Health System Redesign Initiative Implementation Final Report
April 2009 – March 2010

Background

On March 25, 2008, the Board of Supervisors approved a first-year implementation plan for the Health System Redesign Initiative (Redesign), which had 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 includes: Jean S. Fraser, Chief, San Mateo County Health System; Dr. Susan Ehrlich, CEO, San Mateo Medical Center (SMMC); 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 on the initiative's implementation. The BOS accepted updates on October 28, 2008 and April 14, 2009. This document summarizes the progress achieved within the four priority areas (noted below) targeted by the Redesign effort in its second year that involve the Health System and HPSM. It also includes a summary of all of the aspects of the fifth area, the Community Health Network for the Underserved, involving partnerships with key healthcare provider organizations serving San Mateo County. As the official Redesign Initiative was only slated for two years, this will be the final report.

Discussion

As the Redesign effort began its second year, we identified five areas of priority focus:

1) Eligibility and Administration;
2) ACE Policy and Third Party Administration Implementation;
3) Long-Term Care Integration;
4) Strategic Finance Issues ; and
5) Community Health Network for the Underserved

Within each of these areas, goals and activities aim to improve healthcare access and care coordination for the clients we serve, and improve the County's financial position in healthcare delivery. Listed below are the overall goals and key milestones achieved during the April 2009 through March 2010 timeframe. The Redesign team is also overseeing an external evaluation of efforts to strengthen our health coverage offering

(the ACE program) for the indigent and further work to redesign ambulatory care to advance a chronic care model. Findings from this external evaluation are included as a separate attachment.

Eligibility and Administration

Overall Goals:

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

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

Key Accomplishments and Milestones Achieved Since March 2009:

- In follow-up to first year Redesign Initiative efforts aimed at unifying enrollment and retention work, consolidated the Health System's enrollment and eligibility work within a single unit that includes 32 staff. Achieved BOS approval of the salary ordinance and budget changes necessary as part of the September 29, 2009 final budget changes.

- Achieved Memorandum of Understanding between the newly created Health Coverage Unit and San Mateo Medical Center to outline the areas of distinct and shared responsibility and measures that will be used to track progress.

- Initiated joint Health System – Human Services Agency quarterly leadership meetings to focus on areas of joint priority. Identified areas of action for FY 2009-10 involving data sharing across agencies, direction of enrollment capacity across agencies, opportunities to improve Medi-Cal retention and next steps in assessing the One-e-App model(s) to be furthered. Based on this work, we are implementing recommendations for eligibility/ enrollment redesign between the Health System and HSA within the FY 10-11 recommended budget.

- As part of the external evaluation of efforts to improve access to care, implemented a client survey through the One-e-App health coverage enrollment tool and English and Spanish focus groups at four clinic locations.

- Informed by a workgroup involving ACORN, the Central Labor Council, the Legal Aid Society of San Mateo County, Peninsula Interfaith Action, and Ravenswood Family Health Centers, implemented changes to participant materials, consideration of financial hardship, and appeals process that address areas of joint concern.

- Initiated effort to screen and enroll uninsured clients served through the Behavioral Health and Recovery Services (BHRS) system into Medi-Cal or ACE as a pathway to achieve improved pricing for prescription medications. As of the first week in March, 329 uninsured clients are in-process for Medi-Cal or ACE coverage.

ACE Policy and Third Party Administration Implementation

Overall Goals:

- Assure alignment of ACE policies with Health System responsibilities and priorities

- Achieve successful implementation of Third Party Administration (TPA) agreement with HPSM to fully leverage managed care assets for the ACE program

Key Accomplishments and Milestones Achieved Since March 2009:

- Developed approach for identifying and resolving key policy issues related to clinical, operational and financial aspects of the ACE program, involving Health System and HPSM leadership.

- Established review process for quarterly TPA reports that has unearthed priority issues for follow-up related to enrollment staff training, alignment of pharmacy policies and benchmarks for cost and utilization.

- Expanded HPSM role in ACE cases that are pending Medi-Cal determination to align financial and clinical incentives in managing care during clients' change in payer status.

- Developed proposed changes to Indigent Care policy, in consultation with Legal Aid and other partners, to incorporate improvements that put a ceiling on ACE clients' out-of-pocket payment obligations, and align other processes more closely with Medi-Cal.

- Developed amended TPA agreement between the Health System and HPSM to optimize claiming of federal funding and capitalize on HPSM economies of scale as ACE program enrollment has increased.

- Initiated process improvements in key areas of billing and claims review across SMMC and HPSM to improve results across HPSM lines of business affecting SMMC.

- Through the HPSM eligibility review function of its TPA responsibilities,

identified and facilitated conversion of 524 participants from the ACE program to the Medi-Cal program, which furthers the intent for ACE to serve as the coverage program of last resort.

Long-Term Care Integration

Overall Goals:

- Improved financial incentive alignment for caring for older adults and persons with disabilities in the least restrictive and most appropriate setting.

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

Key Accomplishments and Milestones Achieved Since March 2009:

- Achieved agreement with the State of California for the Health Plan of San Mateo to assume risk and responsibility for Medi-Cal skilled nursing facility (SNF) services, a core component of the Health System's Long-Term Supportive Services vision of a client-centered, coordinated system of care and continuum of services for older adults and persons with disabilities.

- Developed plan for HPSM's rollout of local responsibility for SNF services to achieve successful implementation by February, 2010. This includes successful completion of contracts with 108 facilities, tailored site visits to 10 nursing homes that have provided care for a majority of San Mateo County's Medi-Cal beneficiaries requiring long-term care, and implementation of provider payment practices that are achieving significant improvements in payment timeliness.

- Conducted several meetings with the State Director of Health Care Services and high-level State officials to further prospects for achieving full financial integration of long-term care services at HPSM, to ultimately improve the County's flexibility in addressing the healthcare and support needs of older adults and persons with disabilities.

- Presented results of Aging and Adult Services' Uniform Assessment Tool (UAT) to the BOS Housing, Health and Human Services committee. Initiated plans to expand use of the UAT in other Health System settings.

- Initiated comprehensive assessment (using the UAT) of all clients residing at Burlingame Long-Term Care to inform opportunities to achieve safe community placement.

- Explored models for program design and payment structures that support long-term care integration.

Strategic Financial Issues

Overall Goal:

- Improved County financial position in delivering medical care

Key Accomplishments and Milestones Achieved Since March 2009:

- Implemented workplan for $250,000 technical assistance grant, awarded by The California Endowment to strengthen the financial sustainability of the Health System's delivery system responsibilities.

- Hosted a site visit by the Secretary of Health and Human Services, Director of Health Care Services, and other key State staff as part of their outreach and exploration of models for care management and innovation that could inform the State's development of a new Medicaid 1115 waiver with the Federal Government.

- Convened a Health System/ HPSM workgroup to develop a model for redesigning the California Children's Services (CCS) program in San Mateo County to inform the State's consideration of CCS reform within its 1115 waiver.

- Developed a proposal outlining key elements of priority that could be advanced through the State's 1115 waiver application to contribute to the State's proposal development.

- Developed a proposal for an expanded Inter-Governmental Transfer (IGT) between the County and the federal government to support the County's investment in long-term care services.

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 March 2009:

- 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:

- Secured 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 first deliveries under this redesigned model.
- Completed model for contracting structures involving four OB practices, anesthesiologists and pediatricians practicing in Mid-County; Mills-Peninsula Medical Group, and Health Plan of San Mateo, as well as approval from the Peninsula Health Care District (which is investing $366,000 per year for three years to support participation of mid-County physicians in the CHNU OB network).

- Initiated, through joint planning effort involving Lucile Packard Children's Hospital, Stanford School of Medicine, Ravenswood Family Health Center, Health System and HPSM, an effort to improve pediatric primary care and specialist co-management of patients.

- 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 with Stanford Hospital and Clinics for contracted services to Medi-Cal and ACE clients that aligns with Stanford's tertiary/ quaternary services and the terms and conditions agreed upon by other CHNU hospital participants.

- Secured a two-year $4 million grant from the Sequoia Health Care District to support primary care capacity for low-income, uninsured adults living within the District's boundaries.

- Secured a $4.3 million grant from the Sequoia Health Care District and a $2 million from the Lucile Packard Children's Hospital and the Lucile Packard Foundation for Children's Health to support the capital costs for a consolidated South County clinic facility.

- Achieved an agreement with Palo Alto Medical Foundation (PAMF) to enroll 300 ACE-eligible clients in PAMF's charity care program.

- Supported first steps in establishing sustainable primary care capacity on the Coast, given the closure of the Coastside Family Medical Center, including expansion of pediatric services provided by SMMC. Competed to receive a highly competitive federal stimulus funding grant to fund the capital costs for improving the capacity of the County's coastside clinic.

A summary highlighting the roles of CHNU partners is presented below:

Provider Partners

Partner	Role, Contributions
Sequoia	• Reduced payment rates for ACE to align with Medi-Cal • Expanding OB services to up to 100 low-income women covered by Medi-Cal • Piloting real-time ER data sharing with HPSM to reduce unnecessary ER visits
Seton	• Reduced payment rates for ACE to align with Medi-Cal in some services • Support OB capacity for services to low-income women through the New Life Center • One of the largest Medi-Cal providers serving San Mateo County
Mills-Peninsula Health System	• Reduced payment rates for ACE to align with Medi-Cal • Expanding OB services for 200 to 300 low-income women covered by Medi-Cal • Significant Medi-Cal provider for psychiatry services for San Mateo County
Mills-Peninsula Medical Group	• Expanding OB services for 200-300 low-income women covered by Medi-Cal through network of contracted MDs
Lucile Packard Children's Hospital	• Providing funding for 2.0 FTE SMMC pediatricians for 2-3 years • Providing $2 million in capital support for consolidated South County clinic • Will provide pediatric specialist (endocrine and gastro-enterology) services at SMMC, beginning in FY 2010-11. • Leading efforts to improve care coordination within pediatric safety net • One of the largest Medi-Cal provider for pediatric services for San Mateo County
Palo Alto Medical Foundation	• Expanding OB services to up to 100 low-income women covered by Medi-Cal through employed MDs • Providing eight weeks infectious disease coverage at SMMC • Providing two half-days/ month pediatric neurology services at SMMC • Piloting effort to enroll 300 ACE clients in PAMF charity care program
Kaiser	• Expanding OB services for up to 360 low-income women covered by Medi-Cal, as well as newborn and sibling care • Expanding neurosurgery/spine services to accommodate needs of Medi-Cal/ ACE clients who have SMMC as PCP. Implementation will begin in FY 10-11. • Support health coverage programs for 5,571 low-income children

	• Investing $749,648 (over three years) in SMMC/ RFHC specialty care redesign and $300,000 (over two years) in PHASE initiative
Stanford	• Executed HPSM Medi-Cal contract • Reduced payment rates for ACE to align with Medi-Cal
Ravenswood Family Health Center	• Serving as PCP for 2,682 ACE enrollees, 2,979 Medi-Cal members, 43 HealthWorx members, 271 Healthy Families members, 714 Healthy Kids members and 127 CareAdvantage members
Samaritan House	• Serving as PCP for 40 low-income clients unable to be served by SMMC • Important community-based provider for the San Mateo and RWC communities

Funding Partners

Partner	Role, Contributions
Peninsula Health Care District	• Investing $366,000 per year, for three years ($1.1 million total) to support mid-County OB network • Investing $180,000 in the Samaritan House San Mateo clinic in the current recent fiscal year • Provide $682,000 in annual support for Children's Health Initiative
Sequoia Health Care District	• Investing $2 million per year, for two years ($4 million total) to support SMMC primary care capacity in S. County • Investing $4.3 million in capital support for consolidated SMMC S. County clinic • Investing $250,000 per year for three years to supporting RFHC's South County capacity • Investing $570,000 per year to support the Samaritan House RWC clinic • Provide $1.3 million in annual support for Children's Health Initiative

In addition to the above areas of priority, work continues in areas related to management of complex, chronic disease through efforts targeting specialty access and ambulatory care redesign. Significant milestones include the rollout of an electronic health record across SMMC's clinic sites, completion of the first phase of a major specialty care redesign effort supported by Kaiser Permanente and Kaiser Community Benefit, and implementation of an expanded behavioral health and medicine integration at the SMMC Pain Clinic. Implementation of an electronic health record across the BHRS system is underway, in follow-up to several years of planning and focused provider and staff training.

The Redesign team also initiated cross-System focus on the constrained access to

primary care that has resulted from the significant increases in demand for services that have accompanied the recession. As of this report's writing, there are 5,300 clients awaiting primary care appointments as the recession has resulted in the loss of health insurance coverage and lack of access to regular medical care for a growing segment of the population.

The Redesign team also oversees an external evaluation of efforts to improve access and management of chronic disease being conducted by the Urban Institute, a Washington, DC-based research firm, which received core initial support from The California Endowment. We secured a $200,000 grant from the Blue Shield Foundation of California to augment the evaluation and incorporate a focused component related to cost-effectiveness and health care cost reduction results of our work. The evaluators' second annual report is included as Attachment 1. Key findings highlighted in the Executive Summary include:

"The evaluation reveals strong progress along several dimensions where the redesign efforts and coverage expansions are achieving intended results:

- *Focus group interviews and patient surveys show high satisfaction when care is received from safety net providers.*
- *Clinic staff report improved clinic operations and an increased focus on providing high quality primary care.*
- *ACE enrollees experience dramatic increases in having a usual source of care (48 percentage points increase) and in having a particular doctor or other health care provider they usually see at the usual source of care (51 percentage point increase).*
- *They also experience increases in having a doctor visit in the past 12 months (28 percentage point increase) and, for those with chronic conditions, receiving routine care for their condition (36 percentage point increase).*
- *ACE enrollees' improved health is reflected in a reduction in the proportion who reported having any days within the past month when their activities are limited due to physical or mental health problems (6 percentage point decrease)."*

The report also highlights that: "*The greatest challenge facing SMMC during 2009 was a large increase in demand for services as a result of the recent recession. Enrollment in the county-sponsored coverage program, ACE, doubled between January 2008 and December 2009. During this same time frame there were limited increases in the capacity of the county's safety net clinics, resulting in long waits for clinic appointments.*

The evaluation revealed several other indicators of these capacity constraints:

- *Focus group participants, as well as "secret shoppers" hired by the county, report*

- *Clinics experienced reduced appointment availability just after implementing the EMR during 2009.*

- *Preventive care use was low, while the proportion of enrollees with emergency room visits was high at 41.6 percent, over two times the national rate for uninsured adults ages 18-64.*

Next Steps

While officially the Redesign Initiative has ended its term, the Health System has permanently embedded the leader of the Redesign Initiative into our Executive Team as the Director of Strategic Operations. The Director of Strategic Operations has the charge to continue to identify, examine, and lead teams to address issues that are cross-System and cross-County (including especially HSA and HPSM and our CHNU partners). There are many significant areas of opportunity and challenge coming at us quickly: the unprecedented demands for service due to the recession; the design and implementation of the State's next Medi-Cal waiver, including potential SMC pilots in changes to the CCS and long-tern care programs, and the opportunities and challenges presented by the implementation of federal health reform.

During the past year, in addition to the accomplishments listed above, significant focus was directed toward the budget reductions affecting healthcare and supportive services as well as planning and decision-making related to the County's structural budget deficit. We appreciated the opportunity to enlist CHNU partners' advice as we outlined the potential scenarios that the Health System may face as it addresses declines in local and other revenue sources that support safety net healthcare delivery.

As we conclude the formal Redesign Initiative sponsored by the County Manager, we will continue to advance the important partnerships and cross-System initiatives that are required to sustain our healthcare safety net during a time of increased demands and reduced resources.

Questions about the initiative can be directed to the new Director of Strategic Operations, Srija Srinivasan, at 573.2095, or ssrinivasan@co.sanmateo.ca.us.

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

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THE URBAN INSTITUTE

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Executive Summary

Since early 2008, San Mateo County has undertaken a comprehensive health systems redesign initiative to expand adult health care coverage. This effort is intended to improve access to high quality care for uninsured and underinsured adults and improve the financial sustainability of the San Mateo Medical Center (SMMC) and related delivery systems. This report summarizes the findings from the first 18 months of the Urban Institute's four year evaluation of these efforts.

Health systems redesign in San Mateo County includes four components currently being phased in at primary and specialty care safety net clinics across the Health System and in partnership with Ravenswood Family Health Center:

- Team-based care, to increase efficiency and leverage physician time through the use of other health professionals such as nurses. Patients are seen by the same physician, nurse and clerical staff team each time they visit a clinic.

