Healthy San Francisco

Our Health Access Program

Annual Report to the San Francisco Health Commission (For Fiscal Year 2009-10)

TABLE OF CONTENTS

I. SUMMARY AND OVERVIEW OF MAJOR ACCOMPLISHMENTS

Healthy San Francisco (HSF) continued its efforts to improve access and ensure that program participants use services in an appropriate manner.

At the end of fiscal year 2009-10, over 53,400 uninsured adult residents were enrolled in HSF – this represented a 24% increase compared to enrollment at the end of fiscal year 2008-09. With 53,400 participants, HSF provided care to 89% of the estimated 60,000 uninsured adult residents. In addition to increasing access by serving more uninsured adults, the program also expanded access by increasing the number of primary care medical homes that participate in the program. HSF ended the 2009-10 fiscal year with 32 medical homes – a 19% increase from 2007-08 (the program's first year).

Fiscal year 2009-10 data suggests that HSF provides services in an effective manner, promotes the use of primary care and has resulted in a reduction in hospital utilization:

- 76% of HSF participants received a primary care visit and the average number of primary care/preventive visits per participant per year (3) is consistent with the Nat'l Medicaid Avg. (3)
- utilization of emergency department (ED) services held constant at 164 visits for every 1,000 participants -- this is below the State average of 275 visits per 1,000
- 9% of ED visits by HSF participants were avoidable (i.e., the visit could have occurred in a primary care setting) -- this is lower than the State Medi-Cal average of 18% for adults
- from 2008-09 to 2009-10, the program witnessed decreases in hospital admissions, acute hospital days per 1,000 participants and the average length of hospital stay

In the area of quality, HSF exceeded or was near the National Medicaid Average in care standards for diabetic patients and those patients with asthma.

Participant feedback suggests that for the majority of the population, HSF is meeting their needs. The Healthy San Francisco Participant Survey found the 94% of the participants were satisfied with the program. The HSF Health Access Questionnaire found that participants with continuous enrollment reported less ED utilization, a usual source of care, less difficulty accessing care, an improved rate of medical care and less delays accessing care.

The Department's estimated HSF expenditures totaled $140.2 million. Of that amount, $40.4 million was covered by revenue and $99.8 million was covered with a City and County General Fund subsidy. In addition, private community HSF providers incurred $23.62 million in HSF expenditures (above and beyond $11.45 million in Department reimbursement). In total, estimated HSF expenditures totaled $163.9 million serving HSF participants in FY 2009-10. With a total 594,102 participant months in FY2009-10, the estimated total per participant per month expenditure was $276.

Continuing its role in technical assistance and knowledge sharing, the Department released *Policy Brief: Lessons from Healthy San Francisco.* The report notes that HSF highlights important ways to strengthen the local health systems: patient-centered reform, delivery system reform and coverage expansion.

Finally, San Francisco's innovative model was recognized nationally with the:

- 2010 National Association of Public Hospital's "Chair Award" for Healthy San Francisco,
- 2010 National Association of Public Hospital's" Award for Improving the Patient Experience" for the Healthy San Francisco Chronic Care Redesign Projects and
- 2010 American Hospital Association's "NOVA Award" for Healthy San Francisco and its participating hospitals.

II. 2009-10 PROGRAM ACTIVITIES

A. COMMUNICATIONS, OUTREACH, APPLICATIONS AND ENROLLMENT

This section of the report discusses outreach, application and enrollment trends in the Healthy San Francisco program.

Three years after its launch, interest in Healthy San Francisco (HSF) has not abated and the enrollment has increased. From fiscal year (FY) 2008-09 to FY2009-10, year-end enrollment increased 24% with over 53,400 uninsured adult residents enrolled in the program. Based on the 2007 California Health Interview Survey, the program is serving 89% of the estimated 60,000 uninsured adult population in San Francisco. The program continued to identify applicants eligible for, but not enrolled in, public health insurance through the HSF application procress. Almost 2,000 residents obtained health insurance through this process. As enrollment in the program has increased, so has program disenrollment due to such factors as program eligibility and failure to renew enrollment. The program ended the fiscal year with approximately 27,100 individuals disenrolled with 2,044 (7.5%) of those individuals having had multiple disenrollments (i.e., churning through the program). The Department enhanced activities to promote on-time program renewals in FY 2009-10. In total, HSF has provided access to care to over 80,500 uninsured adult residents (53,400 currently enrolled plus the 27,100 currently disenrolled).

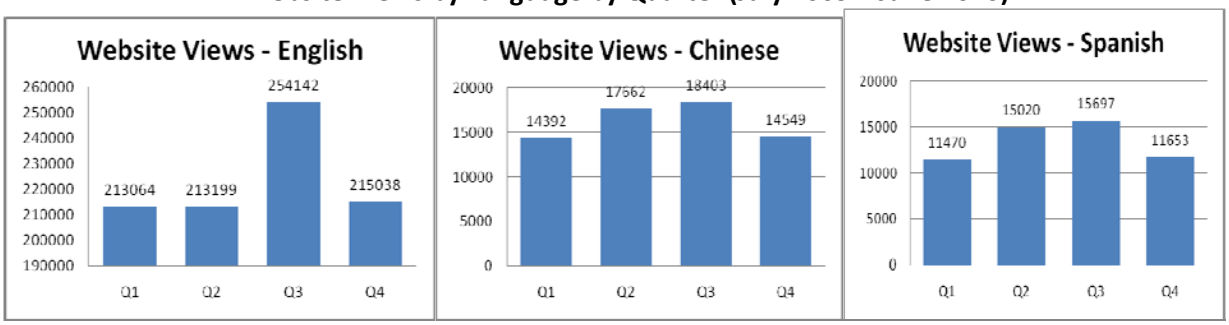
Communications and Outreach

The HSF Communications and Outreach program includes planning, development, and implementation of new and on-going program messaging and materials. On-going tasks include website development and maintenance, coordination of media/public relations, development of participant materials (handbooks, ID cards, correspondence and invoices), mail house services, creative/design services and copywriting. HSF does not have a formal marketing/advertising program in its outreach activities.

The HSF website (www.healthysanfrancisco.org) continues to be the most accessible and versatile program communications tool. HSF uses word of mouth and community outreach to generate interest and attention. The following are website highlights for the year ending June 30, 2010:

- The website had a total of 1,014,289 visitors during the year.
- Of those visitors, a total 895,443 (88.3%) used the English language portion of the website, 65,006 (6.4%) used the Chinese language portion of the website and 53,840 (5.3%) used the Spanish language portion of the website.

Graph A1
Website Views by Language by Quarter (July 2009 – June 2010)



In addition to the website, the general public can obtain information on HSF and where to apply for the program by calling the City and County's 24 hours a day/7 days a week 3-1-1 system. HSF continues to be a top-rated reason that people call 3-1-1 after calls about MUNI information and street repairs. On average, 507 people called 3-1-1 for HSF information each month during FY2009-10 (total of 6,078 calls).

Applications

Communications and outreach are designed to facilitate enrollment and provide participants with readily accessible information about the program. HSF enrollment starts with the trained Application Assistors (AAs). HSF has 137 AAs who assist residents in applying for the program at 28 different locations throughout the City. During FY2009-10, AAs processed over 55,000 applications through the web-based eligibility and enrollment system – One-e-App.

Table A1
Number of HSF Applications Processed[1] (July 2009 – June 2010)

Application Type	# of One-e-App Applications	# of Individuals in Applications	# of Individuals in Applications Applying for Coverage	# of Individuals in Applications Not Eligible for HSF	# of Individuals in Applications Eligible for HSF	# of Individuals Actually Enrolled in HSF	HSF Enrollment Rate
New Application	23,868	31,427	27,160	2,250	24,910	24,663	99.0%
Renewal HSF Applications	19,463	29,410	23,236	383	22,853	22,742	99.5%
Modified Application (mid-term)	2,143	6,423	2,545	532	2,013	1,963	97.5%
Re-enrollment Application	9,846	11,438	11,095	312	10,783	10,677	99.0%
TOTAL	55,320						

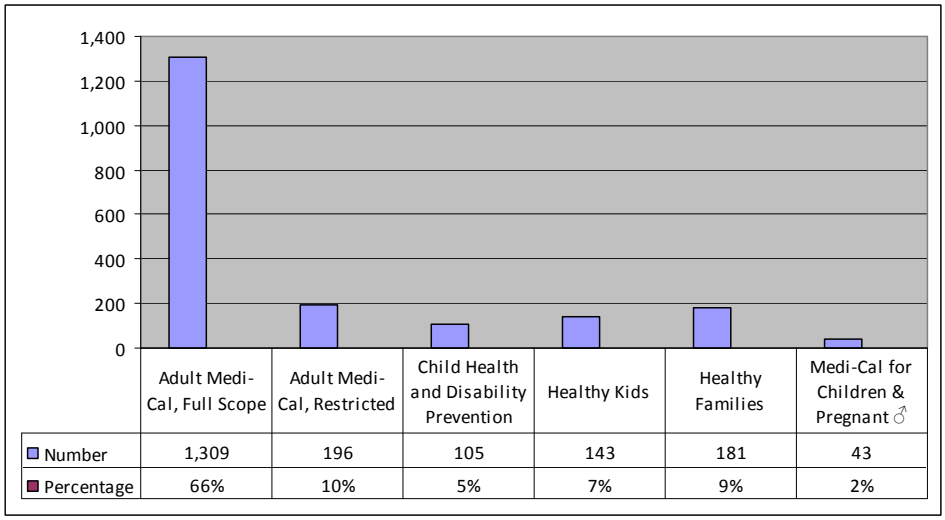
As Table A1 demonstrates, the HSF enrollment rate (i.e., number of individuals enrolled in HSF divided by the number of individuals applying for HSF) ranges from 97% – 99% based on the type of application.

In general, for any new application processed, a resident can be determined eligible for HSF or eligible for another program. Of all applications processed in 2009-10, 1,977 (3.6% of 55,320) of them were for public health programs other than HSF.[2] Of the 1,977 non-HSF applications, approximately 95% were for public health insurance. This provides evidence that 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. As renewal, modify and re-enrollment applications become a larger percentage of total applications, there is a decrease in the percentage of new applications and of individuals who apply for HSF the first time and are also found eligible for another public health program. Graph A2 provides the number and percentage of applications determined eligible for other programs.

[1] An individual can have more than one application and/or application type in the course of a 12-month reporting period (e.g., a new application is created, then modified during term; a renewal application is created; participant disenrolls for an eligibility reason and then re-enrolls later).

[2] The 1,977 non-HSF program applications were part of 1,147 One-e-App applications. Within a given One-e-App application there may be individuals eligible for other programs such as Medi-Cal, Healthy Families, Healthy Kids, etc.

Graph A2
Number of Application Processed for Other Health Programs (July 2009—June 2010)



	Adult Medi-Cal, Full Scope	Adult Medi-Cal, Restricted	Child Health and Disability Prevention	Healthy Kids	Healthy Families	Medi-Cal for Children & Pregnant ♂
Number	1,309	196	105	143	181	43
Percentage	66%	10%	5%	7%	9%	2%

Enrollments and Percentage of Uninsured

The remaining completed applications lead to HSF enrollment. There are an estimated 60,000 uninsured adults in San Francisco based on the 2007 statewide California Health Interview Survey (CHIS).[3] This estimate was used in planning and program development for HSF in FY 2009-10.

At the end of the fiscal year, there were 53,428 participants enrolled in HSF (89% of the estimated 60,000 uninsured adults in San Francisco). This is a 24% increase in enrollment compared to the end of FY2008-09 (43,200 participants). However, while year-end enrollment in HSF was near the estimated number of uninsured adults, since the program's inception in July 2007, it has served in excess of the estimated 60,000 as noted in Table A2. This is based on adding together two FY2009-10 figures: (1) the number currently enrolled in HSF at the end of the fiscal year – 53,428 and (2) the number currently disenrolled in HSF at the end of the fiscal year – 27,137 (discussed in the following section). Table A2 provides this information for each of the three fiscal years with the total being 80,565 uninsured adult residents who have been served and enrolled in HSF by the end of FY2009-10.

Table A2
Current and Previously Enrolled based on 60,000 CHIS Uninsured Adult Estimate

Fiscal Year	Enrollment at end of FY	Enrolled as % of Uninsured Est.	Total Ever Enrolled at End of FY (Enrolled + Disenrolled)
2007-08	24,210	40%	25,269
2008-09	43,200	72%	59,698
2009-10	53,428	89%	80,565

[3] 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 2007 survey findings 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. The CHIS information was used to determine the 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).

Table A2 indicates that over 80,000 uninsured adult San Franciscans have participated in and benefited from HSF over its three-year existence. Some of these residents have maintained their enrollment continuously and some have disenrolled from the program. The fact that HSF enrollment has surpassed the uninsured estimate is a reminder that estimates should consistently be used as guides for planning and that they are subject to revision and modification.

As noted previously, San Francisco's uninsured estimate is based on data from the 2007 CHIS. Recognizing the need to provide updated estimates of the uninsured that would take into account the economic downturns of 2008 and 2009, in late August 2010 (fiscal year 2010-11) the UCLA Center for Health Policy Studies released updated county-level CHIS estimates of the insured and uninsured rates. Extrapolating from this data indicates that the estimated number of uninsured adults increased from 60,000 to 79,000 in San Francisco -- a 31% increase.

Table A3
Comparison of Uninsured Estimates – 2007 CHIS to 2007 CHIS Update

Category	2007 CHIS (2007 Survey)	2007 CHIS Update (2007 Survey + 2008 & 2009 Updates)
Uninsured Estimate (At Time of Survey)	60,000	79,000
Enrollment at end of 2009-10 Fiscal Year	53,428	53,428
Percentage of Estimate Enrolled	89%	68%
SF Uninsured Adults Ever Enrolled in HSF (Currently Enrolled + Currently Disenrolled)	80,595	80,595

The updated adult uninsured estimate of 79,000 would suggest that HSF had enrolled 68% (53,428) of this population by the end of FY2009-10. At the same time, as noted above, HSF enrollment data shows that the program has served over 80,500. While the Department did not use the updated uninsured estimate as part of any analysis contained in this FY2009-10 annual report, it will use the updated estimate of 79,000 for FY2010-11 planning activities until the UCLA Center for Health Policy Studies releases the findings from the 2009 CHIS in winter 2010.

Disenrollments

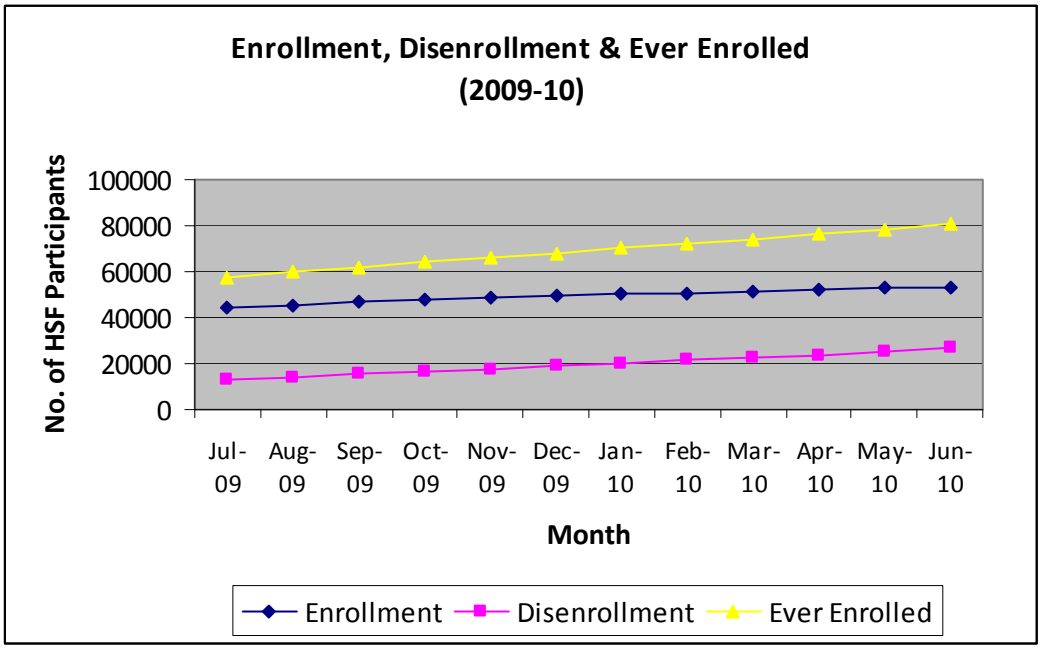
As noted above, there have been 80,565 HSF participants. Of these, 53,428 are current participants, and 27,137 are former participants who are currently disenrolled from the program. The HSF disenrollment rate is 34%.

Table A4
HSF Disenrollment Rate

Total Disenrolled	Less Disenrolled who Re-enrolled	Equals Currently Disenrolled	Add to this Currently Enrolled	Gives HSF Ever Enrolled	Disenrollment Rate = Currently Disenrolled ÷ Ever Enrolled
41,125	13,988	27,137	53,428	80,565	34%

As the number of participants enrolled into HSF continues to rise, the number of participants disenrolled does as well. As more participants are enrolled, more are required to renew, and more may not due so for the reasons cited below. The following chart demonstrates this relationship over the past fiscal year.

Graph A3



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.

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 level of enrollment mobility within the program. At of the end of the FY2009-10, there were 27,137 current disenrollments for the following reasons:

Table A5
Disenrollments by Reason

Current Disenrollments by Reason	***# Disenrolled***	***% of Disenrollments***
Program Eligibility	6,574	24%
Participation Fee	3,104	11%
Annual Renewal	17,311	64%
Other/Voluntary	148	1%

1. *Disenrollment Due to Program Eligibility* (24% - 6,574 participants)

The data indicates that 24% of those who were disenrolled no longer met the HSF eligibility requirements. Specifically, these individuals obtained health insurance (public or private), moved out of San Francisco and no longer met the residency requirement and aged-out of the program when they turned 65.

Table A6
Program Eligibility Disenrollments

Disenrollments Reason	*Number*	*Percentage*
Enrolled in Public Coverage	3,139	48%
Exceeds Program Age Requirements	1,362	21%
Enrolled in Employer-Sponsored Insurance	754	11%
Not a San Francisco Resident	548	8%
Determined Eligible for Other Programs During Renewal or Modification	539	8%
Enrolled in Private Insurance	232	4%

2. Disenrollment Due to Participation Fee (11% - 3,104)

Disenrollments due to insufficient payment of the quarterly participation fee represent 11% of program disenrollments. These disenrollments were reflected in the following manner:

- Participant indicates they could not afford participation fee – 156 disenrollments
- Insufficient payment of participation fee – 2,948 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.

Table A7
Participation Fee Related Disenrollments

FPL Category	**Total No. of HSF Enrollments by FPL (A)**	**% of Enrollments in FPL Category (B = A÷53,428)**	**Total No. of Insufficient Payment Disenrollments by FPL (C)**	**Disenrollments as a % of Enrollments in FPL Category (D = C÷A)**
0-100%	36,647	69%	3[4]	0%
101-150%	6,358	12%	1,256	20%
151-200%	5,801	11%	810	14%
201-250%	2,504	4%	590	25%
250-300%	1.412	3%	239	17%
301% +	806	2%	206	26%
	53,428		3,104	

Disenrollment due to participation fee can occur for many reasons. For some it may be ability to pay and for others, a participation fee related disenrollment may mask other disenrollment reasons. For example, a HSF participant above 100% FPL paying a participation fee, who during their 12-month HSF eligibility period, obtains health insurance may simply ignore the quarterly participant fee invoices. While program guidelines direct HSF participants to contact HSF Customer Service with any changes in health insurance status, some may neglect to do so. In such cases the disenrollment is erroneously coded as failure to pay the participant fee when the correct code should be disenrollment due to

[4] Participants below 100% FPL do not pay participant fees, however, in fiscal year 2009-10 there were three participants disenrolled for failure to pay the fee. In each case, the participant requested to be disenrolled because of concerns that they would be billed for services (even though the individuals would be eligible for charity care at any public or community clinic or San Francisco hospital based on their income level). The Application Assistors were unsuccessful in reassuring the participants that they would not be billed a participant fee or for services. The Application Assistor disenrolled the participants based on their stated reason for disenrollment – participation fee.

eligibility – receipt of health insurance. For some people, participation fee disenrollment may represent the fact that they already received the services they needed.

