Health System Redesign Initiative Implementation Update
November - March, 2009

Background

On March 25, 2008, the Board of Supervisors approved a first-year implementation plan for the Health System Redesign Initiative (Redesign), which has the following overall charge:

Within two years, design and implement a new, sustainable and creative approach to healthcare delivery that incorporates key recommendations of the HMA Phase 2 Final Report and the recommendations of the Blue Ribbon Task Force (BRTF) on Adult Health Care Coverage Expansion.

Led by the County Manager, this initiative's core staff team has included: Sang-ick Chang, CEO, San Mateo Medical Center (SMMC); Susan Ehrlich, Chief Medical Officer, San Mateo Medical Center; Jean Fraser, Chief, San Mateo County Health System; Maya Altman, Executive Director, Health Plan of San Mateo (HPSM); and Srija Srinivasan, Special Assistant to the County Manager for the Redesign initiative.

The Redesign team committed to bring updates to the Board of Supervisors (BOS) summarizing progress in the first six months, as well as the first year. The BOS accepted the first update on October 28, 2008. This document summarizes the progress achieved within the seven priority areas (noted below) targeted by the Redesign effort in its first year, as well as challenges and next steps for moving forward.

Discussion

As outlined in the Implementation Plan accepted by the BOS last March, the Redesign initiative identified seven areas of priority focus:

1) Eligibility and Administration;
2) Chronic Disease Management and Care Coordination;
3) Integration Across Levels of Care;
4) Physician Leadership, Structures, and Accountability;
5) Community Health Network for the Underserved;
6) Long-Term Care; and
7) Strategic and Operational Financial Improvement.

Within each priority area, the Redesign Team developed goals and first-year activities aimed at improving healthcare access and coordination of the clients we serve, as well as improving the County's financial position in healthcare delivery. Listed below are the overall goals and key milestones achieved *since* the six-month update provided in October. Attachment 1 provides a status update on each of the activities targeted during the first twelve months. Given the goals of improving access and outcomes for

the uninsured and underserved, as well as improving the County's financial position in the delivery of healthcare, this report also includes a listing of the projected financial contributions of the Redesign Initiative, to the San Mateo Medical Center 2008-09 budget.

Eligibility and Administration

Overall Goals:

- Maximized enrollment of, and retention in, public health insurance/ coverage programs with emphasis, in the first year, on Medi-Cal

- Streamlined administration of public insurance/ coverage programs for the underserved

Key Accomplishments and Milestones Achieved Since October 2008:

- In follow-up to BOS approval on November 9, 2008, implemented a transfer of administration of the indigent care program from the County to HPSM effective January 1, 2009. This action continues movement toward a seamless and coordinated coverage program for the population with incomes below 200% of the Federal Poverty Level, in alignment with the recommendations of the BRTF.

- With the BOS approval of a contract amendment with The Center to Promote Healthcare Access on March 3, 2009, implemented changes to the screening and eligibility determination process within the web-based One-e-App system to streamline these processes in alignment with HPSM's responsibilities as the administrator of all indigent care programs.

- With the partnership of the Human Services Agency, achieved an increase in the Medi-Cal payer mix at Burlingame Long Term Care (BLTC) and the SMMC outpatient clinics:
  - BLTC: 89% Medi-Cal March '08 vs. 92% Medi-Cal January '09
  - Ambulatory: 37% Medi-Cal March '08 vs. 40% Medi-Cal January '09

  Together, should these improvements continue through the full fiscal year, they represent an estimated $2.8 million increase in Medi-Cal revenue in FY 2008-09 as compared to FY 2007-08.

- With the leadership of the Human Services Agency created a specialized Aged, Blind and Disabled (ABD) unit staffed by Benefit Analysts to improve enrollment and retention of Medi-Cal among older adults and persons with disabilities.

- Standardized uninsured referral process across SMMC clinics to ensure

that all clients are appropriately screened for available programs and enrolled in the program(s) that best meet their circumstances.

- Completed a "system-wide" summary of clinic appointment scheduling to move toward a standardized approach for clients to access primary care. Distributed summary to 48 Certified Application Assistants in the County to enable County and community based organization staff who assist clients with enrolling in health programs to also guide clients in accessing primary care.

- Developed an approach to unify training of front-line staff involved in health coverage enrollment across County entities (Health, Human Services Agency, San Mateo Medical Center) in alignment with the core competencies for all County staff developed by Human Resources.

- Convened a workgroup involving ACORN, the Central Labor Council, the Legal Aid Society of San Mateo County, Peninsula Interfaith Action, and Ravenswood Family Health Centers to improve billing and client cost sharing practices that affect administration of and access to care. Identified several areas for improvement to be implemented by June 30, 2009.

- Initiated a comprehensive approach for improving Enrollment, Eligibility and Retention (EER) of Medi-Cal through strategies that include training, use of information technology (particularly the One-e-App web-based health coverage enrollment tool), and changes in operational practices that focus on Medi-Cal and other federal and state public coverage programs. Planned training for front-line staff from the Health System, Human Services Agency and HPSM.

Chronic Disease Management and Care Coordination

Overall Goals:

- Identification and management of patients/members whose complex and/or combination of chronic disease(s) leads to inefficient/ inappropriate utilization of medical resources

- Improved management of chronic disease across systems to ensure efficiency and effectiveness in care coordination and targeting of medical resources

Key Accomplishments and Milestones Achieved Since October 2008:

- Launched the "Innovative Care Clinic" (which is designed around a "radically redesigned" model of clinical care embodying key principles of

chronic disease management as well as critical access for patients who would otherwise not be able to utilize care appropriately) within the SMMC Main Campus Adult Primary Care Clinic on January 27, 2009. Key features include: (1) team-based care which includes group visits, case management, telephone outreach, and home-health care; (2) flexible/ expanded staff roles and support staff including nutritionist, social worker, community health worker, and therapist; (3) utilization of Chronic Disease Registry, electronic medical record, diabetes retinal camera; and (4) advanced access for all providers with the goal of same day access to any provider; and (5) ongoing review of outcomes: clinic measures, access, satisfaction, finance, patient knowledge, preventative care; These features represent evidence-based practices to improve care for clients with chronic disease.

- Implemented consistent tracking of presence of a chronic disease among clients screened for available health programs seeking care at SMMC or RFHC through the One-e-App web-based enrollment process.

- Awarded a San Mateo County STARS award for program performance for the efforts of the Healthier Outcomes through Multidisciplinary Engagement (HOME) team, which assists clients who had accessed the Emergency Room seven or more times during the prior year in achieving improved access to primary and specialty care.

- Analyzed linkages between primary care and behavioral health and recovery services across five models involving SMMC, Behavioral Health and Recovery Services, Ravenswood Family Health Center and HPSM. Based on this analysis, designed approach to improve primary care based behavioral health services through the targeting of Mental Health Services Act resources designed to be implemented in the 2009-10 fiscal year.

- Studied the health profiles of shared Behavioral Health and Recovery Services (BHRS)/ HPSM Care Advantage (CA) members and learned that these adults with mental illness have the health problems of members without mental illness who are 20+ years older, and that 44% of CA members have a dual diagnosis involving mental illness and a medical condition.

- Through HPSM's Pay for Performance incentives focused on the chronic disease management and prevention measures for Body Mass Index screening, asthma action plans, and diabetes care, SMMC earned a total of $239,495 for services to more than 1,000 patients in 2008.

Integration Across Levels of Care

Overall Goals:

- Increased proportion of clients being served in most appropriate level setting

- Reduced proportion of clients who do not need acute care being served within an acute care setting

- Improved access and integration across systems for long-term care planning and services

Key Accomplishments and Milestones Achieved Since October 2008:

- Through partnerships involving numerous units within the Health System, maintained a medical/ surgical administrative day rate at SMMC of 12% as of February 2009, as compared to a rate of 20% at the same time last year. This represents an estimated net cost avoidance of $0.6 million in 2008-09, as compared to 2007-08.

- In January, 2009, redesigned process for placements to Cordilleras residential mental health facility to improve psychiatric administrative day rate at SMMC.

- Implemented a revised Memorandum of Understanding among SMMC, Behavioral Health and Recovery Services, Aging and Adult Services and the Health Plan of San Mateo that improves incentive alignment to maximize Medi-Cal enrollment and furthers BHRS programmatic initiatives aimed at strengthening co-occurring capacity across settings. In the first six months (July through December, 2008), accomplishments include:
    - Implementation of co-occurring and wellness-recovery-action planning group treatment efforts within the SMMC inpatient psychiatry care program;
    - Training of most inpatient psychiatry staff on effective practices for working with clients with co-occurring behavioral health needs;
    - 2% increase in Medicare inpatient revenue projected for 2008-09 compared to 2007-08.

- Initiated the development of a joint placement fund that will further improve resource coordination and incentive alignment in achieving placement for priority “hard-to-place” patients who do not require acute level care.

- Held discussions with the State of California in follow-up to a business and operational plan for the Long-Term Supportive Services Project (LTSSP) aimed at increased local control of and accountability for Medi-Cal long-term care funding. Identified initial steps to achieve implementation of some components by January 2010.

Physician Leadership, Relationships and Accountability

Overall Goals:

- Increased alignment of physician leadership and accountability with the healthcare delivery system goals and priorities of SMMC, HPSM and HD

- Improved access and outcomes for patients/members accessing medical care within the County system

- Increased cost-effectiveness in SMMC physician arrangements

Key Accomplishments and Milestones Achieved Since October 2008:

- Awarded (from Kaiser Northern California Community Benefit) in partnership with Ravenswood Family Health Center, a $600,000, 2 year implementation grant to improve access to specialty care. This support will enable improved access to five specialties identified for priority focus: cardiology, endocrinology, orthopedic surgery, gastroenterology, and ophthalmology. Specific initiatives funded include: (1) redesigning the medical and surgical specialty care clinics to establish team-based care and improve patient flow, (2) implementing an electronic specialty care referral process, (3) increasing the use of physician extenders in the orthopedics clinic and (4) improving primary care providers' skills and abilities to provide certain specialty care services.

- Expanded pain clinic one day per week in order to focus on patients with chronic musculoskeletal pain. The goal is to reduce inappropriate referrals to neurosurgery and orthopedic surgery and to increase patient satisfaction with and quality of care.

- Engaged medical staff leaders in Redesign-related efforts. For example, the Chief of Staff, has played a leadership role in promoting the CHNU OB system of care, and the Vice Chief of Staff is the clinical champion for managing length of stay in the inpatient unit and a Palliative Care planning grant.

- Negotiated renewal of additional 17 major provider contracts in alignment with regional compensation benchmarks and with predictable annual costs. These contracts include clear expectations and transparency regarding productivity, call coverage, and other parameters.

Community Health Network for the Underserved

Overall Goal:

- Creation of a public-private healthcare delivery system for the medically

underserved (Medi-Cal and uninsured) that includes defined roles for each major private sector hospital, major ambulatory care providers and a redefined role for SMMC/ the County

Key Accomplishments and Milestones Achieved Since October 2008:

- Furthered components to develop a redesigned obstetric (OB) and pediatric network to address access, care and sustainability issues for participating delivery system partners. Specific milestones include:
    - Executed contract with Kaiser Permanente and Permanente Medical Group to expand provision of OB and pediatric services in Redwood City, contracted by the Health Plan of San Mateo (360 deliveries and care for the newborns and siblings of those clients).
    - Achieved agreement with Lucile Packard Children's Hospital (LPCH) to support physician capacity for deliveries at LPCH (600-700), as well as support of County pediatric capacity (2.0 FTE pediatricians for FY 08-09).
    - Achieved agreement with Sequoia Hospital to support increased hospital capacity for deliveries (up to 100) provided to mothers covered by Medi-Cal living in South County.
    - Achieved agreement with Palo Alto Medical Foundation to support physician capacity for deliveries at Sequoia Hospital (up to 100) provided to mothers covered by Medi-Cal living in South County.
    - Achieved agreement with Mills Peninsula Health Services to support increased hospital capacity for deliveries (200-300) provided to mothers covered by Medi-Cal living in Mid-County.
    - Secured up to three-year grant from Peninsula Health Care District, totaling up to $366,000 per year to support participation of mid-County physicians in the CHNU OB network.

- Developed implementation priorities for joint planning effort involving LPCH, Stanford School of Medicine, Ravenswood Family Health Center, Health System and HPSM aimed at strengthening the pediatric safety net for publicly covered children. Identified actions to: a) improve establishment of patients' connection to a medical home; b) improve communication, coordination and information sharing among pediatricians; c) improve consistent collection and maintenance of children's personal health records; and d) reduce inappropriate utilization of the emergency room by children covered by public programs.

- Furthered agreement for an expanded partnership with Kaiser Permanente and Permanente Medical Group to achieve more effective arrangements in provision of neurosurgical/ spinal subspecialty services.

- Achieved agreement for an expanded partnership with Palo Alto Medical Foundation and Palo Alto Foundation Medical Group in the provision of

infectious disease (support for two months of infectious disease coverage/ year) and pediatric neurology (support for twelve clinic days/ year) medical subspecialty services.

- Implemented restructured contracted facility and technical services contracts, at HPSM Medi-Cal rate structure with both Mills Peninsula Health Services and Sequoia Hospital. Implemented a partial restructuring of contracted facility and technical services contracts with Seton Medical Care Center.

- Invited by Sequoia Health Care District to seek continuation of support (currently $1.6 million for FY 08-09) for services to the uninsured adult residents living within the District's boundaries.

Long-Term Care

Overall Goal:

- Improved County financial position in direct delivery of long-term care services

Key Accomplishments and Milestones Achieved Since October 2008:

- Incorporated HMA analysis of optimal staffing for long-term care into 2009-10 budget planning

- Marketed long-term care capacity to CHNU partners considering direction of long-term care referrals

Strategic and Operational Financial Improvement

Overall Goals:

- Improved County financial position in delivering medical care

- Improved finance capacity within SMMC to inform strategic health system decisions

Key Accomplishments and Milestones Achieved Since October 2008:

- Competed to achieve selection as one of three California counties to receive a $250,000 technical assistance grant, awarded by The California Endowment to strengthen the financial sustainability of the Health System's delivery system responsibilities through: (1) a comprehensive revenue strategy to maximize Federal Financial Participation and other revenue capture (short-term and long-term); and (2) strengthened finance

capacity at the delivery system (SMMC) level.

- Completed the first phase of implementation of a financial decision support system that combines disparate data sources into a single reporting data base.

