthia Guerrero
Health Center Board Chair

Our Team

What it Means to be Chief Physician at the Franklin Health Care Center

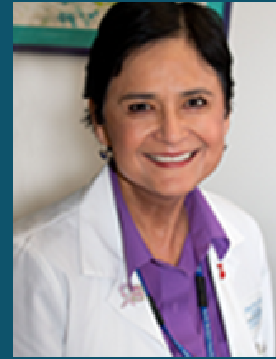
Since arriving into my new role as the Chief Physician at FHCC earlier this year, I have lead our site in its transition to Team Based Care. This model of care focuses on a patient-team partnership, as well as, population management, continuity of care, prompt access to care, comprehensiveness, care coordination and a template of the future.

Our staff have embraced our new model of care, as we actively implement the elements of high-performing Team Based Care, which ultimately improve access to high quality care, streamlines processes and reduces wait times, and prevents staff and provider burnout through a Share the Care paradigm of all team members.

Dr. Kristen Hughes

Chief Physician
Franklin Health Care Center

Welcome Dr. Preciado!



Dr. Phyllis Preciado

Chief Medical Officer

The Health Department is thrilled that Dr. Phyllis Preciado has accepted the appointment as Chief Medical Officer and began serving in this role on February 5th. Before becoming a physician, she worked as a Registered Nurse for 16 years, after which she decided to enroll in Medical School. She has been a Primary Care Physician for 23 years, and as the Chief Physician at the Santa Maria Health Care Center, she has led their clinical team for the last 8 years. Dr. Preciado has extensive leadership experience, including her role as Medical Director of St. Jude Heritage Health Care in Fullerton.

In the CMO role, Dr. Preciado remains committed to ensuring that medical services are efficient, affordable, and accessible to all who need them. She champions patient-centered team-based care, implements evidence-based practices, and ensures the delivery of high-quality healthcare services. Dr. Preciado enjoys swimming for fun, recently climbed Mt. Whitney, and values weekends spent with her family. She has embraced her new role and is a key member of the Health Center Executive team.

Health Care for the Homeless 35th Anniversary

In 1989, the Health Resources and Services Administration (HRSA) announced its first ever funding for Health Care for the Homeless services. The County of Santa Barbara applied for and was granted a Health Care for the Homeless project. Initially the project consisted of 3 Public Health Nurses driving in a dilapidated County van to various locations providing triage in the field and offering transportation to one of the fixed clinic locations. While the project has expanded considerably and now includes shelter based clinics, five fully functioning 330(e) and (h) clinics with in house pharmacies and specialty services such as ortho, endocrinology, rheumatology, etc. all wrapped into scope, the PHN model is still a cornerstone of the program. The van is long gone, but the field team still carries the torch and continues to have one of the toughest jobs in the county.

Street Medicine Program

The Street Medicine Program began as a needs assessment project in April 2023. The idea was to imbed a physician with the PHN/health aide team. The team is well received in the community and partnerships with other homeless agencies have been key in addressing the medical needs of the homeless population.

The team typically goes out once a week to evaluate patients who are experiencing homelessness and have chronic or sometimes urgent medical needs. These may range from assistance with chronic disease management (for example, counseling on Hypertension/Heart failure/Diabetes) as well as acute issues such as mild injuries/skin conditions. The team does not carry prescription medications, but do carry a limited OTC pharmacy and can help direct people to the clinic or to the ER for any severe findings. They also assist patients with opioid/substance use disorder by providing MAT counseling by the physician, and linking to the clinics for care. Additionally, the team collaborates with PHD doctors to closely follow clinic patients experiencing homelessness to continue linkage to care.

Street Medicine Program Wishlist:

- Expanding the role of the physician to include RX dispensing and MAT services
- Use of a limited Pharmacy
- Medical clearance exams for residential recovery programs
- Rapid testing for various conditions
- Pop-up tent, table, chairs, etc. for a mobile clinic
- A mobile medical van
- A means of transporting these clients to the clinic
- A designated transport staff person

WHAT'S NEW?

New Equipment

This year, all of our clinics who see infants were able to acquire a Transcutaneous Bilimeter to measure the bilirubin levels of our newborn patients. This machine is valuable to both our providers and patients, by giving providers immediate results in the clinic to help direct and implement a care plan that is safe for the baby. The results can often times help providers determine whether or not a blood draw is necessary, and keeps families home with their babies, rather than having to go to a lab. For Carpinteria Clinic, the only lab for infants is in Santa Barbara, so in Carp, we are able to avoid unnecessary blood draws and trips to the lab.