3. Disenrollments Due to Incompletion of Annual Renewal (64% -- 17,311 participants)
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.

The majority of disenrollments were due to failure to renew (64%). Of note, approximately 78% of the individuals disenrolled for this reason have annual incomes at or below 100% FPL and therefore pay no participation or point-of-service fees (with the exception of fees for emergency care, when appropriate). As a result, there should be no financial barriers to program renewal for over three-fourths of the individuals disenrolled for this reason. 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 even if their clinical appointment is after their HSF eligibility has expired.

In addition, just as disenrollments due to failure to pay participation fee can mask different disenrollment reasons, the same holds true for disenrollments due to an incomplete annual renewal. For example, someone who has moved outside San Francisco or someone who has obtained health insurance may not contact HSF customer service and inform the representative that they should be disenrolled from the program. The person may simply choose not to respond to the renewal notices which results in the disenrollment being categorized as failure to renew. The Department has no good estimate on how many disenrollments in this category may be due to other reasons. During FY2009-10, the Department augmented its renewal activities to reduce disenrollments due to failure to renew which are highlighted in the section entitled "Renewals" below.

4. Disenrollment Due to Other Reasons (1% - 148*)*
The remaining disenrollments were voluntary or involuntary due to dissatisfaction with the program, death, or providing false or misleading information on the program application.

Table A8
Disenrollments due to Other Reasons

Disenrollment Reason	***Number***	***Percentage***
Program Dissatisfaction	81	55%
Participant is Deceased	47	32%
False or Misleading Information on HSF Application	20	14%

Renewals
Of the 53,428 enrolled in the program on June 30, 2010, 20,322 (38%) were participants who had renewed their eligibility into the program during the fiscal year. Participants can complete the renewal application as early as 90 days prior to their current term. Because all demographic information collected during the participant's original enrollment is retained in the program's electronic One-e-App system, Application Assistors report that participant renewal appointments can be completed in 10 to 15 minutes. If a participant does not renew their eligibility, then they are disenrolled for failure to renew as described above.

To promote on-time renewal, the program mails three renewal reminder notices (90, 60, and 30 days) prior to the end of their annual term reminding participants to do an in-person renewal. The notices are in English, Spanish, and Chinese. The program also contacts participants via an automated telephone call to encourage them to call their medical home to schedule a renewal appointment and stresses the importance of renewing on time in each issue of *Heart Beat*, the HSF participant newsletter. Additional renewal activities launched in FY2009-10 were:

- *Renewal Incentive Lottery*: HSF launched a modest renewal incentive program in April 2010 in which participants who complete the renewal process on time are entered into a lottery to win a Safeway grocery store gift card.

- *Additional of Renewal Question to One-e-App Health Access Questionnaire*: Participants complete a brief survey at enrollment and renewal regarding their health care access in the past twelve months. Effective July 2010 (FY2010-11), the program added an additional question to the questionnaire for participants completing renewal, in which respondents must select which of the program's on-going retention initiatives (mailed notices, phone calls, and incentive program) had the greatest impact in their decision to complete the renewal process. The addition of the question will allow the program to identify and expand upon those retention initiatives which have the greatest impact on renewal.

Reenrollments

Individuals who are disenrolled from the program have the option to re-enroll at any time. Since the inception of the program in July 2007, a total of 7,236 individuals who had been disenrolled from the program re-enrolled and were current participants at the end of FY2009-10.[5] The data indicates that the initial disenrollment reasons for the majority of re-enrollments were incomplete annual renewal (83%). It also indicates that those with incomplete annual renewals have the shortest length of time (in terms of days) between disenrollment and re-enrollment. Those with a program eligibility disenrollment have the longest length of time.

Table A9
Re-enrollments by Original Disenrollment Reason (July 2007 – June 2010)

Original Disenrollment	*Number*	*Percent*	*% Reenroll in 30 Days*	*% Reenroll in 31 - 60 Days*	*% Reenroll in 61 - 365 Days*	*% Reenroll after 365 Days*	*Avg. No. of Days Between Disenroll & Re-enroll*	*Avg. No. of Days for 0 - 60 Days*	*Avg. No. of Days for Those under 365 Days*	*Avg. No. of Days for Those over 365 Days*
Program Eligibility	314	4%	14%	11%	54%	21%	209	29	135	487
Participation Fee Related	866	12%	22%	16%	49%	14%	167	28	111	508
Incomplete Renewal	6,037	83%	43%	17%	35%	5%	94	22	75	451
Other	19	<1%	53%	0%	32%	16%	123	15	61	455

[5] From July 2007 to June 2010, a total of 13,988 individuals re-enrolled after being disenrolled. Of those, 7,236 were re-enrolled and current participants as of June 30, 2010. The remaining 6,752 had re-enrolled, but were subsequently disenrolled and were not program participants as of June 30, 2010.

Demographic information on these 7,236 re-enrolled participants indicates that there are no significant demographic differences between those who re-enroll and the general HSF population with the exception of individuals aged 18-24 who appear less likely to re-enroll.

Churn

In an effort to determine the impact of the program's eligibility and enrollment provisions on program retention, the Department examines 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 2010), 3,219 individuals have had at least two disenrollments.[6] Of those 1,175 (37%) had re-enrolled into the program and 2,044 (63%) were still disenrolled from the program as of June 30, 2010.

Of the 3,219 participants:

- 3,129 (97.2%) had two disenrollments,
- 87 (2.7%) had three disenrollments and
- 3 (less than 1%) had four disenrollments.

The analysis below examines only those who had two disenrollments. The disenrollments were grouped based on the information contained in Table A10.

Table A10
Analysis of Multiple Disenrollments -- Those with Two Disenrollments

Category	*Disenrollment Reasons*	*Number*	*Percent*
1	Two Failure to Complete Renewal Disenrollments	1,507	48%
2	One Failure to Renew Disenrollment & One Participation Fee Disenrollment	720	23%
3	One Failure to Renew Disenrollment & One Program Eligibility	514	16%
4	Two Program Eligibility Disenrollments	148	5%
5	One Program Eligibility Disenrollment & One Participation Fee Disenrollment	116	4%
6	Two Participation Fee Related Disenrollments	99	3%
7	Two Other Disenrollments or One Disenrollment Coded Other & One Disenrollment Coded Another Reason	25	1%

The data indicates that the majority of HSF participants with two disenrollments were disenrolled for failure to renew, program eligibility or other reasons (70%), 27% were in instances in which one of the disenrollments related to the participation fee and 3% were cases in which both of the disenrollments related to the participation fee.

[6] From this analysis were excluded any individuals who had two disenrollments and the second disenrollment was either exceeded the program age requirement (turning age 65) or death. These individuals would not be eligible for re-enrollment and therefore do not constitute "churn." This totaled 189 participants.

B. PARTICIPANT DEMOGRAPHICS AND PARTICIPANT/APPLICATION ASSISTOR EDUCATION

This section of the report provides an overview of uninsured adults residents enrolling in HSF and the education provided to participant and Application assistors.

Overall, the demographics of the HSF participation population did not change significantly between FY2008-09 and FY2009-10. There was an increase in the percentage of participants between the ages of 25 - 44, a decrease in percentage of those who identify as Asian/Pacific Islander and an increase in the percentage of participants who indicate their preferred language is English. The program continues to develop education materials that will assist both participants and Application Assistors in their understanding of the program. There are a total of 137 Application Assistors at 28 enrollment sites who rely on HSF trainings and refreshers to keep them up-to-date on program rules and features.

Participant Demographics

The following provides demographics data on the 53,428 participants enrolled at the end of FY2009-10:

Table B1
Demographics for HSF Participants

Age	10% are 18-24; 42% are 25-44; 24% are 45-54; 24% are 55-64
Ethnicity	38% Asian/Pacific Islander; 25% Latino; 20% Caucasian; 9% African-American; 4% Not Provided; 3% Other; 1% Native American
Gender	53% Male; 47% Female
Income	69% at/below 100%FPL; 23% between 101-200% FPL; 7% between 201-300% FPL; 1% at/above 300% FPL
Language	53% English; 25% Cantonese/Mandarin; 18% Spanish; 3% Other; 1% Filipino (Tagalog and Llocano)

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

Table B2
Changes/Trends in HSF Participant Demographics (FY2008-09 to FY2009-10)

Age:	Increase in percentage of participants aged 25-44 – from 40% to 42%. All other age groups remained stable over the course of the fiscal year.
Ethnicity:	Slight decrease in percentage of Asian/Pacific Islander – from 40% to 38%. Slight increase in percentage of Caucasian – from 18% to 20%.
Gender:	Stable distribution in enrollment by gender.
Income:	Stable distribution in enrollment by income.
Language:	Increase in percentage of participants that indicate English as primary language – from 49% to 53%. Decrease in percentage of participants that indicate Cantonese/ Mandarin as primary language – from 28% to 25%.

The Department is often asked about the immigration status, employment status and pre-existing medical conditions of HSF applicants and participants. The Department does not collect this information as part of the HSF application process. This is consistent with the San Francisco Health Care Security Ordinance which states that HSF program eligibility will not take into account immigration status, employment status and pre-existing medical conditions of uninsured adult applicants

The following provides information on HSF participants by neighborhood residence. Data indicates that homeless individuals compromise 14% of all HSF participants (street, shelter and doubled-up).

Table B3
HSF Participants by Neighborhood (Based on Zip Code Grouping)

Neighborhood	No. of Participants	% of Participants
Excelsior	7,772	14.5%
Mission	5,860	11.0%
Homeless (Street)	4,429	8.3%
Visitacion Valley	4,000	7.5%
Bayview Hunters Point	3,694	6.9%
Tenderloin	3,101	5.8%
Nob Hill	2,877	5.4%
Sunset	2,805	5.3%
South of Market	2,494	4.7%
Forest Hill	2,131	4.0%
North Beach	1,942	3.6%
Outer Richmond	1,873	3.5%
Haight	1,699	3.2%
Inner Richmond	1,343	2.5%
Lake Merced	1,145	2.1%
Chinatown	1,105	2.1%
Western Addition	1,100	2.1%
Potrero Hill	963	1.8%
Castro-Noe Valley	907	1.7%
Twin Peaks	726	1.4%
All Other Neighborhoods	470	0.9%
West Portal	378	0.7%
Treasure Island	367	0.7%
Marina	246	0.5%

HSF Population – New versus Existing

At the end of 2009-10, 20% 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 80% of program participants are existing safety net patients. At the end of 2008-09, 27% of all those enrolled were not previous users of the health care delivery system. It is important to recognize that over time, the percentage of participants that are new will decline as once "new" users become "existing" users after enrollment and as they renew their HSF eligibility.

HSF Participant Demographics Relative to General Uninsured Adult Population

The Department is 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. In FY2008-09, the Department compared the HSF demographics to CHIS demographics to determine if HSF was enrolling a comparable population and did

so again for FY2009-10. The examination yielded the same results for both years due the relative stability of the HSF population with respect to demographic characteristics and because the 2007 CHIS uninsured demographic data has not been updated. Specifically, the 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, 53% of HSF participants are male and 47% 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 69% of its participants fall below 100% FPL and 31% 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 (53% for HSF compared to 66% for CHIS) and more consider Chinese to be their primary language (25% for HSF 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 (10%).

Participant Education

Healthy San Francisco distributes a variety of educational materials and tools post-enrollment to better acquaint participants with program services and aid participants in accessing care.

All Healthy San Francisco participants receive a HSF participant ID card after enrollment. The ID card contains critical program information, including the name and telephone number of the participant's selected medical home, their HSF participant ID number, and the telephone number for Healthy San Francisco Customer Service. In addition, participants receive a Healthy San Francisco Participant Handbook which provides information about how to use the program so participants can begin accessing medical services. The Participant Handbook includes information on such issues as how HSF works, including services, program renewal, and how to contact HSF Customer Service for assistance, information or complaints. All participants (new and existing) receive annually a health prevention brochure to discuss with their primary care provider. The brochure lists preventive screenings and tests that vary by age and gender. Participants also receive *Heartbeat*, a quarterly newsletter focused on wellness and health education.

The Healthy San Francisco website (www.healthysanfrancisco.org) has a designated area for program participants. Participants can visit this section of the website to obtain information on program services, download program materials, such as the HSF Medical Home Directory and the HSF Participant Handbook, as well as, submit questions regarding the program to HSF Customer Service.

Application Assistor Education

In addition to obtaining program information from their medical homes, HSF applicants and participants often rely on their HSF Application Assistor for program information. The Department works collaboratively with its HSF third-party administrator (i.e., San Francisco Health Plan – "SFHP") on training and education support to HSF Application Assistors. Ongoing SFHP tasks include: staffing training leads committee meetings, coordinating HSF Assistor Trainings, preparing and distributing HSF Assistor Updates, maintaining the HSF Assistor User Manual, distributing HSF Collateral, and giving HSF presentations to stakeholders or prospective participants.

The FY2009-10 fiscal year highlights in this area were:

- A total of 10 HSF Assistors trainings and refreshers occurred during the year with a combined attendance of 275. Training attendees continue to rate the usefulness of trainings at 99% useful.
- A total of 24 HSF enrollment site visits took place during the year. Site visits are meetings with an HSF Community Relations Specialist and HSF Application Assistor aimed at improving the quality and increasing the quantity of HSF enrollments by addressing any questions or issues related to eligibility and processes. These visits take place at enrollment sites.
- Twelve (12) monthly assistor updates were distributed to HSF Application Assistors to keep them apprised of any program and/or One-e-App changes.
- A total of 28,361 HSF informational brochures were distributed during the fiscal year.
- DPH and SFHP gave a total of 29 HSF presentations in the community.
- SFHP, in partnership with HSF Administration, created four new assistor tools and revised/redistributed three existing assistor tools.

In addition, the program responds to Application Assistor inquiries. In 2009-10, there were 89 such requests for information on such issues as enrollment procedures and eligibility criteria.

C. PROVIDER NETWORK (DELIVERY SYSTEM)

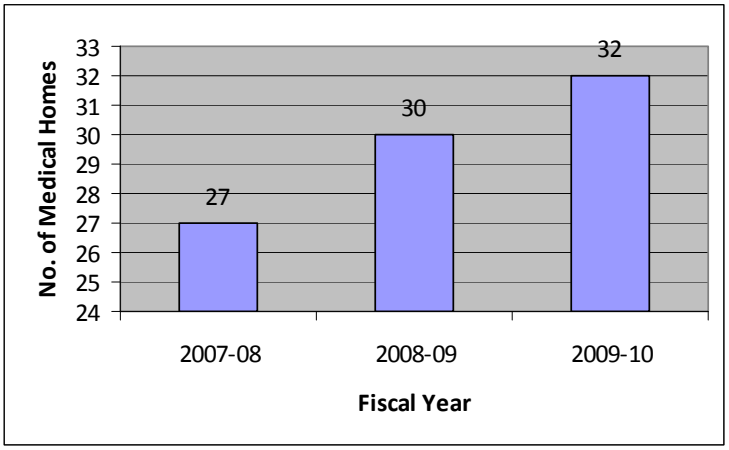
This section of the report describes the HSF delivery system (e.g., medical homes, hospitals, etc.)

During the 2009-10 fiscal year, HSF further solidified the public/private provider partnership with the addition of Kaiser Permanente as a medical home. HSF medical homes increased from 30 to 32 during FY2009-10. For the most part, the five HSF medical home delivery systems ended the fiscal year near their targeted capacity (i.e., meeting between 86% and 99% of their enrollment levels). During the fiscal year, at any one time, no more than 8 of the 32 HSF medical homes were closed to new participants (some short-term closures and others longer term closures). In addition to physical health, 30 of 32 medical homes provide behavioral health services (i.e., some form of mental health assessment, mental health services or substance abuse screening). There were no changes in non-profit hospital participation in HSF with all four of the hospital systems (8 campuses) contributing along with San Francisco General Hospital. HSF's Provider Relations program continued to address provider inquires and develop provider program materials. During FY2010-11, the HSF program will continue to work on efforts to ensure sufficient clinical capacity through the expansion of the provider network.

2009-10 Provider Network Expansions

HSF ended FY2009-10 with 32 medical homes – a 19% increase from 2007-08 (the program's first year of operation).

Graph C1
HSF Medical Homes (2007-08 to 2009-10)

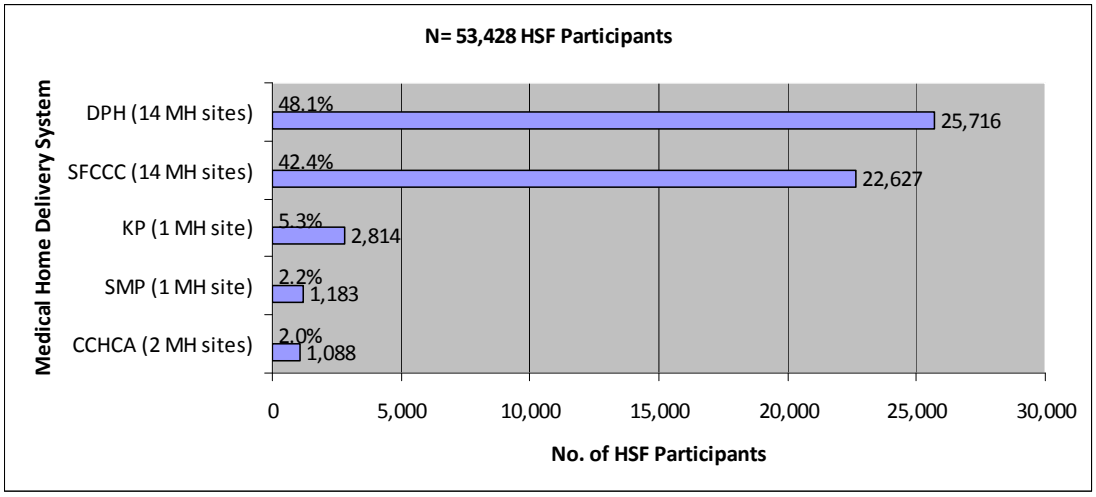


In July 2009, Kaiser Permanente, a health plan, joined the network of providers delivering services to HSF participants. In addition, a long-standing community provider, North East Medical Services, opened up a new health clinic site in May 2010 which will provide services to HSF participants. Finally, the Department undertook significant renovations in two of its health clinics (Castro Mission Health Center – completed and Potrero Hill Health Center – in progress) to expand clinical capacity to service more patients by increasing the number of examination rooms at these clinics. While the Department renovations do not expand the number of medical homes, they do help increase clinical capacity.

Medical Home Distribution

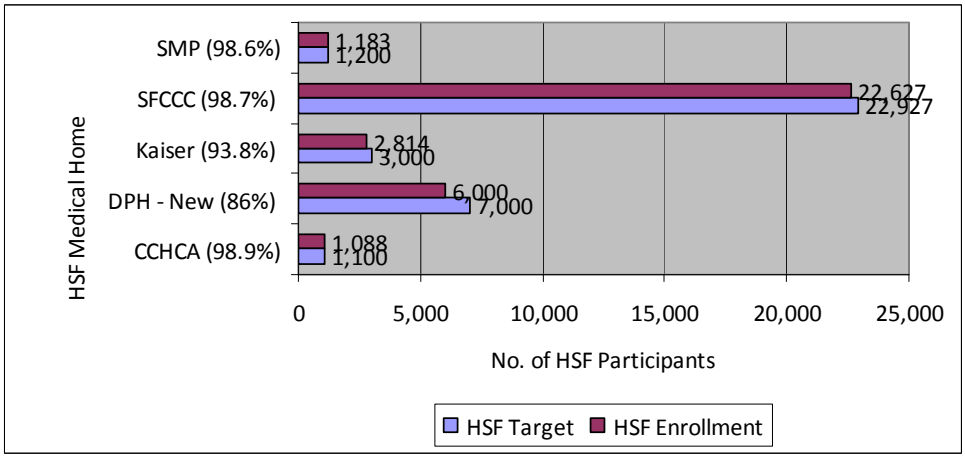
HSF participants select a primary care medical home of their choice at the time that they enroll in the program. The primary care medical home is where participants receive all of their primary care and preventive services. The medical home also coordinates a participant's needed access to specialty, inpatient, pharmacy, ancillary, and/or behavioral health services and helps a participant navigate through the delivery system. All told, HSF had five delivery systems at the end of the fiscal year: the Department, San Francisco Community Clinic Consortium, Kaiser Permanente, Sister Mary Philippa Health Center and Chinese Community Health Care Association. The participant distribution was:

Graph C2
Distribution of HSF Participants by HSF Medical Home Delivery System



Each of the HSF medical home delivery system has a targeted number of HSF participants it will serve in any given fiscal year to ensure that there is sufficient capacity to serve both new and existing HSF participants. Graph C3 provides the target information for each system and the percentage of the target that was met based on enrollment. Note that for the Department, the information on the graph reflects the number of new HSF participants (7,000) that the system indicated it would be able to serve and not the number of new and existing participants.