Overall, the Redesign efforts summarized above have contributed a total of $7.75 million towards the County's 2008-09 efforts to improve its financial position in the delivery of healthcare. This figure comprises the following:

Initiative	Projected 2008-09 impact
Increased Inter-Governmental Transfer through HPSM	$ 4,000,000
EER – Teen Clinics Initiative	$ 850,000
Psychiatric Emergency Services Billing Improvement	$ 250,000
Long Term Care Performance Improvement	$1,000,000
Obstetric and Pediatric Network Restructuring	$ 400,000
Physician Contracts Restructuring	$ 750,000
Hospital Contracts Restructuring	$ 500,000
TOTAL	$ 7,750,000

Next Steps

The Redesign team continues to consider the organizational decisions that can embed the components of the initiative into the operations and partnerships involving the Health System, HPSM and healthcare delivery system partners. With the alignment of all County health functions into a single Health System, and selection of Jean Fraser to lead this system, key structural components are being developed to maximize the County's effectiveness in healthcare delivery. Additional steps in this process will be incorporated within the 2009-10 budget development process and documents submitted to your Board.

The development of the CHNU, including achievement of agreements with seven delivery system partners has specified the commitments made by each of these entities to play a role in serving the healthcare needs of the uninsured and publicly covered populations. The Redesign team will continue to work with the leadership of these organizations to develop the coordination and oversight mechanisms needed for effective joint decision-making, as well as the administrative functions that the network will need to fulfill to facilitate effective care coordination.

The Health System is in the first year of an evaluation, with support from The California Endowment, and conducted by The Urban Institute, to assess our effectiveness in components of the Redesign Initiative and work at the delivery system and operational level to improve access to healthcare and care for clients with chronic disease. The evaluation team conducted an in-depth site visit to establish the baseline for their work in August, 2008, involving 44 key stakeholders from the BRTF and leaders of the Redesign work. The entire report is included as Attachment 2. Two major findings of

this assessment include:

- *With improved efficiency, the San Mateo safety net shows promise of being an excellent source of medical care for uninsured and underinsured low income adults. From a wide range of key informants, we heard that quality of care in the San Mateo safety net clinics is good, and according to patient satisfaction data collected in the clinics those patients that are in the system are very satisfied with their care.*
- *In spite of this very positive finding, there are serious access problems for new patients entering the system, and for specialty care. This is due to resource constraints, but also due to difficult administrative procedures for patients seeking appointments. This means that patients with severe health problems may obtain care through the emergency room or pay out of pocket with private providers, rather than with their primary care provider. Attempts are being made to establish specialty contracts with private delivery systems in the area that will supplement the specialty services currently available at SMMC specialty clinics.*

These findings reinforce the importance of the strategies that are being pursued within the Redesign Initiative. For example, the initiatives outlined on page 6 regarding access to specialty care align well with the evaluators' observations of areas of needed focus. We will look to the further evaluation findings to learn the effectiveness of the approaches we are implementing.

We will continue to post updates on the website established to communicate key milestones. Questions about the initiative can be directed to Srija Srinivasan, 573.2095, or ssrinivasan@co.sanmateo.ca.us.

Health System Redesign Implementation Plan **Attachment 1**

February 2008 thru March 2009

reflects revision to original plan presented on March 25, 2008

		By February, 2008	March – June 2008	July – September 2008	Oct – December 2008	Jan – March 2009	March '09 Status
Overall Redesign Initiative							
1	Create Health System Redesign Initiative Steering Team	x					Completed
2	Secure 07-08, 08-09 Budget and Staff, consulting resources	x	x				Completed
3	Select priorities of focus and develop workplans	x					Completed
4	Develop initiative implementation plan for BOS approval		x				Completed
5	Initiate cross system workgroups	x	x				Completed
6	Initiate and oversee local evaluation of Redesign, CI		x	x	x	x	Completed year 1 activities
7	Monitor progress on workplans, overall effort		x	x	x	x	Ongoing
8	Six-Month update to BOS			x			Completed
9	Year-One update to BOS and key stakeholders					x	Completed
Eligibility and Administration							
1	Appoint cross-system (SMMC, HPSM, HD, HSA) workgroup with accountability to HPSM Executive Director and HSA Director.	x					Completed
2	Identify gaps and problems with current eligibility, enrollment and retention (EER) processes from a client- and systems- point of view.		x				Completed
3	Recommend an organizational structure for optimizing EER and minimizing administrative costs with clear accountability for: a) operational leadership and day-to-day decision-making; b) defined roles for each County entity; c) effective liaison to non-County entities (e.g., Social Security Administration, Private vendors, other); d) policy oversight and decision-making.			x	x	x	Completed
4	Initiate and complete at least two initiatives for increased enrollment and retention of public insurance/coverage programs, first year emphasis on Medi-Cal.		x	x	x	x	Completed
5	Develop proposal and obtain needed agreement by governance/ policy boards to transfer administration of indigent care programs to HPSM in order to implement a seamless and coordinated coverage program.		x	x	x	x	Completed
6	Develop proposal and obtain needed agreement by governance/policy boards regarding optimal placement of client/patient billing and collections functions for clients accessing healthcare at SMMC.			x	x	x	To be initiated next quarter.
7	Monitor progress against targeted goals and develop new initiatives for EER improvement.		x	x	x	x	Completed
Chronic Disease Management and Care Coordination							
1	Initiate cross-system chronic disease and care management “champions” who will work with the SMMC Chief Medical Officer and HPSM Medical Director to guide dissemination and improvement of chronic disease management approach.	x					Largely completed.
2	Complete detailed workplan and then launch and disseminate a “Radically Redesigned” model of clinical care that embodies key principles of chronic disease management as well as critical access for patients who would otherwise not be able to utilize care appropriately.		x	x			Underway
3	Analyze patient/ member statistics and identify target clients to improve assignment of clinical and other resources aimed at improving care and cost management.		x	x	x	x	Underway, will continue thru next quarter

		By February, 2008	March – June 2008	July – September 2008	Oct – December 2008	Jan – March 2009	March '09 Status
4	Initiate mechanisms for continuous/ ongoing monitoring of care statistics to flag areas of focus and resource direction.		x	x	x	x	Underway
5	Develop and implement plan for improving care management of highest cost clients served within SMMC or who "float" between SMMC, HD, HPSM systems to address system issues across continuum of care.		x	x	x	x	Underway
6	Analyze options and develop plans for expanding pilot care coordination initiatives to additional provider setting and/or client populations.				x	x	Underway
7	Develop plan and implementation schedule for pediatric and geriatric expansions designed around learnings in promoting prevention and care coordination.	x	x				Completed
Integration Across Levels of Care							
1	Initiate cross-system workgroup accountable to Health Director and SMMC CEO.	x					Completed
2	Increase lower level psychiatric capacity to enable prompt discharge and/or reduced admissions of non-acute psychiatric patients.		x	x	x	x	Phased approach underway.
3	Develop and implement a plan for increased specialized lower level capacity for priority "hard-to-place" patients whose needs are not able to be served by existing acute or sub-acute options that shares risks and responsibilities across systems.		x	x	x	x	Underway.
4	Improve assessment of need and diversion of patients presenting at the Emergency Room (ER) and Psychiatric Emergency Services (PES) who are not in need of acute medical care.		x	x	x		Underway
5	Develop revised acute admission criteria that better reflect goals and opportunities identified by this workgroup.		x	x			Completed
6	Analyze current gaps and develop plan to increase Burlingame Long-Term Care (BLTC) capacity to serve clients with behavior challenges. Monitor implementation of plan at the end of six months.		x	x			Completed
7	Analyze opportunities and develop plan to maximize reimbursement for allowable acute days. Monitor implementation of plan at the end of six months.		x	x			Completed
8	Standardize philosophy, education and training across systems to achieve increased uniformity and reduced barriers to achieving optimal placement for clients who do not need to be served in an acute care setting.		x	x			Completed
9	Complete and submit to the State business and operational plan for the Long-Term Supportive Services Project (LTSSP) to facilitate increased local control and accountability for Medi-Cal long-term care resources.	x	x				Completed
10	Commission an actuarial study for inclusion of skilled nursing facility (SNF) and adult day health (ADH) funding in HPSM's capitation rates.		x	x	x	x	Initiated. Questions/ refinement continued
11	Achieve state agreement on rates and plan for inclusion of MC SNF and ADH funding within HPSM's capitation rates.		x	x	x	x	To be pursued in followup to State budget
12	Meet with relevant stakeholders to inform and finalize a start-up and operational plan for LTSSP operations. Initiate actions for target LTSSP start-up date of July 2009, pending successful State negotiations.					x	To be initiated in 2009
13	Assess County's long-term care needs (e.g., SNF, Assisted Living, housing with on-site supports, other home- and community-based services) in anticipation of LTSSP and local demographic trends.		x	x	x	x	Underway

Health System Redesign Implementation Plan

February 2008 thru March 2009

		By February, 2008	March – June 2008	July – September 2008	Oct – December 2008	Jan – March 2009	March '09 Status
Physician Leadership, Relationships and Accountability							
1	Create job description and appoint a Chief Medical Officer, with delineated responsibility for physician leadership and accountability distinct from other medical leadership functions in SMMC (e.g., VP of Quality, Department Chairs, other Medical Staff) and HPSM (Medical Director).	x					Completed
2	Develop updated inventory of all employed and contracted physicians to enable analysis and prioritization of opportunities for improved standardization and cost-effectiveness.		x				Completed
3	Determine benchmarks for specialty care access to set employment and contracting standards, expectations and decisions, as well as strategies pursued in developing the Community Health Network for the Underserved.		x				Completed
4	Develop referral standards and guidelines for specialty care services against which access and referrals will be monitored. Develop process for regular monitoring.		x	x	x	x	Underway and to be completed for 5 priorities: cardiology; endocrinology; orthopedic surgery; GI; ophthalmology
5	Develop specific guidelines or models for improving alignment of specialty physicians around chronic disease management. Identify and develop pilot specialties that will serve as models for others.			x	x	x	Underway
6	Initiate regular meetings of Chief Medical Officer and key medical and administrative leaders to ensure alignment of clinical philosophy with operational opportunities and constraints, as well as joint identification of areas for priority focus.				x	x	Underway
Community Health Network for the Underserved							
1	Build on provider capacity analysis completed for the BRTF to create an outline, by service area, of provider capacity needed to address the needs of the underserved.	x	x				Completed
2	Identify, from the deepened provider capacity analysis, targeted roles for each major provider organization that capitalizes on their specific strengths and complements the roles of others to achieve a sustainable distribution of delivery responsibilities across a public/private network.		x	x	x		Underway. To be refined through negotiated agreements with each partner
3	Develop an initial proposal for expanded partnership that targets OB/Pediatrics and achieve agreement from at least three private sector partners.		x	x	x	x	Underway.
4	After completing a successful OB/Pediatrics partnership, develop proposals for expanded partnership for each major provider partner and pursue and achieve agreement from each partner.		x	x	x	x	Underway. To be pursued during FY 09-10.
5	Align scope of services provided by SMMC to complement partnerships achieved with other providers.			x	x	x	Underway
6	Analyze and determine most effective use of unique clinical resources shared across SMMC and the Health Department (Edison Clinic, Mobile Clinics) to best leverage these assets.		x	x	x	x	Underway
7	Consider development of a local "scorecard" that monitors, tracks and publicizes providers' roles in meeting the needs of the underserved.					x	Under consideration.
8	Communicate private providers' roles as partners in a new Community Health Network for the Underserved (CHNU) through a County-led media and communications strategy.		x	x	x	x	Underway

Health System Redesign Implementation Plan

February 2008 thru March 2009

		By February, 2008	March – June 2008	July – September 2008	Oct – December 2008	Jan – March 2009	March '09 Status
Long-Term Care							
1	Assess BLTC to inform County decisions regarding physical plant renovations and/or replacement.			x	x	x	Initiated with DPW strategic planning
2	Determine point-person for leadership of long-term care business development opportunities within leadership of SMMC, HD, HPSM.		x				Completed
3	Host forum with HMA expert on long-term care business development to discuss potential opportunities and strategies to explore in San Mateo County.		x				Completed
4	Analyze number of skilled nursing facility (SNF) beds that could be guaranteed and paid for by private healthcare providers if capacity were available at SMMC or affiliated sites.		x	x	x	x	Underway
5	Develop several operational and financial models for the operation of SNF services, with guaranteed patients from private healthcare providers.		x	x	x	x	Underway
6	Explore potential management structures/ arrangements to assure efficiency and quality of SNF services.				x	x	Underway
7	Develop recommendations and obtain agreement on business development targets from appropriate governing boards and private healthcare provider partners.				x	x	Underway
Finance and Revenue Enhancement							
1	Populate SMMC financial decision support system with data and assumptions necessary to develop and refine strategic financial analyses.		x	x	x	x	Underway
2	Identify appropriate financial performance benchmarks and analyze current productivity to select priorities for operational changes.		x	x	x	x	Underway
3	Develop monthly cost and revenue reporting at the service-line, site, specialty, and payer levels.		x	x	x		In development.
4	Develop plan for increased Medi-Cal Inter-Governmental Transfer (IGT) to the County (via HPSM) to support SMMC operations. Complete negotiations with the State.	x	x	x	x	x	Implemented Phase 1. Second phase underway.
5	Develop and implement plan to improve billing and collections functions.		x	x	x		Underway
6	Analyze opportunities to restructure current debt service.		x	x			Referred to County Managers' Office.

A REPORT ON THE FIRST YEAR OF THE SAN MATEO COUNTY ADULT COVERAGE INITIATIVE AND SYSTEMS REDESIGN FOR ADULT MEDICINE CLINIC CARE

Submitted to:

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THE URBAN INSTITUTE

March 23, 2009

Attachment II

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Tables and Figures

Introduction

In early 2008, San Mateo County embarked on a comprehensive "Health System Redesign and Adult Coverage Initiative." This effort aims to address the financial sustainability of the San Mateo Medical Center (SMMC) system through improved effectiveness, efficiency, and care coordination of the uninsured and underserved. While the "Redesign" has been officially underway for only one year, leaders within the SMMC have been working (in a less coordinated manner) to achieve many of these goals for many years.

This report summarizes the findings from the first six months of the Urban Institute's two and a half year evaluation of San Mateo County's Health System Redesign and Adult Coverage Initiative. This overall evaluation is designed to:

1) Evaluate the impact of the ACE (Access to Care for Everyone) coverage initiative, and the WELL program
2) Assess the activities related to the county's efforts to redesign the health system; and
3) Measure the impact of these innovations.[1]

The preliminary findings presented here draw on the first site visit conducted in August 2008, which included in-depth interviews with 43 key stakeholders and clinic managers and staff[2] as well as waiting room observations at three clinics. Findings from the site visit offer insight into clinic operations, efficiency innovations, and disease management efforts. We also present data on demographic characteristics and health service use for the initial group of ACE (the Adult Coverage Initiative) enrollees. And finally, we present baseline clinic-level data, collected in 2007-2008 before many of the system design activities began, in order to illustrate some of the challenges facing the SMMC system and Ravenswood Family Health Center and highlight some of the county clinics' achievements.

