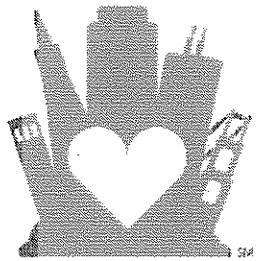

Healthy San Francisco

Our Health Access Program

Annual Report to the San Francisco Health Commission (For Fiscal Year 2008-09)

September 1, 2009

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I. SUMMARY AND OVERVIEW OF MAJOR ACCOMPLISHMENTS

Healthy San Francisco (HSF) was marked by a year of strengthened public/private provider partnerships, and continued operational enhancements. In the program's second year of operation, the expansion efforts centered on increasing the number of eligible residents enrolled in the program and expanding the program's network of medical homes.

On a national scale, HSF and City leaders contributed to the dialogue on health care reform in the United States. The Department also provided technical assistance to several communities interested in determining whether a program such as HSF would be appropriate for their communities (e.g., New Orleans, Miami, State of Connecticut, Pittsburgh, Denver, Howard County, Maryland, etc.). The later created the Healthy Howard program in October 2008, which aims to increase access to health care for uninsured county residents.

At the end of June 2009, HSF completed its second year of operation. Highlights during the last fiscal year were:

- **Increased Program Enrollment**: Over 43,000 uninsured residents were enrolled in the program at the end of the fiscal year.

- **Expanded Access**: Twenty-seven (27%) of all those enrolled were not previous users of the health care delivery system (i.e., defined as an individual who self-reported that they had not received clinical services within the last two years from the primary care medical home they selected as part of the HSF application process).

- **Expanded Program's Income Eligibility**: Expanded HSF's income eligibility requirement to 500% of the Federal Poverty Level (for one person $54,150; for a family of four $110,250).

- **Facilitated Public Health Insurance Enrollment**: While not health insurance, HSF had reduced the number of uninsured by identifying uninsured residents eligible for, but not enrolled in public health insurance (e.g., Medicaid). Approximately 5,200 residents applying for HSF were identified as eligible (either themselves or a family member) for public health insurance.

- **Broaden Network of Providers**: The provider network was expanded to include a non-profit clinic (Sister Mary Philippa), a private physician group with an associated hospital (Chinese Community Health Care Association and Chinese Hospital) and three non-profit hospitals systems (California Pacific Medical Center and its four campuses, Catholic Healthcare West and its two campuses, and University of California, San Francisco Medical Center radiologic facilities at Mission Bay). It also worked to further expand the network effective July 1, 2009 with the addition of a non-profit health plan (Kaiser Foundation Hospitals & Health Plan) for fiscal year 2009-10.

- **Improved Initial Clinic Appointment Scheduling**: The Department launched its New Patient Appointment Unit (NPAU) to assist all new Department patients with making their first clinical appointment at one of the Community Oriented Primary Care clinics or San Francisco General Hospital primary care clinics.

- **Developed and Issued First Set of Utilization Reports:** The third-party administrator, San Francisco Health Plan, developed the program's clinical data warehouse that is used to examine utilization, access, quality and other HSF health data. The first set of utilization reports were issued in March 2009.

- **Launched Quality Improvement Activities:** The HSF chronic care disease management program, Strength in Numbers, was initiated. Its first effort focused on medical homes expanding the use of registries for diabetes disease care management.

- **Offered Program to Employers:** Since implementation of the Employer Spending Requirement, 980 employers have selected the City Option (which includes HSF and a Medical Reimbursement Account component) on behalf of 42,300 employees.

- **Implemented Interface with Human Services Agency:** HSF's web-based system used to enroll applicants (One-e-App) was modified to allow application assistors to electronic interface between Medi-Cal's enrollment database and the HSF applicant screening system.

- **Partnered with Veterans Affairs to Expand Access to Care:** The Department and the San Francisco Veterans Affairs Downtown Clinic joined forces to identify HSF participants who might be eligible to receive veterans' health benefits. In 2008-09, almost 150 HSF participants who served in the armed forces were identified.

- **Documented Low Number of HSF Participant Complaints:** A review of participant complaints suggests relatively few problems with access to care, the provider network or the quality of services. From July 2008 to June 2009, the program's customer service tracking system logged 363 participant complaints.

- **Launched Evaluation Activities:** During the year, the Department launched a health access questionnaire as part of the HSF application process, selected Mathematica Policy Research, Inc. as the program's independent evaluation consultant and worked with Kaiser Family Foundation to conduct an independent participation satisfaction survey. In August 2009, the results of the survey were released with major findings that HSF participants expressed high levels of satisfaction with the program (94%) and signs of improved access to care.

II. 2008-09 PROGRAM ACTIVITIES

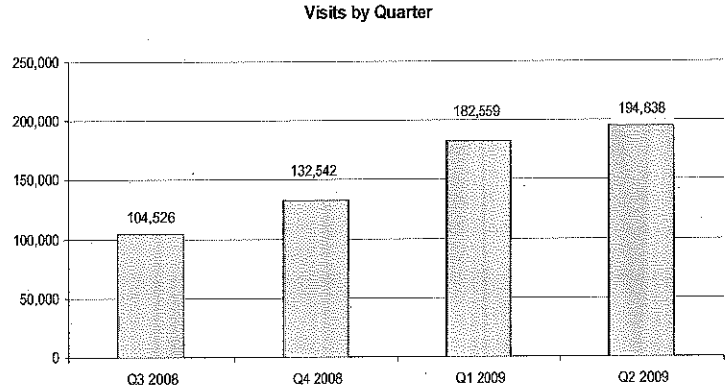
A. COMMUNICATIONS, OUTREACH, APPLICATIONS AND ENROLLMENT

Communications and Outreach

The Healthy San Francisco (HSF) Communications and Outreach program includes planning, development, and implementation of new and on-going program messaging and materials. Key stakeholders impacted by Communications and Outreach activities include participants, future participants, providers, press, community based organizations, employers, employees and others. On-going tasks include website development and maintenance, coordination of media and public relations, development of all participant materials including handbooks, ID cards, correspondence and invoices, mail house services, creative/design services, and copywriting. During the 2008-09 fiscal year the San Francisco Health Plan, serving as the program's third-party administrator, created or revised 34 pieces of HSF program material.

The HSF website (www.healthysanfrancisco.org) continues to be the most accessible and versatile program communications tool. With no formal marketing/advertising program, HSF relies heavily on word of mouth and community outreach to generate interest and attention. The following are website highlights for the year ending June 30, 2009:

- The website had a total of 614,465 visitors during the year with visits rising each quarter.
- On average, over 51,205 people visited the website monthly.



Like website visits, calls to the City and County's 3-1-1 remained steady throughout the reporting year ending June 2009. It is estimated by 3-1-1 staff that on average approximately 310 people called 3-1-1 for information about HSF each month.[1] HSF was one of the top-rated reasons that people called 3-1-1 (behind MUNI and street repairs) from July 2008 through June 2009. This is attributed to the continued widespread publication of 3-1-1 as the primary telephone number for information about applying for HSF.

[1] The City's 3-1-1 does not maintain an exact count of how many calls are received about specific City program or services.

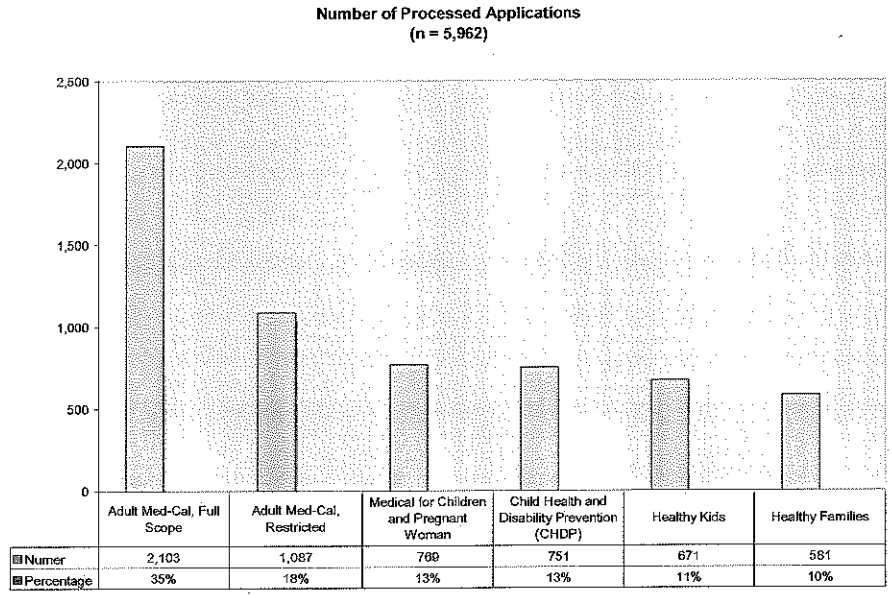
Applications

Communication and outreach are designed to facilitate enrollment and provide participants with readily accessible information about the program. HSF enrollment starts with the Certified Application Assistors (CAAs). HSF has over 100 CAAs who assist residents in applying for the program. CAAs are a critical first step to HSF enrollment. There are over 25 different locations (primarily HSF medical homes) where residents can apply for the program. Since the debut of the program in July 2007, Application Assistors have processed over 70,700 applications for HSF through the web-based eligibility and enrollment system – One-e-App.

Table A1
Number of HSF Applications Processed (July 2007 – June 2009)

Application Type	# of Applications	# of Applicants	Applicants per Application
New HSF Application	52,572	60,056	1.14
Renewal HSF Application	18,177	18,177	1
All HSF Applications	70,749	78,233	1.1

In general, for any new HSF application processed, a resident can be determined eligible for HSF or eligible another program. Of the 52,572 applications for HSF, CAAs processed 5,962 (11.3%) of them for other public health programs. The chart below provides the number and program distribution of non-HSF applications.



Of the 5,962 applications, approximately 5,211 were for public health insurance. This provides evidence that while not health insurance, HSF helps reduce the number of uninsured by identifying uninsured residents eligible for, but not enrolled in, public health insurance (e.g., Medicaid) and facilitates enrollment into the appropriate program with use of One-e-App.

In 2008-09, the Department, the City and County's Human Services Agency and the Center to Promote Health Care Access (One-e-App vendor) made improvements to One-e-App to facilitate enrollment into Medicaid. With the Human Services Agency as the lead agency, One-e-App was modified to enable an

electronic interface between Medi-Cal's enrollment database and the HSF applicant screening system. This linkage enables both agencies to redirect applicants to the most appropriate program. Prior to this modification, CAAs completed Medi-Cal applications for eligible applicants using the One-e-App electronic eligibility system and had to print a paper copy for submission, or complete an entire Medi-Cal paper application. In both cases, a Human Services Agency employee was required to come on-site to collect the completed paper applications and manually transport the application materials to the Human Services Agency for review and processing. This manual process lengthened the disposition process for the applicant and contributed to operational inefficiencies. With the creation of an electronic interface, the CAA can transmit a completed Medi-Cal application, including electronic images of supporting documentation, directly to the Human Services Agency's Cal-Win system. This process streamlines the application process by eliminating the need for data entry by the eligibility worker. Initial results suggest that the interface has resulted in more Medi-Cal applications being submitted through One-e-App. CAAs were trained on this new process in March 2009.

Eligibility Expansion

In keeping with the program's intent to make HSF available to uninsured residents over the Federal Poverty Level (FPL), in February 2009, uninsured San Francisco residents with household incomes up to 500% FPL became eligible to enroll in Healthy San Francisco ($54,150 for a family of one and $110,250 for a family of four). The expansion recognizes the fact that uninsured residents with modest incomes also have difficulty accessing comprehensive health care services. Prior to this expansion, the income eligibility threshold was 300% FPL.

Enrollments

The remaining completed applications lead to HSF enrollment. The most recent data from the statewide California Health Interview Survey (CHIS) estimates 60,000 uninsured adults.[2] CHIS provides information used to determine to potential maximum number of participants (assuming that all uninsured adult residents are all enrolled in this voluntary program at any one time, which is unlikely). The random nature of program enrollment makes it more difficult for the Department to estimate what overall enrollment might be at the peak of the program.

Since the program's inception, there have been 59,698 HSF participants (both current and former), very close to the number of estimated uninsured adults (60,000). This would suggest that the Department has saturated enrollment into the program. However, as the Department has previously noted, CHIS is a bi-annual survey and there is always a lag between when the data is collected and when the analyzed data is released. The current 60,000 uninsured adult estimate was based on the CHIS survey that was conducted in early 2007 during the tail-end of a U.S. economic expansion and the findings were released in late 2008/early 2009 during a U.S. economic downturn. It is difficult to ascertain the exact impact the current recession will have on the health insurance trends. But, it is clear that it will most likely result in an increase in the number of uninsured – although it is not known to what degree given that the economy is still in the midst of the downturn. It is possible that the Department is witnessing aspects of this in the HSF enrollment numbers.

[2] The University of California at Los Angeles' Center for Healthy Policy Studies has conducted the California Health Interview Survey (CHIS) survey since 2001. The survey is done every two years. The most recent survey findings from 2007 were released in December 2008. Because the City and County does not conduct a separate survey to estimate the number of uninsured residents, the Department relies on CHIS for the estimate of uninsured residents.

In addition, as with any survey, CHIS has limitations which may be more pronounced in using it as an estimate for the number of adult uninsured. The limitations are:

- Nature of Phone Survey: CHIS, like any phone survey, undercounts homeless, who have limited phone access. Fifteen percent (15%) of participants (approximately 6,500) are homeless.
- CHIS Statistical Corridor: The 95% confidence interval for the number of adult San Franciscans currently uninsured in 2007 was 6.5% - 14.8% of adult San Franciscans, which means that there is a 95% probability that the actual number of uninsured is between 36,725- 83,620 individuals. The midpoint of this is 60,000.
- Currently Uninsured vs. Uninsured in the Last Year: The 60,000 estimate is the number of currently uninsured at the time of the survey. The total number who indicated in 2007 that they were uninsured for at least part of the past year was at 84,000.[3]

During the 2009-10 fiscal year, the Department will assess whether the estimated number of uninsured adults should be revised based on enrollment activity to date.

While a total of 59,698 have been enrolled in HSF since the program began, at the end of the 2008-2009 fiscal year, there were 43,225 individuals in HSF (72% of the estimated 60,000 uninsured adults in San Francisco). Below is information on the pace of enrollment over the last two years.

Table A2
Average Monthly Enrollment Increase

Fiscal Year (Program Year)	Avg. Monthly Increase
2007-08 (1st program year)	2,000
2008-09 (2nd program year)	1,500

Renewals

Of the 43,225 enrolled in the program at the end of the fiscal year, 13,401 (31 %) were participants who had renewed their eligibility into the program. The HSF eligibility is for a 12-month period and the program requires participants to renew their eligibility annually. If the renewal is not done before the 12-month period expires, the participant is disenrolled from the program due to non-renewal (explained later in this report).

All application assistors have been to trained stress the importance of the program's one-year eligibility and required renewal to applicants/participants. To ensure timely renewals, participants receive mailed renewal notices 90, 60, and 30 days prior to the end of their annual term reminding them to do an in-person renewal. In conjunction with the renewal reminder notices, if a participant has not renewed within 45 days of the end of their annual term, then they will receive an automated phone call reminding them to renew. In addition, during this fiscal year the program began stressing the importance of renewing on time in each issue of Heart Beat, the HSF participant newsletter.

Disenrollments

As noted above, there have been 59,698 HSF participants. Of these, 43,225 are current participants and 16,473 are former participants who have enrolled and then disenrolled from the program. Of those who disenrolled (16,473), 4,515 subsequently re-enrolled into the program resulting in current participant disenrollments of 11,958 (16,473 – 4,515 = 11,958). The 4,515 individuals who re-enrolled are included

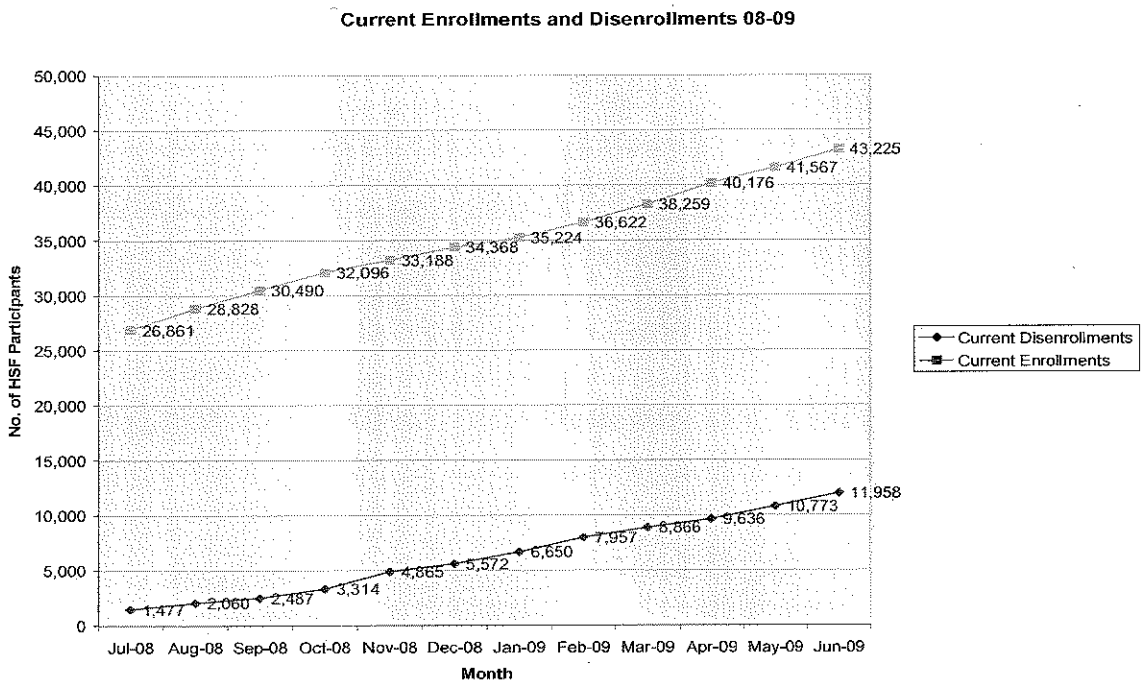
[3] Of those, 45,000 said no insurance for all of the past year, 39,000 said no insurance for at least part of last year.

as part of the 43,225 current participants. The resulting disenrollment rate is 20% (11,958 currently disenrolled participants divided by 59,698 total participants who have ever been in the program).