Graph C3
Distribution of HSF Participants by HSF Medical Home Delivery System



Medical Home Capacity

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 electronic mail twice a month (every 15-calendar days) to the designated point person at each of the medical home delivery systems.

HSF medical home open/closed status is determined primarily by appointment availability. 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. 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. As a result, increased clinical needs among other service populations can result in a medical home being closed to new HSF participants.

During FY2009-10, at any one time, no more than 8 of the 32 HSF medical homes were closed to new participants. At the end of FY2009-10, the following medical homes were closed to new participants for the following reasons:

- on an interim basis with an expected reopening (1) – Potrero Hill Health Center
- reached clinical capacity for accepting new participants (7) – Chinese Community Health Care Association, Family Health Center, Maxine Hall Health Center, Mission Neighborhood Health Center (one location), Ocean Park Health Center, Silver Avenue Health Center, and Sister Mary Philippa.

The medical homes that reached capacity did so at different times during the fiscal year.

Non-Profit Hospital Participation in HSF Network

Hospital care is a critical component in the HSF service continuum. San Francisco General Hospital (SFGH) is the City and County's primary safety net hospital. At the same time, during FY 2008-09, the number of hospitals participating in HSF increased from 1 (SFGH) to 6. The non-profit hospitals continue to play a vital role in HSF through the following mechanisms:

- California Pacific Medical Center (4 campuses) – inpatient services to those with North East Medical Services as the HSF medical home,
- Chinese Hospital – partners with CCHCA to provide the full scope of primary care, specialty and inpatient services to those with CCHCA as the HSF medical home,
- Saint Francis (CHW) – inpatient services to those with Glide Health as the HSF medical home,
- St. Mary's (CHW) – inpatient services to those with Sr. Mary Philippa as the HSF medical home and
- UCSF Medical Center – referral-based diagnostic imaging services at Mission Bay site.

Non-profit hospital participation in HSF is separate and apart from the general ETMALA obligations that all hospitals (public, non-profit or for-profit) must adhere to. In the case of emergency services, HSF participants will receive services at the nearest available hospital with clinical capacity. This may not be the hospital associated with their medical home.

Behavioral Health Services

HSF program offers mental health, and alcohol and drug abuse care. HSF participants have access to these confidential services from either their HSF medical home or health care professionals at San Francisco Community Behavioral Health Services (CBHS). On the back of every HSF Participant ID Card are the telephone numbers for CBHS – 415-255-3737 or 888-246-3333 (TDD Access line at 888-484-7200) which are accessible 24 hours a day, 7 days a week.

Most of the HSF medical homes (30 out of 32) provide some form of either mental health assessment, mental health services or substance abuse screening. The range of services can vary by site. For example, with respect to mental health, site services range from individual to group therapy for mental health needs such as depression or anxiety. If a HSF participant needs access to behavioral health services (mental health and/or substance abuse) that are not provided at their HSF medical home, then a primary care provider can refer the participant to CBHS for care. But, a HSF participant does not need a referral from their HSF medical home provider to access services from CBHS – they can call CBHS directly.

HSF participants have access to the comprehensive array of community-based services offered by CBHS, including, but not limited to: (1) information and referral services, (2) prevention services, (3) a full range of voluntary behavioral health services, including self-help, peer support, outpatient, case management, medication support, dual diagnosis treatment, and substance abuse services and (4) 24-hour psychiatric emergency services and a crisis hotline.

Provider Relations

The HSF Provider Relations function is overseen by the program's third-party administrator, the San Francisco Health Plan. Provider relations is responsible for maintaining current medical home statuses in One-e-App, responding to provider inquires and providing HSF medical homes with updated information on HSF program matters. For fiscal year ending June 30, 2010, HSF Provider Relations received a total of 88 provider inquiries via phone or email.[7] The majority of inquiries pertained to coverage interpretation and program policy. All 88 inquiries were processed and 100% were resolved within 60 days. The following table lists the number of inquiries by category.

Table C1
Provider Inquiries by Category (2009-10)

Category	Total # of Inquires	% of Total Inquiries
Access Issue	2	2%
Coverage Interpretation	26	30%
Enrollment Issue	4	5%
Pharmacy	11	13%
POS Fees	2	2%
Program Policy	30	34%
Quality of Care	0	0%
Quality of Service	0	0%
Other	13	15%
Total	**88**	**100%**

[7] Provider Relations started tracking provider inquiries in January 2009 and from January 2009 to June 2009 there were 43 inquiries.

In the category coverage interpretation, examples of the inquires are inclusion of services (e.g., HPV vaccine, limitations on labs, hospice, DME, ambulance services, transplant related complications, second opinions, audiology services, IUDS, etc.). Examples of program policy inquires include participant enrollment cap, how to obtain authorizations, how to become a medical home/HSF provider and how to participants can switch medical homes

In the area of provider program materials, the Provider Relations created the following tools during FY2009-10:

- HSF Dental/Vision Resource Guide: Dental and vision services are not included services in the HSF program. HSF Provider Relations developed a dental and vision resource guide for providers to use for referrals. The resource guide includes public clinics along with private providers who offer reduced-cost or free dental and/or vision services to uninsured patients. The HSF Dental/Vision Resource Guide was posted on the Medical Home Section of the HSF website and distributed to HSF Application Assistors.

- Location of Services Grids: The HSF Location of Services Grids were developed as a reference tool to assist HSF providers and participants better navigate services through HSF. These grids include the location of services by medical home for general services (e.g. pharmacy and primary care) and specialty services (e.g. cardiology and dermatology). The grids are updated and distributed to medical directors, clinic managers, nurse managers, and key stakeholders r.

- Ambulance Services Communication: HSF Provider Relations sent a communication to all medical directors and clinic directors at each medical home reminding them of the emergency transportation policies and ways to minimize participants receiving bills for covered emergency transportation.

- HSF Network Operations Manual: The HSF Network Operations Manual was updated and distributed via electronic mail to medical directors, clinic managers, nurse managers and key stakeholders on schedule for the reporting year.

D. DELIVERY SYSTEM IMPROVEMENTS AND QUALITY INITIATIVES

This section of the report focuses on Department and HSF efforts to develop a coordinated delivery system, improve quality of care and promote efficient health care delivery.

In FY 2009-10, two care delivery efforts documented improved clinical outcomes in the area of diabetes measures (*Department Chronic Care Redesign Project* and *HSF Strength in Numbers*) through the use of intensive patient management, primary care-specialty care coordination and disease registries. Through partnerships with the San Francisco Health Plan, HSF further initiated efforts to link patients with a medical home provider upon hospital discharge and improve medical home capacity.

DPH System Improvements

The Healthy San Francisco (HSF) Chronic Care Redesign Projects within the Department of Public Health are designed to address two critical issues: (1) the need for increased patient access to care and (2) the need for innovation in ambulatory care. The focus of the HSF Chronic Care Redesign Projects is on the most complicated patients with multiple chronic conditions who often do not do well without targeted support. [8] The projects help to improve patient care and patient outcomes by enhancing the primary care–specialty care collaboration, improving access to specialty care, and increasing chronic care infrastructure. The projects were approved as part of the initial HSF budget in FY2007-08.

The six HSF Chronic Care Redesign Projects consist of:

- five primary care/specialty care clinic collaboration projects (in the areas of diabetes, asthma/COPD [chronic obstructive pulmonary disease], heart failure, back pain, and mental health) and
- one project utilizing nurse practitioners (NPs) to improve patient continuity in resident primary care clinics.

All of the projects are centered in the resident-based primary care clinics at San Francisco General Hospital (i.e., Family Health Center and General Medicine Clinic) which also houses specialty clinics.[9] All of the projects utilize a model of care in which patients are seen for a period of intensive management and then referred back to the primary care provider. The primary care-specialty care collaboration projects support population management through the use of disease registries, clinical guidelines and protocols, and outreach and educational activities.

FY2009-10 outcome data from the projects reveal:

- Clinical Outcomes**:** The Diabetes Project evaluated outcomes in several of its innovative programs, including insulin start groups in Spanish and English, multidisciplinary group medical visits in Spanish and Cantonese, and intensive one-on-one NP management of patients with uncontrolled diabetes taken from the Diabetes Registry. The average A1c percentage (a measure of blood sugar control) was reduced in these interventions by 1.7, with insulin initiation groups being the most successful (average reduction of 2.3), indicating significant improvements in diabetes control.

[8] The projects serve both HSF participants and non-HSF participants.

[9] The following projects are at Family Health Center: back pain, diabetes and mental health within primary care). The following projects are at General Medicine Clinic: asthma/COPD, heart failure and resident continuity.

- Provider Satisfaction**:** The Mental Health Project surveyed referring primary care providers (PCPs) and found:
    - 82% rated PCP-mental health provider communication as good-excellent.
    - 80% felt the mental health intervention helped patients better manage their chronic medical condition.
    - 90% felt the intervention helped patients better manage their mental health issues.
    - 93% felt the intervention helped PCPs better manage their patients.

  The Resident Continuity Project also surveyed participating residents and found:
    - Percent of residents who agreed that their patients received good continuity of care increased from 24% to 100% after implementation of the project.
    - Percent who agreed that the clinic team could prevent medical errors increased from 33% to 73%.
    - Percent who agreed that patients had adequate access to the clinic increased from 19% to 88%.

- Patient Access**:** All patients, not just Healthy San Francisco patients, may access these projects as appropriate. Several thousand patients have benefited from this initiative. For example, the Mental Health project saw 958 unduplicated patients in its first year. Many primary care providers have indicated they can better manage their patient panels with the support provided to their most complex patients through these projects.

In June 2010, the HSF Chronic Care Redesign Projects were recognized nationally by the National Association of Public Hospitals with its 2010 NAPH Award for Improving the Patient Experience. The award was given in recognition of the projects' innovation solutions to improve access to outpatient care.

HSF Quality Improvement Activities

The Healthy San Francisco Quality Improvement Program promotes preventive health services and mprovement in the quality of care. Key stakeholders impacted by the HSF Quality Improvement Program are participants, HSF providers and provider groups, and the Department. Ongoing tasks include mailing preventive health reminders, promoting disease management activities through the program *Strength in Numbers*, facilitating the HSF Quality Improvement Committee, and producing service data reports. The Department works collaboratively with its third-party administrator, San Francisco Health Plan, on the HSF Quality Improvement Program which is overseen by the Medical Management division within the San Francisco Health Plan.

HSF Quality Improvement Committee

Key activities of the HSF Quality Improvement Committee in FY2009-10 were:

- review of HSF complaint trends – by total volume, medical home, and complaint category (or attribute),
- approval to adapt the Well-Woman mailers to reflect recent changes in the US Preventive Services Task Force recommendations
- presentation on the goals, measures and key intervention components of the Patient Navigator Case Management Pilot,

- overview of the clinics participating in the patient experience pilots, covering goals, measures and key intervention components and
- discussion and presentation on data related to assessing primary care access capacity using 24 month panels.

Strength in Numbers Program

In March 2009, the HSF Quality Improvement Program launched the *Strength in Numbers* Program (SINP). SINP was developed in collaboration with San Francisco medical home leaders to improve chronic care and prevention services for HSF participants, invest in chronic care registries, and create standardized measurement and improvement structure across the San Francisco safety net. It aims to improve clinical outcomes by supporting the chronic care model in HSF medical homes through disease registries. Registries enable clinics to make measurable improvements in diabetes measures, spread the use of disease registries to other chronic conditions, and spread the use of panel management to proactively identify and monitor patients overdue for clinical interventions. SINP provides financial incentives and technical assistance to medical homes in order to accelerate the integration of chronic care disease registries. Medical homes that provide care to at least 350 HSF participants are eligible to participate in SINP. Medical homes are required to work on improving diabetes and one additional chronic disease or preventive care project such as chronic pain, hepatitis B and C, and depression depending on their population. SINP requires medical homes to meet thresholds for diabetes measures and optional chronic disease or preventive care measures. The medical home receives incentive funds for meeting improvement thresholds over baseline.

Key SINP findings from the first year of operation (March 2009-March 2010) were:

- A total of 24 medical homes participate in SINP, representing 95% of HSF participants.
- The program achieved statistically significant results for HSF participants in the following four measures: HbA1c Testing, HbA1c Poor Control, LDL Testing, LDL Good Control.

Table D1
Aggregate Rates by Diabetes Measure for 10 DPH Clinics' Members and Participants[10]

Measure	Baseline Rate	Post Intervention Rate	Absolute Improvement[11]	Improvement from Baseline
HbA1c Test within 12 months	78.8%	85.1%	6.3*	7.9%
LDL Test within 12 months	69.7%	74.4%	4.7*	6.7%
HbA1c≥9 (lower is better)	19.7%	16.3%	3.4*	17.3%
LDL <100	61.1%	61.1%	0.0%	0.0%

Other program accomplishments include:

- Eighteen (18) medical homes reported on measures in other clinical areas such as pain management, depression screening and treatment, asthma, and hypertension.
- Medical leaders report that the SINP has revitalized clinics, re-focused team efforts on chronic care improvements, and engaged nurse managers and other non-clinician staff in improvement efforts.
- Twenty-one (21) medical homes attended an 8- hour training on health coaching and panel management and provided the following feedback:
    - 97% agreed that trainings provided new tools in managing patients,

[10] The data includes only Department medical homes using i2i disease registry. This represents 42% of medical homes in SINP.
[11] An (*) indicates a statistically significant results (p≤.01). Chi-square test was used to determine statistical significance.

- 92% "learned skills… [they] could use right away" and
- significant improvements in knowledge and skills gained following the training.

Patient Navigator Pilot

The Patient Navigator Pilot is a partnership between the Department, San Francisco Health Plan, St. Francis Hospital and participating HSF medical homes to conduct on-site patient navigation (non-medical) at St. Francis Hospital. The goals of the program include reducing avoidable emergency services use and linking patients with a medical home provider upon hospital discharge. It is a voluntary program whereby patients consent to receive case management services. Under the pilot a San Francisco Health Plan staff person is physically housed at St. Francis Hospital to provide navigation support. The pilot launched in May 2010.

Because the pilot was only in existence for six weeks during FY2009-10, results are not yet available. However, preliminary data reveal the following:

- Approximately one-third of these patients are homeless, and they are primarily male with a mean age of 43 years.
- A little over half of these patients were uninsured (55%) and the remainder were insured (45%).
- Of the uninsured patients, 45% were previously enrolled in HSF. The program's patient navigator worked with those patients who were not in HSF to set up HSF enrollment appointments, as well as, coordinate their follow-up primary care appointments.

Activities during this initial period include: (1) enrolling new participants into HSF, (2) identifying systemic safety-net barriers and working collaboratively with SFHP and medical home staff to attempt resolution of these issues, (3) strengthening partnerships with medical homes to provide safe care transition for discharged patients, and (4) continuous quality improvement efforts with St. Francis Hospital clinicians regarding timely and complete verbal and written hand-off communication to medical home staff. Based on the findings of the pilot (with at least 12 months of data), the Department will determine whether to continue the existing pilot and/or expand the pilot to other locations.

Optimizing the Primary Care Experience

During FY2009-10, the Department and San Francisco Health Plan (SFHP) jointly funded the Optimizing Primary Care Experience in the Safety Net (OPCE). The project focuses on making measurable improvements in clinics' capacity to provide timely service and access to care for all patients, not just HSF participants. OPCE grew out of SFHP member feedback regarding ability to access adult primary care services, and medical home telephone systems, as well as, concerns with wait times, doctor-patient and staff-patient communication, and obtaining services. Providers described similar concerns about access and communication.

The goals of the OPCE project are to:

1. Optimize care delivery in an effort to reduce waiting times both <u>for</u> and <u>at</u> appointment services.
2. Optimize health outcomes by improving clinical care delivery.
3. Improve the financial status for the clinic.

OPCE tests and evaluates key access interventions in five safety net clinics. The participating clinics are: Chinatown Public Health Center, Lyon Martin Health Services, Maxine Hall Health Center, North East Medical Services and Southeast Health Center. The clinics will test changes in the balance of supply and demand, patient backlog, queues and contingency plans. They will also utilize strategies to reduce demand and increase supply.

E. CLINICAL COMPONENT/SERVICES UTILIZATION

This section examines the clinical and service data of HSF participants to determine whether the program is meeting its goals with respect to improved health outcomes and appropriate utilization of services.

For FY2009-10, the clinical services data was analyzed in areas related to: (a) use of primary care services, (b) quality of care, (c) effectiveness of care and (d) participant perception of health services received.[12] The service utilization questions were:

1. Are members getting the preventive and primary care services they need?
2. Are emergency room, hospital and primary care services being used appropriately?
3. Does the data demonstrate effective care or opportunities to develop or improve interventions?
4. Does the participant's perception of their health status coincide with their utilization of services?

The summary findings are as follows:

- HSF participants use services similar to what is seen in insured populations.
- HSF participants utilize primary care at the same rate as the national Medicaid population.
- It is not possible to analyze the utilization of some preventive services, due to Healthy San Francisco's structure as a payer of last resort with participants accessing screening services through other publicly funded programs.
- HSF data shows that emergency department (ED) utilization is lower than Medicaid averages.
- The use of the ED for avoidable conditions remains lower than State Medicaid benchmark, and hospital admissions have decreased significantly from FY2008-09 to FY2009-10.
- The HSF readmission rate remained stable from FY2008-09 to FY2009-10 at 6%.
- There was a decrease in timely follow-up after an inpatient discharge in FY2008-09 compared to FY2009-10.
- The rate of diabetics and asthmatics getting recommended care is within the range of the insured population. The percentage of participants with diabetes getting A1c tests is 74% compared to the National Medicaid Average of 77%, and the percent of diabetics getting LDL (cholesterol) testing is slightly above the National Medicaid Average, at 72% compared to 71%. For asthma the data shows that 82% of participants with asthma are getting the medication they need to control their asthma, compared to the National Medicaid average of 86%.

An important caveat to keep in mind when reviewing this data is that the inpatient data may appear low. This is because there is incomplete data from all participating hospitals. For this report, 93.5% of the hospital data comes from San Francisco General Hospital. Therefore, it is likely that data for inpatient admissions, hospital days, inpatient surgical procedures and emergency department visits are underreported for FY2009-10. This was also this case for FY2008-09. [13]

[12] Information with respect to participant perception of health services received is contained in Section II.F of this report.
[13] For FY2008-09 Healthy San Francisco Annual Report, 95% of the hospital data was generated by SFGH.

Data Source and Submission

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). In this role, SFHP defines the encounter data submission standards, ensures quality data is collected and processed, and analyzes and reports the data received to the Department annually. Collection and analysis of encounter data is one key approach to ascertaining the extent to which the program is meeting its goals.

The source data for this report came from the HSF data warehouse which includes all medical and pharmacy services, the Health Access Questionnaire which is administered during the HSF application process and membership data from the One-e-App system. The data being reported includes all services incurred from July 2008 through March 2010. For FY2009-10, the analysis allows for a three month lag for data completion. Therefore, the analysis does not use actual data for the months of April 2010 to June 2010. The data has been trended comparing 12 months of actual data from July 2008 to June 2009, and 9 months of actual data from July 2009 to March 2010 (the FY2009-10 data has been annualized for 12 months for comparative purposes).

