HMA

HEALTH MANAGEMENT ASSOCIATES

Assessment of Strategic Priorities for San Mateo Health Services

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Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Introduction

In the summer of 2007, the San Mateo County Board of Supervisors engaged Health Management Associates (HMA) to evaluate the County's current health service configuration and to make recommendations on strategic approaches for the future. This report is actually "Phase 2" of this comprehensive review. The first report, "Phase 1— The Financial Analysis of the San Mateo Medical Center", was delivered to and reviewed by the County earlier in the fall. The analysis and recommendations embodied in this document represent a broader assessment of the clinical, organizational, environmental, financial and political priorities that face the County as it addresses the operation of an effective and efficient delivery system and, at the same time, coordinates access to a continuum of health care services for the residents of San Mateo County.

For the purposes of this project, HMA assembled a team of senior staff with lengthy histories and specific expertise in clinical care, public health and hospital services administration, mental health, managed care, long-term care services, and finance. Over the past four months, scores of people have been interviewed, including: County Supervisors and staff; Health Department leadership; the San Mateo Health Plan leadership; clinical and administrative leadership from all components of the San Mateo Medical Center (SMMC); CEOs and other senior staff from all of the private hospitals in the County; representatives of private physicians, unions and advocacy groups; non-SMMC primary care providers serving predominately indigent populations; academic leadership; and others with histories in San Mateo health care that could contribute to "peeling the onion" to truly understand the unique situation faced by the County as it attempts to meet its mission effectively. A list of those interviewed is provided as Appendix #1. Several community meetings were attended to get a better sense of the view of the broader public about the health care needs in the County and the current County role in providing access to services. In addition, HMA reviewed financial and utilization data and observed in the SMMC's clinics; Emergency Department; Burlingame and SMMC SNF units, and acute medical/surgical inpatient and psychiatric service areas (emergency and acute). Previous reports were reviewed and some authors were interviewed. Finally, HMA held several meetings with the Project Steering Committee to touch base throughout the analysis and to share assumptions and preliminary thoughts on direction.

HMA is grateful to San Mateo County for allowing it to participate in this important process.

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Executive Summary

Over the course of the past four months, HMA has reached the following conclusions about the health care priorities for San Mateo County. These conclusions, generated after extensive interviews, clinical observation, data analysis and comparison to similar systems across the state and the nation, are grouped into "findings" and recommendations" as outlined below and are discussed at greater length within the full report.

The Broader Community: Findings

- There is clear under-service for vulnerable populations in communities within San Mateo County and the County will need to continue a role in both providing and coordinating care.
- The San Mateo County subsidy is significant and will continue to rise in the absence of significant restructuring.
- The private health care provider community is actively competing for the commercially-insured patient market and, thus, such an emphasis for the County system is a waste of effort.
- The response of private providers to Medi-Cal reimbursement indicates that the issue is not only "coverage" but must also be delivery system reform.
- The Blue Ribbon Task Force has brought the key players to the table but must now move into a focus on delivery system.
- The corporatization of providers makes the strategies for restructuring the delivery system more problematic.
- There is a lack of certain health care services, even for the insured.
- Mixed messages about the focus and mission of the County's health system are apparent.
- There is a relatively small and predictable medically underserved population.
- There are smart and committed people in leadership positions.
- The County currently has strategically-placed and comprehensive health services upon which to build an integrated (and managed) approach to care.
- Private providers are willing to come to the table to participate in creating an equitable and sustainable delivery system for the underserved.
- There exists support from the governing body and general public for the County's health leadership.

The Broader Community: Recommendations

- **The County should acknowledge that maintaining the status quo is not a viable option.** Health care costs will continue to rise. The number of those without health insurance—or those "covered" individuals who still cannot gain access to care—will continue to increase. If something drastic is not done to reconfigure the delivery of care, the County will have few options: curtail the number of people eligible to get care; limit the scope of services supported by the County; get out of the business altogether; or continue to put more money into the health system every year and limit the dollars that can be allocated for other services. Assuming the final option is unlikely and the others available can only hurt those with little or no access to care, the County should look seriously at how most effectively to restructure its resources to meet its mission.
- **The County should continue to stay in the business of delivering care, but do it more effectively and efficiently and as a part of an integrated system of care with other providers.** Examples across the country abound in which local governments pulled out of the direct delivery of care, lost their leverage for increased reimbursement, took on mounting costs for indigent patients served in other institutions and found themselves unable to meet the growing burden. More creative solutions have involved developing delivery systems with other providers in which duplication of service was minimized and high utilizing and expensive patient populations were effectively managed, and which built upon the assets and expertise of partners. This is a more difficult approach, but the only sustainable one.
- **The County should become more aggressive at restructuring its own health services and policies to achieve new levels of efficiencies.** There are operational, policy and structural changes that can and must be made to assure that the County's own operations are functioning effectively and efficiently. HMA believes the County will need to continue to remain as a key component of the health care safety net for the broader community and needs to be administratively, financially and clinically sound. These improvements need to be addressed within the delivery system, among the elements of the County's health care service areas and related to the role of the government itself.
- **The County should take the lead in fashioning a new, sustainable and creative approach to health care delivery.** All of the elements are in place—both within the County's own resources and including those of the private sector—to pull together a rational system of health care services for all residents of San Mateo County who need it. The County needs to: clearly identify the population that needs to be "assured" care, identify the scope of services that are needed for the target population, and develop/negotiate a health care network that makes use of the County's own delivery system and programs as well as brings commitment from the private sector providers. It is the County's responsibility—and in its

best interest—to look at using those resources to leverage a rational delivery system. This is a role that the County has started in its efforts with the Blue Ribbon Task Force and now needs to be continued to draw on all resources to establish a new way of delivering care.

- **As much as possible, the County should coordinate all available sources of funding and leverage them to support one multi-dimensional approach to the delivery of effective health care services for vulnerable populations within San Mateo County.** Astute financial evaluation should be part of the creation of a delivery system made up of both public and private partners. The County should define its subsidy—both current and future—and every attempt should be made to maximize the State and federal contributions to the care of these populations. Further, there should be an exploration of the redirection of funding generated by the two health care districts within the County to assure maximum coordination with the broader effort to establish an effective health care safety net for medically fragile populations and communities.

The County's Health Care Role: Findings

- The County has both committed and smart leaders in all areas who are willing to better coordinate between the different "silos" of County health care interests to "raise all boats."
- The coordination of the three areas of health service activity in the County is not institutionalized; there is not a clear expectation for joint planning around common objectives.
- Policies and practices are sometimes implemented that are not beneficial to either the individual institutions within the County or to access to health care services for those patients the County is targeting to serve.
- Data is not readily available across the County's programs and institutions that would help coordinate both an understanding of issues and a determination of best responses.
- The County often projects mixed messages about its role in and commitment to health care access causing some confusion in the larger community.

The County's Health Care Role: Recommendations

- **The County should publicly clarify its role as it relates to health services.** All County officials and institutional leadership should understand and publicly support the County priorities and mission.
- **A County-wide Strategic Plan should be generated.** This plan should identify operational, financial, clinical, utilization, health status, and organizational priorities and benchmarks. It should designate areas of responsibility and call for

regular reporting on progress or on identification of problems. It should be approved by the Board of Supervisors and be overseen by the County Manager. Health care is constantly fluctuating and the County can't afford to not be on top of those fluctuations.

- **The County Manager should require the leadership of SMMC, the health department and the HPSM to meet on a weekly basis and to meet the objectives laid out in the Strategic Health Care Plan.** The three leaders should identify priority issues, develop collaborative responses, and report back monthly to the County Manager, who should play the primary role of coordinating both the health care activity within the County's facilities and any efforts to build a more comprehensive system.
- **The County should review its financial oversight to assure that the review is not done in silos but, rather, reflects the financial commitment, revenue strategies and use of resources of the County as a whole.** Decisions in one area may result in seemingly better financial outcomes, while those same decisions may have significantly adverse repercussions in another area. This coalescing will require improved data collection and staff attention, but is critical to making policy and service allocation determinations that make sense system-wide.
- **The County should assure consistency in Board oversight of health activities.** Different County Supervisors are involved in different aspects of health care services within the County (the SMMC, the HPSM, the Blue Ribbon Task Force, etc.). There should be an attempt to coordinate those efforts as much as possible, particularly as they relate to the overall County strategic health plan.
- **The County should look at organizational changes that would allow for greater flexibility for its health care managers while retaining necessary accountability.** The County should explore procedural fixes that could allow for more timely hiring, for redrafting (and consolidating) job descriptions to gain efficiencies, etc. These changes should be accomplished within clear guidelines for demonstrating budget neutrality or savings. The ability to quickly respond to the changing needs of the health system, however, should allow for a more efficiently run operation.

SMMC Medical Services: Findings

- The primary care network of clinics is the backbone of the safety net in San Mateo County.
- The community-based clinics are well located and staffed with well qualified personnel.
- Productivity and better use of space capacity is possible within the primary care clinics.
- Chronic Disease Management planning and programs have begun but still

remains a marginal strategy.

- Specialty care at SMMC has a wide scope but its depth is shallow compared to need.
- Access to specialty care is limited and difficult, and referral methods are inefficient.
- The organization of specialty care services is rather fragmented and lacks medical leadership from SMMC.
- Current specialty contracting may not provide the highest value to SMMC and its patients.
- The Emergency Department is busy for the size of the hospital, but serves many low acuity patients and functions as a screening site for admissions from primary care and a way of accessing urgent specialty consultation.
- Inpatient acute care has a low census and a low occupancy rate, yet has patients in beds awaiting placement.
- The organization of inpatient acute care at the provider's level is determined by the contracted medical staff, and the mix of specialists who provide hospitalist services reflects group and individual interests.
- Primary care, specialty care, Emergency Department, and inpatient acute care represent relatively separate entities within SMMC and are disjointed from each other as they are from psychiatry and long-term care.

SMMC Medical Services: Recommendations

- **SMMC ambulatory services, both primary and specialty (along with psychiatry and long-term care), should be a critical part of a broader network of care for underserved patients in San Mateo County.** This network should be organized by the County, but it should include contributions of care from other private and community-based providers. The medical services of SMMC should be included as a key element and leader within the network. However, the scope of SMMC medical services and operations will have to change and improve.
- **Financial considerations dictate the continuation of inpatient acute care**; however, the size, volume and scope should be determined through the broader planning process with other providers in San Mateo County.
- **The SMMC medical services (ambulatory, ED, inpatient, psych and LTC) should be prioritized and coordinated around a chronic disease management approach** as the central focus. These efforts should be an organizational priority and funded on "hard money." The plan to create the Radical Redesign Clinic for disease management should allow for rapid deployment throughout the ambulatory system.

- **A method should be devised to identify patients with chronic medical illness**, who present within the system, or are underserved, and they should be recruited into chronic disease management programs.
- **Efforts to increase primary care and specialty care productivity and maxime capacity should be continued and increased until benchmarks are met**. Decreasing the number of part-time physicians and the variability of hours worked should be a goal of SMMC medical administration. New benchmarks, more appropriate for disease management, should be chosen or devised and adopted.
- **The demand for specialty care access necessary for the underserved population in San Mateo County should be determined**. This can serve the organization of a broader network of care within the County and should be accomplished regardless of external grant funding availability, and with other stakeholders at the table. SMMC is likely to play a major role in providing specialty care to the underserved, but should not assume this role alone.
- **Specialty care should be reorganized around chronic disease management**. This should include communication with and training of primary care providers, a refocus of specialists' time, and a new system of prioritizing referrals that is efficient and improves appropriate access.
- **Aggressive efforts should be made to attract and retain pediatric and geriatric patients in the ambulatory system** in coordination with the Health Department and the Health Plan.
- **Medical leadership for specialty care and inpatient acute care should be designated** within the SMMC organizational structure that has the responsibility for defining scope and productivity of medical practice. This leadership should set medical policy in collaboration with the medical departments and divisions.
- **The current practice of contracting with physicians should be significantly redesigned**. SMMC should consider the employment of specialists or a relationship with a large physician group to provide positions and/or coverage.
- **Remove unnecessary obstacles to receiving care at SMMC**, either at the outpatient clinics (i.e., phone access, referral systems or financial policies) or for inpatient admissions (i.e., implement direct admission policies).
- **A Chief Medical Officer (CMO) position for SMMC should be created** to provide strong and accountable medical leadership at SMMC that cuts across and coordinates all care provided within the system. The different clinical departments should meet regularly, share a common strategic plan, and understand their role and the roles of other departments.
- **Integrate medical services into efforts to better address moving patients into lower levels of care.** This would allow more efficient discharge from inpatient acute care and psychiatry. The primary care physician should be part of a team

that supports home and community-based long-term care as well.

Psychiatric and Long-Term Care (LTC) Services: Findings

- A lack of sufficient numbers and types of alternative placements are creating bottlenecks throughout the system and are the major driver of non-paid and paid administrative days.
- Other contributors to administrative days appear to be documentation gaps in inpatient psychiatric services and delays and conflicts around discharge status and discharge planning.
- There are major information gaps that prevent accurate analysis of "social admissions" and administrative days for both psych and med/surg patients.
- There is no high level administrative leader for inpatient psychiatric services.
- The current system has high quality people and a significant commitment to psychiatric and LTC services, but the various levels of care (community-based and institutional) are fragmented.
- Burlingame could be a more significant provider of care for patients with behavioral problems if there was intensive training and ongoing support of staff.
- Burlingame has significant physical plant constraints that reduce the County's ability to serve persons with more complex needs, especially for persons with physical/medical/behavioral complexities.
- San Mateo County appears to have a shortage of LTC beds relative to need.

Psychiatric and Long Term Care Services: Recommendations

- **Comprehensively Assess the Future LTC Service Needs of the County and the County's Role in Meeting These Needs.** Assess the ideal configuration of long-term care options including SNF, assisted living, housing with on-site supports, support at home and specialized models of care (for gero-psych, dementia, TBI, etc.); map out current availability (public and private); determine the scope of the County's responsibility for long-term care; and determine the most feasible model for the County long-term care continuum consistent with the County's mission.
- **Consider conducting a feasibility study regarding the future of the Burlingame facility**. A feasibility study is likely needed to determine how much more money the County should invest in this facility versus the cost to buy or build a better facility. The study should include varying models of care (dementia, gero-psych – although not so large as to present a danger of IMD designation), assisted living and so on. The County should consider whether any patch payments would be eliminated (or future need for same reduced) with access to a newer "multipurpose" facility. The need to continue SNF beds at SMMC, or alternately

to provide additional SNF beds at SMMC (1A), should also be addressed as part of a feasibility study.

- **Implement one or more initiatives to address fragmentation of care and funding silos.** Potential initiatives include:
  - *Develop a County LTC budget* (probably specific to adults, but it could include children). Long-term care not only includes Unit 1A and Burlingame and persons in need of long-term supports presenting at Psychiatric Emergency Services (PES) and/or admitted to the psych unit, but also encompasses long-term care services funded through Aging and Adult Services and Mental Health Services. Only then, can the true cost of patching placements and other measures versus retaining patients at SMMC and Burlingame LTC, be assessed.
  - *Implement a comprehensive care management/coordination program* that provides a unified, multidisciplinary team or single case manager/care coordinator for each patient who then follows the patient across divisions and programs. This program could target specific types of patients.
  - *Implement the Long-term Services and Support Project* (*LTSSP) in as comprehensive a manner as possible, inclusive of mental health services.* The LTSSP offers an integrated model of care that is especially suited to the County, since the County already assumes comprehensive responsibility for Medi-Cal and uninsured County residents and has an existing structure (the HPSM) to deliver coordinated care.
- **Establish and fill a Vice President of Behavioral Health Services position and a Vice President of Skilled Nursing Facility Services position as soon as possible.** The complexity of issues to be dealt with specific to both inpatient psychiatric services and SNF services is such that a high level administrator is required to address issues within their respective service areas and across the entire County continuum of care.
- **Implement an initiative to improve documentation of need for and provision of acute inpatient psychiatric services, using an "unbiased" resource to coordinate and implement.** DMH findings are of sufficient concern to warrant a targeted documentation improvement initiative. By necessity, such an initiative would also include a review of the inpatient psychiatric services model of care and quality of care.
- **Collect data on each "social admit" and patient not in acute status (psych, med/surg, LTC) in order to assess the most appropriate use of resources for other levels and models of care.** This information should be collected systematically in order to identify the needed placements options, the need for patch payments, the utility of a potential step-down unit at SMMC, and the need

for additional long-term care beds and specialized programs (such as dementia and gero-psych).

- **Review and revise the Memorandum of Understanding (MOU) between SMMC and Behavioral Health and Recovery Services to incorporate enhanced reporting requirements and to address what are reported to be poorly aligned financial incentives.** Revised reporting requirements should include detailed tracking of acute and admin days. The MOU should include a revised financial arrangement that better aligns incentives and terminology that is consistent with state and federal regulations and consistent throughout the MOU and across County divisions.
- **Review the current SMMC admission and discharge planning processes across service areas and divisions/programs.** The LTC Admission Criteria should be specific and reflect actual practice. SMMC, MHS and Aging & Adult Services should determine what, if any, changes could be made to speed-up documentation of the appropriate least restrictive placements.
- **Provide additional training to Burlingame staff.** Burlingame LTC staff need additional training to accommodate patients with more challenging behaviors. They also need ongoing assistance/consultation from psychologists regarding behavior planning and approaches. Depending on the needs of such residents, an increase in staffing might also be required.
- **Assess out-of-county placements.** A review of the extent to which these admissions result in an inability to admit San Mateo County residents to SMMC or Burlingame LTC or transfer residents within SMMC and Burlingame LTC, should be quantified. The County should attempt to determine how many San Mateo County residents have become the responsibility of other counties. Once this information is quantified and assessed, the County may want to pursue a MOU with surrounding counties regarding their mutual interests, responsibilities and liabilities.
- **There are enough concerns about the impact of the potential MPHS/SMMC partnership proposal that indicate that more thought should be given to it before it proceeds.** Do not pursue the currently proposed options for an arrangement with Mills Peninsula Healthcare that would threaten to convert SMMC to IMD status or take up SMMC beds until a broader delivery system plan is developed that clearly sets out service requirements for all participating providers.

The Health Plan of San Mateo: Findings

- The HPSM could expand its role within the administration of the County health services.

- The Healthcare Coverage Initiative could be an important vehicle for managing some of the system's most complex patients.
- HPSM administration and operations need to be enhanced to meet the demands, particularly in care management, of the entire delivery system.
- HPSM has demonstrated its ability to successfully diversify and to keep pace administratively with both membership and product line growth.
- Provider access and capacity, both within and outside the contracted network, is an ongoing concern.
- HPSM has not built its CareAdvantage program to the full extent that it could and should.

The Health Plan of San Mateo: Recommendations

- **HPSM should take an even stronger role within County health services, particularly in long-term care services.** HPSM leadership's vision for the health plan includes prominence in the administration of the County's expanding health coverage programs. For example, the health plan is very interested in pursuing the Long-term Services and Support Project (LTSSP) in partnership with the County.
- **HPSM should work closely with SMMC in the administration of the Coverage Initiative.** The health plan appears to be well positioned to play a primary role in the administration of the coverage initiative. HPSM's systems and processes are scalable and can accommodate the projected volume growth.
- **Growing the CareAdvantage program should be a priority.** As one of two special needs plans in San Mateo County, the potential for growth is there. HPSM has relied on passive enrollment for its membership, and has not yet developed a formal marketing plan to promote its benefit design and attract members, or to retain current members.
- **Significant attention should be paid to operational issues within HPSM, particularly in the area of data.** An important emphasis should be placed on the efficiency and accuracy of HPSM's collection and reporting of CareAdvantage members' diagnoses (i.e., risk adjustment factors). It is critical for HPSM to educate its providers on the importance of accurate coding. Reimbursement under Medicare Advantage is now based entirely on risk adjustment factors for individual members. Current analysis of data across the country indicates that the general "rule of thumb" is that $80-$120 per member per month is "left on the table" due to coding errors.
- **The development of an institutional SNP should be explored if/when the moratorium on new SNPs is lifted.** An area worthy of additional analysis for HPSM's Medicare line of business is expansion to an institutional SNP. Both the

County and HPSM are interested in long term care and an institutional SNP could improve care coordination and reimbursement.

- **HPSM should aggressively develop care management capabilities, in connection with both the SMMC efforts and as a part of the development of a broader delivery system for medically fragile people**. Health plan leadership acknowledged the opportunities that exist regarding care management for its members.
- **HPSM should coordinate with other County programs to assure consistency and streamline bureaucracy**. Among the areas of consideration for operational efficiencies county-wide include enrollment and eligibility determination functions, as well as decision support capabilities. The lines of responsibility are at times blurred between the County and HPSM. Examples include the WELL program. The plan's IT and decision support capabilities are quite sophisticated, and are continuing to advance. The health plan is scheduled to replace its claims system and install a medical management system. Opportunities to "share" these resources and staff expertise with SMMC to assist with decision support and analysis (an area of weakness as identified by SMMC financial staff) should be assessed.
- **HPSM should play a pivotal role in defining health care provider needs and gaps**. In recognition of the varying provider participation issues throughout the County, HPSM is urged to monitor the success of its recently implemented PCP incentives. In addition, network inadequacies should be addressed and a broader delivery system plan established which would include current access issues in some parts of the County (e.g., southern portion) and to certain specialties.
- **HPSM should seek accreditation**. As HPSM continues to diversify and increase membership, HPSM leadership are encouraged to consider seeking NCQA accreditation in anticipation of future state or CMS requirements for participation in Medi-Cal or Medicare Advantage. HMA acknowledges the staff and financial costs associated with the preparation required to develop and submit an application and ready the plan for URAC accreditation are high, and that the time for seeking the accreditation is more likely in the future. However, the importance of accreditation should not be completely lost to other demands and priorities.

Health Financing: Findings

- System losses are widespread among service lines.
- Base payments for Med-Cal services do not cover costs in the SMMC system.
- Medicare payment does not cover the costs of serving Medicare patients within the SMMC system.

- Absent any significant changes, the County subsidy will continue to grow and will approach or exceed $80 million by FY 2011.
- The local government subsidy in San Mateo is one of the highest in the nation.
- The FQHC designation for SMMC clinics cannot be extended to new sites without a change in their configuration.
- Despite FQHC limitations, there are ways to increase revenue generation in the SMMC clinics.
- Medi-Cal designation of the clinics as hospital-based is contingent upon maintaining the acute care unit.
- Currently, SMMC does not pursue enhanced Medicare reimbursement for services provided in the clinics.
- Under current constraints, SMMC loses money on long-term care services at both SMMC and Burlingame.
- SMMC needs to avoid converting to IMD status.
- The County does not recoup its cost for delivering psychiatric services.
- There are overwhelming financial reasons for maintaining acute care hospital status for the SMMC.
- The financial implications of providing more acute care are difficult to assess.
- The Inter-Governmental Transfer (IGT) related to the HPSM is one area for potential new federal matching dollars.
- New federal Medicaid rules could have a significant impact on public hospital systems.
- Ongoing operational demands limit SMMC's ability to adequately evaluate all revenue maximization strategies (including psych and LTC) and potential health reform impacts on the County.
- State health reform efforts could have serious consequences (and opportunities) for San Mateo County.