[1] See Appendix A for a list of research questions and data sources for the evaluation.
[2] See Appendix B for a list of those interviewed.

The purpose of this report is to provide the context in which the system redesign and ACE coverage initiative are taking place; to describe initial implementation of the program; to update the Board of Supervisors on the current status of the evaluation; and to present a synopsis of the next steps planned for the evaluation.

Background & Context: San Mateo County

San Mateo County is among the wealthiest counties in the nation, with a median household income of approximately $83,000 in 2007 (U.S. Census Bureau, 2009). It is also one of the most costly places to live, however, and a substantial number of the county's residents struggle economically. While the costs of housing are not rising, they remain high, with the median price for a single family home in San Mateo County at $777,777 in 2008 (San Mateo County Housing Authority 2008). The county has historically benefited from jobs generated by the technology industry, San Francisco International Airport, and the Port of Redwood City, but the current economic recession is taking its toll as in other parts of the country.

Demographic trends are affecting the demand for county health and social services. San Mateo County is ethnically diverse, and becoming increasingly so, with continued immigration of Latino and Asian minorities. The population of the county is also aging (San Mateo County 2008).

In spite of the relative prosperity of the county, many residents lack health insurance coverage. Approximately 11 percent of non-elderly adults (ages 19-65) in San Mateo County have no insurance coverage (California Health Interview Survey 2007), with fully 31 percent of adults in the county below 200 percent of the federal poverty level (FPL) being uninsured. We also heard from both patient advocates and private providers that comprehensive employer-

sponsored insurance is eroding, requiring increased patient cost sharing (premiums, deductibles, and copayments). The 2008 San Mateo Health/Quality of Life Survey found that 23.7 percent of employed residents report that their job does not offer health benefits to employees, a significant increase from 2001 (San Mateo County 2008).

The San Mateo County Health Care Safety Net

The primary sources of care for uninsured and some underinsured individuals in the county are safety net clinics including the San Mateo Medical Center (SMMC) clinics, Ravenswood Family Health Center, two free clinics, and some private providers.

The SMMC operates 11 community clinics, with approximately 250,000 patient visits annually. Six of these clinics are dedicated to adult medicine. There are two north county sites (the Daly City Clinic and South San Francisco Clinic); one mid-county site (the Main Campus/Innovative Care Clinic[3]); the Coastside Clinic; and two clinics serving the south county (Fair Oaks and Willow). In addition, the SMMC operates a small public hospital with both medical and psychiatric emergency rooms, 40 inpatient acute beds, 7 intensive care beds, 34 acute psychiatric beds, and 30 long-term care beds (all in San Mateo), and a 270-bed long-term care facility (in Burlingame).

The county medical services are heavily used, and demand for services is greater than can be met. There are approximately 1800 monthly patient visits at the Main Campus/Innovative Care Clinic, with somewhat smaller volumes at the Willow Clinic (approximately 1700), and Daly City, Fair Oaks with 1000-1500 monthly visits each; followed by the much smaller South

[3] The Main Campus Adult Clinic recently changed its name to the Innovative Care Clinic.

San Francisco and Coastside clinics (see Figure 1)[4]. In addition to the county clinic system, some uninsured and underinsured patients in San Mateo County are served by the Ravenswood Family Health Center, a federally funded Section 330 Community Health Center (FQHC). Ravenswood registers approximately 30,000 patient visits annually at its two sites. Ravenswood has one clinic in East Palo Alto, and another in Menlo Park, where it took over the former SMMC Belle Haven Clinic facility. Ravenswood provides adult medical care, obstetric and gynecological care, and pediatric care. The monthly volume at Ravenswood is similar to that experienced at the larger SMMC adult medicine clinics.

In addition, two free clinics operated by Samaritan House supplement the county services and Ravenswood Family Health Center. Samaritan House is a not-for-profit clinic that provides primary care services, as well as dental services, eye exams, and a pharmacy supplied with donated medicines. Samaritan House manages 3000 to 4000 primary care visits a year. Care is completely free and the clinic operates with volunteer physicians, nurses, and dentists. A few area hospitals will see referred patients free of charge; though obtaining hospital care for this population remains a challenge for Samaritan House.

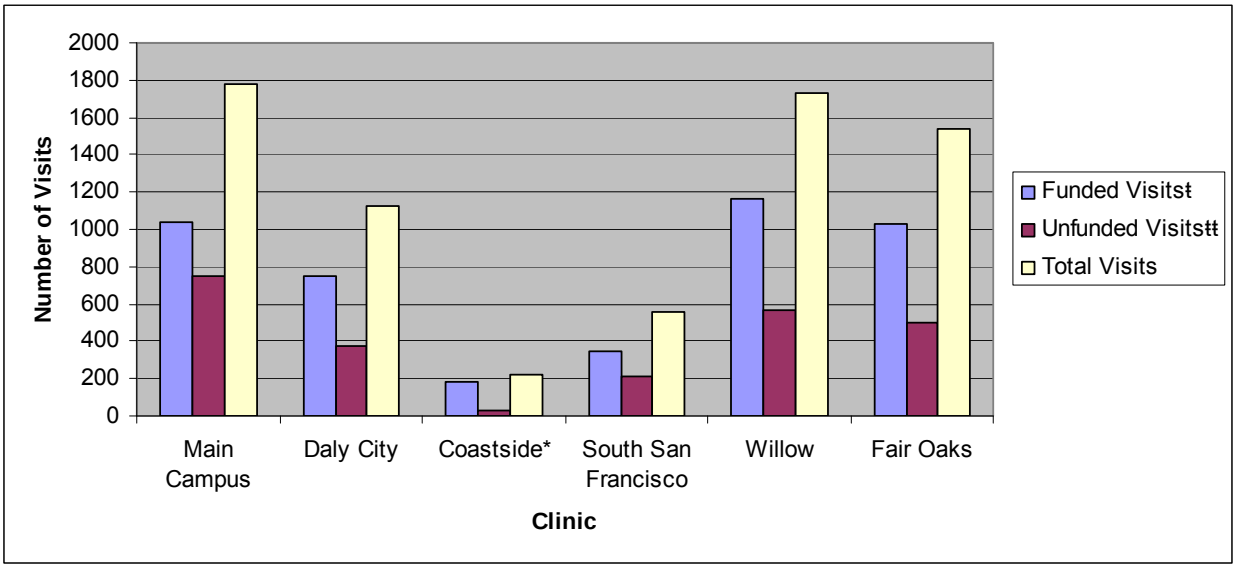
Given the heavy demand on the safety net, a great challenge for the San Mateo County safety net system is to provide preventive and primary care, rather than episodic care. In addition, many of the uninsured and underinsured individuals served by the county system have chronic medical conditions, and providing continuing chronic care management poses an increasing strain on the safety net.

As shown in **Figure 1**, a substantial portion of visits at SMMC are "unfunded" (no source of funding other than county general revenues). Medi-Cal is the single largest source of

[4] In addition to these clinics, the county operates four pediatric clinics, two teen/youth clinics, the Ron Robinson senior care center, four dental clinics, and obstetrics and several other specialty clinics at the main campus site.

reimbursement for SMMC clinics. Since county clinics are designated as Federally Qualified Health Centers (FQHCs) by virtue of the county's receiving a Section 330 Healthcare for the Homeless grant, the county can bill Medi-Cal at cost. Ravenswood is also an FQHC and receives cost-based Medi-Cal reimbursement, but treats a higher proportion of uninsured ("unfunded") individuals. As a result, seeing Medi-Cal patients is relatively profitable for the county safety net clinics, in stark contrast to private providers who are reimbursed at very low rates, and who experience a greater loss when seeing Medi-Cal patients.

Figure 1: Monthly Average Number of Visits at SMMC Adult Medicine Clinics, July-September, 2008



Source: SMMC clinic statistics

* Coastside data shown are for all visits, not exclusively adult medicine visits
t Funded visits include Medicare, Medi-Cal, CHDP, private insurance, Healthy Families, Healthy Kids, ACE, and all other public programs for which the county receives outside funding.
tt Unfunded visits include WELL, full or partial payment from the patient, no pay, Medi-Cal pending, and undetermined.

While patient care in the county safety net is perceived by the stakeholders we interviewed to be of generally high quality, patients, particularly new patients, regularly

experience access difficulties. We were told that a new patient may wait for weeks (or even months) to schedule a primary care visit at SMMC clinics.

Access to specialty care can be even more challenging. A 2008 Health Management Associates (HMA) assessment of SMMC's health services found such access difficulties. For example, in the SMMC clinics, the mix of services is 75 percent primary care vs. 25 percent specialty care, while in some other large public hospital systems this proportion is reversed (HMA 2008). The county is oriented toward achieving a more balanced mix, and is working to establish more stable and broader arrangements with private delivery systems for specialty care. At present, patients who require specialty care that SMMC does not provide are referred to other providers, such as the Mills-Peninsula Health System and Sequoia Hospital.

The increasing demand for health services at the SMMC, and the increasing health problems of those served by the clinics, have led to growing financial burdens for the county. California's "Section 17000" law places responsibility for caring for the medically indigent on the county. This financial obligation, which is increasing more rapidly than county revenues, contributes to a "structural deficit" of $41 million in the county budget (costs which must be covered by the general fund). HMA (2008) projects that, absent substantial changes, the county subsidy for healthcare alone could reach or exceed $80 million by FY 2011.

There are also a handful of private providers in the area that provide primarily inpatient services to the county's publicly insured and underinsured/uninsured population. In particular, Seton Hospital (a Daughters of Charity hospital) provides a substantial amount of Medi-Cal services to residents in the northern part of the county, and Lucile Packard Children's Hospital (a Stanford affiliate) provides a sizable amount of Medi-Cal services to south county residents.

Blue Ribbon Task Force on Adult Health Care Coverage Expansion

These critical issues—the growing number of uninsured and underinsured individuals in the county; the limited capacity of the health care safety net; the structural deficit in the county budget due to the need to finance services for the uninsured at the SMMC; and the limited role of the private sector in meeting that need—led the Board of Supervisors to form a Blue Ribbon Task Force in 2006. The mission of the task force was to "explore options for providing comprehensive health access and/or insurance to uninsured adults in San Mateo County living at or below 400 percent [of the] Federal Poverty Level." The task force was made up of 34 members representing county and city government, health providers, community advocates, and employers. (See **Table 1** for a list of members, their affiliations, and their workgroup assignments). The task force held its first meeting on September 23, 2006, and established three sub-committees, with distinct goals:

- **Population Definition Workgroup** – to identify the size and characteristics of the uninsured adult population by income group.
- **Health Care Model Development Workgroup** – to establish a model delivery system for uninsured adults
- **Financing Workgroup** – to define options for covering the cost of uninsured adults.

The final recommendations of the task force, preliminarily approved in July 2007, include the following:

- To expand coverage to all uninsured adults ages 18-64 below 400 percent of the FPL;
- To establish a unified administration for publicly-funded coverage programs;
- To emphasize coordinated care management with a focus on prevention, primary care, and chronic care management;

- To establish a community health network for the underserved, with a strengthened publicly-funded safety net (SMMC and Ravenswood) playing a key role, and the private sector playing an enhanced role;

- To finance the proposed adult coverage expansion through shared responsibility of individuals, employers, and the community at large.

Table 1: Blue Ribbon Task Force Members with Workgroup Assignments

ORGANIZATION	TASK FORCE REPRESENTATIVE	ORGANIZATION WORKGROUP REPRESENTATIVE		
		Population Definition	Healthcare Model	Financing
Board of Supervisors	Supervisor Adrienne Tissier, Chair			
Board of Supervisors	Supervisor Jerry Hill, Chair			
Burlingame City Council	Ann Keighran		√	
Central Labor Council	Shelley Kessler	√	√	√
Community Member	Gordon Russell			
County Manager's Office	John Maltbie			
Health Department	Srija Srinivasan	√	√	
Health Department	Louise Rodgers	√	√	
HPSM	Ron Robinson			√
HPSM	Maya Altman			√
Human Services Agency	Beverly Beasley-Johnson	√		
Kaiser Permanente	Linda Jensen		√	
Legal Aid Society of San Mateo County	M. Stacey Hawver	√	√	√
Medical Society	Gregory Lukaszewics		√	
Medical Society	John Hoff			
Mills-Peninsula Health Services	Bob Merwin	√	√	√
Palo Alto Medical Foundation	Cecilia Montalvo		√	√
Peninsula Healthcare District	Susan Smith			
Peninsula Interfaith Action	Barbara Keefer	√	√	√
Peninsula Interfaith Action	Tom Quinn/Alvin Spencer	√	√	√
Ravenswood Family Health Center	Luisa Buada		√	
Redwood City Chamber of Commerce	Keith Bautista			√
Redwood City Council Member/Mayor	Barbara Pierce		√	
Samaritan House	Kitty Lopez		√	√
SAMCEDA	Dan Cruey			√
San Mateo Chamber of Commerce	Linda Asbury			√
San Mateo Council Member/Mayor	Carole Groom			
SMMC	Sang-Ick Chang	√	√	√
SMMC	Susan Ehrlich	√	√	√
Sequoia Healthcare District	Stephani Scott			√
Sequoia Hospital	Glenna Vaskelis		√	
Seton Medical Center	Bernadette Smith	√	√	√
Silicon Valley Community Foundation	Frank Lalle			√
Stanford University Medical Center	Gerald Shefren			

Sustainable financing options were still being considered by an offshoot of the financing workgroup at the time of our site visit in August 2008.

We spoke with numerous members of the Blue Ribbon Task Force during our site visit. These members were unanimously supportive of the mission of the task force, and commented on the value of the effort. Specifically, task force members expressed appreciation for the broad task force membership, and cited it as essential to achieving buy-in on some of the hardest issues discussed. Individuals that often meet on very different terms came to a better understanding of each other's priorities and constraints. In addition, members were very appreciative of the support provided by county employees in gathering data and information and keeping the group "on task."

Despite generally congenial feelings, the issue of how to finance the coverage expansion in a sustainable manner persisted at the time the Blue Ribbon Task Force recommendations were made. At the time of our visit, two prominent financing options were being considered – 1) an employer "spending requirement" and 2) a sales tax – and both faced considerable opposition. Labor advocates are strongly in favor of an employer spending requirement, but passage would require action by the 20 different city councils in the county, as well as the county supervisors for unincorporated areas. A sales tax, on the other hand, would require a ballot initiative and a two-thirds majority for approval, yet there is strong anti-tax sentiment in the county, and a recent initiative for a tax to improve county parks failed.

Part of the financing problem has been solved for the near term with a state waiver as described below, which has allowed San Mateo County to expand coverage for uninsured adults up to 200 percent of poverty for three years. As a result, ongoing financing discussions are

focused on whether and how to cover the group between 200 and 400 percent of the FPL, and how to sustain financing for the existing coverage program beyond the three year pilot.