SFH monitors HSF submissions by service category and total submissions received by provider on a monthly basis. This ongoing monitoring provides a better understanding of the total submissions received, loaded and used for the development of utilization analyzes. Analysis of service utilization is dependent upon having complete data from all HSF providers.

Currently, 93% of institutional service data is from San Francisco General Hospital. Beginning in December 2008, SFHP was able to capture data from the following submitters:

- Chinese Hospital: Emergency department and hospital admission as of December 2008
- Saint Mary's Medical Center: Emergency department collection as of December 2008 and hospital admission as of January 2009
- St. Francis Hospital: Emergency department as of December 2008, hospital admission as of September 2009

All of the non-profit hospitals have the potential to provide charity care services to HSF participants. The hospitals are not obligated to provide the Department with encounter level data on services provided to any HSF participants. As a result, in FY2009-10 the Department approached each hospital individually and through the Hospital Council of Northern and Central California and obtained their commitment to provide encounter level data on HSF participants served at their facilities. The Department and SFHP have actively attempted to capture this information in order to reflect this data in utilization analysis. The charity care submitters include: California Pacific Medical Center, Catholic Healthcare West facilities, Chinese Hospital, Kaiser Permanente, and UCSF Medical Center.

However, HSF is in the beginning stages of working with these providers to receive their charity care data. As a result, the charity care data received thus far is not complete because of challenges encountered capturing every HSF encounter. The program received charity care from Chinese Hospital through December 2009, California Pacific Medical Center through March 2010, and UCSF Medical Center through January 2010. The Department and SFHP will continue to work collaboratively with the non-profit hospitals to get a better understanding of the service utilization among the HSF population. The following provides the data request by hospital system:

Table E1
Data Submission Needs from HSF Hospitals

Hospital System	Encounter Data for HSF Population or HSF Service	Encounter Data for HSF Participants Receiving Charity and/or Discounted Care
California Pacific Medical Center (4 campuses)	Encounters for NEMS HSF Participants	Encounters for any HSF participant, irrespective of medical home, that received services from hospital
Chinese Hospital	Encounters for CCHCA HSF Participants	Encounters for any HSF participant, irrespective of medical home, that received services from hospital
Kaiser Permanente	Encounters for Kaiser HSF Participants	Encounters for any HSF participant, irrespective of medical home, that received services from hospital
Saint Mary's Medical Center	Encounters for Sister Mary Philippa HSF Participants	Encounters for any HSF participant, irrespective of medical home, that received services from hospital
San Francisco General Hospital	Encounters for DPH HSF Participants and specialty, diagnostic, inpatient encounters for SFCCC HSF Participants at some medical homes	Encounters for any HSF participant, irrespective of medical home, that received services from hospital
St. Francis Hospital	Encounters for Glide HSF Participants	Encounters for any HSF participant, irrespective of medical home, that received services from hospital
UCSF Medical Center	Encounters for HSF Participants receiving diagnostic services at Mission Bay	Encounters for any HSF participant, irrespective of medical home, that received services from hospital

Preventive and Primary Care Services

This section provides statistics on ambulatory care visits to physician offices for routine office visits, consultations, and preventive well visits. It is subdivided by medical home system to provide more detail about the utilization within the system.

Data indicate that HSF participants utilize primary care at the same rate as the national Medicaid population. However, utilization of preventive services is more difficult to measure, due to HSF's status as a payer of last resort, with participants accessing screening services through other publicly funded programs.

HSF participants' access to preventive care services has remained relatively stable (3 visits per year) when comparing data from FY 2008-09 to FY2009-10 (Table E2). This rate is consistent with that of San Francisco Health Plan's Medi-Cal enrollees (3 visits per year), as well as, the National Medicaid Average of 3 visits per year (National Health Statistics Reports, DHHS (2008); Centers for Medicare and Medicaid Services). When assessing the health care of participants with chronic conditions (which for this report is defined as participants with diabetes, asthma, hyperlipidemia or hypertension) the data shows a rate of 5.47 average office visits per year (Table E3). This is fairly consistent with the previous year's average of 5.55. The data suggests that the ambulatory care utilization rates for HSF participants are similar to that of the U.S. rate of visits for patients with chronic disease which is an average of 5 visits per year for patients with chronic conditions (Division of Health Care Statistics, US Department of Health and Human Services, 2009).

Table E2
Average Office Visits (Including Well Visits) Per Participant

Jul 08 - Jun 09			Jul 09 - Mar 10 (Annualized)			
Office Visits	Participant Months	Avg. Visits per Year	Office Visits	Participant Months	Avg. Visits per Year	Variance
123,725	438,378	3.39	124,839	454,681	3.29	-2.72%

Table E3
Average Office Visits (Including Well Visits) Per Participants with Chronic Conditions

Jul 08 - Jun 09			Jul 09 - Mar 10 (Annualized)			
Office Visits	Participant Months	Avg. Visits per Year	Office Visits	Participant Months	Avg. Visits per Year	Variance
59,592	128,886	5.55	47,883	105,008	5.47	-1.38%

Table E4 displays the information contained in Table E2 by medical home system.

Table E4
Average Office Visit Utilization by System

	Jul 08 - Jun 09			Jul 09 - Mar 10 (Annualized)			
System	**Office Visits**	**Participant Months**	**Avg Visits per Year**	**Office Visits**	**Participant Month**	**Avg Visits per Year**	**Variance**
CCHCA	1,674	5,297	3.79	2,975	9,046	3.95	4.07%
DPH	72,447	239,526	3.63	67,755	229,086	3.55	-2.21%
Kaiser	N/A	N/A	N/A	1,264	10,309	1.47	N/A
SFCCC	47,176	187,124	3.03	49,791	196,129	3.05	0.70%
SMP	2,428	6,431	4.53	3,054	10,111	3.62	-20.00%
Total	**123,725**	**438,378**	**3.39**	**124,839**	**454,681**	**3.29**	**-2.72%**

With the exception of SMP (Sister Mary Philippa), the average number of visits per year per system has not changed dramatically. Kaiser Permanente did not join the HSF provider network until July 2009 and therefore there is no variance to calculate. While not reflected in either of the tables above, there is greater variance seen when comparing medical homes to each other. There were two Department medical homes with specialized populations that showed a higher average number of visits per year: (1) Positive Health at 7.17 visits (an increase of 16% from FY2008-09 to FY2009-10) and (2) Housing and Urban Health Clinic at 6.89 visits (an increase of 2% over previous year). Both of these medical homes have unique circumstances that contribute to their higher averages based on their patient population.

Twenty-four percent (24%) of HSF participants did not have an office visit after twelve months of continuous enrollment. This rate has remained steady when compared to calendar year 2008.

Table E5
Office Visit Frequency (Including Well Visits)

Jan 08 - Dec 08			Jan 09 - Dec 09	
Office Visit	Participants Continuously Enrolled	Percentage	Participants Continuously Enrolled	Percentage
No Office Visit	1,935	24.73%	5,578	23.78%
1-4 Office Visits	3,324	42.48%	10,413	44.38%
5-9 Office Visits	1,802	23.03%	5,489	23.40%
10+ Office Visits	763	9.75%	1,981	8.44%
Total Participants	7,824	100.00%	23,461	100.00%

It is not possible to analyze the utilization of some preventive services, due to Healthy San Francisco's structure as a payer of last resort. Since participants are required to apply to any available public programs, low-income women obtain mammograms and pap smears through State programs (e.g., Every Woman Counts and the State Family Planning Program), and the data is therefore not available for analysis. Although encounter data only shows 9.5% of women aged 42-64 receiving mammograms, and 16% of women receiving cervical cancer screening, it is highly likely that the actual screening rate is much higher.

The data shows 41% of women and 30% of men aged 51 and above received colorectal cancer screening (Tables E6 and E7). The National Medicaid Managed Care benchmark for these services is 55% for colorectal cancer screening.

Table E6
Percentage of Women's Health Preventive Screening
(shaded areas show incomplete data due to use of other public programs)

Jul 08 - Mar 10				
Women's Preventive Screening	Numerator (Participants Received Screening)	Denominator (Eligible Participants)	Percentage	National Medicaid Average
Cervical Cancer	2,819	17,751	15.88%	64.80%
Colorectal Cancer	3,322	8,091	41.06%	54.50%
Mammogram	1,084	11,345	9.55%	50.00%

Table E7
Percentage of Men's Preventive Screening for Colorectal Cancer

Jul 08 - Mar 10				
Men's Preventive Screening	Numerator (Participants Received Screening)	Denominator (Eligible Participants)	Percentage	National Medicaid Average
Colorectal Cancer	2,329	7,720	30.17%	54.50%

Improving colorectal cancer screening rates is proposed as a priority for the *Strength in Numbers Program* for calendar year 2011. The low screening rate is most heavily influenced by the lack of complete data that is reported through other payor sources. Low rates may also reflect data integrity issues (occult blood testing is often done in the office setting, and may be recorded on the chart, but not be submitted with encounter data to the data warehouse). Colorectal cancer screening is often done as part of a routine office visit, and under-documentation can contribute to lower rates when compared to national averages.

Appropriate Utilization

This section provides statistics on the correlation between inpatient admission, emergency department visits, and visits to physician offices for routine office visits, consultations, and preventive well visits. It also examines utilization for those with chronic disease versus those without chronic disease to compare resource utilization among both populations. An important caveat to keep in mind when reviewing this

data is that the inpatient data may appear low because there is incomplete data from all participating hospitals. As noted above, 93.5% of the hospital data comes from San Francisco General Hospital.[14]

Based on the data collected, HSF participants are using services at a rate similar to what is seen in insured populations. The use of the emergency department for avoidable conditions remains lower than the State benchmark, and hospital admissions have decreased from FY2008-20 to FY2009-10.

Emergency Department
Utilization of the emergency department for HSF participants is 164.48 per 1,000 which is low compared to the state average of 275 visits per 1,000 (Henry J Kaiser Family Foundation, State Health Facts, 2008) and even lower when compared to Medicaid 839 visits per 1,000 (N. Tang, J. Stein, R. Hsia, J. Maselli, R. Gonzales, JAMA 2010). There has been no significant change in the last year.

Table E8
ED Visits Per 1,000 Participants Per Year

Jul 08 - Jun 09			Jul 09 - Mar 10 (Annualized)			
ED Visits	Participant Months	ED Visits/1,000	ER Visits	Participant Months	ED Visits/1,000	Variance
6,031	438,378	165.09	6,232	454,681	164.48	-0.37%

The data indicates that the top emergency department diagnoses' among HSF participants were consistent from FY2008-09 to FY2009-10. The top three diagnostic categories included respiratory systems, abdominal pain, and general symptoms.

The emergency department visit rates show that 89% of HSF participants had no emergency room visit from January 2009 to December 2009.[15]

Table E9
ED Visit Frequency

	Jan 09 - Dec 09	
ED Visit	**Participants Continuously Enrolled**	**Percentage**
No ED Visit	21,075	89.83%
1-4 ED Visits	2,299	9.80%
5-9 ED Visits	65	0.28%
10+ ED Visits	22	0.09%
Total Participants	23,461	100.00%

Participants with chronic conditions predictably utilize the emergency room more frequently than those without chronic conditions (188.21/1000 compared to 157.35/1000), but there has been no significant change in utilization comparing FY2008-09 to FY2009-10 (Table E10).

[14] In 2008-09, 95% of hospital data was generated by SFGH.
[15] This analysis uses data from HSF participants who were continuously enrolled during the 12-month period.

Table E10
ED Visits Per 1,000 Participants Per Year for Chronic Disease Participants Versus Other Participants

Jul 08 - Jun 09				Jul 09 - Mar 10 (Annualized)				
	ED Visits	Participant Months	ED Visits/1,000		ED Visits	Participant Months	ED Visits/1,000	Variance
With Chronic Disease	2,043	128,886	190.21	With Chronic Disease	1,647	105,008	188.21	-1.05%
Without Chronic Disease	3,988	309,492	154.63	Without Chronic Disease	4,585	349,673	157.35	1.76%

Avoidable Emergency Department Rate
The avoidable emergency department rate for HSF was 9%, which is well below the average for both San Francisco Health Plan (15%) and the California Medi-Cal average of 18% for adults (Table E11).

Table E11
Average Avoidable ED (AER) Rate

Jul 08 - Jun 09			Jul 09 - Mar 10 (Not Annualized)			
AER Visits	Total ER Visits	AER Rate	AER Visits	Total ER Visits	AER Rate	Variance
561	6,031	9.30%	568	6,232	9.11%	-2.02%

Ninety-eight percent (98%) of participants did not access emergency department care for avoidable conditions (Table E12), which are defined using the "Medi-Cal Managed Care ER Collaborative Avoidable Emergency Room Conditions." Of those that did use the emergency room for avoidable conditions, the top three diagnostic categories remained the same from 2008-09 to 2009-10: headache, urinary tract infections and acute unspecified upper respiratory infections.

Table E12
Avoidable ED (AER) Visit Frequency

Jan 09 - Dec 09		
AER Visit	**Participants Continuously Enrolled**	**Percentage**
No AER Visits	23,136	98.61%
1-2 AER Visits	318	1.36%
3-4 Visits 03-04	4	0.02%
5+ Visits	3	0.01%
Total Participants	23,461	100.00%

HSF data shows that emergency department utilization is lower than Medicaid averages. Patients enrolled in Medicaid use the emergency department at a rate of 839 per 1,000 persons. HSF aims to expand access to primary care and avoid unnecessary use of the emergency department. Low emergency department use compared to benchmarks, and average outpatient primary care utilization, is a sign of success in this area. Even more supportive is the fact that HSF participants are not using the emergency department for diagnoses that can be managed in the primary care setting, as reflected in their low avoidable ED rate. Finally, the fact that only 19 of the avoidable ED visits were for "issuing a

repeat prescription" provides reassurance about the impact of primary care. When patients have access to a medical home, they don't need to go to the emergency room for prescription refills.

Hospitalization

Hospital utilization showed dramatic decreases in utilization for HSF participants between FY2008-09 and FY2009-10, an encouraging finding for the third year of the program:

- Hospital admissions decreased 14.44% for the entire population (Table E13) and 15.43% for those with a DPH medical home (Table E14). But, the data indicate that HSF participants with a DPH medical home have higher hospital admission rates.
- Acute hospital days per 1,000 participants decreased 35% (Table E15).
- Average length of stay decreased 26% (Table E16).

HSF participants' hospital utilization is lower than benchmarks for SFHP Medi-Cal population 237.6 days per 1,000 (Measurement year 2009, Tiermed Database, San Francisco Health Plan) and SFHP Healthy Workers at 201.13 bed days per 1,000.

Table E13
Acute Hospital Admissions Per 1,000 Participants Per Year

Jul 08 - Jun 09			Jul 09 - Mar 10 (Annualized)			
Acute Admissions	Participant Months	Acute Admissions/1,000	Acute Admissions	Participant Months	Acute Admissions/1,000	Variance
1,110	438,378	30.38	985	454,681	26.00	-14.44%

Table E14
Acute Hospital Admissions Per 1,000 Participants Per Year
(Participants with DPH Medical Home ONLY)

Jul 08 - Jun 09			Jul 09 - Mar 10 (Annualized)			
Acute Admissions	Participant Months	Acute Admissions/1,000	Acute Admissions	Participant Months	Acute Admissions/1,000	Variance
816	239,526	40.88	660	229,086	34.57	-15.43%

Table E15
Acute Hospital Days Per 1,000 Participants Per Year

Jul 08 - Jun 09			Jul 09 - Mar 10 (Annualized)			
Acute Days	Participant Months	Acute Days/1,000	Acute Days	Participant Months	Acute Days/1,000	Variance
5,361	438,378	146.75	3,612	454,681	95.33	-35.04%

Table E16
Acute Hospital Average Length of State (ALOS)

Jul 08 - Jun 09			Jul 09 - Mar 10 (Annualized)			
Admits	Days	ALOS	Admits	Days	ALOS	Variance
1,110	5,361	4.83	985	3,612	3.67	-24.07%

The most significant drops in utilization between FY2008-09 and FY2009-10 were also seen in participants with chronic disease:

- admissions decreased 14% (Table E17),

- hospital days decreased 27% (Table E18) and
- average length of stay decreased 15% (Table E19)

This data is reassuring in terms of the impact of primary care in the uninsured population, which should be greatest for those with chronic conditions. When diabetics, for example, are well-managed in the primary care setting, hospital admissions decrease.

Table E17
Hospital Admissions Per 1,000 for Chronic Disease Participants Compared to Other Participants

Jul 08 - Jun 09				Jul 09 - Mar 10 (Annualized)				
	Total Admissions	Participant Months	Total Admissions Per 1,000		Total Admissions	Participant Months	Total Admissions Per 1,000	Variance
With Chronic Disease	473	128,886	44.04	With Chronic Disease	330	105,008	37.71	-14.37%
Without Chronic Disease	637	309,492	24.7	Without Chronic Disease	655	349,673	22.48	-8.99%

Table E18
Hospital Days Per 1,000 for Chronic Disease Participants Compared to Other Participants

Jul 08 - Jun 09				Jul 09 - Mar 10 (Annualized)				
	Total Days	Participant Months	Total Days Per 1,000		Total Days	Participant Months	Total Days Per 1,000	Variance
With Chronic Disease	2,043	128,886	190.21	With Chronic Disease	1,214	105,008	138.73	-27.07%
Without Chronic Disease	3,318	309,492	128.65	Without Chronic Disease	2,398	349,673	82.29	-36.03%

Table E19
Average Length of Stay (ALOS) for Chronic Disease Participants Compared to Other Participants

Jul 08 - Jun 09				Jul 09 - Mar 10 (Not Annualized)				
	Admits	Days	ALOS		Admits	Days	ALOS	Variance
With Chronic Disease	473	2,043	4.32	With Chronic Disease	330	1,214	3.68	-14.83%
Without Chronic Disease	637	3,318	5.21	Without Chronic Disease	655	2,398	3.66	-29.71%

Overall, admissions are low in the HSF population (Table E20 and Table E21). The data reveals that the top three diagnoses for hospitalization are alcohol withdrawal, cellulitis/abcess leg and pneumonia.

Table E20
Hospital Admissions Frequency

Jan 09 - Dec 09		
Admissions	**Participants Continuously Enrolled**	**Percentage**
No Admissions	22,909	97.65%
1-2 Admissions	540	2.30%
3-4 Admissions	10	0.04%
5+ Admissions	2	0.01%
Total Participants	23,461	100.00%

Table E21
Hospital Days Frequency

Jan 09 - Dec 09		
Days	**Participants Continuously Enrolled**	**Percentage**
No Days	22,909	97.65%
1-2 Days	252	1.07%
3-4 Days	145	0.62%
5-9 Days	103	0.44%
10+ Days	52	0.22%
Total Participants	23,461	100.00%

Pharmacy

As expected, the prescription utilization for participants with chronic conditions is significantly higher than the rest of the population. However, for both groups, pharmacy utilization decreased from FY2008-09 to FY2009-10. This finding may be explained by the fact that prescription use is typically high when participants first enter the program (since many participants may not have been able to afford prescriptions until they joined HSF and so they "saved up" all their prescription needs until they were enrolled). Later years of the program will have more participants who are re-enrolling, and therefore will not show an early spike in pharmacy utilization.

Table E22
Average Prescriptions for Participants with Chronic Disease Compared to Other Participants

Jul 08 - Jun 09				Jul 09 - Mar 10 (Annualized)				
	Total Prescriptions	**Participant Months**	**Avg No. of Prescriptions per Year**		**Total Prescriptions**	**Participant Months**	**Avg No. of Prescriptions per Year**	**Variance**
With Chronic Disease	150,360	128,886	14.00	With Chronic Disease	116,355	105,008	13.30	-5.02%
Without Chronic Disease	74,509	309,492	2.89	Without Chronic Disease	74,624	349,673	2.56	-11.35%
Total	224,869	438,378	6.16	Total	190,979	454,681	5.04	-18.12%

Surgical Procedures

Surgical procedures are performed more often for the chronic disease population, and their utilization has increased 12% from FY2008-09 to FY2009-10 (Table E23 and E24). It is difficult to interpret this trend given the decrease in hospitalizations. It is possible that surgeries are being shifted to the

outpatient (elective) setting, as opposed to the inpatient (emergent) setting. It seems to be consistent with the fact that inpatients days for chronic patients have dropped 27%.