Disenrollments can occur because participants no longer meet the program eligibility criteria, no longer choose to remain in the program and voluntarily disenroll, do not pay the required quarterly participation fee, etc. Department staff regularly monitors and analyzes participant disenrollments from the program. In addition:

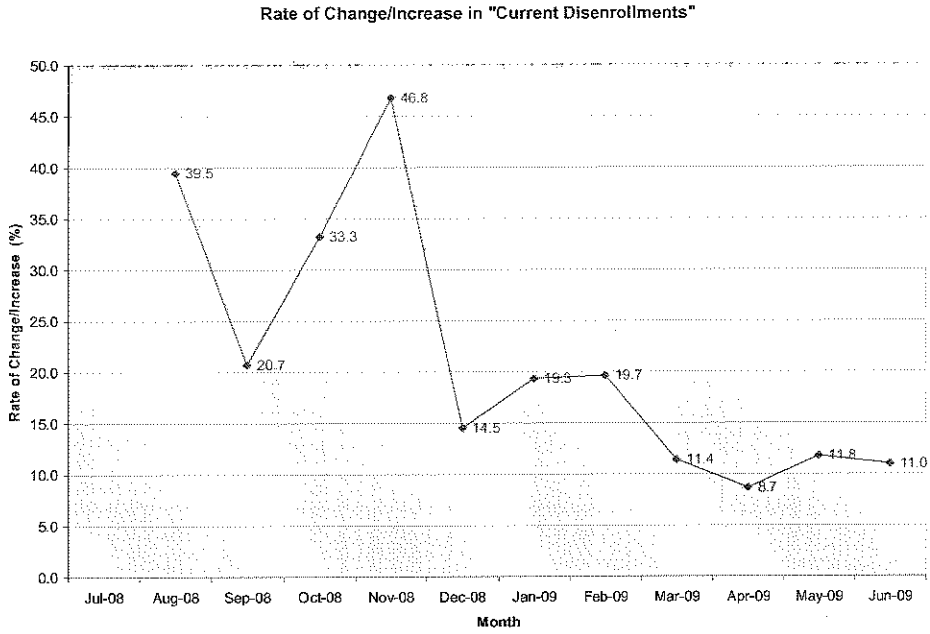
- disenrollments are done by HSF customer service or application assistor supervisors,
- participants receive notification of their disenrollment and
- participants can re-enroll after a disenrollment.

As the number of participants enrolled into HSF continues to rise, the number of participants disenrolled does as well. This parallel relationship is a natural progression. As more participants are enrolled, more are required to renew, and more may not due so for the reasons mentioned above. The chart below demonstrates this relationship over the past fiscal year.



However, it is important to note that while disenrollments have increased over time, the rate of increase slowed during the past year, indicating the renewal efforts made by the HSF Renewal Committee and application assistors are working. Though disenrollment figures are still increasing in reaction to the rise in enrollments, this increase has decelerated. The chart on the next page demonstrates the initial variation but eventual steady decline of the rate of disenrollment increase per month. Note that the spike in the rate of change was highest in the months of September 2008 to November 2008. This is because HSF debuted during the months of July 2007 and August 2007, but was launched City-wide in the month of September 2007. Residents who enrolled during the first few months after the launch were in the initial group of participants who had to renew their eligibility after 12 months of program

participation. While the HSF program sends participants 90, 60, and 30 day renewal notices, this process was new for some participants.



At of the end of the 2008-09 fiscal year, there were 11,958 current disenrollments for the following reasons:

Table A3
Disenrollments by Reason

Current Disenrollments by Reason	*# Disenrolled*	*% of Disenrollments*
Program Eligibility	3,118	26%
Participation Fee	1,826	15%
Annual Renewal	6,934	58%
Other/Voluntary	80	1%

1. Disenrollment Due to Program Eligibility (26% -- 3,118 participants)
The data indicates that 26% of those who were disenrolled no longer met the HSF program eligibility requirements. Specifically, these individuals obtained health insurance, aged-out of the program when they turned aged 65 and moved out of San Francisco and no longer met the residency requirement.

Table A4
Program Eligibility Disenrollments

Disenrollment Reason	*Number*	*Percentage*
Enrolled in Public Coverage	1,459	47%
Exceeds Program Age Requirements	620	20%
Determined Eligible for Other Programs During Renewal or Modification	384	12%
Enrolled in Employer-Sponsored Insurance	346	11%
Not a San Francisco Resident	204	7%
Enrolled in Private Insurance	105	3%

2. Disenrollment Due to Participation Fee (15% - 1,826 participants)
Disenrollments due to insufficient payment of the quarterly participation fee represent 15% of program disenrollments. These disenrollments were reflected in the following manner:

- Participant indicates they could not afford participation fee – 103 disenrollments
- Insufficient payment of participation fee – 1,723 disenrollments

Below is information on disenrollments due to insufficient payment of the participation fee. The information suggests that disenrollment due to insufficient payment of participation fee is not directly related to income level, but may relate to ability to pay.

Table A5
Participation Fee Related Disenrollments

FPL Category	Total No. of HSF Enrollments by FPL (A)	% of Enrollments in FPL Category (B = A÷43,225)	Total No. of Insufficient Payment Disenrollments by FPL (C)	Disenrollments as a % of Enrollments in FPL Category (D = C÷A)
0-100%	30,272	70%	0	0%
101-150%	5,167	12%	797	15%
151-200%	4,523	10%	494	11%
201-250%	1,715	4%	345	20%
250-300%	1,191	3%	145	12%
301% +	357	1%	45	13%
	43,225		1,826	

Disenrollment due to participation fee can occur for many reasons. As the Department has indicated previously:

- Some qualified for public insurance prior to their participation fee being due – based on services data, but an "insufficient payment" disenrollment was recorded and may not be accurate.
- For some people, disenrollment may represent the fact that they already received the services they needed.
- Some may find participation fee costly as highlighted by the 103 individuals that indicated they could not afford the participation fee. If a participant's income is reduced, then they can be re-evaluated for potential lowering of the participation fee.

The Department was interested in understanding the utilization of services among those with a participation fee related disenrollment. It was able to do an analysis on 352 of these disenrolled individuals based on the fact that the disenrolled participant sought services from the Department after disenrollment and the Department maintained services data records in the Invision system. Data show:

Table A6
Department Incurred Health Care Costs for 352 Disenrolled Participants with a Participation Fee Related Disenrollments

Enrollment Status	Est. DPH Cost	Cost Covered by Third-Party Insurance	Perc. of DPH Cost
DPH Health Costs After Disenrolled from HSF	$2,270,067	$1,841,887	81%

Of those who had sought services from the Department after being disenrolled from HSF ($2.27 million), 81% of those costs (or $1.84 million) were coded in the Department's patient financial system with some form of insurance (i.e., Medicare, Medi-Cal, commercial or capitated plan). This supports the notion that some disenrollments coded as "insufficient payment" were most likely in actuality disenrollments due to obtaining health insurance. There may be more disenrollments that fall into this category, but the disenrollment participant has not received services from the Department.

3. Disenrollments Due to Incompletion of Annual Renewal (58% -- 6,934 participants)
An incomplete annual renewal was the most frequent reason for HSF program disenrollments (58%). The majority of individuals disenrolled for not completing the reenrollment process (84%) had annual incomes at or below 100% of the Federal Poverty Level, pay no participation fees or point-of-service fees and as a result, should face no financial barrier to program renewal. But, it is also true that individuals at this income level have many other factors that impact their lives and may not view renewing their HSF enrollment as their highest priority. Some individuals may simply wait until their next clinical appointment to renew their eligibility. To help ensure that eligible participants renew in a timely manner, in 2008-09, the Department the renewal notices with an automated telephone call reminder system and regular message on the importance of renewing in Heart Beat, the participant newsletter.

4. Disenrollment Due to Other Reasons (1% -- 80 participants)
The remaining disenrollments were voluntary or involuntary due to either dissatisfaction with the program, death, or providing false or misleading information on the program application.

Table A7
Other Disenrollments

Disenrollment Reason	*Number*	*Percentage*
Program Dissatisfaction	48	60%
Participant is Deceased	19	24%
False or Misleading Information on HSF Application	13	16%

With respect to enrollment and disenrollment patterns overall, given that HSF is a voluntary program and that people always have the right to rejoin after a disenrollment (unlike health insurance), the Department expects that there will always be a certain proportion of disenrollments within the program.

Reenrollments
Individuals who are disenrolled from the program have the option to re-enroll at any time. In total 4,515 individuals who had been disenrolled from the program re-enrolled into the program and are current participants again. The data below indicates that the initial disenrollment reasons for the majority of re-enrollments were incomplete annual renewal (71%) and participation fee related (19%).

Table A8
Re-enrollments by Original Disenrollment Reason

Original Disenrollment	*Number*	*Percent*
Program Eligibility	416	9%
Participation Fee Related	880	19%
Incomplete Annual Renewal	3,201	71%
Other	18	1%

Churn

In an effort to determine the impact of the program's eligibility and enrollment provisions on program retention, the Department conducted a further analysis of disenrollment examining the frequency of multiple enrollments and disenrollments by program participants (known as "churn" for the purposes of this report).

The Department defines churn as a program participant with two or more disenrollments. Specifically, a participant has enrolled into the program at least twice and has been disenrolled from the program at least twice. Since the program's inception (from July 2007 to June 2009), 314 individuals had at least two disenrollments. The Department analyzed the disenrollments and grouped the data into the following categories:

1. Participant had two or more participation fee disenrollments
2. Participant had at least one participation fee disenrollment and one disenrollment for another reason
3. Participant had two disenrollments, neither of which was related to participation fee

The data indicates that the majority of HSF participants with two or more disenrollments (49%) were in Category No. 3 (no fee related disenrollment reasons), forty-four (44%) had one fee related disenrollment reason and one non-fee related disenrollment reason, and the remaining individuals (7%) had two participation fee related disenrollments.

Table A9
Analysis of Multiple Disenrollments

Category	*Disenrollment Reason (2 or more)*	*Number*	*Percent*
1	Two Participation Fee Related Disenrollments	21	7%
2	One Participation Fee Disenrollment & One Other Disenrollment	139	44%
3	Two Non-Participation Fee Related Disenrollments	154	49%

Of the 314 participants all had two disenrollments; none had more than two disenrollments.

B. PARTICIPANT DEMOGRAPHICS

The following chart provides basic demographic information on the 43,225 participants enrolled at the end of the fiscal year:

Table B1
Demographics for HSF Participants

Age	11% are 18 - 24; 40% are 25 - 44; 25% are 45 - 54; 24% are 55 - 64
Ethnicity	40% Asian/Pacific Islander; 24% Latino; 18% Caucasian; 9% African-American, 3% Other; less than 1% Native American; 6% Not Provided
Gender	48% female; 52% male
Income	70% at/below 100% FPL; 22% between 101 – 200% FPL; 7% between 201 – 300% FPL; 1% at/above 301% FPL
Language	49% English; 28% Cantonese/Mandarin; 19% Spanish; 1% Vietnamese; 1% Filipino (Tagalog and Ilocano); 1% Other

Across neighborhoods, 26% of HSF participants reside in either the Excelsior or Mission districts. Data indicate that homeless individuals comprise 15% of all HSF participants.

Over the course of the fiscal year, the Department observed the following trends with respect to participant demographics:

- Age: Increase in percentage of participants aged 18-24 and 25-44 – from 7% to 11% and from 38% to 40%, respectively.
- Ethnicity: Decrease in number of participants who elect not to provide their ethnicity – from 12% to 6%. Slight percentage increases for participants who indicate ethnicity of Asian/Pacific Islander, Caucasian and Other – 2%, 3% and 1%, respectively.
- Gender: Stable distribution in enrollment by gender
- Income: Decrease in percentage of percentage with incomes at or below 100% of the Federal Poverty Level (FPL) – from 76% to 70% tied to raising the program's income eligibility.
- Language: Stable distribution in enrollment by language

Overall, the average household size per HSF application is 1.1 (number of individuals on each HSF application divided by the number of HSF applications that resulted in HSF enrollment).

Twenty-seven percent (27%) of all those enrolled were not previous users of the health care delivery system (i.e., "new" – defined as an individual who self-reported that they had not received clinical services within the last two years from the primary care medical home they selected as part of the HSF application process). The remaining 73% of program participants are existing safety net patients.

The Department was interested in determining if those enrolling in HSF mirror the overall uninsured adult population based on the 2007 California Health Interview Survey (CHIS) which was used to estimate the number of uninsured adults in the City and County. The Department compared the HSF demographics to CHIS demographics to determine if HSF was enrolling a comparable population.

Data reveals the following:

- Gender: HSF's population is more gender-balanced than the CHIS survey population. According to the CHIS data, 68% of uninsured San Francisco adult residents are male and 32% are female. However, 52% of HSF participants are male and 48% are female.

- Income [Federal Poverty Level (FPL)]: The data suggests that HSF is enrolling a more low-income population. CHIS records indicate 44% of uninsured San Francisco adult residents have incomes below 99% FPL and 56% above 100% FPL. HSF data shows 70% of its participants fall below 100% FPL and 30% above.

- Race/Ethnicity: According to the data, the race/ethnicity of HSF participants seems similar to that of the residents surveyed through CHIS with some differences for Asian/Pacific Islander (i.e., a higher percentage of HSF participants are Asian/Pacific Islander than were found in CHIS).

- Language: In comparison to CHIS, fewer HSF participants consider English as their primary language (49% compared to 66% for CHIS) and more consider Chinese to be their primary language (28% compared to 15% for CHIS).

- Age: The data reveal that HSF has an older population with a higher percentage aged 40 – 64 (CHIS at 42% and HSF in excess of 50%) and that a similar percentage of uninsured between the ages of 18 – 24 for both CHIS (9%) and HSF (11%).

See Appendix A for the more detailed analysis.

C. DELIVERY SYSTEM

HSF services are provided through a public/private partnership. The provider network for HSF is broader than the Department of Public Health by design because:

- the Department does not have the clinical capacity to be the sole provider of health care to all uninsured residents and
- prior to HSF, several safety net/traditional providers delivered care to this population and there is a desire to preserve these existing patient/provider relationships.

This public/private partnership is critical to meeting HSF goals to improve access to care via the primary care medical home and expand access by increasing the number of clinics/providers participating in HSF.

2008-09 Provider Network Expansions

The HSF provider network expanded in 2008-09 to include additional medical homes and hospitals. The following provides an overview of the provider network expansions over the course of last year:

Table C1
Delivery System Changes 2007-08 to 2008-09

Component	At End of Fiscal Year 2007-08	At End of Fiscal Year 2008-09 (New Components Bolded)
Primary Care Medical Homes	o Department of Public Health (14 clinics at 11 sites) o San Francisco Community Clinic Consortium (8 clinics at 13 sites)	o Department of Public Health (14 clinics at 11 sites) o San Francisco Community Clinic Consortium (8 clinics at 13 sites) o **Chinese Community Health Care Association (2 sites)** o **Sister Mary Philippa Clinic**
Hospital Participation	San Francisco General Hospital	o San Francisco General Hospital o **California Pacific Medical Center (4 campuses)** o **Chinese Hospital** o **Saint Francis Hospital** o **St. Mary's Medical Center** o **UCSF Medical Center**
Behavioral Health	Community Behavioral Health Services (DPH)	Community Behavioral Health Services (DPH)

The expansions were:

- Adding a new primary care medical home – Sister Mary Philippa, a non-profit clinic.
- Adding an independent, private physician's group and its associated hospital -- Chinese Community Health Care Association and Chinese Hospital. Participants who select CCHCA-Chinese Hospital as a medical home have the option of accessing services at either Sunset Health Services, Excelsior Health Services, or with an individual CCCHA provider.
- Increasing the number of hospitals participating in HSF from 1 to 6 (including Chinese Hospital referenced above). In addition to San Francisco General Hospital, the following now participate in HSF: [4]

[4] In the case of emergency services, participants will receive services at the nearest available hospital with clinical capacity. This may not be the hospital associated with their medical home.

- Saint Francis (CHW) – inpatient services to those with Glide Health as medical home,
- St. Mary's (CHW) – inpatient services to those with Sr. Mary Philippa as medical home,
- California Pacific Medical Center (4 campuses) – inpatient services to those with North East Medical Services as medical home and
- UCSF Medical Center – referral-based diagnostic imaging services at Mission Bay site.

In addition, during this fiscal year, the San Francisco Health Plan, as the program's third-party administrator, led the effort to ensure that Kaiser Permanente was added to the provider network. In June 2009, Mayor Gavin Newsom announced that effective July 1, 2009 (fiscal year 2009-10), Kaiser Permanente San Francisco Medical Center would participate in HSF. Kaiser, the first health plan to participate in HSF, will provide primary, emergency, specialty, diagnostic, pharmacy and inpatient services. It serves as a medical home for HSF participants. Note that while Kaiser Permanente is a health insurance plan, it is not participating in HSF as a health insurer. HSF is not health insurance and any San Francisco resident who selects Kaiser as their medical home will not be provided health insurance even though their medical home is Kaiser. As with all HSF participants, their health services benefits under the program are confined to the City and County of San Francisco and cannot be used at Kaiser facilities in other counties. Kaiser will be able to accommodate up to 3,000 HSF participants.

Within the Department, expansions to meet increased HSF enrollment and ensure access to care took the form of:

- hiring additional clinical and administrative staff within primary care settings (both Community Oriented Primary Care and San Francisco General Hospital) and
- hiring additional clinical staff at San Francisco General Hospital for pharmacy services, utilization management and specialty services.

Medical Home Distribution

HSF participants select a primary care medical home (i.e., health clinic) of their choice at the time that they enroll in the program. The primary care medical home is where participants receive all of their primary care and preventive services. The medical home also coordinates participant-needed access to specialty, inpatient, pharmacy, ancillary, and/or behavioral health services and helps a participant navigate through the delivery system.

The following provides the 2008-09 distribution of HSF participants across the four primary care medical home delivery systems:

- Chinese Community Health Care Association (CCHCA) – 2.1% (909 participants)
- Department of Public Health (DPH) – 51.2% (22,154 participants)
- San Francisco Community Clinic Consortium (SFCCC) – 44.4% (19,213 participants)
- Sister Mary Philippa Health Center (Sr. Mary) – 2.2% (949 participants)

Medical Home Capacity

It is important that the program works to ensure capacity/access for all participants and this starts at the time a person enrolls into the program. The HSF program tracks each medical home's capacity (i.e., "open/closed" status) by sending an e-mail twice a month (every 15-calendar days) to the designated point person at each of the following delivery systems: San Francisco General Hospital primary care clinics, Community Oriented Primary Care clinics, Chinese Community Health Care Association, Sr. Mary Philippa and San Francisco Community Clinic Consortium clinics.

HSF medical home open/closed status is determined primarily by appointment availability. When HSF medical homes provide information on their open or closed status, they take into account clinical appointment needs for patients with other payor sources such as Medi-Cal, Healthy Families, Healthy Workers, Sliding Scale, self-pay, etc. A HSF medical home is considered "open" in the program's web-based enrollment system (one-e-App) when clinical appointments for new participants are available within 60 days. A HSF medical home is considered "closed" when clinical appointments for new patients are not available within 60 days.