- Disease management, primarily focusing on diabetes management, including an automated diabetes registry, group visits where diabetes patients learn about self-management, and the use of diabetes retinal cameras to do on-site screenings.

- Advanced Access scheduling to improve patient flow and reduce waiting times for appointments at select clinics. Such an approach allows more patients without an appointment to be seen.

- Electronic Medical Records (EMRs) to increase efficiency and coordination of care.

Some of these changes have been implemented to date. EMR implementation is the most widespread change and has been completed in all SMMC primary care safety net clinics as of the close of 2009.

Adult coverage expansions started in September 2007, when the county received a three-year grant of $7.5 million annually from California's Medi-Cal Hospital Financing Waiver. The county used these funds to expand the existing public coverage program that provides coverage for uninsured adults whose income is less than 200 percent of the federal poverty level. The program was later renamed San Mateo Access and Care for Everyone Program (ACE).

The evaluation reveals strong progress along several dimensions where the redesign efforts and coverage expansions are achieving intended results:

- Focus group interviews and patient surveys show high satisfaction when care is received from safety net providers.

- Clinic staff report improved clinic operations and an increased focus on providing high quality primary care.

- ACE enrollees experience dramatic increases in having a usual source of care (48 percentage point increase) and in having a particular doctor or other health care provider they usually see at the usual source of care (51 percentage point increase).

- They also experience increases in having a doctor visit in the past 12 months (28 percentage point increase) and, for those with chronic conditions, receiving routine care for their condition (36 percentage point increase).

- ACE enrollees' improved health is reflected in a reduction in the proportion who reported having any days within the past month when their activities are limited due to physical or mental health problems (6 percentage point decrease).

Claims data from the Health Plan of San Mateo, the ACE administrator, provide additional evidence of adequate care while enrolled in ACE:

- Among those enrolling in the first year of the program, 83 percent of ACE enrollees have at least one ambulatory care visit during their first year of enrollment.

- HEDIS measures show that ACE exceeds performance standards on almost all areas of diabetes care management.

In addition, the report highlights several challenges to improving care for low-income adults. The greatest challenge facing SMMC during 2009 was a large increase in demand for services as a result of the recent recession. Enrollment in the county-sponsored coverage program, ACE, doubled between January 2008 and December 2009. During this same time frame there were limited increases in the capacity of the county's safety net clinics, resulting in long waits for clinic appointments.

The evaluation revealed several other indicators of these capacity constraints:

- Focus group participants, as well as "secret shoppers" hired by the county, report severe difficulty getting appointments.

- Clinics experienced reduced appointment availability just after implementing the EMR during 2009.

- Preventive care use was low, while the proportion of enrollees with emergency room visits was high at 41.6 percent, over two times the national rate for uninsured adults ages 18-64.

The large increase in enrollment also has strained county finances. Funding for San Mateo County from the state coverage waiver was completely used by January 2010. Since that time, the county has absorbed the cost of covering ACE enrollees, resulting in some limits in who can be enrolled.

The successes and challenges of the San Mateo County Adult Coverage Initiative provide lessons for federal, state, and local governments that seek to improve care for uninsured adults in the new era of federal health care reform. In particular, the findings from the evaluation show that merely expanding coverage is insufficient. It is also necessary to expand the supply of preventive, primary, and specialty care services, as well as to improve the quality and efficiency of services through systems redesign. In the year to come San Mateo County will continue to provide such lessons as it further implements its systems redesign and coverage initiative.

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Introduction

Background

In early 2008, San Mateo County embarked on a path breaking "Health Systems Redesign and Adult Coverage Initiative." This effort is intended to improve the health of county adults who rely on publicly-subsidized health care, as well as to address the financial sustainability of the San Mateo Medical Center (SMMC) system. While the initiative has been officially underway for two years, leaders within the SMMC have been working for several years to achieve many of these same goals.

The initiative is designed to address the needs of lower income county residents who do not have adequate access to health care. While San Mateo County is prosperous relative to many parts of California and the U.S., there are significant income disparities in the county. The 2008 Community Assessment of Health and Quality of Life (Healthy Community Collaborative of San Mateo County, 2008) notes that 16.2 percent of the county's residents have incomes below 200 percent of the federal poverty level ($36,620 for a family of three in 2009), a significant increase from the proportion in 2001 (13.2 percent). The report also reveals the growing racial/ ethnic diversity of the county's population. Today (in 2010) Latinos (25.6 percent) and Asians (25.5 percent) comprise a majority of the county population, with whites and African-Americans at 42.6 percent and 3.6 percent respectively.

In 2008, 15 percent of non-elderly adults (about 67,000 people) were without health insurance in San Mateo County, an increase over previous years. In addition, the availability of job-related health insurance has been declining. This is consistent with the decline in insurance coverage statewide in California (Lavarreda et al., 2010). Likely, the rates of poverty and uninsurance have risen during the recent recession. Low income people and those without health

insurance (significantly overlapping groups) reported substantial barriers to accessing health care in the 2008 Community Assessment survey.

The major source of primary and specialty care for the uninsured, and some publicly-insured, adults in the county is the safety net clinic system which includes six San Mateo Medical Center (SMMC) adult medicine clinics, several SMMC specialty clinics, and Ravenswood Family Health Center (a private community-based, federally-funded "safety net" primary care clinic). Other more limited sources include two free clinics and some private providers.

For inpatient and emergency room care, the major sources of care for the uninsured are the SMMC public hospital, as well as five private non-profit hospitals in the county[1] and Stanford University hospital in nearby Santa Clara County. An analysis of data from the California Office of Statewide Health Planning and Development (OSHPD) by the evaluation team showed that in 2007, 61.7 percent of emergency room visits for San Mateo County uninsured adults were to the SMMC with the remaining visits approximately evenly distributed across the other six hospitals. Inpatient stays for the uninsured were less concentrated at the SMMC (44.3 percent), with private hospitals absorbing a substantial burden, particularly Seton (11.6 percent), Mills-Peninsula (13.8 percent), and Stanford (14.5 percent). The SMMC, Seton, Mills-Peninsula and Stanford hospitals are also the major providers of hospital care for the adult Medi-Cal population.

The current county financial situation is—as with most jurisdictions—very difficult. At the same time that revenues are down, demand for public services and expenditures are on the rise. The county is operating with an overall structural deficit of approximately $150 million. The County Manager established a target of reducing the county general fund subsidy to the SMMC

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[1] The five private non-profit hospitals in San Mateo County are Seton, Mills-Peninsula, Kaiser South San Francisco, Kaiser Redwood City, and Sequoia.

to $50 million by 2013. While the Board of Supervisors removed that target earlier this year, the Fiscal Year 2010-11 budget includes a ten percent reduction in county general fund support to the SMMC.

A Blue Ribbon Task Force (BRTF) established by the County Board of Supervisors recommended in 2008 the following major goals for the systems redesign and coverage initiative:

- Increase access to care for low income adults;
- Improve the financial viability of the SMMC system;
- Leverage all partners (public and private) in providing care to the uninsured and underinsured;
- Implement seamless coordination of care across providers;
- Improve the ease of use of the safety net;
- Expand coverage to all adults (with an ultimate goal of covering 36,000-44,000 adults through the ACE program).

As a means of achieving these goals, the county began contracting with the Health Plan of San Mateo (HPSM)[2] to coordinate care for all those with public coverage (including ACE enrollees). This transition was fully accomplished by January 2009. The county also launched an ambitious effort to implement a redesign of care in its safety net clinics.

These efforts are well-underway at the time of this writing. The initiative has faced numerous challenges, the greatest of which is a difficult financial situation attributable to the 2008-2010 recession that has simultaneously limited the county's resources at the same time that the county faces growing demand for county-funded health services. One consequence has been an earlier-than-expected use of all the funding ($7.5 million per year for three years) which the

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[2] The HPSM is the county-sponsored health plan that manages care for all Medi-Cal enrollees as well as several other coverage programs (www.hpsm.org).

county received under the state's Medi-Cal waiver to cover uninsured adults. In spite of these obstacles, the county is vigorously moving forward with the initiative, as documented below.

The Evaluation of the Health Systems Design and Adult Coverage Initiative

The county contracted with the Urban Institute to conduct a four year evaluation of the Health Systems Redesign and Adult Coverage Initiative. The evaluation[3] is designed to:

1) Assess county efforts to redesign the safety net health system; and

2) Evaluate the ACE (Access to Care for Everyone) coverage program.

This second annual report summarizes the findings from the first 18 months of the evaluation. A previous report (Howell et al., 2009) provides more detail on the activities of the county's Blue Ribbon Task Force that launched these efforts, and on the first six months of the initiative. The report updates those implementation findings, and presents some early findings on the impact of the initiative so far.

The evaluation findings presented in the following sections draw on both qualitative and quantitative data. Data sources include: findings from in-depth interviews in late 2009 with 28 key stakeholders;[4] waiting room observations at three clinics (Fair Oaks, main campus Innovative Care Clinic—ICC, and Willow); focus groups with ACE participants at four clinics (Daly City, Fair Oaks, main campus ICC, and Ravenswood); aggregate data from clinics on satisfaction and waiting times before and after the initiative began; data from a special survey of new and renewing ACE enrollees examining the impact of the program on their access, use of services, and health status; and, aggregate data from the Health Plan of San Mateo on use and cost of ACE services.

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

Redesigning Care at the County Safety Net Clinics

Increasingly, policy makers are recognizing that adequately addressing the needs of adults with complex medical needs is one of the major challenges for both public and private health systems (Wagner et al., 2001). This issue has taken on national and international significance recently (Dentzer, 2010). Caring for such complex patients makes up a large proportion of the care provided in safety net settings. Efforts to improve the quality and efficiency of care in San Mateo County safety net clinics have been underway for some time. Clinic and medical center leadership have been very committed to the redesign process, a key factor in the success of early pilot initiatives, as well as more recent redesign efforts.

Clinic Redesign Implementation

Several tools have been developed to improve the quality and efficiency of care provided in a "Patient Centered Medical Home," including the following:

- Increased efficiency through team-based care, which leverages physician time using other health professionals, and improves care coordination through assignment of each patient to a single team;
- Disease management for selected highly prevalent chronic conditions (eg., diabetes), including tracking through disease registries, increased patient education, and other strategies;
- Greater efficiency in appointment scheduling in order to reduce waiting times for appointments, time spent at the appointment, and no show rates;
- Use of Electronic Medical Records (EMRs).

Efforts are underway in San Mateo County to implement each of these four components in safety net clinics.

Team-based Care. Beginning in 2004, each of the San Mateo County safety net adult medicine primary care clinics has participated in one or more pilot efforts to implement "team-based care." In late 2004, using a grant from the California Health care Foundation and internal funding, the county contracted with Roger Coleman and Associates[5] to receive training in improving ambulatory care. This effort coincided with the participation of a number of California's public hospitals in similar redesign projects under the auspices of the Safety Net Institute[6] (also using the help of the Coleman group). Three SMMC adult medicine primary care clinics—Daly City, Fair Oaks, and Willow—began participating in these pilot initiatives in 2004. The Main campus adult medicine clinic (now called the "Innovative Care Clinic" —ICC) received similar training approximately two years later in 2006.

The Coleman redesign program at SMMC primary care clinics lasted approximately six months, and involved teams of personnel from each of the four clinics. Training focused on developing teams—made up of clinical, administrative, and supervisory staff—all of whom participated in intensive group learning sessions with Coleman trainers. All members of the patient care team, including physicians, had to be willing to change their customary work patterns in the interest of improving the patient experience. The format was tailored to the needs of the individual clinic sites, but always included certain key elements: flexible work roles; consistent patient care teams involving provider, nursing, and front desk staff; the use of walkie-talkies for communication among team members; and previewing patient charts and registration forms so that as much paperwork as possible is completed before the patient is actually in the clinic.

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[5] The Coleman group's website contains information about its clinic redesign projects throughout the United States (www.patientvisitredesign.com).

[6] The Safety Net Institute is affiliated with the California Association of Public Hospitals.

For example, the Daly City clinic has been functioning with team-based care for over five years, having transitioned to this care model under the Coleman redesign effort. Within their team-based care model, Daly City is emphasizing role flexibility, for example, using nurses to assess patient needs without requiring a physician visit. The Fair Oaks clinic initiated team care before the Coleman redesign (with some variations on the Coleman model). The Ravenswood Family Health Center also adopted a similar initiative over the past three years. Similar to the team-based model implemented in SMMC clinics, Ravenswood has teams (called "pods") of individuals that know the patient, including a physician, an RN, and a member of the clerical staff.

Team-based care has not been implemented in all SMMC clinics. For example, the Willow clinic tried team-based care about five years ago, but the concept was not embraced by staff. We were told that clinic staff felt that they did not have enough personnel to adopt the model.

Disease Management. The prevalence of chronic conditions is high among the adult patients seen at the San Mateo County safety net clinics. The county has undertaken several disease management efforts that were already underway at the time the BRTF recommendations went into effect. The Daly City and Fair Oaks clinics began improving care co-ordination for patients with diabetes in 2004, through the Study of Effective and Efficient Diabetic Care Project (SEED). The SEED project was a collaboration between public hospitals in California, sponsored by the Safety Net Institute. The approach includes the use of an automated diabetes registry (using CDEMS software in the SMMC clinics), as well as group visits for diabetes patients that include patient education on self-management. County clinics continue to build and expand on those pilot efforts.

The disease management programs vary somewhat from clinic to clinic. For example, at the Daly City clinic the group visits are held in English, Tagalog, and Spanish, the primary languages spoken by the Daly City Clinic patient community. The Fair Oaks program has a diabetes care program which is run in conjunction with a community based organization (El Concilio of San Mateo County). Jointly they operate professional outreach services, a case management unit, and diabetes screenings. In site visits to clinics, we heard from clinic staff that group visits are a particularly successful strategy, and the ICC and Daly City clinics have recently expanded the number of group visits they offer. The Daly City, Willow and Innovative Care Clinics have also acquired diabetes retinal cameras to do on-site screenings.

These disease management programs are beginning to focus on other chronic conditions, including hypertension and obesity.

Advanced Access Scheduling. The demand for care at the San Mateo County safety net clinics is extremely high, and patients—especially new patients—must wait months for an appointment. Reportedly, this results in delayed care, missed appointments ("no shows"), and unnecessary use of emergency room services. One solution that has been tried in other places is "advanced access" appointment scheduling. 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).

The "Optimizing Primary Care" initiative began in June 2007 at the Ravenswood Family Health Center, and is sponsored by the federal Health Resources and Services Administration, through a grant to the California Primary Care Association. The association provided all member 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 much of the schedule 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 seen, an attempt is made to schedule any deferred appointments within at least 30 days of when the patient calls, preferably within two weeks. However, these procedures apply only to "established" patients. Because of limited capacity, Ravenswood is accepting very few new patients.

Both the ICC and the Daly City clinic have had a goal of implementing advanced access appointment scheduling, but neither has yet been able to implement this component. Clinic staff report that implementing advanced access correctly 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. However, they do not yet have enough data to measure the number of patients seen over a year by each team, statistics that are only just becoming available through implementation of the EMR.

Another approach to appointment scheduling to improve efficiency has been adopted at the Willow clinic. All new and returning patients at Willow are required to attend a mandatory orientation called the "Appointment Management Program." The main purpose of this program is to reduce "no show" rates, which were very high prior to the program. The mandatory one hour class (held in the late afternoons/early evenings) covers the importance of attending appointments, chronic care management, establishing a relationship with a doctor, and how to complete needed paperwork. According to clinic staff, in most cases an appointment can be scheduled at the orientation for the next day or some time shortly thereafter. The clinic no show

rate dropped dramatically after this approach was implemented. Willow also operates an unscheduled urgent care clinic all day on Monday and on the afternoons of other week-days.

To address the difficulty faced by patients seeking appointments for urgent health problems at the ICC, and to avoid overuse of the SMMC emergency room, in September 2009 the county opened an urgent care clinic at the main campus site. The clinic is co-located with the surgical specialty clinic, and is open five days a week from 1 to 9 pm. It is staffed by a physician, nurse, and administrative staff person. Since opening, the clinic has operated at capacity of 25 patients per day, and has experienced 2675 visits through March. This new clinic is providing an alternative to the emergency room for many new patients. However, while the clinic has relieved pressure on the emergency room, it has not yet had a marked impact on the length of time patients wait for appointments in primary care clinics.