Table E23
Surgical Procedures Per 1,000 Participants Per Year for Chronic Disease Compared to Other Participants

Jul 08 - Jun 09				Jul 09 - Mar 10 (Annualized)				
	Total Procedures	Participant Months	Procedures Per 1,000		Total Procedures	Participant Months	Procedures Per 1,000	Variance
With Chronic Disease	4,346	128,886	404.64	With Chronic Disease	3,960	105,008	452.54	11.84%
Without Chronic Disease	7,281	309,492	282.31	Without Chronic Disease	8,883	349,673	304.84	7.98%
Total	11,627	438,378	0.32	Total	12,843	454,681	0.34	6.50%

Table E24
Inpatient and Outpatient Surgical Procedures Per 1,000 Participants Per Year for Chronic Disease Compared to Other Participants

Disease	Fiscal Year	IP Surgical Procedures	OP Surgical Procedures	Participant Months	Inpatient Proc/ 1,000	Outpatient Proc/ 1,000	Inpatient Variance	Outpatient Variance
With Chronic Disease	Jul 08 - Jun 09	476	3,870	128,886	44.32	360.32	-27.80%	16.71%
	Jul 09 - Mar 10 (Annualized)	280	3,680	105,008	32.00	420.54		
Without Chronic Disease	Jul 08 - Jun 09	857	6,424	309,492	33.23	249.08	-17.07%	11.33%
	Jul 09 - Mar 10 (Annualized)	803	8,080	349,673	27.56	277.29		

Behavioral Health

In the area of behavioral health, HSF also tracks utilization of mental health and substance abuse services. From FY2008-09 to FY2009-10 there was a 17% decrease in mental health visits and a 42% decrease in substance abuse visits.

Table E25
Average Mental Health Visits Per Participant (CBHS and Encounter Data)

Jul 08 - Jun 09				Jul 09 - Mar 10 (Annualized)				
	Mental Health Visits	Participant Months	Average Visits		Mental Health Visits	Participant Months	Average Visits	Variance
With Chronic Disease	12,710	128,886	1.18	With Chronic Disease	10,798	105,008	1.23	4.28%
Without Chronic Disease	37,487	309,492	1.45	Without Chronic Disease	32,547	349,673	1.12	-23.15%
TOTAL	50,197	438,378	1.37	TOTAL	43,345	454,681	1.14	-16.75%

Table E26
Average Substance Abuse Visits Per Participant

Jul 08 - Jun 09				Jul 09 - Mar 10 (Annualized)				
	Substance Abuse Visits	**Participant Months**	**Average Visits**		**Substance Abuse Visits**	**Participant Months**	**Average Visits**	**Variance**
With Chronic Disease	4,631	128,886	0.43	With Chronic Disease	2,342	105,008	0.27	-37.93%
Without Chronic Disease	13,648	309,492	0.53	Without Chronic Disease	8,663	349,673	0.30	-43.82%
TOTAL	18,279	438,378	0.50	TOTAL	11,005	454,681	0.29	-41.95%

Quality of Care

This section provides statistics on readmission rates and quality of care provided to participants with chronic conditions.

The HSF readmission rate remained stable from FY2008-09 to FY2009-10 at 6%, and the rate of diabetics and asthmatics getting recommended care is within the range of the insured population. These findings may be attributed to the work undertaken by the *Strength in Numbers Program*. The program appears to have accelerated chronic care improvements through the use of registries and population management in HSF medical homes.

Hospital Readmissions

Readmission data is a good indicator for quality of care. According to the Agency for HealthCare Research and Quality (AHRQ), adverse patient safety events during hospitalizations lead to:

- higher probability of readmissions,
- higher probability of in-hospital death following discharge and
- higher inpatient costs following discharge.

The HSF readmission rate of 6% is lower than the national average. The national rate of hospital readmission within 30 days is 18% (AHRQ). As with other hospital data, the HSF readmission rate for 6% does not capture all of the readmissions due to incomplete non-profit hospital data.

Table E27
Readmission Rate 30, 60 and 90 Days

Jul 08 - Jun 09				Jul 09 - Mar 10 (Not Annualized)				
	Readmissions	**Total Admissions**	**Readmission Rate**		**Readmissions**	**Total Admissions**	**Readmission Rate**	**Variance**
01-30 Days	73	1,110	6.58%	01-30 Days	60	985	6.09%	-7.38%
31-60 Days	34	1,110	3.06%	31-60 Days	30	985	3.05%	-0.57%
61-90 Days	16	1,110	1.44%	61-90 Days	22	985	2.23%	54.95%

The data also indicates that there was a decrease in timely follow-up after an inpatient discharge in FY2008-09 compared to FY2009-10 (Table E28). In FY2009-10, 44% of participants hospitalized obtained a follow-up office visit within 30 days of discharge compared to 51% the year prior.[16] In FY2010-11 HSF will work to increase this percentage through its quality improvement activities. The national average from National Committee for Quality Assurance (NCQA) for outpatient follow-up following discharge is 86%. It should be noted that NCQA bases this percentage on those with mental health admissions. The Center for Medicare and Medicaid Services (CMS) reports that in their claims study of 12 million Medicare beneficiaries 50% of patients readmitted within 30 days of discharge did not have a bill for a physician visit during the time between hospital discharge and readmission.

Table E28
Follow-Up Office Visits Within 30 Days of Discharge

Jul 08 - Jun 09			Jul 09 - Feb 10 (Not Annualized)			
Follow-Up Office Visit	**Total Discharges**	**Rate**	**Follow-Up Office Visit**	**Total Discharges**	**Rate**	**Variance**
567	1,110	51.08%	432	967	44.67%	-12.54%

HEDIS Measures

To assess the quality of care provided to HSF participants, we monitor the quality of care for participants with chronic disease. The indicators used are based on the Healthcare Effectiveness and Data Information Set (HEDIS) performance measures, as outlined by NCQA. Participants enrolled for 12 months with asthma and diabetes were measured against HEDIS benchmarks.

The data indicates that the percentage of participants with diabetes getting A1c tests is 74% compared to the national Medicaid average of 77%, and the percent of diabetics getting LDL (cholesterol) testing is slightly above the National Medicaid Average at 72% compared to 71% (Table E29). For asthma, the data shows that 82% of participants with asthma are getting the medication they need to control their asthma, compared to the National Medicaid average of 86% (Table E30).

Table E29
Percentage of Diabetic Care Tests Compared to Medicaid

Jan 09 - Dec 09				
Diabetic Care Test	**Numerator (HSF Participants Received Test)**	**Denominator (Eligible HSF Participants)**	**HSF Percentage**	**National Medicaid Average**
HbA1c	1,925	2,567	74.99%	77.40%
LDL	1,850	2,567	72.07%	70.90%

Table E30
Percentage of Asthma Controlled Tests Compared to Medicaid

Jan 09 - Dec 09				
Asthma Test	**Numerator (HSF Participants Received Medication)**	**Denominator (Eligible HSF Participants)**	**HSF Percentage**	**National Medicaid Average**
Medication	338	412	82.04%	86.90%

[16] Please note that the cut-off date for 2009-10 is February to allow for the 30 day follow-up visit.

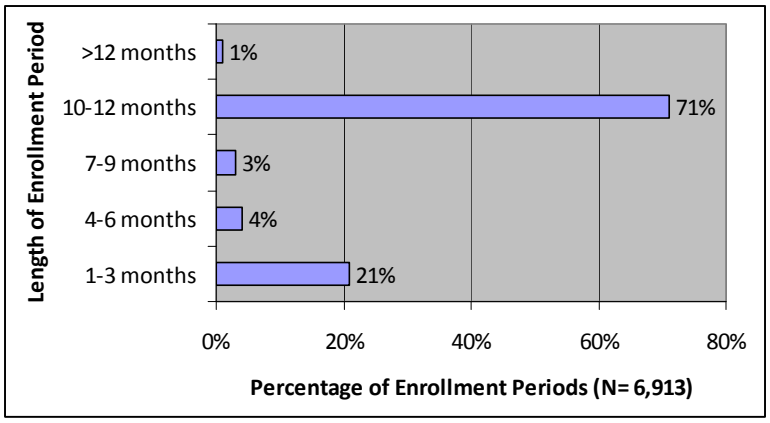
Health Care Utilization Among "Churners"

Section A of the report notes that 3,408 individuals have had two or more disenrollments from HSF and of those, 3,219 individuals were included in the "enrollment churn analysis." The enrollment churn analysis excluded 189 individuals based on the reason for their second disenrollment. [17]

In addition to examining the frequency of multiple enrollments and disenrollments, the Department was also interested in understanding the health care utilization of those who churned through the system. A high-level "utilization churn analysis" was conducted on all 3,408 churners (including the 189 individuals who were excluded from the enrollment churn analysis) who collectively had 6,913 enrollment periods (i.e., the period of time between an enrollment and disenrollment). By virtue of churning through the program, all of these individuals will have more than one enrollment period (e.g., an individual with two disenrollments will have two enrollment periods, etc.).

This analysis examined whether an individual had a service during a given enrollment period. The first component of the analysis examined the length of enrollment in terms of months. This is important to determine whether individuals were enrolled in the program for a sufficient period of time to receive a service. An enrollment period for a "churner" will range in length of days. For example, individuals disenrolled for program eligibility or failure to pay participation fee can be disenrolled mid-year while individuals disenrolled for failure to renew will have 365 days of enrollment before being disenrolled. In addition, while HSF enrollment is primarily done at the medical home site, it is not the case that each person enrolling into the program on a particular day will be in need of a service on that day or shortly thereafter. The data indicates that most of the churners (71%) had enrollment periods lasting 10 – 12 months.

Graph E1
Length of Enrollment Periods of Individuals with Two or More Disenrollments



The second component of the analysis examined utilization of services. The data indicate that 5,112 (74%) of the 6,913 enrollment periods had service utilization during active enrollment. With respect to the first initial office visit after enrollment, the data indicate that 70% had their first visit within the first 60 days of enrollment with over half (54%) having their first visit within 30 days. This suggests that

[17] A total of 3,408 individuals have had two disenrollments. However, of this total, 189 individuals had a second disenrollment that was coded either exceeded the program age requirement (turning age 65) or death. While these individuals technically had two disenrollments they are not eligible for re-enrollment and therefore were not included in the "churn" analysis because their second disenrollment did not constitute "churn."

individuals in this category are in need of health care services soon after enrolling or that health care needs may factor into a decision to enroll in HSF.

Table E31
Length of Days to Initial Office Visit for Individuals with Two or More Disenrollments

First Initial Office Visit (Days After Enrollment)	No. of Enrollment Periods	Rate
01-30 Days	2,751	54%
31-60 Days	838	16%
61-90 Days	465	9%
>90 Days	1,058	21%
Total	**5,112**	**100%**

That being said, with respect to broader service utilization, the data reveals that churners had an average office visit rate of 3.96 per enrollment period in comparison to the overall HSF population with an average office visit rate of 3.29 per year. The ED visit rate is higher at 230 visits/1,000 compared to 164 visits/1,000 for the overall HSF population. It is important to note that the truncated enrollment periods for churners make comparative analysis with the overall HSF population difficult.

Table E32
Service Utilization by Type for Individuals with Two or More Disenrollments

Services Utilized During Active Enrollment Periods (n= 5,112)	Visits	Visit/Enrollment Period
Inpatient Stay	214	0.04
Outpatient Surgery/ASC	486	0.10
Emergency Room	1,157	0.23
Professional Visit:		
--Office Visit	20,225	3.96
--Consultation	416	0.08
--Eye Exam (Diabetic -- Chronic Care)	141	0.03
--Mental Health	711	0.14
--Clinic Visit	2,132	0.42
Ancillary Service	6,511	1.27
Other Service	2,687	0.53
Total	**34,680**	**6.78**

F. PARTICIPANT SATISFACTION AND EXPERIENCE

This section highlights the various mechanisms in the HSF program to obtain feedback from participants and to gauge their experiences. This includes the call center, tracking of complaints and surveys.

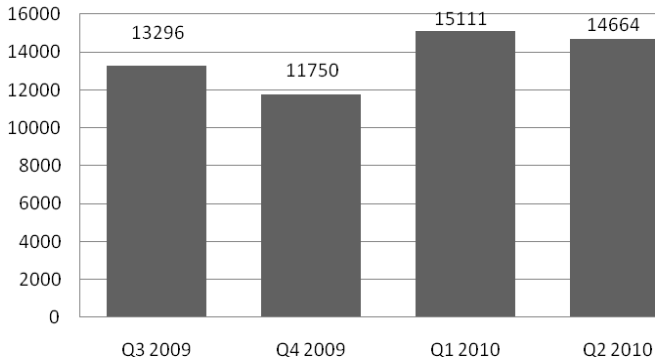
What matters most to patients is access to care when they need it and this is reflected in the data. A review of participant complaints, survey data and self-reported questionnaires indicate that for the majority of participants, HSF is meeting their health care needs. The HSF complaint rate per thousand participants decreased from 0.9 to 0.7 from FY2008-09 to FY2009-10. There were a total of 436 participant complaints with the top complaints in the area of access and quality of service. The Healthy San Francisco Participant Survey, which was administered and generously funded by Kaiser Family Foundation, found the 94% of the participants were satisfied with the program. At the same time, because HSF is still relatively new, the survey uncovered areas for additional improvement such as program awareness/education, challenges for non-English speakers and streamlining the medical appointment process. Finally, data from the HSF Health Access Questionnaire found that participants continuously enrolled in the program reported less ER utilization, being more likely to have a usual source of care, less difficulty accessing care, improved rating of medical care and less delays accessing care. At the same time, these same respondents did not consistently view their general health status as improved. Finally, the data indicates that participants' perception of their health status or of the medical care they receive seems to coincide with their utilization of services.

Customer Service Center Call 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 include providing telephone assistance to participants, providers, and employers, scheduling enrollment appointments for the HSF enrollment site at SFHP and handling participant complaints.

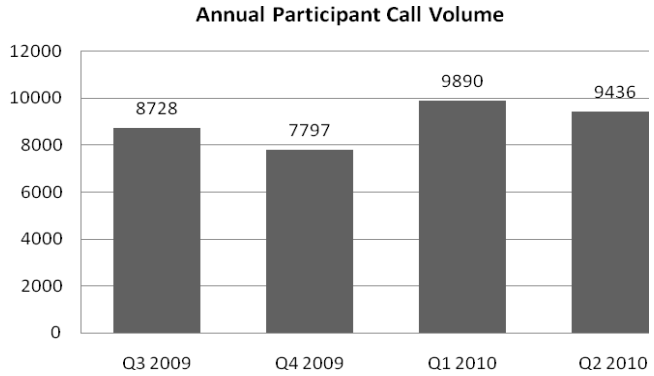
Customer Service Center received a total 54,821 incoming calls (applicants, participants, providers, employers, others) from July 2009 to June 2010 demonstrating a 54% increase from the previous year's total of 35,522 calls.

Graph F1
FY 2009-2010
Total Call Volume



For participants, the call rate for FY2009-10 averaged 61 calls per 1,000 participants compared to 59 calls per 1,000 participants during FY2008-09. Participant fee billing inquiries and renewal questions were the main reasons for calls.

Graph F2



The HSF Customer Service Center has a targeted call abandonment rate of less than 5% and an expected service level of 90% or higher (i.e., answering 90% or more of calls within 30 seconds) which it met in each quarter of FY2009-10.

Table F1
Target verus Actual Call Abandonment Rate

Metric		Average for Quarter			
	Goal	Q3 09	Q4 09	Q1 2010	Q2 2010
Call Abandonment Rate	<= 5%	1.2%	0.7%	0.4%	0.4%
Service Level (answered 90% of calls within 30 seconds)	=> 90%	91.9%	93.9%	95%	95.8%

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 HSF Quality Improvement. The goal is to resolve complaints within 60 days.

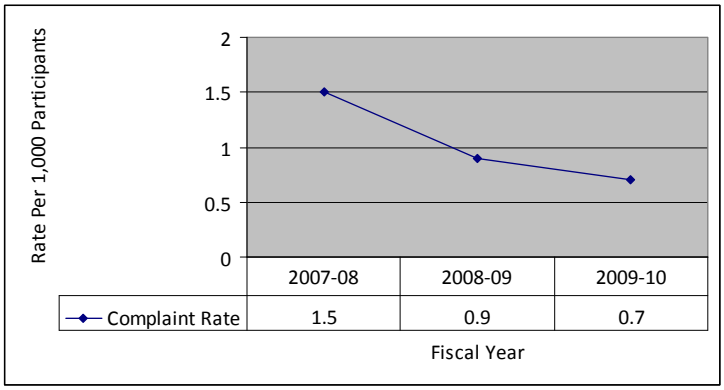
The complaint rate is calculated by taking the number of complaints filed within the specified time period and dividing that number by the number of participants within the program during that specified time period. The resulting number is then multiplied by 1,000. The rate of complaints is a frequency measure, where each participant can complain in any month; therefore, the denominators for each month are added to reflect differences in population from month-to-month and equal probabilities of filing complaints.

During FY2009-10, the HSF Customer Service Center received a total of 436 complaints. The complaint attributes with the most room for improvement are access and quality of service. HSF and SFHP are working to improve both of these issues with five medical homes through the Patient-Centered Communication Pilot and the Optimizing the Primary Care Experience program. Key fiscal year trends include:

- Access issues were 35.1% of the total complaints received in the FY2009-10, compared to 38% of the total complaints received in FY2008-09.
- Quality of service issues were 23.9% of the total complaints received in FY2009-10, compared to 18.3% of the total complaints received in the FY2008-09.[18]
- The complaint rate for FY2009-10 was 0.7; this is down from 0.9 for the FY2008-09.

Over the course of the three years of the program, the complaint rate per 1,000 participants has declined. Because tracking of complaints began in January 2008, the complaint rate for FY2007-08 included only six months of complaint data.

Graph F3
HSF Complaint Rate Per 1,000 Participants by Fiscal Year



The top three complaints categories were Access, Quality of Service, and Medical Home Mismatch.

Table F2
HSF Participant Complaints by Category

Attribute	Total # of Complaints	% of Total Complaints
Access Issue	153	35.10%
Quality of Service	104	23.90%
Medical Home Mismatch	49	11.20%
Enrollment Issue	29	6.70%
Other	30	6.90%
POS Fees	22	5.00%
Pharmacy	19	4.40%
Quality of Care	18	4.10%
Billing	5	1.10%
Participant Fee Bill	4	0.90%
Coverage Interpretation	2	0.50%
Eligibility Issue	1	0.20%
Total	**436**	**100.00%**

[18] Please note that the numbers from the FY2008-09 report differ slightly from the numbers reported in this report. HSF Quality Improvement changed some complaint attributes after submitting the FY2008-09 report.

A descriptive of some of the top complaints is below:

- Access: This refers to clinical services not being available when and where the participant expected. Twenty-two (22) of the thirty (32) medical homes received a complaint of this nature.
- 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, HSF Application Assistor, etc.
- Medical Home Mismatch: The enrollment-related complaints (49) generally reflect issues relating to the participant's medical home selection.
- 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.

With respect to other programs, the HSF complaint rate was higher compared to the complaint rate of other San Francisco Health Plan lines of business.