Of the 30 HSF medical homes, some serve specific populations. For example, HSF has three medical homes that serve participants in specific age brackets. These are Larkin Street Youth Clinic (19-24), Cole Street Youth Clinic (19-24) and Curry Senior Center (55 and above). These medical homes are open to applicants within the clinics age category, but closed to applicants not within these age ranges.[5] In addition, there are three HSF medical homes open to all existing patients and to new patients who meet specific population criteria:

1. *Housing and Urban Health Clinic* is for individuals who reside in supportive housing units managed by the Department. The clinic is on-site or near the housing units. HUH is open to HSF participants, but only those in supportive housing.
2. *Positive Health Clinic* is open to HSF participants, but only to those who are a certain stage in their HIV/AIDS illness. A HSF participant with HIV who has a different medical home has the ability to change their medical home and move into Positive Health if their HIV/AIDS illness progresses to a stage such that their primary care medical home is not equipped to fully care for their primary care needs. This helps ensure that Positive Health maintains its focus on providing needed primary care services to the HIV/AIDS population.
3. *Tom Waddell Health Center* is for the general population, but the vast majority of its patient population is homeless. While all Department clinics serve homeless individuals, Tom Waddell serves a disproportionate number given its clinical and staff expertise. As a result, the clinic shows up as "closed" as one of the medical home selection, but is open to its target population to ensure sufficient clinical capacity for this at-risk population.

During the 2008-09 fiscal year, at any one time, no more than six of the 30 HSF medical homes were closed to new participants. At the end of the 2008-09 fiscal year, the following medical homes were closed to new participants for the following reasons:

- on an interim basis with an expected reopening (1) – Ocean Park Health Center
- reached clinical capacity for accepting new participants (5) – General Medicine Clinic, Family Health Center, Chinese Community Health Care Association, Sister Mary Philippa and Mission Neighborhood Health Center (Excelsior location).

Provider Relations

During the 2008-09 fiscal year, the third-party administrator (San Francisco Health Plan) worked on the following efforts to assist providers in the program:

- Network Operations Manual – December 2008: The Healthy San Francisco Network Operations Manual was developed for Healthy San Francisco providers. The manual provides medical home

[5] The program originally "closed" these medical homes to new patients in One-e-App as a way to prevent application assistors from inappropriately routing applicants who were outside of the age criteria. This resulted in only permitting individuals who self-identified as existing patients at these locations to select these sites as their HSF medical home. In June 2009, the Department modified One-e-App by creating a pop-up screen to facilitate new participant enrollment into Larkin Street Youth Clinic, Cole Street Youth Clinic, and Curry Senior Center. The pop-up message prompts application assistors to double-check that the applicant meets the designated age criteria for these specific sites before confirming the medical home selection.

administrators and staff with a reference to HSF program policies and procedures. It also clarifies the roles of HSF program staff and medical home staff.

- Locations of Services Grids – March 2009: The Healthy San Francisco Location of Services Grids were developed to assist medical home and facility staff navigate HSF services. The grids list ambulatory consultations, services, procedures, and same day surgeries, and the locations in which they should be accessed (i.e. at the Medical Home or affiliated facility). The grids are provided to all participating provider systems.

- Provider Inquiries Report – April 2009: HSF Provider Relations began tracking provider inquiries in January 2009. The HSF Provider Inquiries Report is produced to assist in tracking and analyzing the provider inquiries that HSF Provider Relations receives.

New Patient Appointment Unit

In line with program goals to improve patient access and appointment scheduling, in September 2008, the Department implemented the New Patient Appointment Unit (NPAU). NPAU is a centralized call center for new Department patients seeking to make their first clinical appointment at one of the Community Oriented Primary Care (COPC) clinics and San Francisco General Hospital (SFGH) Primary Care clinics. The NPAU does not make new patient appointments for non-DPH patients and insured patients. New patients are individuals that have not been seen at a Department clinic in the past two years from the date that they were enrolled in a health care program.

The NPAU makes new patient appointments for the following health care programs/payor sources: Healthy Families, Healthy Kids, Healthy San Francisco, Healthy Workers, Medi-Cal, Medicare, and Sliding Scale. All new DPH patients that are enrolled in a health care program receive a one-pager flyer informing them to contact the NPAU to schedule their first clinical appointment. In fiscal year 2008-09, the NPAU received 7,817 calls from individuals (duplicated and unduplicated).

Table C2
New Patient Appointment Unit Call Volume
[Represents Calls, Not Participants]
(September 15, 2008 – June 30, 2009)

Program	*Number of Calls*	*% of Total Calls*
Healthy San Francisco	4,288	55%
Healthy Workers	1,442	18%
Medi-Cal/Medicare	542	7%
Sliding Scale	58	<1%
Healthy Families	1	<1%
Other	1,486	19%

The data indicates that the majority of the NPAU calls related to HSF (55%). The remaining NPAU calls were from individuals covered by Healthy Workers (18%) and Medi-Cal/Medicare (7%). Other NPAU calls (19%) were from individuals that had a non-DPH medical home, were existing patients, or had not enrolled in a health care program. These individuals are directly referred to their medical home or the Department's Eligibility and Enrollment Unit.

NPAU staff will schedule the new HSF participant's first clinical appointment within 60 days of the participant contacting the Unit. From the launch of the NPAU to the end of the fiscal year, 5,779 new

HSF applicants had selected a Department clinic as their HSF medical home. It is important to note that not all new HSF participants selecting a DPH medical home will contact the NPAU to schedule their first clinical appointment immediately after enrollment. Call data indicates that roughly 37% (2,157 of 5,779) of these new HSF participants contacted the NPAU for their first clinical appointment. The 2,157 callers is an unduplicated number.

Of those new unduplicated HSF participants (2,157) that contacted the NPAU, the following provides information on when they did so:

- 42% called within 15 days of enrollment
- 15% called between 16 to 30 days of enrollment
- 10% called between 31 to 45 days of enrollment
- 7% called between 46 to 60 days of enrollment
- 26% called more than 60 days after enrollment

Further, of these 2,157 new unduplicated HSF participants, 51% (1,105) obtained a new patient appointment the first time they called the NPAU. Of the remaining 1,052 that did not receive an appointment the first time they call the NPAU, roughly 60% were contacted by NPAU staff and received a new patient appointment. The other 40% were not scheduled for appointments for such reasons as NPAU staff was unable to reach participant or participant no longer needed an appointment.

D. CLINICAL COMPONENT/SERVICES UTILIZATION

Healthy San Francisco (HSF) maintains a clinical data warehouse that is managed by the program's third-party administrator, the San Francisco Health Plan (SFHP). The major functions of the HSF Data Warehouse are to:

- develop and maintain data standards,
- ensure secure collection, transmission protocols, processing and data quality, and
- analyze and report data findings (with specifications).

SFHP oversees the collection and analysis of all encounter data from entities in the provider network. Collection and analysis of encounter data is one key approach to ascertaining the extent to which the program is meeting its goals. Appendix B provides an overview of the data collection efforts from HSF providers.

In March 2009, the Department reported initial utilization data for the program (based on July 2007 to December 2008 data) and identified key caveats regarding the limitations of data interpretation. Many of these limitations still exist with respect to interpreting the data that follows. Principally they are:

- Analysis of service utilization is dependent upon having complete data from all HSF providers -- medical homes, hospitals and ancillary/specialty providers. At this point, the Department does not have complete data from all of these providers. As a result, it is likely too early for the Department to site conclusive results about the impact of the HSF program on hospital inpatient, ancillary or emergency department utilization. The Department and SFHP remain committed to working collaboratively with participating providers to improve both the quality and completeness of HSF data so that the Department can accurately assess the impact of the HSF program on service utilization.

- All data has been submitted by primary care providers who were active in the program prior to March 31, 2009 with the exception of Lyon-Martin, whose data is not yet usable.

- Between September 2008 and June 2009 an additional five hospitals joined the HSF provider network (St. Francis Memorial Hospital, St. Mary's Medical Center, California Pacific Medical Center (CPMC), Chinese Hospital, UCSF Medical Center [radiologic referral services only]).
    - Though institutional services data has been submitted for four of the five hospitals, the data is still considered incomplete.
    - Hospitals provide some outpatient, emergency department and/or inpatient hospital services to HSF participants via "charity care" and track this information as such as opposed to as an HSF service. SFHP is working with these hospitals to report these encounters going forward so they may be included in HSF service data reporting.

- Currently, 95% of the institutional services reflected in this report were rendered at San Francisco General Hospital (SFGH). Almost all hospital admissions data was provided by SFGH, with the exception of a few admissions reported by other hospitals. Therefore, it is very likely that data on inpatient admissions, hospital days, inpatient surgical and ancillary procedures, and emergency department visits are under-reported for the fiscal year 2008-2009.

- When examining the changes in services data from one year to the next, it is important to remember that initial HSF enrollment can occur at the point of service when participants are receiving or will soon receive a service. Enrollment occurs at the point of highest need and use of services.

- It is not entirely reasonable to expect or witness system-wide affects of participant behavior in the early years of a program. Any changes in utilization or costs that are observed are most likely due to how participants were enrolled in the program (in this case, at the point of service). Changes in health seeking behavior (e.g., emergency department utilization) due to system changes take time, perhaps two to three years to observe.

It should be noted that HSF participants may seek services at non-profit hospitals for any of the following reasons:

1. a hospital has affiliated itself with a HSF medical home for the purposes of providing inpatient services,
2. a participant goes to the hospital for an emergency (either by ambulance or walk-in) or
3. a HSF participant might come to a hospital, as opposed to their medical home, for a non-emergency situation requesting outpatient services.

The Department and hospitals have a vested interest in using data from the hospitals to determine if there is a need to provide specific interventions, education, case management, etc. to HSF participants who may present at hospitals for non-emergencies. The Department and the San Francisco Health Plan are working collaboratively with the non-profit hospitals to obtain encounter level data that can be submitted to the HSF Data Warehouse.

The data that follow are for the 2008-09 fiscal year are based on actual data from July 2009 to March 2009 that has been annualized for a 12 month period (July 2008 – June 2009) unless otherwise noted.[6]

Utilization Data

The table below provides an overview of service utilization within the program. A review of 12 months of enrollment for the time period April 2008 to March 2009 revealed the following for those who utilized at least one of the following services during the time period.

Table D1
Service Utilization with Continuous 12-Month Enrollment

Service Category	% of Participants Utilizing at Least One Service in Any Period of Time
Primary Care Visit	78.32%
Specialty Care Visit	9.61%
Inpatient Admission	3.16%
Prescription	58.74%

The data in Table S2 indicates that utilization of health care services among HSF participants has decreased for the most part from fiscal year 2007-08 to the current fiscal year 2008-09 (annualized). It should be noted that hospital and emergency related data is for SFGH only in both years and may be incomplete. However, while it may be incomplete in that it does not include data from other hospitals and therefore could potentially underestimate utilization in both years, it is an "apples-to-apples" comparison with respect to utilization from one year to the next in those categories since data for both years is based on SFGH only data.

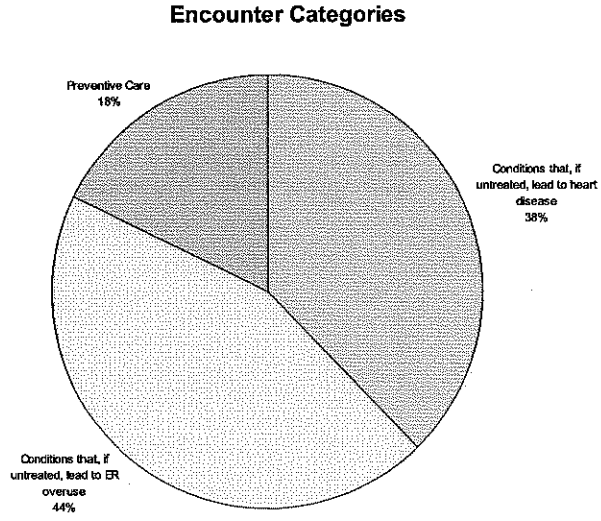
[6] The standard calculation for annualization is total number of visits divided by total participants multiplied by 12.

Table D2

HSF Health Care Utilization Data (July 2007 – June 2009)

Service Utilization	FY 2007-08 Actual	FY 2008-09 Annualized	Percent Change[7]
Avg. primary care visits per participant (w/ well visits)	3.85	3.17	-17%
Avg. specialty care office visits per participant	0.10	0.07	-30%
Outpatient laboratory services per participant	5.97	4.62	-23%
Outpatient radiology services per participant per year	0.84	0.68	-19%
Inpatient surgical procedures per participant	0.04	0.03	-25%
Outpatient surgical procedures per participant	0.34	0.26	-24%
Average number of prescriptions per participant per year	7.81	6.45	-17%
Hospital admissions per 1,000 participants (SFGH only)[8]	43.09	25.88	-40%
No. of hospital days per 1,000 participants (SFGH only)[9]	157.89	104.33	-34%
Average length of stay – hospitalization (SFGH only)[10]	3.66	4.03	10%
ED visits per 1,000 participants (SFGH only)[11]	216	157	-27%
Urgent care visits per 1,000 participants	169	158	-7%
Avg. mental health visits per participant (CBHS only)	1.55	1.28	-17%
Average mental health visits per participant	1.64	1.36	-17%
Avg. substance abuse visits per participant (CBHS only)	0.61	0.52	-15%

When the data is examined to determine the primary reason for a clinical visit, the encounter data for the top 20 primary reasons indicates that:



[7] A percent change from 2008-09 does not necessarily denote a statistically significant change.

[8] Data is from San Francisco General Hospital only.

[9] Data is from San Francisco General Hospital only.

[10] Data is from San Francisco General Hospital only.

[11] Data is from San Francisco General Hospital only.

The data indicates that most encounters are related to illness (82%) and not preventive care (18%) providing some perspective on the health status of HSF participants. Preventive care encounters include general medical exam, health counseling/consultation, cancer screening, pre-op examination. However, it is important to note that preventive care that occurs in the context of disease management (e.g., a mammogram that is ordered during a routine visit for hypertension management) is not counted as a preventive care encounter. Conditions that, if untreated, would lead to ER overuse include, but are not limited to joint pain, respiratory symptoms, back pain, and general symptoms. Conditions that, if untreated, would lead to heart disease are hypertension, diabetes, and high cholesterol. This finding is consistent with analysis of the top 20 medications (by therapeutic class): 5% were miscellaneous, 35% were for conditions that, if untreated, would lead to ER overuse and 60% were for conditions that, if untreated, would lead to heart disease.

Frequency of Visits/Services

HSF, like any health program, is comprised of those who use services in a given month and those who do not based on clinical needs. In addition, some participants may use services more frequently than others based on their clinical needs. The following provides information on the frequency of certain services over a 12-month period (January 2008 to December 2008) for those participants with continuous enrollment during that time period. This was chosen over fiscal year 2008-09 data to provide 12 months of actual data as opposed to 12 months of annualized data.

Table D3

Frequency of Visits/Services – Percentage of Participants

Utilization Category	None	1 – 4	5 – 9	10+
Average Primary or Well Visits[12]	25%	42%	23%	10%
Outpatient Laboratory[13]	40%	19%	22%	19%

Utilization Category	None	1 – 2	3+
Outpatient Radiology Services	67%	24%	10%
Surgical Procedures (Inpatient and Outpatient)	85%	11%	5%

Utilization Category	None	1 – 10	11 – 30	31+
Average Number of Prescriptions	42%	29%	19%	10%

For some participants enrolling in HSF there may be pent-up demand for health care services. One way to track this is by examining the number of participants who made an appointment for an initial office/well visits within a set period of time after enrolling into the program (see Table D4 on the following page). The data is for participants who were either existing or new patients. As the Department further refines its data statistics, it will separate this data out for existing and new patients.

[12] Data is for the Department clinics, Glide Health Services, Haight-Ashbury, Mission Neighborhood Health Center, Native American Health Center, NEMS, St. Anthony Free Medical Clinic and South of Market Health Center.

[13] Data is for the Department clinics, Glide Health Services, Haight-Ashbury, Mission Neighborhood Health Center, Native American Health Center, NEMS, St. Anthony Free Medical Clinic and South of Market Health Center. Frequency category "5 – 9" includes those who also had 10 laboratory services and frequency category "10+" includes only those with 11 or more laboratory services.

Table D4

Frequency of Visits/Services – Percentage of Participants

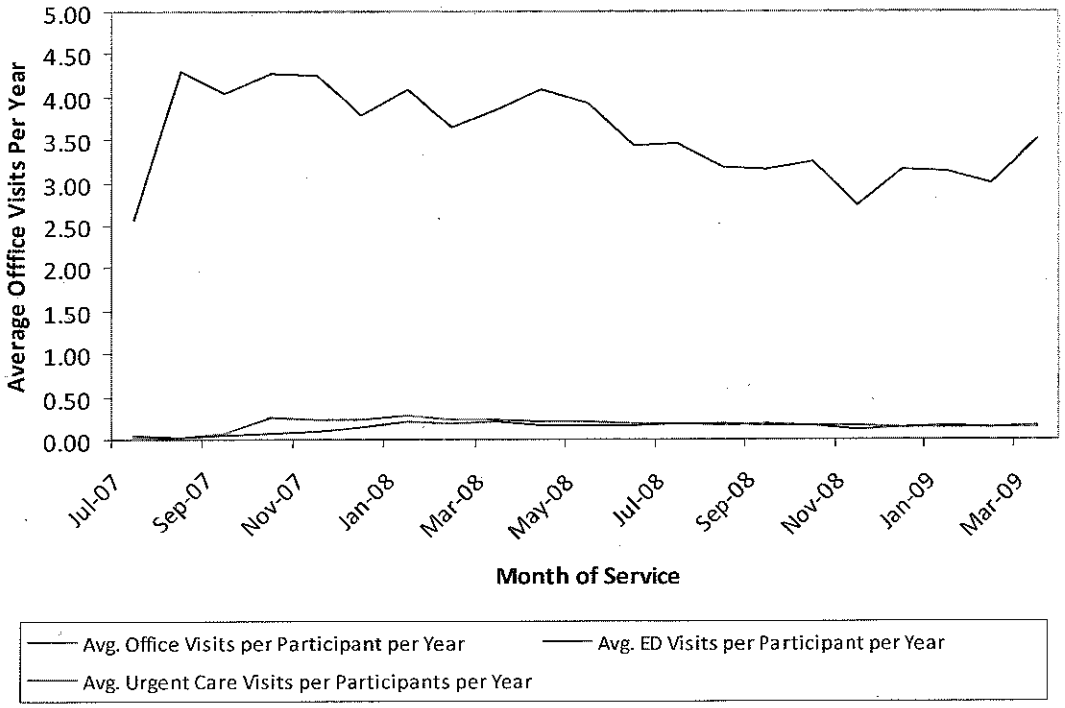
Utilization Category	Within 60 days	No within 60 days
Initial Office/Well Visits within 60 days	41%	59%

The Department uses a 60-day measure because HSF attempts to ensure that new participants receive their first clinical appointment within 60 days of calling for an appointment. The standard is not within 60 days of enrollment since participants may not call for initial appointments for some days or weeks after enrollment. The lack of a visit within 60 days does not denote an access to care issue. For many participants, the value of HSF is in knowing that they can receive care when they need it.