Electronic Medical Record (EMR). All adult medicine clinics in the SMMC system are implementing an electronic medical record system, becoming the first public system in California to adopt such technology. The first among the county's clinics to adopt the EMR, the ICC, began transitioning to the EMR in April, 2009. The county's EMR software product is called eClinical Works (eCW). During this transition, the ICC deliberately reduced the number of scheduled appointments at the clinic, in order to allow time for provider training on the new system. For the first two weeks, the ICC functioned at 50 percent of capacity, and during the next month it operated at 75 percent of capacity. At the time of our site visit in August, the ICC was still operating somewhat below capacity.

Daly City was the second clinic in the county to implement the EMR, which went live at the clinic in May 2009. By the end of July they were back to operating at 90 percent capacity. Fair Oaks began using the EMR in June, and implementation was close to complete by our August

site visit. The Willow clinic began implementing the EMR in August. By the end of 2009, the EMR system was running in all SMMC adult medicine clinics, and implementation was beginning in the SMMC specialty clinics.

Ravenswood also has had plans to implement an Electronic Medical Record. However, the clinic has not been able to do this due to funding constraints. This opens up the possibility of having Ravenswood implement the same EMR software as the SMMC clinics, which would facilitate seamless communication between the county safety net clinics.

The ICC and Specialty Care Systems Redesign Experience in 2009. The newly-named Innovative Care Clinic (ICC) has been the focus of recent clinic redesign efforts in 2009, receiving a substantial portion of the county's coverage initiative funding to implement the full primary care redesign model. The ICC is the largest of the SMMC adult medicine clinics. Following some initial delays and revised expectations, the redesigned ICC was officially launched in early 2009. To implement the redesign, the ICC hired new staff—including one physician, one nurse, one pharmacist, one medical assistant, and one clerk—and reconfigured the space to support team-based care. The staff has been organized into three teams, which entails assigning a panel of patients to a specific physician-led team that is responsible for all aspects of the patients' care including scheduling, prescribing, follow-up, referrals, and care management. Each team consists of two physicians, one nurse, two medical assistants, and one clerk. Within this structure, the non-physician staff is given additional case management and troubleshooting responsibilities. In conjunction with efforts to promote role flexibility, training is provided for nurses and medical assistants who are being asked to take on more responsibility. According to clinic leadership, feedback regarding these efforts has been positive, and the training events have been well attended.

The ICC was originally planned as a new and separate space that would require a referral from the adult medicine clinic, and would focus on a smaller panel of chronically ill patients. Due to space and staffing constraints, it was not possible to establish two separate clinics. Instead, the ICC replaced the adult medicine clinic and occupies renovated space where the adult medicine clinic was located. All adult medicine patients at the main campus clinic are now ICC patients. The clinic, in its new form, is fully operational. However, as a result of implementation of the EMR some of the progress associated with clinic redesign at the ICC has been slowed or deferred, particularly advanced access scheduling.

In our interviews with staff at other SMMC clinics, most viewed the redesign activities in 2009 to be concentrated at the ICC rather than at their clinics, since they have not received additional funds for redesign. (The exception is the EMR implementation, which occurred in all clinics in 2009.) However, as outlined above, most of the clinics have participated in at least one component of systems redesign in prior years.

The SMMC specialty clinics[7] on the main campus are also undergoing a redesign process with funding from the Kaiser Permanente Community Benefit Program. Ravenswood is also a partner in this effort. This Specialty Care Access Initiative grant began December 2009, with a goal of improving specialty care access by reducing waiting times for appointments, decreasing waiting times at the clinic ("cycle times"), and improving staff and patient satisfaction. Coleman Associates is providing technical assistance for the initiative, which includes a plan to create patient care teams. The specialty clinics are also improving the design of the patient registration process (including placing a Community Health Advocate—CHA—in the registration area) and re-configuring the specialty care waiting room space. It is too soon to know definitively what

[7] Specialties include cardiology, dermatology, endocrinology, ENT, gastroenterology, general surgery, nephrology, neurology, neurosurgery, oncology, ophthalmology, orthopedics, plastic surgery, podiatry, pulmonology, rheumatology, vascular surgery, and urology.

the outcomes will be from these efforts, most of which are just getting underway in early 2010, but specialty clinic staff report that no show rates and cycle times have already improved.

Access to Safety Net Clinic Care. Given the increased demand for care, our site visit respondents agreed that there are serious problems with access to care in the San Mateo safety net primary and specialty care clinics that impede the county from achieving its goals of improved access to care by fully implementing systems redesign. In particular it is very difficult for patients—especially new patients—to obtain an appointment for primary or specialty care. For example, the ICC reports having nearly 2000 people on the wait list for appointments for new patients— almost as many as all of the other county clinics combined. We were told that waiting times for new patient appointments were from four to six months at the ICC, and three months for returning patients.

This access problem was evident in the most recent "Secret Shopper" survey conducted by the Health Plan of San Mateo. When posing as an ACE patient who was requesting an appointment at each clinic, the secret shoppers were consistently turned down for an appointment in early fall 2009. The only place where they could have obtained an appointment was at the Willow clinic, where the wait was one month for the orientation and two more months for a medical appointment. (This contrasts with the information obtained from clinic staff who said appointments were more readily available.) No other clinic agreed to make an appointment for the secret shopper.

The problem is also clear in the reports of grievances to the HPSM. In the period September 1, 2008 to August 31, 2009, the plan received 16 complaints, just over one per month (which suggests generally good satisfaction overall). However, of these, 10—over half—related

to two problems: getting appointments and getting prescription refills when the patient was unable to be seen through an appointment.

These impressions of access to care problems were also highlighted in our waiting room observations. We observed generally improved flow in the waiting rooms when compared to our observations during a site visit the previous year (with shorter waiting times once a patient arrived). However, we again observed barriers to appointments. In one waiting room, a patient came directly from the emergency room, having been told to go to the clinic to make an appointment for follow-up care. The patient was turned away and told that there were no currently available appointments for new patients. (The patient was put on a waiting list.) A second example occurred in a different clinic. A patient came in to make an appointment for a pap smear; she was told to call back to make the appointment which would likely be in November. (This was in early August.) Thus, in our brief observations in three waiting rooms we observed two situations where patients deferred needed primary care for a substantial time period.

While this problem is widely recognized, safety net primary care providers are encountering formidable challenges to improving access to appointments. One factor is the economic downturn, which is creating greater demand for safety net services. At the same time, the economy is limiting the availability of public and private charitable funds that might be used to expand space or staff. For example, plans to expand services at the Daly City clinic are on hold due to limited county funding for such efforts, and the fund-raising for an expansion at Ravenswood has been slower than expected. Another major factor is the implementation of the EMR, which temporarily reduced capacity throughout 2009, as indicated earlier.

Clinic Staff and Patient Impressions of Systems Redesign

The success of pilot redesign efforts was reflected in favorable comments by staff during our site visit interviews and clinic observations. Staff commented that improved clinic work flow caused a culture shift, encouraging them to focus more intently on providing high quality primary care to patients. In addition, the positive publicity from the initial pilot redesign initiatives generated interest in replicating the process among clinics that did not initially participate.

The SMMC staff reports that, in general, the transition to the EMR went fairly smoothly, that everyone is using it, and that staff resistance has been minimal. However, in our site visit we observed that some functionality was not yet properly up and running; the greatest challenge was felt among the medical assistants, who were not as comfortable working with computers as some other staff. For example, during clinic observations, we witnessed some frustration with regard to EMR prescription ordering functions. (Many were still working to understand the EMR process at that time.)

It is clear that the various components of the systems redesign efforts are closely intertwined, and that the EMR implementation slowed the other initiative efforts during 2009. For example, as shown later in this report, cycle times (total time between a client entering the clinic and leaving after being seen) are still high, a phenomenon attributed to the EMR implementation. Clinic staff are hopeful that the EMR implementation is now complete, and that they can turn to other aspects of systems redesign in 2010.

In order to gauge patient satisfaction with coverage and care provided in the San Mateo County health system, we conducted four focus groups in September 2009.[8] The focus groups generated quite a bit of frank discussion regarding both appreciation for the program and frustrations with access to care. Concerns voiced by participants varied greatly (though seemed to cluster by location—likely as a result of participants hearing and reacting to what others were concerned about).

Obtaining appointments in a timely manner was cited as a common challenge among focus group participants. Reporting four-month wait times to make an appointment, respondents agreed that urgent care appointments were not an option.

> **If you need an emergency appointment, like if you have the flu or something, you can forget about it!**

Experiencing long wait times to get appointments at their primary care providers, respondents report being told to go to the emergency room for urgent care, or opting themselves to go to there in order to avoid the frustrations they experience trying to be seen at the clinic.

> **In my case, I go straight to the ER, like one time…I didn't bother to just call them [the clinic] because they give you a long time to wait for an appointment.**

Long wait times have also functioned as a deterrent for some in seeking care. Feeling discouraged by how difficult it is to obtain an appointment, some have stopped seeking preventive care. This is consistent with the deterrents to preventive/primary care that we observed in the waiting rooms.

Focus groups reveal that most people are generally very satisfied with care received in safety net clinics, once they have an appointment. One woman offered:

[8] Additional feedback on the ACE program from focus groups is presented later in this report. A second round of focus groups is planned for late spring/early summer of 2010. More information on the design and recruitment for the focus groups is contained in Appendix C.

> **I think they are very professional. My husband goes to *[named a private provider]*… this one is better.**

Another focus group participant boasted about the attentive care she received at her primary care clinic:

> **My doctor and the services are excellent…She used to call me up and find out about my condition, and then she found out that I am really not in good shape, and she tried to call me at home and tried to follow up on my condition…she really care[s] about my condition.**

However, there were some exceptions to this generally high satisfaction. One respondent reported typically being satisfied with the care received, but recently feeling rushed, perhaps due to the increased pressure on providers to see more patients:

> **I have a primary doctor and she is usually good, but the last time I saw her it was just 5 minutes in and out. She said "I have a lot of people waiting for me". Very rushed, didn't even check me out….She just wrote a prescription and said I got to go, I have people waiting….Usually she does well, but this time it was different.**

One person mentioned the "new approach" to primary care, citing phone consultations with the doctor. The respondent is generally satisfied with this, but adds skeptically:

> **What do they know about your health if they are not even willing to look at you?**

There is less overall satisfaction with support staff than with medical staff. While some support staff stand out as particularly helpful and kind, many report being frustrated with the lack of courtesy or politeness they experience with support staff in the clinics, citing impatience and rudeness:

> **They are consistently rude. The counter staff has been so disrespectful to some of the people standing…in line.**

Someone added:

> **They look at me and say: "What do you want? What time is your appointment? You are early." You have paid and you are sick, and you are going to get that treatment like that. That is depressing.**

These less favorable comments from patients, who were generally satisfied with many aspects of their care, came during a period of severe capacity constraints as documented above.

Quantitative Data on Systems Redesign Outcomes

Clinic Productivity. Clinic productivity can be measured by the number of patient visits to the clinic in a given period of time.[9] Table 1 shows the number of visits to each of the adult primary care and specialty care clinics in two time periods: July to December, 2008 (just before the ICC clinic redesign activities began) and July to December, 2009. As shown, the number of visits to the ICC and to the Daly City clinic went up slightly during the period, but visits to the other clinics declined, leading to an overall decline from 62,134 visits over the last six months of 2008 to 60,251 visits in the same period of 2009. This was the period in which the EMR implementation was well underway, when demand for visits was increasing through new ACE enrollment (see below), and when the H1N1 flu epidemic was placing additional strains on the system. Consequently, consistent with data presented later in the report, there were severe capacity constraints in the clinics resulting in reduced access to appointments and high unmet need for some patients.

Cycle Times and Patient Satisfaction. During the period of initial implementation of pilot systems redesign activities in several clinics, SMMC began monitoring the outcomes of these new efforts using selected quantitative measures, including cycle times and patient satisfaction.

[9] This measure is limited, since it does not adjust for any changes over time in the number of providers or in the case mix of patients at the clinic.

Table 1
Adult Clinic Visits, San Mateo Medical Center
July-December, 2008 and July-December, 2009

Clinic	Visits 2008		Visits 2009	
	Number	Percent	Number	Percent
Primary Care:				
Coastside	1,263	2.0	1,283	2.1
Daly City	7,255	11.7	7,879	13.1
Fair Oaks	8,961	14.4	7,882	13.1
Main Campus Primary Care (now ICC)	10,920	17.6	11,823	19.6
South San Franciso	3,512	5.7	3,534	5.9
Willow	9,535	15.5	7,814	13.0
Subtotal, Primary Care	41,446	66.7	40,215	66.8
Specialty Care:				
Main Campus Medical Specialty	9,149	14.7	8,961	14.8
Main Campus, Surgical Specialty	11,539	18.6	11,075	18.4
Subtotal, Specialty Care	20,688	33.3	20,036	33.2
Total	**62,134**	**100.0**	**60,251**	**100.0**

Source: SMMC Board Reports for February 2009 and 2010

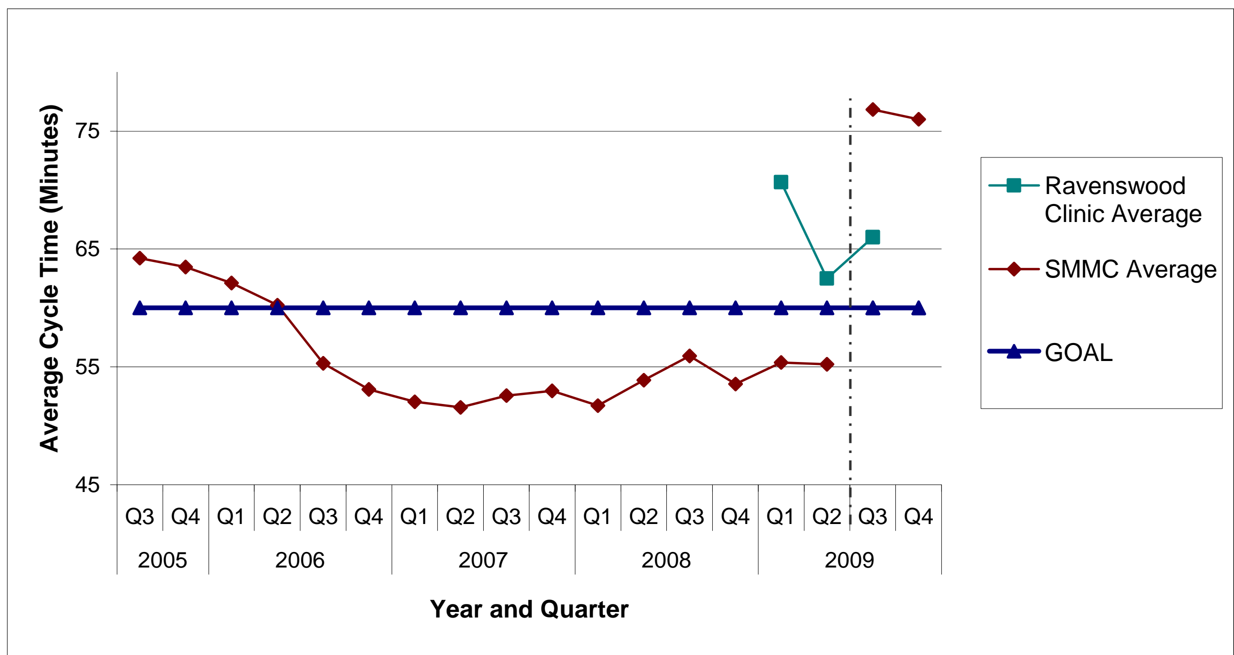
The Ravenswood clinic collects similar data.[10] More recently, the SMMC specialty clinics have also been collecting data on cycle times, the length of time from a referral to a specialty clinic appointment, and no show rates. During this period there were significant changes in data collection. Prior to July 2009, all cycle time data were manually tallied; since that time all data are recorded through the EMR system. A goal of a "cycle time" (the time from when the patient registers to when the patient leaves the clinic) of 60 minutes has been established for the SMMC clinics.

Cycle time data for the SMMC primary care clinics are presented in Figure 1, covering the third quarter of 2005 through 2009. The average cycle time reported for all of the SMMC clinics

[10] Methods of collecting and tabulating data differ somewhat across clinics, and definitions are not entirely uniform.

from the third quarter of 2005 through the second quarter of 2009 (a period when data were tabulated manually) is at or below the goal (60 minutes). Cycle times during the third and fourth quarters of 2009, a period when the data were recorded automatically, were higher than in earlier periods of manual data collection. This jump in cycle times in late 2009 is likely due both to the change in reporting (with a downward bias in manually-reported data), as well as an increase in cycle times due to increased demand on clinics and the decreased appointment capacity during implementation of the EMR.