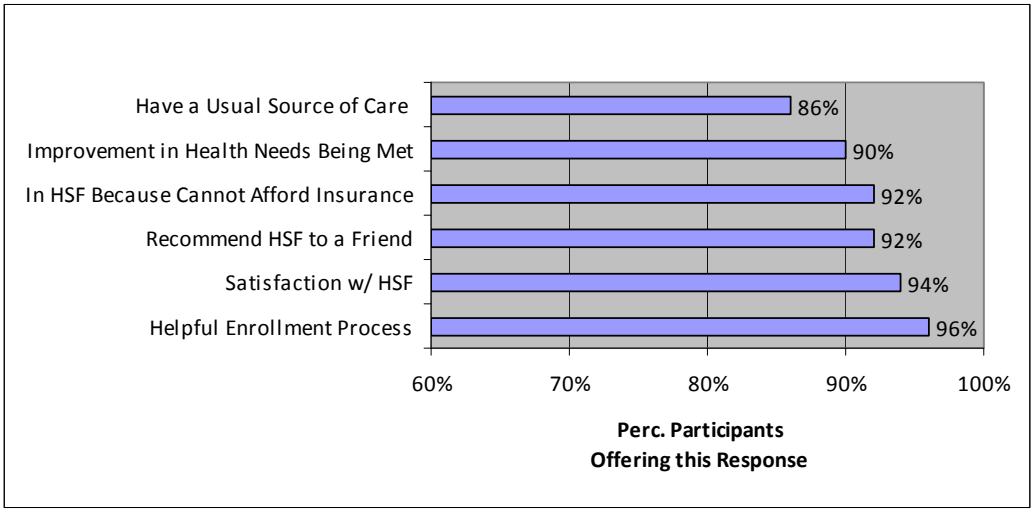
Table F3
Comparative Data of Complaint Rates (2009-10)

Line of Business	Complaint Rate
Healthy San Francisco	0.7
SFHP Healthy Workers	0.3
SFHP Medi-Cal	0.2
All SFHP Lines of Business	0.9

Survey of Healthy San Francisco Participants

Early in FY2009-10, Kaiser Family Foundation released the findings of an independent telephone survey (*Survey of Healthy San Francisco Participants*) of early HSF participants. The survey was administered and funded by the Foundation and it found the 94% of the participants were satisfied with the program. The overall findings documented that HSF is having its intended results:

Graph F4
HSF Participant Survey Results (Kaiser Family Foundation)



At the same time, because HSF is still relatively new, the survey uncovered areas for additional improvement such as program awareness/education, challenges for non-English speakers and streamlining the medical appointment process. Based on feedback from the 2009 Kaiser Family Foundation Healthy San Francisco Participant Satisfaction Survey, HSF developed a series of one-page guides to more clearly communicate key program rules and design to participants. These include a: (1) "Next Steps" hand-out providing key program information such as the fact that HSF is not insurance and is not available outside of San Francisco, (2) a "Dental and Vision Resource Guide" for participants requiring referrals to low or no-cost dental or vision services and (3) a Guide to Behavioral Health Care Services. All materials are available in Chinese, Spanish, and English and can be downloaded from the Healthy San Francisco website.

Health Access Questionnaire

As part of an ongoing evaluation effort, the HSF application process includes a Health Access Questionnaire. The purpose of the survey is to capture applicants' pre- and post- Healthy San Francisco health access experience in a quantifiable manner.

Applicants are asked the survey questions at the time of initial enrollment and at annual renewal by a trained Application Assistor. Questionnaire responses are self-reported data. 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. In FY2009-10, the questionnaire consisted of ten questions and was offered in English, Spanish and Chinese.

During FY2009-10, 47,555 questionnaires were administered through One-e-App to both 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 enrolled in HSF and, as a result, their responses to questions will be based on their health care experiences during HSF enrollment. For FY2009-10, the Department conducted two analyses:

- analyzing all responses and

- conducting a year-to-year comparison of participants who had taken the survey twice.

The first analysis provides summary information on all participant responses and does not distinguish between a new participant and a renewing participant. That is, 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") to the 47,555 questionnaires. The second analysis examines the responses of approximately 10,000 HSF participants who have been continuously enrolled and who have taken the questionnaire twice (at initial enrollment and renewal or for two renewals). The purpose of this analysis is to compare the HSF participants' responses over time.

FY2009-10 Health Access Questionnaire Responses

Table F4 provides the overview of all Health Access Questionnaire (HAQ) responses taken in FY2009-10. The information is for both new participants and those renewing their participation. The 47,555 questionnaires were taken by 46,308 participants:

- 45,062 participants took the survey one time in the year
- 1,246 participants took the survey two times in the year (i.e., a new applicant who renewed eligibility before the end of his/her 12 month term) and
- 1 participant who took the survey three times.

Survey findings suggest that uninsured residents taking the questionnaire in both FY2008-09 and FY2009-10 had similar responses to a range of access the care, health status and medical care experiences. From FY2009-10 to FY2008-09,

- a smaller percentage (52% to 58%) stated their health was excellent, very good, or good,
- a higher percentage (27% to 20%) noted the cost of health insurance and/or co-payments as the reason their were uninsured,
- higher percentage (71% to 54%) indicated that they most often receive care at a clinic, health center, or hospital clinic,
- higher percentage (8% to 4%) stated they most often receive care in an emergency room,
- lower percentage (34% to 43%) stated access to care was either not at all difficult or not too difficult and
- higher percentage (39% to 26%) rated the medical care they received in the past 12 months as excellent or very good.

Table F4
Summary of Health Access Questionnaire Responses
(Both New Applicants and Continuing Participants)

No.	Question	Key 2009-10 Responses	Key 2008-09 Responses
1	Would you say that in general your health is excellent, very good, good, fair, or poor?	52% of all respondents indicated their health was Excellent, Very Good, or Good.	58% of all respondents indicated their health was Excellent, Very Good, or Good.
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.	53% of all respondents indicated that they did not have health insurance for some time in the past 12 months.

No.	Question	Key 2009-10 Responses	Key 2008-09 Responses
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-seven percent (27%) cited it as the reason they 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.
4	In the last 12 months, did you visit a hospital emergency room for your own health?	12% of all respondents stated that had visited a hospital emergency room in the previous 12 months.	14% of all respondents stated that had visited a hospital emergency room in the previous 12 months.
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?	71% of all respondents most often receive care at a clinic, health center, or hospital clinic and 8% of all respondents most often receive care in an emergency room.	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.
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?	34% of all respondents said it was Not At All Difficult or Not Too Difficult to access care when they needed it.	43% of all respondents said it was Not At All Difficult or Not Too Difficult to access care when they needed it.
7	How do you rate the medical care that you received in the past 12 months – excellent, very good, good, fair, or poor?	39% rated the medical care they received in the past 12 months as Excellent or Very Good.	26% rated the medical care they received in the past 12 months as Excellent or Very Good.
8	During the past 12 months, did you either delay getting care or not get a medicine that a doctor prescribed for you?	11% of all respondents said they had delayed getting care or did not get a medicine prescribed to them during the past 12 months.	12% of all respondents said they had delayed getting care or did not get a medicine prescribed to them during the past 12 months.
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.	Overall, 14% of respondents said cost or lack of insurance was a reason why they had delayed care.
10	Do you now smoke cigarettes every day, some days, or not at all?	Overall, 14% of respondents smoked (either every day or some days).	Overall, 16% of respondents smoked (either every day or some days).

Year-to-Year Health Access Questionnaire Comparison

By the end of FY2009-10, a total of 10,052 HSF participants had taken the Health Access Questionnaire (HAQ) two times for a total of 20,104 surveys (since the launch of HAQ in December 2008).[19] For this analysis, HAQ1 refers to the first questionnaire and HAQ2 to the second questionnaire.

[19] Note that 35 of these participants had taken the questionnaire three times. However, responses to the third questionnaire for these 35 participants were not included in this analysis.

Of the ten Health Access Questionnaire questions, seven are appropriate for year-to-year comparative analysis:

1. Would you say that in general your health is excellent, very good, good, fair, or poor?
2. In the last 12 months, did you visit a hospital emergency room for your own health?
3. 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?
4. 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?
5. How do you rate the medical care that you received in the past 12 months – excellent, very good, good, fair, or poor?
6. During the past 12 months, did you either delay getting care or not get a medicine that a doctor prescribed for you?
7. Was cost or lack of insurance a reason why you delayed getting care or did not get a prescription?

The following analysis examines responses in the aggregate. A more detailed analysis of the Health Access Questionnaire responses by demographics and other categories will be a component of the HSF evaluation. However, the Department does provide information on the medical home selection and ethnicity of the 10,052 participants below.

An examination of medical homes provides some perspective on the extent to which the findings may be reflective of a consistent and usual source of care. Table F5 provides the medical home information. The majority of HAQ respondents had either a DPH (48%) or SFCCC (46%) medical home consistent with distribution of all HSF participants across medical homes. From HAQ1 to HAQ2, 10% of the 10,052 participants had changed medical homes. Of those who changed medical homes, 77% selected a new medical home within the same medical home delivery system as their previous medical home.

Table F5
Medical Home Distribution of 10,052 HAQ1 and HAQ2 Participants

Medical Home Delivery System	HAQ1		HAQ2	
	# of Participants	% of Participants	# of Participants	% of Participants
CCHCA	301	3.0%	328	3.3%
DPH	4,879	48.5%	4,841	48.2%
KAISER	13	0.1%	19	0.2%
SFCCC-All Others	1,638	16.3%	1,627	16.2%
SFCCC-NEMS	2,988	29.7%	3,001	29.9%
SMP	233	2.3%	236	2.3%
All Medical Homes	10,052	100.0%	10,052	100.0%

With respect to ethnic distribution, the majority of the participants were Asian/Pacific Islander at 47% as reflected in Table F6.

Table F6
Ethnic Distribution of 10,052 HAQ1 and HAQ2 Participants

	No. of Participants	% of Participants
Asian/Pacific Islander	4,678	47%
Hispanic/Latino	2,202	22%
Caucasian	1,896	19%
African-American	665	7%
Other Ethnic Identity	590	6%
Native American	21	< 1%
All Ethnicities	10,052	100%

The questionnaire responses indicate that from HAQ1 to HAQ2, those who had been continuously enrolled reported less ED utilization, a usual source of care, less difficulty accessing care, an improved rating of medical care and less delays accessing care. At the same time, respondents did not consistently view their general health status as improved. It is important to note that for each questionnaire, an estimated 23% to 34% indicated either they did not know the answer to the question or refused to answer the question.[20] Uniformly, there was an increase in the population that provided either of those responses from the first questionnaire to the second questionnaire.

General Health

An examination of HAQ1 and HAQ2 responses to participant general health (excellent, very good, good, fair, or poor) reveals that after one year of HSF participation, fewer participants considered their health to excellent, very good or fair. More participants indicated that their health was good and fewer said their health was poor.

Table F7
HAQ1 to HAQ2 – General Health

General Health	HAQ1	HAQ2	Variance	☺/😐/☹?
Excellent	7.39%	6.44%	-13%	☹
Very Good	17.08%	13.49%	-21%	☹
Good	33.88%	37.59%	11%	☺
Fair	16.26%	13.96%	-14%	☹
Poor	3.34%	2.28%	-32%	☺
Don't Know	9.50%	10.83%	14%	☹
Refused	12.54%	15.41%	23%	N/A

Hospital Emergency Department

An examination of HAQ1 and HAQ2 responses to hospital emergency department use within the last 12 months reveals that fewer participants indicated that they had received care in an emergency department.

[20] The Health Access Questionnaire (HAQ) requires a response for each household member enrolling or renewing in HSF. HSF does not require every household member to be physically present for the application process and, as a result, a spouse can complete the application and (HAQ) on behalf of themselves and their mate. This design feature can result in an Application Assistors indicating "Refused to Reply" on questionnaire responses if the applicant/participant is not physically present for the application or renewal and his/her spouse does not know that answer for his/her mate.

Table F8
HAQ1 to HAQ2 – Hospital Emergency Department

ED Visit in Last 12 Months	HAQ1	HAQ2	Variance	☺/😐/☹?
Yes	11.27%	8.92%	-21%	☺
No	66.05%	64.74%	-2%	☹
Don't Know	9.12%	10.43%	14%	☹
Refused	13.56%	15.91%	17%	N/A

Medical Care Location
An examination of HAQ1 and HAQ2 responses regarding location of medical care reveals that more HSF participants indicated that they received their care in a doctor's office, clinic, health center or hospital clinic on HAQ2 (70.5%) than HAQ1 (66.9%). Fewer participants indicated that they were most likely to get care from an emergency room or no place at all from 9.1% (HAQ1) to 2.8% (HAQ2).

Table F9
HAQ1 to HAQ2 – Medical Care Location

Medical Care Location	HAQ1	HAQ2	Variance	☺/😐/☹?
Doctor's Office	8.24%	4.38%	-47%	😐
Clinic/Health Center/Hospital Clinic	58.68%	66.13%	13%	☺
Emergency Room	2.24%	0.61%	-73%	☺
Some Other Place	0.88%	0.29%	-67%	😐
No Other Place	6.83%	2.20%	-68%	☺
Don't Know	10.57%	10.45%	-1%	☺
Refused	12.97%	15.96%	23%	N/A

Medical Care Access
An examination of HAQ1 and HAQ2 responses to access to medical care access (extremely difficult, very difficult, somewhat difficult, not too difficult, not at all difficult), reveals that HSF participants encountered less difficulty accessing care.

Table F10
HAQ1 to HAQ2 – Medical Care Access

Medical Care Access	HAQ1	HAQ2	Variance	☺/😐/☹?
Extremely Difficult	1.96%	1.04%	-47%	☺
Very Difficult	5.68%	5.57%	-2%	☺
Somewhat Difficult	15.10%	14.93%	-1%	☺
Not Too Difficult	31.32%	32.14%	3%	☺
Not Difficult at All	16.10%	17.54%	9%	☺
Don't Know	16.32%	12.72%	-22%	☺
Refused	13.53%	16.05%	19%	N/A

Medical Care Rating
An examination of HAQ1 and HAQ2 responses to the rating of medical care finds that between HAQ1 and HAQ2 HSF participants rated their care higher.

Table F11
HAQ1 to HAQ2 – Medical Care Rating

Medical Care Rating	HAQ1	HAQ2	Variance	☺/😐/☹?
Excellent	10.35%	10.75%	4%	☺
Very Good	16.90%	18.46%	9%	☺
Good	32.30%	33.81%	5%	☺
Fair	5.88%	6.39%	9%	☺
Poor	1.22%	0.72%	-41%	☺
Don't Know	19.86%	14.03%	-29%	☺
Refused	13.49%	15.84%	17%	N/A

Delay in Getting Care/Medication
An examination of HAQ1 and HAQ2 responses to delaying care finds that between HAQ1 and HAQ2, fewer participants responded that they delayed getting care or getting prescribed medication.

Table F12
HAQ1 to HAQ2 – Delay in Care

Delay in Care	HAQ1	HAQ2	Variance	☺/😐/☹?
Yes	9.86%	4.38%	-56%	☺
No	62.25%	66.14%	6%	☺
Don't Know	14.13%	13.31%	-6%	☺
Refused	13.77%	16.18%	18%	N/A

Delay in Care
An examination of HAQ1 and HAQ2 responses to delaying care finds that between HAQ1 and HAQ2, fewer participants responded that they delayed care due to cost or lack of insurance.

Table F13
HAQ1 to HAQ2 – Delay in Care due to Costs

Delay in Care -- Cost Reasons	HAQ1	HAQ2	Variance	☺/😐/☹?
Yes	10.71%	6.83%	-36%	☺
No	56.13%	59.46%	6%	☺
Don't Know	14.07%	17.24%	23%	☹
Refused	19.09%	16.46%	-14%	N/A

Participant Perception of Health Status Compared to Utilization
As part of the Department's review of participant experience, there was a desire to assess how a HSF participant's perception of their health status compared to their actual utilization of services. To accomplish this, the analysis trended HSF participants who renewed their participation in HSF and completed the Health Access Questionnaire (HAQ) between July 2009 and March 2010. Included in this were all participants who were continuously enrolled for at least 9 months prior to completing the survey and with no more than a 60-day gap in enrollment.

The data indicates that participants' perception of their health status or of the medical care they receive seems to coincide with their utilization of services. However, since this is the first time that this type of analysis is being conducted and is therefore, baseline data, conclusions cannot be made. This data should be trended over time to assess significance.

To understand HSF participants' perception of health status and the impact of smoking on utilization, the results from the HAQ were compared to utilization data in the HSF data warehouse. Results showed that smokers had more primary care and emergency utilization than non-smokers, despite having roughly the same incidence of hypertension, hyperlipidemia, asthma or diabetes. This finding is consistent with national data showing that smokers use more healthcare services than non-smokers.

Table F14
Do Smokers Utilize Services at a Higher Rate than Non-Smokers and Do They Have a Higher Rate of Chronic Disease?

	Respondents	Avg. Primary Visits	Avg. Specialty Visits	Avg. ED Visits	Rate For Chronic Disease	Rate For Non-Chronic Disease
Smokers	1,479	4.03	0.11	0.17	39.15%	60.85%
Non-Smokers	9,631	3.83	0.16	0.10	41.34%	58.66%

Predictably, participants who reported their health status as poor had twice as many office visits and three times as many ED visits as those who reported their health status as very good or excellent.

Table F15
How Does the Utilization of Services Vary for Those Renewing Participants Based on Their Self-Reported Health Status?

Health Status	Respondents	Average Primary Visits	Average Emergency Visits
Excellent/Very Good	3,012	3.09	0.10
Good	5,444	3.66	0.10
Fair	2,335	4.89	0.12
Poor	365	6.54	0.30

Those participants who reported that access to medical care was "extremely or very difficult" had 22% higher emergency room utilization than those who reported that access was "not that difficult."

Table F16
Do Renewing Participants Who Find it Difficult to Get Medical Care When Needed Have a Higher Rate of Avoidable ED visits?

Access to Medical Care	Respondents	Avg. Avoidable Emergency Visits
Extremely/Very Difficult	2,890	1.14%
Not That Difficult	7,750	0.93%

Renewing participants were asked about their interactions with the system and perception of care and access to services. The data revealed that 37% of participants who rate their health as excellent or good have a chronic condition, compared to 54% of those who rate their health as fair or poor (Table F17).

Table F17
Are Renewing Participants with Chronic Conditions More Likely to Rate Their Health as Fair or Poor Than Those Without Chronic Conditions?

Health Status	Respondents	Rate For Chronic Disease	Rate For Non-Chronic Disease
Excellent/Very Good/Good	8,456	36.99%	63.01%
Fair	2,335	53.02%	46.98%
Poor	365	58.08%	41.92%

There was no significant difference in the incidence of chronic conditions among participants who rated their medical care as good/excellent, compared to those who rated it as fair/poor.

Table F18
Are Renewing Participants with Chronic Conditions More Likely to Rate the Medical Care They Receive as Excellent or Very Good Than Those Without Chronic Conditions?

Medical Care	Respondents	Rate For Chronic Disease	Rate For Non-Chronic Disease
Excellent/Very Good/Good	9,553	42.81%	57.19%
Fair	865	40.00%	60.00%
Poor	104	38.46%	61.54%

G. HEALTH CARE COVERAGE INITIATIVE

This section describes the Department's activities with respect to the Health Care Coverage Initiative (HCCI) which provides vital federal reimbursement to a subset of Healthy San Francisco participants.

In the three years since the HCCI started, the Department has designated almost 15,600 HSF participants as HCCI-eligible surpassing its targeted enrollment of 10,000. Of the $73.1 million in service cost reimbursement awarded the Department, it has received $50.1 million. Service cost claiming in the last two years of the program was 86% of the allocation. No administrative cost reimbursement has been provided to date.

Program Description

In March 2007, the Department was notified of a $73.1 million in available reimbursement under the California Department of Health Services' Health Care Coverage Initiative (HCCI) for the Healthy San Francisco program. The HCCI is part of the State's five-year (2005 – 2020) 1115 Medicaid Demonstration Project Waiver. The time period for the HCCI is September 1, 2007 to August 31, 2010. In addition to services funding, under HCCI, the Department is to receive funding for administrative costs incurred planning and operating HCCI over the three-year period. Funding for the administrative component is not contained in the $73.1 million services reimbursement allocation. The 1115 waiver, and ultimately the HCCI are under the jurisdiction of the Center for Medicare and Medicaid Services (CMS).

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).

