SANTA BARBARA COUNTY ADULT & AGING NETWORK

January 27, 2016
2:30 – 4:30 p.m.
City of Solvang Council Chambers • 1644 Oak Street • Solvang, CA 93463

MINUTES

Attendance: Donna Beal, Hillary Blackerby, Holly Carmody, Eloisa Chavez, Arlene Diaz, Doreen Farr, Eric Friedman, Jennifer Griffin, Cheri Jasinski, Susan Klein-Rothschild, Susan Lindman, joyce ellen lippman, Cynthia McNulty, Brad Parks, Mary Lou Parks,Yolanda Perez, Kathleen Riel, Refujio Rodriguez, Arcelia Sencion, Elizabeth Taylor-Linzey, Erin Weber, Margaret Weiss, Phylene Wiggins

Special Guests: Theresa Herzog, CenCal Health Heart SMART; Hazel Mortensen, Community Member; Hugo Romo, Partners in Care; Patricia Sandoval, Partners in Care; Melissa Zaragoza, Student at California State University Channel Islands

Staff: Barbara Finch, Gloria Munoz, Dennis Tivey

1. **Welcome & Introductions**
   Barbara opened the meeting and introductions were made.

2. **Public Comment**
   Hazel Mortensen shared an information sheet that she created for seniors who have pets. She expressed the importance of making first responders aware that there are pets in the house and to give seniors a way to identify emergency contacts for their pets in the event that the owner is hospitalized or passes away. She also shared that Costco offers veterinary prescriptions at a low cost.

3. **Approval of Minutes, November 18, 2015**
   Susan Klein-Rothschild motioned to approve the minutes from November 18, 2015; Yolanda Perez seconded the motion and the minutes were approved unanimously.

4. **Introduction of new MSSP Provider, Partners in Care**
   Hugo Romo, Director of Health Services at Partners in Care, shared that his organization has replaced CenCal Health as the Multipurpose Senior Service Program (MSSP) provider in Santa Barbara County. They also operate two MSSP's in Los Angeles County and one in Kern County. Hugo introduced Patricia Sandoval, Clinical Supervisor at Partners in Care, who will work in Santa Barbara Monday through Friday from 9-5pm.

   Susan Klein-Rothschild voiced a concern about the local MSSP being managed by an organization that is based in Los Angeles. Hugo indicated that he had read the AAN minutes from the last meeting and felt a sense of shared values. Partners in Care intends to be a part of this Network and to connect with community centers, the Board of Supervisors and State legislators representing Santa Barbara County. He specifically mentioned advocacy in support of MSSP expansion and cited the need for more resources.

   Joyce Ellen Lippman noted that Partners in Care has statewide grants. She asked Hugo to share information about the activities/services from those grants. Hugo described Partners in

Introduction of new MSSP Provider, Partners in Care (continued)

Home, which is a network that sends social workers to chronically ill elders to conduct an assessment and connect clients to resources in the community. They partner with community-based organizations throughout the state, hiring local people to do the work. They also have self-care management programs, workshops and educational programs.

Patricia Sandoval reported that Partners in Care has been contacting everyone on their MSSP client list to streamline the transition. They currently have 144 people in the program and maximum enrollment is 160. They will start working on the waiting list this month. MSSP participants get a monthly phone call, a quarterly face to face visit, and an annual reassessment. Sometimes they speak to the client a few times a month. Anyone can refer seniors to this program.

Hugo mentioned that they are looking for a part time registered nurse and additional social workers for both North and South County. He concluded by letting everyone know that they are happy to be working in Santa Barbara and look forward to collaborating with everyone.