The San Mateo County Adult Coverage Initiative

San Mateo is one of ten California counties to receive a Health Coverage Initiative grant from the state's Hospital Financing Waiver. This grant, awarded in September 2007, provides the county with up to $7.5 million annually for three years, enabling coverage for low-income adults who would not otherwise qualify for public insurance. This new program is named the San Mateo Access and Care for Everyone Program, or ACE. ACE helps to finance the county's adult coverage initiative, and has been enrolling patients since September 2007.

ACE resembles an existing county coverage initiative, the WELL program, which has been in place for nearly two decades. From its inception, the purpose of WELL has been to co-ordinate care for patients served by the SMMC, and thus all individuals who enroll must receive care from the SMMC clinics and other providers. The county has always financed WELL through discretionary general fund dollars. Funding for ACE is expected to relieve some of the financial burden resting on the county.

ACE and WELL offer nearly identical benefits, but the eligibility criteria differ. Low-income (<200 percent of the FPL) uninsured adults (19-64) who reside in San Mateo County, and are legal permanent residents or U.S. citizens, are eligible to enroll in ACE. ACE applicants must formally submit to the DRA (Deficit Reduction Act) test of citizenship that is applied to Medi-Cal applicants, because the program is funded through a state Medicaid waiver.[5] Some perceive this as a barrier to enrollment because of the burden of locating and producing the

[5] The 2005 Deficit Reduction Act imposes citizenship documentation requirements on applications and recipients, including children.

required documentation. ACE enrollees cannot be eligible for Medi-Cal (with or without a share of cost) and must not be enrolled in private or employer-sponsored health coverage. Currently there is a three month waiting period required between having employer-sponsored coverage and becoming eligible for ACE.

WELL does not require citizenship or permanent residence for enrollment, and is open to a broader age range (e.g., the elderly), but it does impose an asset test, which ACE does not[6]. Now that ACE is in place, the WELL program will become smaller and cover only those individuals who do not quality for ACE, primarily undocumented individuals. To date, approximately 40 percent of ACE enrollees were previously enrolled in WELL and 60 percent are new applicants.

Covered services for WELL and ACE enrollees are similar and quite comprehensive, including primary care, chronic care management, emergency room (ER) use, and prescription drugs. Enrollees are required to make co-payments for visits ($40 for an ER visit, $10 for an outpatient visit – if paid at the time of the visit, $20 if billed for an outpatient visit – and $7 for a prescription), and there is a premium of $240 per year. Enrollees are given the option of making premium payments in installments or paying the premium in full and receiving three $10 vouchers to offset copayments. ACE and WELL enrollees who are below 100 percent of the FPL (about half of the ACE population) are exempt from premiums and co-payments. In addition, if WELL enrollees do not use any services for a year they are entitled to a full refund of the premium they have paid. If ACE enrollees transfer to Medi-Cal during the year they will receive a prorated refund of the premium paid. Key informants do not perceive these premiums as barriers to enrollment in either program.

[6] The county is considering eliminating the asset test for WELL.

ACE and WELL enrollees are required to establish a primary care provider at one of the SMMC clinics or at Ravenswood Family Health Center. (Receiving care at Ravenswood was not an option for WELL enrollees at the time of the site visit.[7]) Each clinic is linked to a specific pharmacy from which their patients can fill prescriptions.[8] ACE and WELL patients can use the ER at the SMMC, but if they go to the ER at other hospitals it is not reimbursed by either program. In addition, ACE patients are entitled to acupuncture and home health services, though at the time of the site visit there were no providers yet contracted to provide these services.

Eligibility Determination & Enrollment: The County's adult coverage initiative seeks to enroll every patient seen at SMMC in an appropriate program through which their care and service costs can be managed and financed. The first priority is to enroll eligible individuals in Medi-Cal, and if the patient does not qualify for Medi-Cal he or she will be enrolled in ACE, WELL, or a discounted care program. Community Health Advocates (CHAs), Certified Application Assistors (CAAs), or Benefits Assistors (BAs) help to determine what coverage programs individuals are eligible for, and educate them on how to use the program in which they are enrolled.[9] At the clinic sites, enrollment often occurs just prior to or after a patient is seen.

CHAs and CAAs are employed by the county health department or by community-based organizations and located at the main campus of SMMC, other SMMC clinics, Ravenswood Family Health Center, Samaritan House, and several community based settings (i.e., schools and family service agencies). BAs are employed by the county Human Services Agency (HSA) and are located either at HSA offices, or out-stationed in clinics or other locations. CAAs, CHAs,

[7] RFHC became a primary care provider for WELL on January 1, 2009.
[8] This arrangement ensures 340B pricing, which allows qualifying providers to purchase drugs for outpatient use at substantially reduced rates--approximately 20 percent below the Medi-Cal price.
[9] CAAs are state certified, while CHAs are not.

and out-stationed BAs use a web-based tool, called **One-e-App,** to screen and enroll patients in appropriate health coverage programs. The application uses an interactive, interview approach to help simplify data collection and entry. One-e-App helps to improve the quality and completeness of applications, providing notification if data are entered incorrectly or a required field is incomplete. English and Spanish versions of the application are available, and patients can also select their provider at the time of enrollment using One-e-App.

BAs at HSA rely on a different automated system called **Cal-WIN**, which is used to determine eligibility for welfare and related benefits (including Medi-Cal). Automated data from One-e-App can be transmitted directly to Cal-WIN, but not the reverse. Most BAs at HSA sites enroll only in Medi-Cal, but out-stationed BAs, CHAs, and CAAs enroll in all available coverage/insurance programs. For ACE and Medi-Cal, CHAs and CAAs do the initial screening through One-e-App, and then send along the application to a BA who determines eligibility. While there are inefficiencies that result from using two separate enrollment systems which do not communicate directly, there is no definite plan to move to a single enrollment system in the near future.

In spite of its goal to provide coordinated care to those using the county health system, there has never been an organized managed care approach to managing the care of WELL enrollees. To avoid some of the uncoordinated care and other management challenges encountered with WELL, the county decided to contract with the Health Plan of San Mateo (HPSM) to manage the ACE program from its inception, and HPSM will assume the same responsibilities for WELL in 2009. HPSM is well-respected in the county for its success at managing the care of all county Medi-Cal enrollees as well as other public programs such as Healthy Kids.

Early Demographic and Utilization Findings: Enrollment in ACE grew rapidly in the early months of the ACE program, with a concomitant decline in WELL program enrollment (see **Figure 2**). By October 2008 about 5100 individuals had enrolled in ACE, more than twice as many enrollees as originally planned.

The Health Plan of San Mateo provided the evaluation team with tables that summarize enrollment and claims/encounter data for an initial cohort of ACE enrollees. These data describe demographic characteristics of enrollees, their clinical diagnoses, their health service use, and the cost of services. The cohort includes adults who enrolled in ACE during the six-month period between September, 2007 and February, 2008, and who remained enrolled for six full months continuously thereafter (N=1,981).

Figure 2: ACE and WELL Enrollment Trends 2007-2008
Source: San Mateo County One-e-App

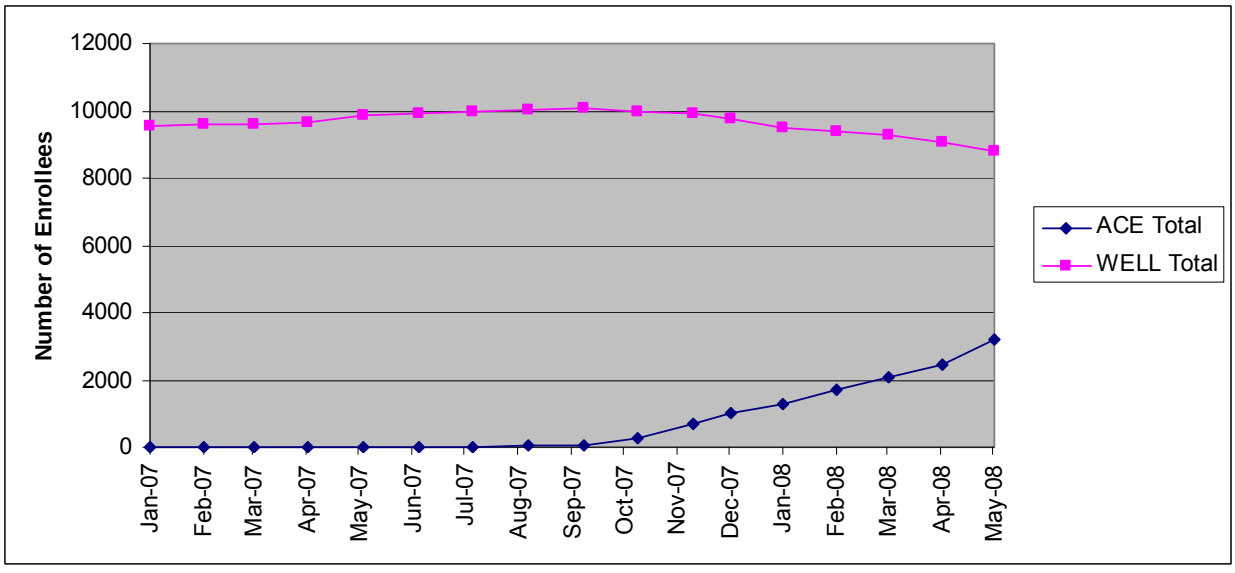
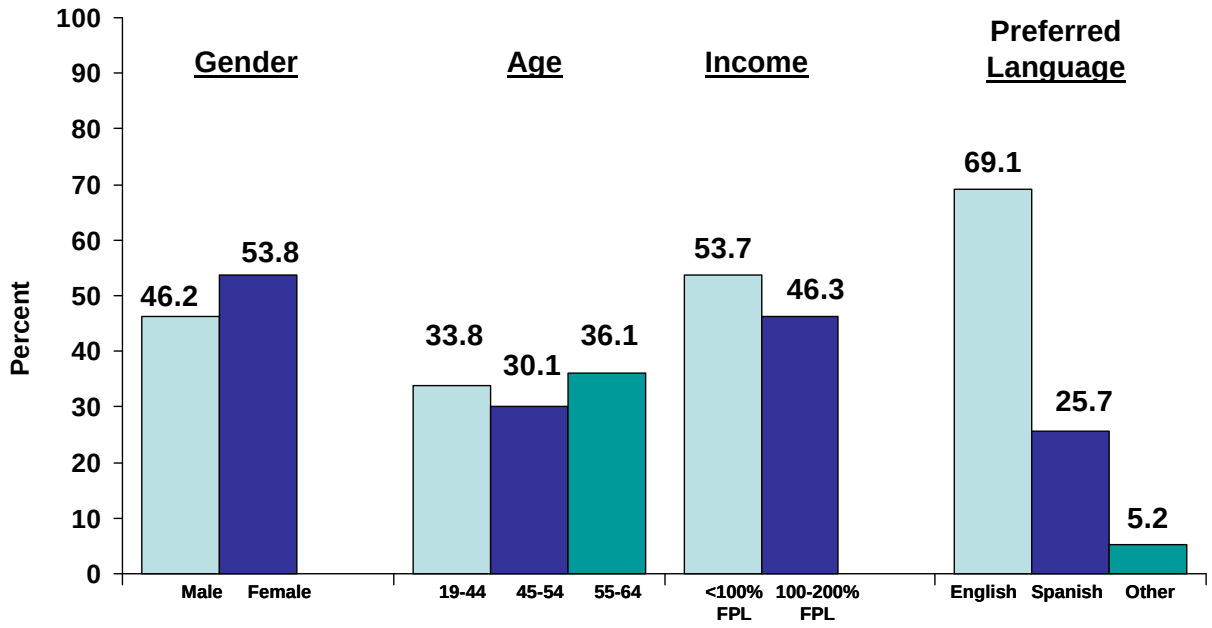


Figure 3 shows the demographic profile of these early enrollees. The majority (53.8 percent) is female, and the largest age group is 55-64 year olds (36.1 percent). ACE enrollees are very poor, with a slight majority (53.7 percent) having incomes below 100 percent of the federally poverty level. The remaining 46 percent have incomes between 100 and 200 percent of poverty. More than two-thirds of ACE enrollees list English as their preferred language, with most of the remainder preferring Spanish. We know from data collected through the One-e-App enrollment tool that half of ACE enrollees are Asian.

Figure 3: Demographic Characteristics of ACE Enrollees



Note: Based on enrollees who initiated coverage between September 2007 and February 2008, and remained enrolled for at least six months.

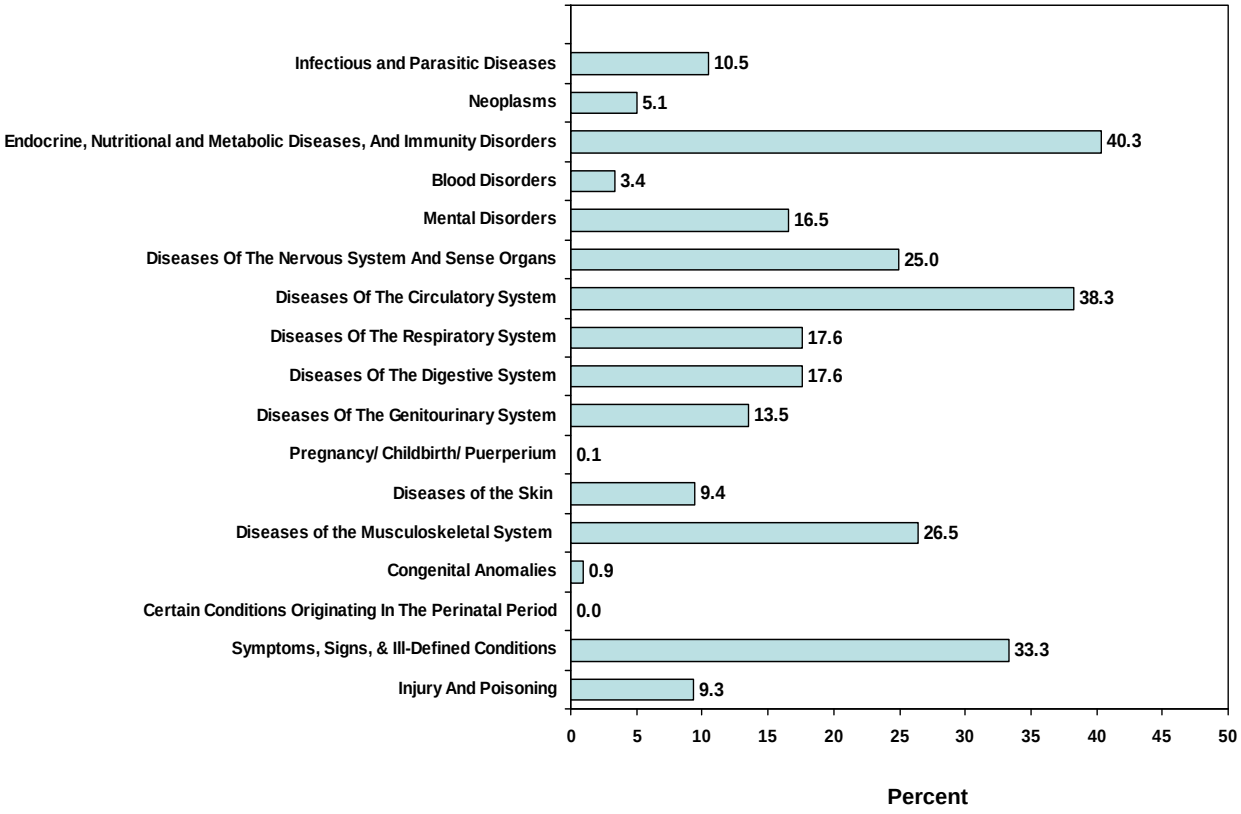
Appendix C Table 1 shows these demographic data arranged by primary care provider (i.e., clinic). There is substantial variation by clinic in demographic characteristics of these early ACE enrollees. At the Main Campus/Innovative Care Clinic (N=1,098), the initial wave of ACE enrollees is more often male and younger than at the other clinics. For example, at most of the adult medicine clinics, close to half of enrollees are between the ages of 55 and 64, while only 30 percent are in that age group at the Main Campus/Innovative Care Clinic. In contrast, the age and gender pattern at the main campus is similar to that in the "unassigned PCP" group (N=137). Furthermore, we observe that younger ACE enrollees are more often male, and have higher incomes (between 100 and 200 percent of the FPL). While speculative, it appears that there are two primary types of ACE enrollees: younger males who are not closely attached to a primary care provider and older females[10] more often attached to the smaller community clinics. These two groups are likely to have very different health care needs.