Figure 1
Average Cycle Time at SMMC Primary Care Clinics, Q3 2005 - Q4 2009



Source: SMMC Quality of Care Committee
Note: Cycle time is the length of time from when the patient registers to when the patient leaves the clinic.

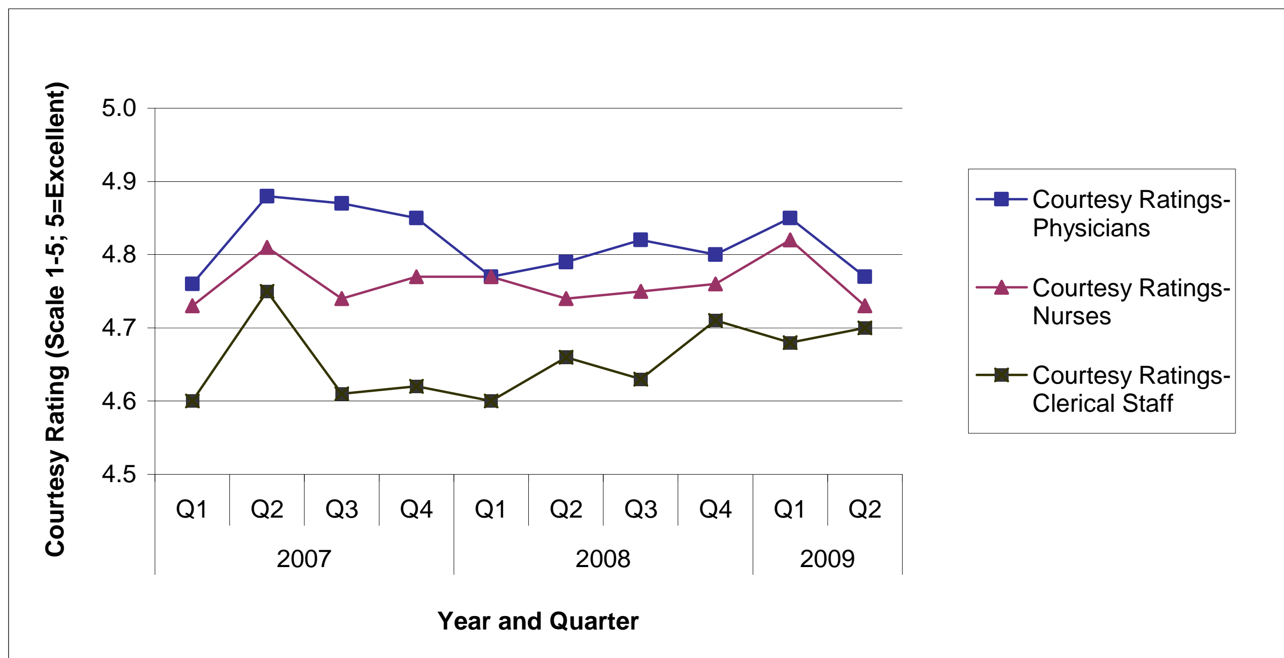
Ravenswood Family Health Center data are only available for three quarters of 2009. Ravenswood collects cycle times one week per month using a semi-automated method with time stamps at check-in and at each stage of the appointment. During this reporting period, the Ravenswood clinic cycle time average was also substantially above the goal established for SMMC (Figure 1), although somewhat lower than the SMMC average in late 2009. This shows that even with advanced access scheduling, cycle times remain high at Ravenswood.

Data on patient satisfaction are collected at all SMMC clinics and at Ravenswood. Most clinics use a brief uniform survey with four questions that a sample of patients is requested to complete before they leave a clinic. The main campus ICC implemented a new patient satisfaction survey in January 2009, which captures the same basic measures as the original survey, but is more extensive. The patient satisfaction survey used by the majority of clinics focuses on the extent to which the patient found the physician, nursing, or clerical services individually courteous. The survey also asks for an overall rating of the clinic (excellent, good, OK, poor, or unacceptable). The ICC's courtesy measure solicits opinions about the staff overall and does not distinguish between types of staff. The ICC patient satisfaction survey is also given to established patients, unlike the other clinics, which distribute the surveys to both new and established patients.

Varying methods are used for selecting patients to complete the surveys across clinics. In all cases, data are collected on a sample of patients. Some clinics are more selective in choosing the sample while others are more random. The staff member who administers the survey to the patient also varies.

Figure 2[11] shows, on a five-point scale, that patients appear to be relatively satisfied with the clinics overall, with some minor fluctuations from quarter to quarter. Patients tend to find physicians most courteous. Nurses' courtesy ratings are only slightly below physicians, both hovering around 4.8 on a 5 point scale. While differences are small, clerical staff is consistently rated as the least courteous among the three groups over time.

Figure 2
Patient Satisfaction with Staff in SMMC Primary Care Clinics, Q1 2007 - Q2 2009



Source: SMMC Qualilty of Care Committee

Figure 3 shows the variation over time in the extent to which patients rate the care at the clinics overall as excellent or good. Most patients rate their care very highly, with some increase

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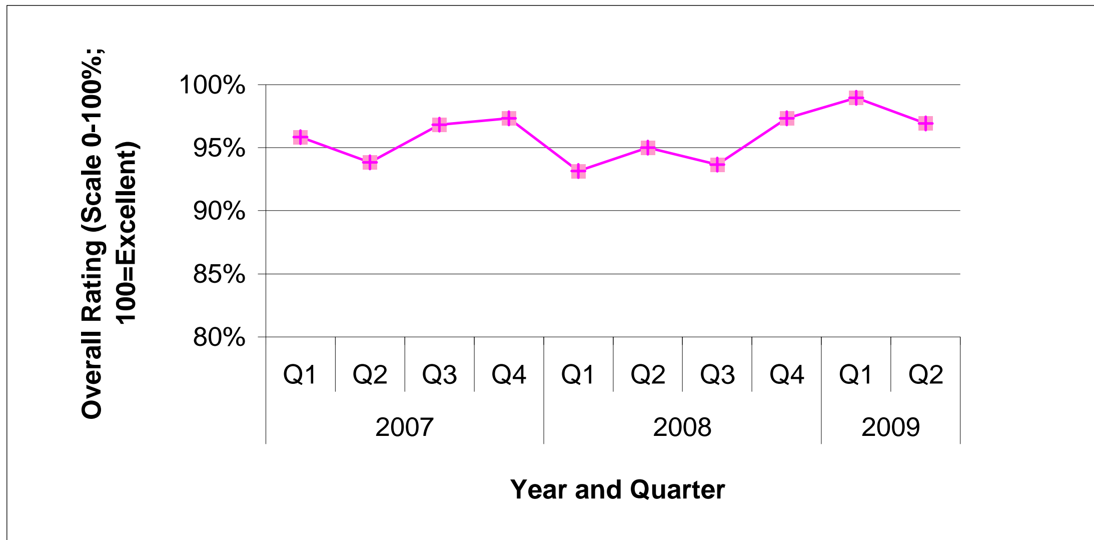
[11] These data are an average of satisfaction data for all SMMC clinics, including the ICC.

in early 2009 as systems redesign began at the ICC. Close to 95 percent or more of respondents rate their care as good or excellent throughout the period.

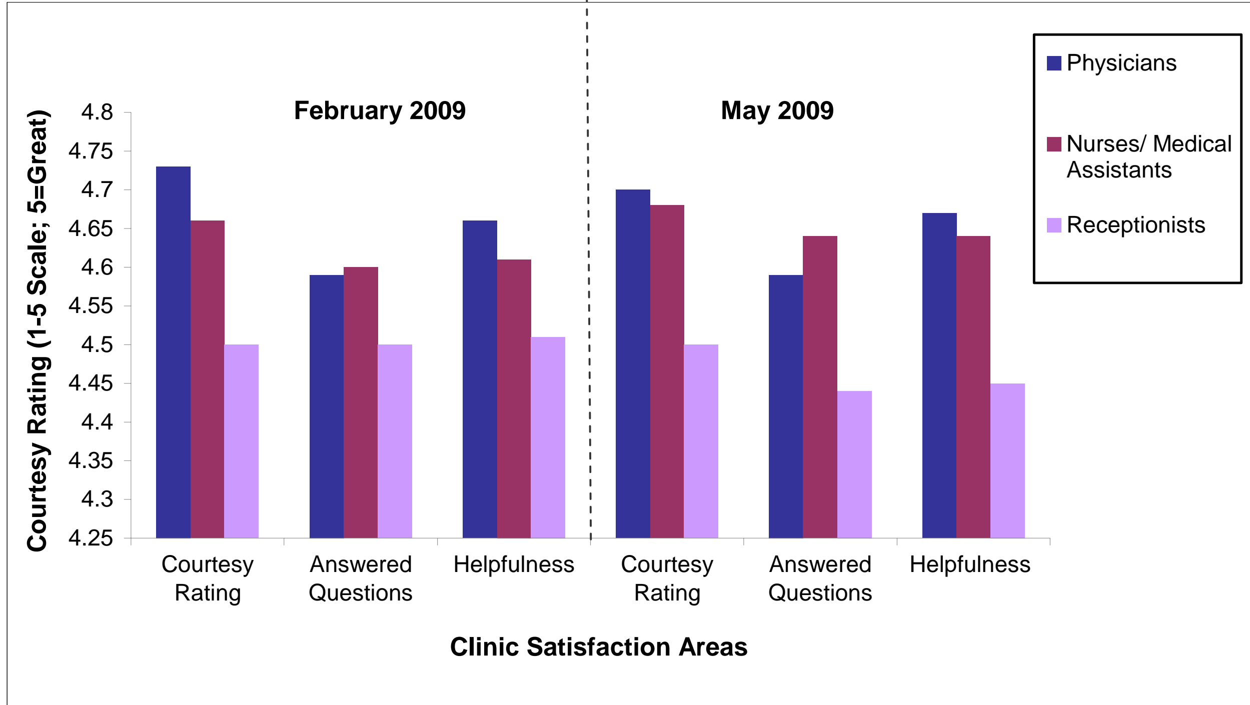
Figure 3
Percent of Patients Rating Care at SMMC Clinics as Excellent or Good
Q1 2007 - Q3 2009



Source: SMMC Quality of Care Committee

Ravenswood uses a different patient satisfaction survey with somewhat different measures. However, based on their instrument, patient satisfaction at Ravenswood also is quite high (see Figure 4). Patients are asked if the physicians/nurses and medical assistants/clerical staff are doing great or good with respect to being courteous/helpful/respectful. As in the SMMC clinics, clinical staff are rated more highly than administrative staff, although differences remain slight.

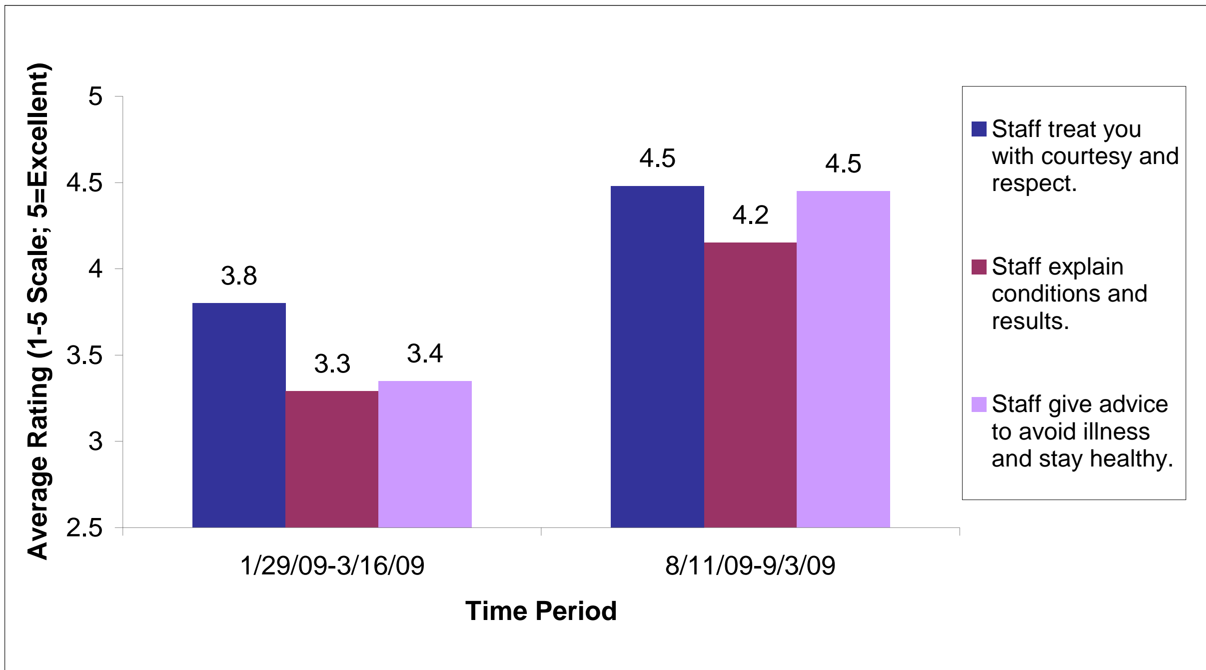
Figure 4
Ravenswood Clinic Patient Satisfaction, February and May 2009



Source: Ravenswood Family Health Center

Figure 5 shows more detail on satisfaction at the Innovative Care Clinic during 2009. Satisfaction scores are also high and rose during 2009, in spite of the strains on clinic capacity during this time. Recall that these questions are asked only of established patients, for whom access problems are not as severe.

Figure 5
Innovative Care Clinic, Patient Satisfaction Clinic Average



Source: Innovative Care Clinic

The Access and Care for Everyone (ACE) Program

ACE Program Description

San Mateo County is one of ten California counties to receive a Health Coverage Initiative grant through the state's Hospital Financing Waiver. This grant, awarded in September 2007, provides the county with $7.5 million annually for three years, enabling coverage for low-income adults who would not otherwise qualify for public insurance. This program, named the San Mateo Access and Care for Everyone program (ACE), helps to finance the county's adult coverage initiative including some of the systems redesign activities at the ICC. While the state-wide waiver does not expire until September, 2010, the San Mateo County funding was spent by January, 2010. The county has absorbed the full cost of ACE enrollees since that time. The state has applied to extend the waiver beginning in fall, 2010. If it is approved, this will re-establish federal funding for those that qualify.

ACE replaces a portion of the county-funded coverage program called WELL, which was in place for two decades and also extends access to some whose assets exceed the former asset limit for WELL. The initial group of ACE enrollees—called "ACE" in the rest of this report—includes documented individuals, the only group that could be covered under the federal waiver. ACE enrollment began in September 2007. During the period September, 2007 to December, 2008, the WELL program remained in place and covered undocumented uninsured adults. Beginning in January, 2009 WELL was renamed "ACE County." Eligibility rules, benefits, co-payments, and care co-ordination are the same for both ACE and ACE County enrollees, that is for both documented and undocumented adults, respectively.

Enrollment in ACE and ACE County. The enrollment process is identical for both ACE programs, but the eligibility criteria for ACE and ACE County differ. Low-income (<200

percent of the FPL) uninsured adults (ages 19-64), who reside in San Mateo County and are legal permanent residents or U.S. citizens, are eligible to enroll in ACE. These ACE applicants must formally submit documentation to meet the DRA (Deficit Reduction Act) test of citizenship that is applied to Medi-Cal applicants, a process that creates some barriers to enrollment for this group. 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 after having had employer-sponsored coverage before becoming eligible for ACE.

ACE County does not require citizenship or permanent residence documentation for enrollment, and is open to a broader age range (e.g., the elderly). In addition, it does impose an asset test (under $2,000 in assets), which ACE does not.

Individuals who are in the income range 200-400 percent of the FPL may qualify for the county discounted health care program. These individuals receive a 65 percent reduction in charges for county health services, in alignment with state law (AB 774) that addresses the charity care requirements for nonprofit hospitals.