Health Financing: Recommendations

- **Advocacy at the federal level to extend the moratorium on implementing the public hospital rules is an important priority for the County.** Under the current waiver, Medi-Cal reimbursement is configured to assure continued losses. From a public hospital perspective, California Health Care Reform must include an increase in State support for Medi-Cal payments to public hospitals. Federal regulations (current and pending) limit financing options available to the

County. The estimated impact in terms of lost federal dollars of this rule on California public hospitals is $500 million annually.

- **Financial objectives and goals should be set and evaluated from a county-wide perspective, with each manager of a program or operating entity striving to maximize the state or federal dollars spent on health care for County residents and minimizing County subsidy**. Financial impact is currently being measured in silos (SMMC, public health, HPSM). An assessment at a higher level may result in more positive financing arrangements for the County as a whole.
- **Acute care services must be maintained at a level to prevent SMMC from reaching IMD status.** Designation as an IMD has serious financial repercussions including the loss of Medi-Cal supplemental payments, conversion of long-term care rates to freestanding instead of hospital-based (enhanced nursing home rates and seeing the hospital-based FQHC rate drop from $300 per encounter to, at best, $125).
- **State level advocacy is needed to alleviate underfunding of LTC services.** The base rate for long-term care is inadequate to cover the costs of the Burlingame facility. The current reimbursement is optimized within existing state and federal policy. Therefore, the solution is to identify additional state funding opportunities.
- **Aggressive efforts should be made to increase pediatric outpatient visits at SMMC clinics**. The costs associated with children are less than the $300 per encounter rate and would generate income to offset the subsidy of other patients and services. SMMC and the health department should explore the provision of mental health services within the SMMC ambulatory clinics in order to access the FQHC rates for those services.
- **Opportunity exists to increase Medicaid HMO payments to public entities in order to guarantee access.** Payment from the State to HMOs can be financed with local dollars (IGT). Medicaid HMO rates are based on "actuarial soundness." The County should advocate expansion of the current arrangement that generates $10 million in additional payments ($5 million net). It may be cost beneficial for the County to engage an actuary to develop the appropriate rationale for optimizing these payments.
- **Additional reimbursement and financial analysis resources are needed to evaluate all revenue maximization strategies (including psych and LTC) and the potential impact of health reform on the County.** SMMC must be proactive, and not reactive, to Medi-Cal funding opportunities and to initiatives like Health Care Reform. With recent activity at both the State and federal levels, the complexity of these programs and the opportunities that exist are increasing dramatically. Further, the impact of various components cannot be calculated in isolation as the effect is often related to other components and initiatives.

Health Care and the Broader Community

The findings and recommendations that are detailed on the pages of this report represent HMA's best thinking on the strategic priorities for San Mateo County as it plans for its role in health care delivery and coordination of health access in the years to come. While these findings and specific recommendations are discussed in greater detail in the report, it is important to understand the context in which these issues were addressed. There are issues related to the provision of health care services for vulnerable populations in San Mateo that are consistent with those faced by local communities across the nation; there are others that are unique. It is important to fully understand the environment in order to craft a strategic approach that is truly viable and sustainable.

The Broader Community: Findings

The following challenges and opportunities have been found to be critical in both understanding the County's situation and in formulating creative and effective responses.

Challenges

Several key challenges face San Mateo County as it addresses its role in coordinating health care access and improving health status for its residents. These challenges include the following:

- **There is clear under-service for vulnerable populations in communities within San Mateo County and the County will need to continue a role in both providing and coordinating care.** There is a universally acknowledged need for a health care safety net in San Mateo County, both for target populations for whom access to care is a persistent concern (the uninsured, under-insured and even Medi-Cal patients) and for all residents seeking particular services (i.e., psychiatric services and long-term care). In communities in which local governments have gotten out of the direct delivery of care, there has been an erosion over time of contribution to the care of indigent patients relative to cost incurred by private providers and access has suffered (e.g., Detroit; Washington, DC; Philadelphia). If, on the other hand, the local government takes the responsibility seriously to assure care for a designated uninsured population and is not delivering the services itself, over time, all of those patients become the local government's responsibility (even those now cared for as "charity" by private providers) and the local government will end up spending more money as it can no longer generate revenue as a provider and will need to cover increasing costs with only local subsidy.
- **The San Mateo County subsidy is significant and will continue to rise in the absence of significant restructuring.** The taxpayers of San Mateo County provide a high level of financial subsidy for the provision of health services to

medically vulnerable populations. That subsidy, coupled with the dollars that are generated by the two health care districts located within the County, represents one of the most significant levels of local subsidy of indigent care (per capita and per indigent care need) that exists in the country. However, the subsidy has continued to increase without a thorough understanding of its effective use in fashioning a coordinated, accountable and demonstrably effective health care system for the most medically fragile residents of the County.

- **The private health care provider community is actively competing for the commercially-insured patient market and, thus, such an emphasis for the County system is a waste of effort.** In the experience that HMA has amassed working with public hospital systems across the country, relying on any significant increase in privately-insured patients as a means of generating new revenue is generally a strategy that is likely to fail. Systems that do have privately insured patients usually have unique centers of excellence (most often, burn and trauma centers) on which to build reputations that would draw in non-traditional county patients. Not only is that not the case with SMMC, but the competition between other well-established providers is intense for that population. While there is some potential for SMMC keeping Medi-Cal kids (on whom the SMMC makes money) and on Medicare patients, concentrating efforts on the commercial insurance population is, we believe, a needless distraction.
- **The response of private providers to Medi-Cal reimbursement indicates that the issue is not only "coverage" but must also be delivery system reform.** It is clear that the ability and/or willingness of private providers to care for significant numbers—or any—patients covered by Medi-Cal is a growing issue for both hospitals and physicians in San Mateo County. The lack of access for these patients is particularly problematic in specialty areas but, as was expressed by every private health care leader that we interviewed, the low reimbursement from the State was causing re-evaluation of the levels of Medi-Cal patients for whom they would deliver care. This issue is an important one for the County as this situation increasingly puts "covered" patients into a category of those having difficulty accessing care.
- **The Blue Ribbon Task Force has brought the key players to the table, but must now move into a focus on delivery system.** Simply providing more people with coverage does not assure access to care. This means that the real work is not just assuring that more people are covered but that there is a delivery system that will meet the needs of all people who are covered, whether privately or through public sources (federal, state or local). There appears to be a willingness by most stakeholders to move to this next step.
- **The corporatization of providers makes the strategies for restructuring the delivery system more problematic.** Most private hospitals in the County are now part of large systems (Kaiser, Sutter, Catholic Healthcare West) and those corporate bodies will need to be engaged in further discussions about delivery

system reform, particularly for vulnerable populations. The pressure on these large systems to enhance their community benefit **(**to justify their tax exempt status**)** offers an opportunity to create defined contributions for providers that are both predictable and documentable, particularly as most hospitals are providing indigent care at levels lower than national norms. Further, the fact that the vast majority of the physicians in San Mateo County are employed in large groups (Kaiser, Pala Alto Medical Foundation, Stanford), primarily because of the significant cost of starting and maintaining private practices, can be both a challenge and an opportunity for the County. It appears to be very difficult to rely on individual practitioners to meet the medical (particularly specialty) needs of the indigent population. However, the opportunities to find creative approaches to securing physician services through employment or through contracting with these large groups should be explored.

- **There is a shortage of certain health care services, even for the insured.** Unlike most other local governments, San Mateo has, to its credit, stepped in to attempt to plug gaps in the delivery system that are often borne by either state government or by the private sector. Most notably, the County has assumed significant responsibility for the delivery of both *psychiatric* and *long-term care* services due, in large part, to a documented gap in the delivery system in these areas. Effectively operating and coordinating mental health and long-term care, in addition to the more traditional roles in the provision of acute outpatient and inpatient medical services, is a very real clinical and management challenge. For example, the fact that access to certain services (such as lower level of care for both psych and acute medicine patients) continues to be a problem in the community contributes to the inappropriate utilization of other levels of care, notably on the inpatient units at SMMC.
- **Mixed messages about the focus and mission of the County's health system are apparent.** There appears to be a lack of a clear, consistent and universally understood direction about both the present operation and future direction of the County's health services delivery system (SMMC). This uncertainty results in clinical utilization, financial policies, and connections between both components within the system itself as well as with other providers that is somewhat unfocused and reactive rather than strategic. Deciding as a County what its role will be in actually providing services, in negotiating for other services, establishing policies that do not create unreasonable and counter-productive barriers to accessing services and being the arbiter of a comprehensive health care delivery system for vulnerable populations and communities within the County is both a significant challenge and, at the same time, absolutely critical to moving forward in any effective way.

Opportunities

It is clear that, unlike many local communities that are mired in a seemingly hopeless morass of an overwhelming number of uninsured, lack of money, poor management, hostility of private providers and no public support, San Mateo has the assets to make the strategic transformation of a health system for the medically underserved not only possible but compelling. These assets and opportunities include the following:

- **There is a relatively small and predictable medically underserved population.** The number of people who are uninsured in the County is small enough to be manageable. It is possible to identify who the uninsured and medically vulnerable residents are, where they live, what health problems they face and what services they need.
- **There are smart and committed people in leadership positions.** HMA has been impressed with the quality of the political, administrative and clinical leadership of the various components of the County's involvement in the health care system. Even in areas in which there are management challenges, there seems to be an understanding of where the system is falling short and an eagerness to find more effective and accountable ways of operating. The value of this asset cannot be understated.
- **The County delivery system has strategically-placed and comprehensive health services.** The County has a framework of a comprehensive system of health care delivery that would be the envy of other counties struggling to assure access to services for medically indigent residents. It operates a continuum that includes: a community clinic network that provides primary care in appropriate communities throughout the County; specialty outpatient, emergent, inpatient med/surg and psych at SMMC; and skilled nursing facility services at SMMC and Burlingame. This asset, however, may not provide the maximum level of benefit unless it is operated as a fully integrated continuum of care with a clear set of priorities and well-defined mission.
- **There is more than enough funding to provide the basis of a comprehensive health care system, if that is the direction the County decides to go.** While the continuing increase in County subsidy is viewed as a challenge, the current level of local tax dollars invested in health care for the indigent also provides an enormous opportunity to seed the development of an effective and efficient system of care. The trick will be to maximize the leverage of whatever local dollars are allocated for health care to draw additional federal and state support, while making decisions about a delivery system that best meets the needs of the target population.
- **Elements exist within the County to build an integrated (and managed) approach to care.** The County has the ability and the structure to build an integrated approach to both delivering and assuring care through the coordination of its delivery system, the Health Department and participation

with the Health Plan of San Mateo. Where coordination of these elements has been a focus, innovative and creative approaches have resulted. Most systems do not have the cooperation and common vision that exist in San Mateo.

- **Private providers are willing to come to the table to participate in creating an equitable and sustainable delivery system for the underserved.** Most of the private providers within the County are represented in the current effort embodied in the Blue Ribbon Task Force, which was created to design an innovative approach to assuring access to health care services for the medically underserved in the County. Privately, many providers understand that their institutions need to be a part of an organized and accountable delivery system that equitably shares responsibility for assuring access to a continuum of care for all of the residents of the County. The opportunity for the County will be to draw on this willingness by creating a delivery system plan in which all providers have specific roles and responsibilities.
- **There exists support from the governing body and general public for the County's health leadership.** There appears to be broad public support for the County to take on the issue of assuring access to health care services for the residents of the County. This is not the case in all local communities across the country and should be viewed as an asset and an opportunity.

The Broader Community: Recommendations

Based on the challenges and opportunities facing San Mateo County, and filled in on the following pages with specific recommendations for clinical, structural, financial, and management changes, HMA believes the following broad approach should be taken to assure an effective, accountable, transparent and sustainable health care system for the County's most vulnerable residents in the years to come:

- **The County should acknowledge that maintaining the status quo is not a viable option.** Health care costs will continue to rise. The number of those without health insurance—or those "covered" individuals who still cannot gain access to care—will continue to increase. If something drastic is not done to reconfigure the delivery of care, the County will have few options: curtail the number of people eligible to get care; limit the scope of services supported by the County; get out of the business altogether; or continue to put more money into the health system every year and limit the dollars that can be allocated for other services. Assuming the final option is unlikely and the others available can only hurt those with little or no access to care, the County should look seriously at how most effectively to restructure its resources to meet its mission.
- **The County should continue to stay in the business of delivering care, but do it more effectively and efficiently and as a part of an integrated system of care with other providers.** Examples across the country abound in which local governments pulled out of the direct delivery of care, lost their leverage for

increased reimbursement, took on mounting costs for indigent patients served in other institutions and found themselves unable to meet the growing burden. More creative solutions have involved developing delivery systems with other providers in which duplication of service was minimized and high utilizing and expensive patient populations were effectively managed, and which built upon the assets and expertise of partners. This is a more difficult approach, but the only sustainable one.

- **The County should become more aggressive at restructuring the County's health services and policies to achieve new levels of efficiencies.** There are operational, policy and structural changes that can and must be made to assure that the County's own operations are functioning effectively and efficiently. HMA believes the County will need to continue to remain as a key component of the health care safety net for the broader community—both as a provider of services and as an coordinator of care—and, to that end, needs to be administratively, financially and clinically sound. These improvements need to be addressed within the delivery system, among the elements of the County's health care service areas and related to the role of the government itself. Specific recommendations in that regard are detailed in this report.
- **The County should take the lead in fashioning a new, sustainable and creative approach to health care delivery.** All of the elements are in place—both within the County's own resources and including those of the private sector—to pull together a rational system of health care services for all residents of San Mateo County who need it. The County needs to: clearly identify the population that needs to be "assured" care, identify the scope of services that are needed for the target population, and develop/negotiate a health care network that makes use of the County's own delivery system and programs as well as brings commitment from the private sector providers. It is the County's responsibility—and in its best interest—to look at using those resources to leverage a rational delivery system. This is a role that the County has started in its efforts with the Blue Ribbon Task Force and now needs to be continued to draw on all resources to establish a new way of delivering care.
- **As much as possible, the County should coordinate all available sources of funding and leverage them to support one multi-dimensional approach to the delivery of effective health care services for vulnerable populations within San Mateo County.** Astute financial evaluation should be part of the creation of a delivery system made up of both public and private partners. The County should define its subsidy—both current and future—and every attempt should be made to maximize the State and federal contributions to the care of these populations. Further, there should be an exploration of the redirection of funding generated by the two health care districts within the County to assure maximum coordination with the broader effort to establish an effective health care safety net for medically fragile populations and communities.

The County's Role in Health Care Services Delivery and Coordination

Overview

San Mateo plays myriad health care roles. It operates a health care delivery system, the San Mateo Medical Center, which, in turn, embodies a network of community clinics, the Burlingame skilled nursing facility, and the medical center itself- a complex institution that houses acute medical/surgical inpatient beds, medical and psychiatric emergency services, inpatient psychiatric care, a skilled nursing unit and both primary and specialty outpatient services. But the County also plays other health care roles. It includes a health department that provides traditional public health services throughout the County and oversees programs for the aging and mentally ill. It is an active participant in the Medicaid managed care entity, the Health Plan of San Mateo, which arranges for and organizes care (both within the SMMC and throughout the provider community) for vulnerable populations within the County. Finally, through both administrative and elective leadership, the County has taken on new roles in attempting to reach consensus on innovative ways to coordinate access for the growing numbers of people that are falling through the cracks of the current health care financing and delivery systems.

In order to effectively meet the health care challenges to come, it is critical that the County addresses how it executes its own areas of responsibility.

The County's Role: Findings

During the course of this analysis, HMA had the opportunity to interact with County elected officials, system-wide and institutional leadership, program managers and front-line clinical and administrative staff. Key findings related to the County's role in health services include:

- **The County has both committed and smart leaders in all areas.** There were no programs or institutions or individuals that seemed disinterested in working more effectively, or to changing where they needed to change in order to meet their missions and their mandates. This is an important finding as leadership is critical to going forward in new and creative ways.
- **There is a willingness to better coordinate between the different "silos" of County health care interests to "raise all boats.**" When the leadership of the SMMC, the health department and the HPSM have come together expressly to work on specific issues, understanding the political and financial constraints, the result has been positive.
- **The coordination of the three areas of health service activity in the County is not institutionalized; there is not a clear expectation for joint planning around**

common objectives. There is often the pull to concentrate on institutional priorities that are sometimes at the expense of the larger system. For example, the need to expand access for HPSM patients to obstetric and pediatric services should be a top priority for collaborative planning between all elements of the County system. This issue is multi-faceted and involves access, health status, financial, clinical and organizational issues and should be a coordinated effort by all elements of the County system.

- **Policies and practices are sometimes implemented that are not beneficial to either the individual institutions within the County or to access to health care services for those patients that the County is targeting to serve.** Some financial policies related to upfront payment for indigent patients to access clinic services in the County system, for example, actually cause a widespread perception throughout the community that patients should be referred directly to the Emergency Room in order to get timely care, generating an extra set of expensive services being delivered. Policies such as these, and others, do not seem to be reviewed on a regular basis to assure that they are having the results they were meant to have. Practices can also be put into place that are ineffective, but are not revisited. For example, the inability to directly refer from outpatient settings into the hospital also generates unnecessary ED use and will discourage those patients with any coverage (particularly Medicare patients) from using the County system.
- **Data is not readily available across the County's programs and institutions that would help coordinate both an understanding of issues and a determination of best responses.** Although some work is being done in this area, there could be greater effort and higher priority given to determining what data to collect and how to use it, integrating financial, service utilization and health status information.
- **The County often projects mixed messages about its role in and commitment to health care access causing some confusion in the larger community.** Because of the variety of voices speaking for the County on health care, it is unclear what the County role is and should be regarding the delivery and/or coordination of care. If the SMMC is the provider for those with no other option, why does it set up barriers to access for that population? If the County is concerned about limiting its financial commitment to health care, why is it promoting a plan to cover more people and generating more funds to do it? If the role of the County is not to compete with the private providers for commercially insured patients, why is that strategy being touted by some in leadership? This lack of a clear set of priorities is causing confusion around the County.

The County's Role: Recommendations

HMA recommends that the County take the following actions to make its own operations more effective and to take on the new responsibility for the development of a broader, community-wide delivery system suggested in the previous section.

- **The County should publicly clarify its role as it relates to health services.** All County officials and institutional leadership should understand and publicly support the County priorities and mission.
- **A County-wide Strategic Plan should be generated.** This plan should identify operational, financial, clinical, utilization, health status, and organizational priorities and benchmarks. It should designate areas of responsibility and call for regular reporting on progress or on identification of problems. It should be approved by the Board of Supervisors and be overseen by the County Manager. Health care is constantly fluctuating and the County can't afford to not be on top of those fluctuations.
- **The County Manager should require the leadership of SMMC, the health department and the HPSM to meet on a weekly basis and to meet the objectives laid out in the Strategic Health Care Plan.** The three leaders should identify priority issues, develop collaborative responses, and report back monthly to the County Manager, who should play the primary role of coordinating both the health care activity within the County's facilities and any efforts to build a more comprehensive system.
- **The County should review its financial oversight to assure that the review is not done in silos but, rather, reflects the financial commitment, revenue strategies and use of resources of the County as a whole.** Decisions in one area may result in seemingly better financial outcomes, while those same decisions may have significantly adverse repercussions in another area. This coalescing will require improved data collection and staff attention, but is critical to making policy and service allocation determinations that make sense system-wide.
- **The County should assure consistency in Board oversight of health activities.** Different County Supervisors are involved in different aspects of health care services within the County (the SMMC, the HPSM, the Blue Ribbon Task Force, etc.). There should be an attempt to coordinate those efforts as much as possible, particularly as they relate to the overall County strategic health plan.
- **The County should look at organizational changes that would allow for greater flexibility for its health care managers while retaining necessary accountability.** Most non-California public hospital systems have created alternate governance and management systems for their health care services (health care districts, public health authorities, public benefit corporations, not-for-profit status, etc.). For the most part, these governance changes have been generated in response to bureaucratic issues and management constraints that

result from working within a public system. While HMA is not recommending an overhaul of governance in San Mateo County, the County should explore procedural fixes that could allow for more timely hiring, for redrafting (and consolidating) job descriptions to gain efficiencies, etc. These changes should be accomplished within clear guidelines for demonstrating budget neutrality or savings. The ability to quickly respond to the changing needs of the health system, however, should allow for a more efficiently run operation.

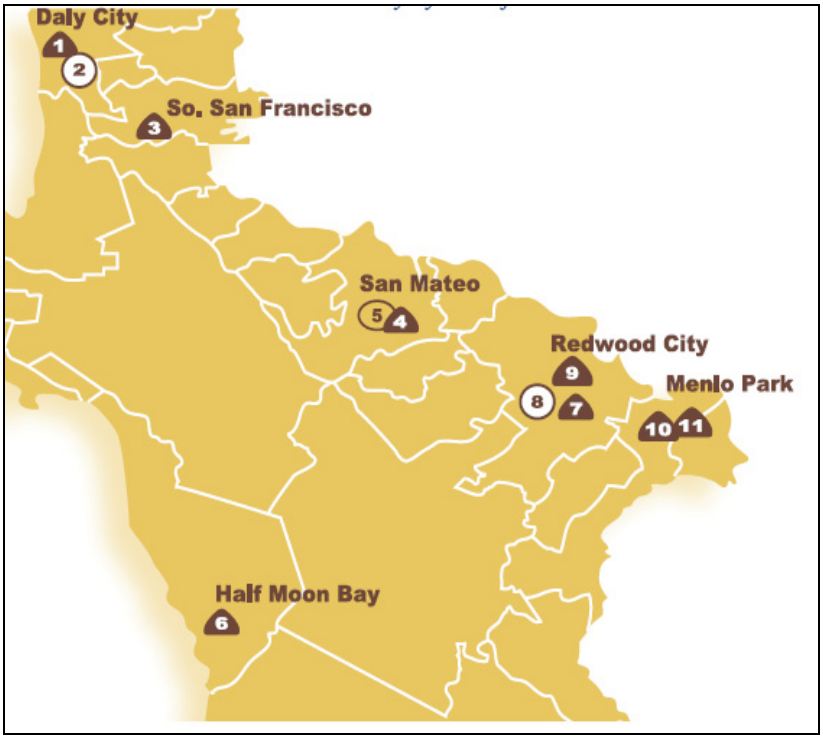
Medical Services: The San Mateo Medical Center (SMMC)

Medical Services: Overview

Primary Care

The San Mateo Medical Center operates a system of clinics that offers primary care in locations dispersed throughout the County's populated areas (see Figure 1). Comprehensive primary care for adults and children is provided at most sites. Prenatal care is only offered at three sites. Services such as dental care and optometry are only offered at some locations, but not at every primary care site. A senior care center, which provides primary care for the elderly, is located at the SMMC main campus site, but is identified as a separate facility. Two adolescent health centers provide age appropriate primary care at locations separate from other health centers. A clinic that cares for persons with HIV/AIDS, as well as Sexually Transmitted Diseases and other infectious diseases, is located on the main SMMC campus and is funded and administered by the Department of Public Health through a cooperative agreement with SMMC.