ACE enrollees have a high prevalence of health conditions. The broad diagnostic categories for early ACE enrollees are shown in **Figure 4** and **Appendix C Table 2**.

For example, 40 percent of ACE enrollees have a diagnosis within the broad category of "Endocrine, Nutritional, Metabolic, and Immunity Disorders." The appendix table shows over 60 percent of enrollees ages 55-64 have a diagnosis in this category. The prevalence of conditions in almost all other diagnostic categories also increases with age.

[10] Perhaps these are individuals whose children are grown, and who therefore do not have access to Medicaid coverage.

Figure 4: Diagnostic Profile of ACE Enrollees[11]



Source: Health Plan of San Mateo

Note: Based on enrollees who initiated coverage between September 2007 and February 2008, and remained enrolled for at least six months.

Table 2 illustrates the prevalence of some important specific conditions. A very high proportion of ACE enrollees have hypertension, diabetes, or both (40.7 percent). These patterns show the high need among ACE enrollees for integrated, coordinated services in this population.

Table 2: Prevalence of Specific Conditions among ACE Enrollees

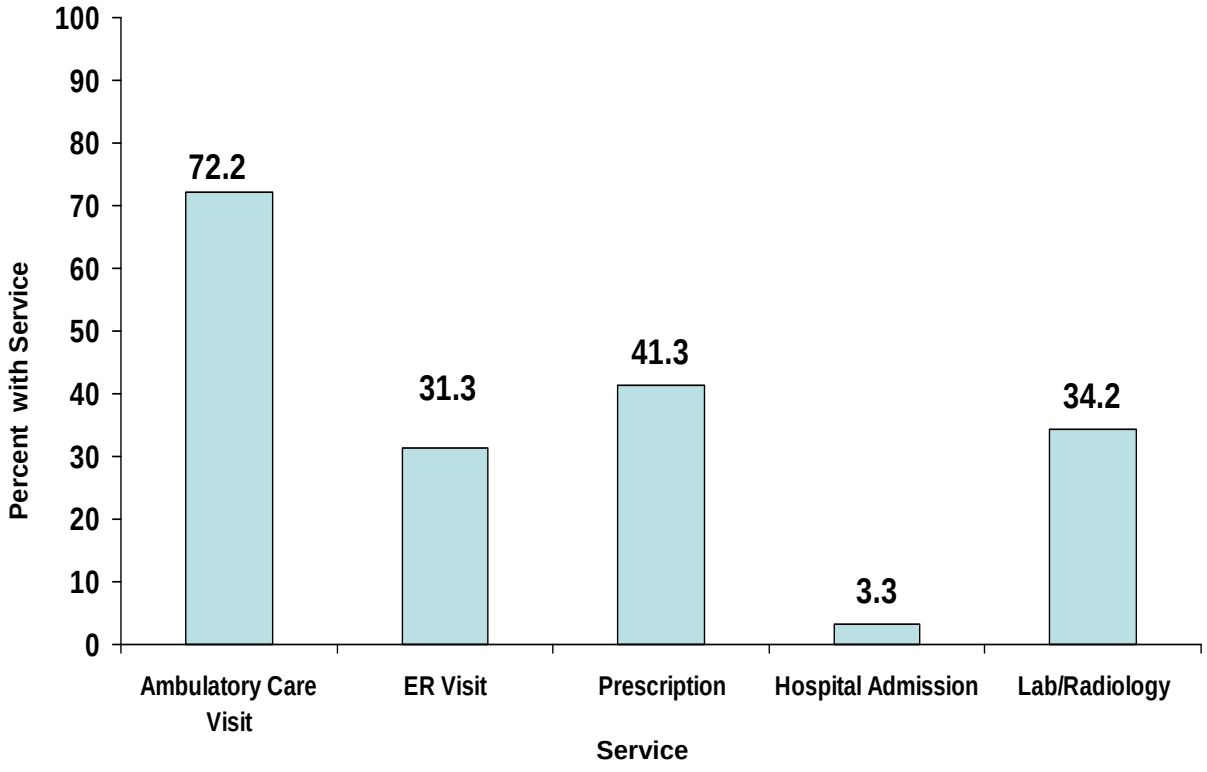
Condition	N	Percent
Hypertension, without diabetes	413	20.8
Diabetes, without hypertension	121	6.1
Co-occuing Diabetes and hypertension	272	13.7
Total Hypertension and/or Diabetes	**806**	**40.6**
Total N	**1981**	**100**

Note: Based on enrollees who initiated coverage between September 2007 and February 2008, and remained enrolled for at least six months.

[11] Percentages do not add to 100, as patients may have co-occurring conditions.

Figure 5 shows the use of some critical health care services during the first six months of ACE enrollment that were paid for by the Health Plan of San Mateo. Almost three-quarters had at least one ambulatory encounter, a third had an emergency room visit, 40 percent had a covered prescription, 3 percent had a hospital admission, and a third had a laboratory/radiology service. **Appendix C Table 3** shows general consistency across clinics in this pattern for health care services, although some rates vary across clinics especially for ER visits and hospital admissions. Though ACE does not cover charges for ER use outside of the SMMC system, some patients do use ER services at other hospitals. This is an unaccounted for patient cost. It is possible that reporting of claims/encounter records to HPSM was incomplete for some or all clinics during this period. It will be important to track these patterns over time as data for more enrollees become available.

Figure 5: Utilization of ACE Enrollees Covered by HPSM in the first Six Months Following Enrollment



Source: Health Plan of San Mateo
Note: Based on enrollees who initiated coverage between September 2007 and February 2008, and remained enrolled for at least six months.

Utilization rates for ACE enrollees are relatively high for a six month period. For example, while almost a third of ACE enrollees had an emergency room visit in six months, in 2003 only 18.1 percent of uninsured adults in the U.S. and 17.4 percent of privately insured adults ages 18-64 had an emergency room visit in a full year. Annual use rates for Medicaid enrollees, however, were much higher (39.7 percent) (Health U.S., 2005). This high use of services translates into high expenses for ACE enrollees (See **Table 3**). During the first six months of enrollment, the HPSM processed charges of an average of $3,178 per ACE enrollee. This compares to an average annual expenditure of $6,714 per person in the United States in 2006 (World Health Organization 2008). Over half the cost was for ambulatory care ($1,718), with the largest other cost categories being emergency room care ($646) and other hospital care ($648). In contrast, the average charge for prescriptions reimbursed by HPSM is very low ($31—compared to an average of $674 per person nationwide in 2005). ACE clients do, however, receive substantially discounted prescriptions at assigned pharmacies (340B pricing), and contribute to the cost of the prescription with a $7 patient co-pay.

The service use among this initial group of ACE enrollees is generally quite high. It remains to be seen whether these patterns will persist over time, or if these data reflect an initial burst in usage. It is conceivable that these figures of early enrollee use and charges are particularly high either because they are more likely to have chronic diseases and have been enrolled in clinic settings, or because they have a high pent up demand for services. The utilization experience for this group of adults is quite different than for the early Healthy Kids enrollees studied under the San Mateo CHI evaluation (Howell, et al., 2004). The early Healthy Kids enrollees had relatively low use of services when compared to Medi-Cal or Healthy Families enrollees.

Table 3: Average Charges per ACE Enrollee in Six Months Following Enrollment

	Age					
	19-24	25-34	35-44	45-54	55-64	Overall Average
Outpatient Clinic	$572	$684	$868	$1,121	$1,344	$1,073
Other Physician	$398	$455	$620	$646	$764	$645
ER						
SMMC	$671	$877	$847	$617	$511	$646
Other	$0	$0	$0	$0	$0	$0
Hospital						
SMMC	$0	$590	$349	$644	$933	$648
Other	$0	$0	$0	$0	$12	$4
Prescriptions	$10	$5	$18	$42	$39	$31
Lab and Radiology	$48	$64	$54	$66	$70	$64
Other	$16	$78	$52	$70	$77	$67
Total	$1,715	$2,753	$2,808	$3,206	$3,750	$3,178

Source: Health Plan of San Mateo

Note: Based on enrollees who initiated coverage between September 2007 and February 2008, and remained enrolled for at least six months.

Systems Redesign of Adult Medicine in San Mateo County

In response to problems with access to care and the need for better management of chronic conditions among adults served by safety net providers in the county, in conjunction with the ACE coverage initiative the county has embarked on a comprehensive "system redesign." The redesign is focused on improving efficiency within the clinics so that more patients can be accommodated; establishing patient medical homes in which preventive and primary care can be emphasized; and managing care of those with chronic conditions. The rollout of this effort is ongoing, and the type and level of redesign activities vary from clinic to clinic. We visited three clinics during the August, 2008 site visit—the Main-Campus/Innovative

Care Clinic, the Daly City adult medicine clinic, and the Ravenswood Family Health Center. Thus, the following description of redesign activities emphasizes care at those clinics, and cannot necessarily be generalized to all others. It also emphasizes plans at the time of the visit, many of which are underway.

Initiated in 2004, the county began piloting certain aspects of adult medicine systems redesign at the Daly City Clinic, the Fair Oaks Adult Clinic, and the Willow Clinic. Three types of pilot initiatives have been implemented: efforts to reduce cycle times (the time between when the patient arrives and leaves the clinic); developing team-based approaches to care (assigning patients to a team of a physician, nurse, and clerical staff who see them each time they visit the clinic); and implementing disease registries for diabetes patients. The county based these efforts on precursor efforts in other parts of the country. For example, the SMMC hired Coleman Associates to help improve clinic efficiency (e.g., efforts to reduce cycle times) and has been involved in a number of efforts with entities such as the Safety Net Institute, the California Health Care Foundation, the Study of Effective and Efficient Diabetic Care, and the McColl Institute to pilot chronic care management innovations (see Wagner et al. 2001; Coleman at www.patientvisitredesign.com).

In addition, as part of the effort to improve quality and boost efficiency, the county is implementing the use of an electronic medical record (EMR). SMMC clinics will be using "E-Clinical-Works," a well-regarded software product used in many other similar settings. The county has raised $2 million from 10 foundations to finance the software implementation and training. The Main Campus/Innovative Care Clinic will be the first of the county clinics to roll out the EMR in April 2009, with an expectation that roll-out will be complete in the early fall of 2009.

As mentioned, these activities have only been implemented in a few SMMC clinics, and no clinic had implemented all of them at the time of our visit. Ravenswood Family Health Center has also adopted some similar activities, but with variations in type and degree from the SMMC clinics. Activities at the three clinics we visited are described in more detail below.

Main Campus/Innovative Care Clinic: The County is receiving new federal/state funding from the Medi-Cal waiver (ACE) and is using a substantial portion of it to redesign clinic operations at the Main Campus/Innovative Care Clinic.

The Main Campus/Innovative Care Clinic is the largest of the county's adult medicine clinics. It is centrally located in the county and is housed in the same facility as the county's specialty clinics (i.e., ophthalmology, surgical, pain, dental, and podiatry), making it a very important place for systems redesign. The new name for the Main Campus clinic – The Innovative Care Clinic – reflects plans to restructure care with an eye toward integrating innovative practices for managing the care of adults with chronic conditions. The goals of the planned changes are to provide improved access to providers, high quality evidence-based medicine, and patient-centered care.

Efforts to improve management of chronic conditions at the Main Campus/Innovative Care Clinic are viewed as especially important, given that an estimated 90 percent of patients seen at this location have at least one chronic condition. As shown previously in Table 2, a large proportion has diabetes and co-occurring conditions such as hypertension.

The Main Campus/Innovative Care Clinic has both a clinic manager and a medical director, as do all SMMC clinics. Using funding from the new Medi-Cal (ACE) waiver, this clinic is expanding its staff by nine new positions. According to the terms of the waiver, these

new positions should be used to increase coverage and improve care coordination. The new positions include a social worker, a community health worker, a pharmacist, a registered nurse, a medical assistant, two clerical staff, one supervisor, and an additional physician (internist or family practitioner). There have been some delays in hiring the new staff, since hiring must follow the County's specified human resources and civil service guidelines.

The additional staff will be used to help to create three patient teams. Each patient at the clinic will be assigned to one of these teams, which will then handle scheduling, advice by telephone, and care during visits. Main Campus/Innovative Care Clinic leadership intends to promote flexibility in role definitions of the members of each team, in order to improve efficiency and to encourage staff to challenge themselves and grow. For example, they hope that the medical assistant in the team can take responsibility for tasks that have been traditionally considered nursing tasks. Despite plans to add staff and increase the number of teams, leadership at the clinic note that the number of patients seen by each team (an important measure of "efficiency") may not grow while they implement the electronic medical record (EMR) in the first half of 2009.

Along with other clinics in the San Mateo system, the Main Campus/Innovative Care Clinic has also undertaken a diabetes disease management program. At each visit for a patient with diabetes, staff collect clinical measures and enter them into the diabetes registry, and provide patient education. The clinic waiting room also has signs providing information on diabetes disease management, flyers with information about diabetes, and invitations to attend diabetes group classes.