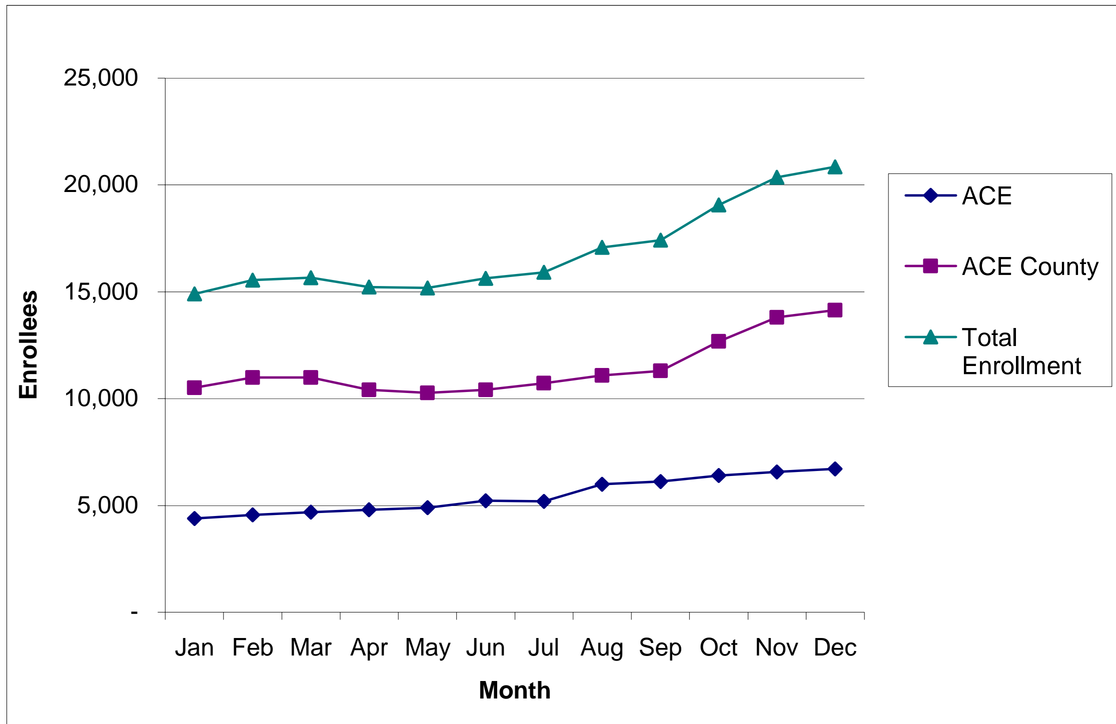
Patients are enrolled in ACE with the assistance of Community Health Advocates (CHAs). An on-line enrollment system called One-e-App, initially developed for the county's children's coverage programs, is used for enrollment in ACE and ACE County. This is done during a face-to-face session with a CHA. Each clinic (and some other sites such as free clinics and community locations) has a CHA on site to provide enrollment assistance. As part of the redesign effort, all CHAs are now centrally managed by county health system staff.

When ACE enrollment began in September 2007, the WELL (now ACE County) program had about 10,000 enrollees—a number that had been stable for some time. Enrollment in ACE

began growing rapidly, reaching about 4,000 by mid-2008. There was a concomitant (but not fully offsetting) decline in WELL enrollment to about 9,000 enrollees (Howell et al., 2009).

Figure 6 shows trends in enrollment in ACE and ACE County (renamed from WELL) throughout 2009. It shows that ACE began the year with about 4,500 enrollees and ACE County (formerly WELL) enrollment was just over 10,000 enrollees. However, as the recession deepened, enrollment in both programs climbed precipitously throughout the year, reaching 6,715 for ACE (an increase of 52.9 percent over the year) and 14,136 for ACE County (an increase of 34.5 percent). Thus enrollment in county-sponsored coverage doubled from January 2008 to December 2009.

Figure 6
ACE and ACE County Enrollment Trends in 2009



Source: Health Plan of San Mateo

This dramatic growth—without substantial increases in the supply of services for these enrollees—largely explains the prevalent access problems described above for these growing coverage groups, who are enrolled in a program with a limited network of providers. Given financial constraints, aside from the modest staffing expansions in the ICC financed by the coverage initiative grant, the SMMC system has not had the resources to increase capacity along with the increased demand.

Rapid enrollment growth has greatly increased the workload of the CHAs. Often they cannot see all clients needing help with enrollment in a day, reportedly sometimes as many as 40 people. The financial challenges facing the county and decreased philanthropic support for outreach and enrollment has necessitated reductions in CHA capacity while application numbers have increased. An electronic scheduling tool that is part of the EMR software has helped to manage this influx of clients.

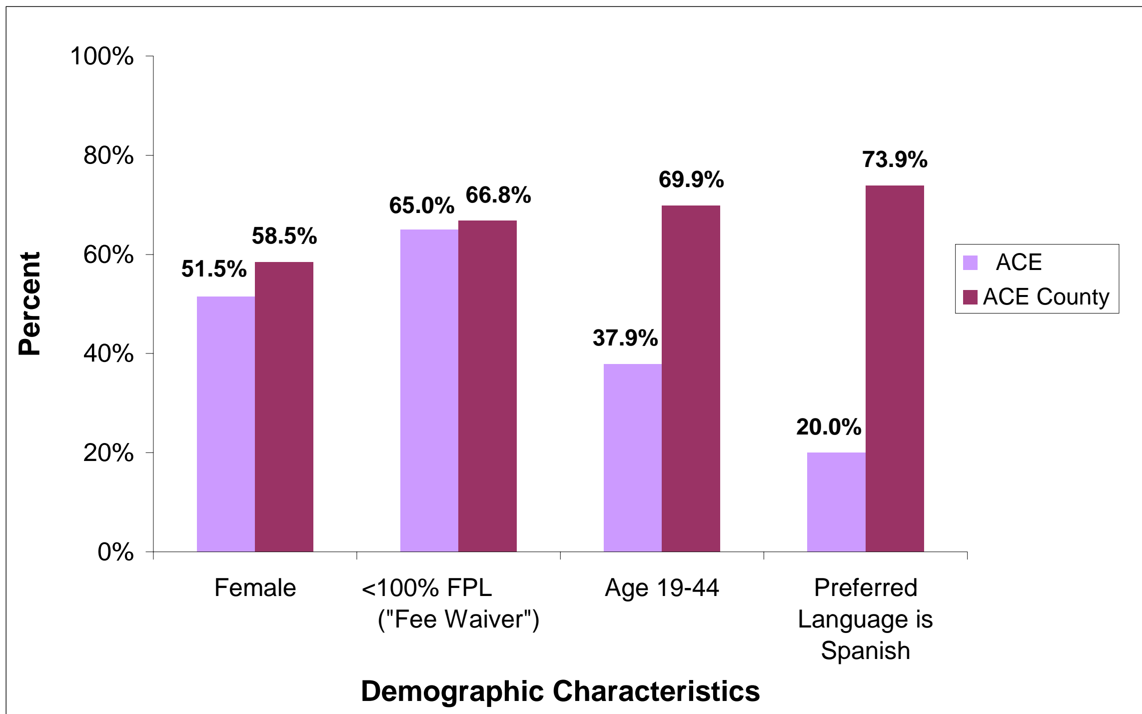
The CHAs are seeing more people who have recently lost jobs and consequently health coverage. While the situation is distressing, it has had some benefits. The CHAs perceive that the help they provide has resulted in an improved public perception of county health care services. The CHA team, too, is pursuing areas of service redesign, to streamline client waits for health coverage screening and enrollment.

The demographic characteristics of ACE and ACE County enrollees in late 2009 are shown in Figure 7. A slight majority of both groups is female, and about two-thirds of both groups are below 100 percent of the federal poverty level (and thus are exempt from cost sharing). However, the ACE and ACE County enrollees differ in age, with the ACE County group being much younger, with about two-thirds between 19 and 44 (in contrast to only a third of ACE

enrollees in that younger age group). In addition, only a fifth of ACE enrollees have Spanish as their preferred language while about three-quarters of ACE County enrollees prefer Spanish.

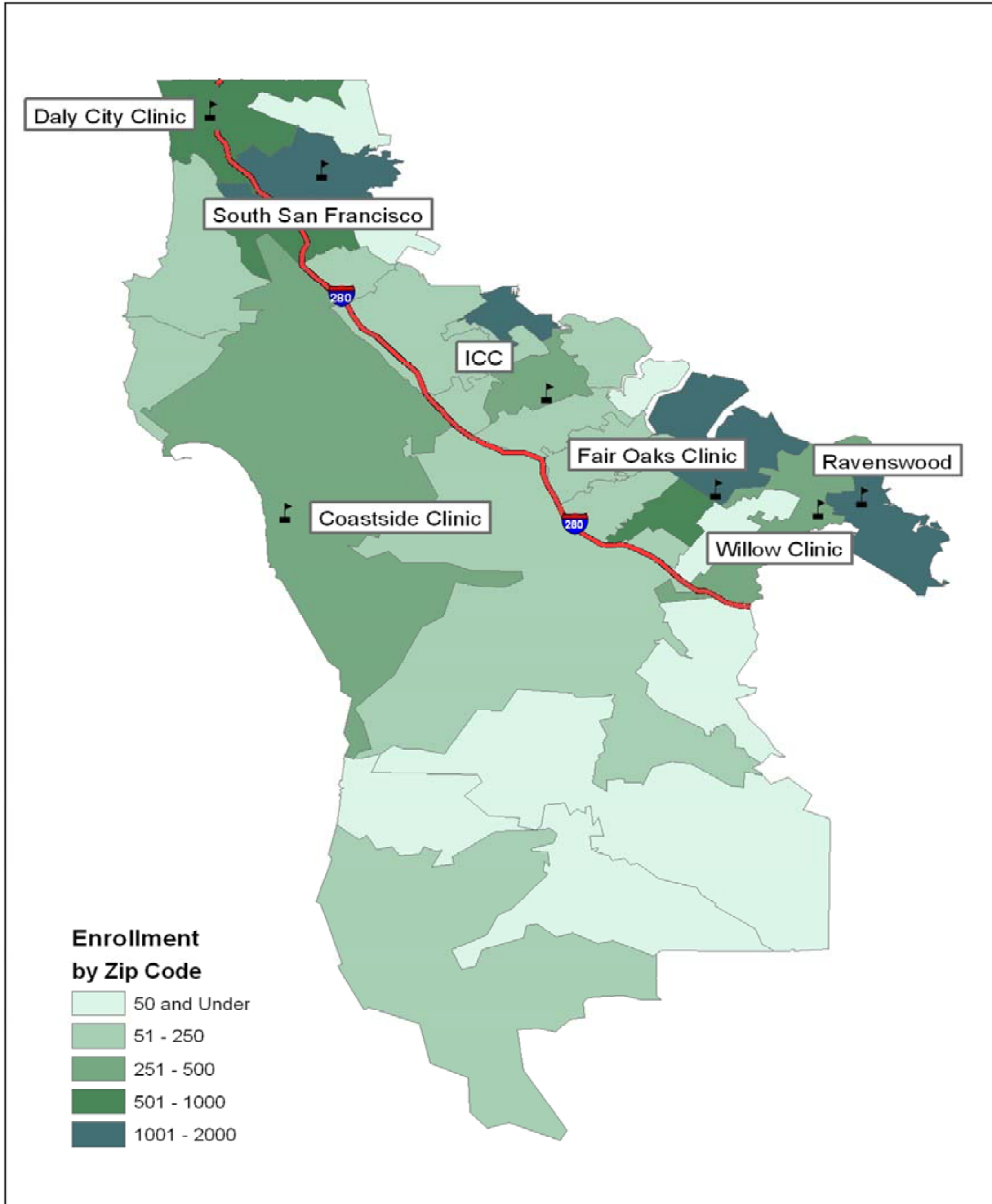
A map of the distribution of enrollees across the county is provided in Figure 8, which also shows the location of the seven primary care safety net clinics. All of the clinics are located in or very near the zip codes with the highest number of ACE and ACE County enrollees.

Figure 7
Demographic Characteristics of ACE and ACE County Enrollees
October-December 2009



Note: Includes a cross-section of all persons enrolled in ACE and ACE County during October-December, 2009.
Source: Health Plan of San Mateo

Figure 8
Geographic Distribution of ACE and ACE County Enrollees, 2009



Source: San Mateo County One-e-App data for ACE/ACE County Enrollees, 2009

Covered Services. Covered services for both ACE and ACE County programs are identical and quite comprehensive, including primary care; specialty care; emergency room visits; inpatient stays; and prescription drugs. Dental care is not covered, except for emergencies, nor are long term care or specialty mental health services.

Cost Sharing. Enrollees are required to share in the cost of care. However, ACE and ACE County enrollees who are below 100 percent of the FPL are exempt from premiums and co-payments. For those subject to cost sharing, there is an enrollment fee of $240 per year. Enrollees are given the option of making enrollment fee payments in monthly installments or paying the fee in full and receiving three $10 vouchers to offset copayments. Copayments include $40 for an emergency room 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. Copayments for inpatient services are higher, $300 per hospitalization and ambulatory surgery procedure. The program has a maximum out-of-pocket cost of $1000.

Provider Network. From its inception, the purpose of WELL, ACE, and ACE County has been to co-ordinate care for patients served by the SMMC system (including care at the inpatient hospital, the emergency room, and the SMMC clinics). In January 2009, this network was expanded to include the Ravenswood Family Health Center.[12] All individuals who enroll must receive care from this network; care outside the network is not covered without prior approval. The limited provider network has made it difficult to expand capacity to serve the growing ACE and ACE County population. The county is working with some private providers to provide free or discounted care, particularly specialty care. These include plans to have private providers offer primary care, obstetrical care, specialty services not provided at the SMMC, and tertiary

[12] Ravenswood's role in providing care for ACE patients was initially small, due to capacity and funding constraints. It has recently expanded its role substantially by accepting new ACE patients at its Belle Haven site.

hospital services. For example, Palo Alto Medical Foundation and Kaiser Permanente are each covering primary care (including pharmacy) for 300 and 397 uninsured patients respectively, and several private hospitals are offering certain negotiated specialty care and hospital services. The county is considering developing a publication that recognizes these private providers' roles in meeting the needs of the underserved.

Third Party Administration through the Health Plan of San Mateo (HPSM). The county contracts with the Health Plan of San Mateo (HPSM) to administer care for ACE and ACE County enrollees. HPSM leadership describes their goal as dedicated to ensuring that they bring value to the program as its "third party administrator." One important achievement to this end includes the improved ability to track ACE program costs, which the county was not fully equipped to do under the WELL program. In addition, since HPSM also administers Medi-Cal, the plan is to identify patients who qualify for Medi-Cal but are currently enrolled in ACE or ACE County. HPSM has not yet implemented the type of utilization management that they use in other programs (for example, identifying high frequency emergency room users), but they plan to do so in the near future.

HPSM extended privileges to use its nurse advice line to ACE enrollees in January 2009. The monthly call volume has ranged from 564 to 998 over the past year. Before HPSM formally granted access to the advice line for ACE patients, many called and were not turned away. There remained some confusion at the time of our site visit, however, among some CHAs who were still under the impression the advice line was not intended for ACE recipients.

The plan is not at risk for the cost of care, but takes responsibility for tracking and reporting on costs, completing quality of care reports, and educating enrollees on benefits. The plan receives funds from the county and pay providers at Medi-Cal rates. The county pays HPSM a

monthly administrative fee for each enrollee; the growth in enrollment has meant that the county has exceeded its initial projections for this expense. HPSM and the county amended the agreement in late 2009 to structure the arrangement as a tiered and fixed administrative fee.

Primary Care and Pharmacy Providers. ACE enrollees are required to establish a primary care provider at one of the SMMC clinics or at Ravenswood Family Health Center. Each clinic is linked to a specific pharmacy from which their patients can fill prescriptions. 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.

Patient Satisfaction with the ACE Program

During the four focus groups described earlier, ACE enrollees were asked about their perceptions of the ACE coverage programs. Responses were generally very positive. Most participants find ACE coverage to be affordable, and are quite appreciative of the county's effort to provide health coverage for the uninsured. The ACE satisfaction findings from the focus groups can be grouped into three categories: 1) enrollment; 2) access/utilization; and 3) cost sharing.

Enrollment. Focus group participants learn about the ACE program in many different ways. Most participants hear about it by word of mouth, often from friends or relatives. Some are encouraged to apply when seeking medical care, for example during a clinic or emergency room visit. Some hear about the program in other ways, for example from information at a public library. Few respondents report experiencing barriers to enrollment. Application assistors

always speak the preferred language of enrollees, and their help is greatly appreciated by clients. One focus group participant commented:

They try to make things easier for us.

Immigration status does not appear to be a concern among enrollees, indicating a reasonable level of trust between immigrants and their application assistors.