Figure 1: SMMC Clinic Locations



The location of primary care clinics appears adequately situated with regard to the areas where the underserved population of San Mateo County resides. The possible exception to this regards the population that resides in the rural coastside area of the County. This thinly populated area is served by limited adult and obstetric care provided in Half Moon Bay and supplemented by the mobile health van operated by the Health

Department. The mix of services at each primary care clinic within the SMMC system is different and reflects the needs of the local population and historical factors. Obstetric services are offered only in the central, coastside, and southern sections of the County.

The primary care clinics of SMMC represent the backbone of the safety net in the County. Approximately 170,000 primary care visits occur in this system annually. This represents approximately 70% of all ambulatory care visits in community clinics within the County. Nearly thirty percent of SMMC primary care patients are uninsured and about 35% are supported by Medi-Cal. SMMC clinics are the largest provider of primary care for the Health Plan of San Mateo, and in doing that supports one of HPSM's missions: providing access to care for Medi-Cal patients who cannot find adequate it within the private system.

Community organizations and other health care providers in San Mateo County report that the primary care clinics are critical to them and they believe the services offered there are of high quality. They do report meeting increasing difficulty when attempting to refer patients to SMMC primary care clinics. Some of this reflects availability of new appointments, but the efficiency of other systems, such as phone answering, also contributes to this phenomenon. Patients seem to be able to access primary care by walking into the clinics. The SMMC Emergency Department staff do not report having problems referring patients into primary care. Apparently, the ED has access to new appointments in the schedule that have been sequestered for their use.

As in most community-based clinics, there is no attempt (currently) to recruit certain types of patients. Seventy percent (70%) of patients seen in primary care are adults. However, there is no method to prioritize filling new slots in the schedule with patients with chronic illnesses. Patients who only need routine health maintenance appear to be afforded the same priority for new appointments as those who have illnesses such as diabetes, heart disease or asthma. Children on Medi-Cal are reported to have increasing difficulty finding willing providers in certain sections of the County, although almost all children are covered by Medi-Cal or other specific county programs to cover children. Pediatric visits are lower cost to the SMMC system than adult visits, yet are reimbursed as well or better, and may offer an opportunity to SMMC for gaining revenue to support the uninsured or costly adult patients. Pediatric patient access is limited by the number of pediatric providers and the number of spots in their schedules, but there does not seem to be any formal effort to increase pediatric volume.

The physicians and mid-level providers in the primary care clinics interviewed by HMA were uniformly well-trained, friendly, creative and committed to a mission of service to their patients and the population of the underserved in the County. A review of their productivity reports for physicians reveals that they see less than 2.3 patients per hour. We were told that this is an improvement over previous, lower productivity levels. The benchmark of productivity for Federally Qualified Health Centers is approximately 3 patients per hour. Nurse practitioners/Physicians Assistants reportedly see 1.8 patients

per hour. This approximates the FQHC benchmark for mid-level practitioners in primary care.[1] Often, the productivity of physicians and other providers can be limited by poor patient flow within a health center. However, due to recent operational initiatives, the cycle time, which is the time that an average patient spends in the center when receiving care, has been reduced within the SMMC primary care system to 50-55 minutes. This is an impressive accomplishment. When this is accomplished, patients are more satisfied that they spend shorter periods of time waiting to be registered, seen by a provider, and discharged. We saw few patients sitting in the SMMC clinic waiting rooms, which is likely to be a reflection of the success of this project. A reduction in cycle time should also improve productivity of individual providers, yet the numbers of patients seen per hour worked by a provider remains below the benchmark.

A review of primary care provider schedules demonstrates that many physicians work part-time at their clinical site. Also, the number of hours worked by each provider shows a marked variability from pay period to pay period. This variability persists whether the providers are part-time or full-time, physician or mid-level provider. There are reasons that variability will occur in a clinic schedule, including: vacation, sick time, and other personal time off, as well as when other assignments are made. However, the variability in the report of provider hours worked seemed excessive compared to other primary care systems reviewed by HMA. This level of variability will cause exam rooms to be vacant and nursing and clerical staff to be underutilized. The exact reasons for this variability were not determined as part of this project. However, management of it appears to be an opportunity to increase capacity without increasing resource allocation. No-show rates hover around 30% according to clinic staff.

The primary care services staff have limited connection with inpatient acute care services. While they can access results from a common medical information system, they have little direct communication with the SMMC inpatient hospitalist who manages patients admitted there. This connection between inpatient hospitalists and primary care providers and a clearly designated accountability are currently topics of concern in the medical profession.[2] The need for communication is even more important when the patient does not have a primary care provider prior to admission, as is often the case with admissions to SMMC. The primary care providers we spoke to have no relationship with the Long-Term Care Services of SMMC. In many health systems, primary care physicians are important members of the long-term care team, especially if home and community-based care is an important part of the long-term care approach.

The community clinics of SMMC do not typically have robust relationships with community-based agencies compared to community-based primary care health centers

[1] Health Resources and Services Administration Information Center 2006, www.askhrsa.gov.

[2] "Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care." JAMA. 297(8):831-41, 2007 Feb 28.

in other county health systems, nor do they have community boards. Although community relationships can, at times, be complicated, overall they can assist the clinics in meeting their missions of serving the target population and they could amplify the efforts of SMMC. Community-based agencies visited during this project knew of SMMC primary care clinics, but spoke of them as being operated by a distant entity, "the County," rather than an entity especially related to their community.

Chronic illness is typically the cause of poor health status within communities or subgroups within their populations. There are proven, evidence-based methods and interventions to improve the outcome of chronic illnesses. Chronic Disease Management, the Chronic Care Model, or the Care Model, are names given to an approach to the organization of services that deliver this evidence-based care to individuals and populations. Most Chronic Disease Management is delivered at the primary care level. Community Health Centers that are Federally Qualified Health Centers are required to begin orienting their services toward Chronic Disease Management.[3] The recommendations of the Blue Ribbon Taskforce assume that Chronic Disease Management is the basis of a health delivery system that would efficiently allows expansion of health care in San Mateo County. In many ways, the primary care clinics of SMMC are more prepared to perform Chronic Disease Management than most health centers. The clinic provider staff is supportive and knowledgeable about the concepts of Chronic Disease Management. There have been several programs that have implemented parts of the model in certain clinics of SMMC. Staff from two SMMC health centers are participating in learning collaboratives to assist in establishing the Chronic Care Model within the SMMC primary care clinic system. All of these efforts, to date, have been grant funded and budget items dedicated to implementing the chronic care model were not evident or prominent to our review, although the planned Radical Redesign Clinic may represent more of an institutional commitment to Chronic Disease Management.

Specialty Care

Access to outpatient specialty consultation is a challenge in the safety net throughout the country. Disparity in health status has been linked to lack of primary care access, but access to specialty care is necessary for a certain subset of patients receiving primary care. Subspecialty services support the SMMC primary care clinics, other community-based primary care centers such as Ravenswood CHC or Good Samaritan House, as well as patients referred from the Emergency Department and inpatient acute services of SMMC. The Health Plan of San Mateo also includes the ambulatory specialty providers at SMMC as potential sites for referrals. There is a relatively complete scope of subspecialty services offered at SMMC. However, given the scope of services, and the number of clinics and other sites that refer to SMMC for specialty care, the 43,000

[3] Overview. Rockville (MD): Health Disparities Collaboratives; [cited 2006 Mar 30]. Available from: http://www.healthdisparities.net/hdc/html/collaborativesOverview.aspx.

specialty care visits produced within the SMMC is a surprisingly low number. This number should be seen in the context of the approximately 170,000 patient visits provided in the SMMC primary care clinics alone in FY 2006/07. The percentage of specialty care to primary care within the SMMC ambulatory system is very low compared to other county health systems that receive referrals from their own primary care sites, other community-based primary care clinics, and busy Emergency Departments.

Table 1: Specialty Visits Compared with Primary Care Visits per Year in Selected Public Hospitals - August 2006

Public Hospital System	No. Specialty Visits/ No. Primary Care Visits	% Specialty Visits of Total Visits
San Francisco General Hospital	298,903/344,892	87%
LA County/USC Medical Center	358,300/500,432	72%
Cook County Bureau of Health Service	357,141/529,298	67%
San Mateo Medical Center	**43,087/169,401**	**25%**

The percentage of specialty to primary care visits has decreased in the recent past. During the previous four budget years, the SMMC primary care clinic volume increased 10%, while specialty clinic volume increased less than 5%. A review of the wait times for new appointments reveals what are clearly excessive waits for new subspecialty visits.

Table 2: Time to Next Appointment for Selected Medical Specialties at SMMC - October 2007

Specialty	New Patient Visit	Follow-Up Patient Visit
Cardiology	14-20 weeks	13 weeks
Pulmonology	9 weeks	1 week
Gastrointestinal	12 weeks	9 weeks
Nephrology	14 weeks	14 weeks
Hepatology	13 weeks	13 weeks
Obstetrics	8 weeks	6 weeks
Gynecology	8 weeks	6 weeks
Orthopedics	6 weeks	6 weeks
Ophthalmology	13 weeks	13 weeks

In addition, a number of clinics take new patients only after the approval of the attending physician or his/her designee has been obtained and do not report the wait time for new patients (e.g., Oncology-Mulligan, Pain Clinic, Plastic Surgery, ENT). Subspecialists and staff report that patients that "really need to be seen" can always get

in through a phone call to the subspecialist. Phone call approvals have been shown to be inefficient, tedious, and an obstacle to referrals at other systems where they are used. Subspecialists should primarily consult and refer patients, along with recommendations for work-up or treatment, back to their primary physician. Therefore, a higher percent of their patients should be new patients, perhaps one out of every four or five. There is a need for new referrals to be vetted for appropriateness, but the current system does not seem to be working. It appears illogical to use the time of the subspecialist for triage, if they are as busy and under demand as they seem. A busy primary care physician finds it difficult to invest the time to contact a specialist for every referral, yet feels that almost every referral is "really needed." If patients have any type of coverage, primary care providers tend to refer to places that will accept them. This leaves a disproportion of uninsured in the population of those referred to SMMC. Approximately half of patients seen in the specialty clinics at SMMC are unfunded versus a third of patients seen in primary care. This is reflective of the fact that most patients in specialty clinics are adults who are less likely insured, but it may also reflect the adverse selection that occurs.

The actual current demand for appropriate subspecialty consultation and care is unknown by SMMC. Staff of San Mateo community-based providers and the HPSM expressed difficulty and frustration obtaining specialty consultation from SMMC. However, any expanded access initiatives, such as the recommendations of the Blue Ribbon Task Force or the Coverage Initiative, will increase the pressure on subspecialty services.

The SMMC specialty medical staff is comprised of a few full-time physicians and many part-time providers who work a fraction of an FTE in the ambulatory clinics. The most common situation is that of a subspecialty division that has two or more physicians who are 0.25 of an FTE or less in the clinic. The specialty medical staff that we interviewed seemed quite competent and up to date. They are clearly concerned about their own patients and the quality of care that is delivered to them. However, perhaps because of their part-time relationship there, they are generally removed from any of the strategic needs or plans of SMMC.

In many ambulatory care systems, the subspecialists determine much of the scope and content of practice in their particular specialty. This is due to the technical niches and new developments that they alone are competent in or fully aware of. However, at SMMC, the specialists have an uncommon amount of control over what they do, who they see, and what they refer outside. One of the reasons is that, unlike the primary care clinics, SMMC does not currently have a medical director role assigned for specialty care. The clinic manager serves some of this role in terms of space allocation, equipment acquisition, and through personal relationships handles some of the aspects of professional affairs for the specialty providers. However, the sheer number of different providers within the specialty ambulatory clinics makes the lack of medical leadership conspicuous by its absence.

Initiatives are currently underway within SMMC to improve access to subspecialty services. They include a process of defining the true demand for specialty services

within the population that SMMC desires to serve. A coalition of stakeholders within the County has been loosely convened on the topic of specialty care access. It includes Ravenswood Family Health Center, the Health Plan of San Mateo, and the Department of Public Health. The intention is to begin the groundwork for planning to address specialty care access. This includes coming to a consensus vision on specialty care, developing a baseline database relevant to planning, including a broader group of stakeholders in setting priorities, and developing a three-year work plan. However, it currently appears that this effort depends upon obtaining external grant funding to proceed.

Emergency Department

The Emergency Department at SMMC sees approximately 30,000 acute care and 3,000 psychiatric patients per year. It is a bright and well-equipped facility. The physician staffing is filled by board-certified emergency physicians provided by a physician group, California Emergency Physicians. ED medical staff describe the patient population as being "low acuity, but high complexity." They state that patients have socioeconomic and family issues that are difficult and time consuming to address, but the patients do not actually need much acute medical intervention. Although most admissions to SMMC acute care beds are admitted by ED staff (2,246 out of 2,814, or 80%), the percentage of visits to the ED that result in an admission is approximately 9%.[4] This is about half of the percentage of other public hospital emergency departments.

The Emergency Department admission rate would be even lower if it were not for the requirement that all admissions from SMMC ambulatory care be admitted to the Emergency Department first. It was stated that this policy was implemented because gravely ill patients had been admitted directly to the acute care bed in the past without hospitalist staff being aware of the acuity of their condition. However, the solution of sending all patients, even those that are not emergent, through the emergency room causes undue waiting and discomfort for patients.

The Emergency Department staff and physicians state they have no problems referring patients into primary or specialty care at SMMC clinics. Certain spots in the clinic schedules have been blocked from being filled by anyone but ED staff. Community providers and SMMC primary care staff report referring patients to the SMMC ED simply to access subspecialty appointments.

The diagnoses of admissions to SMMC reflect mainly adult medical conditions. It seems that certain surgical subspecialty diagnoses, such as orthopedic conditions, are missing. On the other hand, the diagnoses of patients transferred to other facilities appear similar to the conditions of patients who were admitted. The coding of these diagnoses does not tell the entire story of why patients may have been transferred, such as ICU bed

[4] California Office of Statewide Health Planning & Development, Hospital Utilization Profile Report – 2006; http://www.oshpd.cahwnet.gov/HID/DataFlow/HospMain.html.

availability. Chart reviews were not done, but might be valuable to understand the pattern of who is admitted and who is transferred and why.

Inpatient Acute Care

The inpatient medical/surgical acute care service unit at SMMC has a very low average daily census of about 36, mainly adult patients. Although the length of stay is a respectable 4.8 days, the hospitalist staff states that there are always patients who could be discharged but remain on the acute care service because of a lack of appropriate lower level of care beds in which to discharge them. Approximately 1,000 surgeries were performed as inpatients at SMMC out of 2,814 admissions made directly to acute care and approximately another 600 to long-term care within the system. The surgical cases done as an outpatient lasted an average of 114 minutes as opposed to the 140 minute average statewide.[5] This reflects the less complex cases done at SMMC.

In spite of the low census, the hospital was on diversion to the Emergency Medical System 8.64% of the time, which is higher than the statewide average of 6.14%. Other providers in the County believe that the hospital is full because they state "there is never an available bed at the County." There was a sentiment expressed by SMMC staff, during our review of inpatient services, that beds should be protected from transfers of patients, who might be indigent or Medi-Cal, from other area providers.

Patient care on the inpatient services is provided by physicians who are described as hospitalists. All are from the Associated Medical Specialists physician group. Hospitalists are most often general internists or family physicians who practice almost solely on the inpatient services of hospitals and care for patients of primary care physicians that require inpatient care.[6] There is one general internist hospitalist, but hospitalist duties are also shared by a cardiologist, a pulmonologist and a rheumatologist. These other physicians had internal medicine training and may be quite competent as hospitalists. However, the contracted salaries of these specialists are significantly higher than the general internist hospitalist and community hospitalist salaries in general. In addition, the ICU is covered by the hospitalists. The general internist cares for most ICU cases she states, although the pulmonologist is listed on the AMS contract as a Critical Care (ICU) specialist, and many patients in ICUs are there for respiratory disease. When asked why this staffing pattern exists, hospitalist staff stated that it reflects the interests of the individual physicians and the final decisions are determined by and within the AMS group. There is no medical leader designated by SMMC for inpatient acute care.

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[5] OSHPD hospital utilization report 2006

[6] Hoff TH. Whitcomb WF. Williams K. Nelson JR. Cheesman RA. Characteristics and work experiences of hospitalists in the United States.] *Archives of Internal Medicine. 161(6):851-8, 2001 Mar 26*.

The inpatient services and hospitalist staff appeared to be somewhat dissociated from SMMC ambulatory care, psychiatry, and long-term care. The hospitalist staff reported that behavioral issues were common in acute care inpatients and this limits options for placement at time of discharge. Physicians did state that they had no problems referring patients into SMMC specialty or primary care ambulatory services on discharge.

Physicians

Overall, the medical staff at SMMC is clearly of high quality and should be considered a community resource. Reconstructing it would be difficult and would take years to accomplish. The employment status of physicians within the system is split between employees and those whose services are contracted. Primary care physicians are mainly employees, and the specialists are contracted. The primary care physicians are often part-time, but generally work a higher percentage of full-time than the typical specialist. The primary care physicians seem to identify themselves with their clinics, the communities in which they are located, and the County health care system.

SMMC has approximately sixty different contracts for specialty care services. Some of them include several different physicians within one contract. The services include outpatient care, inpatient acute care, and coverage duties. The duties are often vaguely described such as "Provision of four hours of General Surgery on a day of the week mutually determined within the Division of Surgery." This describes very little about the amount or types of surgery performed. Decision-making and accountability is often assigned to the Division or Department of a specialty. These are actually bodies defined by the Medical Staff Bylaws and are separate from the SMMC administration. The majority of the funds within these contracts are often spent on 24-hour coverage. How much this coverage has been worth in the past, as defined by how much effort was expended by the covering physician, is unknown.

Relative Value Units (RVUs) are a standard measure used to display the relative intensity of resources required to care for a broad range of diseases and conditions and are a means of determining the productivity of an individual practitioner or a unit of health care service and what should be paid for different clinical activities. Some of the contracts with specialists include payments based on RVUs. Although this is a rational step, given the large number of specialist physicians and the small number of admissions and outpatient specialty visits, managing this system with RVUs will be a major challenge. The RVU system is included in newer contracts, but measurement, reconciliation and payment do not appear to have begun in any substantial way.

Physician practice in San Mateo County is increasingly being dominated by several large physician group practices, including Palo Alto Medical Foundation, Kaiser Permanente, Stanford and others. This situation limits opportunities to contract with subspecialists. Management of the numerous subspecialty contracts is difficult, expensive, and contentious. Delivering subspecialty care through many different physicians, who work onsite at SMMC a small percentage of their practice time, results in a staff that is not likely to be well attuned to new priorities and directions that have been set. The lack of

SMMC medical leadership for the subspecialty areas and abdicating most clinical decision making to Medical Staff Divisions and Departments further complicates the situation of building, maintaining, and managing a specialty medical staff.

The strategy of placing SMMC specialists at Mariner Clinic, in order to attract more privately insured patients to use SMMC services, has clearly not worked. It also costs the County $200,000 per year in lease and management services and assigns contracted subspecialists who are underutilized.

The Coverage Initiative

The Coverage Initiative is the result of a three-year grant of federal funds administered by the State of California. It will provide $7.5 million to SMMC in each of those years to expand access to care, encourage new approaches to health care delivery, and design ways of decreasing health care costs over the long-term. Additional staff, including more specialty care providers, will be added. A new Radical Redesign Clinic is being created at the 39th Street Primary Care Facility as an effort to model idealized chronic care management. Interdisciplinary teams will utilize the Chronic Care Model enhanced with care management to attempt to keep patients with complex chronic illness well, and out of emergency departments, and to avoid inpatient admissions. Ravenswood Family Health Center is a cooperating partner in this effort.

The Coverage Initiative is targeting 2,100 uninsured patients with high medical needs between 19 to 64 years of age. They must be legal residents, but there is no asset test to qualify. The Coverage Initiative and the lessons from the Radical Redesign Clinic are explicitly intended to be pilots for the recommendations of the Blue Ribbon Task Force on Adult Health Care Coverage Expansion. Currently, there are enrollment efforts in the SMMC Primary Care Center and Ravenswood FHC. However, there does not appear to be a specific, ongoing strategy to recruit patients with complex chronic illnesses into this initiative.

Medical Services: Findings

- **The primary care network of clinics is the backbone of the safety net in San Mateo County.** It provides the majority of access to preventive and chronic illness services within the County. It is widely recognized by other agencies and providers that Medi-Cal patients, through the Health Plan of San Mateo, and uninsured patients depend on the primary care clinics and do not have ready or access to medical care without it.
- **The community-based clinics are well located and staffed with well qualified personnel.** The clinics are dispersed within communities in which underserved populations live and the staff is well trained and committed to serving this population. They are aware of the benefits of and are open to innovative approaches to improve practice such as Chronic Disease Management. Involvement with the community or by the community in these clinics appears

modest compared to other public primary care networks.