In another effort to improve efficiency at the Main Campus/Innovative Care Clinic, plans are in place to transition to "Advanced Access" scheduling in 2009. This is designed to address

ongoing concerns about wait times for appointments. At the time of our site visit in August 2008, appointments could only be scheduled by telephone between 9AM and 11 AM Monday to Friday, and long wait times for the next available appointments were common.

Our clinic observations confirmed that patients who walk in seeking an appointment are sometimes sent away without being seen and told to call back for an appointment, even when the waiting room was not full and there appeared to be capacity to see the patient. During the two-hour waiting room observation, evaluators observed two patients who walked in to request either an appointment that day or to make an appointment in the future. Though both patients arrived at the clinic between 9 AM and 11 AM, they were not able to make an appointment in person and were told that they had to leave and call back by telephone. Another patient who needed to be seen for follow-up was unable to schedule an appointment because he did not have a phone number at which he could be reached.

Advanced Access would eliminate such situations by matching provider supply with patient demand on a daily basis. Under Advanced Access, all patients will be seen whether they call ahead for an appointment or walk in. To accomplish this, a portion of each team's appointment time is kept open for unscheduled patients, making it unnecessary to shuffle schedules to fit in patients who need to be seen urgently (Murray and Berwick 2003). Advanced Access also reduces the problem of "no-shows" (patients who schedule appointments but do not come). Advanced Access is designed to facilitate consistent care with the same provider, again by keeping provider schedules mostly open at the beginning of the day.

Implementing Advanced Access effectively requires data on the number of unscheduled patients and the number of no shows for each team, in order to plan for the right amount of unscheduled time per team. Clinic staff expressed concern that they may not have enough data

to do this well, at least initially. Delayed implementation of the EMR has posed challenges in collecting this data.

***Daly City Adult Medicine Clinic*:** The Daly City Clinic (part of the SMMC system) is located in the northern part of San Mateo County. In addition to adult medicine, the Daly City Clinic also offers pediatric care, dental care, family planning and other women' health services, optometry, laboratory services, and podiatry services. Formerly a public health clinic, this location also houses a tuberculosis clinic, HIV services, and a Health Department-sponsored communicable disease investigator.

The clinic has undertaken several systems redesign pilot initiatives over the past two years, under the leadership of the clinic manager and medical director. For example, The Daly City Clinic, along with Fair Oaks, was a pilot clinic for team-based care using the "Coleman Approach." Patients are assigned to teams, as described for the Main Campus/Innovative Care Clinic, made up of a physician, a nurse, and clerical staff. From the time that the patient arrives at the clinic, they are triaged to their team (using walkie-talkies issued to each team member). The team clerical staff greets the patient in the waiting room and takes them to their provider team where any paperwork is completed, and where a medical provider sees them. Follow-up patients can call directly to their team for an appointment, rather than the central appointment line. The Daly City Clinic patient population is linguistically diverse, and the teams often use a telephone interpreter line in one of 20 languages.

The team-based care model encourages patients to call their assigned team for medical advice or other concerns. However, we heard that this is not working as well as other aspects of the initiative, as many provider teams are overwhelmed and unable to field patient calls.

As with other clinics in the SMMC system, long waits for appointments are common, especially for new patients. We were told that the team-based care innovation has reduced wait times some, but that a new patient must still wait 4-6 weeks for an appointment. During observations of the Daly City Clinic waiting room, evaluators noted that—as with the Main Campus/Innovative Care Clinic—the clinic was fairly busy, but not excessively so. In fact there were times during our observations that no one was waiting for an appointment, and those who had been waiting has been seen and checked out.

To address persistent long wait times to obtain an appointment, the clinic has adopted a modified approach to Advanced Access whereby each team reserves appointments for urgent visits. However, these spots are often filled ahead of time due to strained capacity. As a result of these gaps, we learned that patients in non-emergent situations are often referred to the emergency room because of an inability to schedule them for an urgent care visit. The clinic plans to adopt a more comprehensive approach to Advanced Access, similar to the Main Campus/Innovative Care Clinic, in the near future.

The Daly City Clinic has also addressed the need for improved care co-ordination for patients with diabetes, through the Study of Effective and Efficient Diabetic Care Project (SEED). The SEED project is collaboration between public hospitals in California, sponsored by the Safety Net Institute, an organization affiliated with the California Association of Public Hospitals that sponsors innovations in public hospital and health care systems which began in 2004. Daly City and Fair Oaks are the clinics in San Mateo County that participate in this program. All diabetic patients at the Daly City Clinic are seen by the same team, consisting of a physician, an RN, a medical assistant, and a clerk. As at the Main Campus/Innovative Care Clinic, clinical measures are being carefully tracked through use of a registry. Patient education

is provided at monthly group visits of 5-8 patients, where clinical measures are also collected. Staff at the Daly City Clinic noted that these group visits are a cost-effective approach to patient care, and that patient education can be provided more effectively in a group setting where patients share experiences. Group visits are held in English, Tagalog, and Spanish, the primary languages spoken by the Daly City Clinic patient community. The Daly City Clinic hopes to replicate this team-based disease management model for patients with high cholesterol and hypertension.

***Ravenswood Family Health Center*:** The Ravenswood Family Health Center (RFHC) is a federally-funded primary care clinic located in the southern part of the county. The clinic is funded through the Health Resources and Services Administration (HRSA) 330 Community Health Center program, which was first granted six years ago.[12] Approximately one quarter of the scheduled visits are for pediatric patients, and the remainder are adult visits (including obstetrics).

In 2006, Ravenswood took over the Belle Haven clinic, which was formerly part of the SMMC system, and now operates it as a second site. In spite of this additional space, the RFHC continues to operate over capacity. Part of the reason for this is that the clinic is operating in an outdated facility without space to add needed staff. To address their space constraints, Ravenswood is launching a $10 million capital campaign with the help of the David and Lucile Packard foundation to renovate the main facility. They have also obtained a large grant from Packard to buy the land across the street and build a new dental clinic.

The payer mix at Ravenswood is not as favorable as it is in the county system, with fewer Medi-Cal patients. Fully 59 percent of patients (primarily adult) are uninsured. This has created

[12] Ravenswood replaced a previous 330-funded clinic, Drew, which closed.

a major funding gap, since their HRSA grant does not cover all the cost for the uninsured, and consequently they have imposed a cap on the number of new uninsured patients they can see. Ravenswood is participating as a primary care provider under ACE, and this should help to cover the cost of documented uninsured adults at the clinic. At the time of our visit, the clinic was beginning to enroll patients in ACE. Undocumented patients are not covered under ACE. Ravenswood became a primary care provider for the former WELL program on January 1, 2009, which means that undocumented patients enrolled in the WELL program will now be covered if seeking primary care services at Ravenswood.

Specialty care is not provided at Ravenswood, so patients rely on the SMMC specialty clinics or private providers for specialty care. Staff report satisfaction with the quality of care provided at the SMMC specialty clinics, but are frustrated by barriers to access for specialty care. There is someone on staff who helps adult medicine patients access specialty care, and apply for programs that could cover the costs of this care within the SMMC system, including filling out WELL applications. Specialty appointments are very difficult to schedule, and we were told that the records that they fax over are regularly misplaced. As a result, Ravenswood has started hand delivering paper work to the SMMC specialty clinics.

Over the past two years, Ravenswood has adopted some of the same system reform initiatives as are being adopted for the SMMC clinics. For example, similar to the team based model implemented by the Main Campus/Innovative Care Clinic and the Daly City Clinic, Ravenswood has teams (called "pods") of individuals that know the patient, including a physician, an RN, and a member of the clerical staff. In the Ravenswood model, the patient is considered "part of the team" as well.

Another systems redesign initiative is the "Optimizing Primary Care" initiative, which began in June 2007. The Main Campus/Innovative Care Clinic is also part of this collaborative. "Optimizing Primary Care" emphasizes reducing cycle times and waiting times for appointments. The initiative is sponsored by HRSA through a grant to the California Primary Care Association (CPCA). The association provides all federally funded Community Health Centers in the state with technical assistance in order to help them implement Advanced Access scheduling. At Ravenswood, only 30 percent of appointment time slots are scheduled for a given day, leaving all the other time open with the goal of "seeing patients when they want to be seen." Since not all patients can be seen on the day they want to be, an attempt is made to schedule any deferred appointments within at most 30 days of when the patient calls, preferably within two weeks. The efforts appear to have had a positive effect on cycle times. Our observations in the waiting room at Ravenswood showed that, while the volume in the clinic was very high, few patients during the time we were there waited for more than 30 minutes.

As at the Main Campus/Innovative Care Clinic and the Daly City Clinic, Ravenswood has implemented a diabetes disease registry in order to improve diabetes care coordination. Clinical measures are entered in the registry for all patients, including indicators such as the use of statins and other cholesterol measures. They hope to expand the registry to include other chronic diseases such as asthma. In addition, they would like to begin using it to track receipt and results of mammograms, pap smears, and colon screenings.

The clinic is planning to move to using an Electronic Medical Record by June 2009. This system will replace the existing data management system. They plan to use EPIC, which is the product used by the Palo Alto Medical Foundation and Stanford. EPIC is also used and supported by their network of 26 CHCs, and has capabilities for HRSA reporting and billing.

The software adopted by Ravenswood for its disease registry and for its EMR differ, in both cases, from that adopted by the SMMC clinics. SMMC will provide read-only access of the EMR to providers at Ravenswood.

Baseline Clinic Monitoring Data

There are existing data for all SMMC clinics and the RFHC that can be used to track clinic performance as these new systems redesign initiatives are taking hold. Among the measures already being collected across clinics are waiting times for first appointments (through HPSM "Secret Shopper" data), cycle times, and patient satisfaction.[13] In some cases, these data can be examined for the adult patient population separately from other age groups; in other cases, the data are available for the entire clinic and therefore do not allow us to look at the specific impact for adults or for ACE enrollees specifically. An additional limitation is that the methods of collecting and tabulating data differ across clinics, and definitions of some measures are not entirely uniform. The evaluation team is working with the clinics to develop a uniform set of measures that can be used to track clinic performance, allowing us to compare across clinics and over time.

Wait Times for Primary Care Appointments: The Health Plan of San Mateo (HPSM) instituted a "Secret Shopper" calling program in 2007, whereby health plan staff made calls to primary care providers, including SMMC clinics, to seek a first time appointment. The goal of this effort was to determine how long it would take for a Medi-Cal or CareAdvantage patient to be seen as a new patient. While this was not done for ACE patients specifically, it can be considered as a

[13] Standardized data from the SMMC clinics are presented here. Similar data exist from Ravenswood, and are also discussed. However, the Ravenswood data are not directly comparable with SMMC data due to methodological differences.

baseline measure of time to new appointment for adult medicine in these clinics, prior to systems redesign. The 2007 effort was repeated during a two month period in 2008.

HPSM secret shoppers were unable to reach any SMMC clinics during the 2007 effort. In 2008, all but one clinic was reached. In some cases, though they were able to reach someone, "shoppers" were told to call back at another time to schedule an appointment. When callers were able to schedule an appointment, appointments were often not available within the recommended time of four weeks or less for a routine physical exam. These findings support anecdotal data indicating access difficulties for new patients at SMMC clinics. However, the secret shopper findings may overstate the situation. Calls were not made at any specific time, but throughout the day, even though the clinic may have a designated time for scheduling appointments.

Ravenswood was not included among the clinics called in the HPSM "Secret Shopper" project, but included in the clinic's patient satisfaction survey patients are related questions such as: 1) "How long did it take you to get an appointment for a physical exam with a doctor?", and 2) "How long did it take you to get a routine/non-urgent appointment with the your doctor?" Results indicate that around half were able to get an appointment for a physical exam the same day, and 15-20 percent scheduled an appointment in less than seven days. A similar proportion of respondents reported that they were able to make appointments for routine non/urgent visits within seven days. While this is in stark contrast to the long wait times (4-6 weeks) reported anecdotally for the SMMC clinics, the results are not directly comparable since Ravenswood is reporting data for people who got in to see a doctor, and did not capture those who may have been discouraged or unable to schedule an appointment.

Still the data suggest that, consistent with our clinic observations, the Advanced Access approach that has been in place for some time at Ravenswood has had an impact by reducing waiting times for appointments, and thus has improved access to primary care, particularly preventive care. This suggests the promise of improved access at the Main Campus/Innovative Care Clinic and the Daly City Clinic as they move to Advanced Access.

Cycle Times: "Cycle time" refers to the lapsed time between when the patient checks into the clinic, and when the patient checks out. For at least the past two years, all clinics in the SMMC have been collecting cycle time information (although using somewhat different methods), and regularly reporting the data to the central quality of care committee comprised of clinic and SMMC leadership. We requested and obtained baseline cycle time data for each of the clinics in order to track how these indicators change over time as team-based care and Advanced Access are being implemented. Figure 6 shows these data.

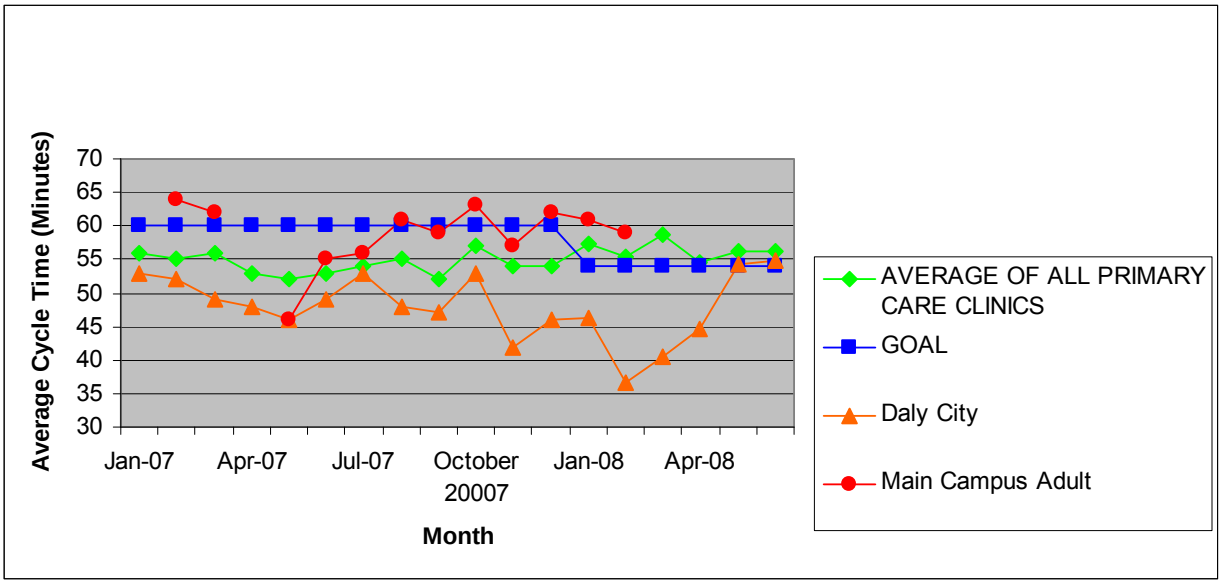
The graph compares cycle times at the Main Campus/Innovative Care and Daly City Clinics to the average for the SMMC clinic system as a whole from January 2007 to June 2008 and to SMMC's target for cycle time, which during this period was 60 minutes in 2007 and 54 minutes in 2008. For most of this reporting period, average cycle time at both clinics fell within this target, as did the average across all SMMC clinics.