A concern voiced repeatedly by respondents involves late receipt of their ACE membership cards. This may inhibit them from receiving services. Several reported feeling that they cannot legitimately access their benefits until they have a card in hand.

> **I went back and asked them when am I going to get my card? I said it had been six or seven months already and I still haven't received it. I called numerous times about it, and I said when should I expect to receive my card?....I still haven't received one, so if I get sick, what am I supposed to show them?**

One respondent, also troubled by a lack of ACE documentation, commented:

> **I don't go to the doctor's nearly as much as I used to, and part of it is because of the wait and the treatment. But I haven't even gotten my card yet. So if I got sick, what do you want me to do? ….I would love to go to the doctor and get at least a check up or something.**

Others were more certain of their enrollment status, despite not having a card. One participant offered:

> **I never got the card, but I know that I'm still in the program.**

These concerns regarding the legitimacy in seeking care without a card varied by site. This may be attributable to communication differences during the application process, or administrative practices at specific clinics.

Use of Health Services. We queried focus group participants about health care utilization prior to enrolling in the ACE program, and how it has changed with ACE enrollment. Most focus group participants had no insurance prior to ACE enrollment. These individuals

particularly appreciate the preventive health care covered under ACE, and other aspects of the program associated with care management, such as reminder calls and the nurse advice line. One person lauded the preventive approach:

> **You get a free flu shot and they keep giving you the right medicine even though it is generic. They are promoting health because even though you are not sick you are being asked to come in to have your follow up. Generally speaking, all aspects of a person's health are being looked at. They are so concerned about human dignity.**

Many previously uninsured participants indicate that prior to enrolling they would typically seek health care at the emergency room when they needed it, "even for little problems." Others, who had private insurance or Medi-Cal previously, report being less likely to seek care under ACE now due to problems getting appointments.

> **There [are] times when I get really sick and if I had my old insurance where I could go into the doctor and get seen and get my medicine and things were a lot easier, oh yes, I would go. But I know how hard it is now to get seen and I think – if I don't feel like I am going to die, I am not going to go there…. I think a lot of people are just like that. They don't want to go because they realize how much trouble it is going to be if they do go.**

These complaints are consistent with HPSM reports that some enrollees have had to go to the emergency room just to get a prescription filled, resulting in a $40 copayment. (These barriers are being addressed by the new urgent care center near the emergency room.)

Most focus group participants report using the emergency services at the San Mateo Medical Center. Some expressed confusion regarding whether they could go to emergency rooms other than the SMMC, which is not a covered benefit under ACE and ACE County.

> **I found out that we could have been going to *[named private hospital]* all this time. I am still not sure about that. When you ask the administrative staff they say: "don't ask me." Who should we ask?**

Repeatedly, focus group participants extol the affordability of the ACE program's pharmacy benefits (providing a service for which they formerly paid out-of-pocket). However, there is dissatisfaction with the inconvenience of being able to go to only one pharmacy. This

requirement comes from the fact that San Mateo County incurs large savings through participation in the federal 340b pharmacy program, which results in deep discounts. However there are only four 340b pharmacies in the county, which are located at the SMMC and at Ravenswood Family Health Center, as well as two independent pharmacies that contract with SMMC.

In addition, several people also expressed dissatisfaction with short hours and language barriers at the pharmacies. (This is the only service for which language barriers appear to be a problem for ACE enrollees.) In addition, some reported long wait times for filling prescriptions.

> **At the pharmacy, there is only one person that speaks Spanish, but she is rarely there. When she is not there, there is an American that talks [a little Spanish], but he doesn't help. They're there yelling at you, you turn in your prescription and paperwork doing hand signals…...**

Pharmacy location also is a concern of several participants. For some, the pharmacy they are required to use is quite far from where they live, and therefore inconvenient. Others mentioned a recent pharmacy switch that came as a surprise.

> **They didn't tell me it changed; there just was a different address that I didn't notice. Instead of South San Francisco, it is in San Mateo.**

Cost Sharing. Many focus group participants are beneficiaries of the fee waiver option within the ACE program. These enrollees, who are not subject to cost sharing, are particularly appreciative of the generous benefits ACE offers. (Some recently shifted from the cost-sharing to fee waiver program due to job loss or other changes in their financial circumstances.)

Among those who have cost-sharing requirements, some report struggling to afford their co-payments, while others think that the small amounts required for co-pays and the ability to pay the annual fee in installments makes the costs affordable. When asked, some paying respondents

offered that they would be willing to pay more to ensure the existence of the program, up to $300 annually, as long as they could continue to pay the annual fee in installments.

In certain cases, willingness to pay more was contingent on a perceived improvement in quality and access. One participant said:

> **I don't mind paying the $250 [annual fee] or $20 co-payments; however, I would like to see more politeness and better treatment when you go in. You make an appointment and wait three months and you show up and they start treating you like you are an animal or something like that.**

This is consistent with reports from the Health Plan of San Mateo staff, who report that clients are frustrated when they have paid their annual fee and are unable to get an appointment. Preventive care seems to be unrealizable for many of these patients. The option to request a refund if no services are accessed within a year remains available to ACE patients, and many have requested their money back because they were not able to get services.

In sum, findings from the focus groups indicate that—while there are a few service-oriented complaints—the ACE program is well-regarded. Nearly all respond that they would recommend the program to friends and family. The current annual fee seems fair to most cost-sharing program participants, provided that they can continue to pay in installments. Furthermore, there is strong appreciation for the county's efforts to help provide health coverage for a vulnerable population. Intentions to renew their membership are universal. Many voice concern that the program might go away, and acknowledge gratefully that ACE is their only opportunity for health coverage. The main problems concern access to appointments within the limited ACE network of providers. This is consistent with similar findings documented elsewhere in this report.

Quantitative Data on ACE Outcomes

The ACE and ACE County programs were designed to improve access to health care for uninsured adults in San Mateo County. By providing health coverage through these programs to more adults, the county expects to increase the likelihood that new enrollees will have a usual source of health care and have their health needs addressed. This, in turn, should improve their health and functioning.

One-e-App Survey. In order to assess the impact of the ACE and ACE County programs on these outcomes, we compared the health care experiences after enrollment in the program to experiences prior to enrolling while uninsured. This research design follows that used in prior studies of public health coverage expansions (Kenney, 2007; Howell et al., 2008). Renewal applicants serve as the "treatment group," a group that has been enrolled in ACE for a year. Using an innovative survey as part of the enrollment and renewal process for ACE, [13] they are asked about their health care experiences during the prior 12 months enrolled in ACE or ACE County. Individuals who are just enrolling in ACE or ACE County are the comparison group, providing information on their health care experiences in the prior year while they were uninsured.

The survey is imbedded in the One-e-App online application system for public health coverage programs in San Mateo County. Between April and September of 2009,[14] thirteen additional questions on access to care, use of services, unmet need, and health status were asked as part of the One-e-App process. Approximately 5,000 non-elderly adults applying for or renewing ACE or ACE County enrollment were asked these questions at the end of the application process. We present findings as regression-adjusted percentages, based on

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[13] For more detailed information on methods used to collect and analyze the data from San Mateo County, see Appendix C.

[14] The survey will be repeated in April-September, 2009.

regressions that control for observed differences in the demographic and socioeconomic characteristics of the initial and renewal applicants.[15]

In spite of the severe access problems for ACE enrollees documented earlier in this report (primarily difficulties getting appointments for care in the county safety net clinics), Figures 9 through 12 suggest that enrollment in ACE/ACE County led to substantial improvements in access to care for these previously uninsured individuals. Moreover, the programs seem to be improving the health and functioning of enrollees.

Enrollees were asked four questions that are used to measure access to care:

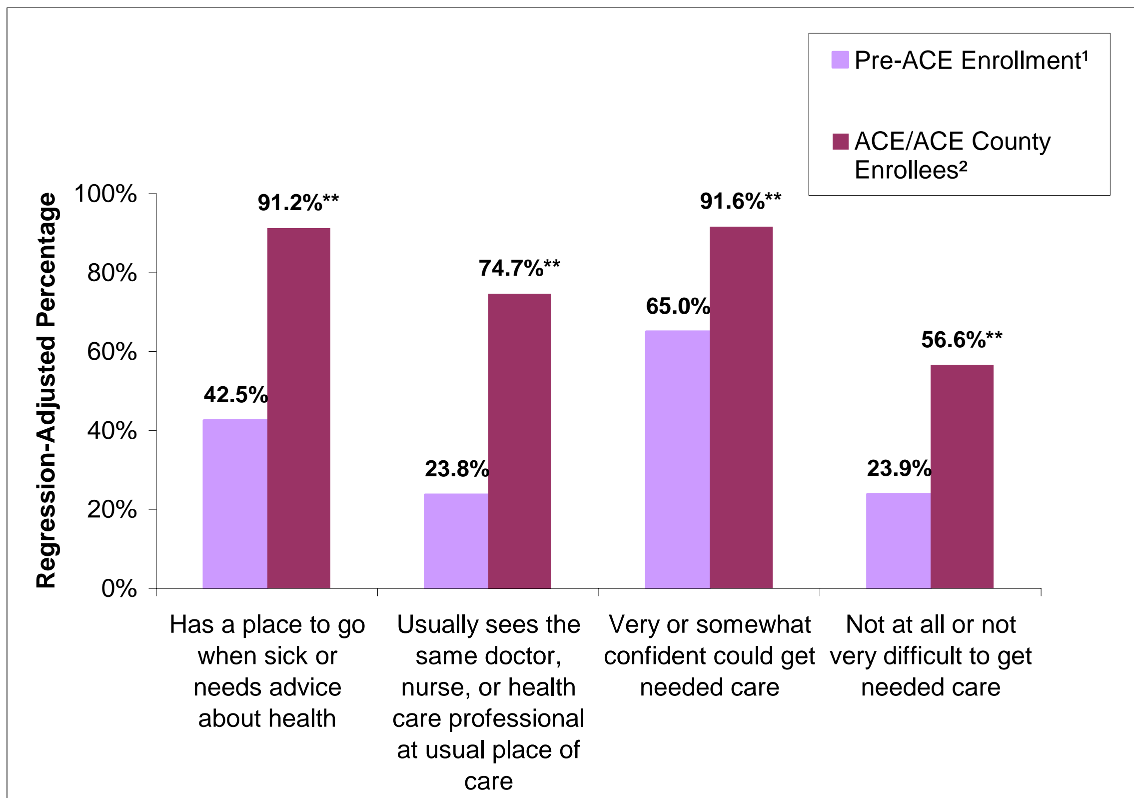
- Is there a place that you usually go to when you are sick or need advice about your health?
- Do you usually see the same doctor, nurse or other health care professionals when you go to this place?
- During the past 12 months, how confident were you that you could get health care if you needed it – very confident, somewhat confident, not very confident, not at all confident?
- Overall, how difficult is it for you to get medical care when you need it – very difficult, somewhat difficult, not very difficult, or not at all difficult?

As measured by their answers to these questions, enrollees in ACE and ACE County experience dramatic, statistically significant increases in access to care after being continuously enrolled for one year. Nearly all enrollees have a place to go when they are sick or need advice about their health, compared to less than half while uninsured (Figure 9). These effects for adults are stronger than the effects for children measured in the evaluation of the San Mateo County Healthy Kids program (Howell et al., 2008). The percent of children with a usual source of care increases from 59.4 percent to 89.1 percent after new coverage, while for adults the increase is from 42.5 percent to 91.2 percent.

[15] As shown in Appendix C, the findings presented in the text that are based on regression-adjusted differences are very similar to the patterns found in the unadjusted means.

Once they have a usual source of care, the ACE program also improves continuity of care for enrollees. The majority of enrollees (74.7 percent) have a person or group of health professionals they usually see at their usual place of care (Figure 9). Only 23.8 percent of the uninsured group indicated the same. This finding may reflect the efforts that the county has made to adopt team-based care.

Figure 9
Impact of ACE/ACE County Enrollment on Access to Care



**Significantly different from uninsured, $p<0.01$, two-tailed test; the estimates are adjusted for differences in the demographic, health, and socioeconomic characteristics of the two groups.

Notes: 1) Based on the experiences that uninsured ACE/ACE County applicants had prior to enrolling.
2) Based on the experiences that ACE/ACE County re-enrollees had after enrolling in ACE/ACE County.

Source: San Mateo County One-e-App data for ACE/ACE County enrollees, 2009

Enrollees also express that this improved access to a usual source of care improves their confidence in getting care. Nearly all (91.6 percent) enrollees indicate that they are very or somewhat confident they can get health care when they need it, compared to 65.0 percent of enrollees while they are uninsured (Figure 9).

Many of those enrolled for a year do experience difficulties getting needed care, although over half of enrollees (56.6 percent) say it is not at all or not very difficult to get care that they need. This compares to 23.9 percent of uninsured individuals. According to this measure, enrollment in ACE or ACE County doubled individuals' ability to get needed health care.

These positive results from the ACE program are in spite of the access problems reported earlier in the report. However, the need for improvements remains, since almost half still find it difficult to get needed care.

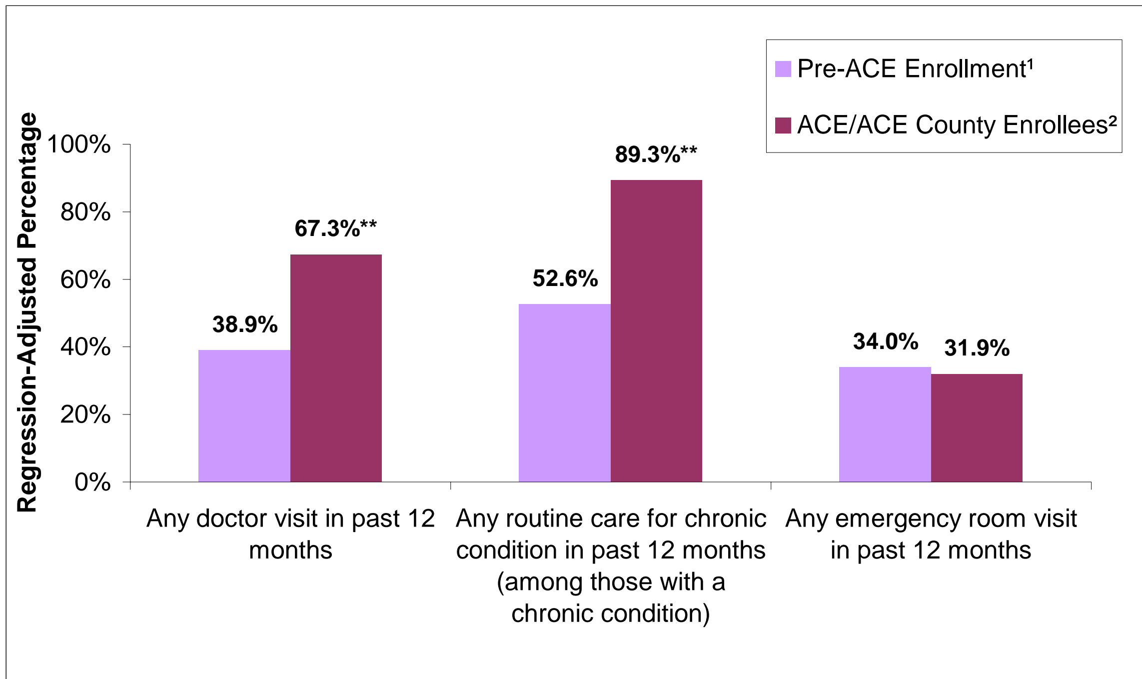
Compared to the group who are uninsured, enrollees in ACE and ACE County are 1.7 times more likely to have received care from a doctor in the past 12 months. Among those enrolled for a full year, 67.3 percent report a doctor visit in the past 12 months, compared to only 38.9 percent of new enrollees in the previous year while they were uninsured (Figure 10).

The gains in treatment for chronic conditions are even more impressive. Nearly 90 percent of enrollees with at least one chronic condition say that they received routine care for their condition in the past 12 months, compared to 52.6 percent of the uninsured with chronic conditions (Figure 10).

However, these gains in ambulatory care are not enough to cause a substantial decline in emergency room care. The rate of emergency room use over the past 12 months remains high for ACE/ACE County enrollees at 31.9 percent, only slightly below the proportion of uninsured

individuals reporting an emergency room visit (34.0 percent; Figure 10). These rates of ambulatory care and emergency room use are lower than those reported below using HPSM data.