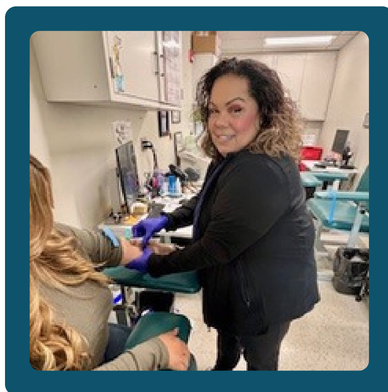
The other machine we acquired and will be acquiring in all of our clinics is the Spot Vision Screener. This machine allows young children to be screened for common vision defects, as early as 1 year old. Early identification of vision impairment helps to prevent amblyopia, which is a preventable form of blindness. We are also able to use this tool on our many patients with special needs, who are unable to perform the typical vision screen.

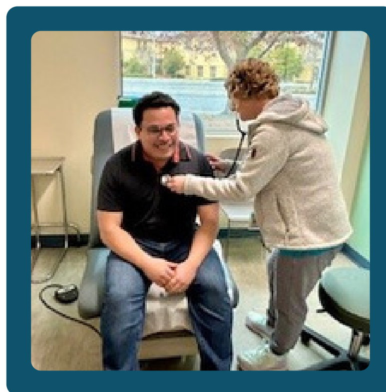
We are grateful to have these two new instruments in our clinics, which help us quickly identify children who are at risk for illness and be able to prevent further complications, but also make their lives easier by avoiding unnecessary medical intervention when not needed. Both tools improve our quality of care for children who come to our clinics.

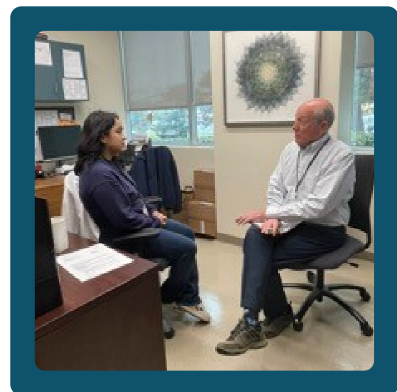
WHAT'S NEW?

Team Based Care

The SBCPHD Health Care Centers (HCCs) implemented the Team Based Care Policy and Procedure to engage the entire care team to work as a cohesive unit in the care of the patient to provide optimal patient - centered care, utilizing staff to the top of their licensure/training. This team-based model of care strives to meet patient needs and preferences by actively engaging patients as full participants in their care, while encouraging and supporting all health care professionals to function to the full extent of their education, certification, licensure, and experience. Health care teams are defined as two or more health care professionals who work collaboratively with patients and their caregivers to accomplish shared goals. Team-based care not only enhances how health care teams work together; it also positively influences patient experiences, and prioritizes preventative care and health promotion efforts.







EXPANSIONS

Medi-Cal Expansion

On January 1, 2024, California opened the Medi-Cal program to anyone aged 26 to 49 whose income is low enough to qualify, no matter their immigration status. This was the last age group remaining to be covered and was the largest expansion of coverage since the Affordable Care Act was implemented in 2014. The State had previously expanded Medi-Cal to include children, young adults, and seniors regardless of their legal status.

In preparation of the expansion, The Public Health Department's IT and EHR teams identified 1,400 uninsured patients already being seen at our health care centers and appeared they would be eligible for Medi-Cal. With this information in hand, our clinic front office staff and the PHD Benefits and Referral Center (BRC) reached out to these patients to assist with enrolling them into Medi-Cal. As they were already being served by us, once they were enrolled, CenCal Health assigned them to us as CenCal members, which ensured continuity of care.

This effort paid off. The number of assigned CenCal Health Members was 29,308 in December 2023 and following the expansion in January, the number of assigned CenCal Members jumped to 32,329 by February 2024. Many of these new members were our existing patients. Ensuring our existing uninsured patients enroll in Medi-Cal helps them get insured for ongoing health care coverage and provides a payor source to eliminate their out of pocket expenses. It also helps us increase the number of Medi-Cal members we serve without impacting access.