- **Productivity and better use of space capacity is possible within the primary care clinics.** Patient flow is efficient following initiatives to improve cycle time within the clinics. However, using the conventional measures of visits per hour SMMC primary care falls below benchmarks. No show rates are not unusual for many public systems but have been significantly improved elsewhere. The presence of part-time providers and variability in hours worked per week appears to limit optimal use of space.
- **Chronic Disease Management planning and programs have begun but still remains a marginal strategy.** These programs, along with basic preventive services, are the best method to use primary care to improve health status and decrease overall costs. Efforts to introduce Chronic Disease Management, such as the Radical Redesign Clinic, depend on grant or special funding which may not be forthcoming, and if successful, will be implemented in only a fraction of clinical sites.
- **Specialty care at SMMC has a wide scope but its depth is shallow compared to need.** Although medical and surgical specialties are well represented at SMMC, the amount of visits, procedures and surgeries is less than other public systems offer given the number of primary care visits and the number of underserved in the County.
- **Access to specialty care is limited and difficult, and referral methods are inefficient.** Community clinics, SMMC primary care providers, and staff at HPSM express difficulty referring patients into specialty care in a timely way. Reports of the next available appointments reveal excessive waits. The growth of specialty outpatient care has not kept up with primary care growth. Depending upon the method of directly calling a specialist to obtain urgent or needed access is inefficient and an obstacle to access.
- **The organization of specialty care services is rather fragmented and lacks medical leadership from SMMC.** A relatively small number of outpatient specialty visits and other specialty services are delivered by a large number of part-time specialists who have contracted with SMMC. Given their part-time status, most specialists are unaware of the strategic direction of SMMC, and absent specialty care medical leadership from SMMC, they set their own direction and scope of practice.
- **Current specialty contracting may not provide the highest value to SMMC and its patients.** The sheer number of specialty contracts for the amount of specialty services represents a huge challenge to manage. Much of the investment is paid for on-call and other coverage that may not represent the greatest value.
- **The Emergency Department is busy for the size of the hospital, but serves many low acuity patients and functions as a screening site for admissions from**

primary care and a way of accessing urgent specialty consultation. The ED staff reports low acuity of patients and the low percentage of them admitted seems to confirm this impression. SMMC primary care sites are required to refer all admissions to the emergency room rather than having direct access to inpatient staff or beds. The ED has special access to specialty outpatient appointments. Primary care and community clinics report using the ED to obtain urgent access to outpatient specialty appointments.

- **Inpatient acute care has a low census and a low occupancy rate, yet has patients in beds awaiting placement.** The primary care clinics admit few patients to SMMC, the percentage of ED visits that result in an admission is low, and the HPSM admits few patients to SMMC. Inpatient staff has the impression that a significant number of patients at any time are awaiting placement to lower levels of care but are delayed, often due to the presence of behavioral problems.
- **The organization of inpatient acute care at the provider's level is determined by the contracted medical staff, and the mix of specialists who provide hospitalist services reflects group and individual interests.** Inpatient coverage is partially provided by specialists from services where outpatient access is poor and whose salaries are higher than conventional hospitalists. The lack of medical leadership for SMMC at an inpatient level had defaulted planning and organization to the contracted medical group.
- **Primary care, specialty care, Emergency Department, and inpatient acute care represent relatively separate entities within SMMC and are disjointed from each other as they are from psychiatry and long-term care.** Awareness of the needs and roles of each other is not shared between these different departments. Forums for communication and joint planning were not obvious or mentioned by staff. There are vacancies and gaps in medical leadership. The overall structure of medical leadership does not lend itself to the inclusion of clinical departments in a shared strategic plan.

Medical Services: Recommendations

- **SMMC ambulatory services, both primary and specialty (along with psychiatry and Long-Term Care), should be a critical part of a broader network of care for underserved patients in San Mateo County.** This network should be organized by the County, but it should include contributions of care from other private and community-based providers. The medical services of SMMC should be included as a key element and leader within the network. However, the scope of SMMC medical services and operations will have to change and improve.
- **Financial considerations dictate the continuation of inpatient acute care**; however, the size, volume and scope should be determined through the broader planning process with other providers in San Mateo County.

- **The SMMC medical services (ambulatory, ED, inpatient, psych and LTC) should be prioritized and coordinated around a chronic disease management approach** as the central focus. These efforts should be an organizational priority and funded on "hard money." The plan to create the Radical Redesign Clinic for disease management should allow for rapid deployment throughout the ambulatory system.
- **A method should be devised to identify patients with chronic medical illness**, who present within the system, or are underserved, and they should be recruited into chronic disease management programs.
- **Efforts to increase primary care and specialty care productivity and maximize capacity should be continued and increased until benchmarks are met**. Decreasing the number of part-time physicians and the variability of hours worked should be a goal of SMMC medical administration. New benchmarks, more appropriate for disease management, should be chosen or devised and adopted.
- **The demand for specialty care access necessary for the underserved population in San Mateo County should be determined**. This can serve the organization of a broader network of care within the County and should be accomplished regardless of external grant funding availability, and with other stakeholders at the table. SMMC is likely to play a major role in providing specialty care to the underserved, but should not assume this role alone.
- **Specialty care should be reorganized around chronic disease management**. This should include communication with and training of primary care providers, a refocus of specialists' time, and a new system of prioritizing referrals that is efficient and improves appropriate access.
- **Aggressive efforts should be made to attract and retain pediatric and geriatric patients in the ambulatory system** in coordination with the Health Department and the Health Plan.
- **Medical leadership for specialty care and inpatient acute care should be designated** within the SMMC organizational structure that has the responsibility for defining scope and productivity of medical practice. This leadership should set medical policy in collaboration with the medical departments and divisions.
- **The current practice of contracting with physicians should be significantly redesigned**. SMMC should consider the employment of specialists or a relationship with a large physician group to provide positions and/or coverage.
- **Remove unnecessary obstacles to receiving care at SMMC**, either at the outpatient clinics (i.e., phone access, referral systems or financial policies) or for inpatient admissions (i.e., implement direct admission policies).

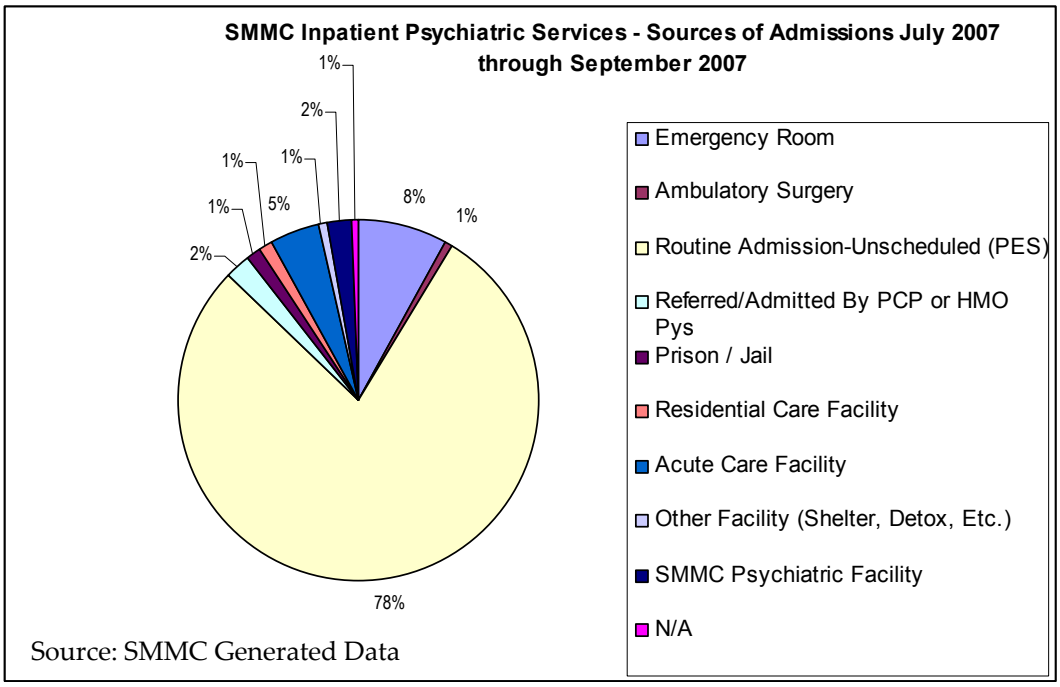
- **A Chief Medical Officer (CMO) position for SMMC should be created** to provide strong and accountable medical leadership at SMMC that cuts across and coordinates all care provided within the system. The different clinical departments should meet regularly, share a common strategic plan, and understand their role and the roles of other departments.
- **Integrate medical services into efforts to better address moving patients into lower levels of care.** This would allow more efficient discharge from inpatient acute care and psychiatry. The primary care physician should be part of a team that supports home and community-based long-term care as well.

Psychiatric and Long-Term Care Services

Psychiatric Services: Overview

SMMC operates a 34-bed locked psychiatric unit and Psychiatric Emergency Services (PES), which includes 8 lockable rooms (beds) and operates 24 hours a day, seven days a week. The majority of admissions to the inpatient psychiatric unit originate from PES. A smaller percentage of patients are directly admitted after authorization by a SMMC psychiatrist.

Figure 2: SMMC Inpatient Psychiatric Services Admissions



Source: SMMC Generated Data

Patients admitted to the inpatient psychiatric unit are supposed to be diagnosed as experiencing an acute episode of a mental illness and to be unable to benefit from services provided at a lower level of care. Medi-Cal requires that patients meet the admission criteria specified in Title 9 of the California Code of Regulations (see Appendices), which includes a diagnosed mental illness and a determination that the patient's needs cannot be adequately met at a lower level of care. Medicare requires that patients admitted to distinct part psychiatric units of acute care hospitals require active

treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, and have a psychiatric principal diagnosis.[7]

SMMC's acute inpatient admission policy is based on Title 9 requirements (see Appendix #2). However, as discussed later, patients admitted to the unit do not always meet the specified admission criteria.

Patients admitted through PES are assessed by a nurse who then communicates the assessment findings to a psychiatrist. The psychiatrist makes a determination regarding admission. A social worker is available to PES Monday through Friday on the day shift and may be able to assist in diverting the patient to a lower level of care when appropriate and when a lower level of care is available. (Examples of lower levels of care are Cordilleras Mental Health Center, a locked psychiatric health facility, and board and care placements.) PES case management is not available after hours or on the weekend. As might be expected with limited case manager coverage, nurses in PES are reportedly performing activities social workers could be performing, including obtaining contact information and contacting families and former providers to obtain a patient's history and to gather other background information.

Once a person is admitted to the inpatient psychiatric unit, they are assigned a case manager who will work with them throughout their stay, addressing social issues and discharge planning. SMMC has two full-time social workers on the inpatient psychiatric unit, each of whom provides case management services to fourteen patients. The remaining six patients receive case management services from the supervisor of acute care services case management (med/surg). Each Tuesday a mental health resources meeting is held where the array and number of available placements is reviewed.

Treatment team meetings are held regularly for each patient and are attended by a Mental Health Services (MHS) Division resource specialist who identifies and makes arrangements for potential placements or services needed to support discharge. Case managers and the MHS resource specialist may also work with Aging and Adult Services staff, including staff of the Public Guardian, and case managers who coordinate services funded by the Older Americans Act, Medi-Cal (including In-Home Supportive Services or IHSS), and Adult Protective Services.

From an organizational perspective, MHS and Aging and Adult Services are part of the Health Department – the Health Director reports to the County Manager, who reports to the Board of Supervisors. The County clinics, which provide health care services to a portion of persons admitted to the inpatient psychiatric unit, are also part of the health department. The SMMC CEO reports to the County Manager. Therefore, arrangement of

[7] Diagnosis is listed in the Fourth Edition, Text Revision of the American Psychiatric Association's Diagnostic and Statistical Manual, or in Chapter Five ("Mental Disorders") of the International Classification of Diseases, Ninth Revision, Clinical Modification. (Medicare Benefit Policy Manual, Chapter 2 – Inpatient Psychiatric Hospital Services, Section 20.)

discharge supports for patients on the psychiatric unit requires coordination across two separate County departments/entities – the Health Department and SMMC.

MHS's role in regard to SMMC psychiatric services is multifaceted – MHS is a conduit to county, state and federal mental health services funding for inpatient services **and** controls access to non-hospital-based mental health placements, services and funds. MHS is the mental health services provider for members of the HPSM.

MHS, as the designated Mental Health Authority for the County, receives block grant funds from the State Division of Mental Health. A portion of these funds (about $1.3 million in 2007) are distributed as a lump sum payment to SMMC each year and represent the federal financial participation (FFP) amount generated from DHS' submission of claims to Medi-Cal. The amount of the disbursement by DHS to SMMC is calculated based on prior year experience with Medi-Cal claims. DHS uses mental health realignment funds as the match for the FFP.

MHS funds a range of services and placements for patients discharged from the inpatient psychiatric unit including:

- Case management;
- The Full Service Partnership that provides intensive wraparound services to a limited number of persons with mental illness and intensive needs (240 slots for 2007);
- Contracted residential providers, such as Cordilleras, a locked, psychiatric health facility; Redwood House, a board and care facility with enhanced services; and housing with on-site supports; and
- Patch (supplemental) payments made to board and care facilities and to private providers of specialized services, such as Crestwood, a provider of neurobehavioral services; and
- Other outpatient behavioral health services.

Table 3 provides a "snapshot" of patch payments for persons discharged from SMMC inpatient psychiatric services. Compare the daily patch rate to the cost to maintain a patient at SMMC inpatient psychiatric services (over $1,200/day in 2005-2006). Additional use of patch payments will be constrained by the limited supply of residential placements. The County's ability to develop alternatives (like board and care and housing with on-site supports) might be essential if there are no additional private providers able to or willing to accept patch payments. This will, of course, substantially increase the true cost of patch payments.

Table 3: Patch Payment Rates

Type	Number of persons	Daily Patch Rate
Board and Care patch (supplemental) payments from MHS[8]	140	$400
		$100
The Suites (Board and Care)	49 beds	$110
Cordilleras (MHRC – IMD)	62	$240
Out of County Daily Patch Payments		
Crestwood (SNF/STP or MHRCs, most classified as an IMD)	15	$50-$180
7th Ave (SNF/STP - IMD)	2	$165
Creekside (SNF)	3	$125
Serra Vista (SNF/STP – IMD)	1	$175
Board and Care	5	$100
SNF daily patch payments for older/medically fragile adults or adults with organic brain syndrome		
SNF (MHS patch)	12	$118
SNF (Aging and Adult Services patch)	5	$118
SNF (MHS or A and AS patch)	17	$25-$118

Source: MHS staff, November 5, 2007

Other supports and services that may be accessed by eligible patients discharged from the inpatient psychiatric unit include services administered, funded and/or overseen by Aging and Adult Services such as Older American Act services or In-Home Supportive Services (IHSS). Funding for supplemental payments may be provided for conserved patients, who require locked facilities. These patch payments are typically made for placement in a SNF like Crestwood or Idlewood. Staff of Aging & Adult Services report they are serving a growing population of persons with psychiatric diagnoses who also meet the Aging & Adult Services criteria.

Adult Protective Services (APS) also makes emergency funding available for up to 30 days in a Board and Care facility or to fund attendant care at home while a consumer's care needs are being assessed. Staff report many persons who access APS funding are ultimately conserved.

Aging & Adult Services staff report that the SNF supply is shrinking – while there were reported to be 24 SNFs in San Mateo County 3 years ago there are now 21, and another SNF that accepted Medi-Cal recipients recently announced closure. Section 8 housing is also a limited resource. Aging & Adult Services contracts with the Legal Aid Society to assist consumers with accessing affordable housing. If a patient is eligible for other community-based services from Medicare, the Veterans Administration, a private insurer or other sources, these services might also be accessed.

[8] Majority at $400/month, a few at $100/month: $600,000 total.

There is uniform agreement among SMMC, MHS and Aging & Adult Services staff that there are insufficient placement options and services to meet the special needs of some persons admitted to and/or awaiting discharge from the inpatient psychiatric unit. Lack of access to appropriate alternatives to acute inpatient care is cited by staff as a major factor driving the number of "administrative" days on the inpatient psychiatric unit.

Inpatient Psychiatric Services Administrative Days

"Administrative days" as defined by the SMMC include any day when a patient does not need acute inpatient psychiatric services. Administrative days are paid at the Medi-Cal administrative day rate (less than the acute care rate). The current Medi-Cal maximum payment for an acute inpatient day on the SMMC psychiatric unit is **$1,035.57/day.** This amount is subject to cost settlement with Medi-Cal so it could be lower (although this is reportedly unlikely).[9] The payment to SMMC from MHS also includes funds for "indigent" (non-covered) patients who are classified as acute or as "administrative".

The Medi-Cal maximum for PES crisis stabilization is $97.19 an hour. If a patient was previously "acute" during their stay on the psychiatric unit, is ready for discharge (and no longer "acute") and has an identified placement meeting specified criteria but is waiting for a bed at this placement, they are classified as "administrative" and Medi-Cal administrative payment is available. The current Medi-Cal payment for an administrative day is **$397.74**. This amount is also subject to cost settlement with Medi-Cal.[10] According to MHS staff, the FY 05-06 cost report showed SMMC inpatient psychiatric services costs as $1,281.76 a day/patient and PES costs as $127.21 an hour, both of which exceed reimbursement levels.

SMMC states that patient days may only be classified as Medi-Cal "administrative" days when the recommended placement is one of the following: skilled nursing facility (SNF), intermediate care facility (ICF), a locked facility (such as Cordilleras or Crestwood), Redwood House (a board and care facility with specific on-site supports funded by MHS), Wally's Place and Hawthorne House (transitional housing with on-site supports), or Eucalyptus House (a residential treatment facility).

From July 2006 through July 2007, SMMC reported administrative days as high as 57% of all psychiatric services patient days. (SMMC medical/surgical services administrative days comprise a smaller percentage of total medical/surgical days (a high of 24% during the same reporting period)). Medical/surgical administrative days are addressed in the Long-Term Care Services section below.

SMMC inpatient psychiatric services staff report that approximately 85% of administrative days on the psychiatric unit result from patients who are ready for

[9] DMH Information Notice 7-22, Enclosure 1

[10] DMH Information Notice 7-23. November 16, 2007

discharge, but do not have an appropriate placement/program to be discharged to. This includes patients in the following situations:

- Looking for alternative placements because existing placements have openings but will not accept the patient due to a prior history with the facility; or
- No longer meets the requirements for acute psychiatric services but the patient's needs cannot be met in existing programs/placements – they need an alternative "step-down" program that will enable them to gain readiness for available programs/placements.

The SMMC staff report that MHS requires they document numerous attempts to locate placements at a lower level of care before they will consider a higher level of care placement. (This is also reported to be an issue when seeking residential options from Aging & Adult Services for patients who meet Aging & Adults Services criteria.) SMMC staff feel this is an unnecessarily burdensome requirement for some patients with intensive needs and is often a "paperwork" exercise. They state that the requirement also creates problems with the providers of alternative placements because they must contact providers knowing (in advance) the provider will not accept the patient for placement. This repeated contact to obtain a denial is reported to damage relationships with these providers. In addition, some providers will not return calls. Staff believe the process contributes to the number of administrative and non-covered days.

Referrals are reportedly complicated in some instances when there is disagreement between the clinical team and the resource specialist regarding the most appropriate placement. The SMMC staff state they provide a clinical recommendation regarding placement and that rejection of this recommendation by MHS is "insulting". However, MHS has an obligation to ensure the least restrictive placement is authorized and to demonstrate this by documenting that alternatives were pursued and were unsuccessful.

Ten percent of administrative days are reported to result from the time it takes to finalize a discharge plan and reach consensus that the patient is ready for discharge and a suitable discharge option is available.

A portion of administrative days are reported to result from a conflict between the California DMH standards for what constitutes need for acute psychiatric services and the treating psychiatrist's evaluation of the patient as in need of acute psychiatric services and not ready for discharge.

A very small percentage of administrative days are reported to result from:

- Failure to complete forms and documents timely;
- Medical issues (completing testing or medical treatment); and/or
- Waiting for conservatorship.

Staff at SMMC and MHS described the typical scenarios where placement is difficult:

- One group of patients is described as patients who have a serious mental illness (SMI) and serious behavioral issues who do not need medical care. They might

be able to go to a Psychiatric Health Facility (PHF, referred to phonetically as a "puff") if there are beds available. The County contracts with a PHF (Cordilleras) for 62 beds but there is a reported waiting list for these beds.

- Some of the patients sent to SMMC PES have assaulted other patients or staff at previous placements, have destroyed property and are not likely to be accepted back to their prior placements. Some of the patients are described as having mastered the behaviors needed to get admitted to SMMC (and subsequently cannot be placed without extraordinary efforts and funding).
- Another group of patients are those in "non-medical" placements who develop medical problems. When a resident of a "non-medical" placement develops a medical problem, they generally are sent to PES and may be admitted to the inpatient psychiatric unit. Recently a resident of Cordilleras was sent to PES because they needed to use a walker.
- Some patients have a SMI with medical issues and serious behavior problems. They are not accepted for placement at Burlingame (as currently configured) due to behaviors and their behavior may even be too extreme for a SNF/STP like Crestwood.
- Another group of patients have no diagnosis of mental illness, but have diagnoses that present with behavioral issues. This includes patients with dementia, patients with Traumatic Brain Injury, and a small number of patients with "organic brain syndromes" (who tend to get "stuck" in the system and account for large numbers of administrative days per patient).
- A small number of patients have MR/DD. They might have a secondary diagnosis of MI, although the diagnosis might be questionable and may have resulted from use of medication typically used to treat a diagnosed mental illness but which is being to address behavioral issues. While there are reportedly only a small number of these patients each year, they tend to stay for a very long time on administrative days. One such patient has been at SMMC almost 2 years awaiting an appropriate placement. There is concern that this group will increase due to recent closures of the developmental centers. A very complicated subgroup is persons with MR/DD, who are mentally ill and who use/abuse drugs and/or alcohol.
- Another group of patients have alcohol abuse/substance abuse diagnoses and no diagnosed mental illness, although they present with behavior problems. Crystal meth abuse is a common finding.

The following placement options were described by SMMC psychiatric services staff and/or by MHS staff as not available or as having a waiting list:

- Additional locked facility beds, like Cordilleras and Crestwood. However, MHS expressed a concern that making more locked facility beds available perpetuates a less desirable option – "if you make it available it will fill up and you will likely

need even more beds". Access to Cordilleras beds is also impacted by the "continuum of care". For example, if persons residing at Cordilleras are waiting for a "lower level of care" bed, the flow of patients through SMMC is impacted.