Emergency Room and Hospitalization

Data indicates that the average number of office visits is higher than the average number of emergency department or urgent care visits suggesting that participants are relying more on their medical homes as a usual site of care. The following graph notes that average office visits range from two point five (2.5) to four point five (4.5) per year while average emergency department or urgent care visits range from zero (0) to point two (0.20) per year.

ED, Office and Urgent Care Visits Comparison



One key goal of HSF is to provide participants with a usual source of care (i.e., primary care medical home) in the hope that this will reduce episodic care, reduce emergency department and urgent care visits, and reduce avoidable emergency department visits. The data indicates that for 2008-09, 7.9% of

the ED visits to date were avoidable which is lower (15%) in comparison to San Francisco Health Plan data for adults Medi-Cal recipients (20 – 64 year olds).[14]

HSF hospitalization and emergency department data was compared to data from other public health insurance programs within the San Francisco Health Plan (i.e., Medi-Cal [adults only] and Healthy Workers). Table D5 reveals that hospital admissions among HSF participants is lower than that found within the Medi-Cal population and slightly higher for Healthy Workers population (both adult populations). The data also indicates that emergency department visits were higher among HSF participants than for Healthy Workers members and similar rates experienced in the Medi-Cal population. The emergency department utilization may be a reflection of the fact that 15% of HSF participants are homeless and many of these participants may continue to receive services in the emergency room despite a medical home selection. It is important to note that the data for hospital utilization is for San Francisco General Hospital and does not at this time include hospital utilization from other hospitals in the City.

Table D5
Selected HSF Utilization Data in Comparison to Public Health Insurance Utilization Data
July 2007 – June 2009 (two year period)

Service Category	Healthy Workers	Medi-Cal (Adults Only)
Hospital Admissions per 1,000 (SFGH) – 33 for HSF	HSF is Higher Than HW (31)	HSF is Lower Than M-Cal (45)
No. of Hospital Days per 1,000 (SFGH) – 127 for HSF	HSF is Lower Than HW (140)	HSF is Lower Than M-Cal (193)
Avg. Length of Stay-Hospital (SFGH) – 3.54 for HSF	HSF is Lower Than HW (4.55)	HSF is Lower Than M-Cal (4.26)
ED Visits per 1,000 (175 for HSF)	HSF is Higher Than HW (125)	HSF is Same as M-Cal (175)

Disease Prevalence

HSF data also examines disease prevalence. This is important in ascertaining the extent of illness and chronic disease in the population. Data reveals that 28% of the HSF population (roughly 9,400 participants) has at least one of the following chronic diseases[15]:

- asthma (1.2% of participants),
- diabetes (8% of participants),
- hyperlipidemia (14.9% of participants) or
- hypertension (18.5% of participants).

Utilization of services for those with chronic illnesses is higher than that for the overall HSF population which is to be expected.

Table D6
Frequency of Visits/Services (Over 12 Months) – Chronic Disease Participants Only

Utilization Category	None	1 – 4	5 – 9	10+
Average No. of Outpatient Visits	0.5%	23%	40%	37%
Average No. of Chronic Disease Visits	1.5%	55%	35%	8.5%

Strength in Numbers Program

[14] Note that the 7.9% rate is based on ED visits at San Francisco General Hospital only and does not include any ED visits that HSF participants might have had at other San Francisco hospitals. As a result, the data used to develop this rate may be incomplete.

[15] Data is for the Department clinics, Glide Health Services, Haight-Ashbury, Mission Neighborhood Health Center, Native American Health Center, NEMS, St. Anthony Free Medical Clinic and South of Market Health Center. Data is for those enrolled in the program as of January 1, 2008.

To enhance the delivery of services to those with chronic illnesses and to support prevention efforts for this population, the program developed the "Strength in Numbers" Program. The program is an innovative effort designed to improve the quality of chronic care through medical home-based disease management programs. Specifically, the program provides "seed" funding to medical homes in order to support the integration of disease registries into the medical home, as well as incentive payments that reward improvements in targeted chronic disease measures.

Phase I (fiscal year 2008-09) of the project focused explicitly on diabetes care through increased use of disease registries. Through a competitive request for proposals process, eleven HSF medical homes fully participated in the program and an additional three clinics were awarded seed money. All medical homes were also offered a health education budget, based on membership, for materials that support chronic care and prevention. Medical homes participating in Phase I focused on diabetes and reach improvement thresholds. The Phase I improvement thresholds and results were:

Table D7
Strength In Number – Phase I Program Results

Improvement Thresholds	Phase I Results
5% improvement over baseline in LDL and A1c testing (defined as 1 test in the last 12 months)	Overall, medical homes increased A1C screening rates on average by 8.7% and LDL screening rates by 7.1%
10% improvement over baseline in LDL and A1c testing	Three medical homes improved their baselines by 10%
Reaching the threshold where 85% of all patients have obtained A1C and LDL testing	Three medical homes reached the 85% threshold for A1C and LDL testing

As the table above notes Phase I demonstrated promising early results. Medical homes also reported practice enhancements such as expanded use of medical assistants and health workers for panel management, staff training in health coaching, use of recall lists to bring patients in for overdue interventions, and other new practices.

Quality and Access Measures

The Department will monitor the quality of care provided within HSF using HEDIS (Healthcare Effectiveness Data and Information Set), a set of performance measures that is widely used in the health care industry. HEDIS is designed to allow consumers to compare health plan performance, facilitate trending of results on an annual basis. HEDIS incorporates a continuous enrollment requirement – essentially the number of years that a participant must be enrolled in the health plan in order to report on the measurement. HSF has not been in existence long enough for a significant number of program participants to meet the continuous enrollment requirement.

Given this, for the purposes of this report, the targeted HEDIS measures are measured against national benchmarks for state Medicaid agencies and health plans. Benchmark is defined as the Medicaid National Average (mean) for all plans reporting that data element. Each year National Committee for Quality Assurance (NCQA) determines an expected range of results (based on their database) and provides comparative performance data on the Medicaid and commercial populations for the benchmarked measures. The data is the national average of all reporting plans in each group (e.g.., the commercial mean is the average for care of the plan's commercial enrollees; the Medicaid mean the average for the plan's Medicaid enrollees). HSF uses the national average (it is reported in 2009 based on 2008 data). NCQA determines the HEDIS measures portion of the score by comparing results to the

national benchmark (the 90th percentile of national results) and to regional and national thresholds (the 75th, 50th and 25th percentiles). NCQA "uses the higher of two scores: the result based on comparison to the average of the regional and national thresholds, or the result based on comparison to national thresholds. "

The data indicates that in the area of diabetes care, HSF exceeds the National Medical Average in all areas with the exception of diabetes eye examinations. The data also show that HSF is less than seven percentage points from meeting the asthma National Medicaid Average and eight percentage points from meeting the standard in adult access to care. In the area of colorectal cancer screening, HSF's rate is 30% and the National Medicaid Average is almost 55%. Of note, the data reveals that almost 71% of all mental health patients have had at least one HSF medical office visit and that 47% of substance abuse patients have had at least one HSF medical office visit.

Table D8
Quality and Access Measures

	Denominator (HSF eligibles on 1/1/2008)	Numerator (Eligible participants receiving intervention)	HSF Rate	National Medicaid Average
Diabetes Eye Exams (blindness prevention)	2,677	720	26.9%	50.1%
Diabetes HbA1c (test of average sugar control)	2,677	2,104	78.6%	77.4%
Diabetes LDL (test of cholesterol)	2,677	1,971	73.6%	70.9%
Diabetes Medical Attention for Nephropathy (prevention of kidney failure)	2,677	2,013	75.2%	74.4%
Asthma (using controller medication)	397	319	80.4%	86.9%
Colorectal Cancer Screening (includes fecal blood occult testing)	13,207	3,956	30.0%	54.5%
Adult Access to Care	33,305	23,800	71.5%	79.6%
% of Mental Health Patients with One Medical Office Visit	3,868	2,728	70.5%	NA*
% of Substance Abuse Patients with One Medical Office Visit	1,271	599	47.1%	NA*

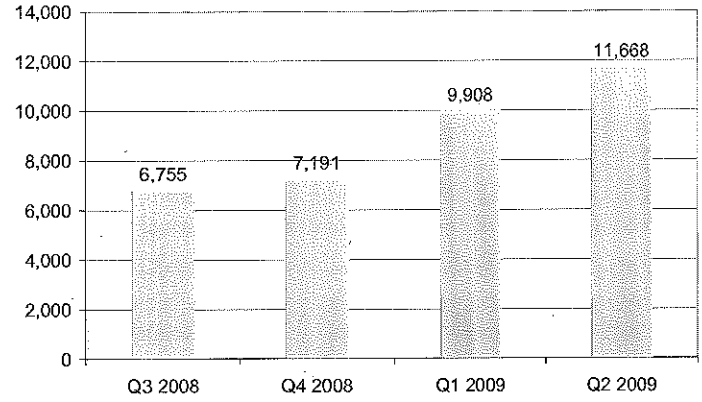
E. CUSTOMER SERVICE CENTER

The Healthy San Francisco Customer Service Center supports all HSF customers, including participants, potential participants, medical homes, City Option employers and City Option employees. These activities are performed by the third-party administrator, the San Francisco Health Plan. Functions supported by the Customer Service Center include providing telephone assistance to participants, providers, and employers, scheduling enrollment appointments for the HSF enrollment site at SFHP, processing HSF to MRA transfers for City Option employees, and handling participant complaints.

Call Center

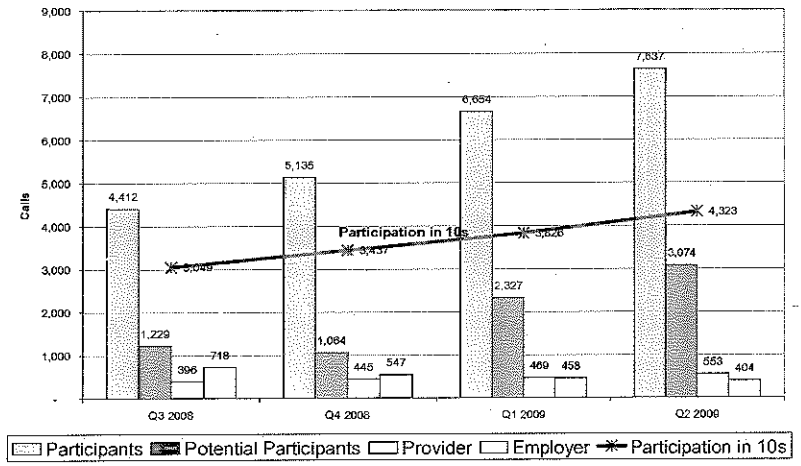
Total inbound call volume grew steadily through the course of the fiscal year ending June 30, 2009 with a total of 35,522 calls received (on average 2,960).

Total Call Volume



The volume of calls from participants and providers grew steadily, roughly matching the rate of growth in program participation. Conversely, the volume of calls from City Option employers steadily declined as employers became more accustomed to the process by which to comply with the Health Care Security Ordinance via the City Option Employer Portal.

Calls by Customer Type

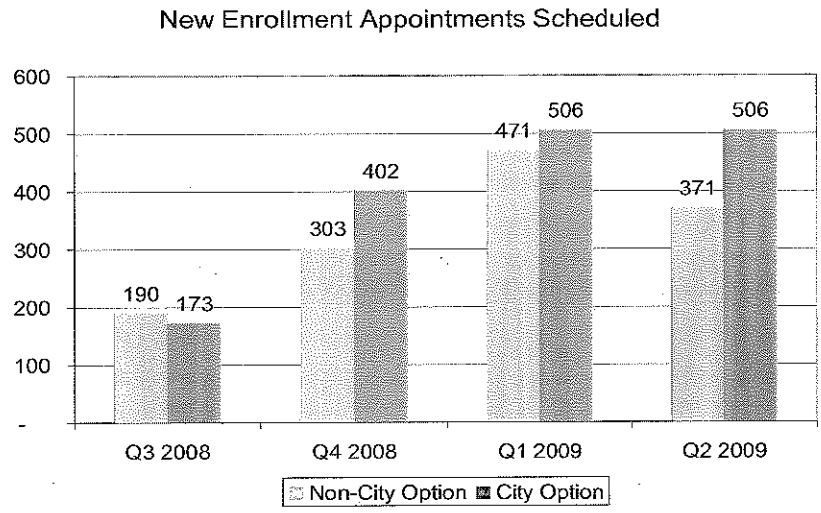


Calls by customer indicate, 5% were providers, 6% were employers, 22% were potential participants and 67% were participants. Participant calls were conducted primarily in English (62%), with the remainder of calls split between Chinese (18%) and Spanish (20%).

The HSF Customer Service Center has a targeted abandonment rate of less than 5% and to answer 90% of calls in less than 30 seconds. Customer Service Center staff met these goals in all four quarters of the fiscal year with the abandonment rate averaging 1.3% per quarter and 92.1% of calls answered within 30 seconds. Top call reasons remained consistent throughout the fiscal year: inquiries regarding program eligibility, participant fee billing inquiries and included services.

Third Party Administrator Enrollment Appointment Scheduling

The HSF Customer Service Center schedules enrollment appointments for the HSF enrollment site located at the San Francisco Health Plan. Appointments include those for City Option employees as well as those for non-City Option applicants. The HSF enrollment appointments scheduled for the SFHP enrollment site grew steadily through the first three quarters of the fiscal year and stayed steady in the quarter ending June 30, 2009.



HSF Provider Inquiry Report (January – June 30, 2009)

As noted above, in January 2009, the Healthy San Francisco Provider Relations Department developed a HSF Provider Inquiry Report. The HSF program received a total of 43 provider inquires via phone or email. The majority of inquiries were received by phone. The top inquiry categories were program policy (16 inquiries or 37%) and coverage interpretation (13 inquiries or 30%). Of the 43 inquiries, 95% were resolved within 60 days. During this time, the highest volume of inquiries came from San Francisco Community Clinic Consortium (10 or 23%) and Chinese Community Health Care Association (9 or 21%).

Participant Complaints

The HSF Customer Service Center intakes all customer complaints and is responsible for resolving all non-clinical complaints. Resolution of all clinical complaints, as well as, complaints oversight and reporting are handled by the SFHP Quality Improvement department. The goal is to resolve complains within 60 days.

During this period, the HSF Customer Service Center received a total of 363 complaints and as of June 30, 2009 key highlights are:

- Of total complaints received, 357 (98%) were resolved within 60 days and 6 (2%) remained open and were still within the 60 day period for resolution

- The complaint rate for the 2008-2009 fiscal year was 8.2 complaints per 1,000 participants.
- The average complaint rate per quarter was 2.1 per 1000 participants.
- The top three complaints categories were Access, Quality of Service, and Enrollment.

Table E1
Participant Complaints by Category

Attribute	Total	% of Total Complaints
Access Issue	135	37.20%
Quality of Service	73	20.10%
Enrollment Issue	61	16.80%
Other	28	7.70%
Quality of Care	25	6.90%
Pharmacy	15	4.10%
Point of Service Fees	10	2.80%
Medical Home Mismatch	7	1.90%
Billing	3	0.80%
Participant Fee Bill	3	0.80%
Undetermined	2	0.60%
Coverage Interpretation	1	0.30%
Total	**363**	**100%**

In summary, an analysis of complaints reveals the following:

- Access: This refers to clinical services not being available when and where the member expected. Twenty-one (21) of the thirty (30) medical homes received a complaint of this nature. Access-related complaints (135) by medical home reveals that the highest volume of access-related complaints came from Family Health Center (25 or 19%) and General Medical Clinic (21 or 16%) both of which are located on the San Francisco General Hospital campus. These clinics have the second and third highest number of HSF participants.

- Quality of Service: This refers to the participant's perception of the service they received (both clinical and non-clinical). Quality of service complaints may relate to any of the following: (1) participant interaction with the care provider(s), (2) the environment in which care is delivered, (3) interactions with the care provider staff, (4) administrative or communication difficulties with physicians/staff, the hospital or other providers and/or (5) service interactions with customer service staff, participant billing, CAAs, etc. There were 73 complaints related to quality of service across 23 of the 30 medical homes. No HSF medical home had more than 10 participant complaints related to quality of service. The medical homes with the highest volume of quality of service related complaints were North East Medical Services-North Beach (8 or 10%) and Castro Mission Health Center (7 of 10%). All other medical homes received five or fewer such complaints.

- Enrollment: The enrollment-related complaints (61) generally reflect issues relating to the participant's medical home selection. The primary source of complaints was the Department's Eligibility and Enrollment Unit (35 or 57%). The San Francisco Community Clinic Consortium had the second highest with 8 complaints (or 13%).

- Quality of Care: This refers to the actual care or treatment rendered and/or the outcome of that care. Examples include incorrect diagnosis, improper or inadequate treatment, and complications resulting from procedures performed. Less than half (14) of the medical homes received complaints related to quality of care (25) and no medical home received more than three such complaints. The clinics that received three complaints were: Lyon-Martin, General Medical Clinic and NEMS - North Beach.

The following table provides the number of complaints per thousand participants for each Medical Home ranked by complaints per 1,000 HSF participants:

Table E2
Participant Complaints by Medical Home

Medical Home	Participant[16]	Complaints	C/1KP
Native American Health Center	295	7	23.7
Mission Neighborhood - Excelsior	563	13	23.1
Haight Ashbury Free Medical Clinic	654	12	18.3
General Medical Clinic @ SFGH	2,844	45	15.8
Tom Waddell Health Center	1,348	21	15.6
Glide Health Services	1095	17	15.5
Castro Mission Health Center	2,595	31	11.9
South of Market Health Center	1377	14	10.2
Silver Avenue Family Health Center	2,218	21	9.5
Family Health Center @ SFGH	4,505	41	9.1
Larkin Street Clinic	116	1	8.6
Housing and Urban Health Clinic	237	2	8.4
Saint Anthony Free Medical Clinic	1417	11	7.8
CCHCA/Chinese Hospital	924	7	7.6
Positive Health	528	4	7.6
Maxine Hall Health Center	2,396	18	7.5
Southeast Health Center	1214	9	7.4
Potrero Hill Health Center	1,777	13	7.3
Haight Ashbury Integrated Care Center	554	4	7.2
Lyon-Martin	704	5	7.1
Ocean Park Health Center	429	3	7.0
Chinatown Public Health Center	1,768	12	6.8
NEMS - Visitation Valley	1124	6	5.3
Curry Senior Center	213	1	4.7
Mission Neighborhood - Shotwell	1,652	7	4.2

[16] Based on enrollment as of July 13, 2009.

Medical Home	Participant[17]	Complaints	C/1KP
NEMS - Chinatown North Beach	8,374	25	3.0
St. Mary Philippa Health Center	952	2	2.1
NEMS - Sunset	1512	11	1.3
Cole Street Clinic	57	0	0.0
South of Market Senior Center	12	0	0.0
Not Provided	2	0	0.0
Total	**43,497**	**363**	8.2

[17] Based on enrollment as of July 13, 2009.