Behavioral Health Services Expansion

HRSA awarded the PHD the Behavioral Health Services Expansion award to help launch and expand mental health and substance use disorder services in our health centers and shelter-based clinics. This funding will help expand access to needed care to help tackle the county's mental health and opioid crisis. The funding will add: One Full-time Behavioral Health Specialist (BHS) in Santa Maria, One Full-time Administrative Office Professional dedicated to work with the BHS team, Contracted Psychiatrist or Psychiatric Nurse Practitioner to offer tele-psych psychiatry services 16 hours per week. (4-hour sessions rotating through health center and shelter clinic locations in Carpinteria, Santa Barbara, Santa Maria, and Lompoc). The psychiatric services performed as part of this new effort will focus primarily on psychiatric medication management services and will be available to all registered patients covered by Medi-Cal, Medicare, as well as uninsured and/or sliding fee scale in compliance with HRSA's requirements.

MAT – Medically Assisted Treatment for Substance Use Disorder

- **Appropriate and Consistent Testing Process**
  - Added fentanyl and alcohol testing as standardized screening for every MAT visit; adjusted supply ordering in face of supply shortage.
  - Developed UDS insight list and shared with clinicians for guidance on false positive/negative results on urine drug screens. Compiled list of appropriate lab codes for confirmatory testing, developing a favorites list in Epic for ease of access to support efficient workflow.
- **Patient Treatment Access**
  - Established MAT patient list for case management, tracking, and communication among the MAT team. Utilized this list to ensure smooth transition w/departure of PA from Good Sam Shelter Clinic, including communicating with pharmacy to ensure adequate resources (Vivitrol) available at time of visit.
  - Obtained appropriate fridge to be able to offer Sublocade as treatment option.
- **Resources for Clinicians**
  - Provided smoking cessation clinical tips handout for clinicians.
  - Developed Smart Phrase for easy referral to Quit Coach resources.
  - Provided training to PA to add Vivitrol to practice when covering at Good Sam Shelter Clinic, to improve consistent access to treatment during times of clinician transition.
- **Harm Reduction Resources**
  - Pursued obtaining naloxone and fentanyl testing strips from DHCS for distribution as harm reduction methods for overdose death prevention. Developed information card with education on proper administration of naloxone and connection to resources, to include w/materials distributed.
- **Program Development**
  - Designed MAT Integrated Care Model to guide discussion and planning for development of a comprehensive, integrated care MAT program.
  - Participating in monthly SB County Opioid Coalition meetings for communication and collaboration with community partners.
  - Established MAT Provider Meeting following quarterly North County Provider Meeting, for discussion of work flow, protocols, access, resources, clinical trends, and clinical guideline review.

National Health Center Week

The Santa Barbara County Public Health Department organizes annual Back-to-School Health Fair events hosted at three of our Health Care Centers during National Health Center Week.

A truly joyful community effort that provided increased community awareness and access to our healthcare centers. In addition, the fairs prepared students throughout the county for the upcoming school year.

The events connected 2,450 community members with much-needed resources such as Cal Fresh, CenCal Health, Medi-Cal, blood pressure screenings, WIC, nutrition information, and mental health education, as well as the many health services provided at each of the healthcare centers.

SUCCESSES

2450
Community member attendance

240
Administered Vaccinations

55
Sport Physical Exams

1200+
Students who received free backpacks + school supplies

The Back-to-School Health Fairs were successful by every measure!

