Healthy San Francisco

Our Health Access Program

Annual Report to the San Francisco Health Commission (For Fiscal Year 2010-11)

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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.

Since its inception, the Department has enrolled over 100,000 uninsured residents into HSF – serving over 12% of San Francisco's population. This critical milestone was reached during FY 2010-11. The total number ever served by the program reflects both current enrollment and previous enrollment.

At the end of fiscal year 2010-11, 54,348 uninsured adult residents were enrolled in HSF. This constituted 85% of the estimated 64,000 uninsured adult residents. The program expanded access by adding two additional primary care medical homes providers and ended the 2010-11 fiscal year with 36 medical home sites.

Fiscal year 2010-11 clinical data suggests that HSF provides services in an effective manner and promotes the use of primary care:

- HSF participants utilize primary care at the same rate as the national Medicaid population – 3 office visits per year.
- The use of the ED for avoidable conditions (9%) remains lower than State's Medi-Cal average of 18% for adults.
- The HSF hospital readmission rate was 9% - below the national rate of 18%.

A two-year evaluation of HSF conducted by Mathematica Policy Research, Inc. found that:

> *"HSF is providing access to timely and coordinated primary care services to a population that greatly needs them. In general, HSF participants are very satisfied with their access to health care services. Overall, the results suggest that, even though the majority of these HSF participants were established patients in the HSF medical homes prior to enrolling, participating in the program alleviated financial and nonfinancial barriers to medical care for a large portion of enrollees. Most HSF participants are regularly receiving outpatient care at their medical homes, including recommended preventive services, and are using fewer ED services over time, both emergent and non-emergent, which suggests both improved care-seeking behavior and health status."*

The Department's estimated HSF expenditures totaled $149.6 million. Of that amount, $49.9 million was covered by revenue and $99.7 million was covered with a City and County General Fund subsidy. In addition, private community HSF providers incurred $28.1 million in net HSF expenditures. In total, estimated HSF expenditures totaled $177.7 million serving HSF participants in FY 2010-11. With a total of 654,129 participant months in FY2010-11, the estimated total per participant per month expenditure was $272.

San Francisco again received recognition for its innovative health care delivery model:

- Listed among the "Top 25 Innovations in Government" for 2010 by the Ash Center for Democratic Governance and Innovation at the John F. Kennedy School of Government, Harvard University,
- 2011 "Supporting The Safety Net Award Honorable Mention" by the Association for Community Affiliated Plans and
- 2011 "Joseph Mignola, Jr. Award" by Curry Senior Center.

II. 2010-11 PROGRAM ACTIVITIES

A. COMMUNICATIONS, OUTREACH, APPLICATIONS AND ENROLLMENT

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

HSF ended fiscal year (FY) 2010-11 with over 54,300 uninsured adult residents enrolled in the program, a 2% increase from the end of FY 2009-10. Based on the 2009 California Health Interview Survey (released in February 2011), the program is serving 85% of the estimated 64,000 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 process. Almost 2,000 residents obtained health insurance through this process. The program ended the fiscal year with approximately 45,900 individuals disenrolled. The Department enhanced activities to promote on-time program renewals in FY 2010-11. In total, since inception, HSF has provided access to care to over 100,000 uninsured adult residents (54,300 currently enrolled plus the 45,900 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 website had a total of 325,365 visitors during the year – an average of 27,100 monthly. 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, 548 people called 3-1-1 monthly for HSF information during FY2010-11 (total of 6,578 calls).

Applications

HSF enrollment starts with the trained Application Assistors (AAs). HSF has 176 AAs who assist residents in applying for the program at 32 different locations throughout the City. During FY2010-11, AAs processed over 56,600 applications through the web-based eligibility and enrollment system – One-e-App (see Table A1). As renewal, modify and re-enrollment applications become a larger percentage of total applications, there is a decrease in the percentage of new applications. In general, for any new application processed, a resident can be determined eligible for HSF or eligible for another program.

Table A1

Application Volume - Number of HSF Applications Processed (July 2010 – June 2011)

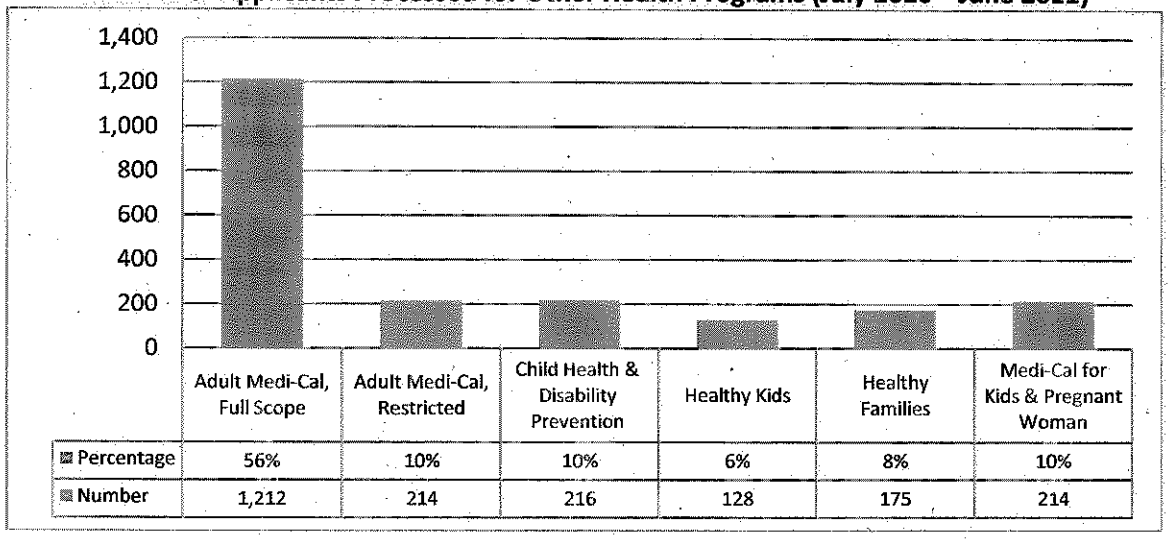
Distribution of One-e-App Applications by Type	# Applications	Average Household Size Applying
New	20,698	1.1
Renewal	21,540	1.2
Modified	14,384	1.2
	56,622	1.2

There are 60,566 unique applicants among the 56,622 applications. An individual can have more than one application in a fiscal year. For example: (1) a new application and a renewal or modified application or (2) a renewal application and a modified application. Of the 60,566 applicants, almost 96% were determined eligible for a health program (either HSF or another public program), 4% did not have an eligibility determination made and less than 1% were determined ineligible. An eligibility determination may not be made if the application is still in process or if the application is cancelled before a final eligibility determination is made. Ineligibility occurs if the applicant exceeds the income eligibility threshold, has health insurance or is not a San Francisco resident.

Of the applicants with an eligibility determination (96% or 57,868), 2,159 (almost 4%) were applicants for other programs. Graph A1 provides the distribution of applicants across the other health programs. Over three-quarters were determined eligible for Medi-Cal showing that HSF continues to be helpful in reducing the number of uninsured by identifying uninsured residents eligible for, but not enrolled in, public health insurance and facilitating enrollment into the appropriate program with use of One-e-App.

Graph A1

Number of Applicants Processed for Other Health Programs (July 2010—June 2011)



	Adult Medi-Cal, Full Scope	Adult Medi-Cal, Restricted	Child Health & Disability Prevention	Healthy Kids	Healthy Families	Medi-Cal for Kids & Pregnant Woman
Percentage	56%	10%	10%	6%	8%	10%
Number	1,212	214	216	128	175	214

Enrollments and Percentage of Uninsured

HSF is a voluntary program. As such, there is no expectation that all uninsured adults will enroll in the program. While the program is designed to facilitate enrollment to the greatest extent possible, it is inevitable that some uninsured adult residents will elect not to participate. According to the 2009 statewide California Health Interview Survey (CHIS) released in February 2011, there are an estimated

64,000 uninsured adults in San Francisco.[1] At the end of the fiscal year, there were 54,348 participants enrolled in HSF (85% of the estimated 64,000 uninsured adults in San Francisco). This is a 2% increase in enrollment compared to the end of FY2009-10 (53,400 participants). Since its inception in July 2007, HSF has served over 100,000 uninsured San Francisco adult residents – or over 12% of San Francisco's population – as noted in Table A2.

Table A2
Enrollment, Percentage of Uninsured Adults Enrolled and Ever Enrolled

Fiscal Year	Enrollment at end of FY	Estimated No. of Uninsured Adults	Enrolled as % of Uninsured Est.	Total Ever Enrolled at End of FY (Enrolled + Disenrolled)
2007-08	24,210	73,000	33%	25,269
2008-09	43,200	60,000	72%	59,698
2009-10	53,428	60,000	89%	80,565
2010-11	54,348	64,000	85%	100,237

Disenrollments

As noted above, there have been over 100,000 HSF program participants since July 2007. Of these, 54,348 are current participants, and 45,889 are former participants who are currently disenrolled from the program. At the end of the FY 2010-11, the HSF disenrollment rate was 46%.

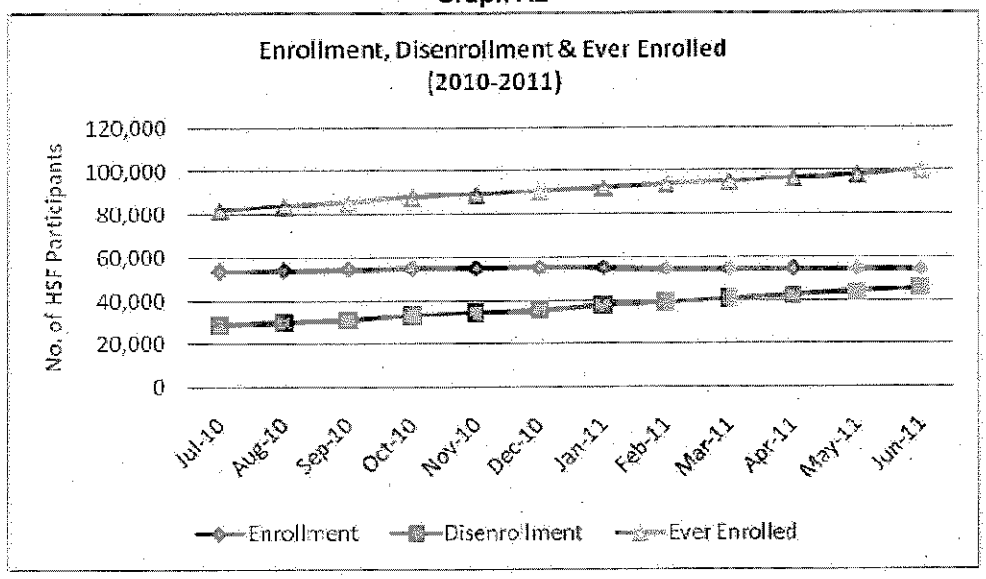
Table A3
HSF Disenrollment Rate

Total Ever Disenrolled	Less Disenrolled who Re-enrolled	Equals Currently Disenrolled	Add to this Currently Enrolled	Gives HSF Ever Enrolled	Disenrollment Rate = Currently Disenrolled ÷ Ever Enrolled
71,795	25,906	45,889	54,348	100,237	46%

As the number of participants enrolled into HSF continues to increase, the number of disenrolled increases as well. As more participants are enrolled, more are required to renew, and more may not because they no longer meet the program eligibility criteria, no longer choose to remain in the program and voluntarily disenroll, etc. The following graph shows the relationship over the past fiscal year.

[1] The University of California at Los Angeles' Center for Health Policy Studies has conducted the California Health Interview Survey (CHIS) survey since 2001. The survey is done every two years. The 2009 survey findings were released February 2011. 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).

Graph A2



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, participants receive notification of their disenrollment and can re-enroll after a disenrollment at any time without penalty.

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) without penalty, the Department expects that there will always be a certain level of enrollment mobility within the program.

At the end of the 2010-11 fiscal year, 45,889 HSF participants were currently disenrolled from the program. The current disenrollments are a result of the following reasons:

Table A4
Disenrollments By Reason

Current Disenrollments by Reason	***# Disenrolled***	***% of Disenrollments***
Program Eligibility	9,829	21%
Participation Fee	4,441	10%
Annual Renewal	31,417	68%
Other/Voluntary	202	<1%

1. *Disenrollments Due to Program Eligibility* (21% - 9,829 participants)

The data indicates that 21% of those who were disenrolled no longer met the HSF eligibility requirements. Of particular note, almost 70% of those were ineligible due to having obtained public or privately-funded health insurance as noted in Table A6.

Table A5
Program Eligibility Disenrollments

Disenrollment Reasons	*Number*	*Percentage*
Enrolled in Public Coverage	4,461	45%
Exceeds Program Age Requirements	2,190	22%
Enrolled in Employer-Sponsored Insurance	1,365	14%
Not a San Francisco Resident	875	9%
Determined Eligible for Other Programs During Renewal or Modification	551	6%
Enrolled in Private Insurance	387	4%

2. *Disenrollments Due to Participation Fee* (10% - 4,441 participants)

Disenrollments due to insufficient payment of the quarterly participation fee comprised 10% of program enrollments at the end of fiscal year 2010-11. These disenrollments were reflected in the following manner:

- Participant communicates that they could no longer afford the participation fee – 219 disenrollments
- Insufficient payment of the participation fee – 4,222 disenrollments

Disenrollment due to participation fee can occur for many reasons and may mask other disenrollment reasons. These disenrollments do not always indicate inability to pay. 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 disregard 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 eligibility – receipt of health insurance. For some people, participation fee disenrollment may represent the fact that they already received the services they needed.

The Department analyzed the utilization of services among those with a participation fee related disenrollment from the time period July 2007 to June 2011. It was able to do analysis on 2,586 (61% of 4,222) of these disenrolled individuals based on the fact that the individual sought services from the Department after disenrollment. These 2,586 had a total of 29,924 clinic visits/hospital days after a participation fee related disenrollment. Because there is no program penalty for re-enrollment after a disenrollment, the data documents that many of these individuals (85%) with participation fee disenrollments re-enrolled in HSF and received a health care service under HSF. As a result, it does not appear that the participation fee was a deterrent to continued program enrollment. In addition, another 14% of these individuals had the clinical care they received after a participation fee-related disenrollment paid for by health insurance. This provides data to support the notion that some disenrollments coded as "insufficient payment" are in actuality disenrollments due to obtaining health insurance. Table A6 provides the detail on the financial class data.