HCCI is not a separate program – it provides funding for a subset of HSF participants who meet the HCCI eligibility criteria.

Enrollment

The Department's initial target for HCCI enrollment was 10,000 over the three year period. From September 2007 to June 2010, the Department designated 15,564 HSF participants as HCCI-eligible. As of the end of June 2010, there were 9,200 individuals (17% of HSF population) in HSF who were designated HCCI-eligible. 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; 37% are 25 - 44; 21% are 45 - 54; 34% are 55 - 64
Ethnicity	35% Asian/Pacific Islander; 26% Caucasian; 17% Latino; 15% African-American, 5% Other; 2% Not Provided
Gender	49% female; 51% male
Income	72% at/below 100% FPL; 28% between 101 – 200% FPL
Language	68% English; 19% Cantonese/Mandarin; 7% Spanish; 3% Vietnamese; 3% Other

Note that there are over 6,300 HSF participants pending HCCI-eligible. HSF participants in the pending HCCI status are those who principally lack a valid form of HCCI identification, citizenship/legal residency documentation or both. This has been a challenge for San Francisco and other county HCCI awardees because many low-income adults do not have ready access to HCCI verifiable citizenship documentation. In addition, for San Francisco a sizeable portion of the HSF population are homeless and those individuals may lack both identification and citizenship. The Department continues to work diligently on this eligibility provision partnering with various local, regional and statewide entities.

Funding

HCCI funding is for both services and administrative expenses. Services funding is reimbursed based on costs and takes into account enrollment and service utilization. Administrative funding is reimbursed based on certain allowable administrative expenses. Below is information on funds allocated to and received by San Francisco under HCCI.

Table G2
HCCI Reimbursement

Cost Category	Reimbursement Potential	PY1 (9/2007 – 8/2008) Funding	PY2 (9/2008 – 8/2009) Funding	PY3 (9/2009 – 8/2010) Funding	Total Reimbursement Provided	% of Allocation Received All 3 Yrs	% of Allocation Received Last 2 Yrs
Service Cost Reimbursement	$73.12 million ($24.37M/yr) State Allocation	$8.1M	$19.2M	$22.9M	$50.1M	69%	86%
Admin. Cost Reimbursement	$2.15 million DPH Estimate[21]	None	None	None	None	N/A	N/A

Funding in Program Year 1 was significantly lower than funding in subsequent years because of a change in the initial HCCI services reimbursement allocation methodology. Initially, San Francisco submitted a proposal for gradual HCCI enrollment and service cost reimbursement based on the realization that the program would not reach its enrollment target in the first few months of Program Year 1 and maintain that static enrollment target throughout the three years. For any program, there is a ramp-up period. This was approved in San Francisco's HCCI application. However, gradual ramp-up enrollment and service cost reimbursement was not approved by CMS due to the nature of the HCCI funding in the 1115 waiver which is based on a set amount in each of the three years (i.e., $180 million a year for three years for a total of $540 million statewide over the life of the HCCI). This decision effectively meant that San Francisco would not be able to fully capture reimbursement in the first year because it was forced to set the same enrollment target in each of the three years in order to capture the same level of reimbursement ($24.37 million) in each of those years.

With respect to the Program Year 2 and Program Year 3, the Department, like all HCCI counties have the opportunity to update reimbursement claims to capture costs not initially identified. The Department continually undertakes this process as it identifies individuals in HSF (pending HCCI) who eventually become eligible for HCCI. For example, potential reimbursement associated with the over 6,000 HCCI-pending eligibles is estimated in excess of $14 million. The Department is unable to claim services costs

[21] This estimate does not include time-study administrative reimbursement or start-up cost reimbursement.

associated with this population. It is unable to do so until the citizenship and identification documentation for each individual has been obtained and verified.

San Francisco received its first reimbursement for services in October 2008 (in Program Year 2). As of the writing of this annual report, San Francisco has not received any reimbursement for administrative activities related to development and ongoing operation of the program. Delays in developing an administrative cost claiming protocol has hampered State reimbursement of these costs. As a result, Department has received no administrative cost reimbursement since it began planning for HCCI in March 2007.

Program Continuation

As noted above, HCCI funding is part of a more expansive five-year hospital-based financing 1115 waiver that the State received from the federal Center for Medicare and Medicaid Services ("CMS"). The HCCI and its funding were scheduled to cease when the five-year waiver expired on August 31, 2010. However, in August 2010, the State requested and received from CMS a 60-day extension of the existing waiver (new expiration date of October 31, 2010).

The State took this course of action because it is trying to secure a new 1115 waiver to continue HCCI and implement other efforts. In June 2010, the State submitted a continuation 1115 waiver proposal to the CMS in which it sought to outline how a comprehensive 1115 waiver could serve as a critical bridge to federal health reform. The State has requested to begin early implementation of key coverage expansion and delivery system reform components of federal health reform. Through this waiver application, the State seeks to accomplish six critical goals:

1. To immediately begin phasing in coverage for the "newly eligible" adults aged 19-64 with incomes up to 133% FPL who are not otherwise eligible for Medicaid.
2. To immediately begin phasing in coverage for adults with incomes 133% - 200% FPL.
3. To create more accountable, coordinated systems of care with a focus initially on Seniors and People with Disabilities and Dual Eligibles.
4. To continue and expand the safety net care pool (SNCP) to assure support for its safety net hospitals and other critical programs which are paid for through the SNCP.
5. To implement improvements to the existing service delivery systems that will strengthen the infrastructure, prepare the State for full implementation of reform, and test strategies to slow the rate of growth in health care costs throughout the State.
6. To pilot payment reforms within the public hospital system that better aligns payment and care delivery incentives.

The State views HCCI as critical to accomplishing the first two goals. Its waiver proposes to not only continue all of the existing HCCI counties, but expand the HCCI model throughout the State to all 58 counties. The State believes that the expanded HCCI will serve as an important vehicle to seamlessly transition HCCI enrollees into Medi-Cal or the statewide insurance exchange in 2014. As the State looks to expand the program to additional counties, it will undoubtedly work to ensure that there is standardization with respect to certain program features across HCCI counties (i.e., benefits, eligibility and enrollment process, evaluation/performance metrics, etc.). The HCCI would sunset on December 31, 2013 timed with the January 1, 2014 expansion of health insurance options under federal health reform.

In addition to federal approval, implementation of the waiver requires California legislative authority. Under the 1115 waiver and via State legislation, the Health Care Coverage Initiative (HCCI) would be renamed to Coverage Expansion and Enrollment Demonstration (CEED) Projects. Assembly Bill 342 (Perez) is the legislative vehicle to implement the HCCI/CEED component of the California's 1115 waiver, if the waiver is approved by the CMS.

The State is still in the negotiating the waiver with CMS. The State hopes to have the continuation 1115 waiver approved on or before October 31, 2010 - the current expiration date for the existing 1115 waiver.

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. During FY2009-10 as part of the HCCI waiver discussions held by the State, UCLA released preliminary evaluation data on all of the 10 HCCI counties to help inform policymakers, the State and others exploring expansion of this important model.

H. EMPLOYER SPENDING REQUIREMENT

This section examines employer selection of the City Option (Healthy San Francisco and Medical Reimbursement Accounts) to meet the mandate of the Employer Spending Requirement as outlined in the San Francisco Health Care Security Ordinance.

There was a 15% increase in the number of San Francisco employers who elected to use the City Option (Healthy San Francisco/Medical Reimbursement Account) to meet the Employer Spending Requirement (from 980 in FY2008-09 to 1,126 in FY2009-10). By the end of the fiscal year, these 1,126 employers had elected to use the City Option to make health care expenditures on behalf of almost 55,600 employees. Since its beginning in July 2007, the Employer Spending Requirement has worked under the cloud of a federal lawsuit which challenged the legality of the Employer Spending Requirement one of the funding sources for HSF. This lawsuit was effectively settled in June 2010 when the United States Supreme Court declined to hear the lawsuit keeping intact the Employer Spending Requirement.

Program Description

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 and not the Department of Public Health.

Golden Gate Restaurant Association (GGRA) Lawsuit

The ESR underwent a legal challenge. In June 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. In June 2010, the U.S. Supreme Court announced that it would not hear GGRA's petition for review. As a result, the U.S. Ninth Circuit Court of Appeal's September 30, 2008 decision upholding the Employer Spending Requirement remains in effect for all covered businesses. The U.S. Supreme Court's denial of the petition followed the May 2010 United States Solicitor General brief which urged the Supreme Court not to take the case. The Solicitor General stated that the U.S. Ninth Circuit Court of Appeal's ruling in favor of the City and County did not conflict with any prior ERISA preemption decision of the Supreme Court. The Solicitor General also noted that passage of federal health care reform had dramatically changed the landscape regarding health coverage, making it much less likely that state and local governments would seek to enact programs like San Francisco's, thereby rendering the ERISA preemption question presented in the GGRA case much less important.

City Option Activity

The Employer Spending Requirement Portal, maintained by the San Francisco Health Plan as HSF's third-party administrator, is the mechanism by which employers identify employees for whom the employer is using the City Option. 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, 2010:

- 1,126 employers had selected the City Option to meet the ESR. At the end of last fiscal year there were 980 employers -- an increase of 146 employers using the City Option.

- During FY2009-10, employers deposited $34.124 million to provide the City Option for their employees. Employer contributions decreased by an average of 3% each quarter in FY2009-10. To date, $79.6 million in funds have been committed on behalf of 55,595 employees.[22]

- One-half of employees are potentially eligible for HSF and one-half would potentially receive a Medical Reimbursement Account.

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, $36.39 million in employer contributions ($13.97 million in FY2009-10) 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. In FY2009-10, over 1,800 transfers were completed.

Employee Data

As noted above, under the City Option, employees are eligible for either HSF or they receive a Medical Reimbursement Account (MRA). Of the 55,595 employees for whom employers have made contributions, the following is the distribution of those employees with respect to program eligibility:

[22] This figure represents the number of unique employees for whom the employer payment has cleared bank processing and been posted in the Employer Spending Requirement portal.

Table H1
City Option Employees by Program (Unduplicated Count) as of June 30, 2010

Category	Description	Number
HSF-Eligible Employees	City Option employee whose contributing employer has at some time in the past submitted these specific attributes: residency as "San Francisco," other insurance flag as "no," AND age between 18 and 64, inclusive.	27,480
MRA Employees	City Option employee whose contributing employer has at some time in the past submitted any combination of the following information for this City Option employee: residency not in "San Francisco," or other insurance flag as "yes", or age between 0-17 inclusive, or age greater than or equal to 65.	31,921
HSF and MRA Employees	City Option employee whose contributing employer(s) has at some time in the past submitted contributions designating this employee both as HSF eligible and MRA eligible.	(3,806)
Total City Option Employees	Employees with HSF contributions + employees with MRA contributions - employees with both HSF & MRA contributions.	55,955

City Option employees who are determined eligible for a MRA receive information in the mail informing them that a MRA account has been established for them. In addition, these employees receive information on how to access funds from their MRA account to reimburse them for eligible health care expenses. As Table H1 notes, more than half of the City Option employees have MRAs. City Option employees who are determined eligible for HSF receive information in the mail informing them of their potential eligibility for HSF, what information is needed to apply for HSF, and how to make a HSF eligibility and enrollment appointment.

Since implementation of the ESR, there have been 28,201 employees designated as potentially eligible for HSF enrollment.[23] Until the employee has an appointment with a HSF Application Assistor, they are designated as potentially HSF eligible because: (1) the HSF designation is initially based solely on data provided by the employer which may or may not be accurate and (2) final HSF eligibility can only be conferred after a completed HSF application has been submitted. A subset of uninsured employees may be eligible for public health insurance programs such as Medi-Cal. Consistent with HSF's eligibility provisions, application screening for public health insurance is required prior to HSF enrollment.

Of the 28,201 employees potentially eligible for HSF, the group is divided into known HSF dispositions, unknown HSF dispositions and inadequate data/unresponsive. A known disposition is one in which the program has contacted the employee and the employee has responded (i.e., the disposition of the employee's HSF eligibility is known). An unknown disposition is one in which the program has contacted the employee and is waiting for the employee to respond (i.e., the disposition of the employee's HSF eligibility is unknown). Inadequate data/unresponsive are instances in which the data provided by the employer on the employee is not correct or the employee has not responded/is unreachable.

It is important to note that the data is a point-in-time snapshot because an employee's disposition can change from unknown and inadequate data/unresponsive to known based on the outreach activities done by HSF dedicated staff at the San Francisco Health Plan (the program's third-party administrator.)

[23] The analysis is based on data from January 2008 (ESR implementation) to mid-September 2010. As a result, the number of employees designated as potentially eligible for HSF enrollment at 28,201 is greater than the 27,480 number as of June 30, 2010.

Table H2
Potential City Option HSF Eligible Employees by Disposition

HSF Eligibility Disposition	Number	Percentage
Known	11,310	40%
Unknown	5,227	19%
Inadequate Data/Unresponsive	11,664	41%
All Dispositions	28,201	100%

Of those employees with a known disposition (11,310):

- 48% (5,374) are enrolled in HSF,
- 45% (5,085) were determined ineligible for HSF and received a MRA, and
- 8% (851) indicated that they were not interested in HSF or MRA (if ineligible for HSF).

Of those employees with an unknown disposition (5,227), all received the HSF mailing discussing their employer's health care expenditure, outlining their potential eligibility for HSF and encouraging them to make a HSF eligibility determination and enrollment appointment. None of these employees responded to the mailing. When an employee fails to respond to the mailing, a live outreach telephone call is placed to the employee encouraging them to contact HSF to schedule an appointment to enroll in the program. The status of these calls is as follows:

- For 7% (352) the program made the live outreach call, the employee indicated interest in enrolling in HSF and the employee was transferred to the HSF enrollment center to make an eligibility determination and enrollment appointment.
- For 55% (2,875) the program has made the live outreach call (or left a voice mail message) and is waiting for the employee to respond and contact the program to make an HSF eligibility determination appointment.
- For 38% (2,000) the program is in the process of making live outreach calls to these individuals to discuss HSF, assess HSF interest and to facilitate scheduling a HSF eligibility determination and enrollment appointment.

If the findings from the known dispositions are any indication of the findings for the unknown dispositions, it is anticipated that 40 – 45% (2,100 – 2,400) of employees in the unknown HSF eligibility disposition category are likely eligible for a MRA.

As with those in the known and unknown HSF eligibility disposition categories, those employees in the inadequate data/unresponsive category (11,664) also received HSF materials in the mail. However, contact information for these individuals is either incorrect or the employee has not been reached. Specifically:

- 31% (3,594) are employees whose telephone and address information provided by the employer through the Employer Spending Requirement Portal is incorrect. Employers have been notified by the HSF program to provide updated or corrected contact information for these employees to ensure that the employees are informed of their potential HSF eligibility.
- 69% (8,070) are employees who are unreachable/unresponsive. Included in this category are employees who have not responded to any HSF mailings (the mail has not been returned

indicating a correct address) or live telephone inquiries (there are no indications that telephone number is incorrect). It is also possible that in this category are employees for whom the employer provided some incorrect information, but this cannot be verified since the employee has not responded to any outreach efforts.

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 (153 out of 1,126), the data indicate that:

- the majority of employers who have elected the City Option are either in the other services (26%), retail trade (16%) or professional/scientific/technical services (12%),
- 2% have fewer than 20 employees, 15% have 20 – 49, 12% have 50 – 99, 24% have 100 – 499 and 47% have 500 or more employees, and
- 87% are for profit, 12% are non- profit and less than 1% are public (i.e., publicly-traded since public entities are exempt from the ESR).

Table H2
City Option Employers by Industry Type

Count by Industry (***North American Industry Classification System*** code)	Number
Accommodation and Food Services (72)	70
Administrative & Support and Waste Management & Remediation Services (56)	6
Agriculture, Forestry, Fishing and Hunting (11)	2
Arts, Entertainment, and Recreation (71)	50
Construction (23)	18
Educational Services (61)	34
Finance and Insurance (52)	84
Health Care and Social Assistance (62)	66
Information (51)	23
Management of Companies and Enterprises (55)	3
Manufacturing (31-33)	21
Mining, Quarrying, and Oil and Gas Extraction (21)	2
Other Services (except Public Administration) (81)	254
Professional, Scientific, and Technical Services (54)	121
Public Administration (92)	3
Real Estate and Rental and Leasing (53)	27
Retail Trade (44-45)	153
Transportation and Warehousing (48-49)	16
Utilities (22)	3
Wholesale Trade (42)	17
Unreported	153
Total contributing employers	**1,126**

Table H3
City Option Employers by Company Size

Count by Company Size	Number
0-19 employees	19
20-49 employees	149
50-99 employees	120
100-499 employees	231
500+ employees	454
Not reported	153
Total contributing employers	**1,126**

Table H4
City Option Employers by Tax Status

Count by Tax Status	Number
For-profit	848
Non-profit	119
Public (Publicly-traded)	6
Not reported	153
All Contributing Employers	**1,126**

I. EVALUATION

This section discusses the formal evaluation of the Healthy San Francisco program.

In FY2009-10, the Department began its external program evaluation by retaining Mathematica Policy Research, Inc. The evaluation will help determine if HSF is achieving its goals to improve access to health services for uninsured adults in a non-health insurance model. 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.

Evaluator Activities

During FY2009-10, Mathematica undertook the following activities:

- Development and Presentation of HSF Evaluation Plan: Developed the HSF evaluation plan and participated in the evaluation kick-off meeting with Department staff. Met with and made presentations on the evaluation framework to the San Francisco Health Commission, the Department's Integration Steering Committee, HSF Advisory Committee, HSF Evaluation Committee and HSF Provider Work Group.

- HSF Site Visits: Conducted two series of in-depth stakeholder interviews/ site visits. The site visits were conducted with providers and other key stakeholders to help Mathematica gain the perspective of key HSF partners as it assesses how HSF is meeting its goals and objectives. In addition, Mathematic met/conferred with key staff providing administrative services for the HSF program (San Francisco Health Plan and Social Interest Solutions).

- HSF Evaluation Committee: Participated in the quarterly meetings of the HSF Evaluation Committee to obtain feedback on key aspects of the evaluations.

- HSF Pre-Post Analysis: Mathematica issued a memorandum indicating that a pre-post analysis for HSF could yield misleading results and, in some cases, erroneous conclusions. This was principally due to the following three issues: (1) utilization in the "pre" period was not a credible measure of patients' utilization in the absence of HSF, (2) the existence of data collection biases in the "pre" and "post" periods, and (3) limited statistical power. As a result, a pre-post analysis will not be a component of this evaluation.

- HSF Provider Survey: In conjunction with subcontractor Correy, Canapary & Galanis, Mathematica developed an on-line survey instrument for clinicians who treat HSF participants. The purpose of the survey was both to gauge provider perspective about the HSF program and to measure differences in care coordination activities across the medical homes. The survey was fielded from early May to late June 2010. Preliminary data indicates a 69% survey response rate.

- HSF Medical Home Model Assessment: Began initial work on an assessment of the HSF medical model. The assessment includes determining whether a primary care medical home model promotes improved and more efficient use of primary care and preventive services and, if so, is this for all enrolled populations.

- HSF Participant Focus Groups: Planned for conducting the first series of participant focus groups in FY2010-11. This series will be conducted with early HSF enrollees to glean findings on participant experience and satisfaction. The focus groups will be held in English, Chinese and Spanish.

Formative and Summative Reports

The following is a list of the various formative/topical reports that will be developed during FY2010-11:

- HSF primary care medical home model,
- provider participation and satisfaction,
- program participation rates, enrollment and disenrollment trends,
- differences in utilization patterns and
- assessment of lessons learned/program replicability.

The final summative evaluation report will highlight aspects from the various topical reports and will also discuss the program's impact on access, quality and costs, and financial sustainability. This report will be finalized in the beginning of fiscal year 2011-12 (i.e., July or August 2011). Key components of this report will be presented to the Health Commission in the Department's 2010-11 HSF Annual Report.