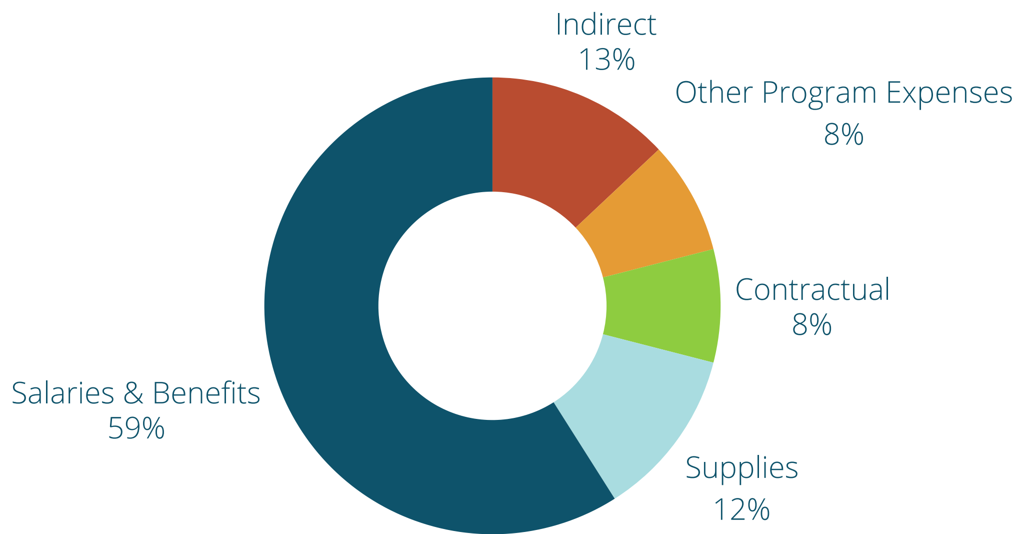
BY THE NUMBERS

	Attendees	Sports Physicals	Immunized Individuals	Doses Administered
Franklin Health Care Center	200	11	19	43
Lompoc Health Care Center	1050	23	30	71
Santa Maria Health Care Center	1200	21	52	126
TOTALS	**2450**	**55**	**101**	**240**

National Health Center Week

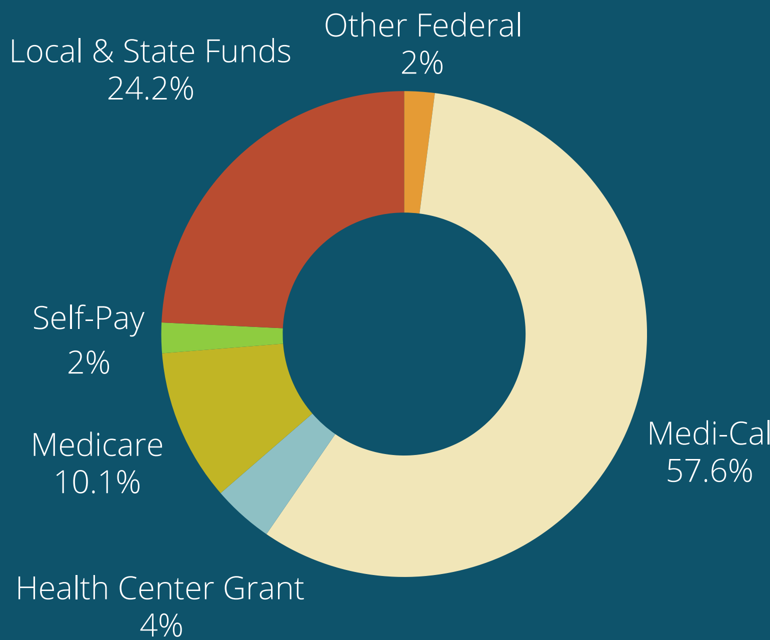
IN PICTURES

FISCAL SNAPSHOT



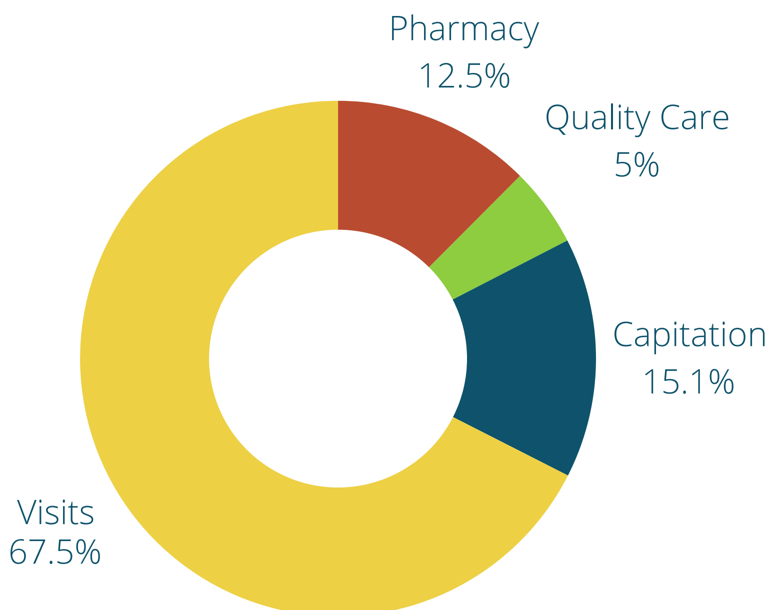
Health Center Expenses $61,875,177

Expenses ended the year over budget mostly because of increases in pharmaceutical costs, professional services, and physician fees.