- More transitional housing with on-site support beds. Especially needed are more options like Redwood House that has an average length of stay of less than 30 days and can serve 17 people.
- A "step-down" option that is locked and has some level of nursing and physician presence, possibly regular clinical on-site hours plus on-call capability. Clinical psychiatric services staff believe there is a need for eight step-down beds at SMMC.
- A specialized dementia program unit. These types of programs are often provided in board and care facilities and SNFs.
- A gero-psychiatric program or unit. This option might operate under a hospital license or SNF license. SMMC already has a specialized geriatric program (the Ron Robinson Center) that is reported to be providing excellent differential diagnosis, community-based physician services (including home physician visits) and case management services. SMMC has previously evaluated the business case for a gero-psych program. A report prepared by HFS Consultants with Jim Watts Consulting was completed in May 2006 and concluded that such a program was not financially viable, although a reduction in the growth of future patch payments might be achieved. The authors suggested the impact of access to a gero-psych unit on patch payments be explored further.
- A formalized PES diversion function staffed primarily by social workers. This could operate in conjunction with a crisis stabilization unit as a way to provide case management "at the door" for very rapid stabilization and quick reentry into community-based placements, avoiding admission to inpatient psychiatric services or strengthening discharge planning by beginning immediately. This option would likely work well for persons not meeting acute criteria or who have some level of existing support in the community, but would also require an investment in other community-based options in order to work effectively. It might also help address some of the deficiencies cited by DMH specific to discharge planning by elevating case management to a critical function (along with nursing and psychiatry).
- On-demand detox services and housing models for persons with substance abuse and alcohol abuse diagnoses that utilize a "harm reduction" policy. San Mateo County reportedly has one "wet" shelter for the entire County. There are 50-70 emergency beds and 20-40 transitional beds in this shelter. Housing with on-site supports with a philosophy of harm reduction is an approach that is reported to be difficult to develop in San Mateo. Communities (especially more affluent communities) are not very receptive to users living near them who are

not "dried out", even though a core group of users fail in these settings (drying out, leaving, abusing and repeating the cycle over and over).

Aging & Adult Services state they have been taking a more active role with SMMC staff to arrange placements, and recently worked out a shared patch payment (between Aging & Adult Services and MHS). They note that problems should be brought to their attention immediately.

The State Department of Mental Health Review

Staff report they have narrowed their interpretation of what constitutes "acute" psychiatric status following an audit of the inpatient psychiatric services conducted by DMH in December 2006. Clinical staff noted that the stringent requirements established by DMH have led to an increase in administrative days. They further note that DMH may find a patient's stay contains days that alternate between acute and administrative days while clinical staff believe that all of the days should be considered acute since patients need a period of stabilization of symptoms before they can be discharged. This period of stabilization is reportedly now being claimed as administrative days or is not claimed at all (non-covered), depending on the patient's situation and discharge plans.

The DMH report was reviewed by HMA and is summarized below:

DMH reviewed a sample of patient charts (10) for a prior three month period and determined that of 186 patient days claimed as acute, 83 days were not acute. They reviewed 31 days claimed as administrative and found all to be appropriate. (They also noted in the narrative portion of the review a situation where days claimed as acute and subsequently denied could have been claimed as administrative days.) The reviewers also determined there was no medical necessity established for admission for 2 of the 10 patients reviewed and no medical necessity for continued stay for 8 of the 10 patients reviewed. The total amount of claims disallowed were $73,406.82 of which $36,703.41 was recouped (the amount comprising federal financial participation (FFP), returned to federal government).

Of particular note is that the review included a note of concern from the reviewer about the difference in status between the physicians' notes and nurses' notes. In addition, documentation was cited as lacking. Findings included: No admission description of functional level, plans of care do not contain measurable or specifically observable objectives, failure to document achievement of stated objectives, shortcomings in social service evaluations, lack of clear and specific discharge plans, and lack of patient signatures on some treatment care plans.

The types of documentation issues noted by DMH impact the ability of a reviewer to substantiate the need for acute psychiatric services and the provision of "active treatment", the standard applied to the type of treatment provided in a psychiatric hospital or unit. It is possible that lack of adequate documentation is contributing to denials of Medi-Cal acute days, rather than solely the DMH criteria.

Furthermore, documentation shortcomings could also impact determinations by other payors such as Medicare. The SMMC should ensure it is providing active treatment

services consistent with currently accepted best practices and consistent with recent CMS interpretation of Medicare certification requirements for psychiatric hospitals, (which have become more stringent over time). Review of inpatient psychiatric services by CMS for Medicare certification could result in findings similar to those noted by DMH. An adverse determination by CMS would place the hospital at risk of loss of Medicare certification for psychiatric services. Experience in other states indicates that CMS will condition the receipt of Disproportionate Share Hospital (DSH) and other Medicaid payments on successful Medicare certification. In addition, the documentation shortcomings likely reflect clinical practice issues that should also be addressed.

Sample Classification Array of Patients

Table 4 summarizes the "classification" of patients on the psychiatric unit on October 30 and 31, 2007. Note that just over 21% of patients on the unit on October 30 and 31 were reported as never having met acute criteria. Only 10% of patients were classified as meeting criteria for Medi-Cal administrative days on the reviewed days. The majority of patients were non-acute and not eligible for administrative payments (i.e. non-covered).

Table 4: Classification of Patients –Psychiatric Unit

Item	30-Oct	%	31-Oct	%
Beds	34		34	
Census	29		32	
Patients Identified as Acute	9	31%	8	25%
Patients Identified as Medi-Cal Admin	3	10%	3	9%
Non-acute, Non-admin (not covered)	17	59%	22	69%
Patients Identified as Never Acute	6	21%	7	22%

Source: SMMC UM Daily Report for 3A/B – October 30, 2007 and October 31, 2007

The majority of patients on the psychiatric unit appear to either not need acute inpatient psychiatric services or their need for such services has not been adequately documented. Over 20% of patients during the 2-day snap shot are reported as never needing acute inpatient psychiatric services.

The MPHS and SMMC Behavioral Health Partnership

San Mateo County is currently exploring a possible partnership between SMMC and Mills Peninsula Health Services (MPHS) that includes a proposed "step-down" option.

MPHS operates a hospital in Burlingame, the Mills Peninsula Medical Center, which will be replaced by a new facility. The Medical Center currently includes adult psychiatric, adolescent and chemical dependency beds. MPHS representatives have indicated they do not intend to include these services in the new building. They have expressed an interest in making these services available in unused space at SMMC. MPHS representatives also have stated that absent an agreement with SMMC, they will seek other alternatives to continue psychiatric services outside of the new hospital building.

The County has also recently been approached by other hospitals to discuss a potential partnership for SMMC provision of inpatient mental health services.

The County is completing a preliminary analysis of options in order to determine which, if any, of the four options should be pursued further. MPHS and SMMC have developed some preliminary cost and income projections for illustrative purposes. A primary concern is whether a specific option places SMMC at-risk of being classified as an institution for mental diseases (IMD), a classification that would result in a loss of Med-Cal funding for most patients at SMMC (including patients in medical/surgical beds). Each option is briefly reviewed below. (IMD regulations are summarized in Appendix #3.)

Option 1: Two Licenses, No Step Down Unit

This option proposes that MPHS and SMMC provide their current psychiatric services under their respective licenses. SMMC would continue to operate 34 beds for adult psychiatric services, while MPHS would operate 38 beds, 18 for adult psychiatric services, 8 for adolescent psychiatric service and 12 for chemical dependency treatment.

Issues

- Uses unused bed capacity – SMMC gains income from "rent" and some administrative charges.
- Preserves SMMC DSH payments for psych.
- No change in service array for SMMC. No clinical advantage to this arrangement.
- Little likelihood of "counting" patient days from MPHS-operated beds in the SMMC patient days – low risk of causing SMMC to move into IMD status.
- Impact on PES – Increased demand for PES not assessed at present, but impact will be the same or similar for all of the options.

Conclusion

This option permits SMMC to rent out unused space. There is a low-risk of IMD designation as long as SMMC can demonstrate complete independence from MPHS.

Option 2: Two Licenses with Step Down Unit

This option proposes that behavioral health services operate under two separate hospital licenses, plus a third type of license for a step-down unit to be held by either SMMC or MPHC and to be utilized primarily by SMMC. SMMC would operate 17 beds for adult psychiatric services and 17 for step-down, while MPHS would operate 38 beds, 18 for adult psychiatric services, 8 for adolescent psychiatric service and 12 for chemical dependency treatment. MPHS would lease space from SMMC.

Issues

- Uses unused bed capacity – SMMC gains income from "rent" and some administrative charges.
- Adds step-down capability but reduces acute inpatient psychiatric services beds (unless there could be "swing beds").

- Preserves SMMC DSH payments for psych.
- At present, it is unclear how a step-down unit would be funded. It is also unclear what the most appropriate licensure for a step-down unit is.
    - The initial exploration of options does not include in-depth analysis of the most suitable step-down unit type based on clinical data. Two possibilities have been suggested for illustrative purposes: SNF and PHF.
    - If the hospital's DP/SNF license were used for the step-down beds, it would be important to ensure the step-down unit would not push the SMMC DP/SNF (including Burlingame) into IMD status. This appears unlikely at present as only 45 of 266 patients residing at Burlingame LTC on 11/16/2007 were reported to have a diagnosed mental illness. However, should Burlingame and Unit 1A serve greater numbers of persons with a mental illness in the future, the balance would require ongoing monitoring.
- There is little likelihood of "counting" patient days from MPHS-operated beds in the SMMC patient days – there is a low risk of causing SMMC to move into IMD status based on the MPHS patient days.

Conclusion

This option permits SMMC to rent out unused space. There is a low-risk of IMD designation as long as SMMC can demonstrate complete independence from MPHS. If a SNF step-down unit were developed, the impact on the SMMC DP/SNF designation would need to be considered.

While a step-down unit might be desirable and feasible (but this cannot be determined at present), the development of a step-down unit can occur independent of MPHS. Note that the development of an alternative "step-down" unit at SMMC does not reduce the need for additional community-based options and capacity.

Hospital costs are high – no hospital-based option is likely to be the most cost-effective option to address the long-term needs of patients now awaiting discharge or inappropriately admitted absent access to additional and adequately funded residential options in the community. In addition, a hospital is not a suitable physical plant for long-term placement. There is a concern that a step-down unit will become another bottleneck – an inappropriate "holding" unit that will replicate existing problems.

Option 3: SMMC License with Step Down Unit

All behavioral health services would operate under the SMMC license. Beds would be expanded to accommodate MPHS clients and services.

Issues

We believe this arrangement would result in SMMC being determined an IMD. This option is not viable.

Conclusion

Not viable.

Option 4: MPHS License with Step Down Unit

All behavioral health services would operate under the MPHS license at the SMMC site.

Issues

- Uses unused bed capacity – SMMC gains income from "rent" and some administrative charges.
- Adds step-down capability – unclear how step-down would be funded.
- Probably protects SMMC from IMD status as along as MPHS is completely separate from SMMC clinically and administratively/operationally.
- Unknown whether MPHS would operate psychiatric services consistent with the County mission.
- SMMC would lose DSH payments specific to psych.

Conclusion

It is unclear whether there is an advantage to this arrangement, and the loss of a portion of DSH payments is a cause for concern.

Long-Term Care Services: Overview

SMMC reports a high proportion of medical/surgical administrative days, contributing to facility financial losses. Medical/surgical administrative days are reported to be resulting from a variety of factors including the inability to discharge to appropriate long-term care settings, including SMMC Unit 1A and Burlingame LTC.

SMMC provides long-term care services in its distinct part/skilled nursing facility (DP/SNF), comprised of 32 beds within the SMMC facility (Unit 1A) and another 276 beds at Burlingame LTC (Units 1, 2, 3 and 4). While Burlingame LTC has a license for 281 beds, 276 beds are available for residents. The space for 5 beds is used as staff office space. Burlingame is located just under 10 miles from SMMC. In 2006, SMMC suspended use of 32 DP/SNF beds at SMMC (Unit 1B) in order to use excess capacity at Burlingame LTC.

While the LTC units at the SMMC building and at Burlingame LTC operate under a single license, staff describes Unit 1A as more "acute" than Burlingame LTC.

SMMC LTC Unit (1A)

Unit 1A is located within the SMMC. The unit has semi-private and private rooms and is configured like a typical hospital SNF unit. It was quiet on the unit during the time period we toured the unit (October 2007). SMMC has an outdoor green area contained within the building walls that may be used by patients of Unit 1A.

The most common primary diagnosis for patients entering Unit 1A is reported to be post surgical repair – hip fracture. A portion of patients may also have a diagnosed mental

illness. For example, on November 16, 2007, four patients had a diagnosed mental illness.

During the third quarter of 2007, the average daily census of Unit 1A was 30.

- During this quarter there were 31 admissions (all from SMMC medical/surgical units) and 50 discharges.
- Fifty-two percent of discharges were to home and 24% to Burlingame LTC. The remaining 14% of patients were discharged to board and care or assisted living facilities, to another hospital, left against medical advice, exceeded their bed hold (losing access to the bed and being discharged) or expired.
- While the majority of discharged patients (19) had a length of stay under 30 days or between 30 and 90 days (10 patients), one patient had resided on Unit 1A for two years and another patient for three years.

Nursing staffing hours per patient day are budgeted at about 4.2, one hour per patient day more than at Burlingame. This is reportedly due to the higher acuity of patients in Unit 1A relative to the acuity of residents at Burlingame. In addition, patients on Unit 1A are reported to require some services that are not available or not available as needed at Burlingame. These are respiratory services, which are not available at Burlingame, and weekend rehabilitative services, which prevent transfer of patients needing therapy services on a seven day a week basis.

There are also reported to be between 10 and 15 patients at any one time residing on Unit 1A who could be transferred to Burlingame LTC who refuse to do so. Patients and/or their families prefer SMMC, which has a far more pleasant physical environment than Burlingame LTC. Staff report prior efforts to transfer patients from Unit 1A to Burlingame have been appealed to the State and the State has ruled in favor of the patient.

Burlingame LTC

Burlingame LTC is an older two story facility with 276 usable beds comprised of 2- or 3-bed rooms (and one 4-bed room). In November, one bed was "off-line" due to the need for extra space to accommodate an extra large bed.

Rooms are crowded and privacy is made available using curtains separating bed areas. The absence of private rooms limits the type of patient that can be admitted to Burlingame. For example, a patient with behavioral problems might not be able to be admitted to a room that is shared with others or that affords only limited privacy. Problems might result for both the admitted patient (increased anxiety and agitation) and for the patients residing in the room (potential for patient to patient altercations). Occasionally, a Burlingame resident contracts an infectious disease and then must occupy a room alone, resulting in 1, 2 or 3 beds being taken "off-line".

Burlingame LTC does not have disease- or condition-specific units (for example, a dementia unit). The second floor houses the majority of persons with dementia and

residents who need substantial or total assistance with meals and other activities of daily living, while the first floor houses ambulatory residents and residents who are more independent, including those with rehabilitation goals. The most common primary diagnosis is dementia, followed by primarily chronic conditions such as CVA and diabetes. On November 16, 2007 Burlingame had 45 residents with a diagnosed mental illness. Some patients at Burlingame LTC have alcohol and drug use histories and a portion leave the facility, use/abuse drugs and alcohol, and bring drugs and alcohol back to the facility. In some instances, patients have been selling drugs at the facility. When Burlingame LTC has attempted to discharge these residents for this behavior, the resident files an appeal and the State Department of Health Care Services has reportedly consistently overruled the facility's discharge notice citing a lack of a suitable community placement alternative.

All exits are now alarmed and a receptionist monitors use of the front entrance (since the front entrance is alarmed only when the facility ends visiting hours).

The average daily census at Burlingame LTC in October 2007 was reported to range from 260 to 264 persons.

- On November 5, 2007 the census was 267 residents, with 3 beds held for "bed-hold" and 6 vacancies (four "male" and two "female"). (By early December, the census had risen to 275 residents.)
- Nineteen of the 267 residents (7 percent) in October were from "out of county" (not from San Mateo County).
- For a two week period ending November 5, 2007, Burlingame LTC had fourteen (14) active referrals from SMMC – one from unit 1A, twelve (12) from Medical/Surgical units and one from the inpatient psychiatric unit.
    - Of these, 7 were accepted for admission (with 3 admitted during this time period and 4 admissions pending) and 7 were denied admission. Six of 12 referrals from the medical/surgical unit were denied due to "psychiatric management issues". The one referral from the inpatient psychiatric unit was denied due to violent behaviors.

For the three months of July through September 2007, Burlingame admitted 61 patients and discharged 48 patients.

- Of the 61 patients admitted to Burlingame, 46% came from SMMC (20% from the SNF unit and 26% from other units).
- 35% of admitted patients were admitted from another hospital.
- Of the 48 patients discharged from Burlingame, an almost equal number went to another hospital or home (15 or 31% and 17 or 35%, respectively). Hospital admissions and discharges to a hospital other than SMMC are frequently made to Mills Peninsula Healthcare, which is located across the street from Burlingame.

Table 5: Burlingame SNF Units - Admission and Discharges July - September 2007

Location From/To	Admissions		Discharges	
	Number	%	Number	%
Home	4	7%	17	35%
SMMC Acute Care	16	26%	4	8%
Other Hospital Acute Care	21	34%	15	31%
SMMC SNF (1A)	12	20%	2	4%
Other SNFs	8	13%	1	2%
Expired	NA		9	19%
Total	61	100%	48	100%

HMA visited Burlingame LTC in early November 2007, touring the facility, attending an Interdisciplinary Team Meeting and holding a meeting with key staff to talk about "hard to place patients" and what actions Burlingame LTC could take that would permit the facility to accept certain types of patients and to speed up discharges to free-up LTC beds.

During the facility tour, the following observations were made:

- The facility was generally clean and free of odor;
- Some residents were observed engaged in activities. Others were in their beds or in the hallways in wheelchairs or ambulating;
- Residents appeared clean and dressed appropriately;
- There were a larger number of younger residents than are generally encountered in the average (non-county) nursing home. In fact, 45% of residents in October 2007 were under the age of 70, with 20% under the age of 60. (See Table 6.)

Table 6: Burlingame Resident Age Distribution October 2007

Age Range	Number	%
30-50	17	7%
50-60	34	13%
60-70	63	25%
70-80	55	22%
80-90	71	28%
90+	15	6%
Total	255	100%

- The facility was noisy – there was a lot of activity in the hallways and some overhead paging. At one point an alarm sounded;
- The hallways contained a significant amount of "overflow" wheelchairs and lifts – this is reportedly due to a lack of space for storage;
- There are several small terraces – one is used by residents who smoke. There is no facility "open space" - therefore there is no resident access to green space;
- The patient rooms are not conducive to long-term placement. They are small and contain, 2, 3 or 4 beds separated by curtains. These rooms are much more suited to short-term rehab stays; and
- The facility lacks the preferred environment for residents with dementia or for residents with significant behavior problems. The lack of outdoor space, and lack of quiet indoor, barrier-free walking areas, also limits the ability to meet the need for resident exercise and fresh air.

HMA attended an Inter-Disciplinary Team (IDT) meeting at Burlingame during early November 2007. Of particular note were the following issues.

- A resident attended a portion of the meeting. The resident was very articulate discussing her needs, raising questions and expressing appreciation for the care she has received at Burlingame LTC. Some of her needs were for a possible change in her medication administration time and the need for someone to accompany her off-facility for the first time in over a year (following recovery from a fracture). She noted she is not ready to leave yet because she cannot use the bathroom without assistance and needs to gain muscle strength and improve her ability to transfer and use her wheelchair independently.
- Another resident's IDT meeting was attended by her family members. They expressed concern about their family member's care and reported the CNAs are not positioning their family member correctly. They visit frequently and had made signs for the staff to post reminding the CNAs how to position their family member correctly.
- Finally, staff noted that an out-of-county resident was recently accepted for admission to Laguna Honda Hospital DP/SNF in San Francisco (the resident's county of origin).

Based on a review of data, interviews and attendance at the IDT meeting, there were several factors identified that impact access to Burlingame LTC:

- There are a number of residents who remain at Burlingame because they are non-ambulatory. Their need for 24-hour access to assistance makes it difficult to discharge them despite them being cognitively capable of living in another setting at a lower level of care. Such a setting could be a board and care facility that accommodates non-ambulatory residents (which requires a waiver from the State) and that can provide daily assistance with personal care and medications.

Burlingame staff also report that many of the patients at Burlingame have no family and/or were homeless when entering the facility. They cannot afford the typical Residential Care for the Elderly (RCFE) rent. Access to a suitable board and care facility would require a supplemental (patch) payment, which might be provided by Aging & Adult Services or MHS when available. A reported lack of adequate "numbers" of patch payments and numbers and types of board and care facilities makes it difficult to discharge some residents from Burlingame.

- There appears to be general agreement that staff at Burlingame LTC do not have all of the necessary skills to accommodate residents with challenging behaviors or greater acuity.
- Nursing staffing hours per resident day at Burlingame are budgeted at about 3.2, 1 hour per resident day less than Unit 3A.
- Out-of-county residents are occupying 19 beds at Burlingame LTC.
- Burlingame staff report a common difficulty related to discharging residents from Burlingame occurs when they receive admissions of younger persons with a diagnosed mental illness who develop medical problems, like a colostomy or fracture. Once the medical issue is resolved or stable, they cannot find a suitable place to discharge the patient even though they no longer need SNF care.

HMA met with key staff to discuss what can be done to improve flow into and out of Burlingame LTC. Staff discussed the following issues:

- *We are not a mental health facility. We do not have the training or staffing to take people with serious mental illness. Our facility is also not suited for this (i.e., crowded and unlocked).*
- *We do take some patients with challenging behaviors and it is very difficult for us. We have had psychotic residents who scream, a resident with multiple personality disorder, and a resident with severe obsessive compulsive disorder. Staff described several patients with challenging behaviors and noted they had been able to accommodate them but it was very stressful for everyone (staff and other patients). One of these residents had previously been on the former locked gero-psych unit.*
- *The patient must meet skilled care requirements. We cannot take people solely to free-up beds at SMMC.*
- *When we take patients with serious behavioral problems and their medical condition improves, we get stuck with no place to discharge them to. They then do not meet SNF level of care, but we have no alternative but to keep them here. We have accepted residents from Cordilleras and then they have refused to admit back once the medical issues are resolved.*
- *We are trying to make some changes to improve our ability to take more difficult patients. We limit overhead paging and are exploring the purchase of portable phones for nurses to eliminate paging except in emergencies.*

- *We developed a suggested dementia program design, but the funding to implement the proposed program was denied by the County. (HMA subsequently reviewed the proposed program documentation and found it inadequate to justify the expenditures requested.)*
- *We have many frail elder residents who are vulnerable.*
- *Sometimes when we accept someone with behavior problems we tie up a bed that we could have used for a "Medicare rehab patient".*
- *Roommate compatibility issues limit our ability to admit some patients.*
- *We sometimes have problems accessing psychological services for residents. This is especially true for Kaiser covered residents. Staff report it can take up to 25 days to get approval for a psychological evaluation. We also have difficulty accessing SMMC psychiatric assistance.*
- *We are limited by the LTC guidelines regarding limitations on the types and amounts of medications we can administer to SNF residents.*

When asked what could be done to improve the capability to accept more difficult patients from SMMC, staff noted the following:

- *Perhaps if we grouped residents and assigned staff to groupings, staff could acquire the skills to work with a specific group. Some staff noted that they had gone back and forth between assigned versus floating staff and had problems in the past with assigned staff and "burn out".*
- *Nurses and CNAs need behavioral training, especially how to deescalate behaviors.*
- *If we had additional rehab raining, we could accept more Medicare rehab patients.*
- *We need more access to board and care to ensure timely discharge when medical issues are resolved.*
- *Some of our residents might be more easily discharged if they had access to a day program like adult day care. The original design for Units 1A and 1B at SMMC reportedly included the outdoor space to accommodate an eventual day program.*
- *We also need access to more Section 8 housing to support discharge (with supports).*

In summary, lack of alternative placements, especially for non-ambulatory residents, physical plant limitations and training needs are contributing to restrictions on admissions and discharges, thus compounding the "bottle-neck" at SMMC and resulting administrative and non-covered days of care.