Figure 10
Impact of ACE/ACE County Enrollment on Use of Services



**Significantly different from uninsured, p<0.01, two-tailed test; the estimates are adjusted for differences in the demographic, health, and socioeconomic characteristics of the two groups.
Notes: 1) Based on the experiences that uninsured ACE/ACE County applicants had prior to enrolling.
2) Based on the experiences that ACE/ACE County re-enrollees had after enrolling in ACE/ACE County.
Source: San Mateo County One-e-App data for ACE/ACE County enrollees, 2009

There were geographic differences among enrollees in use of services. ACE/ACE County enrollees living in the mid-county region were less likely to have had a doctor visit in the past 12 months (55 percent of mid-county enrollees compared to 71-72 percent of enrollees in the other regions) or to have had routine care for their chronic condition (85 percent of mid-county

enrollees compared to 88-94 percent of enrollees in the other regions—data not shown).[16] This information is consistent with qualitative findings from the evaluation, particularly the finding that the waiting list at the ICC (the only county clinic in the mid-county region) is two times that for any other county clinic

Consistent with the observed increases in access to care and use of services, enrollees in ACE and ACE County experience significant decreases in unmet need. In the 12 months prior to renewing coverage, 17.1 percent of enrollees report delaying or not getting needed medical care or prescription medicines. While this is still high, it is substantially below the 27.9 percent of the uninsured who report delaying or missing needed care (Figure 11). Enrollment in ACE or ACE County also dramatically decreased enrollees' probability of having unmet need due to cost or lack of insurance. Only 4.4 percent of all enrollees report having unmet medical needs for this reason, compared to 22.4 percent of all uninsured individuals (Figure 11).[17]

The improvements in access to care and use of services following enrollment in ACE and ACE County programs appear to pay off in terms of enrollees' level of functioning. Those enrolled for a year are significantly less likely to experience at least one day in the past month when their activities were limited, compared to those newly enrolling (13.0 percent compared to 19.1 percent, respectively—Figure 12).

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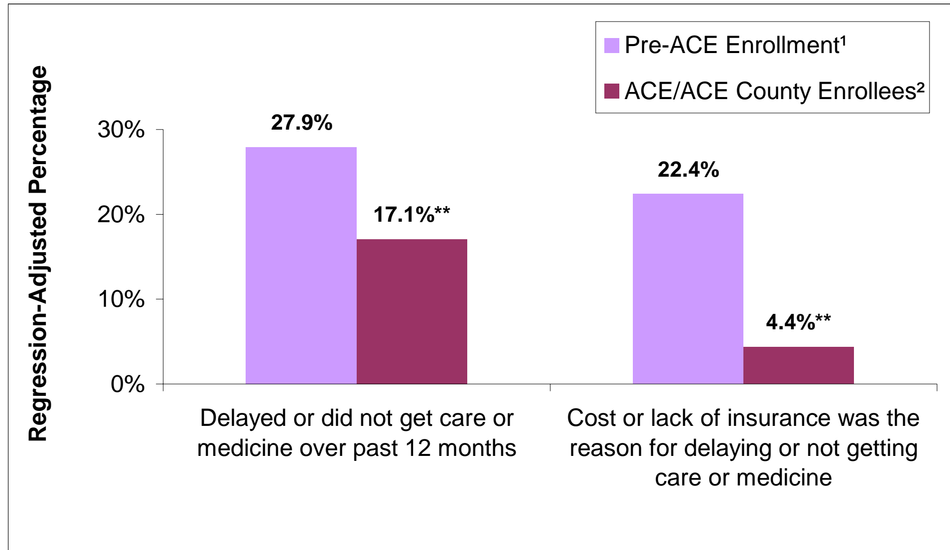
[16] These results come from analysis that used only ACE/ACE County re-enrollees.
[17] The evaluation question on cost as a reason for unmet need was added to the One-e-App later than the other questions. Therefore, results for this outcome reflect a smaller sample than was used for the rest of the analysis.

Figure 11
Impact of ACE/ACE County Enrollment on Unmet Health Needs

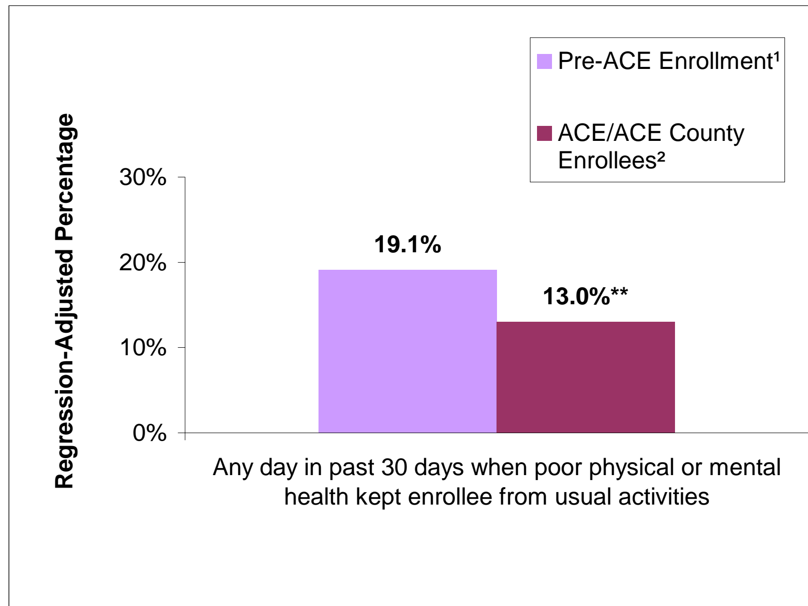


**Significantly different from uninsured, $p<0.01$, two-tailed test; the estimates are adjusted for differences in the demographic, health, and socioeconomic characteristics of the two groups.

Notes: 1) Based on the experiences that uninsured ACE/ACE County applicants had prior to enrolling.
2) Based on the experiences that ACE/ACE County re-enrollees had after enrolling in ACE/ACE County.

Source: San Mateo County One-e-App data for ACE/ACE County Enrollees, 2009

Figure 12
Impact of ACE/ACE County Enrollment on Activity Limitation



**Significantly different from uninsured, $p<0.01$, two-tailed test; the estimates are adjusted for differences in the demographic, health, and socioeconomic characteristics of the two groups.

Notes: 1) Based on the experiences that uninsured ACE/ACE County applicants had prior to enrolling.
2) Based on the experiences that ACE/ACE County re-enrollees had after enrolling in ACE/ACE County.

Source: San Mateo County One-e-App data for ACE/ACE County enrollees, 2009

Results from a survey conducted by the Kaiser Family Foundation of Healthy San Francisco enrollees provide a useful benchmark for these outcome measures, affirming the finding that a public coverage program targeted at low-income adults, many of whom are undocumented immigrants, can achieve high levels of access to care (Kaiser Family Foundation 2009).[18] In that survey, 86 percent of enrollees had a usual source of care, compared to 91.2 percent of enrollees in our analysis of ACE/ACE County. The Kaiser Family Foundation survey also showed that 60 percent of Healthy San Francisco enrollees had a regular doctor or nurse at their usual place of care, compared to 74.7 percent of ACE/ACE County enrollees in our analysis. While ACE/ACE County enrollees were more likely to report having a usual source of care and to have a regular doctor relative to Healthy San Francisco enrollees, ACE enrollees were less likely to report a doctor visit in the prior year.

In San Francisco, 88 percent of enrollees reported at least one doctor visit in the past year, compared to 67.3 percent of San Mateo County's ACE/ACE County enrollees. Methodological differences in the survey may explain some of these differences between the counties.

Like the ACE/ACE County enrollees, Healthy San Francisco enrollees' increased access to care did not keep them from using the emergency room. In the Kaiser Family Foundation survey, 29 percent of participants had an emergency room visit in the past year.

Use and Cost of ACE Services in the First Year of Enrollment. As additional measures of access to care, we obtained data from the Health Plan of San Mateo for those who enrolled in ACE during the first year of the program and who remained continuously enrolled for the year following enrollment. This group enrolled during the period September 2007 through August

[18] The Kaiser Family Foundation survey examined individuals who had been enrolled for at least four months (including those who had been enrolled for over a year). Their sample is not fully comparable to our sample of ACE/ACE County enrollees (who had been enrolled in ACE or ACE County for 12 months before responding to the survey).

2008. In this first year of the program, all ACE enrollees were eligible for the federal waiver and thus were citizens or legal residents. The group differs from One-e-App survey enrollees who enrolled about a year later and included both ACE and ACE County enrollees. Demographically they were very similar to the ACE enrollees (in contrast to ACE County enrollees) shown earlier in Figure 7.

Each ACE enrollee must select a clinic as a primary care provider (PCP). Table 2 shows the PCPs for this initial group of ACE enrollees. Only about 18 percent of all primary care visits within the SMMC primary care system are to the ICC (see Table 1)—these are visits for all payor sources, not just ACE. However, data from HPSM show that, during the same time period, a majority of ACE enrollees (52.7 percent) selected the ICC as their ACE primary care provider. There are several possible reasons for this disparity. It is possible that the CHAs on the main campus were more active in enrolling individuals into ACE during this early phase. It also could be that the main campus primary care site is selected more often by individuals who use other services at the main campus, such as the emergency room, inpatient care, and specialty clinic care. In any case, it is not surprising that the ICC was experiencing particularly severe access issues during this period when they were implementing many new systems reform initiatives, and while they were beginning to serve many new ACE enrollees.

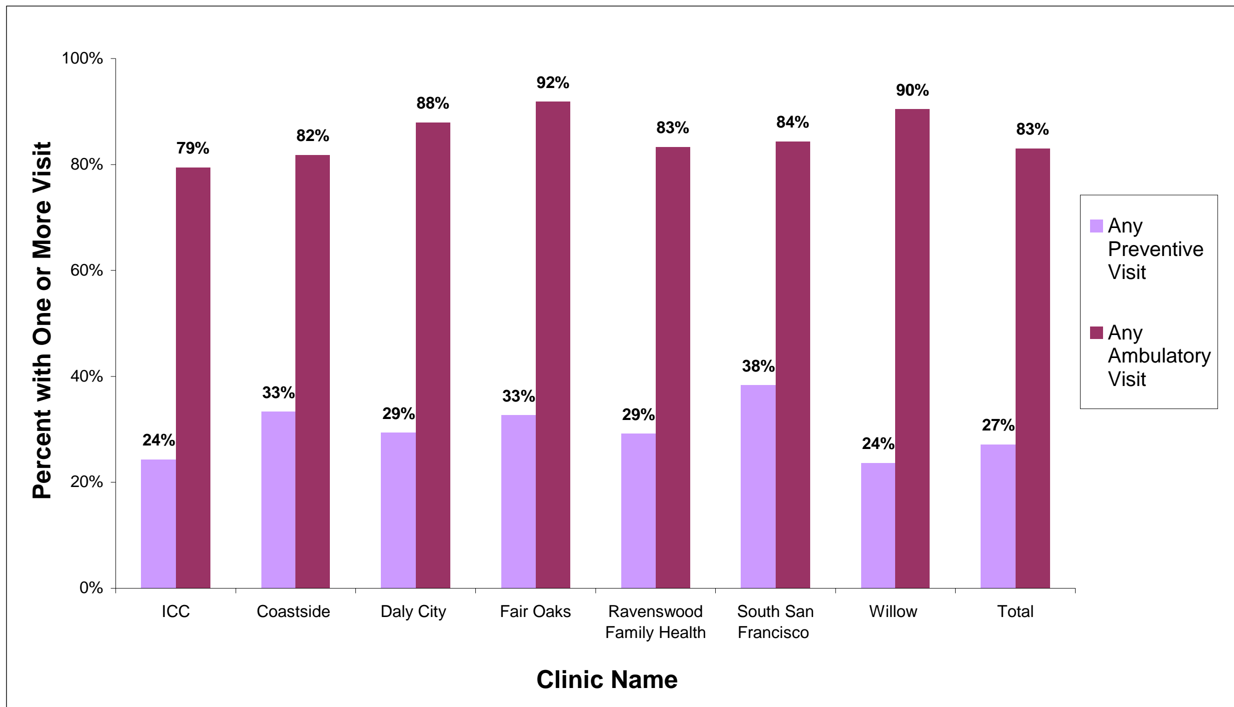
Table 2
Primary Care Providers Assigned to Persons
Enrolled in ACE Between September, 2007- August, 2008

Primary Care Provider	N	Percent
Coastside	66	1.6
Daly City	671	16.4
Fair Oaks	367	9.0
Innovative Care Clinic	2,157	52.7
Ravenswood	120	2.9
South San Francisco	326	8.0
Willow	262	6.4
Unassigned	123	3.0
Total	**4,092**	**100.0**

Source: Health Plan of San Mateo

Figure 13 shows the percent of this early ACE cohort who had any ambulatory and preventive care visits during their first year of enrollment. While access to appointments was difficult during this period, over 80 percent of enrollees had at least one ambulatory care visit. This varied from about 80 percent at the ICC to over 90 percent at Fair Oaks. This rate of ambulatory care visits is closer to the rate of visits reported in the Kaiser Healthy San Francisco survey, and substantially higher than reported in the San Mateo County One-e-App survey.

Figure 13
Preventive and Ambulatory Visits by Clinic PCP, ACE Enrollees
September 2007 - August 2008



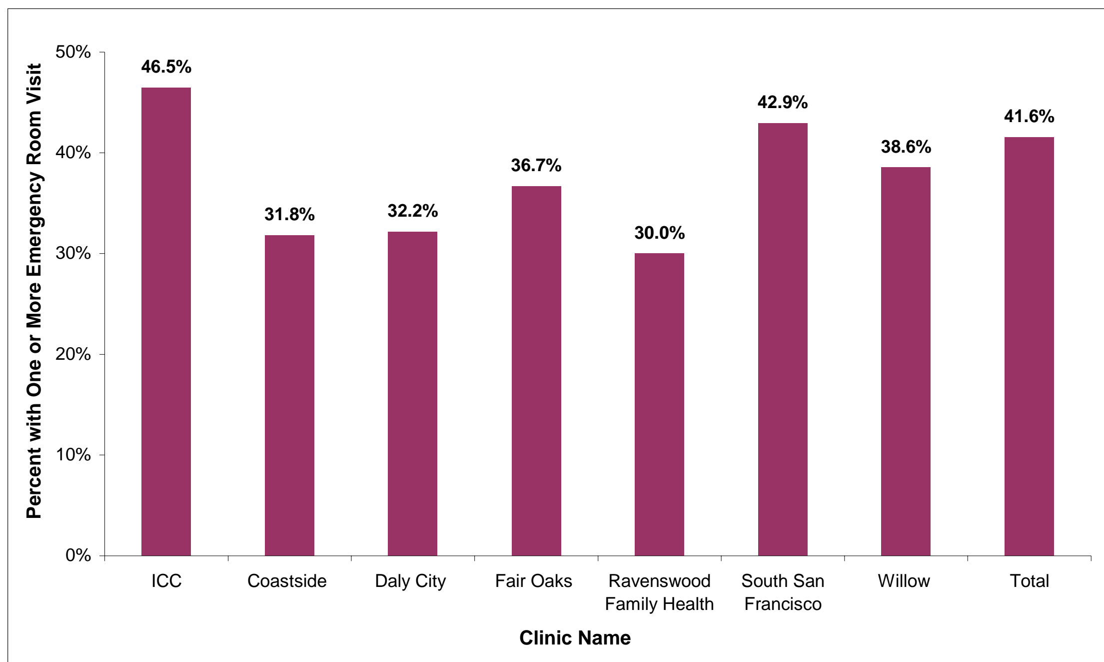
Note: Includes all services in the year following enrollment for those enrolling in Sept. 2007 - Aug. 2008
Source: Health Plan of San Mateo

It is possible that poor recall of visits by survey respondents (especially those visits that occurred many months before) may have led to underreporting of such visits in the One-e-App Survey. In any case, these recall issues would apply equally to new enrollees and those renewing coverage.

Use of preventive care (for example, check-ups) was low, however (Figure 13).[19] Less than 40 percent have a preventive care visit during their first year of enrollment, regardless of the PCP. While not all adults need a preventive visit each year, during the first year of enrollment in a new health plan or to a new primary care provider, such a visit is necessary to assess patient needs. The limited use of preventive care is consistent with the qualitative findings that access to preventive care is very limited.

Figure 14 shows that a large portion, just over 40 percent, of ACE enrollees have at least one emergency room visit in the year following enrollment, even higher than the rate reported in the One-e-App survey. This also is over twice the rate for uninsured adults ages 18-64 years of age nationally, 18.9 percent in 2006 (U.S. Department of Health and Human Services, 2009).