Table A6
Department Provided Health Care Services for 2,586 Individuals with a Participation Fee Related Disenrollments (Post Disenrollment)

Financial Class	# of Visits/Days	Percentage
Patient Pay	1	0.0%
Workers Compensation (CCSF)	10	0.0%
Private Health Insurance	12	0.0%
CMAP	32	0.1%
Not Recorded	292	1.0%
Public Health Insurance/Program	4,252	14.2%
Healthy San Francisco	25,325	84.6%
All Financial Classes	29,924	100.0%

HSF participants are informed at the time of application and in program materials that modifications to their application can be made at any time due to changes in San Francisco residency, household size and/or household income. These changes can also be processed at re-enrollment and at renewal. Changes in household size and/or household income may impact the applicant's federal poverty level. From 2007 to 2010, the 4,155 HSF participants had adjustments that resulted in a lower FPL group. The lowering of the FPL resulted in either (1) a reduction in the participation fee or (2) no participation fee at all. Table A7 provides the specifics.

Table A7
HSF Participants with a Lower FPL Group in a Later Application

Process Used to Adjust Participant Household Income	HSF Participants with a Lower FPL Group in a Later Application
Mid-Term Modification	1,608
Re-Enrollment	24
HSF Renewals	2,523
All	4,155

3. *Disenrollments Due to Incompletion of Annual Renewal* (68% -31,417 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.

Similar to what occurred in fiscal year 2009-10, the majority of disenrollments were due to failure to renew (68%). Of note, approximately 78% or 24,475 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.

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 FY2010-11, the Department augmented its renewal activities to reduce disenrollments due to failure to renew which are highlighted in the section entitled "Renewals" below.

4. *Disenrollments Due to Other Reasons* (<1% - 202 participants)
The remaining disenrollments are 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 Reasons	*Number*	*Percentage*
Program Dissatisfaction (admin, services, medical home, etc.)	111	55%
Participant is Deceased	60	30%
False or Misleading Information on HSF Application	31	15%

Renewals

During FY 2010-11, HSF Application Assistors processed over 21,500 applications for HSF participants renewing their eligibility for the program. Participants can complete the renewal application as early as 90 days prior to their current term. As noted above, failure to renew before the end of the HSF eligibility term is the primary reason for disenrollments. To promote on-time renewal, HSF:

- 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,
- contacts participants via an automated telephone call to encourage them to call their medical home to schedule a renewal appointment,
- enters all renewing participants who complete the renewal process on time into a lottery to win a $25 Safeway grocery store gift card and
- stresses the importance of renewing on time in each issue of *Heart Beat*, the HSF participant newsletter.

The HSF program tracks program retention rates on a monthly basis to inform retention improvement initiatives and program enrollment projections. These regular reports are distributed to HSF provider organizations to aid enrollment locations in monitoring site-specific retention trends and efforts.

The HSF retention rate target (i.e., on-time renewals) is 52.5%. The program defines retention as the percentage of those eligible to renew who complete renewal prior to term end. The retention rate was based on the live outreach calls to participants who had not yet renewed as of 30 days prior to term end. The calls revealed that a significant percentage (20% - 30%) of contacted participants did not intend to complete renewal because they no longer lived in San Francisco or had obtained health insurance (public or private). In addition, detailed data from the HSF evaluation conducted by Mathematica Policy Research, Inc. and discussed later is this report found that between 2008 and 2010:

- 58% of HSF participants completed on-time renewals,

- 12% did not renew but returned to re-enroll within one year and
- 30% did not renew and never re-enrolled.

In other words, retention is capped at 70% of all participants (i.e., 100% enrolled less 30% that do not renew or re-enroll). HSF's targeted renewal rate of 52.5% represents an ambitious goal of 75% (52.5% of 70%) of the participants who are likely to ever renew. As noted above, the HSF disenrollment rate is 46%. This leaves a HSF retention rate of 54% -- higher than that program's target of 52.5%.

In 2010-11, HSF implemented the following new program features to support program renewal:

- Targeted Case Management: HSF launched a case management initiative for participants in demographic groups with the lowest reported retention rates. During the fiscal year, this effort targeted two groups: (1) participants ages 18-25 and (2) African-Americans.
- HSF Retention Technical Assistance Pilot: In 2011, three HSF enrollment locations (Glide Health Services, Haight Ashbury Free Medical Clinic and Maxine Hall Health Center) received HSF retention technical assistance from experienced San Francisco Health Plan enrollment staff.
- Evaluation of Retention Initiatives: HSF added an additional question to the *Health Access Questionnaire* to ascertain the primary reason why participants come in to renew and to determine which of the program's retention initiatives influence renewal decisions.

Reenrollments

Individuals who are disenrolled from the program have the option to re-enroll at any time with no penalty or wait period. Since the inception of the program in July 2007, a total of 8,265 individuals who had been disenrolled from the program re-enrolled and were current participants at the end of the 2010-11 fiscal year.

Table A9
Re-enrollments by Original Disenrollment Reasons (July 2007 – June 2011)

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 & Reenroll*	*Avg. No. of Days of 0-60 Days*	*Avg. No. of Days for Those undue 365 Days*	*Avg. No. of Days for Those over 365 Days*
Program Eligibility	343	4.2%	11.4%	5.2%	37.9%	45.5%	375	26	143	652
Participation Fee Related	833	10.1%	16.1%	14.5%	47.9%	21.5%	234	30	118	657
Incomplete Renewal	7,073	85.6%	39.5%	15.2%	33.6%	11.7%	134	22	76	567
Other	16	0.2%	25.0%	6.3%	31.3%	37.5%	286	23	90	614

The data indicates that the initial disenrollment reasons for the majority of re-enrollments were incomplete annual renewal (86%). 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.

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 2011), 8,768 individuals have had at least two disenrollments. Table A10 provides information on their current enrollment status.

Table A10

Enrollment Status of Individuals with Multiple Enrollments and Disenrollments as of June 30, 2011

	No. of Participants	% of Total Multiple
Currently Enrolled	2,388	27.2%
Currently Disenrolled	6,380	72.8%
Total	8,768	100.0%

Of the 6,380 participants with multiple disenrollments, who were disenrolled as of June 30, 2011

- 5,759 had two disenrollments,
- 588 had three disenrollments and
- 33 had four disenrollments.

The analysis below examines those who had two disenrollments or 5,759 disenrollments. The disenrollments are grouped by disenrollment type as noted in Table A11. The data indicates that the majority of HSF participants with two disenrollments were disenrolled for failure to renew, program eligibility or other reasons (79%), 18% 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.

Table A11

Churn Analysis of Multiple Disenrollments -- Those with Two Disenrollments (July 2007 – June 2011)

Disenrollment Reasons	*Number*	*Percent*
Two Failure to Complete Renewal Disenrollments	3,397	59%
One Failure to Renew Disenrollment & One Participation Fee Disenrollment	1,052	18%
One Failure to Renew Disenrollment & One Program Eligibility	755	13%
Two Program Eligibility Disenrollments	231	4%
Two Participation Fee Related Disenrollments	179	3%
One Program Eligibility Disenrollment & One Participation Fee Disenrollment	125	2%
Two Other Disenrollments or One Disenrollment Coded Other & One Disenrollment Coded Another Reason	20	0%

B. PARTICIPANT DEMOGRAPHICS

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 FY2009-10 and FY2010-11. It continues to serve a low-income, older and ethnically-diverse community. be There was an increase in the percentage of participants who identify as Asian/Pacific Islander, a decrease in the percentage of participants who indicate their preferred language is English and a decrease in the percentage of the population at or below 100% of the Federal Poverty Level (FPL).

Participant Demographics

The following provides demographic data on the 54,348 participants enrolled at the end of FY2010-11:

Table B1
Demographics for HSF Participants

Age	9% are 18-24; 42% are 25-44; 23% are 45-54; 26% are 55-64
Ethnicity	41% Asian/Pacific Islander; 24% Latino; 19% Caucasian; 7% African-American; 3% Other; 1% Native American; 5% Not Provided
Gender	48% Female; 52% Male
Income	66% at/below 100%FPL; 24% between 101-200% FPL; 8% between 201-300% FPL; 2% at/above 300% FPL
Language	51% English; 27% Cantonese/Mandarin; 18% Spanish; 1% Vietnamese; 1% Filipino (Tagalog and Ilocano); 2% Other

Over the course of the fiscal year, the Department observed the following demographic trends.

Table B2
Changes/Trends in HSF Participant Demographics (FY2009-10 to FY2010-11)

Age:	Slight increase in percentage of participants aged 55-64 – from 24% to 26%. All other age groups remained stable over the course of the fiscal year.
Ethnicity:	Increase in the percentage of Asian/Pacific Islander – from 38% to 41%. Slight decrease in the percentage of African Americans – from 9% to 7%.
Gender:	Stable distribution in enrollment by gender.
Income:	Slight decrease in the percentage of participants with incomes at/below 100%FPL – from 69% to 66%.
Language:	Slight increase in the percentage who indicate English as their preferred language – from 53% to 51%

The Department does not collect demographic information on an applicant's immigration status, employment status and/or pre-existing medical conditions 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.

HSF Participant Demographics Relative to General Uninsured Adult Population

The Department routinely examines the California Health Interview Survey (CHIS) to determine if those enrolling in HSF resemble the overall uninsured adult population. The 2009 CHIS results were released in February 2011. In summary, the gender distribution between CHIS and HSF are similar, HSF has an older and lower-income population, and both CHIS and HSF reflect a racially diverse uninsured community. Specifically, the data reveals the following:

- Age: The data reveal that both CHIS and HSF have the same percentage of uninsured between the ages of 18 – 24 (9%), that there were more 25 – 54 years in the CHIS survey and in HSF's population (81% in CHIS compared to 65% in HSF) and that HSF has an older population with a higher percentage aged 55 – 64 (HSF at 26% versus CHIS at 9%).

- Ethnicity: Ethnicity data in CHIS is based on the Department of Finance/OMB race/ethnicity categories with information for the following: African-American, Asian-American, Latino and White. The data reveals a similar distribution for Whites (19% for both CHIS and HSF), more Latinos (36% CHIS compared to 24% HSF) and African-Americans (14% CHIS compared to 7% HSF) in CHIS and fewer Asian-Americans in CHIS (31% CHIS compared to 41% HSF).

- Gender: HSF's population has a similar distribution to the CHIS survey population. According to the CHIS data, 53% of uninsured San Francisco adult residents are male (34,000) and 47% are female (30,000). This is similar to HSF with 52% male and 48% are female.

- Income [Federal Poverty Level (FPL)]: The data suggests that HSF is enrolling a more low-income population. CHIS records indicate 16% (10,000) of uninsured San Francisco adult residents have incomes below 100% FPL and 84% (54,000) are above 100% FPL.[2] HSF data shows 66% of its participants fall below 100% FPL and 34% are above 100% FPL.

- Language: Because CHIS asks about language spoken at home and allows respondents to indicate more than one language, the comparison to HSF is not exact. This being noted, in comparison to CHIS, a slightly smaller percentage of HSF participants consider English as their primary language (51% HSF compared to 53% CHIS), roughly the same indicate Spanish as their primary language (18% HSF compared to 17% CHIS), more consider Chinese to be their primary language (27% HSF compared to 16% CHIS) and fewer indicate another language (4% HSF compared to 15% CHIS).

HSF Population – New versus Existing

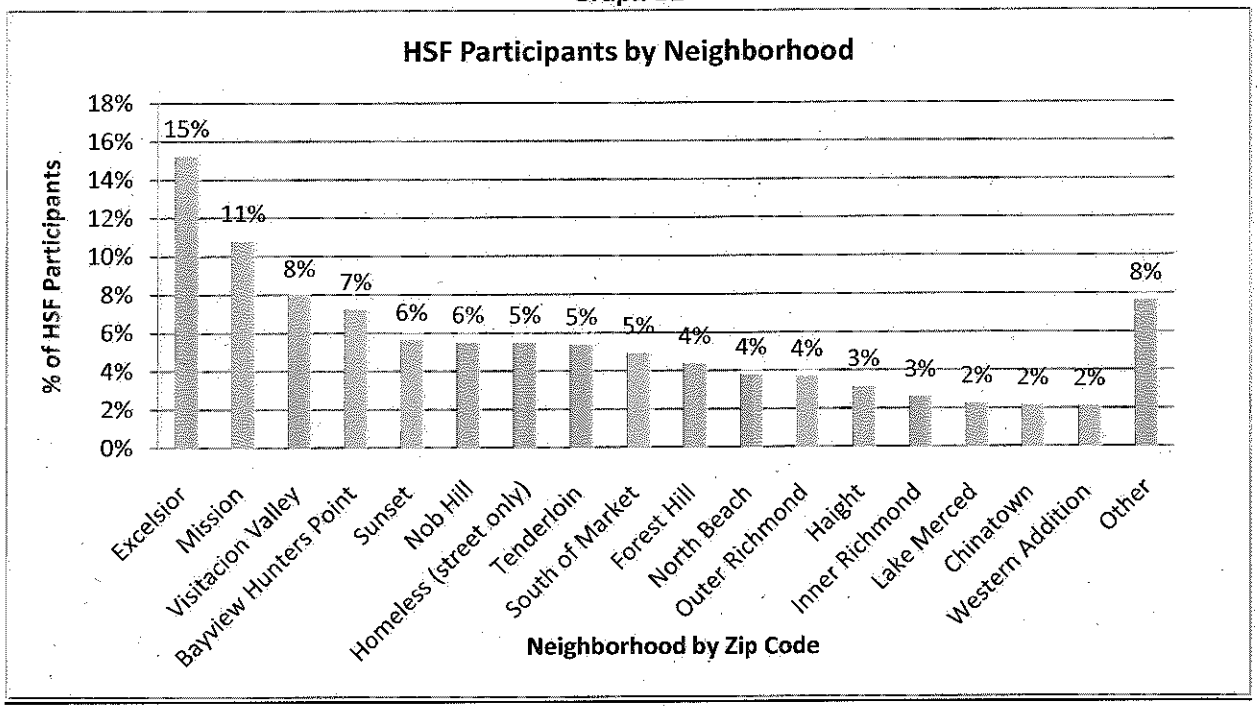
At the end of the FY2010-11 fiscal year, 80% of those enrolled were existing safety net patients (indicated that they had a previous visit, within two years, to a HSF medical home prior to enrollment). The remaining 20% were "new" – defined as an individual who self-reported that they had not received clinical services within the last two years from the primary care medical home they selected as part of the HSF application process). It is important to note 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.