Lessons Learned Policy Brief

During the fiscal year, the Department retained a graduate student from the University of California at Berkeley, Goldman School for Public Policy to develop a policy brief on lessons learned from the development, planning and implementation of Healthy San Francisco.[24] The policy brief is a resource for other communities interested in developing more coordinated delivery systems.

Policy Brief: Lessons from Healthy San Francisco notes that HSF offers a model for improving access and the delivery of care to low-income uninsured individuals through the health care safety net. San Francisco's experience illuminates three important ways of strengthening the local health system:

- the program created a simpler, more transparent system of care to reduce barriers to needed services ("patient-centered reform"),
- the program restructured the county indigent health system to emphasize preventive care and continuity in primary care, rather than costly episodic and emergency care ("delivery system reform") and
- the program expanded access to care to all uninsured adult residents of San Francisco ("coverage expansion").

The policy brief states that policymakers will need to decide which of these health reforms is most important to pursue based on the local health needs, political will and resources of their communities.

The policy brief further notes that underlying San Francisco's health reforms is a set of conditions and circumstances, which made reform achievable at the local level. In addition to the political support for comprehensive reform, San Francisco had the advantages of a strong existing public health infrastructure, a unified local government and critical administrative partners. These factors both shaped and supported the policy development of the city's health care law. Finally, it notes that while many of San Francisco's reforms can be adopted in other jurisdictions, each policy will necessarily look different depending on the local context.

[24] This policy brief was written by Mr. Jacob Ackerman. The author conducted this study as part of the program of professional education at the Goldman School of Public Policy, University of California at Berkeley. The report was submitted in partial fulfillment of course requirements for the Master of Public Policy degree. The judgments and conclusions are solely those of the author and are not necessarily endorsed by the Goldman School of Public Policy, the University of California or by any other agency.

J. EXPENDITURES AND REVENUES

The Department does not maintain a separate budget division for Healthy San Francisco (HSF). 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.

The FY2009-10 Department costs and revenue calculations are estimates. In addition to providing the Department's estimated costs, this section also provides information on the estimated costs of non-Department private community HSF providers. The financial data that follows is comprised of the following components:

- estimated private community provider HSF expenditures,
- estimated system-wide HSF expenditures (all HSF providers -- Department and non-Department) and,
- estimated Department cost of care to indigent and uninsured persons (HSF and non HSF).

In summary, it is estimated that HSF expenditures totaled $163.9 million in FY 2009-10. Department HSF expenditures totaled $140.25 million in FY2009-10. Of that amount, $40.45 million in expenses were covered by revenue and $99.8 million was covered by a City and County General Fund subsidy. Private community HSF providers incurred $23.62 million in HSF expenditures (above and beyond the $11.45 million in Department reimbursement received by HSF medical homes to cover a portion of HSF costs).

With a total of 594,102 participant months in FY2009-10, the estimated total per participant per month expenditure was $276 ($163.9 million divided by 594,102) based on all estimated HSF expenditures. If the calculation is based solely on estimated Department HSF expenditures, the estimated per participant per month expenditure was $236 ($140.2 million divided by 594,102).

From FY2008-09 to FY2009-10, there was a:

- 41% increase (173,044) in HSF participant months,
- 11% increase ($3,913,961) in Department revenue,
- 12.6% increase ($15,718,435) in Department expenditures,
- 13.4% increase ($11,804,474) in City and County General Fund and
- 20.2% decrease ($60) in Department per participant per month expenditures.

The above comparison is limited to changes in Department expenditures and revenues because FY2009-10 was the first year that financial data from non-Department providers was available for analysis.

Overall, Department expenditures for uninsured individuals (those enrolled in HSF and those not enrolled in HSF) in FY2009-10 is estimated at $187.25 million.

Estimated Private HSF Provider Costs and Revenue of Serving HSF Participants

There are 16 other health entities that provide health care services to HSF participants in addition to the Department. These entities incur costs related to the provision of care. For FY2009-10, the Department requested expenditure and revenue information from these providers. This information was requested to ascertain, to the fullest extent possible, the total costs of providing services to uninsured HSF participants. Data was requested of the following entities:

Table J1
Requested Expenditure and Revenue Information from Private HSF Providers

Medical Homes	Hospitals
Chinese Community Health Care Association	California Pacific Medical Center
Kaiser Permanente (including hospital)	Chinese Hospital
San Francisco Community Clinic Consortium (8 clinics)	Saint Francis Hospital
	St. Mary's Medical Center
Sister Mary Philippa Clinic	UCSF Medical Center

Expenditure data was requested for all HSF participants served by the health system – both those that were a part of the medical home network and those that were not part of the network (e.g., provision of emergency services to a HSF participant that was not a member of a particular medical home/hospital affiliation). It is estimated that health services to HSF participants cost private HSF providers $23.6 million when Department reimbursement of $11.45 million to HSF medical home systems is subtracted.

Table J2
Estimated Expenditures of Private HSF Providers

Medical Home and Hospital Charity Care	2009-10 or 2009 Costs
California Pacific Medical Center	$1,084,857
CCHCA & Chinese Hospital	$2,204,557
Kaiser Permanente	$5,287,225
San Francisco Community Clinic Consortium (SFCCC)	$17,622,202
St. Mary's Medical Center (including Sister Mary Philippa Clinic)	$4,031,298
Saint Francis Hospital (including Glide Health Services specialty care)	$5,184,462
UCSF Medical Center[25]	$121,160
All Non-DPH Health Systems	$35,077,479
Less: Department Reimbursement to Medical Homes	($11,448,386)
Non-DPH Health System HSF Expenditures	$23,629,093

In examining the HSF private community provider expenditure data, it is important to underscore that there is no uniform mechanism for calculating HSF costs for these providers. Each health entity used its own established processes and procedures for estimating its costs and provided that information to the Department. In addition, some providers report costs on a calendar year, not fiscal year basis. As a result, the information will be for the January 2009 to December 2009 time period and not the July 2009 to June 2010 time period. For hospital providers, the Department used 2009 hospital charity care data

[25] The UCSF Medical Center expenditure amount is based on reported 2008-09 financial data provided by the hospital for 2009 charity care reporting purposes. The Department has developed a process to assist UCSF better identify HSF participants who receive services at its facilities.

unless the hospital provided other cost data.[26] The expenditure data combines the costs for medical homes and hospitals that are affiliated with that medical home respect to the provision of services for HSF participants.

Non-Department HSF medical homes receive reimbursement from the Department. It totaled $11.45 million in FY2009-10. Department funding to private HSF providers is not designed or intended to cover the entire costs of delivering care to HSF participants. The Department does not have sufficient funding to provide reimbursement at that level. In addition, prior to HSF, the majority of the HSF providers were providing services to their HSF participants, but through their specific sliding scale clinic programs for uninsured clients. To the fullest extent possible, HSF providers have worked to enroll their existing uninsured clients into the HSF program. Prior to HSF, with a few exceptions, these providers were not receiving City and County funding to provide services to their uninsured population.[27] Under HSF, these providers are now receiving some reimbursement for a population that they provided services to and previously received no City and County reimbursement for.

As noted in Table J2, non-Department providers incurred net expenses of $23.6 million. This reflects a financial contribution which private community providers cover using a variety of funding sources ranging from revenues to grants. Private community HSF providers did not consistently provide a revenue dollar value tied to their HSF expenditures and therefore this information is not provided in this analysis. In the case of hospitals and hospital-based medical homes, shortfalls are often covered by revenues paid by other payers that contract with the hospital. For SFCCC medical homes (eight clinics), the shortfall is covered by various revenue sources such as government and foundation grants, funding from State health programs, private donations and patient fees.

During FY2010-11, the Department will explore development of a HSF financial expenditure and revenue form for private community HSF providers to use to provide this information annually to the Department in a more consistent manner.

Total Estimated HSF Expenditures and Revenues

System-wide estimated HSF expenditures for FY2009-10 are estimated at $163.9 million as shown in Table J3. It includes estimated HSF expenditures for private providers and the Department. Because the Department expenditure calculation includes reimbursement to non-Department HSF medical home providers and to avoid potential double-counting of expenditures, the reimbursement amount was subtracted from the private community provider expenditure estimate. Expenditure detail is in Table J4.

Table J3
Estimated System-wide FY2009-10 HSF Expenditures (All HSF Providers) -- Summary

Delivery System	Estimated Cost
Total Department HSF Expenditures	$140,258,475
Private Provider HSF Expenditures	$35,077,479
Less: Department Private Provider Reimbursement	($11,448,386)
Private Provider Expenditures Above HSF Reimbursements	$23,629,093
All HSF Provider Expenditures	**$163,887,568**

[26] The charity care data is based on information provided to the Department by non-profit hospitals as of September 9, 2010.
[27] Haight Ashbury Free Clinic, Lyon-Martin Health Center and Mission Neighborhood Health Center had contracts with the Department to provide health services to medically indigent adults.

Table J4
Estimated Total Department and Non-Department HSF Expenditures (Fiscal Year 2009-10)

	2006-07[28]	2007-08	2008-09	2009-10
ENROLLMENT				
Total Participant Months	0	126,268	421,058	594,102
REVENUE				
General Fund	$4,866,402	$0	$0	$0
Health Care Coverage Initiative	$0	$8,136,224	$19,199,749	$22,855,381
Participation Fees	$0	$836,493	$3,208,577	$5,046,830
ESR (Employer Health Care Expenditures)	$0	$4,187,554	$18,236,251	$13,970,440
Reserve for Unearned Rev. (Enrollee & ESR)	$0	($1,046,889)	($4,559,063)	($1,563,176)
Philanthropic Grants (Evaluation)	$0	$0	$450,000	$140,000
TOTAL REVENUE	**$4,866,402**	**$12,113,382**	**$36,535,514**	**$40,449,475**
DPH EXPENDITURES				
Administration				
HSF Administration (including Evaluation)	$277,000	$0	$752,122	$697,757
Third-Party Administrator (SFHP)	$2,306,311	$3,039,107	$5,132,291	$6,180,527
Services				
Cost of Services (SFGH, Clinics, Pharmacy, UCSF)	$0	$38,030,229	$91,431,700	$97,374,760
Behavioral Health Services (Contractors, Pharmacy, CBHS)	$0	$2,183,284	$20,099,554	$23,440,070
Private Provider Reimbursement (incl. Ambulance)	$885,000	$2,153,255	$6,683,671	$11,516,867
Information Systems				
Eligibility/Enrollment System (One-E-App)	$693,091	$393,000	$240,702	$282,636
Siemens Information Technology	$705,000	$200,000	$200,000	$203,578
Capital				
Capital Project (Potrero Hill Health Center)	$0	$0	$0	$562,280
TOTAL DPH EXPENDITURES	**$4,866,402**	**$45,998,875**	**$124,540,040**	**$140,258,475**
NON-DPH EXPENDITURES				
Private Provider HSF Expenditures Less Medical Home Reimbursement ($11.45M)	--	--	--	$23,629,093
DPH AND NON-DPH EST'D HSF EXPENDITURES	**$4,866,402**	**$45,998,875**	**$124,540,040**	**$163,887,568**
ESTIMATED PER PARTICIPANT PER MONTH EXPENDITURE ($163.9M ÷ 594,102)	N/A	--	--	$276
DPH REVENUE LESS DPH EXPENDITURES = GENERAL FUND SUBSIDY ($140.25M - $40.45M)	N/A	($33,885,493)	($88,004,526)	($99,809,000)
DPH PER PARTICIPANT PER MONTH EXPENDITURE ($141.3M ÷ 594,102)	N/A	$364	$296	$236
DPH PER PARTICIPANT PER MONTH REVENUE ($40.4M ÷ 594,102)	N/A	$96	$87	$68
PER PARTICIPANT PER MONTH GF SUBSIDY ($100.9M ÷ 594,102)	N/A	($268)	($209)	($168)

[28] FY2006-07 was the start-up year for the program. No HSF enrollment occurred during this time period.

Participant months totaled 594,102 in FY2009-10 (i.e., the addition of the number of participants enrolled at the end of each month for the 12 month fiscal year). A "per participant per month" expenditure amount represents, on average, the cost of services utilized by a participant on a monthly basis. This cost recognizes that some participants will use services in any given month and that some will not. The estimated total per participant per month expenditure was $276 ($163.9 million in expenditures divided by 594,102 participant months). This represents all estimated costs and not just Department costs. Later in this section, the Department does a similar calculation for Department expenditures.

The FY2009-10 per participant per month cost of $276 cannot be compared to the FY2008-09 estimate of $296 because the FY2008-09 estimate reflected only Department expenditures. The Department did not have the systems in place to collect financial information from non-Department private community providers in FY2007-08 and FY2008-09.

Department Expenditures

Department expenditures totaled an estimated $140.2 million in FY2009-10. Department expenditures are categorized into the major categories of administration, services, information systems (IS) and capital. Key expenditures highlights are:

- service costs were 94% of total estimated Department expenditures at $132.2 million,
- administration was roughly 5% of total estimated Department expenditures at $6.88 million,
- capital and information systems were less than 1% of total estimated Department expenditures at $1.05 million.

A portion of Department expenditures reflects reimbursement for non-Department medical homes and emergency ambulance transportation ($11.5 million), incremental UCSF reimbursement for services rendered at San Francisco General Hospital ($5.1 million), and incremental behavioral health provider funding ($1.7 million).[29] This totaled an estimated $18.3 million in FY2009-10 or 14% of Department service costs.

Department Revenues

Non-General Fund revenues totaled $40.4 million. As noted in Table J1, it includes Health Care Coverage Initiative reimbursement, contributions from employers using the City Option to fulfill the Employer Spending Requirement, grants for the evaluation and participant fees (both participation and Department point-of-service fees). 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, 2010, approximately 31% of participants (16,781 participants) were at or above 101% of FPL. For the fiscal year ending June 30, 2010, the participant payment rate was approximately 77% with quarterly participation fees of $4.5 million received from participants and forwarded to the Department.[30] 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, 2010, the Department collected an estimated $537,000 in HSF point-of-service fees. The amount of point-of-service fees paid

[29] Note that the behavioral health services amount noted above reflects the budgeted incremental funding for behavioral health contractors and does not represent total funding provided to these contractors for serving HSF participants during FY2009-10. This is equally true for UCSF.
[30] 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.

by HSF participants to non-Departmental HSF providers is not known to the Department and is not included in the calculations. [31]

General Fund Subsidy

The difference between the expenditures and the revenue was covered by a City and County General Fund subsidy of approximately $99.8 million. It is represented as a negative number to show the shortfall between revenues and expenditures. The FY2009-10 General Fund subsidy represented a 13.4% increase over the FY2008-09 General Fund allocation.

Department Per Participant Per Month Costs

As noted above, there was a total of 594,102 participant months in FY2009-10. The estimated total Department per participant per month expenditure was $236 ($140.2 million in expenditures divided by 594,102 participant months). Of the $236 per participant per month cost, $68 (29%) was covered by revenue and $168 (71%) was covered by General Fund subsidy.

From FY2008-09 to FY 2009-10, there was a 20.2% decrease in Department per participant per month expenditures (from $296 to $236 -- a $60 reduction). Department per participant per month expenditures decreased with an increase in expenditures because the percentage increase in participant months (41%) was greater than the percentage increase in expenditures (12.6%) and resulted in the estimated total costs being allocated over more participants which results in a lower average costs.

Estimated Department 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 complete picture of the City and County costs of serving indigent and uninsured persons. It is estimated that the costs of providing services to this population was approximately $47 million for FY2009-10. As a result, the Department's total estimated cost of serving the indigent and uninsured in FY2009-10 is $187.25 million.

Table J5
Total Estimated Costs of Serving Indigent and Uninsured (Fiscal Year 2009-10)

Uninsured Patient Population	Estimated Cost
HSF Uninsured Population	$140,258,475
Non-HSF Uninsured Population	$46,995,131
Entire Uninsured Population	$187,253,606

[31] Non-departmental HSF medical homes/providers are not required to report or remit to the Department any point-of-services fees collected from HSF participants. Fees collected by the non-Department private community providers support the delivery of care at those medical homes.

III. 2010-11 Program Activities

For FY2010-11, in addition to general operational oversight and continued operation of the program, the Department will focus on the following activities (in alphabetic, not priority order):

- **City Option for ESR**: Ensure continued operation of the City Option and explore additional opportunities to enhance employee response to City Option materials (HSF or MRA).

- **Department-wide Activities**: Support and/or participate in a range of Department activities in that will affect HSF participants and other patient populations by improving access to care. These include, but not limited to:
    - implementation of the nurse advice line,
    - primary care enhancements within Community Oriented Primary Care and
    - behavioral health-primary care integration.

- **Encounter Data Submission**: Continue to work with all HSF providers on the submission of encounter data to the HSF Clinical Data Warehouse (including non-profit hospitals for HSF charity care data).

- **Evaluation**: Ensure that the independent evaluation proceeds according to the established scope of work and work to address participant challenges raised in the 2009 independent survey of participants.

- **Federal Health Reform**: Monitor local, regional, state and federal activities in the area of federal health reform that may affect the HSF program and its participants.

- **Health Care Coverage Initiative**: Ensure Department preparations for any expansion or modification in the Health Care Coverage Initiative.

- **Program Renewals**: Continue to improve on-time participant renewals by continuing the HSF renewal incentive program, instituting a new question in the Health Access Questionnaire regarding a participant's decision to renew, and working with Application Assistors in medical homes to test best practice renewal strategies.

- **Provider Network**: Expand the provider network to ensure sufficient access to care by strengthening and /or broadening the HSF provider network.

- **Quality Improvement**: Expand the Strength in Numbers program to focus of other chronic care populations in addition to those with diabetes. HSF will explore systemic avenues to address the reporting of colorectal screening and improve timely follow-up care after an inpatient discharge.

For FY2010-11, planning and program activities will be based on an estimated 79,000 uninsured adults as reported by the California Health Interview Survey in August 2010. The Department will use this updated estimate until the UCLA Center for Health Policy Studies releases the findings from the 2009 CHIS in winter 2010.

Appendix A – HSF Data Warehouse Data Collection Summary

	2008						2009												2010		
Submitting Medical Homes	July 08	Aug 08	Sept 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09	July 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10
CCHCA/Chinese Hospital			😐	😐	😐	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
DPH Clinics	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
Glide Health Services	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
Haight -Ashbury Free Medical Clinic	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
Kaiser Permanente													☺	☺	☺	☺	☺	☺	☹	☹	☹
Lyon-Martin Health Services	☹	☹	☹	☹	☹	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☹	☹
Mission Neighborhood Health Center	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
Native American Health Center	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☹	☹	☹	☹
Northeast Medical Services	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
Saint Anthony Free Medical Clinic	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
South of Market Health Center	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
Sr. Mary Phillipa Health Center			😐	😐	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺

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.

☹: No data available for program

Pharmacy Services Data Submissions

	2008						2009												2010		
Submitting Entity	July 08	Aug 08	Sept 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09	July 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10
CBHS	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
DPH	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
NEMS	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺

SFGH Hospital Data Submissions

	2008						2009												2010		
Submitting Entity	July 08	Aug 08	Sept 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09	July 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10
SFGH	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺

Non-SFGH Hospital Data Submissions for affiliations with Medical Homes or Provision of Other Services

	2008						2009												2010		
Submitting Entity	July 08	Aug 08	Sept 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09	July 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10
Chinese - CCHCA			😐	😐	😐	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
CPMC - NEMS						☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
Kaiser													☺	☺	☺	☺	☺	☺	☹	☹	☹
St Francis - Glide						☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
St Mary's – Sr Mary Phillipa						☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
UCSF -- Radiology						☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺

Charity Care Hospital Submissions

	2008						2009												2010		
Submitting Entity	July 08	Aug 08	Sept 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09	July 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10
Chinese													☺	☺	☺	☺	☺	☺	☹	☹	☹
CPMC													☺	☺	☺	☺	☺	☺	☺	☺	☺
Kaiser													☺	☺	☺	☺	☺	☺	☹	☹	☹
St. Francis													☺	☺	☺	☺	☺	☺	☺	☺	☺
St. Mary's													☺	☺	☺	☺	☺	☺	☺	☺	☺
UCSF													☺	☺	☺	☺	☺	☺	☺	☹	☹