Discharge Planning

Discharge planners are charged with discharging patients from the psychiatric, med/surg and SNF units as quickly as possible based on each patient's readiness for discharge and access to viable community-based options for care (if care is needed post-discharge). SMMC leadership believe that discharge planning as a hospital function has not previously been optimally organized and has not had the level of visibility or

importance it should have within the hospital structure. Recent and ongoing changes seek to address these issues.

Discharge planners historically reported to the quality division and were assigned to the finance department for oversight. Recently, SMMC has implemented changes to the discharge planning structure and process. LTC discharge planners now report to Sandra Kissoon, Vice President of Patient Care Services. Discharge planners are social workers who function both as case managers and who also complete social work functions required in SNFs (primarily discharge planning).

SMMC has admission policies for LTC, inpatient psychiatric services and for the so-called "social admissions". None of the policies are comprehensive and they do not reflect current practice. For example, the LTC Admission Policy states:

> *The following patients will be excluded from admission: Patients with disruptive violent, assaultive (physical and sexual) and suicidal behaviors.*

However, in practice, staff acknowledge they do admit patients with these characteristics, but only after making a determination regarding current behaviors and ability to deal with current behaviors. The criteria also states:

> *If the applicant has a history of psychiatric disorder(s), complete diagnostic evaluation must have been done with documented evidence of adequate behavioral management. The facility reserves the right to investigate.*

However, there is no detail regarding what constitutes "adequate behavior management" (or what a complete diagnostic evaluation consists of).

Each Thursday a Utilization Review meeting is held at SMMC to review patients awaiting transfer or discharge from medical/surgical beds to SNF beds or to other levels of care. Included in the meeting are discharge planners, physicians, rehab staff and the LTC Director of Nursing (DON). The weekly UR meetings started several months ago and are reported to have been helpful.

HMA attended a weekly meeting in early November 2007 during which the status of each patient on Unit 1A was discussed along with potential admissions to and discharges from 1A. Of the 30 patients on the unit reviewed during the meeting, diagnoses and/or treatments/services included:

- Rehabilitation services;
- IV antibiotics;
- Wound care for stage II, III or IV decubitus ulcers;
- Dialysis;
- Staph infection;
- COPD and mental health issues;
- End-of-life care;
- Urinary tract infection, catheter, morbid obesity;
- Dehydration upon admit from a board and care facility (also has mental health diagnoses), problems with ambulation;

- Colostomy; and
- CVA.

Several of the reviewed patients were planning discharge to home once their medical conditions were resolved or stable, several were recommended for SNF placement (at Burlingame LTC) and 3-4 were expected to be discharged to a board and care facility.

During discussion, staff noted the back-up on the medical/surgical unit with patients waiting for admission to 1A or to Burlingame LTC or for discharge to another setting (like board and care).

SMMC physicians attending the meeting noted they have been utilizing outpatient and home IV antibiotic therapy when feasible to support patients discharged from Unit 1A and this has been successful. However, if a patient needs IV antibiotics three times daily or is a drug user, these alternative arrangements are not feasible.

Staff noted they have two private pay patients at present on Unit 3A. The family of the patients stated they could take their family member to another facility for care, but are happy with SMMC and the staff noted they want to keep private pay patients.

Discharge planners reported that they had received requests from physicians to move their patient(s) from medical/surgical beds to SNF beds on Unit 1A, but Unit 1A had no immediate openings. Some doctors are reported to be reluctant to discharge patients to Burlingame LTC or other SNFs because they want patients retained at SMMC at least in part because they can easily check on them.

The UR meeting was immediately followed by a meeting reviewing planned admissions and discharges for the SNFs (Unit 1A and Burlingame). Discharge planners, physicians, rehab services staff and the SNF DON were present.

Burlingame LTC was reported to have 264 patients, with 5 "male" beds open. One female bed was "closed" due to a need for a private room. There were 5 bed holds. The bed holds were for patients admitted to MPHS (4) and SMMC (1). There were 2 planned discharges within the next 5 days.

In order to admit patients to Burlingame LTC, staff stated patients must be determined medically stable, and Burlingame LTC must be able to accommodate any behavior issues. Burlingame staff noted they cannot accommodate morbidly obese patients due to space limitations in patient rooms.

Among the patient needs discussed at this meeting, were the following:

- A patient who suffered a head injury would like to go home with family, but needs oversight and assistance during the day. He is not Medi-Cal approved yet, and the discharge planner noted it could take up to six months to get through the disability and Medicaid eligibility determination process. The team discussed possible board and care, but payment for room and board is an issue.
- A younger patient on IV antibiotics could potentially be discharged to Burlingame LTC, although he has no Medi-Cal coverage or other coverage. His

personal physician at SMMC wants the patient to remain on Unit 1A. The SMMC physician stated she would follow-up with the patient's personal physician to address possible discharge to Burlingame LTC.

- A patient with osteomyelitis and diabetes mellitus is a good candidate for Burlingame.
- A patient from out-of-county who has never "been in the mental health system" has been diagnosed as having dementia and schizophrenia, has hallucinations and has been selling methadone in the past. The team indicated he needed a psychiatric conservatorship and was a potential admission to Burlingame LTC.
- A patient with mental health and medical problems appears appropriate for discharge to Burlingame LTC.
- One patient is waiting to go to Cordilleras (MHRC) – there is no bed available currently.
- Two patients are "social admits". One patient has "severe" dementia and has been referred to a number of dementia facilities. The other is incontinent, wheelchair bound, has a history of addiction and has a sitter at the hospital due to using his wheelchair to get around the unit and disrupt other patients.
- One patient is currently on a medical/surgical unit and will need to be admitted to Unit 1A. The patient has surgical drains, had a gastrectomy and is in a lot of pain. The patient could go to Burlingame LTC once stable on Unit 1A.
- Other patients were too acute for LTC at Burlingame, but if beds were open on Unit 1A could be transferred from medical/surgical units.

Burlingame LTC reported they planned to admit three patients from SMMC during the coming week and to evaluate one patient the day of the meeting for potential placement at Burlingame LTC. The Burlingame staff noted they cannot take multiple admissions at the same time (therefore, they were to be transferred to Burlingame LTC over the next few days).

Other Issues

During the meeting several other issues arose. These were:

- Staff noted that Medi-Cal requires seven day medical bed holds for patients residing in SNFs and being hospitalized. (HMA subsequently reviewed the Medi-Cal policy and it requires seven day bed holds only when requested by the attending physician. The policy limits bed-holds to seven days. If the attending physician notifies the SNF that the patient requires more than 7 days of acute hospitalization, the SNF is not required to hold the bed.)
- The discharge planners utilize in-home support services (IHSS), but report that arranging IHSS for the date of discharge is a major problem. The patient needs

IHSS on the day of discharge, but policy requires discharge in order to access IHSS.

- Use of HCBS waivers to support discharge from LTC is almost non-existent. One staff person reported having discharged to a HCBS waiver slot twice in sixteen years. The process is reported to be cumbersome and time consuming. Discharge planners do utilize specialized case management (MSSP for example), home health services (Medi-Cal, Medicare) and other services whenever possible.
- The County reportedly discussed operating a RCFE in the past, but staff believes there were concerns about the liability around operating an RCFE.
- Some "patch" payments are available to patients discharging to RCFEs through the County Division of Aging and Adult Services. Discharge planners report the process to access these payments is very time consuming requiring numerous alternative placement "denials" before they can be accessed. (HMA discussed this issue with staff of Aging & Adult Services. They noted their obligation to ensure patients are admitted to the least restrictive placement and, for patients who are conserved, must make a formal report to the Court. They indicated they are available at any time to discuss such issues and urged SMMC staff to let them know when they have problems accessing timely placements.)
- Some patients are "Aid Code 55"[11] – this means they are immigrants with emergency Medi-Cal coverage only. These patients cannot be discharged without losing access to all Medi-Cal health care except for emergency care. There are reported to be a few (less than five) persons in this situation at Burlingame LTC.
- Out-of-county admissions – patients from another county may present at the ER and be admitted to SMMC. They may become the financial responsibility of San Mateo County. Staff noted that this works "both ways" with San Mateo residents presenting at ERs in other counties. There is no written agreement with other counties to address the responsibility for, and disposition of, out-of-county residents. (This is also an issue for Psychiatric Emergency Services.)
- Collecting patient responsibility (such as share of cost) is reportedly a problem. There is reportedly no statement in the patient admission agreement addressing share of cost. Collections that were previously under the purview of the County Treasurer are now operating in-house. There appears to be mixed opinions regarding performance under either of these arrangements for collections.

[11] Undocumented aliens qualifying for Medi-Cal who currently reside in long-term care (LTC) facilities who are not determined to have PRUCOL (permanently residing under color of law) status by the Immigration and Naturalization Service. Non-PRUCOL aliens are eligible for non-emergency LTC services; all emergency benefits (including labor and delivery, and Renal Dialysis (RD) services); and all non-emergency pregnancy-related medical benefits.

- A portion of patients are Medi-Cal pending. According to staff, if a patient is approved for Medi-Cal retroactively and has had a stay of at least 30 days, there is no payment from Medi-Cal.

Burlingame LTC –Facility Issues

- Burlingame is a large nursing facility. Facilities of more than 150 beds are more difficult to manage. Larger facilities also present greater challenges in offering a more "home-like" environment residents would prefer.
- At present, the Vice President of Patient Care Services is "administering" Burlingame as well as overseeing nursing services at SMMC "proper". Burlingame and SMMC 1A each need an administrator at the helm who is solely responsible for the facility and for the beds on 1A. County SNFs typically serve a different population from the "average" non-county SNF. This is certainly the case at Burlingame where residents are predominantly younger, poorer and more likely to have problem behaviors including substance abuse. The size and nature of the facility require an administrator who is not also responsible for other tasks outside of the SNF beds (although they will of course need to ensure they are part of the larger continuum).
- The facility is aging and less than ideal in many ways. It may need to be replaced in order to better meet the needs of residents and to serve the more complex residents who will continue to turn to the County for LTC services.

The Long-Term Support Services Project (LTSSP)

The LTSSP is an initiative of the Division of Aging and Adult Services and is San Mateo County's long-term care integration project that ultimately envisions a fully capitated and integrated program encompassing Medicare, Medi-Cal, Older American Act funds, County funds and other funds to provide acute and long-term care services to elders and disabled adults. The project was proposed over 15 years ago and recently has been reactivated following reported encouragement from California DHCS officials.

As part of this effort, Aging & Adult Services is implementing a uniform assessment tool (a modified Minimum Data Set – Home Care or MDS-HC) integrated with a single automated case management system for all members of the target population entering home and community-based LTC services. The Ron Robinson Center at SMMC will also be using this assessment tool. The modified MDS-HC will eventually assist with prioritization of resources for consumers based on their assessed need.

The project is mentioned here because it will impact some patients served on the inpatient psychiatric unit and could also impact SMMC financing, since SMMC would likely become a subcontracted provider of various hospital and LTC services for LTSSP enrollees. While LTSSP is still in the planning stages, SMMC leadership should become familiar with this project and seek involvement in planning for implementation. SMMC

case managers will need to understand the scope of services associated with this type of capitated arrangement.

Psychiatric Services and Long-Term Care Services: Findings

The following represent the primary findings of psychiatric and long-term care services within the County system:

- **A lack of sufficient numbers and types of alternative placements are creating bottlenecks throughout the system and are the major driver of non-paid and paid administrative days.** The high proportion of administrative non-paid days of care at SMMC appears to result primarily from a lack of available and appropriate alternative placement options.
    - Lack of placements is causing "bottlenecks" that prevent or delay flow of patients from SMMC medical/surgical units to Unit 1A (SNF), from Unit 1A to Burlingame and from all units, including the inpatient psychiatric unit back to the community.
    - Lack of placements also results in admission of persons who do not require care at SMMC but who are reported to have no available alternative placements/options and who are determined to otherwise be homeless, at-risk of exploitation, neglect, and/or abuse and/or deterioration if not admitted (social admits).
- **Other contributors to administrative days appear to be documentation gaps in inpatient psychiatric services and delays and conflicts around discharge status and discharge planning.** Factors that also appear to be contributing to administrative, non-paid days are inadequate documentation on the inpatient psychiatric unit and physical plant and staffing limitations at Burlingame that limit admission of patients with substantial behavioral problems. Other factors that might be contributing to this problem, but require additional investigation, include a reportedly overly time-consuming procedure required to document need for placement options and "patch payments", and admission of out-of-county residents to SMMC (including to Burlingame) who occupy beds that may be needed by San Mateo County residents.
- **There are major information gaps that prevent accurate analysis of "social admissions" and administrative days for both psych and med/surg patients.** There is a lack of sufficient data to analyze "social admissions", administrative days, the need for specific types and numbers of placements, the overall impact of funding "patch" payments, and the specific decision points and outcomes of the referral process, including referrals within SMMC from med/surg and inpatient psychiatric units to LTC.
- **There is no high level administrative leader for inpatient psychiatric services.** There is a pressing need for an administrative leader for psychiatric services: a

single person who is not consumed by clinical tasks and who is responsible for addressing and resolving issues as a representative of psychiatric services (both PES and inpatient services).

- **The current system has high quality people and a significant commitment to psychiatric and LTC services, but the various levels of care (community-based and institutional) are fragmented.** Funding occurs in silos and contributes to decisions that address the needs of a specific division or entity (such as SMMC) rather than the overall County budget. Patient care is not comprehensively coordinated across the continuum.
- **Burlingame could be a more significant provider of care for patients with behavioral problems if there was intensive training and ongoing support staff.** Burlingame LTC staff report they do not have the specialized training and/or experience necessary to work with patients with more challenging behaviors. Some staff believe they could accept additional patients with such behaviors with additional training and with ongoing assistance and consultation from qualified clinicians (such as psychologists) regarding behavior planning and approaches.
- **Burlingame has significant physical plant constraints that reduce the County's ability to serve persons with more complex needs, especially for persons with physical/medical/behavioral complexities.** The Burlingame building design is not conducive to providing adequate care to patients with serious behavior problems, either resulting from a mental illness, head injury or dementia. In addition, Burlingame is providing care to some patients who could benefit from assisted living (Board and Care) and housing with on-site supports. Resources might be better directed to the development of alternative programs and placements.
- **San Mateo County appears to have a shortage of LTC beds relative to need.** There is a widely reported shortage of SNF beds and this situation is likely to worsen. At the same time, some SNF beds are occupied by people who could be served at lower levels of care. The County has relatively recently accepted responsibility for providing longer term SNF placements by assuming operation of Burlingame. If this responsibility is to be continued, the County would be better served by analyzing the entire LTC continuum and making a determination regarding the future of Burlingame in the context of this bigger picture.

Psychiatric Services and Long-Term Care Services: Recommendations

- **Comprehensively Assess the Future LTC Service Needs of the County and the County's Role in Meeting These Needs.** Assess the ideal configuration of long-term care options including SNF, assisted living, housing with on-site supports,

support at home and specialized models of care (for gero-psych, dementia, TBI, etc.), map out current availability (public and private), determine the scope of the County's responsibility for long-term care and determine the most feasible model for the County long-term care continuum consistent with the County's mission.

Burlingame LTC as currently configured cannot provide a locked unit for patients with serious behavior problems, either resulting from a mental illness, head injury or dementia. The County needs to determine how many of these types of beds are needed (the additional recommendation regarding social admits, administrative days tracking and admission/discharge planning should facilitate this analysis). If the County has a need for additional "locked" placements, it will either need to contract for more of these types of beds or build/lease a suitable space to operate these beds. A gero-psychiatric unit could meet some of this need (but a cost-effective model for gero-psych has not been identified to date).

This assessment might also include a feasibility study of Burlingame. (This recommendation is discussed separately below.)

- **Consider conducting a feasibility study regarding the future of the Burlingame facility**. A feasibility study is likely needed to determine how much more money the County should invest in this facility versus the cost to buy or build a better facility. The study should include varying models of care (dementia, gero-psych – although not so large as to present a danger of IMD designation), assisted living and so on. The County should consider whether any patch payments would be eliminated (or future need for same reduced) with access to a newer "multipurpose" facility. The need to continue SNF beds at SMMC, or alternately to provide additional SNF beds at SMMC (1A), should also be addressed as part of a feasibility study.
- **Implement one or more initiatives to address fragmentation of care and funding silos.** Potential initiatives include:
    - **Develop a County LTC budget** (probably specific to adults but that could include children). Long-term care not only includes Unit 1A and Burlingame and persons in need of long-term supports presenting at Psychiatric Emergency Services (PES) and/or admitted to the psych unit, but also encompasses long-term care services funded through Aging and Adult Services and Mental Health Services. Only then, can the true cost of patching placements and other measures versus retaining patients at SMMC and Burlingame LTC, be assessed. Such a budget could be developed by population subgroups – persons with a mental illness, the elderly, the non-elderly adult with a disability and potentially a "complex" category (meets two or more criteria, such as elderly, disabled and has a diagnosed mental illness). Analyze the "cost" of various long-term care options across the entire

continuum in order to better identify the most cost-efficient placement and funding options for hard-to-serve and high-cost patients.

- **Implement a comprehensive care management/coordination program** that provides a unified, multidisciplinary team or single case manager/care coordinator for each patient who then follows the patient across divisions and programs. This program could target specific types of patients. Suggested groups for this enhanced care coordination are:
  - Persons with a visit to PES or an admission to an inpatient psychiatric unit within a 12-month period;
  - Patients residing in an IMD;
  - Patients with specific morbidities (such as diabetes, COPD, dementia, HIV/AIDs); and
  - High "utilizers" – patients who are high cost and who utilize a large quantity of services – acute care, primary care, mental health services, long-term care services.
- **Implement the Long-Term Support Services Project (LTSSP) in as comprehensive a manner as possible, inclusive of mental health services.** Medi-Cal members and uninsured members of the HPSM receive their mental health and LTC services outside of the health plan (with the exception of emergency services). While the HPSM is not at-risk for mental health and LTC services for these members, the County remains at-risk. Safety net providers serve a disproportionate proportion of at-risk and high-risk patients – as such, the County needs to unify the system of care and align incentives across divisions and programs to ensure the best possible health and financial outcomes. The LTSSP offers an integrated model of care that is especially suited to the County, since the County already assumes comprehensive responsibility for Medi-Cal and uninsured County residents and has an existing structure (the HPSM) to deliver coordinated care. (A description of two long-term care integration models implemented elsewhere is provided in Appendix #4.)

- **Create and staff a Vice President of Behavioral Health Services position and a Vice President of Skilled Nursing Facility Services position as soon as possible.** The complexity of issues to be dealt with specific to both inpatient psychiatric services and SNF services is such that a high level administrator is required to address issues within their respective service areas and across the entire County continuum of care. Reconvene regular meetings with Health Department leadership, especially with MHS, HPSM and Aging & Adult Services leadership, to address and resolve areas of tension and areas of joint responsibility.

- **Implement an initiative to improve documentation of need for and provision of acute inpatient psychiatric services, using an "unbiased" resource to coordinate and implement.** DMH findings are of sufficient concern to warrant a targeted documentation improvement initiative. By necessity, such an initiative would also include a review of the inpatient psychiatric services model of care and quality of care.
- **Collect data on each "social admit" and patient not in acute status (psych, med/surg, LTC) in order to assess the most appropriate use of resources for other levels and models of care.** This includes all patients who have "administrative days". The assessment should consider a range of potential options and the determination must be based on patient characteristics, not available placement options. This information should be collected systematically in order to identify the needed placements options, the need for patch payments, the utility of a potential step-down unit at SMMC, and the need for additional long-term care beds and specialized programs (such as dementia and gero-psych). The level of care/placement options would include, at a minimum:
    - SNF with patch payment;
    - SNF without patch payment;
    - PHF;
    - RTF;
    - Board and Care with a patch payment;
    - Community with FSP;
    - Community with HCBS waiver services;
    - Housing with on-site supports; and
    - Independent (home or apartment with ongoing case management).
- **Review and revise the Memorandum of Understanding (MOU) between SMMC and Behavioral Health and Recovery Services to incorporate enhanced reporting requirements and to address what are reported to be poorly aligned financial incentives.** Revised reporting requirements should include detailed tracking of acute and admin days. The MOU should include a revised financial arrangement that better aligns incentives and terminology that is consistent with state and federal regulations and consistent throughout the MOU and across County divisions.
- **Review the current SMMC admission and discharge planning processes across service areas and divisions/programs.** The LTC Admission Criteria should be specific and reflect actual practice. For example, it appears that patients with a variety of behaviors listed on the LTC admission policy as exclusionary are actually admitted to LTC units. The criteria should be revised to reflect how this occurs and ensure the process is clearly delineated. The current meetings at SMMC to facilitate placements/movement are a good start in improving flow, but might be improved by providing more structure to the process, such as indicating in writing for each patient under review what specifically prevents

admission to LTC units or discharge to the community and tracking referral outcomes in a formal and measurable way. SMMC, MHS and Aging & Adult Services should determine what, if any, changes could be made to speed-up documentation of the appropriate least restrictive placements.

- **Provide additional training to Burlingame staff.** Burlingame LTC staff need additional training to accommodate patients with more challenging behaviors. They also need ongoing assistance/consultation from psychologists regarding behavior planning and approaches. Depending on the needs of such residents, an increase in staffing might also be required.
- **Assess out-of-county placements.** A review of the extent to which these admissions result in an inability to admit San Mateo County residents to SMMC or Burlingame LTC or transfer residents within SMMC and Burlingame LTC, should be quantified. The County should attempt to determine how many San Mateo County residents have become the responsibility of other counties. Once this information is quantified and assessed, the County may want to pursue a MOU with surrounding counties regarding their mutual interests, responsibilities and liabilities.
- **There are enough concerns about the impact of the potential MPHS/SMMC partnership proposal that indicate that more thought should be given to it before it proceeds.** Do not pursue the currently proposed options for an arrangement with Mills Peninsula Healthcare that would threaten to convert SMMC to IMD status or take up SMMC beds until a broader delivery system plan is developed that clearly sets out service requirements for all participating providers.