Figure 6 shows that cycle times at the Main Campus/Innovative Care Clinic are generally above the average of other primary care clinics in the system, though they are approximately at or below the county's target. At the Main Campus/Innovative Care Clinic, data are collected manually by front desk staff during one or two clinic sessions a month. The

infrequency with which these data are collected may also contribute to the fairly large variability in cycle times by month.

Cycle times at the Daly City Clinic were consistently lower than both the average of all SMMC clinics, and the goal targeted by the county, averaging 47 minutes during the period. In addition, cycle times declined during this time period at the Daly City Clinic. Clinic staff believe that implementation of team-based care has contributed to this reduction in cycle times. Cycle times based on our clinic observations were consistent with this estimate, varying between 20 and 60 minutes during the time period we observed.

Figure 6: San Mateo Medical Center Cycle Times (Daly City Adult and Main Campus Adult) – 2007 and first half of 2008



Source: SMMC Quality of Care Committee

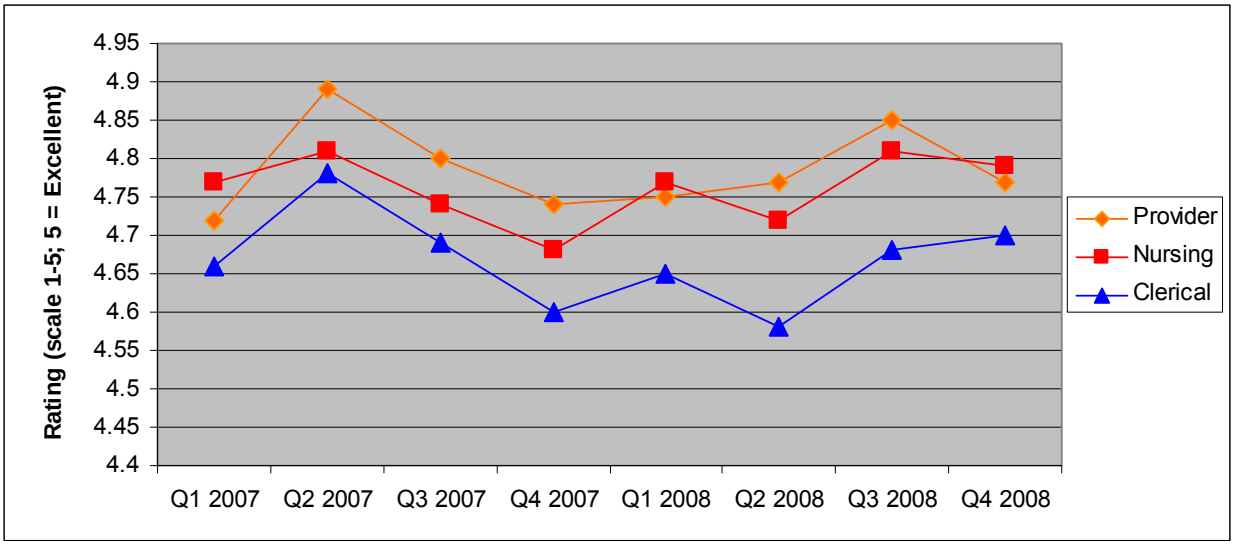
There are no consistent data on cycle times at RFHC during this period that can be compared to the data for the SMMC clinics.

***Patient Satisfaction*:** Data on patient satisfaction are collected at all SMMC clinics through a brief uniform survey with four questions that a sample of patients are requested to complete

before they leave the clinic.[14] Patient satisfaction measures focus on the extent to which the patient found the nursing, clerical and provider (doctor or nurse practitioner) services individually courteous. The survey also asks for an overall rating of the clinic (excellent, good, OK, poor, and unacceptable). Data are collected on a sample of patients. Varying methods for sampling patients are used across clinics. For example, the clinics differ in who hands the survey to the patient and who collects it; how they sample patients; and how many surveys are collected each month. The data are also centralized for review by the quality of care committee, which provided the data to us.

Figure 7 shows patient satisfaction with staff courtesy for the county as a whole. Ratings are consistently high, ranging from 4.55 to 4.9 on a scale of 1 to 5. Typically, physicians, nursing, and clerical staff were all considered courteous, although the clerical staff somewhat less so.

Figure 7: Outpatient Courtesy Ratings (All SMMC Clinics)

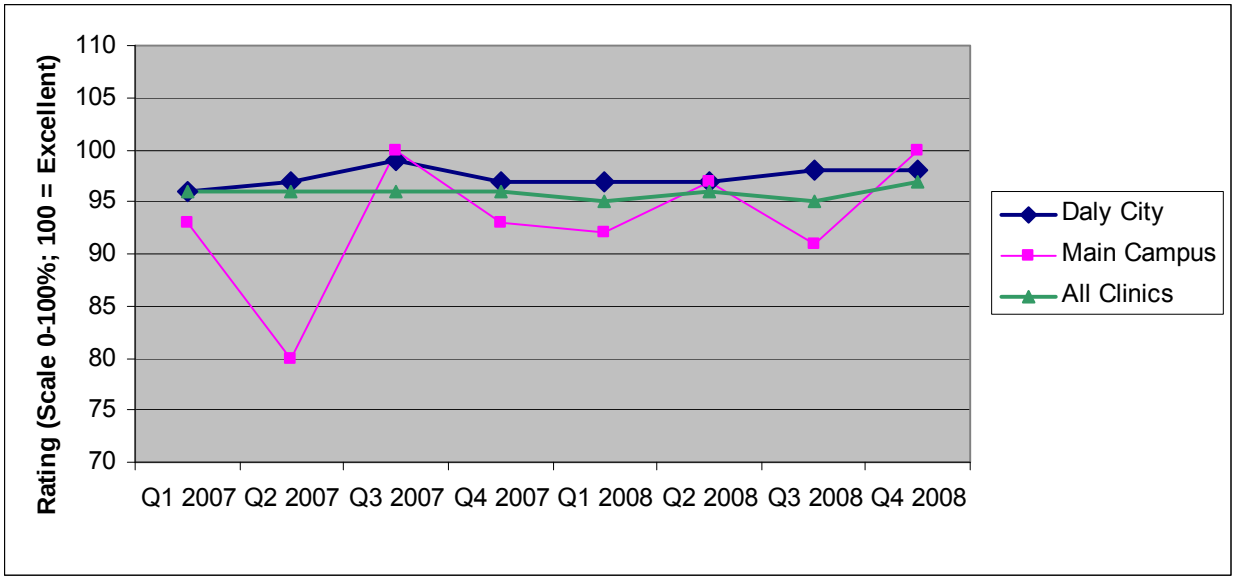


[14] The Main Campus/Innovative Care Clinic implemented a new patient satisfaction survey in January 2009, which captures the same basic measures as the original survey, but is more expansive. Whether it will be feasible to compare the Main Campus/Innovative Care Clinic patient satisfaction survey results to past patient satisfaction findings, from the same or other SMMC clinics going forward, remains to be seen.

While it is positive that the satisfaction for existing patients is generally very high, it is important to be cautions when interpreting these data, since in general, patient satisfaction data such as these tend to be highly favorable and because the methods were so variable. Moreover, patients provided the data voluntarily, and there was no effort to follow-up with patients who did not turn in surveys they were offered. These data may also be skewed toward positive responses, since patients may feel that their provider will know how they have answered the questions. Finally, the data are not collected from patients who came to the clinic but could not see a provider.

The overall clinic rating for all clinics, and separately for the Main Campus/Innovative Care Clinic and Daly City Clinic, are shown in **Figure 8**. Ratings were very high across all clinics. The overall clinic rating is also high at the two clinics, but the sample sizes were low at the Main Campus/Innovative Care Clinic (N=107). The rating was uniformly high at the Daly City Clinic, based on a larger number of surveys (N=506).

Figure 8: Overall Clinic Rating



Although the data derive from a different patient satisfaction survey using different measures, patient satisfaction at Ravenswood also is quite high. Patients are asked if the provider/nursing staff/clerical staff were doing great or good with respect to being courteous/helpful/respectful. Data for the third and fourth quarter of 2008 show ratings for provider care satisfaction in the mid 90's (on a scale of 1-100).

In summary, it appears that satisfaction with their primary care providers and other staff is generally high in all the safety net providers in San Mateo County, for the patients who are able to obtain appointments and be seen. Again, this suggests that access to care is a central problem with the system, so it is appropriate that it is an important focus of the health system redesign effort. At the same time, it will be important to continue to monitor patient satisfaction to assure that it remains high as changes are made. It will also be helpful to achieve more uniformity in methods of collecting the data, including attempts to achieve high response rates to the surveys.

Summary and Conclusions

This report—based on data gathered during the initial six months of the evaluation—provides several clear findings about the county's safety net for uninsured adults in fall, 2008 just prior to the implementation of intensive systems redesign at the Main Campus/Innovative Care Clinic. The key findings are described separately for the adult coverage and systems redesign components.

The Adult Coverage Initiative: There has been strong growth in ACE program enrollment (and an associated decline in WELL program enrollment), which suggests positive results for county

finances, since these individuals' health expenses are now covered by state and federal financing rather than the county general fund. Other key findings include the following:

1) The initial group of ACE patients has high morbidity and is very costly.

2) Since there has not been intensified outreach to bring in new individuals into ACE who have less severe health problems (or no health problems), the current system (in place and as planned) does not have a strong emphasis on health prevention and promotion. Most enrollment is done in clinic settings where patients come with health problems, and not in non-health community-based sites. This undoubtedly contributes to the high morbidity of the average ACE enrollee at this time.

3) Sustained financing for the ACE program, beyond the three year pilot, has not yet been identified, nor has financing for adults from 200 percent to 400 percent of the federal poverty level. This will be a critical task for the county and the broader community in the coming year and beyond.

Systems Redesign: We learned that, at the time of the site visit, several pilot initiatives were underway and others were planned for the very near term. These include the following four types of initiatives:

- Team-based care
- Special initiatives for patients with diabetes, including patient registries (to be expanded to other conditions in the future)
- Advanced Access scheduling for appointments
- Electronic Medical Records (not yet implemented in any site at the time of the visit).

There is evidence that, in the places where these initiatives have been underway the longest, they have led to improvements in patient satisfaction and reduced waiting times in clinics. However, those conclusions are based on the opinions of key informants and on data that are not collected in a uniform manner across clinics and across time.

At the time of this writing, system reform initiatives are intensifying, particularly at the Main Campus/Innovative Care Clinic. At that site, the largest adult medicine clinic in the San Mateo County safety-net, new staff have been hired, Advanced Access scheduling is being

piloted, and implementation of an Electronic Medical Record will soon be underway. Because other smaller pilot initiatives have already apparently yielded improved efficiencies, these substantial changes at the Main Campus/Innovated Care Clinic should soon begin to lead to similar improvements at that site.

At the other two clinics that we visited—the Daly City Clinic and Ravenswood—pilot systems redesign efforts have been underway for some time. Both the Daly City and Ravenswood clinics are gearing up for the next phase of their redesign, including expanding disease registries and implementation of the EMR.

Other key findings from the evaluation concerning the systems redesign include the following:

1) With improved efficiency, the San Mateo safety net shows promise of being an excellent source of medical care for uninsured and underinsured low income adults. From a wide range of key informants, we heard that quality of care in the San Mateo safety net clinics is good, and according to patient satisfaction data collected in the clinics those patients that are in the system are very satisfied with their care.

2) In spite of this very positive finding, there are serious access problems for new patients entering the system, and for specialty care. This is due to resource constraints, but also due to difficult administrative procedures for patients seeking appointments. This means that patients with severe health problems may obtain care through the emergency room or pay out of pocket with private providers, rather than with their primary care provider. Attempts are being made to establish specialty contracts with private health care delivery systems in the area that will supplement the specialty services currently available at SMMC specialty clinics.

Next Steps for the Evaluation

Over the next year we will continue and augment evaluation activities as follows:

Case Study: In a second week-long site visit, planned for August 2009, we will conduct additional interviews with key informants. We will revisit the three clinics we visited during the initial site visit, and also spend time speaking with staff and observing in the waiting rooms at

two additional clinics: Fair Oaks and Willow. The goals of this site visit will be to 1) assess any changes in clinic operations that have occurred in the past year; 2) understand the impact of ACE and systems redesign activities on clinic operations and solvency; and 3) gain insight regarding successes and barriers to redesign implementation.

Clinic Indicators: As part of the overall evaluation of the implementation of ACE and the health system redesign in San Mateo County, the evaluation team is collecting, tracking, and analyzing clinic-specific data on measures of "customer service." We are examining patient satisfaction with clinic personnel and services, wait times for a new appointment, cycle times (time lapsed from registration to completion of the visit), and no show rates. We hope to be able to determine if any changes in these measures occurred following the implementation of clinic policies and procedures designed to improve patient care.

Given the short duration of the evaluation, as well as the staggered nature of the implementation of these innovations, the evaluators do not anticipate finding dramatic, or even modest changes. Nonetheless, we are laying the ground work for such an analysis for this evaluation and for future assessments in the following ways:

- Inventorying data already collected by clinics in these domains;
- Clarifying and documenting the definitions used, collection methods, and frequency of collection by clinic;
- Documenting and monitoring over time systems changes that could affect these outcome measures; and
- Following trends in the measures, by clinic, prior to and after implementation of systems redesign and mapping to these trends implementation dates of major innovations in each clinic.

One-e-App Survey: In an effort to gauge the impact of the systems redesign and ACE, the evaluation team designed 16 survey questions that have been added to the county's One-e-App enrollment tool (see Appendix D for a list of the questions). These questions measure changes in

usual source of care, ER use, and health outcomes, before and after enrollment in ACE or WELL. The amended tool takes between 7-10 minutes to administer, and is also available in Spanish. The tool has been piloted by select CHAs/CAAs in the county. All CHAs, CAAs, and BAs who use One-e-App, will receive training for administering this instrument in early March, 2009, in preparation for full implementation at end of March.

HPSM Utilization Data: We will continue to use data from the HPSM to study the characteristics of ACE (and eventually WELL) enrollees, including their demographic characteristics, diagnostic mix, use of services, and cost.