5. Cottage Health Community Case Management/PATTH Program

Elizabeth Taylor-Linzey noted similarities between the Public Health Nurse position that is being proposed by the Network and the work that Cottage Health, MSSP and CenCal are doing to address the needs of the most vulnerable seniors. The Cottage Health Community Case Management Program accepts referrals from within the hospital and provides services that are aimed at improving the 30 day readmission rates. They have the following programs:

- PATTH – Nurses follow-up by telephone with vulnerable clients who may require additional support to manage chronic illness and associated health needs
- High Risk Program – Nurses follow up with clients in the home and connect them to community services and resources. The focus is transitions in care for the most vulnerable, high risk individuals.

Program activities may include accompanying clients to medical appointments, advanced care planning, linking to primary care, and developing and strengthening support networks. They are not a replacement for primary care providers or home health services. Their scope of practice includes Medicare and Medi-Cal insured clients. Collaboration with community partners and family members is critical in addressing the needs of clients.

Elizabeth introduced Theresa Herzog, a nurse practitioner working with the Heart SMART program. She creates and coordinates the Congestive Heart Failure Care Management Disease Management Program for CenCal Health. Theresa can keep them in her program from three months up to a year. Dignity and Cottage both transition qualifying patients to her program.

6. Update on Senior Nutrition Services Assessment

During the November Board presentation, Supervisors requested information about available meal services and nutritional support for seniors and people with disabilities. Senior Nutrition Services subcommittee will survey community providers to identify who receives these services, where they are available, and where there are gaps. Eloisa mentioned that the Foodbank has a large data base of food providers. Supervisor Farr suggested looking at the Foodbank information first to see what else is needed. The subcommittee agreed to meet with Eloisa to look over the data.

7. **Discussion about Public Health Nurse and Community Needs**

Daniel Nielson, Dr. Wada and Susan Klein-Rothschild met with Barbara to talk about where the Public Health Nurse (PHN) position might be housed. The decision was made for Public Health to host the position if the Network wants it to be housed within a County department. They encouraged the Network to brainstorm about every possible configuration in order to maximize use of resources to meet community needs.

Supervisor Farr mentioned that the Board will be going into Budget Workshops in April. The sooner these asks can get out there and be a part of the discussion, the better.

It was recommended that AAN Work Groups lead specific projects requested by the Board:

- Community Planning → Senior Nutrition Project
- Advocacy Group → Transportation Project
- Education & Outreach → Foundation Roundtable Project/ Outreach to City Govt

Supervisor Farr encouraged members to be mindful that this is an election year and therefore an opportunity to raise issues of concern to seniors and people with disabilities. She feels that AAN priorities are not going to get the resources they need unless everyone is out there consistently bringing up the needs. No one is talking about senior issues in any of the presidential debates. She feels that these issues will not get attention unless advocacy builds locally and in an organic way and the pressure comes up from the people.

PHN Target Population & Services

The group decided that the target population would be all seniors and people with disabilities - anyone for whom there is a health and/or safety concern. Medi-Cal eligibility would not exclude people from a PHN Assessment but might guide the referral process.

- At the last meeting, the Geriatric Assessment Program (GAP) was discussed – a similar model could serve a broad range of seniors. Referrals to IHSS or Multipurpose Senior Services Program (MSSP) could be made as appropriate.
- The focus of the position would be to provide short-term assessment/case management (maximum 60 days) with linkages and referrals, not long-term case management.
- Looking at income level / Medi-Cal eligibility can be secondary.
- Clients can be self referred, agency referred, family referred, etc.
- To be consistent with Area Agency on Aging, target population will be seniors 60 and over.
- There will be an intention to focus most services on those who are in the eligibility gap – not able to qualify for subsidized programs and unable to pay on their own.

How is this different than APS?

- This program would not necessarily involve abuse and neglect, although there is an overlap. This is more medically focused. APS may make a referral to this program and this program could refer to APS as appropriate.

Where is the need? How will the project identify the need? Potential data sources?

- Public Health Department's Community Health Assessment. They have over 3,000 surveys and a portion of these were completed by seniors.
- AAA Elder Needs Assessment, which included 2,000 respondents.
- National Trauma Database - information about elderly patients seen at the trauma center.