The Health Plan of San Mateo

Overview

The Health Plan of San Mateo (HPSM) was established in 1987 as a public entity under a federal waiver, state law and San Mateo County ordinance. Initially launched as a pilot project to demonstrate how a locally administered managed care plan could improve access and service delivery for San Mateo's Medi-Cal beneficiaries, HPSM has expanded its business to include HealthWorx, Healthy Kids, Healthy Families and CareAdvantage (Medicare Advantage Special Needs Plan (SNP)).

After two decades of operations, the health plan should be at a point where its operations are mature and stable enough to cover costs. However, HPSM's Medi-Cal program, its largest line of business, has operated at a deficit since 1999. To its credit, HPSM has softened the impact of these losses through diversification and expansion of its insurance products to include Healthy Kids, Healthy Families, HealthWorx and CareAdvantage.

As a one Medi-Cal plan county, HPSM has no competitors and membership growth opportunities are limited to the size of the Medicaid population in the County. As a result, the threats and opportunities facing HPSM are restricted to operational efficiencies, financially sound provider contracts and the changes to the state's rate setting methodology, which currently has not kept pace with health care costs.

The Health Plan of San Mateo: Findings

HPSM has established itself in the County as a quality health plan and enjoys broad support form the provider community. While its contracted provider network includes providers throughout the County, HPSM and SMMC are significantly dependent on each other. SMMC provides the core providers in the health plan's network, and the health plan directs many of its members to the County's providers. Timely access to care for HPSM members varies throughout the County due to the differences in the breadth and depth of contracted providers in various parts of the County.

- **The HPSM could expand its role within the administration of the County health services.** HPSM leadership's vision is broader and deeper than its current operations and includes an interest in other County health programs, including assuming a greater role with the WELL program, and long-term care. Staff expressed a commitment and interest in assuming additional responsibilities for the administration and management of all coverage initiatives within the County.
- **The Healthcare Coverage Initiative could be an important vehicle for managing some of the system's most complex patients.** HPSM is a key player in the Blue Ribbon Task Force discussions and is establishing itself as the

administrator for the health coverage program(s) that may arise among the Task Force's final recommendations. Regardless of whether the product(s) under the health coverage initiative is an insured product, HPSM is an apparent choice for to provide the administration of the program. It has as much (or more) experience than any other organization within the County and the scalability of its operations can accommodate anticipated "membership" growth. County staff support this broader role, and expressed an expectation that HPSM would take the lead in defining the benefit design, developing/contracting the provider network and administering the program.

- **HPSM administration and operations need to be enhanced to meet the demands, particularly in care management, of the entire delivery system.** HPSM and the County providers are dependent on one another for their mutual viability. The County providers are an integral part of HPSM's contracted provider network and HPSM (through its members) is an important feeder of patients to SMMC and its clinics. Current relationships should be analyzed to identify areas for improvement and additional partnership opportunities. For example, both entities have a mutual interest managing health plan members' care to keep them out of the hospital. However, current care management practices are not very formalized or sophisticated. HPSM is looking to enhance its care management program and is looking to contract with an external vendor. However, the ability to house this service within SMMC may be a better option.
- **HPSM has demonstrated its ability to successfully diversify and to keep pace administratively with both membership and product line growth**. The health plan leadership is interested in expanding its business and its role within the broader context of the administration of health care services for the County's uninsured population. The areas of greatest opportunity include Medicare Advantage Special Needs Plan (SNP) expansion, long-term care and the Blue Ribbon Task Force and WELL program.
- **Provider access and capacity, both within and outside the contracted network, is an ongoing concern**. HPSM recently changed its payment arrangements with contracted primary care providers from a risk-sharing arrangement to an incentive arrangement. Provider focus groups were held recently to gain a better of understanding of provider issues and struggles. Although reimbursement was not cited as a factor for participation with HPSM, it is suspected that reimbursement issues may be masked behind spoken issues for non-participation, including provider doesn't take Medi-Cal or provider is not accepting new patients. HPSM staff indicated a renewed effort to address provider network issues is currently underway.
- **HPSM has not built its CareAdvantage program to the full extent that it could and should**. HPSM's SNP enrollment is not dissimilar to other SNPs across California and the United States, and is, in fact, above average. Kaiser is the only Medicare Advantage plan in the County with more members than HPSM, and

only four plans (including HPSM) have meaningful enrollment (i.e., more than 1,000 members).[12] However, plan leadership acknowledge that membership was acquired almost entirely through passive enrollment at the onset of the program in 2005, and no formal efforts have been made to either retain existing members or attract new members. As a result, membership has declined a bit due to attrition from death and those members who opted to return to Medicare fee-for-service and a Part D only plan.

The Health Plan of San Mateo: Recommendations

HPSM's role in the County's health care system continues to grow and evolve. The diversification of products and the associated membership growth have been positive changes. The recommendations outlined below build upon current operations and successes.

- **HPSM should take an even stronger role within County health services, particularly in long-term care services.** HPSM leadership's vision for the health plan includes prominence in the administration of the County's expanding health coverage programs. Leadership also has an interest in capitalizing on the County's assets related to long-term care and pursing a long-term care integration plan with the state. The health plan is very interested in pursuing the long-term Services and Support Project (LTSSP) in partnership with the County. While long-term care integration models are still emerging across the country, a few models are worthy of analysis. (See Appendices for models).
- **HPSM should work closely with SMMC in the administration of the Coverage Initiative.** The health plan appears to be well positioned to play a primary role in the administration of the coverage initiative. HPSM is in the process of developing the systems necessary to assume responsibility for the WELL population (scheduled for a February 2008 implementation). HPSM's systems and processes are scalable and can accommodate the projected volume growth.
- **Growing the CareAdvantage program should be a priority.** Building on the recent success of its Medicare Advantage product, and with a few years of experience under its belt, HPSM is in a position to grow this line of business. Until now, HPSM has relied on passive enrollment for its membership, and has not yet developed a formal marketing plan to promote its benefit design and attract members. As one of two special needs plans in San Mateo County, the potential for growth is there. Using a proxy of 18% of the Medicare population that are dually eligible for Medicaid, approximately 16,000 persons in San Mateo County are "eligible" for enrollment in CareAdvantage. HPSM's SNP membership includes just over half (53%) of this population. The only Medicare

[12] http://www.cms.hhs.gov/MCRAdvPartDEnrolData; Enrollment by State/County/Contract, November 2007

Advantage plan in the County with more members is Kaiser, with an enrollment of 24,000. The need to retain current members is also critical. Medicare beneficiaries have a number of insurance options, including enrollment in another Medicare Advantage plan or continuing in/returning to fee-for-service and a Medicare Part D only plan. As the only Medicaid managed care plan in the County, HPSM should focus marketing on "low-hanging fruit:" its Medicaid members who are aging-in to Medicare[13]. These members are familiar with HPSM and its network of providers and could easily transition into CareAdvantage. In addition, the implementation of a formal marketing initiative could result in meaningful membership growth. Included in this plan should be benefits or program design features that are unique to HPSM and not part of other SNPs in the County.

- **Significant attention should be paid to operational issues with HPSM, particularly in the areas of data.** The ability for the CareAdvantage program to continue to be financially viable is highly dependent on the formalization of management controls and the implementation of a sound utilization management program. An important emphasis should be placed on the efficiency and accuracy of HPSM's collection and reporting of CareAdvantage members' diagnoses (i.e., risk adjustment factors). It is critical for HPSM to educate its providers on the importance of accurate coding. Reimbursement under Medicare Advantage is now based entirely on risk adjustment factors for individual members. Current analysis of data across the country indicates that the general "rule of thumb" is that $80-$120 per member per month is "left on the table" due to coding errors.

  In addition, under CMS' direction, the National Committee for Quality Assurance (NCQA) has developed structure and process measures to evaluate SNPS in the areas of integration of benefits and services, case management, care transitions, member experience and clinical quality improvement. Draft measures were released in December for public comment. The measures will be finalized in March/April 2008. Afterwards, NCQA and CMS will notify plans and work with them to begin the data collection and submission process.[14]

- **The development of an institutional SNP should be explored if/when the moratorium on new SNPs is lifted.**[15] Approximately 92,000 Medicare beneficiaries reside in San Mateo County. An analysis of growth opportunities in Medicare Advantage could identify a niche or additional prospects. An area worthy of additional analysis for HPSM's Medicare line of business is expansion

[13] It is HMA's understanding that HPSM began identifying and focusing on age-ins in September.

[14] http://www.cms.hhs.gov/SpecialNeedsPlans/

[15] On 12/29/07 President Bush signed the *SCHIP Extension Act of 2007* which extended existing SNPs through 12/31/09, but placed a moratorium on new SNPs and expansions of service areas.

to an institutional SNP. Key elements for analysis would include the percentage of Medicare patients/residents at Burlingame and SMMC and an actuarial analysis using estimated risk scores of patients. If a decision is made to move forward with an institutional SNP, HPSM would be required to submit an institutional SNP proposal; a full Medicare Application would not be necessary, as HPSM is an existing SNP and the service area would remain unchanged. The key components of the institutional SNP proposal include a specialized model of care of the institutionalized members (and members living in the community by requiring an institutional level of care, if these beneficiaries would be targeted), evidence of the contractual arrangement (including all required language) with the long-term care facilities and the provider network (if different than the existing SNP network).

- **HPSM should aggressively develop care management capabilities, in connection with both the SMMC efforts and as a part of the development of a broader delivery system for medically fragile people**. Health plan leadership acknowledged the opportunities that exist regarding care management for its members. Under its Medicare Advantage SNP contract with CMS, HPSM is required to conduct risk assessment on all members and provide care management to all high-risk members. While HPSM is meeting this requirement, it is seeking to enhance this function and to expand it to include proactive care management to all lines of business. The health plan has struggled with recruiting and retaining nursing staff for medical management and utilization management. As a result, discussions have been held with external vendors to provide care management services. While external contracting is an acceptable arrangement, this could also be an opportunity for the health plan to partner with the SMMC for these services. This arrangement would require the County to build the necessary infrastructure to provide these services, but it could further align the incentives of SMMC and HPSM regarding the service delivery for HPSM members.
- **HPSM should coordinate with other County programs to assure consistency and streamline bureaucracy**. Among the areas of consideration for operational efficiencies county-wide include enrollment and eligibility determination functions, as well as decision support capabilities. The lines of responsibility are at times blurred between the County and HPSM. Examples include the WELL program. The plan's IT and decision support capabilities are quite sophisticated, and are continuing to advance. The health plan is scheduled to replace its claims system and install a medical management system. Opportunities to "share" these resources and staff expertise with SMMC to assist with decision support and analysis (an area of weakness as identified by SMMC financial staff) should be assessed.
- **HPSM should play a pivotal role in defining health care provider needs and gaps**. In recognition of the varying provider participation issues throughout the

County, HPSM is urged to monitor the success of its recently implemented PCP incentives. In addition, network inadequacies should be addressed and a broader delivery system plan established which would include current access issues in some parts of the County (e.g., southern portion) and to certain specialties.

- **HPSM should seek accreditation**. As HPSM continues to diversify and increase membership, HPSM leadership are encouraged to consider seeking NCQA accreditation in anticipation of future state or CMS requirements for participation in Medi-Cal or Medicare Advantage. HMA acknowledges the staff and financial costs associated with the preparation required to develop and submit an application and ready the plan for URAC accreditation are high, and that the time for seeking the accreditation is more likely in the future. However, the importance of accreditation should not be completely lost to other demands and priorities.

County Health Care Financing

Overview

Phase 1 of this project was completed in September of 2007 with a report presented to the Board. In that phase, HMA was retained by the County of San Mateo to perform a financial analysis of San Mateo Medical Center (SMMC). The two key directives of Phase 1 were to:

- Review the SMMC internal financial analysis of gain and loss by service line; and
- Develop a five-year financial projection, assuming there are no changes to the configuration and operation of the SMMC, clinics, and long-term care facility.

The findings below were first reported in Phase 1 and expanded upon in Phase 2, during which time strategic financing strategies were further assessed and linked with operational findings and recommendations.

County Health Care Financing: Findings

- **System losses are widespread among service lines.** Rate increases for Medi-Cal seem destined to fall below historical levels of cost growth. Therefore, the trend in subsidy seems to be a continued increase.
- **Base payments for Med-Cal services do not cover costs in the SMMC system.** The Medi-Cal program includes several supplemental payments that are supported by local funds (IGTs) or through Certified Public Expenditures (CPEs). The revenue from the supplemental payments is critical to the financial viability of SMMC. Medi-Cal reimbursement policy is complex. In order to contain the growth of the State budget, determining Medi-Cal reimbursement to individual providers is often a matter of allocating fixed payment pools among eligible providers. Other payments (e.g., FQHC) have been transitioned from cost-based to fixed rates with annual updates tied to cost indices. Supplemental payments have been expanded in recent years to offset the negative impact of the State budget containment policies. Allocation of the supplemental payments to specific services is not precise.
- **Medicare payment does not cover the costs of serving Medicare patients within the SMMC system.** It was suggested in the Phase 1 report that Medicare payments should cover costs. Further analysis found that not only are Medicare margins declining to a negative level nationwide, but within California, the level of Medicare reimbursement is well below costs for nearly all hospitals.
- **The County subsidy will continue to grow.** Absent any significant changes, the County subsidy to support health care services will approach or exceed $80 million by FY 2011.

- **The local government subsidy in San Mateo is one of the highest in the nation.** The San Mateo subsidy for hospital services is high relative to other communities (see Appendix #5) and is not sustainable at the present level of growth.
- **The FQHC designation for SMMC clinics cannot be extended to new sites without a change in their configuration.** The SMMC clinics operate as hospital-based Federally Qualified Health Centers approved under the Health Care for the Homeless Program by the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services. Under this designation, the clinic boards are allowed to remain under hospital control. The requirement that clinics serve patients from medically underserved areas is also not part of the criteria for designation under the Health Care for the Homeless Program provisions. FQHC designation results in gross Medi-Cal reimbursement for Medicaid patients of about $300 per visit. This enhanced Medicaid rate is paid for both Fee-For-Service (FFS) patients and for patients enrolled in the HPSM. In addition, the clinics receive an annual HRSA grant in recognition of services to the uninsured of about $1.4 million. Expansion of clinic hours and/or services beyond that already approved requires HRSA approval. All indications are that approval as an amendment to the existing designation would be granted only if the services were primarily focused on the homeless population. The option of pursuing new FQHC designation under Section 330 of the Public Health Service Act or requesting status as an FQHC Look-Alike is a possibility. However, this would require meeting the criteria of location in a Medically Underserved Area (MUA) or serving a Medically Underserved Population (MUP). "Look-Alike" status may serve a whole or partial MUA/MUP so long as it demonstrates that it serves the neediest population in the service area or addresses gaps in services and/or health disparities. New designation would also require compliance with FQHC governance requirements (a community-based board). Designation as hospital-based is somewhat problematic for new FQHCs as most with that designation were grandfathered in some time ago. Therefore, the practical limitation for expansion is within the scope of the existing designation for both services and locations.
- **Despite FQHC limitations, there are ways to increase revenue generation in the SMMC clinics.** Within the existing approved scope of services and site locations, it is permissible to expand the volume of services and the mix of patients. Therefore, it is possible to positively impact revenue in two ways:
    - Increase the productivity within the clinics. This would have the effect of lowering the average cost per case and should maintain the present average revenue per visit.
    - Modify the existing mix of patients by promoting expanded services within "profitable" populations. For example, within the Medi-Cal population, the $300 per visit payment covers much more of the cost for a typical pediatric

patient than for an adult patient with associated ancillary testing and more expensive pharmacy needs.

- **Medi-Cal designation of the clinics as hospital-based is contingent upon maintaining the acute care unit.** The loss of "hospital-based" status for the FQHC would result in establishment of a new prospective rate for the clinics. Under this scenario, the current Medi-Cal prospective rate of about $300 per visit would be limited to about $125. The Medi-Cal reimbursement for clinic services is cost-based with a base period of FY 2000. Due to the federal requirement that rates be prospective, Medi-Cal policy restricts clinic payments to the base cost plus an annual update equal to growth in the Medicare Economic Index (MEI). Historically, the annual MEI update has been in the 2% to 3% range. Therefore, if cost increases average anything more than that, the clinic payments will not cover costs.
- **Currently, SMMC does not pursue enhanced Medicare reimbursement for services provided in the clinics.** It appears that the services to Medicare patients are eligible for per visit reimbursement similar to that being provided by Medi-Cal. A per visit rate is optional under Medicare and should be evaluated relative to existing reimbursement. According to the Medicare provider manual, provider-based FQHCs can elect to either be reimbursed as an FQHC through the FQHC intermediary (and bill non-FQHC services separately to Part B), or continue billing as a Part B provider to their Part B intermediary. In the latter case, the clinics will not be reimbursed for the preventive services that are only covered in the FQHC benefit. They also cannot waive the Part B deductible, as FQHCs can.

  The Healthcare for the Homeless program is authorized under section 330(h) of the Public Health Services Act and thus the Medicare criteria for FQHC status seems to be met. Per the Social Security Act Section 1866(aa) (4), the term "Federally qualified health center" means an entity which— (A)(i)is receiving a grant under section 330 of the Public Health Service Act, or (II) is receiving funding from such a grant under a contract with the recipient of such a grant, and (III) meets the requirements to receive a grant under section 330 of such Act. The current Medicare cap for urban FQHCs is $115.33 and will be updated by the MEI (2 to 3%) in January.
- **Under current constraints, SMMC loses money on long-term care services at both SMMC and Burlingame.** In determining the Med-Cal payment rates to SMMC, the costs of the Burlingame and the main campus are merged. The gross payment from Medi-Cal is in two parts:
  - The base payment is funded with general tax dollars and is about $318 per day in FY 2008 ($159 state and $159 federal).
  - The supplemental payment is the difference between actual costs and the base payments. However, the net gain for SMMC is limited to 50% of the

supplemental. In FY 2008, the net Medi-Cal payment for LTC patients is expected to be about $80 less than costs.

The initial expectations that the supplemental payment would be based upon the historical SMMC costs and/or not be limited to overall actual costs were erroneous. The current funding arrangements are consistent with both the Medi-Cal published policy and federal Medicaid regulations. The options to reach equilibrium of payments relative to costs are either to: 1) Reduce daily LTC costs for Burlingame to not more than the state funded rate of $318, or 2) to secure legislative approval for an increase in the State-funded portion of the gross LTC payment.

- **SMMC needs to avoid converting to IMD status.** Per the CMS State Medicaid Manual (Section 4390): In 1988, P.L. 100-360 defined an institution for mental diseases as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. This definition is in §1905(i) of the Act and in 42 CFR 435.1009. The regulations also indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. IMD status is based on acute services only (not SNF beds).

  While the criteria is "overall character", an accepted "safe harbor" is to maintain acute inpatient days as more than 50% of the facility's days, The most recent data provided to HMA indicates that acute days are about 57% of total facility days. Section 1905(a)(16) and Section 1905(a)(27)(b) of the Social Security Act provide that federal financial participation (FFP) is not available for medical assistance under Title XIX for services provided to any individual who is under 65 years of age and who is a resident in an institution for mental diseases (IMD) unless the payment is for inpatient psychiatric services for individuals under 21 years of age. Therefore, designation as an IMD would affect coverage for psychiatric patients between the ages of 21 and 64 and Medicaid payments would also be prohibited to any residual acute care patients within that age group.

- **The County does not recoup its cost for delivering psychiatric services.** Since 1995, Medi-Cal has used county-operated mental health plans (MHPs) and a managed care model to provide mental health services. The San Mateo County Mental Health Program is capitated for each Medi-Cal recipient and pays for services at SMMC using a "block grant" type methodology that is based upon an underlying FFS calculation using historical utilization as a predictor for the current year. In addition, the MHP has some responsibility for indigent services. SMMC receives additional payment from Medi-Cal in the form of DSH payments and safety net care pool allocations that include recognition of mental health services. There are alternative ways to allocate the gross amount of the supplemental Medi-Cal payments to psychiatric services. Allocation using days

results in a more favorable picture for psychiatric services. However, a more defensible approach is allocation based upon resources (e.g., square footage, allowable costs), which would assign the preponderance of the special payments to the acute service lines. Regardless of the allocation methodology for supplemental payments, the total reimbursement for psychiatric services is less than cost.

- **There are overwhelming financial reasons for maintaining acute care hospital status for the SMMC.** As noted elsewhere, operation of an acute care unit at least as large as the psychiatric unit is essential for several reasons:
  - Hospital-based status for the clinics is worth roughly $175 per visit;
  - IMD status would cause lost reimbursement for adult psychiatric services;
  - Medicaid DSH payments are predicated upon the existence of an acute care unit; and
  - Classification of the LTC unit as hospital-based is worth about $150 per day in additional state funded payments.
- **The financial implications of providing more acute care are difficult to assess.** Certainly, if the expansion brings significant commercial payments that cover costs, the benefit is positive. The net Med-Cal reimbursement of expanded acute care services is limited to 50% of the incremental cost of Medicaid services plus 50% of the cost of uninsured services. The expanded services could mean an increase in the SMMC share of the safety net pool. However, the pool is fixed in size and allocated based upon SMMC's share of uninsured relative to other public hospitals. Therefore, prospective determination of the impact of an expansion is not possible.
- **The Inter-Governmental Transfer (IGT) related to the HPSM is one area for potential new federal matching dollars.** Beginning in FY 2006, the HPSM was able to augment the capitation payments from Medi-Cal through use of IGT funds from the County to increase payments. This arrangement is possible because Medicaid HMO rates are based on "actuarial soundness." Following are the gross amounts each year (the County puts up 50%):
  - FY 2006 = $8 million
  - FY 2007 = $8 million
  - FY 2008 = $10 million

As outlined in the CRS Report for Congress, "Medicaid Reimbursement Policy," states have considerable latitude in setting capitated rates for recipients enrolled in HMOs.[16]

> *Federal Medicaid law requires simply that "prepaid payments to the entity [be] made on an actuarially sound basis." Until recently, federal regulations provided that state payments for enrollees in MCOs could not exceed the "fee-for-service equivalent" — the estimated amount the state would have spent for a comparable population not enrolled in the MCO and continuing to receive services on a fee-for-service basis. (This limit was similar to the adjusted average per capita cost (AAPCC) formerly used in setting Medicare HMO payments.) The use of the fee-for-service equivalent as an upper limit was dropped in 2001, partly because some states had enrolled so many beneficiaries in MCOs that they no longer had reliable data on fee-for-service experience. Instead the regulations now provide detailed specifications of what would constitute "actuarially sound" payment rates.*
>
> *Under the new rules, a qualified actuary must certify that the state's capitation rates have been developed in accordance with generally accepted actuarial principles and practices. Rates must be based only on services covered under the state's Medicaid plan; that is, the state may not pay extra for services available under the MCO contract but not provided to other beneficiaries. Finally, the state must provide CMS with documentation of the basis for the rates and with an explanation of any incentive arrangements, or stop-loss, reinsurance, or other risk-sharing methodologies.*

These provisions clearly allow for including in the Medicaid HMO rates an allowance for the supplemental payments that have been historically made only for FFS Medicaid patients. It also allows for higher payments to safety net providers as a means of assuring access to quality care for Medicaid patients. Criteria for economy and efficiency continue to apply as constraints against unreasonable payment arrangements. The State's actuary sets rates within a band that takes into account a number of factors. It is in the County's best interest to have the rates set as high as possible and to make arrangements to provide an IGT to supplement the state general fund amounts and allow the maximum allowed Medicaid capitation to be paid to HPSM.