F. EMPLOYER SPENDING REQUIREMENT

Certain San Francisco businesses are required to make health care expenditures on behalf of their employees in accordance with the Health Care Security Ordinance. The requirement is known as the Employer Spending Requirement (ESR). The ESR went into effect on January 9, 2008 for employers with 50 or more employees and on April 1, 2009 for for-profit employers with 20 – 49 employees. In complying with the Ordinance, employers have a variety of options to choose from, such as health insurance, direct reimbursement to employees, health spending accounts, the City Option, etc. The ESR is overseen by the San Francisco Office of Labor Standards Enforcement.

Golden Gate Restaurant Association (GGRA) Lawsuit

The ESR has undergone legal challenge. On June 8, 2009, GGRA filed a petition with the U.S. Supreme Court requesting that the Supreme Court rule on the legality of the Employer Spending Requirement (ESR) of the Health Care Security Ordinance. On August 24, 2009, the City and County submitted its opposition to GGRA's petition. While the U.S. Supreme Court considers whether to hear the case, the United States Ninth Circuit Court of Appeal's decision upholding the ESR remains in effect.

City Option Activity

San Francisco employers are selecting the City Option to meet the ESR. When an employer chooses the City Option, their employees will receive either Healthy San Francisco or a Medical Reimbursement Account depending upon the employee's eligibility.

- If the employee is eligible for HSF, the employee will be notified and must complete the HSF application process to get enrolled in the program. An employer does not enroll an employee into HSF. The employee must take action and go through the HSF application process in order to become a HSF participant.
- If the employee is ineligible for HSF, then they will be given a Medical Reimbursement Account (MRA). All funds contributed on the employee's behalf by the employer are deposited into this account and the employee can access these funds for reimbursement of out-of-pocket health care expenses.

Since implementation, data on the City Option indicate the following as of June 30, 2009:

- 980 employers had selected the City Option to meet the ESR
- Employers have committed $45.82 million in funding for 42,313 employees.
    - One-half of employees are potentially eligible for HSF and one-half would potentially receive a Medical Reimbursement Account.
- Of the total funds committed, $45.48 million (99.3%) has been collected to date.

Employer payments are submitted to the HSF Third-Party Administrator (the San Francisco Health Plan) for processing. SFHP transfers the Healthy San Francisco component of the employer payments to DPH on a periodic basis. DPH then submits these funds to the City Controller's Office for processing and deposit. In accordance with the Health Care Security Ordinance, those funds are used for the HSF program. Since the ESR began, $22.4 million in employer contributions ($18.2 million in fiscal year 2008-09) have been transferred from the Third-Party Administrator to the City and County of San Francisco.

Employer health care expenditures designated for a Medical Reimbursement Account are not transferred to the City and County of San Francisco. Participant eligibility and contribution information for these employees is forwarded to the Medical Reimbursement Account vendor and accounts are created for each employee to use for reimbursable health care expenses. Funds are transferred weekly to the MRA vendor for claims and monthly for administrative fees.

During the fiscal year, HSF Customer Service Center began completing transfers of City Option employer contributions from HSF to MRA based on an employee's ineligibility for HSF (i.e., because they were insured, did not reside in San Francisco, or were not between the age of 18 and 64). The volume of HSF to MRA transfers has steadily increased from quarter to quarter, with a significant increase of 138% from the quarter ending March 31, 2009 to the quarter ending June 30, 2009.

Employer Data

The following is basic information on employers electing to use the City Option for all or some of their employees. Note that an employer may use City Option to augment any existing health care expenditures that they are making which are below the required ESR expenditure levels.

Excluding those employers for which no data is reported (206 out of 980), the data indicate that:

- the majority of employers who have elected the City Option are either in the other services (25%), retail trade (16%) or professional/scientific and technical services industries (12%),
- 1% have fewer than 20 employees, 14% have 20 – 49, 12% have 50 – 99, 24% have 100 – 499 and 49% have 500 or more employees, and
- 75% are for profit, 13% are non- profit and 12% are public (most likely publicly-traded since public entities are exempt from the ESR).

Table F1
City Option Employers by Industry Type

Count by Industry (North American Industry Classification System code)	Number
Accommodation and Food Services (72)	61
Administrative & Support and Waste Management & Remediation Services (56)	5
Agriculture, Forestry, Fishing and Hunting (11)	1
Arts, Entertainment, and Recreation (71)	37
Construction (23)	12
Educational Services (61)	30
Finance and Insurance (52)	66
Health Care and Social Assistance (62)	53
Information (51)	15
Management of Companies and Enterprises (55)	3
Manufacturing (31-33)	17
Mining, Quarrying, and Oil and Gas Extraction (21)	2
Other Services (except Public Administration) (81)	195
Professional, Scientific, and Technical Services (54)	92
Public Administration (92)	3
Real Estate and Rental and Leasing (53)	25
Retail Trade (44-45)	127
Transportation and Warehousing (48-49)	13
Utilities (22)	2
Wholesale Trade (42)	15
Unreported	206
Total contributing employers	**980**

Table F2
City Option Employers by Company Size

Count by Company Size	Number
0-19 employees	11
20-49 employees	106
50-99 employees	91
100-499 employees	183
500+ employees	383
Not reported	206
Total contributing employers	**980**

Table F3
City Option Employers by Tax Status

Count by Tax Status	Number
For-profit	580
Non-profit	104
Public (Publicly-traded)	90
Not reported	206
All Contributing Employers	980

Employer MRA Contributions Data – Geographic Impact Analysis

The San Francisco Health Care Security Ordinance addresses the need for health care among not only uninsured adult residents through HSF, but also uninsured individuals who work in San Francisco through the Employer Spending Requirement. The ESR applies to all eligible individuals who work in San Francisco, irrespective of the employees' county of residency. There is great interest in understanding how communities outside the City and County of San Francisco potentially benefit from the ESR.

To understand this better, the Department undertook an analysis of employers who had selected the City Option to comply with the ESR. The analysis was restricted solely to examining the geographic distribution of employees who received Medical Reimbursement Accounts and their contribution amounts. The Department does not have any demographic information (e.g., ethnicity, gender, language spoken, etc.) on these employees because they did not go through the Healthy San Francisco eligibility and enrollment process.

It is important to note that the employee is under no obligation to use the funds deposited into their MRA in the community in which they reside. The employee may receive services in an entirely different county from which they reside or work and use their MRA benefit to support providers in that county. As a result, there is no necessary correlation between accrued MRA benefits to a community and the county of residence for the employee with the MRA account.

The analysis was based on contributions made from January 9, 2008 to June 30, 2009. During that time, $23 million had been contributed on behalf of 23,000 employees for Medical Reimbursement Accounts – on average, $1,000 per employee. As the chart below indicates, the majority of the MRA contributions remained in the nine Bay Area counties.

Table F4
Employer MRA Contributions Data – Geographic Impact Analysis

Community	No. of Employees	Employer MRA Contributions	% of MRA Contributions
California (9 Bay Area Counties)	21,483	$21,815,940	94.8%
California (49 Other Counties)	1,110	$937,705	4.1%
Midwest	63	$40,469	0.2%
Northeast	88	$47,844	0.2%
South	98	$63,051	0.3%
West (excluding California)	180	$106,195	0.5%
United States Territories (Guam)	2	$650	0.0%
All Communities	**23,024**	**$23,011,854**	**100%**

Collectively, for the entire State of California, employees from the nine Bay Area counties (San Mateo, Alameda, San Francisco, Contra Costa, Santa Clara, Marin, Solano and Sonoma) received 95% of all MRA contributions while the remaining 4% of employer MRA contributions were disbursed among the remaining 49 counties (including Los Angeles). Within the Bay Area counties, San Mateo had the largest amount of employer MRA contributions, totaling $5,723,173. Alameda and San Francisco counties had the second and third most employer MRA contributions, respectively.

The data reveals that 5,994 San Francisco employees residing in the City and County had combined employer MRA contributions of $5,545,701 (approximately 25% of all Bay Area contributions). An employee residing in San Francisco would receive an MRA as opposed to HSF if they did not meet HSF eligibility requirements. For example, these employees received an MRA, because it was discovered during the HSF application process that they had dependent health care insurance or individual coverage. Their employer may not have been aware of the fact that the employee had dependent health insurance because that insurance is not provided to the employee by the employer. In these cases, money that would have been contributed towards the employee's Healthy San Francisco enrollment is instead transferred to an MRA for that employee.

More detailed information on the analysis is in Appendix C.

G. HEALTH CARE COVERAGE INITIATIVE

In March 2008, the Department was notified of a $73 million award under the State Department of Health Services' Health Care Coverage Initiative (HCCI) for the Healthy San Francisco program. The time period for the HCCI is September 1, 2007 to August 31, 2010. In addition to services funding, the Department will receive funding for administrative costs incurred in operating Healthy San Francisco over the three year time period. Funding for the administrative component is not contained in the $73 million services award.

Because HCCI funding comes from the federal Medicaid program and must comply with certain Medicaid provisions, it supports only a subset of HSF participants. Specifically, HCCI funding will support HSF participants who meet the following criteria:

- are between the ages 19 – 64,
- have income at or below 200% of the federal poverty level,
- have a primary care medical home within the Department and
- have documentation of their identification (government-issued) and
- have US citizenship or legal permanent residency status (at least five years).

The Department's initial target for HCCI enrollment was 10,000 over the three year period. From September 2007 to June 2009, the Department designated 10,963 HSF participants as HCCI-eligible. There are currently 7,733 individuals (18%) in HSF who are designated as part of the HCCI program. The difference between the current enrollment and those who have ever been in the program is due to disenrollments. The following chart provides basic HCCI demographic information:

Table G1
Demographics for HSF Participants with HCCI Designation

Age	8% are 19 - 24; 34% are 25 - 44; 22% are 45 - 54; 36% are 55 - 64
Ethnicity	37% Asian/Pacific Islander; 24% Caucasian; 17% Latino; 13% African-American, 4% Other; 5% Not Provided
Gender	49% female; 51% male
Income	71% at/below 100% FPL; 29% between 101 – 200% FPL
Language	64% English; 22% Cantonese/Mandarin; 8% Spanish; 3% Vietnamese; 3% Other

Note that there are approximately 4,500 HSF participants pending HCCI-eligible. Those in the pending status are designated as such principally because of the lack of either identification or citizenship/legal residency documentation. This has been a challenge for other county HCCI awardees because many low-income adults do not have ready access to citizenship documentation. In addition, for San Francisco a sizeable portion of the population are homeless and those individuals may lack both identification and citizenship. The Department continues to work diligently on the eligibility process partnering with the Human Services Agency, Social Security Administration and using California birth records.

HCCI funding is for both services and administrative expenses. Services funding is reimbursement based and takes into account enrollment and service utilization. San Francisco received its first reimbursement for services in October 2008. Neither San Francisco, not any of the other nine HCCI counties, has received in reimbursement for administrative activities related to the ongoing operation of the program. This is principally because the approved reimbursement protocols and invoices for claiming administrative costs have not been finalized.

HCCI funding is part of a more expansive five year hospital-based financing waiver that the State of California received from the federal Center for Medicare and Medicaid Services. HCCI funding is scheduled to cease when the five-year waiver expires on August 31, 2010. The State, counties and other interested parties are currently working to provide input into the renewal of the waiver and this vital funding source. San Francisco and other HCCI counties are documenting the activities accomplished under HCCI to show the value of this effort.

H. EXPENDITURES AND REVENUES

The Department does not maintain a separate budget division for Healthy San Francisco. Administrative and service related expenditures for HSF occur in the following divisions:

- Health at Home,
- Mental Health,
- Primary Care,
- San Francisco General Hospital and
- Substance Abuse

The Department tracks expenditures through the financial class that has been created for HSF. The expenditures in each of these divisions are combined to provide an overview of HSF finances. To create a budgetary division for HSF would not be practical since it would involve significant reallocation of expenses from these existing divisions into any new division.

It is important to note that the cost data that follows reflect the Department's costs of operating HSF. HSF participants may receive services through other providers (e.g., emergency care at a hospital [other than SFGH] under the hospital's charity care program). The cost figures do not include the cost of such care and as a result do not reflect the total costs of providing services to uninsured HSF participants. At present, the Department does not have access to the costs of services provided to HSF participants that were rendered: (1) outside the HSF provider network or (2) by non-profit hospitals. The Department recognizes that HSF would not be possible were it not for the existing safety net which has historically provided high quality care to uninsured and indigent persons.

The following financial data is comprised of three components:

- incremental HSF expenditures and revenues and
- total HSF expenditures and revenues,
- total DPH cost of care to indigent and uninsured persons.

The 2008-09 costs and revenue calculations are estimates because the Department is still in the midst of completing its year-end financial close.

ESTIMATED INCREMENTAL EXPENDITURES AND REVENUES

Table H1 on the following page provides information on incremental HSF revenues and expenditures. In addition, it provides participants based on a participant month calculation. Participant months reflect the number of participants per month aggregated over a 12-month period. To provide the Health Commission with a full picture of costs that have been incurred for HSF, the Department provides three years of financial data.

The table indicates that during the start-up year (2006-07), expenditures were supported solely with City General Fund. During the first year of implementation (2007-08), HSF incremental expenditures exceeded revenue by $4.3 million. This was not unexpected given necessary ramp-up and the number of participant months during the first year. For 2008-09, it is estimated that anticipated revenue will exceed anticipated expenditures by $1.9 million. However, this does not result in Department surplus for HSF. On the contrary, these dollars are used to help fund overall program costs.

As the Department has noted previously, a key feature of HSF is its public-private partnership. This is demonstrated by the equitable distribution of incremental revenue. In 2008-09, the Department funded provider reimbursements at $6.7 million, University of California San Francisco Medical Center at $5.1 million, San Francisco Heath Plan at $5.1 million and behavioral health providers at $1.1 million.

Table H1
HSF Estimated Incremental Expenditures and Revenues

	2006-07 Start-Up	2007-08 Actual	2008-09 Estimated
ENROLLMENT			
Participant Months	0	126,268	421,058
REVENUE			
General Fund	$4,866,402	$0	$0
Health Care Coverage Initiative	$0	$8,136,224	$19,253,926
Participant Fees	$0	$836,493	$3,208,577
Employer Spending Requirement Funds	$0	$4,187,554	$18,236,251
Reserve for Unearned Rev. (25%)		($1,046,889)	($4,559,063)
TOTAL REVENUE	**$4,866,402**	**$12,113,382**	**$36,085,514**
EXPENDITURES			
Administration (incl. Evaluation)	$277,000	$384,287	$752,122
Non-Admin Salary/Benefits (New Positions)	$0	$2,921,387	$8,432,332
Behavioral Health Contracted Services	$0	$1,117,184	$1,117,184
Material and Supplies	$0	$866,914	$1,716,950
UCSF Services	$0	$3,636,987	$5,111,948
Operating Expense	$0	$45,794	$164,059
Pharmacy	$0	$1,692,000	$4,467,054
Home Health Agency	$0	$0	$120,499
Third-Party Administrator	$2,306,311	$3,039,107	$5,132,291
Provider Reimbursement	$0	$2,153,255	$6,683,671
DPH Eligibility/Enrollment Unit (Capital)	$885,000	--	--
Eligibility/Enrollment System (OEA)	$693,091	$393,300	$240,702
IT Infrastructure and Siemens	$705,000	$200,000	$200,000
TOTAL EXPENDITURES	**$4,866,402**	**$16,450,215**	**$34,138,812**

With respect to revenues, as the Health Commission is aware, participants with income at or above 101% of the Federal Poverty Level (FPL) pay participation fees to remain in the program and are billed quarterly. As of June 30, 2009, approximately 30% of participants (12,970 participants) were at or above 101% of FPL. Participants have 60 days to fully pay the balance in quarter one to remain in the program. For those participants who receive an employer contribution, a discount is applied to their invoice if their income is at or above 101% FPL. For the fiscal year ending June 30, 2009, the participant payment rate was 79% with quarterly participation fees of $2.794 million received from participants.[18] Participants with incomes at or above 101% FPL also pay point-of-service fees when accessing certain services. The Department only collects information on point-of-services fees paid by HSF participants accessing services within the Department. For the fiscal year ending June 30, 2009, the Department collected an estimated $413,765 in HSF point-of-service fees. The amount of point-of-service fees paid by HSF participants to non-Departmental HSF providers is not known to the Department. Non-

[18] The payment rate is calculated using the Quarterly Cash Received and dividing by the Quarterly Billed Amount. Cash received represents cash collected in that quarter only. Cash collected and Billed Amount will never match by quarter because participants have 60 days to pay their invoice. Therefore, payments will not always be made in the same quarter they were billed.

departmental HSF medical homes/providers are not required to report or remit to the Department any point-of-services fees collected from HSF participants. These fees support the delivery of care and can allow the existing private, non-profit safety net system to expand.

TOTAL ESTIMATED EXPENDITURES AND REVENUES

The Department believes that it is important to clearly separate incremental expenditures from total expenditures. The total estimated expenditures and revenues include both incremental costs and existing costs for all services and administrative costs. The financial data indicate that for 2008-09, estimated expenditures for HSF were $125.65 million with revenue of $36.08 million and a General Fund subsidy of $89.57 million (the difference between expenditures and revenues). Based on estimated participant months, the monthly estimated per participant cost incurred by the Department is $298 ($3,580 annually). This cost represents on average the cost of utilized services by a participant on a monthly basis. This cost recognizes that some participants will not use services in any given month.

Table H2
HSF Total Estimated Costs

	2006-07 Start-Up	2007-08 Actual	2008-09 Estimated
ENROLLMENT			
Participants Months	0	126,268	421,058
REVENUE			
General Fund	$4,866,402	$0	$0
Health Care Coverage Initiative	$0	$8,136,224	$19,253,916
Participant Fees	$0	$836,493	$3,208,577
Employer Spending Requirement Funds	$0	$4,187,554	$18,236,251
Unearned Rev. Reserve (25%)	$0	($1,046,889)	($4,559,063)
TOTAL REVENUE	**$4,866,402**	**$12,113,382**	**$36,085,514**
EXPENDITURES			
Administration (incl. Evaluation)	$277,000	$384,287	$752,122
Cost of Services - SFGH and Clinics	$0	$37,645,942	$92,547,506
Behavioral Health Contract Services	$0	$2,183,284	$20,099,544
Third-Party Administrator	$2,306,311	$3,039,107	$5,132,291
Provider Reimbursement	$885,000	$2,153,255	$6,683,671
Eligibility/Enrollment System (OEA)	$693,091	$393,000	$240,702
Siemens	$705,000	$200,000	$200,000
TOTAL EXPENDITURES	**$4,866,402**	**$45,998,875**	**$125,655,846**
REVENUE LESS EXPENDITURES (GENERAL FUND SUBSIDY)	$0	($33,885,493)	($89,570,332)
PER PARTICIPANT EXPENDITURE		$364	$298
PER PARTICIPANT REVENUE (EXCLUDES GF)		$96	$86
GENERAL FUND SUBSIDY		($268)	($213)

ESTIMATED COSTS OF SERVING INDIGENT AND UNINSURED

The Department provides services to uninsured individuals ineligible for HSF or not yet enrolled in HSF, and provides services that are not in the HSF scope of benefits (e.g., dental, long-term care, etc.) on a sliding scale basis to uninsured individuals. These costs must be provided to give a fuller sense of the costs of serving indigent and uninsured persons. It is estimated that the costs of providing services to uninsured persons not enrolled in HSF is $$39.79 million for fiscal year 2008-9. As a result, the total estimate costs of serving the uninsured in 2008-09 is $165.44 million.