[2] CHIS records indicate 16% (10,000) of uninsured San Francisco adult residents have incomes below 100% FPL, 50% (32,000) are between 100% – 200% FPL, 17% (11,000) are between 200% – 300% FPL, 3% (2,000) are between 300% – 400% FPL and 14% are above 400% FPL.

Neighborhood Distribution

HSF participant distribution by neighborhood highlights the geographic dispersion of enrollment. The City's Excelsior and Mission neighborhoods collectively represent roughly 26% of all participants. Homeless individuals comprise 10% of all HSF participants (street, shelter and doubled-up). Included in the "Other" category are the Castro-Noe Valley, Twin Peaks, Treasure Island, West Portal, Marina and other neighborhoods .

Graph B1



C. PROVIDER NETWORK (DELIVERY SYSTEM)

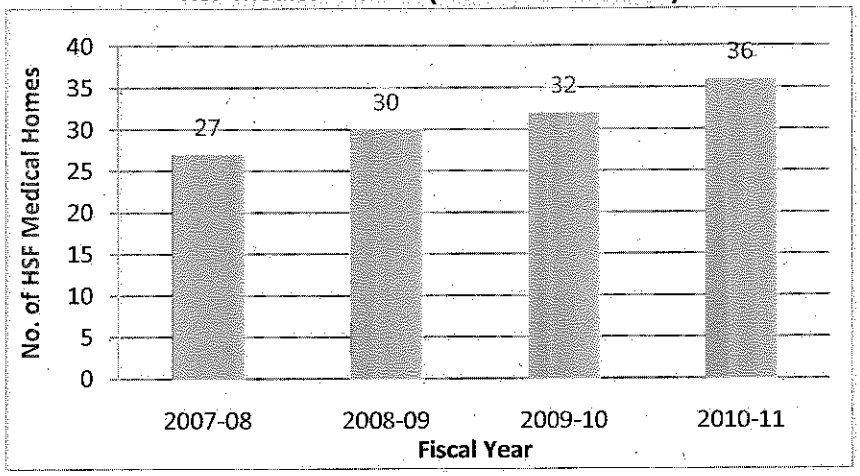
This section of the report describes the HSF delivery system (e.g., medical homes, hospitals, etc.)

During the FY2010-11, HSF further solidified the public/private provider partnership with the addition of Brown & Toland Physicians and BAART Community HealthCare as medical homes. HSF medical homes increased from 32 to 36 during FY2010-11. During the fiscal year, at any one time, 68% of the medical homes were open to accepting new participants. 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.

2010-11 Provider Network Expansions

HSF ended the FY2010-11 with 36 medical homes – a 13% increase from fiscal year 2009-10.

Graph C1
HSF Medical Homes (2007-08 to 2010-11)

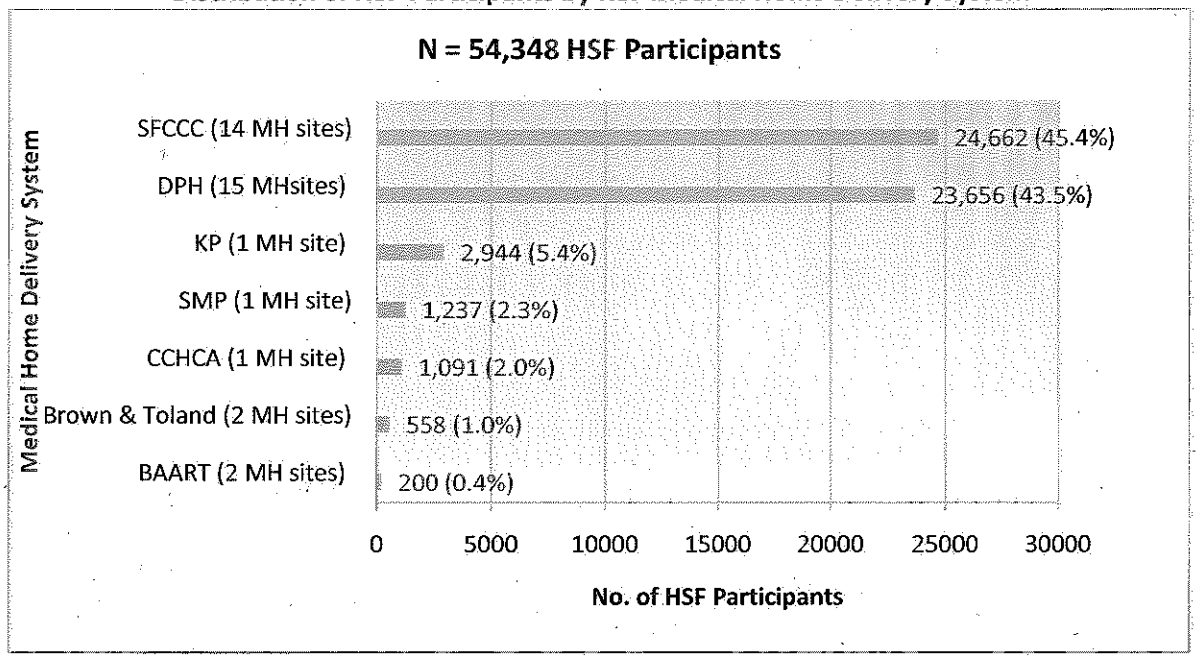


In October 2010, BAART Community HealthCare joined the HSF provider network. BAART provides primary and preventive care. BAART has two medical home sites. In December 2010, Brown & Toland Physicians – California Pacific Medical Center (CPMC) joined the HSF provider network. Through this partnership, Brown & Toland-CPMC provides primary, preventive, emergency, specialty, diagnostic, pharmacy and inpatient services. Brown & Toland-CPMC is a private practice model with individual practitioners who serve as medical homes at two medical office locations.

Medical Home Distribution

At the time of enrollment, HSF participants select a medical home. The primary care medical home is where participants receive all of their primary care and preventative care 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. HSF had a total of seven delivery systems at the end of the 2010-11 fiscal year: BAART Community HealthCare, Brown & Toland Physicians – California Pacific Medical Center, Chinese Community Health Care Association – Chinese Hospital, Department of Public Health, Kaiser Permanente Medical Center San Francisco, San Francisco Community Clinic Consortium (SFCCC) affiliated clinics and Sister Mary Philippa Health Center.

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



During FY 2010-11, the Department approved the transition of 120 HSF participants from Lyon Martin Health Services (SFCCC affiliated), to two other SFCCC affiliated medical homes (Glide Health Center and South of Market Health Center) after Lyon Martin's January 2011 announcement that it was on the verge of clinic closure. Lyon Martin, the Department, SFCCC and the San Francisco Health Plan (SFHP) worked collaboratively to reduce the clinic's HSF participants by transitioning participants with non-urgent clinical needs to the other medical homes. In addition, SFHP transferred other HSF participants from Lyon Martin who requested medical home transfers in light of the clinic's announcement.

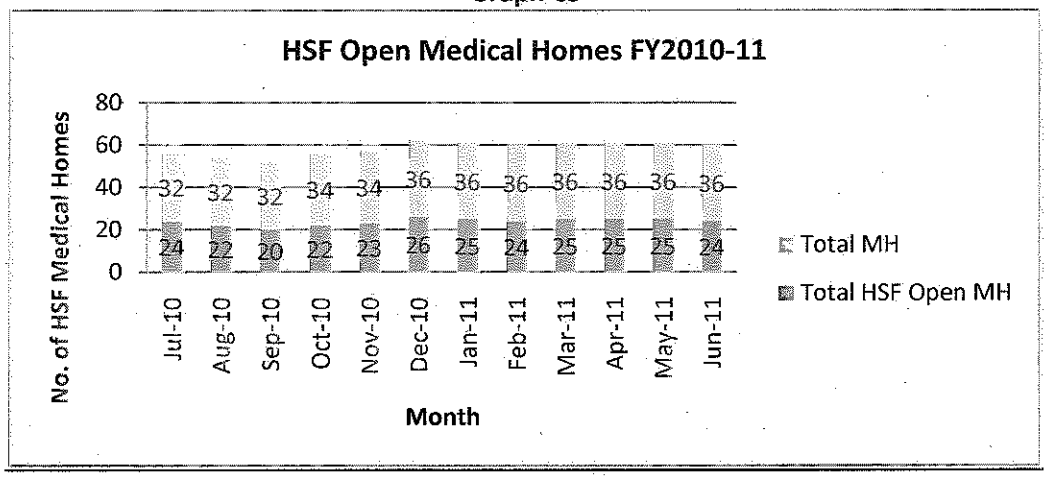
Medical Home Capacity

Each of the private HSF medical home delivery systems has a targeted number of HSF participants that it will serve in any given fiscal year. The private medical home delivery system determines the targeted HSF enrollment, not the Department.

To ensure that there is sufficient capacity to serve both new and existing HSF participants the HSF program tracks each medical home's capacity (i.e., "open/closed" status) twice a month. HSF medical home open/closed status is determined primarily by appointment availability. A HSF medical home is considered "open" 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.[3] During the FY2010-11, on average, 24 (68%) of all HSF medical homes were open to new HSF participants at any given time as noted in Graph C3. It's important to note that the total number of medical homes increased over the course of the fiscal year from 32 at the beginning of the 2010-11 to 36 by the end of the 2010-11 fiscal year.

[3] 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.

Graph C3



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. Table C1 provides a summary of SFGH services provided to each HSF delivery system and their HSF participants.

Table C1

San Francisco General Hospital Services Provided to Medical Home Delivery System

HSF Medical Home Delivery System	SFGH Services Provided to Non DPH Medical Homes
San Francisco Department of Public Health	Specialty, urgent care, diagnostic, emergency care, home health, pharmacy, durable medical equipment (DME), and inpatient services
BAART Community HealthCare	Specialty, urgent care, diagnostic, emergency care, home health, DME, inpatient
Brown & Toland Physicians/CPMC	Home health, urgent care clinic
Chinese Community Health Care Ass'n	None
Glide Health Services (SFCCC affiliated)	• Home health, DME, inpatient, urgent care clinic • Specialty, emergency and/or diagnostic services not available via affiliation with Saint Francis Memorial Hospital
Kaiser Permanente Medical Center	Home health
North East Medical Services (SFCCC affiliated)	• Home health, DME, emergency care, urgent care clinic • Specialty and/or diagnostic services not available at medical home
Six San Francisco Community Clinic Consortium (SFCCC affiliated) clinics: • Haight Ashbury Free Health Center • Lyon Martin Health Services • Mission Neighborhood Health Center • Native American Health Center • South of Market Health Center • St. Anthony's Medical Clinic	Specialty, urgent care, diagnostic, emergency care, home health, pharmacy, DME, and inpatient services
Sister Mary Philippa Health Center	• Home health, inpatient (obstetrics) • Specialty, diagnostic, emergency care, family planning services, gynecological surgeries not available via affiliation with St. Mary's Medical Center

In addition to SFGH, nonn-profit hospitals continue to play a vital role in HSF through the following mechanisms:

- California Pacific Medical Center (4 campuses) – (1) inpatient services to those with North East Medical Services as their medical home and (2) inpatient and hospital-based outpatient services to those with Brown & Toland Physicians as their HSF medical home,
- Chinese Hospital – partners with Chinese Community Health Care Association (CCHCA) to provide the full scope of primary care, specialty and inpatient services to those with CCHCA as the HSF medical home,
- Saint Francis Memorial Hospital (Catholic Healthcare West) – inpatient and other specialty services to those with Glide Health as the HSF medical home,
- St. Mary's Medical Center (Catholic Healthcare West) – inpatient and other specialty 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.

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 or may not be the hospital associated with their medical home.

Behavioral Health Services

While most of the HSF medical homes (32 out of 36) provide some form of either mental health assessment, mental health services or substance abuse screening, the Department provides all contracted behavioral health services for HSF participants at all of the medical homes – both its own and the private providers.

Specifically, HSF program offers mental health, and alcohol and drug abuse care. HSF participants have access to the comprehensive array of community-based services offered by Community Behavioral Health Services (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. HSF participants have access to these confidential services from either their HSF medical home or health care professionals at CBHS.

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 (Department or non-Department), then a primary care provider can refer the participant to CBHS for care. In addition, HSF participants do not need a referral from their HSF medical home provider to access services from CBHS – they can call CBHS directly and self-refer.

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, 2011, HSF Provider Relations received a total of 81 provider inquiries.[4] All 81 inquiries were processed and 100% were resolved within 60 days, the program's standard.

There was a decrease in provider inquiries from the previous fiscal year which may reflect better understanding of the program because of the various provider and medical resources that have been created and disseminated (e.g., Network Operations Manual, Location of Services grid, newsletter articles, etc.). The majority of inquiries pertained to "other" and program policy. Other inquires includes those not related to the major categories noted below in Table C2. Examples of program policy inquires include participant enrollment cap, service authorizations, HSF provider network, participant medical home changes, etc.

The following table lists the number of inquiries by category.

Table C2
Provider Inquiries by Category (2010-11)

Category	Total # of Inquires	% of Total Inquiries
Access Issue	3	4%
Coverage Interpretation	7	9%
Enrollment Issue	1	1%
Other	34	42%
Pharmacy	9	11%
POS Fees	2	2%
Program Policy	25	31%
Quality of Care	0	0%
Quality of Service	0	0%
Total	**88**	**100%**

[4] Provider Relations started tracking provider inquiries in January 2009. From January 2009 to June 2009 there were 43 inquiries. In fiscal year 2009-10, there were 88 provider inquiries.

D. DELIVERY SYSTEM IMPROVEMENTS AND QUALITY IMPROVEMENT 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 2010-11, HSF participated in and/or co-funded several efforts to improve primary care delivery systems these include Strength in Numbers, Optimizing the Primary Care Experience and Patient-Centered Communication all of which documented improvements in patient care.