Discussion about Public Health Nurse and Community Needs (continued)

- Meals on Wheels Program – service eligibility implies a certain level of disability, infirmity, poverty, etc.
- Community-based organizations that track who has received services and who has been turned away.
- County Poverty Study -demographic information on seniors who are 60 and above or 85 and above
- DASH program
- AAA has a senior information and referral program that receives about 5, 000 calls a year. They categorize according to why people are calling and keep a list of calls for which they couldn't find a referral source.
- Community Action Commission can also pull data from the 211 database and see what people are asking for.
- UCLA California Health Interview Survey (CHIS).
- Behavioral Risk Factor Surveillance Survey – to capture information on dementia.
- LEON – information on undocumented seniors
- Hospital data from Marian and Cottage
- American Community Survey (Census Data)- information about disability and functional impairments

How to structure the proposal?

- Pilot Program to meet immediate needs, test the waters, gather data.
- More money available for one-time asks and a pilot program could be funded from this source. If ongoing support is indicated by the pilot project, it can inform future requests.
- The pilot program will help assess what the longer term need is.
- The pilot program will be100% funded through the General Fund.

Supervisor Farr anticipates questions from the Board:

- Who else is out there that is doing this that is not County government? Can they do it better? Can they do it more cost effectively? Why should the County take this on?
- We have to make an argument that this is a county responsibility, it is not being done by someone else
    - Frame it in terms of public safety. The county has a huge public safety responsibility –entry points for senior services at the county level are extremely limited right now
    - Community-based orgs cannot address the eligibility gap without government support
    - GAP showed that many people were Medi-Cal eligible but didn't know where to go. This pilot would help people access appropriate resources
    - Between 2007 and 2013 there were 33 positions that were eliminated in the Community Health component of Public Health, including GAP. Action is needed to meet community health needs.

Who else is doing this?

- Compile information from agencies that are doing some component of this.
- Form a subcommittee to flesh out proposal –VNHC, CenCal, DSS, Cottage, DASH, PHD, FSA, MSSP, AAA, Marian

Discussion about Public Health Nurse and Community Needs (continued)

How is this proposal similar to GAP?
Susan- It is similar but this proposal will not have the same time frames or community supports that were previously available. GAP was short term but more flexible. It was defined by the worker and supervisor based on the needs.

Supervisor Farr – The service time frame is important for a pilot program - we are trying to reach out to as many people as we can. There will be some short term assessment and some case management that will take longer. Some people won't need 60 days.

Barbara –it will be important to track the number that were referred to the program, who they were referred out to, those that didn't have anywhere to refer them to, those that are cycling back, and those that were referred and had to be on the waiting list.

This proposal will focus on adding somebody with a medical background who can do the comprehensive assessment of medical needs as well as a psychosocial and environmental assessment. They can then do a short-term care plan and include family members and give information and referrals.

Arcelia –travel and associated costs will need to be considered if this is to be a county wide position. Part-time, regionally-based positions might have advantages.

8. Updates and Announcements

- Dennis showed the group the new Adult & Aging Network website.
- Supervisor Doreen Farr mentioned that there was a story in the Santa Maria Times about the need for adequate transportation for seniors and the disabled. This was one of the unmet needs that was highlighted at the Needs Assessment Hearing. She encourages everyone to go to the Santa Barbara County Association Governments website and share their comments on transportation for seniors and the disabled.
- Phylene announced that there will be holding care-map workshops February 24-26th. The workshops are for anybody that is working with family caregivers. They will be having two sessions for social workers and three sessions for family caregivers. They will be held in Santa Barbara, one in Lompoc, and two in Santa Maria. Phylene will forward the flyer to Gloria once it is ready.
- joyce ellen announced that AAA is having their public hearings and she encourages everyone to attend.

9. Adjourn
The meeting adjourned at 4:37 p.m.

Respectfully submitted by Gloria Munoz