Table H3

Total Estimated Costs of Serving Indigent and Uninsured (Fiscal Year 2008-09)

Uninsured Patient Population	Estimated Cost
HSF Uninsured Population	$125,655,846
Non-HSF Uninsured Population	$39,791,718
Entire Uninsured Population	$165,447,564

I. EVALUATION

The Department will evaluate HSF to determine if it is achieving its goals to improve access to health services for uninsured adults in a non-health insurance model. The Department has developed a multi-pronged approach to the evaluation that takes into account the need to have evaluative information: (1) on the early aspects of the program, (2) on an ongoing basis, (3) both within and outside a formal evaluation process. The HSF program has an Evaluation Committee. The function of the HSF Evaluation Committee is to provide input into the goals, design and processes for evaluation. The Committee also identifies targeted audiences (both internal and external) and provides support to the evaluation consultant retained for this effort. The Committee is not responsible for conducting the evaluation.

Independent Evaluator

In March 2009, DPH released the Healthy San Francisco Program Evaluation Request for Proposals (RFP). Based on the RFP process, the Department selected Mathematica Policy Research, Inc. to conduct the evaluation. The evaluation is structured to provide formative findings, in addition to a summative analysis, that can be used to guide development of any program improvements or modifications. Specific evaluation activities include examining utilization, administrative and financial data. In addition to City and County funding for the evaluation, the Department secured generous financial support (totaling $800,000) from the following foundations for the evaluation: Blue Shield of California Foundation, The California Endowment, the Commonwealth Fund and the Metta Fund.

Applicant Health Access Questionnaire

On December 19, 2008, the HSF eligibility/ enrollment system (One-e-App) was enhanced to include a Health Access Questionnaire for all HSF participants. The purpose of the survey is to capture applicants' pre- and post- Healthy San Francisco health access experience in a quantifiable fashion. This enhancement was funded with the generous financial support of the California HealthCare Foundation.

Questionnaire responses are self-reported data. The ten-question survey is offered in English, Spanish and Chinese. Applicants are asked the survey questions at the time of initial enrollment and at annually renewal by a trained Certified Application Assistor. An applicant's response to the questions in no way affects their eligibility for HSF. An applicant may indicate that they do not know the answer to a question or can refuse to answer a question. On a regular basis, the Department will be able to extract responses to the questionnaire and analyze it for program and evaluation purposes.

For this report, the Department examined survey responses for the time period December 19, 2008 to June 30, 2009. During this time period, 22,791 surveys were administered through One-e-App to new program participants and those renewing their program eligibility. A new participant is one who is enrolling into HSF for the first time and as a result, their responses to questions will be based on their health care experiences prior to HSF enrollment. A renewal participant is one who has been in HSF for at least one year and as a result, their responses to questions will be based on their health care experiences during HSF enrollment. Sixty-three percent (63%) of the surveys were administered to new participants, thirty-six percent (36%) administered to renewing participants and one percent (1%) to participants re-enrolling after a break in program participation and were not in program for at least one year.

What follows is summary information on the responses. In general, initial data from the questionnaire responses indicate that those participating in HSF report having established a relationship with a medical home, better access and better quality care relative to those just enrolling in HSF for the first time. Because the questionnaire was launched in the middle of the fiscal year, the data does not

provide any year-to-year comparative analysis since no participant has taken the questionnaire twice (at initial enrollment and re-enrollment/renewal). The analysis examines responses overall and then segments information for those who are new participants and those who are renewing in the program. Specifically, it provides overall summary information for each question based on all recorded responses (i.e., stated responses, "yes," "no," "don't know" or "refused to answer"). It then examines responses for new and renewal applicants, but excludes from the analysis any "don't know" or "refused to answer" responses from both groups. The more detailed analysis can be found in Appendix D.

Table I1
Summary of Health Access Questionnaire Responses

No.	Question	Summary of Responses
1	Would you say that in general your health is excellent, very good, good, fair, or poor?	58% of all respondents indicated their health was Excellent, Very Good, or Good. 5.4% of New participants indicated their health was Poor and 4.6% of Renewal participants indicated their health was Poor.
2	During the past 12 months, was there any time you had no health insurance at all?	53% of all respondents indicated that they did not have health insurance for some time in the past 12 months. 76% of New participants indicated that they did not have health insurance for some time in the past 12 months and 58% of Renewal participants provided the same response.
3	What is the main reason why you did not have health insurance?	The most common reason noted was "cost of health insurance and/or co-payments." Twenty percent (20%) cited it as the reason they did not have health insurance. 30% of New participants stated cost of health insurance as the main reason and 19% of Renewal participants stated cost of health insurance as the main reason.
4	In the last 12 months, did you visit a hospital emergency room for your own health?	14% of all respondents stated that had visited a hospital emergency room in the previous 12 months. 21% of New participants had visited a hospital emergency room and 15% of Renewal participants had visited a hospital emergency room.
5	What kind of place do you go to most often to get medical care? Is it a doctor's office, a clinic, an emergency room, or some other place?	54% of all respondents most often receive care at a clinic, health center, or hospital clinic and 4% of all respondents most often receive care in an emergency room. 60% of New participants most often receive care at a clinic, health center, or hospital clinic and 93% of Renewal participants most often receive care at a clinic, health center, or hospital clinic. 7% of New participants indicated that they most often sought care from an emergency room while only 1% of Renewal participants indicated so.

No.	Question	Summary of Responses
6	Overall, how difficult is it for you and/or your family to get medical care when you need it – extremely difficult, very difficult, somewhat difficult, not too difficult, or not at all difficult?	43% of all respondents said it was Not At All Difficult or Not Too Difficult to access care when they needed it. 17% of New participants said it was Very Difficult or Extremely Difficult to access care while only 6.6% of Renewal participants said it was Very Difficult or Extremely Difficult.
7	How do you rate the medical care that you received in the past 12 months – excellent, very good, good, fair, or poor?	Overall, 26% rated the medical care they received in the past 12 months as Excellent or Very Good. 36% of New participants believed their quality of care was poor, whereas only 10% of Renewal participants provided this response.
8	During the past 12 months, did you either delay getting care or not get a medicine that a doctor prescribed for you?	12% of all respondents said they had delayed getting care or did not get a medicine prescribed to them during the past 12 months. 23% of New participants indicated that they had delayed care while only 8% of Renewal participants stated this.
9	Was cost or lack of insurance a reason why you delayed getting care or did not get a prescription?	Overall, 14% of respondents said cost or lack of insurance was a reason why they had delayed care. Specifically, 29% of New participants said cost or lack of insurance was a reason they delayed care and 6% of Renewal participants cited these reasons.
10	Do you now smoke cigarettes every day, some days, or not at all?	Overall, 16% of respondents smoked (either every day or some days). 23% of New participants indicated they smoked and 16% of Renewal participants did.

The Department conducted additional analysis on the smoking behavior question. The analysis suggests that those who did not smoke at all tended to perceive themselves more often in excellent health than those who smoked. Figures also showed that HSF participants who smoked more often were more likely to report that they had visited the emergency room in the past 12 months and more likely to delay receiving care or getting a prescription. More detailed information on this can be found in Appendix D.

Participant Satisfaction Survey

This one-time telephone survey was designed to ascertain the experience of early HSF enrollees. Questions were in the areas of: enrollment process, knowledge and understanding of HSF, uninsured status, satisfaction with HSF, health status, access to care and health care utilization. This was a representative survey of enrolled participants in Healthy San Francisco as of October 31, 2008. The survey was administered during the months of March/April 2009. This survey was being conducted on an in-kind basis with the very generous support of the Kaiser Family Foundation.

As the Health Commission is aware, the survey results were released on August 26, 2009 and can be retrieved from both the Kaiser Family Foundation and Healthy San Francisco websites. For the most part, the survey findings are quite positive with 94% indicating that they are satisfied with the program. At the same time, because HSF is still relatively new, there were some challenges that survey respondents identified which are more reflective of the start-up nature of the program. The Department will work to address challenges raised in the survey during the 2009-10 fiscal year. Key findings from the survey include:

Key Findings That Suggest HSF Is Meeting Its Goals

- *Healthy San Francisco participants represent a population with substantial health care needs. Compared to the general population, they are sicker and older, and report somewhat greater utilization of health care services.*
- *Participants in Healthy San Francisco report high levels of satisfaction and voice a resounding endorsement for the program. Ninety-four percent say they are satisfied with the program overall, and nine in ten say they would recommend the program to a friend.*
- *A large majority of participants (86 percent) report having a usual source of care. Most understand that they have a medical home, and most have had an initial visit since joining the program.*
- *Nearly all participants say their health needs are being well met today, and four in ten report improvements in meeting their health needs since joining Healthy San Francisco.*
- *Most participants say they feel well-protected when it comes to their health care needs, and more than four in ten say they are paying less for care now than before they joined Healthy San Francisco.*
- *Participants overwhelmingly say the reason they decided to enroll in Healthy San Francisco is because they could not afford health insurance or health care services.*
- *Compared to previous estimates for the uninsured in San Francisco before the program was created, Healthy San Francisco participants are more likely to report having a usual source of care and more likely to report accessing health care services.*

The Department is pleased that HSF is serving those in greatest need, with the high overall satisfaction rate, high rate of follow-through with using medical homes, provides financial protection for participants, is seeing more residents who are unable to obtain health insurance through commercial routes and is serving as a usual source of care

Key Findings That Underscore Diversity and Health Status of Population, and Importance of Outreach and Education

- *Most participants say they understand how Healthy San Francisco works overall, but awareness and education challenges remain, particularly for certain groups of enrollees, including those in fair or poor health and those with lower levels of education.*
- *Participants give positive reviews to the Healthy San Francisco enrollment process and written materials, but non-English speakers report slightly more challenges.*
- *Program participants who report being in fair or poor physical or mental health stand out as reporting particular challenges.*

It is not uncommon for those in poor health and those with lower levels of education to have more difficulty understanding health program material due to their health literacy. The Department is particularly interested in ensuring that participants have a good understanding of the program and how it works. To facilitate this, the program: (1) translates all materials into Chinese and Spanish in recognition of the primary languages spoken by program participants, (2) ensures that program materials are written at 7th - 9th grade level, (3) uses a cadre of multi-lingual application assistors

who conduct the application in the language primarily spoken by the applicant and (4) a centralized multi-lingual customer call center (415.615.4555) to respond to participant requests for program clarification, materials, concerns, etc. In some ways the finding that those in poorer health have particular challenges is not unexpected, data indicates that those in poor physical and mental health often face more barriers (irrespective of the health care delivery system they use). Those in poorer health are more likely to use health services more and therefore may be more inclined to worry about payment of health care costs. The Department will continue to look at opportunities to improve its processes and materials to ensure that they are understandable.

Key Findings Related to Access to Care

- *Many report easier access to care under Healthy San Francisco, though small but important shares report some aspects of accessing care are more difficult now than before they joined the program, and nearly three in ten (29 percent) say at least one thing is harder now than before.*
- *Small but notable shares of participants report problems with delaying or skipping care. Overall, about a quarter of participants say that since joining Healthy San Francisco, they have either delayed or not gotten medical care or medication, or had problems getting recommended follow-up care; 13 percent say that one of these things happened due to cost or lack of insurance.*

HSF is designed to improve access to minimize the extent to which participants are delaying or skipping care. The Department works to ensure that there is sufficient clinical capacity in the system via monitoring open/close medical home status, implementing the New Patient Appointment Unit (NPAU) and expanding e-referral.

Key Findings Related to Potential Improvements (Participant Perspective)

- *Participants recommend some ways they think the program could be improved, most notably streamlining the appointment process and providing additional services, such as dental and vision care.*

The Department will continue to work with its medical homes and providers to ensure that the HSF participants can get appointments (primary and specialty) in a timely manner. The Department recognizes the importance of access to a full range of comprehensive services including dental and vision. However, there are funding constraints that prevent the Department from including these services. Unfortunately, it is not uncommon for many people with insurance (both public and private) to lack dental and vision coverage.

Health Care Coverage Initiative Evaluation

The UCLA Center for Healthy Policy Research has a contract with the State Department of Health Care Services to evaluate all ten Health Care Coverage Initiative programs. The Department provides all necessary reports and data to support this evaluation. In June 2009, the State evaluators released a report discussing the medical home models used by various Health Care Coverage Initiative counties.

III. 2009-10 Program Activities

For 2009-10, in addition to general operational oversight and continued operation of the program, the Department will focus on the following activities:

- Ensure that the independent evaluation proceeds according to the established scope of work and work to address participant challenges raised in the participant satisfaction survey.

- Continue to improve on-time participant renewals by implementing an incentive program that will encourage earlier and/or on-time renewal by current program participants and exploring implementation of an online or mail-in renewal process.

- Continue to work with all HSF providers (including non-profit hospitals) on the submission of encounter data to the HSF Data Warehouse.

- Ensure continued operation of the City Option and undertake activities to enhance enrollment of eligible employees into either HSF or MRA as a result of their employer's contribution

- Explore opportunities to ensure sufficient access to care by strengthening and /or broadening the HSF provider network.

- Expand the Strength in Numbers program to focus of other chronic care populations in addition to those with diabetes.

- Continue to develop appropriate provider and participant resource guides that facilitate access to care (e.g., a dental/vision resource guide).

- Continue to monitor enrollment activity over the course of the year to determine if adjustments should be made to the estimated number of uninsured adults.

IV. HSF AND FEDERAL HEALTH CARE REFORM

The Department has actively followed and will continue to follow the national health care debate. While the final form of the proposed health care reform is still taking shape, it is clear that any effort that expands health care insurance to the uninsured will be beneficial for the City and County of San Francisco.

Expansion of health insurance would naturally lead to a reduction in the number of participants enrolled in Healthy San Francisco. For example, the current proposal is to expand Medicaid to uninsured adults with incomes at or below 133% of the Federal Poverty Level. As of July 31, 2009, almost 34,900 HSF participants (81% of all participants) had income at or below this level and would be potential eligible to enroll in Medicaid if it were expanded to that level. It's important to note that passage of a national health care reform bill would not result in the wholesale dismantling of HSF. This is because the reform effort will not include all uninsured individuals such as those who may be undocumented or who may not have full permanent legal residency status. For those uninsured individuals, a local health care access program such as HSF will still be needed.

While HSF could not be a public option as currently being discussed because it is not health insurance, nevertheless, HSF has many aspects of health care reform debated at the national level:

- Provide coverage and choice – HSF does this by providing a comprehensive set of services, not excluding people with pre-existing conditions from the program and having a network of providers that serve uninsured people.

- Make coverage affordable – HSF does this by setting a person's out-of-pocket costs to their income level (the lower a person's income, the less they pay)

- Instill shared responsibility – HSF does this with a funding mechanism comprised of public funding, employer funding and participant funding.

- Promote prevention and wellness – HSF does this by focusing on the delivery of primary and preventive care and ensuring that all participants select a primary care medical home that can provide and coordinate these services for individuals

- Control costs – HSF has documented that the City and County's costs of providing this program is less expensive than the cost of the providing health insurance and that emergency room use among this population decreased from the first year to the second year of the program.

Healthy San Francisco also demonstrates that the public sector can be a critical provider of care alongside the private sector. It should be noted that HSF expands access without disrupting the current health insurance market also consistent with the national reform goal to protect current coverage.

V. LESSONS LEARNED

Since the debut of the Healthy San Francisco Program, the Department has learned valuable lessons with respect to undertaking a complex delivery system restructuring effort such as this. The HSF program HSF is an innovative model that stitches together the patchwork of existing public and private safety net providers and builds on existing resources.

Some of the salient lessons learned are:

- Implementation of HSF required significant systems change which could not be accomplished in "one giant leap." The phased implementation approach allowed the Department to make appropriate adjustments and modifications in the program.

- It is important to consistently manage program expectations. Because HSF is a local program, it cannot and does not address all of the problems that are inherent in the health insurance market and/or safety net delivery system that are based on federal or state regulations and policies.

- There is often external interest in obtaining program data to draw conclusions with respect to program impact which may be premature in the initial years of a new program.

- HSF benefited from the fact that there was an existing safety delivery system and infrastructure comprised of primary care clinics (public and non-profit), a public hospital and non-profit hospitals providing charity care.

- HSF development, implementation and ongoing operation requires stronger partnerships between the Department and non-profit/private providers to ensure access to care.

- The Department identified a strong third-party administrator, San Francisco Health Plan, and a solid eligibility/enrollment/system of record vendor, the Center to Promote Health Care Access (for One-e-App), that have been instrumental in the ongoing operation of the program.

- HSF participants appreciate and respond positively to the notion of selecting a medical home and developing a relationship with a primary care provider/clinic that can serve as a usual service of care.

- Participants appear to respond and perceive that HSF is not a charity care program. This may be a function of the choice of providers, streamlined enrollment process, customer service center and other factors.

- Targeted strategies are needed to promote on-time program renewals by participants.

- Participant education takes on added importance for any program as a system seeks to change participant health seeking behavior, particularly for a diverse population such as that enrolled in HSF.

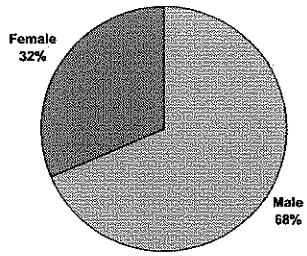
APPENDICES

APPENDIX A
California Health Interview Survey and Healthy San Francisco Demographic Comparison

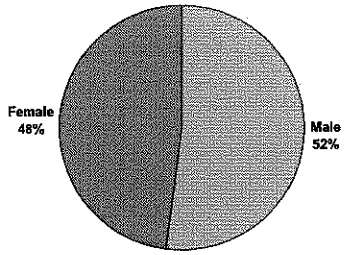
The Department compared HSF demographics to CHIS demographics to determine if HSF was enrolling a comparable population. The information provided below utilizes data from the 2007 CHIS records, as well as figures from the Healthy San Francisco database as of June 2009. Both the CHIS and HSF pie charts refer to San Francisco residents who do not have health insurance.