CMS expectations are that the gross amount of any increased payments to HPSM will be spent on services to Medicaid patients (i.e., no recycling of funds back to the County). However, as long as the subsidy from the County to SMMC is significant, meeting this expectation should not be problematic.

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[16] A description of the requirements is outlined in a CRS Report for Congress – "Medicaid Reimbursement Policy" by Mark Merlis, Contractor to CRS Domestic Social Policy Division dated October 25, 2004 (page 90) and found at:
http://www.cq.com/flatfiles/editorialFiles/temporaryItems/20041101Medicaid.pdf

- **New federal Medicaid rules could have a significant impact on public hospital systems.** The May 29, 2007 Federal Register contained the final rule: "Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership". This rule placed new Medicaid limits on classifying providers as "public" and limited reimbursement to public providers to 100% of cost. The status of the rule is uncertain at this point. Congress has placed a moratorium on CMS implementation of the rule until May 2008. Unless the moratorium is extended, the rule will have an effective date in California of July 1, 2008. Because of the moratorium, clarification on several issues is not available. It appears that both the acute facility and the LTC units of SMMC will be public providers under the new rule. Extending the moratorium would assure the continued ability to fund special payments using IGT and CPE arrangements.

  The new rule includes a limitation on payments to 100% of costs. There is uncertainty on the exact implications of these requirements in two areas:

  - Applicability to payments from HMOs for Medicaid patients; and
  - Potential elimination of the ability to CPE uninsured costs for the safety net pool.

- **Ongoing operational demands limit SMMC's ability to adequately evaluate all revenue maximization strategies (including psych and LTC) and potential health reform impacts on the County.** The financial capabilities of SMMC would benefit from additional high level staff (e.g., a Controller in addition to the CFO). There is also need for more resources in analyzing SMMC contractual relationships and accessing/improving the decision support capabilities.

- **State health reform efforts could have serious consequences (and opportunities) for San Mateo County.** The Governor's proposal has five major elements:

  - Requiring all Californians (with some affordability-related exceptions) to acquire coverage.
  - Extending eligibility for Medi-Cal and Healthy Families up the income scale and offering tax credits to others.
  - Requiring employers who do not meet a spending minimum for coverage to pay a fee to the state.
  - Revising insurance market rules.
  - Establishing a purchasing pool to serve as a source of cost-effective coverage for employees of non-offering employers and some others.

  Per the California Association of Public Hospitals, the proposal has three critical policy and funding issues that are central to the sustainability of public hospitals:

- Medi-Cal rate increases for public hospitals. The historical under-funding of the Medi-Cal system must be addressed in order to maintain and improve access to care for low-income Californians.
- A Local Coverage Option is an essential element of any health care reform plan. As more individuals become eligible for insurance, a system needs to be implemented to ensure that public hospitals have a diverse mix of patients.
- Any county share of cost to help finance health care reform should only be considered if and when counties actually realize cost reductions.

County Health Care Financing: Recommendations

- **Advocate at the federal level to extend the moratorium on implementing the public hospital rules is an important priority for the County.** Under the current waiver, Medi-Cal reimbursement is configured to assure continued losses. From a public hospital perspective, California Health Care Reform must include an increase in State support for Medi-Cal payments to public hospitals. Federal regulations (current and pending) limit financing options available to the County. The estimated impact in terms of lost federal dollars of this rule on California public hospitals is $500 million annually.
- **Financial objectives and goals should be set and evaluated from a county-wide perspective, with each manager of a program or operating entity striving to maximize the state or federal dollars spent on health care for County residents and minimizing County subsidy**. Financial impact is currently being measured in silos (SMMC, public health, HPSM). An assessment at a higher level may result in more positive financing arrangements for the County as a whole.
- **Acute care services must be maintained at a level to prevent SMMC from reaching IMD status.** Designation as an IMD has serious financial repercussions including the loss of Medi-Cal supplemental payments, conversion of long-term care rates to freestanding instead of hospital-based (enhanced nursing home rates and seeing the hospital-based FQHC rate drop from $300 per encounter to, at best, $125).
- **State level advocacy is needed to alleviate underfunding of LTC services.** The base rate for long-term care is inadequate to cover the costs of the Burlingame facility. The current reimbursement is optimized within existing state and federal policy. Therefore, the solution is to identify additional state funding opportunities.
- **Aggressive efforts should be made to increase pediatric outpatient visits at SMMC clinics**. The costs associated with children are less than the $300 per encounter rate and would generate income to offset the subsidy of other patients and services. SMMC and the health department should explore the provision of

mental health services within the SMMC ambulatory clinics in order to access the FQHC rates for those services.

- **Opportunity exists to increase Medicaid HMO payments to public entities in order to guarantee access.** Payment from the State to HMOs can be financed with local dollars (IGT). Medicaid HMO rates are based on "actuarial soundness." The County should advocate expansion of the current arrangement that generates $10 million in additional payments ($5 million net). It may be cost beneficial for the County to engage an actuary to develop the appropriate rationale for optimizing these payments.
- **Additional reimbursement and financial analysis resources are needed to evaluate all revenue maximization strategies (including psych and LTC) and the potential impact of health reform on the County.** SMMC must be proactive, and not reactive, to Medi-Cal funding opportunities and to initiatives like Health Care Reform. With recent activity at both the State and federal levels, the complexity of these programs and the opportunities that exist are increasing dramatically. Further, the impact of various components cannot be calculated in isolation, as the effect is often related to other components and initiatives.

Appendices

#1 Interviewees

#2 Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services

#3 Institutions for Mental Diseases (IMD) Regulations

#4 Long-Term Care Integration Models

#5 Comparison of Local Subsidies for Indigent Health Care

Appendix #1: Interviewees

In addition to scores of administrative and clinical leadership, as well as front line staff of the San Mateo Medical Center (hospital, clinics, Burlingame), the San Mateo Health Department, the Health Plan of San Mateo and those in the Office of the County Manager, the following people were interviewed during the course of this assessment:

Hon. Rose-Jacobson-Gibson, *Supervisor, San Mateo County Board*
Hon. Jerry Hill, *Supervisor, San Mateo County Board*
Hon. Mark Church, *Supervisor, San Mateo County Board*
Hon. Adrienne Tissier, *Supervisor, San Mateo County Board*
Hon. Rich Gordon, *Supervisor, San Mateo County Board*
John Maltbie, *County Manager, San Mateo County*
Glenna Vaskelis, *President and CEO, Sequoia Hospital*
Bernadette Smith, *President and CEO, Seton Hospital*
Chris Dawes, *President and CEO, Lucille Packard Hospital*
Linda Jensen, *Senior Vice-President, Kaiser-Permanente*
Gerald Shefren, MD, *VP for Ambulatory Services, Stanford University Medical Center*
Cecelia Montalvo, *Vice-President and CIO, Palo Alto Medical Foundation*
Bob Merwin, *President and CEO, Mills-Peninsula Hospital*
Louisa Buada, *CEO, Ravenswood Family Health Center*
Kitty Lopez, *Executive Director, Samaritan House*
Sharon Peterson, *Director of Programs, Samaritan House*
Beverly Abbot and JR Elpers, *Consultants, Abbot/Elpers*
Mari Cantwell, *Research Director, California Association of Public Hospitals*
Mitch Katz, MD, *Director, San Francisco Department of Public Health*
Stephani Scott, *CEO, Sequoia Health Care District*
Nadia Bledsoe, *Senior Business Agent, AFSCME*
David Sharples, *Head Organizer, San Mateo County ACORN*
Shelley Kessler, *Executive Secretary/Treasurer, San Mateo Central Labor Council*
Kristen Spaulding, *Health Consultant, San Mateo Central Labor Council*
Mary Klein, *Peninsula Interfaith*
Margaret Taylor, *Chairman, United America Bank*
Dr. David Goldschmidt, *President, San Mateo Medical Society*
Dr. Stephen Schiefele, *Chairman, San Mateo Health Commission*
Dr. Myriam Curet, *Senior Associate Dean, Stanford Medical School*
Carolyn Rapier, *Clinical Director Cordilleras*

In addition to these individual interviews, HMA participated in the following group discussions:

- San Mateo Central Labor Council/ACORN/Peninsula Interfaith
- Pescadero Municipal Advisory Council
- North Fair Oaks Municipal Advisory Council

Appendix #2: Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services

California Code of Regulations
Title 9. Rehabilitative and Developmental Services
Division 1. Department of Mental Health

Section 1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services.

(a) For Medi-Cal reimbursement for an admission to a hospital for psychiatric inpatient hospital services, the beneficiary shall meet medical necessity criteria set forth in Subsections (a)(1)-(2) below:

(1) One of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, DSM-IV™ (1994), published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders
(B) Disruptive Behavior and Attention Deficit Disorders
(C) Feeding and Eating Disorders of Infancy or Early Childhood
(D) Tic Disorders
(E) Elimination Disorders
(F) Other Disorders of Infancy, Childhood, or Adolescence
(G) Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
(H) Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
(I) Schizophrenia and Other Psychotic Disorders
(J) Mood Disorders
(K) Anxiety Disorders
(L) Somatoform Disorders
(M) Dissociative Disorders
(N) Eating Disorders
(O) Intermittent Explosive Disorder
(P) Pyromania
(Q) Adjustment Disorders
(R) Personality Disorders

(2) Both the following criteria:

(A) Cannot be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; and

(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either Subsection (a)(2)(B)1. or 2. below:

1. Has symptoms or behaviors due to a mental disorder that (one of the following):
   a. Represent a current danger to self or others, or significant property destruction.
   b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.
   c. Present a severe risk to the beneficiary's physical health.
   d. Represent a recent, significant deterioration in ability to function.

2. Require admission for one of the following:
   a. Further psychiatric evaluation.
   b. Medication treatment.
   c. Other treatment that can reasonably be provided only if the patient is hospitalized.

(b) Continued stay services in a hospital shall only be reimbursed when a beneficiary experiences one of the following:

(1) Continued presence of indications that meet the medical necessity criteria as specified in (a).

(2) Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.

(3) Presence of new indications that meet medical necessity criteria specified in (a).

(4) Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a hospital.

NOTE: Authority: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

Appendix #3: Institutions for Mental Diseases (IMD) Regulations

Facilities that are determined to be Institutions for Mental Diseases (IMD) and that have more than 16 beds, are subject to the Medicaid IMD exclusion. Section 1905(a)(27(B) of the Social Security Act contains the IMD exclusion, which prohibits Medicaid payments for care or services for:

- Any individual who is an inmate of a public institution (except as a patient in a medical institution);
- Any individual who has not attained 65 years of age and who is a patient in an IMD.

Section 1905(a)(16) permits states to cover inpatient psychiatric hospital services for individuals under age 21. Therefore, the IMD exclusion applies to non-elderly adults.

Note that the exclusion encompasses all Medicaid-funded services. While inpatient psychiatric services may be covered for children, other services are not covered for children during the period of receipt of inpatient psychiatric services.

Any type of residential facility that provides "psychiatric/psychological care and treatment", where "the current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases" might be determined an IMD. If any of the following 5 criteria are met, The Medicaid Manual states "a through IMD assessment must be made". The criteria are:

1. The facility is licensed as a psychiatric facility;
2. The facility is accredited as a psychiatric facility;
3. The facility is under the jurisdiction of the State's mental health authority. (This criterion does not apply to facilities under mental health authority that are not providing services to mentally ill persons.);
4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs; and
5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases.

Since the IMD exclusion applies only to facilities with seventeen or more beds, IMDs that have **sixteen or fewer beds** and serve persons with a mental illness, regardless of the nature of the facility, the staff, the treatment provided or the diagnoses of the residents of the facility, are not subject to the IMD exclusion. However, if the institution is affiliated with, or part of, another institution, the two "institutions" might be viewed

as a single institution and be subject to the IMD test. There are a variety of criteria used to make this determination, discussed later.

Even though hospitals are "medical institutions", those with large psychiatric units or whose total patient days are comprised of a significant percentage from the psychiatric units must monitor the balance of psychiatric and non-psychiatric patient days to ensure they do not "tip over" into IMD status, thus jeopardizing Medicaid payments for everyone within the facility (except children receiving psychiatric services and persons 65 or older receiving psychiatric services).

Likewise, nursing facilities with a significant proportion of residents who have a mental illness, must also monitor the balance of patient care days for persons with a mental illness versus persons without a mental illness to ensure they do not "tip over" into IMD status.

It is important to note that once a facility is determined to be an IMD and larger than 16 beds, the exclusion applies to everyone in the facility even if the facility has medical surgical beds, since the patients on the medical/surgical unit(s) are now considered to be residing in an IMD.

There is an important exception for facilities, like SMMC, with units that are certified as different types of providers, such as NFs and hospitals. These differently certified units are considered independent from each other.

Since CMS notes that components that are certified as different types of providers, such as NFs and hospitals, are considered independent from each other. (Medicaid Manual, Section 4390(B)), it is our understanding that the SMMC SNF and Burlingame SNF, which are licensed under the SMMC Distinct part (DP) SNF license are distinct from the SMMC hospital licensed portion. Therefore, the SMMC DP SNF license neither affords the SMMC hospital portion protection from, or increases the risk of, IMD status.

The critical IMD issues for SMMC are:

- How many beds/patient days can be added at SMMC under the SMMC license without SMMC being declared an IMD?
- How can beds operated under MPHS be certain to be excluded from SMMC bed/patient day counts?

At present, SMMC has less than 50% of its patient days attributable to patients on the psychiatric unit.

	2006		**2007**	
	Patient Days	**% of total days**	**Patient Days**	**% of total days**
Med/Surg (including ICU)	13,200	55.00%	13,700	57.32%
Psych Unit	10,800	45.00%	10,200	42.68%
	24,000		**23,900**	

We can use historic utilization data to project possible future ratios of medical/surgical days to psychiatric patient days. In the table below, we project the possible impact of adding 38 beds to the SMMC license (Option 3). Under this scenario, we expect SMMC would be declared an IMD since patient days attributable to psychiatric patient days would likely exceed 50%:

2007 psychiatric beds SMMC	34
2007 patient days psych SMMC	10,200
2007 patient med/surg days SMMC	13,700
2007 psych beds to patient days	300
Proposed new beds	38
Projected pt days using historic SMMC bed to patient days	11,400
Total psych days	21,600
Total psych days as a % of all days	61.19%

However, there are a number of other changes in circumstances under which SMMC could be determined an IMD, and because of the size of the facility, be subject to the IMD exclusion. These include:

- Additional patient days are identified for patients who do not have patient days on the psychiatric unit but who might have patient days that would be counted as "psychiatric or psychologically-related" because they were provided "psychiatric/psychological care and treatment" and had a diagnosed mental disease, but were receiving care on the medical/surgical unit (for example, detox).
- Medical/surgical days decline to the point where they comprise less than 50% of all patient days.
- SMMC enters into a relationship with another hospital where the unused beds at SMMC are subsequently used for services provided to persons with a mental illness and determined to be part of SMMC, despite arrangements to operate the beds under the other hospital's license. (Options 2 and 4.)

A further issue that SMMC will need to address should a step-down unit licensed as a SNF be pursued, is any potential impact this unit would have on the total DP/SNF standing in regard to IMD status.

In reviewing the relationship between SMMC and MPHS, CMS would assess SMMC and the additional beds for MPHS to determine if they are separate components or part of the larger facility. The ideal outcome is for a determination that each component is a distinct part separate from the other. Questions used by CMS when assessing components include:

1. Are all components controlled by one owner or one governing body?
2. Is one chief medical officer responsible for the medical staff activities in all components?
3. Does one chief executive officer control all administrative activities in all components?
4. Are any of the components separately licensed?
5. Are the components so organizationally and geographically separate that it is not feasible to operate as a single entity?
6. If two or more of the components are participating under the same provider category (such as NFs), can each component meet the conditions of participation independently?

HMA has experience with other situations where hospital components have been evaluated for IMD status.

In Grand Rapids, Michigan there was a very similar situation in which St. Mary's Hospital operates an adult psychiatric unit on the campus of Pine Rest Christian (Pine Rest Christian operates a psychiatric hospital along with a range of other services like residential and home care services). The distance is less than 15 miles. Pine Rest primarily serves the populations over age 64 and under age 19. The relationship is described on the St. Mary's Internet site at: http://www.smmmc.org/clinicalservices/behavioral.shtml

The keys to distinct part status are with governance and practice privileges. We believe that beds utilized at SMMC by MPHS could be considered distinct from SMMC if:

- Operating under the MPHS license; and
- Accountable to the MPHS CEO; and
- Included on the MPHS cost report; and
- Operating under the MPHS Medical Director; and
- The professionals with practice privileges at MPHS have (as appropriate) practice privileges at SMMC.

There is language in the CMS regulators' guidance that to be considered a single hospital the units must not be so far apart geographically that they cannot function as a single entity.

Appendix #4: Long-Term Care Integration Models

Long-term care integration models that should be considered by the County include the Washington Medicaid Integration Project (WMIP) and the Evercare model.

WMIP

The WMIP is a single county pilot project that combines medical, mental health, long-term care services and chemical dependency treatment services in one package. The objectives of the project are to improve individuals' health outcomes and decrease expenditures through preventive care and the coordination of services. Molina Healthcare of Washington is the sole health plan administering this initiative. Individuals enrolled in the project are required to use Molina-contracted providers. Molina has consulting nurses available 24 hours per day and assigns clients to care coordination teams to assist with coordinating services. The program will begin its third year on January 1, 2007. The WMIP project was recently named a finalist in URAC's "Best Practices in Consumer Empowerment and Protection Awards" competition.

The WMIP Steering Committee's most recent findings of the program include the following general improvements (comparing the WMIP cohort with a comparison group):

- Growth in per member per month expenditures is slightly lower;
- There has been a relative decrease in outpatient physician visits, ER visits and number of prescriptions filled;
- The use of chemical dependency treatment is lower;
- The number of outpatient mental health therapy visits are up slightly; and
- The number of state mental hospital days is higher.[17]

Evercare

A second model for review is the Evercare model. Evercare is a dominant player in the managed long-term care arena. Evercare's approach uses proactive planning whose focus comes less from the clinicians and more from the patient and his/her network of caregivers and family members. The model draws on the following set of core principles:

- Treatment for older people must focus on the whole person;
- Primary care is the central organizing force;

[17] http://fortress.wa.gov/dshs/maa/MIP/; "A Summary of WMIP Monitoring Findings," Washington State Department of Social and Health Services Research and Data Analysis Division, November 2007

- Medical care is delivered in the least invasive manner in the least intensive setting possible;
- The side effects of polypharmacy should be recognized and minimized; and
- Data should drive decisions.

The benefits resulting from the implementation of the Evercare model, according to one evaluation, include a 50 percent reduction in avoidable hospital admissions, a 97 percent patient satisfaction rate, and a 7 percent savings to the Medicare budget for this population.[18]

[18] Care model could change approach to chronic disease management in NHS, The Pharmaceutical Journal, Vol 272, 15, May 2004.

Appendix #5: Indigent Care Local Government Subsidy Comparison

Hospital	County	2004 Population	Below 100% FPL	Below 200% FPL	2004 State/Local Subsidies to Hospital	Subsidy per capita	Subsidy per person <100% FPL	Subsidy per person <200% FPL
San Francisco General & Laguna Honda	San Francisco	723,359	73,845	179,944	$123,270,392	$170	$1,669	$685
Dallas -- Parkland Memorial	Dallas	2,246,063	382,174	897,327	$322,108,538	$143	$843	$359
Atlanta -- Grady Memorial	Fulton	780,677	144,256	262,977	$105,279,081	$135	$730	$400
Miami -- Jackson Memorial	Miami Dade	2,308,805	392,984	968,457	$273,635,383	$119	$696	$283
Houston/Harris County -- Ben Taub and LBJ	Harris	3,588,842	526,937	854,502	$351,030,000	$98	$666	$411
San Mateo Medical Center	**San Mateo**	**687,809**	**36,075**	**120,223**	**$53,199,859**	**$77**	**$1,475**	**$443**
Alameda County Medical Center	Alameda	1,422,291	162,391	370,549	$99,135,334	$70	$610	$268
Indianapolis -- Wishard	Marion	842,127	106,114	291,527	$55,495,041	$66	$523	$190
Santa Clara Valley Health and Hospital System	Santa Clara	1,654,209	144,093	339,701	$102,397,782	$62	$711	$301
Denver Health	Denver	542,525	81,948	177,862	$26,900,000	$50	$328	$151
Bakersfield -- Kern Medical Center	Kern	699,175	135,152	326,882	$34,013,787	$49	$252	$104
Ventura Medical Center & Santa Paula Hosp	Ventura	780,982	60,081	152,429	$36,056,000	$46	$600	$237
Chicago -- Cook County*	Cook	5,208,808	759,192	1,291,599	$232,871,723	$45	$307	$180
San Joaquin General Hospital	San Joaquin	631,466	92,347	230,005	$27,904,112	$44	$302	$121
Natividad Medical Center	Monterey	389,292	61,824	150,225	$13,547,928	$35	$219	$90
Contra Costa Regional Medical Center	Contra Costa	995,974	98,996	221,543	$34,058,405	$34	$344	$154
Arrowhead Regional Medical Center	San Bernadino	1,861,971	274,135	689,478	$47,768,422	$26	$174	$69
Riverside County Regional Medical Center	Riverside	1,822,017	258,566	600,479	$40,275,592	$22	$156	$67
Median						**$56**	**$562**	**$213**
Mean						**$72**	**$589**	**$251**

Notes -- Population and Poverty Level Data from US Census Bureau, 2004 American Community Survey

Subsidy Levels are 2004 State/Local Subsidies to Hospitals from NAPH Member Surveys except for Ventura which is 2006 Ventura County Financial Statements
Cook County includes Stroger, Oak Forest and Provident
hospitals