Quality Improvement Program

The HSF Quality Improvement Program promotes preventive health services, improves the quality of chronic care, facilitates the HSF Quality Improvement Committee, and provides quality and utilization data reporting. Key stakeholders impacted by the HSF Quality Improvement Program are participants, HSF providers and provider groups, the Department and the San Francisco Health Plan, as third-party administrator. Functions handled by the HSF Quality Improvement Program include:

- monitor and improve HSF participant clinical outcomes and access through Strength in Numbers,
- improve HSF participant access to medical appointments through the Patient Access Pilot,
- improve participant experience and quality of care through the Patient Communications Pilot Program,
- facilitate provider and medical group input for program improvement through the HSF Quality Improvement Committee,
- reduce emergency department usage and inpatient admission through the Patient Navigator Program and
- manage and monitor participants' clinical complaints.

Strength in Numbers

Strength in Numbers Program 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. Medical homes that provide care to at least 350 HSF participants are eligible to participate in the program. Medical homes are required to work on improving clinical outcomes in certain chronic conditions and met specified clinical care measures. Strength in Numbers provides financial incentives and technical assistance to medical homes in order to accelerate the integration of chronic care disease registries and based on meeting improvement thresholds over baseline.

The 2009-10 Strength in Numbers ended in December 2010 and achieved the following outcomes:

- A total of 24 medical homes participate in the program, representing 95% of HSF participants.

- Aggregated medical homes' self-reported data showed improvement for most clinics in all four diabetes measures:
    - 56% of clinics improved in A1c testing from baseline
    - 75% of clinics improved in A1c poor control from baseline
    - 63% of clinics improved in LDL testing from baseline

- 75% of clinics improved in LDL good control from baseline

- Aggregated medical homes' self-reported data demonstrated that more clinics reached the program's thresholds in three out of the four diabetes measures:
  - A1c testing – 56% reached the 85% testing threshold compared to 44% at baseline
  - A1c poor control – 100% reached the threshold of 29% compared to 69% at baseline
  - LDL testing – 23% reached the threshold of 85% compared to 13% at baseline

- Sixteen medical homes attended an 8- hour training on health coaching and panel management in 2009 and 2010 where:
  - 87% stated that they would recommend the course to colleagues
  - Significant improvements in knowledge and skills following the training
  - A six-plus month post survey revealed that over 50% of the clinics had integrated health coaching and panel management into their clinics

Strength in Numbers 2011 was launched in January 2011 and included the following changes:

- SFHP contributed to the program budget for the first time in 2011.
- Program measure definitions are more standardized for all participating medical homes.
- The formula for judging improvement has been standardized using a formula for Relative Improvement, across the board.
- Changes in the incentive payments to promote continued focus on measures and ensures the maximum overall potential for payments for each medical home.

The measures set for Strength in Numbers 2011 include the following clinical and operations measures:

Required Measures

1. HbA1c Testing
2. HbA1c in Good Control (under 8)
3. HbA1c in Poor Control (over 9)
4. LDL Testing
5. LDL Less than 100
6. Blood Pressure Electronic Documentation
7. Colorectal Cancer Screening
8. Smoking Status Documentation
9. Appointment Show Rate
10. Third-Next Available Appointment (TNAA)

Optional Measures

11. Breast Cancer Screening (mammography)
12. Chronic Pain Patients with Annual Pain Management Assessment
13. Continuity of Primary Care
14. Hepatitis B Vaccination in high-risk population
15. Depression Screening Documentation
16. HIV+ Patients with 1 or more CD4 Count Tests in 6 months

Patient Experience Pilots with Nine HSF Medical Homes

During fiscal year 2009-10, the San Francisco Health Plan (SFHP) launched a two year-long learning collaborative aimed at improving two key dimensions of the patient experience: communication and timely access to care. HSF contributed financially to these efforts and all of the participating clinics were part of the HSF provider network. The access collaborative "Optimizing the Primary Care Experience (OPCE)" focused primarily on improving access to primary care appointments and had four community clinics participating. The communication collaborative "Patient-Centered Communication (PCC)" focused on enhancing the provider/staff patient relationship and had five community clinics participating.

The projects demonstrated that the combination of expert training and practice coaching were able to significantly improve measures of access and patient experience for the nine clinic sites. Half of the access clinics cut wait times by more than 50%, even as their average panel size grew during the intervention year. In 12 months, clinics achieved the following outcomes:

Table D1
Results from Patient Experience Pilots

Optimizing the Primary Care Experience (OPCE)	Patient-Centered Communication (PCC)
Methodology: The clinics used the count of days until the Third-Next Available Appointment (TNAA) as the measure for appointment access, and took the average for all providers as the value for the clinic overall. For the final result, the average of the final four weeks' TNAA data was used to help account for TNAA variation week to week.	Methodology: Using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) primary care visit survey three times over the course of the project, with the third survey fielding period 10 months after the initial baseline fielding period.
Results: • Chinatown Public Health Center reduced delay by 81% (from 28 days to 5.3 days) • Lyon-Martin Health Services by 33% (from 12 days to 8 days) • Maxine Hall Health Center by 58% (from 44 days to 18.7 days) • Southeast Health Center by 38% (30 days to 18.6 days)	Results: At second survey, the five clinics showed improvement from baseline in all provider communication and composite measures, staff communication and composite measures, and in global measures such as overall rating of provider and recommending clinic to family and friends. Third survey demonstrated sustained improvements in most measures and a statistically significant improvement in willingness by patient to recommend. Eight of 12 measures showed a positive absolute change, one remained flat, and three measures declined slightly. Participating Clinics: • Castro Mission Health Center • Family Health Center at SFGH • Mission Neighborhood Health Center • Silver Avenue Family Health Center • St. Anthony Free Medical Clinic

Patient Navigator Program

San Francisco Health Plan (SFHP), Healthy San Francisco, and Saint Francis Memorial Hospital (SFMH) collaborated on a Patient Navigator Pilot Program. The program was designed as a pilot, to test the hypothesis that putting a full-time navigator in a hospital-based emergency department would increase the ability of patients to access primary care follow-up appointments, and keep the appointments. The over-arching goal was to decrease over-use of the emergency room for primary care sensitive conditions. A 12-month assessment of the program determined that while the program was successful in many ways, it did not warrant continuation. Although the program is ending in its current form, the program sponsors will work together to find ways to continue its successes and accomplishments through alternative models.

The navigator screened over 4,029 patients for navigation. A total of 1,403 primarily contacts occurred. Of the total number of patients screened (4,029), 689 patients met program criteria and gave their verbal consent to participate in the services of the Patient Navigator Pilot Program. Essentially 17% for the population seen by the navigator were eligible for services.

Of the 689 eligible patients, 90% (621) entered through the hospital's emergency department and 10% (68) entered through inpatient services. With respect to those entering via the emergency department (ED), it's unclear if the cases were appropriate or inappropriate ED visits. Navigation activity on the 689 cases included coordination of follow-up care, referrals and medical appointment verification. Of note, the outcomes of the medical appointment verification assistance (for 280 patients) were that 54% (15) kept their appointment, 27% did not show for their appointment and 20% rescheduled or cancelled their appointment.

Demographically, the majority of patients who participated were men (67%) with housing (71%). Only 6% (42 of 689) were repeat contacts. In terms of health care coverage, 44% (305) were insured and 56% (384) were uninsured. Of those 384 uninsured patients, 21% (143) were enrolled in HSF – with 19% (27) having Glide Health Services as their medical home and 81% (116) having another HSF medical homes. SFMH is the designated hospital for HSF participants with Glide as their medical home. The remaining 241 had no health access program of any kind. Of those eligible for HSF, all were encouraged and referred to enroll in HSF by the navigator. Of those referred, 28% (67) completed HSF enrollment.

The Patient Navigator Pilot Program created a culture shift – medical homes became willing to see patients in urgent care follow-up even if the HSF participant had not yet had their first clinical visit at the primary care medical home. While the program had many successes, a combination of factors led to the decision to discontinue the program, including, but not limited to, the number of patients navigated was relatively low, and the fact that SFHP and SFMH were not contracting together.

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.

Consistent with previous years, 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.[5] 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 utilize primary care at the same rate as the national Medicaid population – 3 office visits per year.
- HSF data shows that emergency department (ED) utilization is lower than the State average.
- The use of the ED for avoidable conditions (9%) remains lower than State's Medi-Cal average of 18% for adults.
- The HSF readmission rate was 9% - below the national rate of 18%.
- Timely follow-up after an inpatient discharge remained relatively constant from FY2009-10 to FY2010-11.
- 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 70% compared to the National Medicaid Average of 77%, and the percent of diabetics getting LDL (cholesterol) testing is slightly less than the National Medicaid Average, at 68% 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%.

As the Department has noted in the past, analysis of service utilization is dependent upon having complete data from all HSF providers – hospitals and medical homes. For this report, over 90% of the hospital data comes from San Francisco General Hospital. While all non-profit hospitals have provided clinical data on HSF participants, the Department believes that the data may be incomplete. Therefore, emergency department visits, inpatient admissions, hospital days, and surgical procedures are likely underreported for FY2010-11 leading to low rates of utilization in these clinical areas. This was also the case for FY2008-09 and FY2009-10.[6] In addition, inpatient stays may be artificially low in the last reporting segment (April 2010 to March 2011) due to longer processing times used by non-profit hospitals for submission of clinical data. It is anticipated that the number of inpatient days will increase as remaining encounter data is processed. Finally, a few of the private HSF medical homes did not consistently provide clinical data on a monthly basis during FY2010-11.

[5] Information with respect to participant perception of health services received is contained in Section II.F of this report.

[6] For FY2008-09 and FY2009-10 Healthy San Francisco Annual Report, 95% and 93.5% of the hospital data was generated by SFGH, respectively.

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 2011. For FY2010-11, the analysis allows for a three month lag for data completion. Therefore, the analysis does not use actual data for the months of April 2011 to June 2011. The data has been trended comparing 12 months of actual data from July 2008 to June 2009, 12 months of actual data from July 2009 to June 2010, and 9 months of actual data from July 2010 to March 2011. The FY2010-11 data has been annualized for 12 months for comparative purposes.

SFHP monitors HSF submissions by service category and total submissions received by provider on a monthly basis. See Attachment A. 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. In FY2010-11, over 90% of institutional service data was from San Francisco General Hospital which strongly suggests underreporting of HSF encounter level data is occurring at the private hospitals.

In addition, at any given time, a non-profit hospital could provide charity care services to a HSF participant. In FY2009-10, the Department worked with hospitals to receive utilization data on this population. While data has been received from each hospital system in FY2010-11, for some hospital systems, the data has not been consistently submitted and may not capture all of the services provided. The Department will continue to work collaboratively with the non-profit hospitals to get a better understanding of the charity care service utilization among the HSF population.

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

Rate of Chronic Conditions

Utilization across medical homes is in large part determined by the health status of the population. Data from the independent program evaluation of HSF conducted by Mathematica Policy Research, Inc. (Mathematica) found significant variation in the percentage of HSF participants with chronic conditions across medical homes. Chronic conditions are defined as HSF participants with diabetes, asthma, hyperlipidemia and/or hypertension.

Table E2
Rate of Chronic Conditions Across Medical Homes

	Number	All MHs	DPH	SFCCC	NEMS-SFCCC	CCHCA	Kaiser	SMP
No chronic conditions	22,374	37.3%	33.0%	41.1%	42.3%	27.0%	60.0%	35.0%
One chronic condition	12,195	20.3%	19.0%	21.4%	22.4%	17.0%	17.0%	23.0%
Two or more chronic conditions	25,439	42.4%	48.0%	37.5%	35.3%	56.0%	23.0%	42.0%
	60,008	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

CCHCA had the highest percentage of participants with chronic conditions – at 73%. This is not too surprising given the fact that it has an older population. Chronic conditions were less prevalent in HSF participants with Kaiser as their medical home – at 40%. Within Department clinics, the range of HSF participants with two or more chronic conditions ranged from 21% (Cole Street Clinic) to 76% (Curry Senior Center) with almost half (7 of 15) of its clinics having 50% or more of their HSF participants with two or more chronic conditions. A little more than one-third of SFCCC's HSF participants have two or more chronic conditions. Neither BAART Community HealthCare nor Brown & Toland Physicians – CPMC were medical homes during the time period in which Mathematica examined the clinical data.

Summary of Key Utilization

The data reveals that overall primary/specialty care, inpatient admissions and prescription drug utilization declined slightly for HSF participants who were continuously enrolled in the program. The declines in utilization from 2009-10 to 2010-11 could be due to a number of factors including improved health status.

Table E3
Summary of Utilization Data

	April 2009 - March 2010			April 2010 - March 2011		
	No. of Participants Continuously Enrolled	No. of Participants Utilizing at Least One Service	Percentage	No. of Participants Continuously Enrolled	No. of Participants Utilizing at Least One Service	Percentage
Primary / Specialty Care	27,169	20,488	75.41%	34,486	25,263	73.26%
Inpatient Admission	27,169	655	2.41%	34,486	536	1.55%
Prescription	27,169	13,011	47.89%	34,486	15,691	45.50%

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 for both those with and without chronic conditions. 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' average office visits decreased slightly in 2010-11 to 3.02 per participant per year (Table E4). However, the office visit rate is still consistent with the National Medicaid Average of 3 visits per year (National Health Statistics Reports, DHHS (2009); Centers for Medicare and Medicaid Services).

Table E4
Average Office Visits (Including Well Visits) Per Participant (All Participants)

Data periods	Office Visits	Participant Months	Avg. Visits	Variance
Jul 08 - Jun 09	122,643	436,014	3.38	N/A
Jul 09 - Mar 10 (annualized)	125,581	453,326	3.32	-1.51%
Apr 10 - Mar 11	173,807	681,221	3.06	-7.90%

When examining the office visit rate of participants with chronic conditions the data shows a rate of 4.83 average office visits per year (Table E5). The data suggests that the ambulatory care utilization rate for HSF participants with chronic conditions is similar to the U.S. rate with an average of 5 visits per year for patients with chronic conditions (Division of Health Care Statistics, U.S. Department of Health and Human Services, 2009).

Table E5
Average Office Visits (Including Well Visits) Per Participants with Chronic Conditions

Data Periods	Office Visits	Participant Months	Avg Visits	Variance
Jul 08 - Jun 09	65,329	152,251	5.15	
Jul 09 - Mar 10	67,231	152,285	5.30	2.89%
Apr 10 - Mar 11	78,702	195,554	4.83	-8.84%

Table E6 displays the information contained in Table E4 by medical home system.