Gender

CHIS: Gender



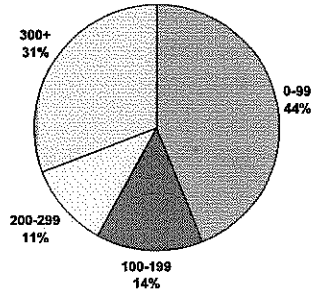
HSF: Gender



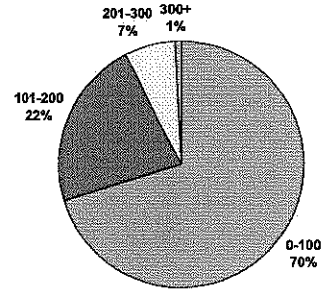
HSF's population is more gender-balanced than the CHIS survey population. According to the CHIS data, 68% of uninsured San Francisco residents are male and 32% are female. However, 52% of HSF participants are male and 48% are female.

Income [Federal Poverty Level (FPL)]

CHIS: Federal Poverty Level



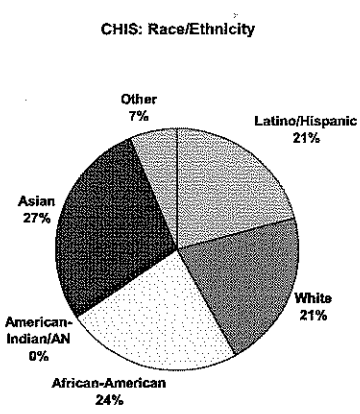
HSF: Federal Poverty Level

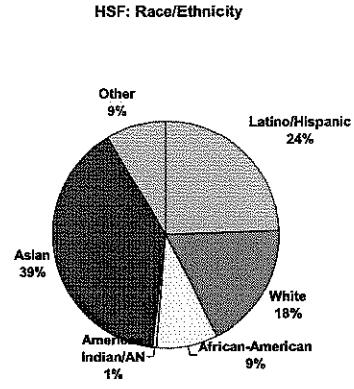


Due to variations in the initial data collection process, a direct comparison cannot be made between the CHIS and HSF data regarding Federal Poverty Level. Overall, the data suggests that HSF is enrolling a more low income population. CHIS records indicate 44% of uninsured San Francisco residents are below 99% FPL, 25% are between 100% and 299% FPL, and 31% are at or above 300% FPL. HSF data shows

70% of its participants fall below 100% FPL, 29% lie between 101% and 300% FPL, and 1% are above 300% of the FPL.

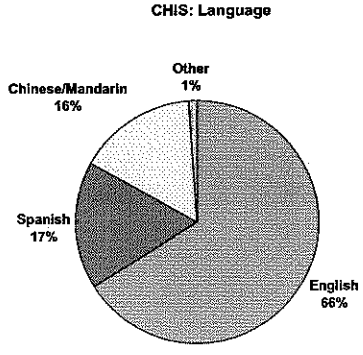
Race/Ethnicity

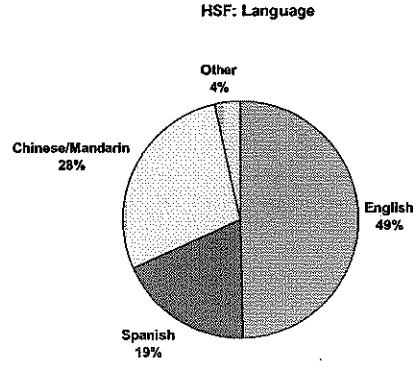




According to the data, the race/ethnicity of HSF participants seems similar to that of the residents interviewed through CHIS with some differences for Asian/Pacific Islander. CHIS data indicated that 21% of uninsured San Francisco residents were Latino/Hispanic, 21% were White, 24% were African-American, 27% were Asian, and 7% were another race or ethnicity. Data shows 24% of HSF participants are Latino/Hispanic, 18% are White, 9% are African-American, 1% are American-Indian or Alaskan Native, 39% are Asian, and 9% are another race or ethnicity.

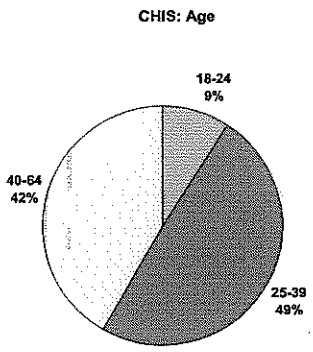
Language

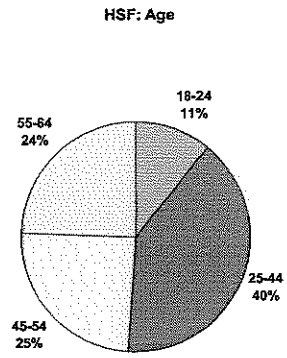




In comparison to CHIS, fewer HSF participants consider English as their primary language and more consider Chinese to be their primary language. According to the CHIS data, 66% of the uninsured San Francisco population speaks English, 17% speak Spanish, 15% speak Chinese/Mandarin, and 1% speak another language. Only 49% of HSF participants speak English, while 19% speak Spanish, 28% speak Chinese/Mandarin, and 4% speak another language.

Age





Again, due to variations in the initial data collection process, the CHIS and HSF data cannot be directly compared regarding age. The data reveal that HSF has an older population with a higher percentage aged 40 – 64 and that a similar percentage of uninsured between the ages of 18 – 24 for both CHIS and HSF. According to CHIS data, 9% of uninsured San Francisco residents were between the ages of 18 and 24, 49% were 25 to 39, and 42% were 40 to 64. According to HSF data, 11% of HSF participants are age 18-24, 40% are 25 to 44, 25% are 45 to 54, and 24% are 55 to 64.

Appendix B – HSF Data Warehouse Data Collection Summary

	2007						2008												2009		
Submitting Entity	July 07	Aug 07	Sept 07	Oct 07	Nov 07	Dec 07	Jan 08	Feb 08	Mar 08	Apr 08	May 08	Jun 08	July 08	Aug 08	Sept 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09
DPH Clinics	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
CCHCA/Chinese Hospital															⍾	⍾	⍾	⍾	☺	☺	☺
Northeast Medical Services	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
Sr. Mary Phillipa Health Center															⍾	⍾	☺	☺	☺	☺	☺
Glide Health Services			⍾	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
Mission Neighborhood Health Center			⍾	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
Lyon-Martin Health Services	**DATA NOT AVAILABLE**																				
Native American Health Center			⍾	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
South of Market Health Center			⍾	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
Haight -Ashbury Free Medical Clinic			⍾	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
Saint Anthony Free Medical Clinic			⍾	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
Total #			⍾	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺

Key

All outpatient services including office visits, radiology, laboratory and outpatient hospital.

Gray: Program not yet started.

⍾: Program started. Low volume of services reported.

☺: Data available for program.

Pharmacy Services

	2007						2008												2009		
Submitting Entity	July 07	Aug 07	Sept 07	Oct 07	Nov 07	Dec 07	Jan 08	Feb 08	Mar 08	Apr 08	May 08	Jun 08	July 08	Aug 08	Sept 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09
CBHS	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
NEMS	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
DPH	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺

*Includes SFGH Outpatient Pharmacy and participating Walgreen's pharmacies

Hospital Admissions (SFGH only)

	2007						2008												2009		
Submitting Entity	July 07	Aug 07	Sept 07	Oct 07	Nov 07	Dec 07	Jan 08	Feb 08	Mar 08	Apr 08	May 08	Jun 08	July 08	Aug 08	Sept 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09
SFGH	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺

*Includes revenue codes for inpatient hospital services

Hospital Admissions (non SFGH)

	2007						2008												2009		
Submitting Entity	July 07	Aug 07	Sept 07	Oct 07	Nov 07	Dec 07	Jan 08	Feb 08	Mar 08	Apr 08	May 08	Jun 08	July 08	Aug 08	Sept 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09
St Mary's Hospital																			☺	☺	☺

Key

Gray: Program not yet started.

Ω: Program started. Low volume of services reported.

☺: Data available for program.

Emergency Department Services (SFGH only)

	2007						2008												2009		
Submitting Entity	July 07	Aug 07	Sept 07	Oct 07	Nov 07	Dec 07	Jan 08	Feb 08	Mar 08	Apr 08	May 08	Jun 08	July 08	Aug 08	Sept 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09
SFGH	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺

Emergency Department Services (non SFGH)

	2007						2008												2009		
Submitting Entity	July 07	Aug 07	Sept 07	Oct 07	Nov 07	Dec 07	Jan 08	Feb 08	Mar 08	Apr 08	May 08	Jun 08	July 08	Aug 08	Sept 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09
St. Mary's Hospital															☺	☺	☺	☺	☺	☺	☺
St. Francis Hospital													☺	☺	☺	☺	☺	☺	☺	☺	☺

Key

Gray: Program not yet started.

Ω: Program started. Low volume of services reported.

☺: Data available for program.

APPENDIX C
Geographic Impact Analysis of Medical Reimbursement Account Contributions

The San Francisco Health Care Security Ordinance addresses the need for health care among not only uninsured adult residents, but also individuals who work in San Francisco through the Employer Spending Requirement component of the Ordinance. The ESR applies to all eligible individuals who work in San Francisco, irrespective of the employees' county of residency.

Many of these workers do not reside in the City and County of San Francisco. Any decision that an employer makes with respect to compliance with the ESR will benefit not only the employee, but may have an indirect impact on the community in which the employee resides. Specifically, the employee may seek health care services in the community in which they reside and those providers in that community may now have access to a funding source (ESR benefit) to care for those employees. It should be noted that the employee is under no obligation to use the ESR benefit in the community in which they reside. The employee may receive services in an entirely different county from which they reside or work and use their ESR benefit to support providers in that county. As a result, there is not a direct correlation between accrued benefits to a community and the county of residence for the employee with the ESR benefit.

There is great interest in understanding how communities outside the City and County of San Francisco might benefit from the ESR.

To understand this better, the Department undertook an analysis of employers who had selected the City Option to comply with the ESR. When an employer chooses the City Option, their employees will receive either Healthy San Francisco or a Medical Reimbursement Account depending upon the employee's eligibility. If the employee is eligible for HSF, the employee will be notified and must complete the HSF application process to get enrolled in the program. An employer does not enroll an employee into HSF. If the employee is ineligible for HSF (i.e., does not reside in San Francisco, has dependent health care coverage, not 18 years of age, etc.), then they will be given a Medical Reimbursement Account (MRA).[1] All funds contributed on the employee's behalf by the employer are deposited into this account and the employee can access these funds to reimburse for out-of-pocket health care expenses.

The analysis was restricted solely to examining the geographic distribution of employees who received Medical Reimbursement Accounts and their contribution amounts. The Department does not have any demographic information (e.g., ethnicity, gender, language spoken, etc.) on these employees because they did not go through the Healthy San Francisco eligibility and enrollment process.

[1] All City Option employer payments are submitted to the HSF Third-Party Administrator (the San Francisco Health Plan) for processing. Employer health care expenditures designated for a Medical Reimbursement Account, along with participant eligibility, are forwarded to the Medical Reimbursement Account vendor and accounts are created for each employee to use for reimbursable health care expenses. Funds are transferred weekly to the MRA vendor for claims and monthly for administrative fees.

The analysis was based on all ESR contributions made from January 9, 2008 to June 30, 2009. During that time, $23 million had been contributed on behalf of 23,000 employees for Medical Reimbursement Accounts – on average, $1,000 per employee.

The analysis sorted the geographic impact as follows:

1. California counties (9 Bay Area counties and the 49 remaining counties) and
2. United States regions (according to the United States Census Bureau) – see below.

Region	Division	States Included
Midwest	East North Central	WI, MI, IL, IN, OH
	West North Central	ND, SD, NE, KS, MN, IA, MO
Northeast	Mid-Atlantic	NY, PA, NJ
	New England	ME, NH, VM, MA, RI, CT
South	East South Central	KY, TN, MS, AL
	South Atlantic	DL, MD, DC, VA, WV, NC, SC, GA, FL
	West South Central	OK, TX, AR, LA
West	Mountain	ID, MT, WY, NV, UT, CO, AZ, NM
	Pacific	AK, WA, OR, CA, HI

Key Findings

As the chart below indicates, the majority of the MRA contributions remained in the nine Bay Area Counties.

Community	No. of Employees	Employer MRA Contributions	% of MRA Contributions
California (9 Bay Area Counties)	21,483	$21,815,940	94.8%
California (49 Other Counties)	1,110	$937,705	4.1%
Midwest	63	$40,469	0.2%
Northeast	88	$47,844	0.2%
South	98	$63,051	0.3%
West (excluding California)	180	$106,195	0.5%
United States Territories (Guam)	2	$650	0.0%
All Communities	**23,024**	**$23,011,854**	**100%**

Collectively, for the entire State of California, employees from the nine Bay Area counties (San Mateo, Alameda, San Francisco, Contra Costa, Santa Clara, Marin, Solano and Sonoma) received 95% of all MRA contributions while the remaining 4% of employer MRA contributions were disbursed among the remaining 49 counties (including Los Angeles). Within the Bay Area counties, San Mateo had the largest amount of employer MRA contributions, totaling $5,723,173. Alameda and San Francisco counties had the second and third largest employer MRA contributions, respectively.

The data reveals that 5,994 San Francisco employees residing in the City and County had combined employer MRA contributions of $5,545,701 (approximately 25% of all Bay Area contributions). An employee residing in San Francisco would receive an MRA as opposed to HSF if they did not meet HSF

eligibility requirements. For example, these employees received an MRA, because it was discovered during the HSF application process that they had health insurance as a dependent from another household member. Their employer may not have been aware of the fact that the employee had dependent health insurance because that insurance is not provided to the employee by the employer. In these cases, money that would have been contributed towards the employee's Healthy San Francisco enrollment is instead transferred to an MRA for that employee.

On a regional level, data indicates that employees living in the Western region of the U.S., including California, received the most employer MRA contributions – a total of 99.1% of the total employer MRA contributions made on behalf of San Francisco employees residing across the United States. In the Western region, 22,773 employees received a combined total of $22,859,840.49 in MRA contributions. Excluding California, employees in the Western region of the U.S. received only 0.5% of MRA contributions made nationwide, indicating the vast majority are made to employees residing within California.

On a national level, the impact of employer MRA contributions may be insignificant given the number of employee and contributions by region. A total of 45 states (excluding California) had a resident who received an employer MRA contribution. In total, 427 individuals or roughly nine residents per state had contributions with an average employer MRA contribution across the 45 states of $5,718 (based on total MRA contributions of employees residing in other states of $257,301).

Appendix D
Detailed Data on Health Access Questionnaire

On December 19, 2008, Healthy San Francisco launched the Health Access Questionnaire (HAQ) in its eligibility/ enrollment system (One-e-App). The HAQ is a set of 10 health questions administered to both new applicants and those renewing their enrollment in the program. Questions referred to the quality and ease of access to medical care the applicants experienced in the past 12 months, locations at which they most frequently received medical care, use of emergency rooms, health insurance status, and one health behavior question regarding smoking. The purpose of the questionnaire is to capture applicants' pre- and post- Healthy San Francisco health access experience in a quantifiable fashion. The questionnaire is useful in helping analyze the program and for evaluation purposes.

The ten-question survey is offered in English, Spanish and Chinese. Questionnaire responses are self-reported data by applicants/participants. There is no right or wrong answer to the questions and applicants/participants are informed to answer the questions from their own experiences. An applicant may indicate that they do not know the response to a question or can refuse to answer a question. An applicant/participant can refuse to answer all questions. This does not invalidate their application for the program. An applicant's response to the questions in no way affects their eligibility for HSF. The questionnaire is administered after the applicant has been determined eligible for the program and the applicant has been informed that they have been enrolled in the program. The questionnaire must be completed in order to finish an individual's application.

The Department examined survey responses for the time period December 19, 2008 to June 30, 2009. During this time period, 22,791 surveys were administered through One-e-App for a total number of 227,910 responses (22,791 questionnaires * 10 questions). Of the total number of responses, there are a recorded 164,731 (72%) stated responses, 33,409 (15%) "don't know" responses and 29,770 (13%) "refused" responses.

The questionnaire is administered through One-e-App to new program participants and those renewing their program eligibility. A new participant is one who is enrolling into HSF for the first time and as a result, their responses to questions will be based on their health care experiences prior to HSF enrollment. A renewal participant is one who has been in HSF for at least one year and as a result, their responses to questions will be based on their health care experiences during HSF enrollment. The distribution of the survey respondents during this time period was as follows

- 61% were new participants,
- 34% were renewing participants (with no break in program participation),
- 2% were renewing participants (with a break in program participation),
- 2% were participants who had their initial application modified within first year of program enrollment and
- 1% were re-enrolling participants who had not been in the program for at least one year.

Because the questionnaire was launched in December 2008, the data does not provide any year-to-year comparative analysis since no participant has taken the questionnaire twice (at initial enrollment and re-enrollment/renewal). The Department examined the data by analyzing overall responses and by conducting additional analysis on the health behavior questions related to smoking habits. The information that follows is on the aggregate level, not the individual level. However, because each questionnaire is linked to an application and participant, individual level analysis can be performed.

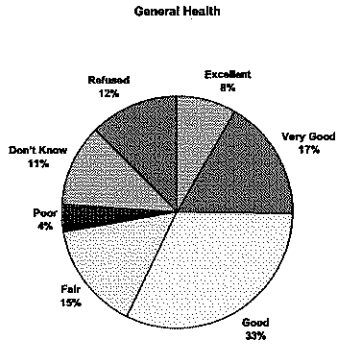
OVERALL QUESTIONNAIRE FINDINGS

The following analysis is comprised of two components:

1) The overall responses to all survey responders/participants (new, modified, renewing and re-enrolling) and all possible responses (including stated, unknown and refused).

2) Specific analysis for those New and Renewal participants with stated responses only. This excludes any participants who provided a "Don't Know" or "Refused" answer to a question, as there exists no way to determine what responses these participants would have chosen had they been required to choose a more specific answer. This analysis is meant to distinguish those who are just enrolling in the program for the first time from those who have been in the program for at least one year. For the purposes of this analysis:
   - new participants includes both applicants enrolling for the first time and those whose applications have been modified, and
   - renewal participants includes those who are renewing their enrollment on time without a break in participation and those who passed their one-year renewal period; experienced a break in participation, and are now re-enrolling.

1. Would you say that in general your health is excellent, very good, good, fair, or poor?

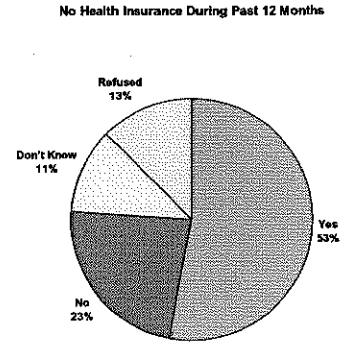


Overall, approximately 8% of respondents believed their general health to be "Excellent," 17% believed it to be "Very Good," and 33% believed it to be "Good."

When "Don't Know" and "Refused" responses are excluded and respondents are separated into New and Renewal, 5.4% of New participants indicated their health was "Poor" and 4.6% of Renewal participants indicated their health was "Poor."