Figure 14
Use of Emergency Room Care by Clinic PCP, ACE Enrollees
September 2007 - August 2008

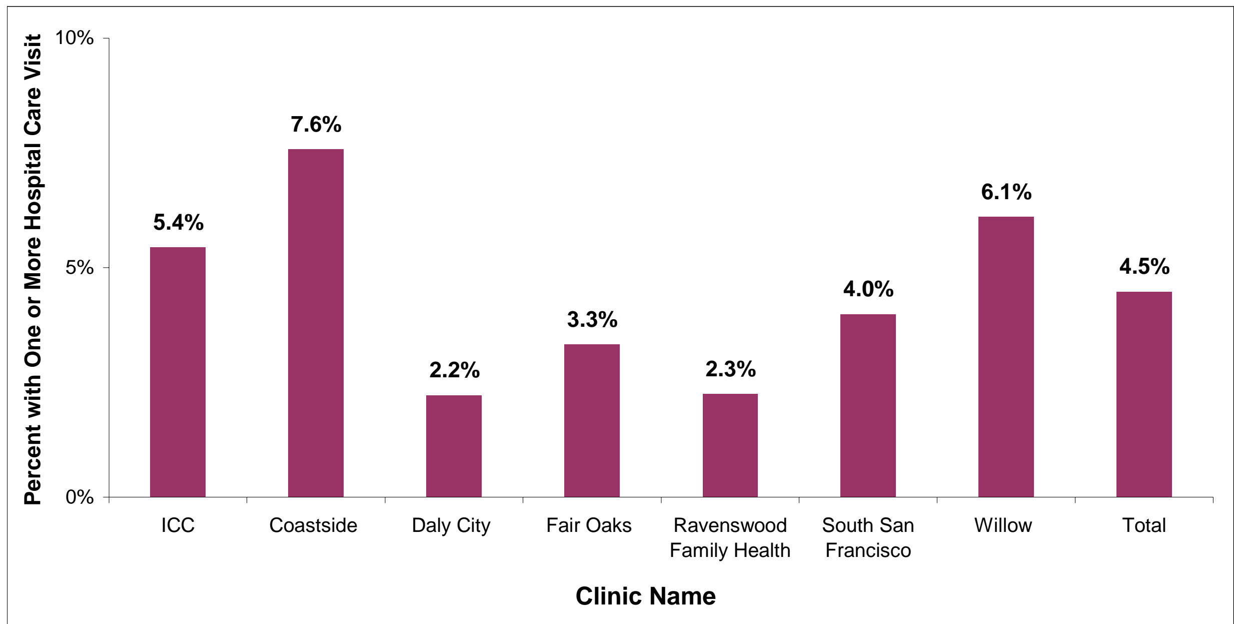


Note: Includes all services in the year following enrollment for those enrolling in Sept. 2007 - Aug. 2008
Source: Health Plan of San Mateo

[19] Our measure of preventive care uses codes for preventive services to identify a preventive care visit. It is likely that many chronically ill patients receive preventive care services (for example, advice and counseling on nutrition and smoking) that are not coded separately on encounter records. Thus, our measure of preventive care underreports preventive care services.

In contrast, use of hospital services is low for this group, with less than 5 percent of enrollees having a hospitalization at the SMMC in the year (Figure 15). This rate varies substantially across PCPs, from 2.2 percent for Daly City clinic patients to 7.6 percent for Coastside clinic patients. In addition, the hospitalization rate excludes use of hospitals other than the SMMC, since such stays are not covered by ACE.

Figure 15
Use of Hospital Care by Clinic PCP, ACE Enrollees
September 2007 - August 2008



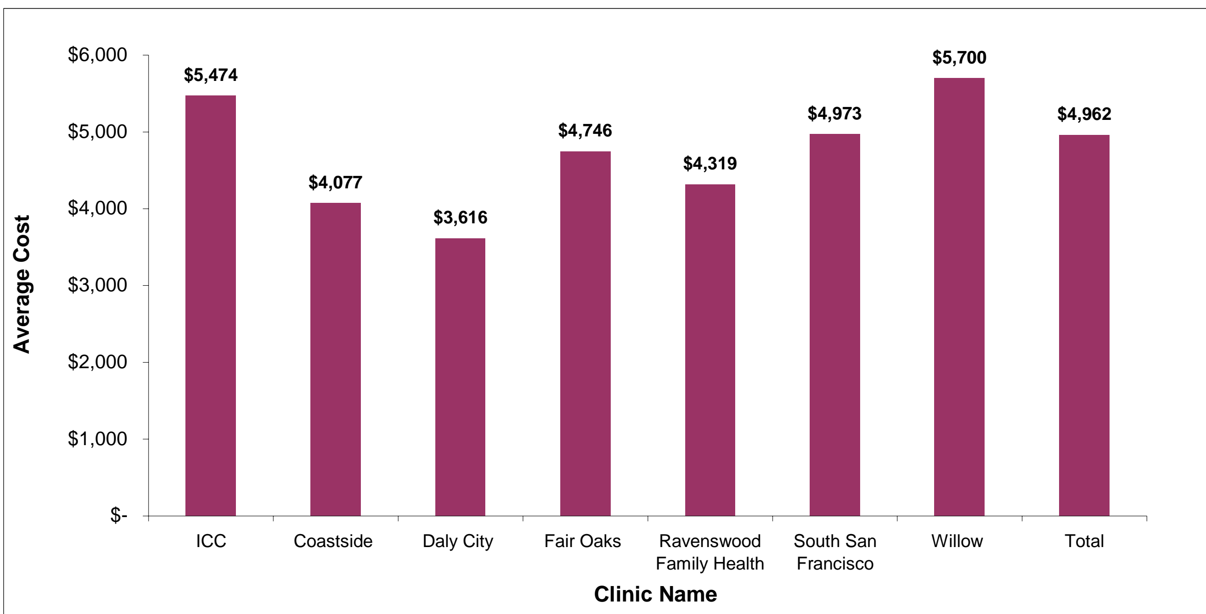
Note: Includes all services in the year following enrollment for those enrolling in Sept. 2007 - Aug. 2008
Source: Health Plan of San Mateo

The cost of services for ACE enrollees is difficult to measure, because several types of services that these enrollees receive are excluded from the claims/encounter records received by the HPSM. These exclusions are: hospital inpatient and emergency room services outside the SMMC; mental health services; and pharmacy services. The first two types of services (services in hospitals other than SMMC and mental health services) are not covered under ACE. Most

pharmacy services (for 340b pharmacies) are billed under a separate mechanism; those claims do not flow through the HPSM.

With these limitations in mind, we see (Figure 16) that the average charges per person (using only the claims reported to the HPSM, and excluding the costs outlined above) was approximately $5,000 per person for the year (or about $415 per member per month). While these charges are close to that reported for the average person in the U.S.—$5,711 in 2007 (Kaiser Family Foundation, 2007)—given that it excludes substantial hospital, mental health, and pharmacy cost it is clear that the individuals covered under the first year of the ACE program are a relatively high resource using population. It should be noted that the distribution of charges per person per clinic PCP does not adjust for differences in underlying illness burden among the patients.

Figure 16
Average Annual Total Charges per Person by Clinic PCP, ACE Enrollees
September 2007 - August 2008



Note: Includes all services in the year following enrollment for those enrolling in Sept. 2007 - Aug. 2008
Source: Health Plan of San Mateo

Table 3 shows how these charges are distributed across types of services. A majority (51.5 percent) are for the care provided during clinic visits. The other two large cost components are hospital services (21.1 percent) and emergency room visits (18.2 percent).

Table 3
Average Annual ACE Charges per Person by Type of Service
Persons Enrolled in September, 2007- August, 2008

Type of Service	Average Annual Cost per Person	
	Amount	**Percent**
Clinic Visits	$2,556	51.5
Emergency Room Visits	$903	18.2
Hospital Services	$1,046	21.1
Prescriptions	$246	5.0
Laboratory and Radiology	$95	1.9
Other	$116	2.3
Total	**$4,962**	**100.0%**

Notes: 1) Includes services in the year following enrollment for those enrolling between September 2007-August 2008
2) Exludes charges for non-SMMC hospitals, mental health services, and for 304b pharmacy services.
Source: Health Plan of San Mateo

Quality of Care for ACE Enrollees with Diabetes. To measure quality of care for diabetes patients, the Health Plan of San Mateo collects selected HEDIS measures for ACE enrollees using an NCQA certified vendor. The results for 2008, shown in Table 4, are impressive and provide another indication that most ACE patients who are able to access care are receiving excellent care. The table shows that HEDIS® results for the ACE population meet or exceed the performance standard in most measured aspect of diabetes care management, including:

- HbA1c testing;
- LDL-C screening;
- LDL-C control (<100);

- Diabetic nephropathy monitoring.

These HEDIS results provide yet another indication that, once enrolled and receiving care at a PCP, ACE patients receive high quality care from their providers.

Table 4
ACE HEDIS® 2008 Report Card

Measure[1]	HPSM ACE Score	Benchmark[2]
Hemoglobin A1c (HbA1c) tested	90.9	88.8
HbA1c uncontrolled (>9.0%) (a lower score indicates better performance)	34.4	≤32.4
HbA1c controlled (<8.0%)	53.5	NE
Eye exam (retinal) performed	62.6	67.6
LDL-C screened	86.0	81.8
LDL-C controlled (<100 mg/dL)	49.2	42.6
Nephropathy monitored	85.4	85.4
Blood pressure controlled (<130/80 mm Hg)	46.5	NE
Blood pressure controlled (<140/90 mm Hg)	66.3	NE

[1] Measures the percentage of members ages 18–75 with diabetes (type 1 and type 2) who met each of the listed criteria.
[2] The benchmarks are the Medi-Cal high performance levels. NE indicates measures where the high performance level is not established.
Source: Health Plan of San Mateo

Conclusions

This report presents a wide range of findings from the second year of the evaluation of the San Mateo County Systems Redesign and Adult Coverage Initiative. The findings build on those in the first annual report, and confirm that county partners are actively implementing the two components of the initiative (systems redesign and coverage expansion), despite the difficult economic climate and the consequent growing demand for services.

The major systems redesign implementation success during 2009 was the implementation of an Electronic Medical Record (EMR) in all six of the SMMC adult primary care clinics. This is a key component of systems redesign, and should—over time—provide more accurate data to facilitate implementing other components such as advanced access. Implementation of the EMR is currently underway for the SMMC specialty clinics as well. Unfortunately Ravenswood clinic could not implement its EMR, due to resource constraints. This, however, does provide the possible opportunity to implement the same software (eClinicalWorks) at Ravenswood as has been adopted by the SMMC clinics and/or plan for a system that can interface with the SMMC system.

The resource demands of the EMR implementation—combined with increased clinic demand associated with growing enrollment in ACE and ACE County—slowed the implementation of other systems redesign components, such as advanced access. Only the ICC—using funds from the federal waiver—was able to increase staff and modify their space in order to serve additional patients. Other clinics—most of which have adopted some systems redesign components in previous years—did not take on new systems redesign activities other than EMR implementation in 2009.

The ACE and ACE County programs continued to expand enrollment throughout 2009. Enrollment doubled in these two programs combined over the period 2008-2009, a period during which the capacity of the delivery system serving this new caseload did not change substantially.

In spite of these severe capacity constraints, the data from this year's evaluation show strong positive effects of the initiative. These include the following:

- Greatly increased access to care after formal enrollment in the ACE/ACE County program, and when compared to the time clients are uninsured.
- Relatively high use of services when enrolled, in spite of severe difficulties for some individuals (particularly new patients) in getting appointments.
- High satisfaction with the care provided in the safety net system once a patient is seen by their provider.
- Good quality of care, as shown by both key informant and patient impressions, as well as good diabetes care outcomes.

While this picture is very positive, there are several less positive findings that deserve consideration as the county moves forward with the initiative. The most prominent of these is the access problem created by the capacity constraint in the county system. All sources of information—both qualitative and quantitative—point to the potential problems created by this capacity constraint. We were told that it is impossible to get timely appointments in any of the county clinics, and we observed that patients defer needed preventive and primary care for this reason. In addition, the costs of this are high, since emergency room use is very high, and clients told us that they usually go to the emergency room when they cannot get appointments for urgent conditions. The implementation of an urgent care clinic will, hopefully, ease some of the overuse of the emergency room in the coming year.

San Mateo County, like all California counties, is facing significant budget shortfalls due to declining revenues from the state government as well as declining local tax income. This

situation has made the critical goal of improving the financial viability of the SMMC system especially challenging.

Other problems that emerged from this year's evaluation include the following issues:

- While clients are generally very satisfied overall, they are substantially less satisfied with some clerical staff in the clinics, suggesting some need for improvement in patient relationship skills.

- While our measure of preventive care is imperfect and underreports preventive care, it appears that the use of preventive care is lower than desirable. In their full year following initial enrollment, only about 1/5 of enrollees have a preventive visit. While not all adults should be seen for preventive care each year, all should be seen for a screening visit when enrolled for the first time.

- Unmet health need among ACE/ACE County enrollees, though lower than that reported while uninsured, remains high at 17 percent, with most of the unmet need due to issues that are not related to cost (likely reflecting access barriers).

- The cost of care is high and enrollment is growing. These factors, combined with the lack of near-term federal/state financing, means that the county's goal of improved financial sustainability remains a still-distant hope.

These findings underscore the ongoing challenges of providing health care to a chronically ill and underserved population, under severe financial and capacity constraints.

When comparing our findings to the goals set out by the BRTF, we see the following results:

1. Increase access to care for low income adults: **Substantial progress, but capacity constraints limit success.**

2. Improve the financial viability of the SMMC system: **Substantial progress, because of the federal waiver, but gains are offset by increased demand for services and a lack of federal funding in 2010.**

3. Leverage all partners (public and private) to provide care to the uninsured and underinsured: **Some progress. Private providers are beginning to increase care to the uninsured and underinsured, but there is a continued need for increased capacity.**

4. Implement seamless coordination of care across providers: **Substantial progress through the implementation of the EMR.**

5. Improve the ease of use of the safety net: **Substantial progress, particularly through use of HPSM management strategies, but difficulties obtaining appointments continue.**
6. Expand coverage to all adults by maximizing coverage under existing public programs including Medi-Cal and ACE: **Substantial progress with doubling of enrollment in coverage programs in two years.**

Thus the county has made substantial progress, but further progress will hinge on increasing the capacity to provide timely preventive and primary care (either by expanding provider capacity through increasing the number of provider sites (public or private), by increasing the staff and space at existing clinics, or by increasing the efficiency of clinics). In addition, the county must sustain the already-successful efforts to continue implementing all the components of systems redesign across all county clinics. In particular, it will be critical to improve the process of scheduling appointments and to lower wait times for appointments.

In summary, despite growing demands on the system and corresponding budget shortfalls, the county has made important strides in increasing access to care for low income adults and providing high quality care to those enrolled in county coverage programs. The redesign process continues to focus increased attention on the patient experience, a concept that is central to the medical home model. The culture of accountability that is encouraged by data gathering and self-examination has prepared San Mateo's clinics to become true "Primary Care Providers" or "medical homes." By taking on this process and sustaining it through difficult financial times, the county provides a model for other local communities that wish to better serve low income, uninsured residents.

The evaluation findings demonstrate clearly that patients who are being seen by the San Mateo County safety net clinics are receiving high quality care with which they are

overwhelmingly satisfied. While access remains a challenge, those who are able to receive consistent care are clearly benefitting from the coverage initiative and redesign efforts.

San Mateo County's experiences with systems redesign and expanded coverage have important implications for health reform and expanded coverage for uninsured adults nationally. The most prominent lessons are the following:

- Providing coverage does not assure access to care. Expanded enrollment requires expanded services. A lack of such expansion will lead to lower-than-optimal use of preventive/primary care and high emergency room use.

- Expanded coverage should be combined with a strengthened and redesigned health care safety net for primary and specialty care. Such changes can lead to high quality care within a safety net system.

- New adult enrollees who were previously uninsured are likely to have high health care needs and be costly to serve.

- A strong commitment from all levels of the health care system is needed to redesign the safety net system and improve care for the low income uninsured adults.

We look forward to documenting the county's continued progress and the effects of the initiative in our evaluation during the coming year. In particular, it will be critical to observe whether the capacity constraints are relieved by economic improvements in the county and improved efficiency from systems redesign efforts, or whether more innovations are needed to fully address the BRTF goals.

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