Clinic Data: A final evaluation component is to obtain data for a cohort of patients served at the Main Campus/Innovative Care Clinic prior to systems redesign activities there (in 2006) and similar data after the redesign has been implemented. We will obtain One-e-App data for demographic characteristics and income, and linked claims/encounter data from the clinic data base. These data will be used to measure changes in utilization, continuity of care, health outcomes (with limited data on the latter), and cost for WELL/ACE adult medicine patients at the clinic. The baseline 2006 cohort is being provided to the evaluation team at the time of writing this report.

In the coming year we look forward to tracking the developments of the SMMC systems redesign and the ACE coverage initiative. Additional data collection, the implementation of the One-e-App survey questions, and qualitative data gathered from the second site visit will help us to more fully assess the impact of these changes in 2009.

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Appendix A
Evaluation Questions & Data Sources[15]

	Case Study	Main Campus/ICC Data	Cross-Clinic Data	HPSM Encounter Data	One-e-App Data
Research Questions					
What is being done under the system redesign? What changes have been made to the enrollment and service delivery system for low income adults?	**P**				
Who is served by the system redesign? How has the composition of enrollees changed over time?		**P**		**P**	**S**
What services do clients receive? What are the trends over time?	**S**	**P**		**P**	**S**
What is the quality of care in redesigned clinics?	**S**	**P**	**P**		
Are clients satisfied with the redesigned program and its services?	**S**		**P**		
Are providers and other key stakeholders satisfied with the systems redesign?	**P**				
What is the impact of the systems redesign on access to care and use of medical services?	**S**	**P**	**S**	**S**	**P**
Does the system redesign have an impact on the health status of clients?		**P**			**P**

[15] Data from the Main Campus/Innovative Care Clinic are individual-level data. Cross-Clinic data are aggregate.

Appendix B
Key Informants Interviewed During August 2008 Site Visit

Name	Title	Agency
Maya Altman	Executive Director of Health Plan of San Mateo	Health Plan of San Mateo
David Amann	Financial Advisor	Redwood City Chambers of Commerce
Jeanette Aviles	Medical Director of Ambulatory Service/Medical Director of Fair Oaks Clinic	San Mateo Medical Center
Laurie Bauer	Compliance, Quality and Risk Management Officer	Ravenswood Family Health Center
Irais Bazan	Member Benefits Coordinator	Ravenswood Family Health Center
Marmi Bermudez	Program Manager	SMMC/Child Health Initiative
Nadia Bledsoe	Business Representative	AFSCME (Local 829)
Luisa Buada	Chief Executive Officer	Ravenswood Family Health Center
Athena Cabezas	Community Health Advocate	San Mateo Medical Center
Jaime Chavarria, MD	Associate Medical Director, Family Practice, Adult Clinic	Ravenswood Family Health Center
Sang-ick Chang, MD	Chief Executive Officer	San Mateo Medical Center
Susan Ehrlich, MD	Chief Medical Officer	San Mateo Medical Center
Rob Fleming	Clinic Manager	San Mateo Medical Center
Rob Fucilla	Community Partner Liaison	Health Plan of San Mateo
Linda Franco	Program Manager for the Senior Care Center/Deputy Director of Ambulatory Service	San Mateo Medical Center
Anita Galang	Interim Director of Financial Planning and Analysis	San Mateo Medical Center
Mary Giammona, MD	Medical Director	Health Plan of San Mateo
Carol Groom	Vice President Mills-Peninsula Health Services	Mills Peninsula Health Services:
Shelley Kessler	Executive Secretary Treasurer	San Mateo County Central Labor Council
Noris Larkin	Charge Nurse for Adult Primary Care	San Mateo Medical Center
Jonathan Lee	Medical Director	SMMC: Daly City Clinic
Cathy Lemkuhl	Clinic Manager	SMMC: Daly City Clinic
Kitty Lopez	Executive Director	Samaritan House
Gregory Lucaszewicz, MD	Physician	Kaiser Permanente
Judy Manuel	Triage Nurse	SMMC: Daly City Clinic
Christina Meacham	Front Desk Supervisor	Ravenswood Family Health Center
Jean Merwin	Principle	Jean Merwin & Associates
Cecilia Montalvo	VP of Strategic Planning and Business Development: Peninsula Coastal Region	Palo Alto Medical Foundation
Isela Montenegro	Patient Access Manager	SMMC/Child Health Initiative
John Ngo	Clinic Operations Director	Ravenswood Family Health Center
Sharon Petersen	Director of Program Operations	Samaritan House
Sosefina Pita	Community Health Advocate	SMMC/Child Health Initiative
Audrey Ramberg	Consultant	County Manager Office
Diana Reddy	Co-Chair of Peninsula Interfaith Action (PIA).	Peninsula Interfaith Action (PIA)
Debbie Rivera	Clerical Supervisor	SMMC: Daly City Clinic
Ron Robinson	Director of Finance and Administrative Services	Health Plan of San Mateo
Maria Rueda	Community Health Advocate	SMMC: Daly CityClinic
Jagruti Shukla, MD	Medical Director	San Mateo Medical Center
Charlene Silva	Director	San Mateo County Health Department
Tammi Siu	Social Worker Supervisor	Aging and Adult Servieces
Srija Srinivasan	Special Assistant to the County Manager	County Manager Office
Glena Vaskelis	Hospital President and Administratior	Sequoia Foundation
Wayne Yost	CPA, CFE, Chief Financial Officer	Ravenswood Family Health Center

Appendix C

Appendix Table 1
Demographic Characteristics of ACE Enrollees by Clinic
(%)

	Main Campus/ ICC	Coast Side	Daly City	Fair Oaks	Ravenswood	S. San Francisco	Willow	Unassigned	Total
Gender									
Female	49.8	58.6	61.4	66.2	64.0	55.6	59.6	46.0	53.8
Age									
19-24	10.6	6.9	4.4	4.1	4.0	0.8	2.6	6.6	7.6
25-34	12.4	3.4	9.2	3.4	10.0	6.8	8.8	16.1	10.8
35-44	16.7	17.2	11.0	14.9	12.0	16.5	10.5	18.2	15.4
45-54	30.2	17.2	27.2	29.1	54.0	30.1	34.2	27.0	30.1
55-64	30.1	55.2	48.2	48.5	20.0	45.8	43.9	32.1	36.1
Preferred Language is English	75.7	62.7	67.7	62.2	56.0	63.9	65.8	73.0	69.1
Income Below 100% of Federal Poverty Level	58.7	48.3	54.4	52.0	56.0	54.9	67.5	1.5	53.7
Total ACE Enrollees	1098	29	272	148	50	133	114	137	1981

Appendix Table 2
Diagnostic Profile of ACE Enrollees by Age
(% with Diagnosis)

Diagnostic Profile		Age											
		19-24		25-36		35-44		45-54		55-64		Total	
	DX Codes	#	%	#	%	#	%	#	%	#	%	#	%
Infectious And Parasitic Diseases	001-139	16	10.6%	15	7.0%	23	7.5%	83	13.9%	70	9.8%	207	10.5%
Neoplasms	140-239	1	0.7	6	2.8	7	2.3	37	6.2	49	6.9	100	5.1
Endocrine, Nutritional And Metabolic Diseases, And Immunity Disorders	240-279	17	11.3	34	16.0	79	25.9	228	38.2	441	61.7	799	4.0
Blood Disorders	280-289	4	2.7	5	2.4	7	2.3	28	4.7	23	3.2	67	3.4
Mental Disorders	290-319	18	11.9	33	15.5	65	21.3	112	18.8	99	13.9	327	16.5
Diseases Of The Nervous System And Sense Organs	320-389	18	11.9	38	17.8	59	19.3	164	27.5	216	30.2	495	25.0
Diseases Of The Circulatory System	390-459	11	7.3	29	13.6	68	22.3	226	37.9	425	59.4	759	38.3
Diseases Of The Respiratory System	460-519	26	17.2	51	23.9	53	17.4	89	14.9	130	18.2	349	17.6
Diseases Of The Digestive System	520-579	33	21.9	34	16.0	53	17.4	120	20.1	109	15.2	349	17.6
Diseases Of The Genitourinary System	580-629	17	11.3	21	9.9	40	13.1	91	15.2	98	13.7	267	13.5
Pregnancy/Childbirth/Puerperium	630-679	0	0.0	1	0.5	0	0.0	0	0.0	0	0.0	1	0.1
Diseases Of The Skin	680-709	12	8.0	17	8.0	33	10.8	58	9.7	66	9.2	186	9.4
Diseases Of The Musculoskeletal System	710-739	28	18.5	38	17.8	77	25.3	162	27.1	219	30.6	524	26.5
Congenital Anomalies	740-759	2	1.3	1	0.5	1	0.3	6	1.0	8	1.1	18	0.0
Certain Conditions Originating In The Perinatal Period	760-779	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Symptoms, Signs, & Ill-Defined Conditions	780-799	46	30.5	64	30.1	113	37.1	190	31.8	247	34.6	660	33.3
Injury And Poisoning	800-999	25	16.6	21	9.9	35	11.5	56	9.4	47	6.6	184	9.3

Appendix Table 3
Utilization of ACE Enrollees by Clinic
First Six Months Following Enrollment
(% with service)

Service	Main Campus/ ICC	Coast Side	Daly City	Fair Oaks	Ravenswood	S. San Francisco	Willow	Unassigned	Total
Ambulatory Care Visit	73.0	72.4	59.1	85.8	90.0	80.5	87.7	66.4	72.2
ER Visit	36.9	13.8	19.2	25.7	20.0	28.6	27.2	30.7	31.3
Prescription	41.2	37.9	53.7	27.7	34.0	44.4	50.9	25.6	41.3
Hospital Admission	3.8	3.5	1.1	1.4	2.0	4.5	6.1	2.2	3.2
Lab/Radiology	38.3	17.2	25.4	32.4	42.0	30.1	36.0	24.1	34.2
N	1098	29	272	148	50	133	114	137	1981

Note: Based on enrollees who initiated coverage between September 2007 and February 2008, and remained enrolled for at least six months.

Appendix D
One-e-App Survey Questions

1. **During the past 12 months, how confident were you that you could get health care if you needed it?**

   Very confident
   Somewhat confident
   Not very confident
   Not at all confident
   Don't know
   Refused

2. **During the past 12 months, how financially difficult was it to meet your health care needs? Would you say…**

   Very difficult
   Somewhat difficult
   Not very difficult
   Not at all difficult
   Don't Know
   Refused

3. **Is there a place that you USUALLY go to when you are sick or need advice about your health?**
   [If the individual answers "Yes," ask "What is the name of that place?"
   If the individual names more than one place, ask "Where do you go most often?"]

   39th Avenue (SMMC) Adult Primary Care Clinic
   Coastside Health Center
   Fair Oaks Adult Clinic
   Mike Nevin (Daly City) Health Center
   Ravenswood Family Health Center-Belle Haven
   Ravenswood Family Health Center-East Palo Alto
   Samaritan House
   South San Francisco Health Center
   Willow Clinic
   SMMC Emergency Room
   Other Emergency Room
   Other Place (Specify:_____)
   No Place
   Don't Know
   Refused

4. [Ask this question only if the individual has a place he/she goes when sick or needing advice about health. Otherwise, choose "Not Applicable (does not have a usual place of care)."]

Do you have a doctor, nurse, or other health provider or team of health providers that you usually see when you go there?

Yes
No
Not Applicable (does not have a usual place of care)
Don't Know
Refused

5. Did you delay or not get a MEDICINE that you or a doctor believed necessary during the past 12 months?

Yes
No
Don't Know
Refused

6. Did you delay or not get CARE from a regular doctor or other health care professional for an illness, accident, or injury when you thought you needed it during the past 12 months?

Yes
No
Don't Know
Refused

7. Have you seen a doctor or any other health care professional such as a physician assistant or nurse during the past 12 months? (Do not include doctors or health professionals you saw during an overnight stay in a hospital or a visit to a hospital emergency room.)

Yes
No
Don't Know
Refused

8. [Ask this question only if the individual saw a doctor or other health care professional. Otherwise, choose "Not Applicable (did not see a health care professional)."]

Sometimes people need to see a specialist, such as a pulmonologist, cardiologist,

endocrinologist, psychiatrist, or other doctor who takes care of special parts of the body. Were any of those visits you just mentioned to see a specialist?

Yes
No
Not Applicable (did not see a health care professional)
Don't Know
Refused

9. **During the past 12 months, how many times have you received care in a hospital emergency room?**

0 times
1 time
2 times
3 times
4 times
5 to 9 times
10 to 14 times
More than 15 times
Don't Know
Refused

10. [Ask this question only if the individual had one or more ER visits in the past 12 months. Otherwise, choose "Not Applicable (no ER visits in past 12 months)."] **Thinking about your MOST RECENT visit, what was the MAIN reason you went to the emergency room instead of somewhere else like a doctor's office or clinic?**

Injured in an accident
Had an urgent medical problem, like a heart attack or stroke
Doctor or nurse told me go to there
No other place open
Pregnancy related
It's where I always go
Do not have a regular doctor or clinic
Some other reason: _____
Not Applicable (no ER visits in past 12 months)
Don't Know
Refused

11. **In general, compared to people your age, is your current health excellent, very good, good, fair, or poor?**

Excellent

Very Good
Good
Fair
Poor
Don't Know
Refused

12. Compared with 12 months ago, is your health better, worse, or about the same?

Better
Worse
About the same
Don't Know
Refused

13. How many days during the past 30 days did poor physical or mental health keep you from doing your usual activities?

0 days
1 day
2 days
3 days
4 days
5 days
6-10 days
11-15 days
16-20 days
21-25 days
26-30 days
Don't Know
Refused

14. Now I'd like to ask you about whether you have ongoing health conditions for which you need to be monitored regularly or for which you often need medical care. Do you have:

Arthritis or rheumatism
Asthma or other lung disease
Diabetes
Heart failure or other heart condition
High cholesterol
High blood pressure or hypertension
Liver disease
Depression
Any other physical or mental health problem (Specify _____)

Don't Know
Refused

15. [Ask this question ONCE if the respondent has any ongoing health conditions. Otherwise, choose "Not Applicable (no chronic condition)."]

During the past 12 months, did you receive routine care (such as checking blood pressure) for these health condition(s) from a doctor, nurse, or other health professional? Please include routine and/or preventive care you received during any visit.

Yes
No
Not Applicable (no chronic condition)
Don't Know
Refused

16. During the past 12 months, was there any time that you did not have any health insurance or coverage?

Yes, there was a time that I did not have health insurance or coverage during the past 12 months.
No, I was enrolled in ACE for the past 12 months.
No, I was enrolled in ACE County (WELL) for the past 12 months.
No, I had other health insurance or coverage during the past 12 months.
Don't Know
Refused