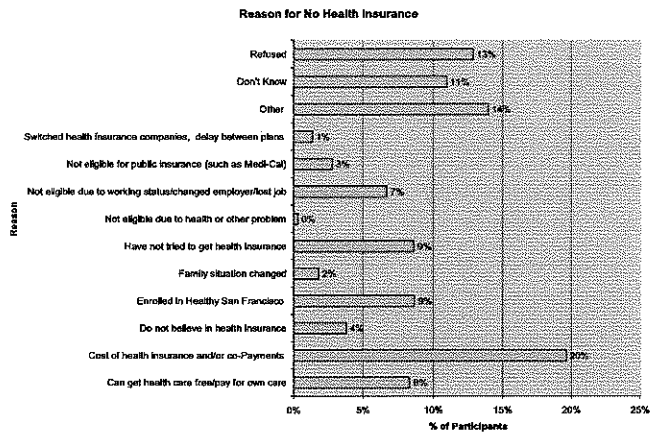
2. During the past 12 months, was there any time you had no health insurance at all?

Overall, approximately 53% of respondents indicated there had been a time during the past 12 months when they did not have health insurance.



Naturally, when "Don't Know" and "Refused" responses are excluded and participants are separated by New and Renewal, 76% of New participants stated no health insurance at some point during the past 12 months and 58% of Renewal participants indicated so. Though HSF is not health insurance, Renewal participants who indicated they had consistent health insurance during the past 12 months (answered "No") may consider HSF to be insurance and feel protected although all program materials indicate that HSF is not health insurance.

3. What is the one main reason why you did not have health insurance?



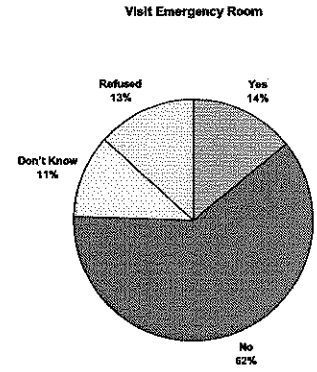
The next question referred to why the respondent did not have health insurance during the past 12 months. Overall, 20% cited "Cost of health insurance and/or co-payments" as their reason, while 9% indicated it was because they were enrolled in Healthy San Francisco. Another 8% were able to receive health care for free or could pay for their own care, and an additional 4% did not have health insurance because they did not believe in it.

Again, if the "Don't Know" and "Refused" responses are excluded and the participants are divided by amount of time enrolled in HSF, 30% of New participants stated cost of health insurance as a reason why they were not insured, while 19% of Renewal participants used this reason. Not surprisingly, of all those who did not have health insurance at some time because they were enrolled in Healthy San Francisco, 90% were Renewal participants.

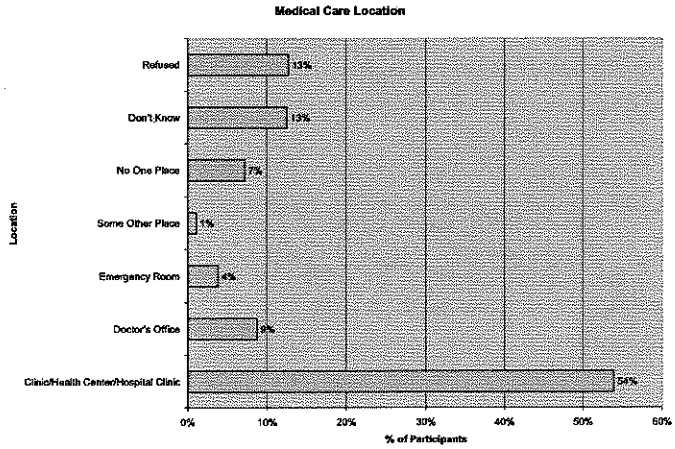
4. In the last 12 months, did you visit a hospital emergency room for your own health?

Overall, approximately 14% of respondents had visited a hospital emergency room in the previous 12 months.

When "Don't Know" and "Refused" answers are excluded and participants divided based on length of time enrolled in HSF, new percentages are again revealed. Approximately 21% of New participants had utilized a hospital emergency room in the past 12 months, whereas only 15% of Renewal participants had used an ER.



5. What kind of place do you go to most often to get medical care? Is it a doctor's office, a clinic, an emergency room, or some other place?

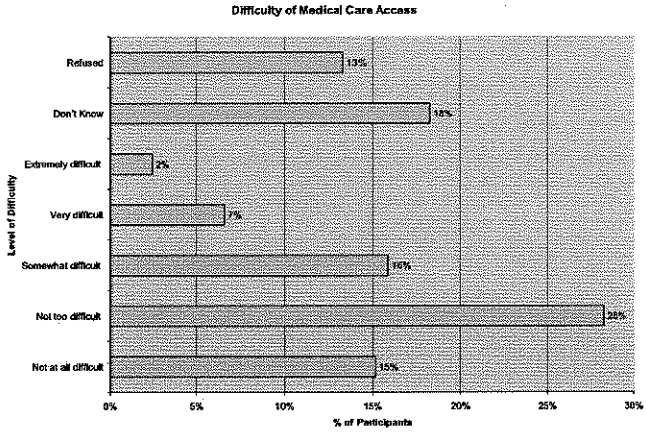


Overall, the majority of respondents – 54% - most often received medical care at a clinic, health center, or hospital clinic. Approximately 9% received care in a doctor's office, while 4% received it in an emergency room.

When "Don't Know" and "Refused" responses are excluded and participants are separated again based on enrollment length, data shows that 60% of New

participants received most of their care in clinics, health centers, and hospital clinics, whereas 93% of Renewals received their care in these places. These figures suggest that use of medical homes increase with HSF program participation. Furthermore, 7% of New participants received most of their care in Emergency Rooms, but less than 1% of Renewal participants received most of their care in ERs.

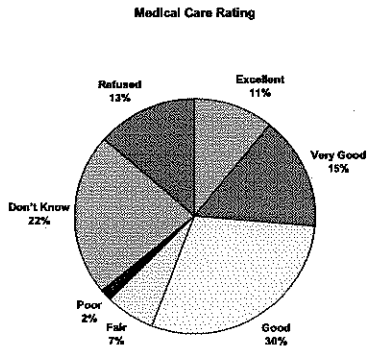
6. Overall, how difficult is it for you and/or your family to get medical care when you need it – extremely difficult, very difficult, somewhat difficult, not too difficult, or not at all difficult?



Overall, approximately 15% of respondents said it was "Not At All Difficult" to receive medical care when they needed it, 28% said "Not Too Difficult," 16% said "Somewhat Difficult," 7% said "Very Difficult," and 2% said "Extremely Difficult."

After excluding "Don't Know" and "Refused" responses and grouping participants by length of enrollment, 17% of New participants reported that receiving medical care when they needed it was "Extremely Difficult" or "Very Difficult," whereas only 7% of Renewal participants reported it as such. Similarly, 20% of New participants reported receiving the care was "Not At All Difficult," and this percentage increased to 25% for Renewal participants.

7. How do you rate the medical care that you received in the past 12 months – excellent, very good, good, fair, or poor?

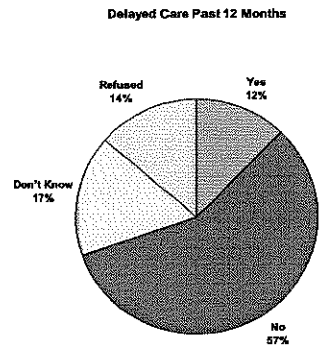


Overall, approximately 11% rated the medical care they had received in the past 12 months as "Excellent," 15% said it was "Very Good," 30% said "Good," 7% "Fair, and 2% said "Poor."

After "Don't Know" and "Refused" responses are excluded and participants are grouped by enrollment length, 36% of New participants indicated their quality of care was "Poor," whereas only 10% of Renewal participants chose this response. These figures suggest that participants enrolled in HSF longer may perceive their medical care as better quality than those recently enrolled or enrolling for the first time.

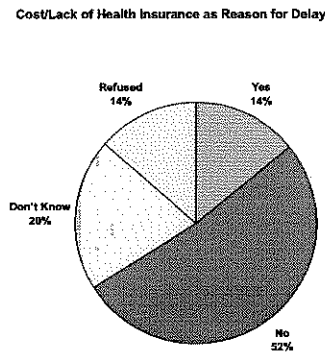
8. During the past 12 months, did you either delay getting care or not get a medicine that a doctor prescribed for you?

Overall, approximately 12% of respondents said they had delayed getting care or did not get a medicine that was prescribed to them during the past 12 months.



After the "Don't Know" and "Refused" answers are excluded and the participants are divided by length of enrollment, 23% of New participants had delayed care in the past 12 months, whereas only 8% of Renewal participants had delayed care. These figures suggest that those who have been enrolled in HSF may be less inclined to delay seeking care than enrolling for the first time.

9. Was cost or lack of insurance a reason why you delayed getting care or did not get the prescription?



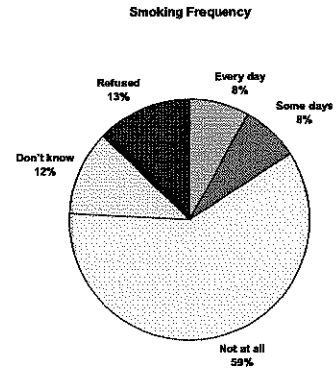
Overall, approximately 14% of respondents said cost or lack of insurance was a reason why they delayed getting care or did not get a prescription.

After the "Don't Know" and "Refused" responses are excluded and participants are grouped by time enrolled in HSF, 29% of New participants said cost or lack of insurance was a reason they delayed care, while only 6% of Renewal participants said these were reasons. These figures suggests that Renewal participants are less likely he is to delay getting care or filling a prescription because of cost, than New participants.

10. Do you now smoke cigarettes every day, some days, or not at all?

Overall, approximately 8% of respondents reported they smoked every day, 8% reported they smoked some days, and 60% reported they did not smoke at all.

After the "Don't Know" and "Refused" responses are excluded and participants are grouped by the length of time enrolled in HSF, data revealed that 23% of New participants smoked, while only 8% of Renewal participants smoked.



FURTHER ANALYSIS OF SMOKING FREQUENCY DATA (QUESTION 10)

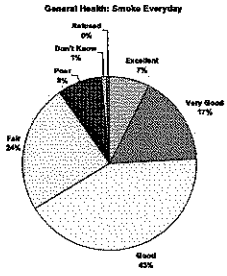
In order to ascertain more information about New and Renewal Healthy San Francisco participants who indicated that they smoked, the Department conducted further analysis of question 10 of the Health Access Questionnaire. Specifically, it segments the stated smoking response (i.e., do not smoke, smoke some days and smoke everyday) from participants and examines how these participants responded to the other questions on the questionnaire. The Department believes that this type of analysis can be instructive and provides for a deeper understanding of the participant's perceived health status and health access issues.

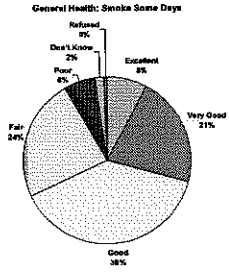
In the future, the Department intends to take data from the health access questionnaire and compare clinical data maintained in the HSF Data Warehouse. Comparisons of this type can be instructive in ascertaining whether a participant's perception of his/her health status and access to care is reflected in

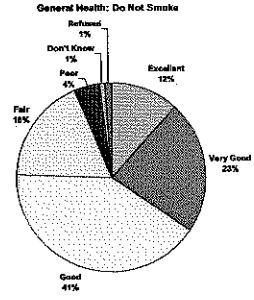
their actual utilization of services. This type of analysis can be performed the information in both the Health Access Questionnaire database and the HSF Data Warehouse have unique identifier information.

General Health

In general, those who smoked more frequently tended to more often consider themselves in "Poor" health than those who did not smoke at all. Similarly, those who did not smoke at all tended to perceive themselves more often with "Excellent" health than those who smoked. Data indicates that of all those HSF participants who smoke everyday, 7% consider themselves to be in "Excellent" health, 17% consider themselves in "Very Good" health, 43% in "Good" health, 24% in "Fair" health, and 8% in "Poor" health. For those who smoke on some days but not others, 8% said they had "Excellent" health, 21% said "Very Good" health, 39% said "Good" health, 24% said "Fair" health, and 6% said "Poor" health. For those HSF participants who do not smoke at all, 12% report they are in "Excellent" health, 23% in "Very Good" health, 41% in "Good" health, 18% in "Fair" health, and 4% in "Poor" health.

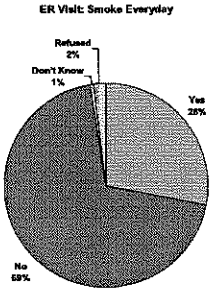


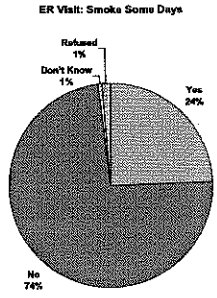


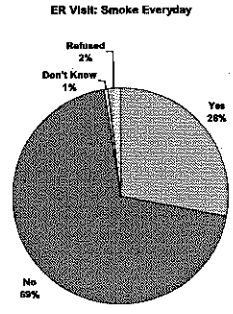


ER Visit in the Past 12 Months

Data reveals that 28% of those who reported smoking everyday had visited a hospital emergency room in the past 12 months, 24% of those who smoked some days had visited an ER, and 16% of those who never smoked visited an ER. These figures suggest that HSF participants who smoked more often were also more likely to have visited the ER in the past 12 months.

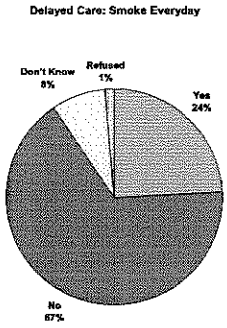


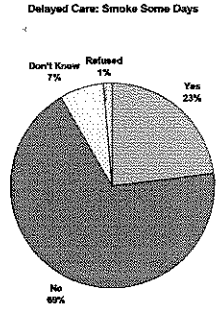


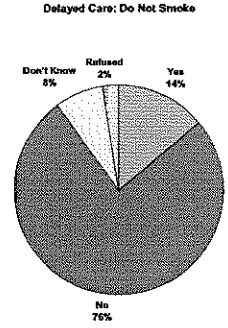


Delayed Care in the Past 12 Months

Data shows that 24% of those participants who smoke everyday have delayed care or not filled prescription given to them by a doctor in the past 12 months. In addition, 23% of those who smoke on some days delayed care but only 14% of those who do not smoke at all delayed care. These numbers suggest that those HSF participants who smoked more often tended to indicated that they delayed medical care more often as well.

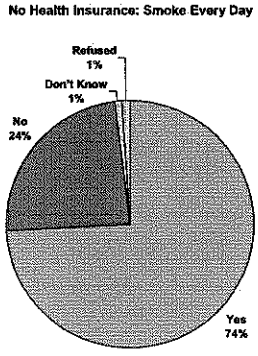


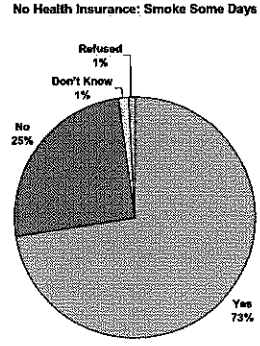


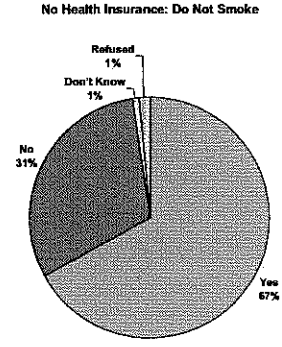


No Health Insurance in the Past 12 Months

Data indicates that 74% of those HSF patients who smoke everyday had been without health insurance at some time during the past 12 months. Furthermore, 73% of participants who smoke some days had been without health insurance, and 67% of participants who do not smoke at all had been without health insurance. These figures indicate that HSF patients who do not smoke at all tended to have more consistent health coverage in the past 12 months than those who smoked.

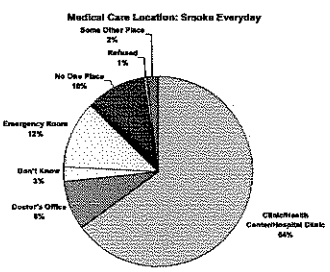


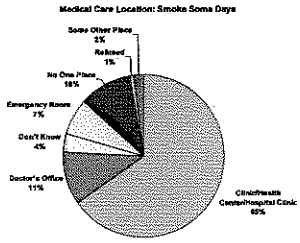


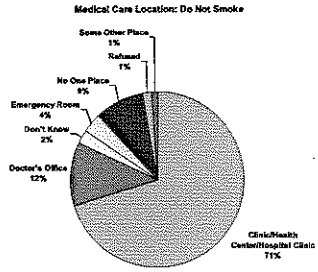


Medical Care Location

Data indicates that 64% of those HSF patients who smoke everyday, 65% of those who smoke some days and 71% of those who do not smoke utilize clinics, health centers, or hospital clinics most often for medical care. Though 12% of patients who smoke everyday most often use emergency rooms for care, only 4% of patients who do not smoke at all use ERs



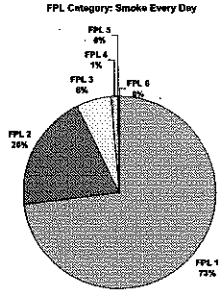


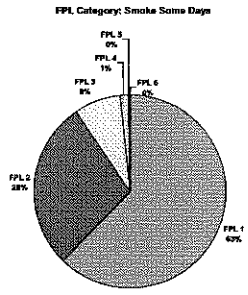


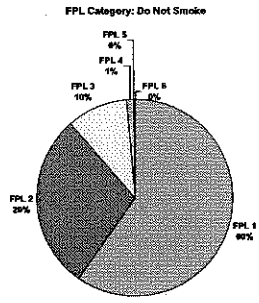
The Department also analyzed the smoking behavior question (question 10) in conjunction with demographic information collected for each participant.

Federal Poverty Level

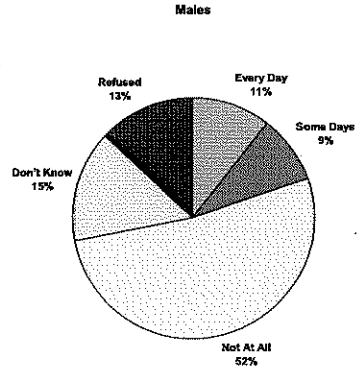
Data indicates that 73% of those HSF participants who smoke everyday are at or below 100% of the Federal Poverty Level (FPL), 62% of those who smoke some days are so and 60% of those who do not smoke at so.

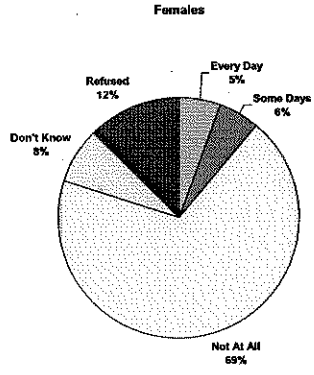






Gender





Data shows that 5% of female HSF participants smoke everyday, 6% smoke some days, and 69% do not smoke at all. Men seem to smoke more often: 11% of male HSF respondents smoke everyday, 9% smoke some days and 52% do not smoke at all.