Table E6
Average Office Visit Utilization by System

Medical Home System	July 2008 - June 2009	July 2009 - March 2010	April 2010 - March 2011	Last 2 Year Variance
BAART	N/A	N/A	1.18	N/A
Brown & Toland	N/A	N/A	2.06	N/A
CCHCA	3.82	4.08	4.23	3.7%
DPH	3.62	3.56	3.50	-1.7%
Kaiser	N/A	2.06	2.01	-2.4%
SFCCC	3.01	3.07	2.64	-14.0%
SMP	4.53	3.62	3.65	0.8%
Total	**3.38**	**3.32**	**3.06**	**-7.8%**

With the exception of medical homes affiliated with the San Francisco Community Clinic Consortium, which witnessed a 14% decrease in utilization, and Chinese Community Health Care Association, which experienced an almost 4% increase in utilization, most medical homes experienced little change in the average number of office visits per year. Both BAART and Brown & Toland did not join the HSF provider network until fall 2010 and therefore have no variance to calculate. Because 45% of HSF participants have a SFCCC medical home, a significant change in utilization within this medical home will have a substantial effect on the overall utilization rate, in this case a reduction.

Almost 27% of HSF participants did not have an office visit after twelve months of continuous enrollment. This is a slight rise in comparison to calendar year 2009.

Table E7
Office Visit Frequency (Including Well Visits)

	Jan 2008 - Dec 2008		Jan 2009 - Dec 2009		Jan 2010 – Dec 2010	
Office Visit	Participants Continuously Enrolled	Percent	Participants Continuously Enrolled	Percent	Participants Continuously Enrolled	Percent
No Office Visit	1,935	24.73%	5,578	23.78%	8,823	26.55%
1-4 Office Visits	3,324	42.48%	10,413	44.38%	15,585	46.89%
5-9 Office Visits	1,802	23.03%	5,489	23.40%	6,472	19.47%
10+ Office Visits	763	9.75%	1,981	8.44%	2,357	7.09%
Total Participants	7,824	100.00%	23,461	100.00%	33,237	100.00%

The Department cannot reliably use HSF utilization data 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 18% of women receiving mammograms, and 22% of women receiving cervical cancer screening, it is highly likely that the actual screening rate is much higher. The data shows 50% of women and 37% of men aged 51 and above received colorectal cancer screening (Tables E8 and E9). The National Medicaid benchmark for these services is 55% for colorectal cancer screening.

Table E8
Percentage of Women's Health Preventive Screening
(shaded areas show incomplete data due to use of other public programs)

	July 2008 – March 2011			
Women's Preventive Screening	Numerator (Participants Received Screening)	Denominator (Eligible Participants)	Percentage	National Medicaid Average
Cervical Cancer	6,065	28,182	21.52%	64.80%
Colorectal Cancer	5,846	11,733	49.83%	54.50%
Mammogram	2,962	16,740	17.69%	50.00%

Table E9
Percentage of Men's Preventive Screening for Colorectal Cancer

July 2008 – March 2011				
Men's Preventive Screening	Numerator (Participants Received Screening)	Denominator (Eligible Participants)	Percentage	National Medicaid Average
Colorectal Cancer	4,469	11,933	37.45%	54.50%

Improving colorectal cancer screening rates is a priority for the 2011 Strength in Numbers Program as noted in Section D of this annual report. 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 inpatient admission, emergency department visits, and visits to physician offices for routine office visits, consultations, and preventive well visits.

As noted above, over 90% of the hospital data comes from San Francisco General Hospital and there is likely underreporting from the participating private hospitals. As a result, the decreases witnessed in utilization of hospital-based services (in particular, inpatient admissions and emergency department visits) may be low and may not be a complete representation of utilization within this population.

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 decreased from FY2009-10 to FY2010-11.

Emergency Department

Utilization of the emergency department (ED) for HSF participants is 149 per 1,000 participants for all hospitals and 191 per 1,000 participants for those with a Department medical home. In both cases, the utilization of ED is low compared to the State average of 275 visits per 1,000 (Henry J Kaiser Family Foundation, State Health Facts, 2008).

Table E10
ED Visits Per 1,000 Participants Per Year

Data Period	ER Visits	Participant Months	ER Visits/1,000	Variance to Previous Period
Jul 08 - Jun 09	6,006	436,014	165.30	N/A
Jul 09 - Mar 10	6,310	453,326	167.03	1.05%
Apr 10 - Mar 11	8,440	681,221	148.67	-10.99%

Table E10A
ED Visits Per 1,000 Participants Per Year (DPH Medical Home Only)

Data periods	ER Visits	Participant Months	ER Visits/1,000	Variance to Previous Period
Jul 08 - Jun 09	4,247	238,267	213.89	
Jul 09 - Mar 10	4,121	228,430	216.49	1.21%
Apr 10 - Mar 11	5,109	320,521	191.28	-11.65%

Consistent with previous years, the top four diagnostic categories for emergency department (ED) visits were: (1) respiratory systems, (2) abdominal symptoms, (3) general symptoms and (4) other cellulitis and abscess. The ED visit rates show that 91% of HSF participants had no emergency room visit.[7]

Table 11
ED Visit Frequency

	January 2009 – December 2009		January 2010 – December 2010	
ER Visit	Participants Continuously Enrolled	Percentage	Participants Continuously Enrolled	Percentage
No ER Visit	21,075	89.83%	30,218	90.92%
1-4 ER Visits	2,299	9.80%	2,897	8.72%
5-9 ER Visits	65	0.28%	96	0.29%
10+ ER Visits	22	0.09%	26	0.08%
Total Participants	23,461	100%	33,237	100%

The data indicates homeless participants were more likely to have 3 or more ED visits (3.91%) than a housed participant (0.54%) and men were more likely to also have three or more ED visits (1.36%) compared to women (0.60%). Finally, participants with chronic conditions utilize the emergency room more frequently than those without chronic conditions (172 visits per 1,000 participants compared to 139 visits per 1,000 participants).

Avoidable Emergency Department Rate

The avoidable emergency department rate for HSF was 9% (Table E12) using conditions defined by the "Medi-Cal Managed Care ER Collaborative Avoidable Emergency Room Conditions." This rate is below the average for both San Francisco Health Plan (15%) and California's Medi-Cal average for adults (18%).

Table E12
Average Avoidable ED (AER) Rate

Data Period	AER Visits	Total ER Visits	AER Rate	Variance to Previous Period
Jul 08 - Jun 09	559	6,006	9.31%	N/A
Jul 09 - Mar 10	577	6,310	9.14%	-1.75%
Apr 10 - Mar 11	720	8,440	8.53%	-6.71%

Ninety-nine percent (99%) of participants did not access emergency department care for avoidable conditions (Table E13). Of those that did use the emergency room for avoidable conditions, the top diagnostic categories were: headache, lumbago, urinary tract infections and acute unspecified upper respiratory infections.

[7] This analysis uses data from HSF participants who were continuously enrolled during the 12-month period.

Table E13
Avoidable ED (AER) Visit Frequency

AER Visit	January 2009 – December 2009		January 2010 – December 2010	
	Participants Continuously Enrolled	Percentage	Participants Continuously Enrolled	Percentage
No AER Visits	23,136	98.61%	32,855	98.85%
AER Visits 01-02	318	1.36%	378	1.14%
AER Visits 03-04	4	0.02%	4	0.01%
AER Visits 05+	3	0.01%	0	0.00%
All Participants	23,461	100%	33,237	100%

Hospitalization

Data showed continued decreases in hospital utilization for HSF participants between FY2009-10 and FY2010-11:

- Hospital admissions decreased 31% for the entire population (Table E14) and 29% for those with a Department medical home (Table E14A). But, the data indicate that HSF participants with a Department medical home have higher hospital admission rates which are consistent with high levels of chronic conditions within the population.
- Acute hospital days per 1,000 participants decreased 37% (Table E15).
- Average length of stay decreased 8% (Table E16).
- Ninety-eight percent of those continuously enrolled do not have a hospital admission (Table 17).

HSF participants' hospital utilization is lower than for SFHP Medi-Cal's population with 55.68 hospital discharges per 1,000 members, 219.6 hospital days per 1,000 members and an average length of stay of 3.94 days. (Measurement Year 20109, Tiermed Database, San Francisco Health Plan).

Table E14
Acute Hospital Admissions Per 1,000 Participants Per Year

Data periods	Acute Admissions	Participant Months	Acute Admissions/1,000	Variance to Previous Period
Jul 08 - Jun 09	1,123	436,014	30.91	N/A
Jul 09 - Mar 10	1,085	453,326	28.72	-7.07%
Apr 10 - Mar 11	1,119	681,221	19.71	-31.37%

Table E14A
Acute Hospital Admissions Per 1,000 Participants Per Year
(Participants with Department Medical Home ONLY)

Data periods	Acute Admissions	Participant Months	Acute Admissions/1,000	Variance to Previous Period
Jul 08 - Jun 09	830	238,267	41.80	N/A
Jul 09 - Mar 10	727	228,430	38.19	-8.64%
Apr 10 - Mar 11	724	320,521	27.11	-29.03%

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

Data periods	Acute Days	Participant Months	Acute Days/1,000	Variance to Previous Period
Jul 08 - Jun 09	5,420	436,014	149.17	N/A
Jul 09 - Mar 10	4,151	453,326	109.88	-26.34%
Apr 10 - Mar 11	3,954	681,221	69.65	-36.61%

Table E16
Acute Hospital Average Length of State (ALOS)

Data periods	Admits	Acute Days	ALOS	Variance
Jul 08 - Jun 09	1,123	5,420	4.83	N/A
Jul 09 - Mar 10	1,085	4,151	3.83	-20.73%
Apr 10 - Mar 11	1,119	3,954	3.53	-7.64%

Hospital admissions for HSF participants continuously enrolled is low at 2% (Table E17). The data reveals that the top three diagnoses for hospitalization are cellulitis/abcess leg, alcohol withdrawl and pneumonia. This was consistent with last year's data.

Table E17
Hospital Admissions Frequency

	Jan 09 - Dec 09		Jan 10 - Dec 10	
Acute Days	Participants Continuously Enrolled	Percentage	Participants Continuously Enrolled	Percentage
No Admissions	22,909	97.65%	32,590	98.05%
1-4 Admissions	540	2.30%	628	1.89%
3-4 Admissions	10	0.04%	17	0.05%
5+ Admissions	2	0.01%	2	0.01%
Total Participants	23,461	100.00%	33,237	100.00%

Pharmacy

Pharmacy utilization provides valuable insight into the health status of HSF participants. Pharmacy utilization for those with chronic conditions is significantly higher than for those without these conditions. While pharmacy utilization for those with chronic conditions has decreased, utilization for those without chronic conditions increased from FY2009-10 to FY2010-11.

Table E18
Average Prescriptions for Participants with Chronic Disease Compared to Other Participants

	Data periods	Total Prescriptions	Participant Months	Average Prescriptions	Variance to Previous Period
With Chronic Disease	Jul 08 - Jun 09	158,446	152,251	12.49	
	Jul 09 - Mar 10	141,930	152,285	11.18	-10.44%
	Apr 10 - Mar 11	173,483	195,554	10.65	-4.81%
Without Chronic Disease	Jul 08 - Jun 09	65,186	283,763	2.76	
	Jul 09 - Mar 10	49,778	301,041	1.98	-28.02%
	Apr 10 - Mar 11	90,874	485,667	2.25	13.16%

Consistent with the prevalence of chronic conditions in the population, the top 10 prescriptions by drug class in FY2010-11 were:

1. Cardiovascular - Other Antihypertensives
2. Cholesterol Lowering Agents
3. Diabetic Agents
4. Antidepressant Agents
5. Blood Pressure
6. Cardiovascular - Beta-blockers
7. Narcotic Analgesics
8. Respiratory/Asthma Agents
9. Dermatological Agents
10. Anti-inflammatory Analgesics

Surgical Procedures

Surgical procedures (both inpatient and outpatient) are more often performed for those with chronic disease. At the same time, there was decreased utilization in surgical procedures from FY2009-10 to FY2010-11, although decreases in outpatient procedures per 1,000 participants were minimal (Table E19).

Table E19
Inpatient and Outpatient Surgical Procedures Per 1,000 Participants Per Year for Chronic Disease Compared to Other Participants

Disease	Data Period	IP Surgical Procedures	OP Surgical Procedures	Participant Months	Inpatient Proc/1,000	Inpatient Variance	Outpatient Proc/1,000	Outpatient Variance
With Chronic Disease	Jul 08 - Jun 09	542	4,413	152,251	42.72		347.82	
	Jul 09 - Mar 10	440	5,269	152,285	34.67	-18.84%	415.20	19.37%
	Apr 10 - Mar 11	423	6,725	195,554	25.96	-25.14%	412.67	-0.61%
Without Chronic Disease	Jul 08 - Jun 09	800	5,833	283,763	33.83		246.67	
	Jul 09 - Mar 10	748	6,765	301,041	29.82	-11.87%	269.66	9.32%
	Apr 10 - Mar 11	722	10,602	485,667	17.84	-40.17%	261.96	-2.86%

Behavioral Health

Mental health and substance abuse service utilization increased for both those with and without a chronic disease from FY2009-10 to FY2010-11. Mental health utilization is significantly higher than substance abuse utilization. It is unclear how much of the increase witnessed in FY2010-11 was due to increased demand for services or improved data collection with the July 2010 implementation of Avatar within Community Behavioral Health Services.

Table E20
Average Mental Health Visits Per Participant (CBHS and Encounter Data)

	Data periods	Mental Health Visits	Participant Months	Average Visits	Variance to Previous Period
With Chronic Disease	Jul 08 - Jun 09	14,548	152,251	1.15	
	Jul 09 - Mar 10	12,321	152,285	0.97	-15.33%
	Apr 10 - Mar 11	17,374	195,554	1.07	9.81%
Without Chronic Disease	Jul 08 - Jun 09	35,404	283,763	1.50	
	Jul 09 - Mar 10	30,960	301,041	1.23	-17.57%
	Apr 10 - Mar 11	55,403	485,667	1.37	10.92%

Table E21
Average Substance Abuse Visits Per Participant

	Data periods	Substance Abuse Visits	Participant Months	Average Visits	Variance to Previous Period
With Chronic Disease	Jul 08 - Jun 09	4,901	152,251	0.39	
	Jul 09 - Mar 10	3,197	152,285	0.25	-34.78%
	Apr 10 - Mar 11	5,909	195,554	0.36	43.93%
Without Chronic Disease	Jul 08 - Jun 09	13,313	283,763	0.56	
	Jul 09 - Mar 10	9,433	301,041	0.38	-33.21%
	Apr 10 - Mar 11	19,241	485,667	0.48	26.43%

Quality of Care

This section provides statistics on readmission rates and quality of care provided to participants. The 30-day HSF readmission rate was 9% in FY2010-11, and the rate of diabetics and asthmatics getting recommended care are within the range of the insured population.