Health Center Revenues $61,875,177

Patient service revenues for visits were below budget for the year, but were helped by increases in Medi-Cal and Medicare pharmacy revenue.



Medi-Cal Revenue $35,041,093

At our health care centers, more patients are covered by Medi-Cal than any other insurance.

In 2024, more Californians were eligible for Medi-Cal than ever before offering access to doctor visits, immunization, pregnancy-related services and behavioral health care.

CalAIM ECM

The State of California has undertaken a multi-year transformation of Medi-Cal to help people maximize health and life trajectory by making the program more equitable, coordinated, and person-centered. The transformative endeavor, California Advancing and Innovating Medi-Cal (CalAIM), puts people's needs at the center of care through coordinating clinical and support services to meet each Medi-Cal enrollee's physical, developmental, behavioral, service, dental, and social support needs. Moving to a population health approach, CalAIM also addresses Social Determinants of Health (SDOH), which include a wide variety of situational factors that affect risks, health, functioning, and quality-of-life outcomes. CalAIM better aligns funding, infrastructure, and service delivery to meet overarching goals and to incentivize local service providers accordingly. CalAIM includes specific initiatives to provide equal access to health and well-being for individuals who have historically faced substantial barriers to access and consequently suffered poor outcomes. One such initiative is Enhanced Care Management (ECM), a new Medi-Cal benefit available to eligible members with complex needs.

Statewide, more than 50 percent of Medi-Cal spending is attributed to the five percent of members with the highest-cost needs. These Medi-Cal members typically experience several complex health conditions involving interacting physical health, behavioral health, and social needs. Members with complex needs must often engage multiple delivery systems to access care, including primary and specialty care, dental, mental health, substance use disorder treatment, housing assistance, and long-term services and supports. ECM is designed to meet the uniquely intense needs of these members by providing a care manager to connect individuals to these supports.

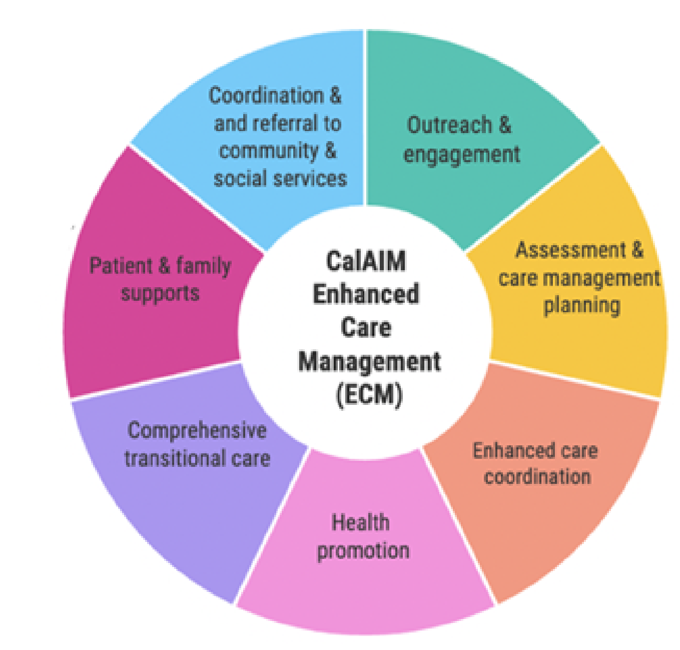
Through ECM, these most-vulnerable, highest-need members will receive comprehensive care management from a single lead care manager who coordinates all their health-related care and facilitates access to community supports. ECM makes it easier for members to get the right care at the right time in the right setting, and to receive integrated, coordinated, comprehensive care that extends beyond the doctor's office or hospital. Lead care managers meet members where they are—on the street, in a shelter, in their doctor's office, or at home—to provide interdisciplinary, high touch, person-centered services through face-to-face interactions with members where they live, seek care and prefer to access services.

What Next?

CenCal Health has awarded the Santa Barbara County Public Health Department (PHD) $950,499 to support the design, development, and implementation of ECM services to CenCal Health members. Among the populations eligible for ECM, PHD will use this initial funding to serve persons experiencing homelessness and persons at risk for avoidable hospital or emergency department care. Awarded funds will be used to create four new positions, procure necessary equipment, provide training, and cover operating costs associated with the startup of ECM.

The following positions have been funded to begin the delivery of ECM services:

- One (1) 1.0 FTE Staff Nurse, Supervisor
- Three (3) Health Service Aides



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