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 30-day readmission rate of 9% is lower than the 18% national rate of hospital readmission within 30 days (AHRQ). While there was an increase (19%) in the readmission rate within 30 days of discharge, there were decreases in the rates for 31 – 60 (15%) and 61 – 90 days (11%) after discharge.

Table E22
Readmission Rate 30, 60 and 90 Days

	Data Period	Readmissions	Total Admissions	Readmission Rate	Variance to Previous Period
01-30 Days	Jul 08 - Jun 09	85	1,123	7.57%	
	Jul 09 - Mar 10	72	1,085	6.64%	-12.33%
	Apr 10 - Mar 11	88	1,119	7.86%	18.51%
31-60 Days	Jul 08 - Jun 09	40	1,123	3.56%	
	Jul 09 - Mar 10	33	1,085	3.04%	-14.61%
	Apr 10 - Mar 11	29	1,119	2.59%	-14.79%
61-90 Days	Jul 08 - Jun 09	21	1,123	1.87%	
	Jul 09 - Mar 10	23	1,085	2.12%	13.36%
	Apr 10 - Mar 11	21	1,119	1.88%	-11.47%

The data also indicates that the follow-up office visits within 30 days of discharge have remained stable over the last three report periods (Table E23) at 68% to 69% for all participants. For those with chronic

disease, the rate was 76% (a 4% increase from the previous year) and for those without chronic disease it was essentially unchanged at 64.5%. The Center for Medicare and Medicaid Services reports that in a Medicare beneficiary claim study, 50% of patients readmitted within 30 days of discharge did not have a bill for a physician visit between hospital discharge and readmission. The national average from National Committee for Quality Assurance (NCQA) for outpatient follow-up following discharge is 86%. However, NCQA bases this percentage on those with mental health admissions which would not be a comparable baseline.

Table E23
Follow-Up Office Visits Within 30 Days of Discharge

	Data Period	Follow-Up Office Visit	Total Discharges	Rate	Variance to Previous Period
All Participants	Jul 08 - Jun 09	762	1,123	67.85%	
	Jul 09 - Mar 10	746	1,085	68.76%	1.33%
	Apr 10 - Mar 11	772	1,119	68.99%	0.34%
With Chronic Disease	Jul 08 - Jun 09	384	532	72.18%	
	Jul 09 - Mar 10	381	519	73.41%	1.70%
	Apr 10 - Mar 11	329	432	76.16%	3.74%
Without Chronic Disease	Jul 08 - Jun 09	378	591	63.96%	
	Jul 09 - Mar 10	365	566	64.49%	0.83%
	Apr 10 - Mar 11	443	687	64.48%	-0.01%

HEDIS Measures

To assess the quality of care provided to HSF participants, the Department monitors 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 70% compared to the national Medicaid average of 77%, and the percent of diabetics getting LDL (cholesterol) testing is slightly less than the National Medicaid Average at 68% compared to 71% (Table E24). 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 E25).

Table E24
Percentage of Diabetic Care Tests Compared to Medicaid

January 2010 – December 2010				
Diabetic Care Test	Numerator (Participants Received Test)	Denominator (Eligible HSF Participants)	HSF Percentage	National Medicaid Average
HbA1c	2,507	3,589	69.85%	77.40%
LDL	2,456	3,589	68.43%	70.90%

Table E25
Percentage of Asthma Controlled Tests Compared to Medicaid

January 2010 – December 2010				
Asthma Test	**Numerator (Participants Received Medication)**	**Denominator (Eligible HSF Participants)**	**HSF Percentage**	**National Medicaid Average**
Medication	555	674	82.34%	86.90%

Out of Network Utilization

HSF is based on the premise that participants receive their care through a network of providers affiliated with the medical home they have selected. HSF requires the selection of a medical home by the applicant at the time of program enrollment to help ensure that the participant has a usual source of care and to minimize episodic care. At the same time, in the first few years of the program, the Department recognized that it was not entirely reasonable to expect or witness system-wide affects of participant behavior in the beginning years. Changes in health seeking behavior (e.g., emergency department utilization) due to system changes take time, perhaps two to three years to observe.

Out-of-network utilization provides some perspective on whether participants are seeking care appropriately. Out of network can be defined in many ways, for the purposes of this report, it is defined as a HSF participant's receipt of services by a medical home or hospital that is not affiliated with their medical home. For this annual report, the Department examined hospital-based emergency department (ED) utilization within the HSF population with a specific focus on where a HSF participant received this care.

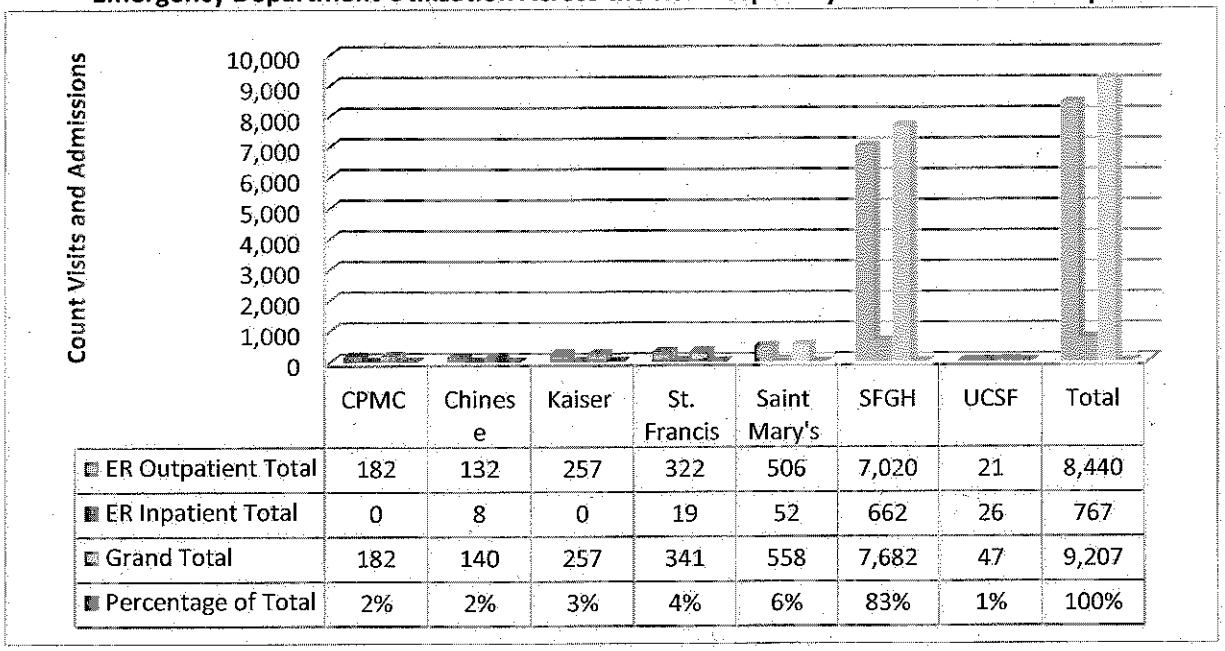
This is the Department's first analysis of utilization data in this manner and the analysis is somewhat crude because it examines solely the location where the service was received and not the type of clinical service provided. For example, while each medical home has a designated inpatient facility, HSF participants may receive ED services at other hospitals for 911 related emergencies which transport individuals to the nearest ED with capacity, irrespective of the HSF participant's medical home-hospital affiliation. In such cases, utilization of a non-affiliated hospital for an emergency may be appropriate and justified. At the same time, it is possible that a HSF participant may seek services at a hospital unaffiliated with its medical home due to the proximity of the hospital and the HSF participant's community and/or the participant's lack of understanding about the hospital associated with their medical home. The Department would seek to minimize the extent to which the later incidences occur. The Department worked with hospitals to develop HSF flyers that could be distributed to HSF participants who sought services at their facilities.

The other limitation of this initial analysis is the relatively limited amount of non-profit hospital data. The Department's goal is to better refine its analysis over time working with the hospitals and SFHP. It will provide this data on a periodic basis as part of its annual reports.

Overall, the data reveal that the majority of ED services were provided by San Francisco General Hospital (SFGH). Graph E1 provides summary information on the count of HSF participants with hospital-based ED visits and inpatient stays by hospital system. San Francisco General Hospital provided 83% of the care. As noted previously in this report, SFGH provides ED services for the Department, SFCCC and BAART medical homes.

Graph E1

Emergency Department Utilization Across the HSF Hospital Systems for HSF Participants



	CPMC	Chinese	Kaiser	St. Francis	Saint Mary's	SFGH	UCSF	Total
ER Outpatient Total	182	132	257	322	506	7,020	21	8,440
ER Inpatient Total	0	8	0	19	52	662	26	767
Grand Total	182	140	257	341	558	7,682	47	9,207
Percentage of Total	2%	2%	3%	4%	6%	83%	1%	100%

Table E26 provides more detailed information on ED outpatient visits by the medical home of the HSF participant. It should be read as follows using St. Francis Memorial Hospital and Glide Health Services as a sample based on their medical home-hospital affiliation:

- During FY 2010-11, St. Francis Memorial Hospital provided 322 ED outpatient visits of which 301 (93.5%) were to HSF participants who had Glide as their medical home and 21 (6.5%) to HSF participants who had other HSF medical homes
- During FY2010-11, there were 636 ED outpatient visits by HSF participants who had Glide as their medical home. Of those, 301 (47%) occurred at St. Francis Memorial Hospital and 335 (53%) were at other San Francisco hospitals.

Table E26

Emergency Department Outpatient Utilization Across Hospital Systems by HSF Medical Home

	CPMC	Chinese	Kaiser	St. Francis	Saint Mary's	SFGH	UCSF	**Total**	**Percent**
BAART	0	0	0	0	0	3	0	**3**	**0%**
Brown & Toland	1	0	0	0	0	0	0	**1**	**0%**
DPH Clinics	137	32	0	7	0	4,918	15	**5,109**	**61%**
CCHCA	1	58	0	7	0	4	0	**70**	**1%**
Glide	10	1	0	301	37	287	0	**636**	**8%**
SFCCC Clinics (6)	17		0	1	0	1,210	3	**1,231**	**15%**
Kaiser	0	0	257	0	1	11	0	**269**	**3%**
NEMS	14	41	0	0	0	564	3	**622**	**7%**
Sr. Mary Philippa	2	0	0	6	468	23	0	**499**	**6%**
Total	**182**	**132**	**257**	**322**	**506**	**7,020**	**21**	**8,440**	**100%**
Percent	**2%**	**2%**	**3%**	**4%**	**6%**	**83%**	**0%**	**100%**	

The data in Tables E27 an E27A provide some general information on out-of-network ER access by HSF participants. Both tables should be read as follows using CCHCA – Chinese as a sample: "HSF participants with t CCHCA – Chinese as their medical home had 70 ED outpatient visits of which 58 were within the network and 12 were outside of network. These participants also had 4 ED inpatient visits of which three were within the network and one was outside of network."

Table E27

Emergency Room Outpatient Utilization – Within and Outside Medical Home Network

Medical Home and Affiliated Hospital	Within MH Network	Outside MH Network	Total	Percentage Outside MH
BAART - SFGH	3	0	3	0%
Brown & Toland - CPMC	1	0	1	0%
DPH Clinics - SFGH	4,918	191	5,109	4%
CCHCA - Chinese	58	12	70	17%
Glide - St. Francis	301	335	636	53%
Six SFCCC Clinics - SFGH	1,210	21	1,231	2%
Kaiser - Kaiser Med. Center	257	12	269	4%
NEMS – SFGH	564	58	622	9%
Sr. Mary Philippa - St. Mary's	468	31	499	6%
Total	**7,780**	**660**	**8,440**	**8%**

Table E27A

Emergency Room Inpatient Utilization – Within and Outside Medical Home Network

Medical Home and Affiliated Hospital	Within MH Network	Outside MH Network	Total	Percentage Outside MH
BAART - SFGH	0	0	0	0%
Brown & Toland - CPMC	0	0	0	0%
DPH Clinics - SFGH	469	17	486	3%
CCHCA - Chinese	3	1	4	25%
Glide - St. Francis	18	22	40	55%
Six SFCCC Clinics - SFGH	99	6	105	6%
Kaiser - Kaiser Med. Ctr	0	8	8	0%
NEMS - SFGH	62	7	69	10%
Sr Mary Philippa - St. Mary's	51	4	55	7%
Total	**702**	**65**	**767**	**8%**

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 was 0.8 for FY2010-11. There were a total of 531 participant complaints with the top complaints in the area of access (28%) and quality of service (27%). Finally, data from the HSF Health Access Questionnaire found that participants continuously enrolled in the program reported less ER utilization, 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.

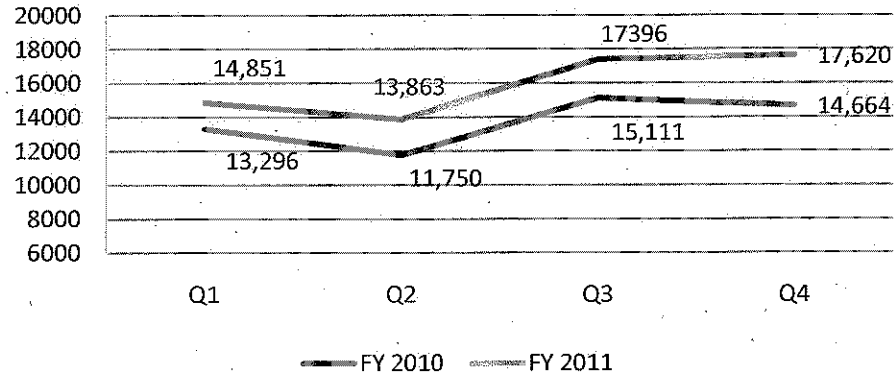
Customer Service Center Call Center

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 63,730 incoming calls (applicants, participants, providers, employers, others) from July 2010 to June 2011 demonstrating a 16% increase from the previous year's total of 54,821 calls.

Graph F1

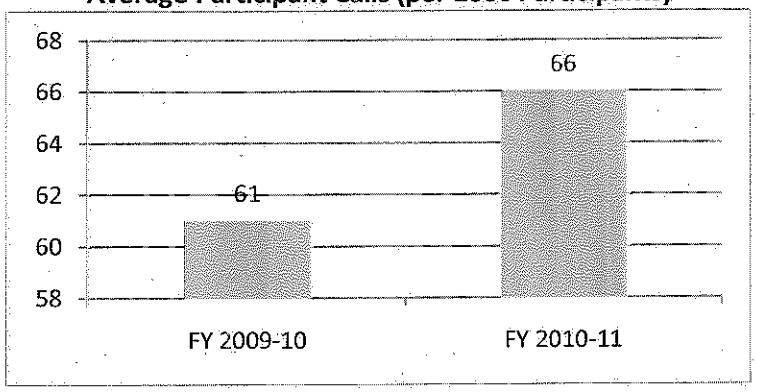
Total Call Volume per Quarter



Of those calls, 43,207 were participant calls, 17,479 were potential participant calls, 1,178 were employer calls and 1,866 were provider calls from July 2010 to June 2011. Total participant call volume for FY 2010-2011 (43,207) increased by 21% from the previous year (35,851). For participants, the call

rate for FY2010-11 averaged 66 calls per 1,000 participants compared to 61 calls per 1,000 participants during FY2009-10.

Graph F2
Average Participant Calls (per 1000 Participants)



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.

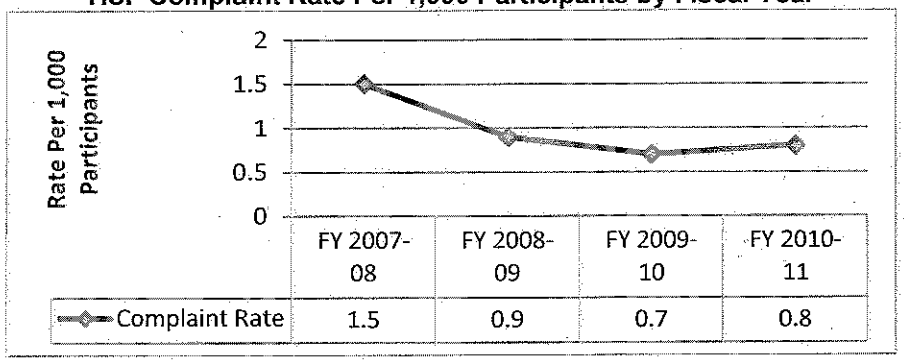
During FY2010-11, the HSF Customer Service Center received a total of 531 complaints. Key fiscal year trends include:

- The rate for the 2010-2011 fiscal year was 0.8 per 1000 participants, up from the rate of 0.7 for the 2009-2010 fiscal year.
- Access issues were 27.5% (146) of the total complaints received in the 2010-2011 fiscal year, compared to 35.1% (153) of the total complaints received in the 2009-2010 fiscal year.
- Quality of service issues were 26.6% (141) of the total complaints received in the past year, compared to 23.9% (104) of the total complaints received in the previous fiscal year.

Over the last three fiscal years, the participant complaint rate per 1,000 participants has remained relatively stable – fluctuating from 0.7 to 0.9 per 1,000 participants.[8]

[8] Note that 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 Other. 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.
- 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.
- Other: This category includes complaints about the medical home that deal with a myriad of issues, such as participant wants a specialized treatment/provider that is only available at another medical home or participant has general complaints about a medical home that are not related to a specific service or a specific appointment (e.g., a medical homes serves too many homeless people from participants perspective and does not like that, etc.)

Table F1
HSF Participant Complaints by Category

Attribute	Total # of Complaints	% of Total Complaints
Access Issue	146	28%
Quality of Service	141	27%
Other	94	18%
Enrollment Issue	75	14%
Billing	29	5%
Quality of Care	24	4%
Coverage Interpretation	12	2%
Cultural, Linguistic & Health Education	10	2%
Total	**531**	**100%**

Health Access Questionnaire

Healthy San Francisco administers a Health Access Questionnaire at the point of application and at annual renewals. HSF participant responses to this questionnaire allow us to gauge individuals' pre- (if

participant is a first time applicant) and post-HSF (for renewers) experiences with healthcare in a quantifiable manner.

Application Assistors ask HSF participant the designated questions from the questionnaire. Responses to the questionnaire represent self-reported data. Eligibility for HSF is not affected by a participant's responses to the questionnaire. A participant is given the options of refusing to answer a question or saying that they do not know the answer. Questionnaires are available in Spanish, English, and Chinese as needed.

As mentioned in the previous section, DPH strives to have participants renew on a timely basis. Towards this goal, a new survey question was added to the Health Access Questionnaire in the spring of 2011 to capture data about what helps participants renew their HSF membership on-time. A significant number of participants were not asked the eleventh question in FY2010-2011, due to when the additional question was added to the questionnaire.

During FY2010-2011, HSF administered 54,848 questionnaires to first time HSF enrollees and renewing members. The survey answers of those who were new to the program reflect those participants' experiences with healthcare access before HSF membership, while renewal applicants' answers should reflect the HSF experience with healthcare access. Three separate analyses were conducted for this year's report:

- An analysis of all responses from all the questionnaires received.
- A year-to-year analysis for those participants who took the survey twice (in FY2009-2010 and again in FY2010-2011 upon renewal).
- A 3-year analysis for those participants who have been continually enrolled in HSF without breaks in coverage.

The first analysis summarizes data on all participants and does not distinguish between new HSF participants and renewal participants. It provides a snapshot of the answers from all 54,848 surveys administered in FY2010-2011. The second analysis examines the responses of the 19,818 participants continuously enrolled and who took the survey twice (initial enrollment and renewal OR two renewals). The third analysis similarly examines the responses of the 5,871 participants who have been enrolled in HSF for three consecutive years without breaks in coverage. The purpose of the second and third analyses is to track how participants' responses change over time.

FY2010-2011 Health Access Questionnaire Responses

Appendix B provides detailed information on all participant responses to the 11 survey questions in FY2010-2011. The 54,848 questionnaires were administered to 53,692 participants:

- 52,548 participants took the survey one time only during the year
- 1,135 participants took the survey twice during the year (i.e. a new applicant who renewed eligibility before the end of his/her 12 month term)
- 8 participants took the survey three times and
- 1 participant took the survey four times

Several trends from questionnaire data suggest that the patient experience with health care in San Francisco is improving over time. Compared to FY2008-2009 and 2009-2010, questionnaire respondents in FY2010-2011 indicated:

- A lower percentage (49%) had no health insurance during the previous 12 month period than respondents in past years (53% in FY2009-2010 and FY 2008-2009).

- The most common reason (29% of respondents) for not having health insurance was enrollment in HSF, as opposed to "the cost of health insurance and/or copayments" in past years (27% of respondents in FY2009-2010 and 20% in FY 2008-2009).

- A greater proportion (45%) reported that it was not difficult to access medical care when necessary than in FY2009-2010 and FY2008-2009 (34% and 43%, respectively).

- A lower percentage of respondents (8%) delayed getting care or a prescription in the past 12 months than in FY2009-2010 and FY2008-2009 (11% and 12%, respectively).

- A steady decline in the percentage of respondents visiting a hospital emergency room for their own health over the years (14% in FY 2008-2009, 12% in FY 2009-2010, and 10% in FY 2010-2011).

- A steady decline in the percentage of respondents claiming to smoke cigarettes over time (16% in FY2008-2009, 14% in FY2009-2010, and 11% in FY2010-2011).

Year-to- Year Health Access Questionnaire Comparison

By the end of FY2010-2011, 19,818 HSF participants had taken the Health Access Questionnaire twice in consecutive years of unbroken coverage, and 5,871 participants had taken the questionnaire three times in consecutive years of enrollment.[9] In FY2010-2011, these individuals were beginning their second and third years, respectively, of continuous enrollment in HSF. For this analysis, HAQ1 refers to the first questionnaire participants took, HAQ2 refers to the second time, and HAQ3 refers to the third time.

Information on the medical home selection and ethnicity of the 19,818 individuals taking the questionnaire twice and the 5,871 individuals taking the survey three times is presented below. The majority of those HSF participants continuously enrolled were Asian/Pacific Islanders at 43% over a two year period, and 51% over a three year period.

Table F2

Ethnic Distribution of Participants with Multiple HAQs Based on Continuous Enrollment

	Two Years (FY2009-10 & 2010-11)		3 Years (FY2008-09, 2009-10, 2010-11)	
Ethnicity	**No. of Participants**	**% of Total**	**No. of Participants**	**% of Total**
Asian/Pacific Islander	8,487	43%	3,003	51%
Black/African American	1,380	7%	246	4%
Hispanic	4,716	24%	1,402	24%
Native American/Alaskan Native	75	<1%	5	<1%
Other	1,443	7%	269	5%
White	3,717	19%	946	16%
All Ethnicities	***19,818***	***100%***	***5,871***	***100%***

Multi-Year Questionnaire Data

Of the eleven 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?

[9] Note that of the 19,818 participants, 546 participants had taken the survey three times, and 8 participants had taken the survey four times. However, the extra questionnaires for these individuals were not included in this analysis.

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 questionnaire data from those continuously enrolled in HSF indicates that over time participants reported less ED utilization, a usual source of care, less difficulty accessing care, an improved rating of medical care, and fewer delays accessing care. For those participants with two years of questionnaires, HAQ1 refers to answers given to surveys administered in FY2009-2010, and HAQ2 refers to FY2010-2011. For those with three years of data, HAQ1 refers to FY2008-2009, HAQ2 to 2009-2010, and HAQ3 to FY2010-2011.

Analysis of participants' responses over a three year membership allows for the effects of HSF programming on participant health perceptions and behaviors to be inferred over the greatest amount of time, between 2008 and 2011. Similarly, an analysis of questionnaire responses over a two year membership reveals the effects of HSF programming over the period of time between 2009 and 2011. The combination of these two analyses reveals how HSF participants' health perceptions and behaviors change over a shorter and longer period of time. It is important to note that there was a uniform increase over time in the number of participants that elect not to answer survey questions.[10]

General Health

An examination of HSF participant responses in their second and third years of continuous enrollment reveals consistent results. Over time, participants are more likely to rate their general health as good instead of excellent, very good, fair, or poor.

Table F3
General Health

General Health	HAQ1	HAQ2	Variance	☺/😐/☹
Excellent	8.6%	5.9%	-3%	☹
Very Good	16.1%	13.9%	-2%	☹
Good	35.1%	38.9%	4%	☺
Fair	14.6%	11.6%	-3%	☹
Poor	2.7%	2.2%	-1%	☺
Don't Know	6.9%	6.6%	<-1%	😐
Refused	16.0%	20.9%	5%	N/A

[10] 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 Assistor 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 the answer for his/her mate.

General Health	HAQ1	HAQ2	HAQ3	HAQ1-HAQ3 Variance	☺/😐/☹
Excellent	7.27%	6.39%	4.41%	-3%	☹
Very Good	17.94%	14.49%	11.85%	-6%	☹
Good	37.63%	40.52%	46.18%	9%	☺
Fair	17.88%	16.18%	12.03%	-6%	☹
Poor	3.25%	2.32%	1.92%	-1%	☺
Don't Know	4.56%	5.09%	6.30%	2%	😐
Refused	11.46%	15.01%	17.31%	6%	N/A

Hospital Emergency Department

An examination of survey data to hospital emergency department use within the last 12 months reveals that over time, fewer participants indicated that they received care in an emergency department.

Table F4
Hospital Emergency Department Use

ED Visit in Last 12 Months	HAQ1	HAQ2	Variance	☺/😐/☹
Yes	11.7%	8.7%	-3%	☺
No	64.9%	63.9%	-1%	☹
Don't Know	6.6%	6.4%	<-1%	😐
Refused	16.8%	21.0%	4%	N/A

ED Visit in Last 12 Months	HAQ1	HAQ2	HAQ3	HAQ1-HAQ3 Variance	☺/😐/☹
Yes	11.24%	9.10%	7.34%	-4%	☺
No	72.12%	70.86%	69.17%	-3%	☹
Don't Know	4.17%	4.70%	6.08%	2%	😐
Refused	12.47%	15.35%	17.41%	5%	N/A

Medical Care Location

An examination of questionnaire data reveals that over both a shorter and longer timeframe, participants are less likely to receive health services at the doctor's office or emergency department, and more likely to get them a clinic, health center, or hospital clinic.

Table F5
Medical Care Location

Medical Care Location	HAQ1	HAQ2	Variance	☺/😐/☹
Doctor's Office	8.9%	5.0%	-4%	😐
Clinic/Health Center/Hospital Clinic	54.7%	64.8%	10%	☺
Emergency Room	2.6%	0.8%	-2%	☺
Some Other Place	1.1%	0.4%	-1%	😐
No One Place	8.4%	1.6%	-7%	😐
Don't Know	7.9%	6.4%	-1%	😐
Refused	16.4%	21.0%	5%	N/A

Medical Care Location	HAQ1	HAQ2	HAQ3	HAQ1-HAQ3 Variance	☺/😐/☹
Doctor's Office	9.10%	4.34%	5.88%	-3%	😐
Clinic/Health Center/Hospital Clinic	63.52%	72.51%	69.60%	6%	☺
Emergency Room	1.99%	0.56%	0.44%	-2%	☺
Some Other Place	0.72%	0.26%	0.20%	-1%	😐
No One Place	6.95%	2.16%	0.58%	-6%	😐
Don't Know	5.83%	4.67%	5.79%	<-1%	😐
Refused	11.91%	15.50%	17.51%	6%	N/A

Medical Care Access

An examination of questionnaire data reveals that over both a shorter and longer timeframe, participants are less likely to report that access to care is extremely difficult, very difficult, or somewhat difficult and more likely to report that access to care is not too difficult or not difficult at all.

Table F6
Medical Care Access

Medical Care Access	HAQ1	HAQ2	Variance	☺/😐/☹
Extremely Difficult	2.3%	1.0%	-1%	☺
Very Difficult	7.7%	3.1%	-5%	☺
Somewhat Difficult	16.8%	15.1%	-2%	☺
Not Too Difficult	26.7%	29.6%	3%	☺
Not Difficult at All	15.5%	21.4%	6%	☺
Don't Know	14.3%	8.7%	-6%	😐
Refused	16.7%	21.0%	4%	N/A

Medical Care Access	HAQ1	HAQ2	HAQ3	HAQ1-HAQ3 Variance	☺/😐/☹
Extremely Difficult	1.77%	0.89%	1.06%	-1%	☺
Very Difficult	5.83%	6.27%	2.45%	-3%	☺
Somewhat Difficult	16.45%	16.50%	16.52%	0%	☺
Not Too Difficult	33.62%	33.32%	35.70%	2%	☺
Not Difficult at All	17.51%	20.24%	19.40%	2%	☺
Don't Know	12.06%	7.22%	7.46%	-5%	😐
Refused	12.76%	15.57%	17.41%	5%	N/A

Medical Care Rating

An examination of questionnaire data reveals that over a shorter timeframe, participants are less likely to rate their medical care as fair or poor, and more likely rate it as excellent, very good, or good. Over a longer timeframe, they are also less likely to rate their medical care as excellent, but still more likely to rate their care as very good or good.

Table F7
Medical Care Rating

Medical Care Rating	HAQ1	HAQ2	Variance	☺/😐/☹
Excellent	9.3%	10.0%	1%	☺
Very Good	14.5%	18.8%	4%	☺
Good	30.9%	34.4%	3%	☺
Fair	7.2%	5.2%	-2%	☹
Poor	1.4%	0.7%	-1%	☺
Don't Know	19.7%	9.9%	-10%	😐
Refused	17.0%	21.0%	4 %	N/A

Medical Care Rating	HAQ1	HAQ2	HAQ3	HAQ1-HAQ3 Variance	☺/😐/☹
Excellent	11.28%	11.62%	8.43%	-3%	☹
Very Good	18.16%	20.46%	19.64%	1%	☺
Good	34.58%	36.01%	40.18%	6%	☺
Fair	6.35%	7.22%	5.59%	-1%	☹
Poor	1.26%	0.72%	0.53%	-1%	☺
Don't Know	15.76%	8.60%	8.21%	-8%	😐
Refused	12.62%	15.38%	17.42%	5%	N/A

Delay in Getting Care/Medication
An examination of questionnaire data reveals that over both a shorter and longer timeframe, participants are less likely to report having delayed care or getting prescribed medication.

Table F8
Delays in Getting Care

Delay in Care	HAQ1	HAQ2	Variance	☺/😐/☹
Yes	11.8%	4.9%	-7%	☺
No	57.9%	65.5%	8%	☺
Don't Know	13.2%	8.5%	-5%	😐
Refused	17.1%	21.1%	4%	N/A

Delay in Care	HAQ1	HAQ2	HAQ3	HAQ1-HAQ3 Variance	☺/😐/☹
Yes	9.81%	4.36%	4.29%	-6%	☺
No	67.82%	72.19%	71.03%	3%	☺
Don't Know	9.74%	7.84%	7.29%	-2%	😐
Refused	12.62%	15.62%	17.39%	5%	N/A

Delay in Care for Cost Reasons
An examination of questionnaire data reveals that over both a shorter and longer timeframe, participants are less likely to report having delayed care for reasons of cost.

Table F9
Delays in Care due to Costs

Delay in Care—Cost Reasons	HAQ1	HAQ2	Variance	☺/😐/☹
Yes	15.1%	6.0%	-9%	☺
No	52.7%	63.1%	10%	☺
Don't Know	14.8%	9.8%	-5%	😐
Refused	17.4%	21.1%	4%	N/A

Delay in Care—Cost Reasons	HAQ1	HAQ2	HAQ3	HAQ1-HAQ3 Variance	☺/😐/☹
Yes	10.36%	7.63%	6.17%	-4%	☺
No	62.12%	65.88%	66.62%	4%	☺
Don't Know	14.34%	10.42%	9.78%	-5%	😐
Refused	13.18%	16.06%	17.44%	4%	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 2010 and March 2011. 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. 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 less incidence of hypertension, hyperlipidemia, asthma or diabetes.

Table F10
Do Smokers Utilize Services at a Higher Rate than Non-Smokers and Do They Have a Higher Rate of Chronic Disease?

	Respondents	Average Primary Visits	Average Specialty Visits	Average Emergency Visits	Rate For Chronic Disease	Rate For Non-Chronic Disease
Smokers	1,400	3.77	0.08	0.17	39.0%	61.0%
Non-Smokers	11,017	3.68	0.13	0.09	43.3%	56.7%

Predictably, participants who reported their health status as poor had more than 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 F11
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	3,126	2.72	0.07
Good	6,939	3.52	0.10
Fair	2,059	5.08	0.14
Poor	340	7.36	0.36

Those participants who reported that access to medical care was "extremely or very difficult" had 10% higher emergency room utilization than those who reported that access was "not that difficult."

Table F12
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	Average Avoidable Emergency Visits
Extremely/Very Difficult	3,249	0.90%
Not That Difficult	8,910	0.82%

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 63% of those who rate their health as poor (Table F13).

Table F13
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	10,065	38.91%	61.09%
Fair	2,059	57.65%	42.35%
Poor	340	62.65%	37.35%

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 poor.

Table F14
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	10,987	43.55%	56.45%
Fair	882	47.85%	52.15%
Poor	108	42.59%	57.41%

G. HEALTH CARE COVERAGE INITIATIVE AND LOW INCOME HEALTH PROGRAM

This section describes the Department's activities with respect to the Health Care Coverage Initiative (HCCI) and the Low Income Health Program (LIHP). Both programs were created as a result of California's 1115 Medicaid Waiver. HCCI ended on October 31, 2010 and coincided with the end of the State's 2005 – 2010 Waiver. LIHP is part of the State's 2010 – 2015 Waiver. It began on November 1, 2010 and will end on December 31, 2013 timed with implementation of the individual health insurance mandate under federal health reform on January 1, 2014. HCCI provided vital federal reimbursement to a subset of Healthy San Francisco participants and LIHP will provide federal funding for a new program called SF PATH ("San Francisco Provides Access To Healthcare").

HSF – HCCI – LIHP Eligibility Provisions

While HSF, HCCI and LIHP seek to accomplish the same goal -- improving access to care for uninsured residents, the eligibility, provider networks and federal funding provisions for the three differ as noted in Table G1 below.

Table G1
HSF – HCCI – LIHP Eligibility Provisions

	HSF	HCCI	LIHP
Eligibility			
Age	18 – 64 years old	19 – 64 years old	19 – 64 years old
Citizenship	Not Required	US Citizen, Naturalized Citizen, Permanent Legal Resident for 5 or more years	US Citizen, Naturalized Citizen, Permanent Legal Resident for 5 or more years
Government Issued ID	ID requested, but not required	Required	Required
Health Insurance	Must be uninsured	Must be uninsured	Can be insured (MCE only)
Medi-Cal Eligible	No	No	No
Income	0% - 500% FPL	0% - 200% FPL	0% - 133% FPL - MCE 134% - 200% FPL - HCCI
Residency	San Francisco residency required	San Francisco residency required	San Francisco residency required
Federal Funding (Designated)	No	Yes – via State 2005-2010 1115 Waiver	Yes – via State 1115 Waiver (2010-2013 only)
Provider Network	DPH and Non-DPH	DPH Only	DPH Only
Separate Program from HSF	Not Applicable	No – funding component of HSF for HCCI-eligibles	Yes – SF PATH
Time-Limited	No	Yes – September 2007 to October 2010	Yes – November 2010 to December 2013

Health Care Coverage Initiative

At the end October 2010, roughly 10,250 HSF participants were designated as HCCI-eligible. The Department's initial target for HCCI enrollment was 10,000 over the life of the three year (September 2007 – October 2010) program. Over the three year period, over 18,800 uninsured residents were designated HCCI eligible.

During FY2010-11, the Department worked aggressively to obtain required citizenship documentation for individuals potentially eligible for HCCI designation. It verified citizenship status on approximately

7,500 HSF participants with Department medical homes through a partnership with CalWIN and by securing some birth certificates from the vital records divisions of various states. These efforts resulted in the Department obtaining an additional $4-$5 million in reimbursement for services costs that it had already incurred by enrolled and disenrolled HCCI-eligibles in HSF. With respect to administrative cost reimbursement, the Department has received some, but not all funding. Of the $2.15 million the Department estimated in reimbursable costs, it has received $1.1 million, based on claims processed by the State to date. The Department has not received any federal reimbursement to offset a portion of the estimated $2.1 million in HCCI start-up costs eligible for funding.

The UCLA Center for Health Policy Research had the contract with the State Department of Health Care Services to evaluate all ten HCCI programs. In June 2010, UCLA provided the State with interim evaluation results of HCCI to help the federal Center for Medicare and Medicaid Services determine whether HCCI was meeting its goals and if a similar type of program should be included in any new California 1115 Waiver. The evaluation research questions and UCLA findings were:

Table G2
UCLA – Interim Evaluation Findings of Health Care Coverage Initiative

No.	Evaluation Question	UCLA Finding
1	What impact did the Health Care Coverage Initiative have on program income and expenditures in each county during the project period, including per capita costs?	The increased efficiencies achieved by counties are expected to lead in reductions in costs of care per enrollee.
2	How effective was the Health Care Coverage Initiative in allowing counties to expand the number and proportion of Californians who have health care coverage between September 1, 2007 and August 31, 2010?	Significant expansions in health care coverage have been achieved by the HCCI counties.
3	Did participating Health Care Coverage Initiative counties strengthen and build upon the local health care safety net system, including disproportionate share hospitals, county clinics, and community clinics?	Strong evidence exists to demonstrate the enhancement of the local health care safety net system
4	Did the Health Care Coverage Initiative improve access to high quality health care and health outcomes for Coverage Initiative enrollees in each county?	The HCCI program has resulted in improved access to high quality health care and health outcomes
5	Did the Health Care Coverage Initiative create efficiencies in the delivery of health services that could lead to savings in health care costs?	Counties have achieved efficiencies in health care. However, it is too early to conclusively demonstrate savings in health care costs as a result of those efficiencies.
6	Did the Health Care Coverage Initiative provide grounds for long-term sustainability of the programs funded under the initiative beyond August 31, 2010?	Long term sustainability of the gains made under HCCI may be limited.
7	Were the county Health Care Coverage Initiative programs implemented in an expeditious manner to meet federal requirements regarding the timing of expenditures?	Despite limited program planning, implementation of the programs has been largely successful.

The State's 2010-2015 "Bridge to Reform" Medicaid 1115 Waiver approved by the federal government included a new voluntary called the Low Income Health Program (LIHP). LIHP builds upon the previous HCCI program, to provide a statewide expansion of health care coverage to eligible, low-income adults. Implementation of the LIHP demonstration will be phased in beginning November 1, 2010. The State's goal is to cover up to 500,000 uninsured individuals in LIHPs statewide.

Low Income Health Program

LIHP differs significantly from the prior waiver's HCCI in that it:

- Creates two different coverage populations for adults and sets of benefits based in federal poverty level (FPL) -- Medicaid Coverage Expansion (MCE) for 0% - 133% FPL and Health Care Coverage Initiative (HCCI) for 134% - 200% FPL.
- Outlines a range of benefits for the MCE population that are similar to Medi-Cal and creates a two-tiered health care delivery system by not requiring the same set of benefits for the HCCI population.
- Identifies two different enrollment levels and federal funding streams for each of the populations – MCE (open-ended funding) and HCCI (capped funding).
- Standardizes various aspects of the program for all participating counties.
- Imposes managed care provider network requirements and clinical access standards.
- Increases county costs (both services and administrative) above and beyond costs currently incurred by county to provide services to population.

LIHP is voluntary for counties. The Department made a decision to participate in LIHP and created a separate program in order to meet the various State and federal requirements. The program is called SF PATH or 'San Francisco Provides Access To Healthcare.' During the fiscal year, the Department worked to ensure implementation of LIHP by the mandated July 1, 2011 start date. At the time of application, the Department elected an upper income eligibility 133% of the federal poverty level for LIHP.

The federal requirement was that any person designated as HCCI-eligible under the previous waiver program be automatically transferred into the LIHP on July 1, 2011. These HCCI-eligibles who were HSF participants were essentially grandfathered into the LIHP. As noted in Section A of this report, there were 54,348 HSF participants as of June 30, 2011. Effective July 1, 2011, 10,274 (19%) of these 54,348 HSF participants who were designated as HCCI-eligibles were simultaneously disenrolled from HSF and enrolled into San Francisco's LIHP or SF PATH. Of the 10,274 total LIHP participants, 8,638 (84%) were MCE participants and 1,636 (16%) were HCCI participants. The remaining 44,049 (81%) participants remained enrolled in HSF as of July 1, 2011. As a result, the Department's 2011-12 HSF Annual Report will show a decrease in enrollment due to this population transfer from HSF to LIHP/SF PATH.

As with the HCCI program, LIHP will be evaluated by the UCLA Center for Health Policy Research as part of a state-wide evaluation. The Department will participate in this evaluation as a condition of program participation.

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 12% 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 1,126 in FY2009-10 to 1,265 in FY2010-11). By the end of the fiscal year, these 1,265 employers had elected to use the City Option to make health care expenditures on behalf of almost 69,500 employees. A total of $35.1 million was contributed in FY 2010-11 by employers on behalf of eligible employees.

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, not the Department of Public Health.

City Option Activity

The Employer Spending Requirement Portal which is a component of the HSF website is maintained by the San Francisco Health Plan as HSF's third-party administrator. The portal 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 ESR implementation, data on the City Option indicate the following as of June 30, 2011:

- 1,265 employers had selected the City Option to meet the ESR -- an increase of 139 employers using the City Option from last fiscal year when there were 1,126 employers.

- During FY2010-11, employers deposited $35.100 million to provide the City Option for their employees. Employer contributions increased nominally each quarter in FY2010-11.

- Of the funds contributed in FY2010-11, 63% ($22.117 million) were for employees receiving a Medical Reimbursement Account and 37% ($12.983 million) were for employees are potentially eligible for HSF.

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, $49.36 million in employer contributions ($12.9 million in FY2010-11) 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). In FY2010-11, over 1,600 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). The following is the distribution of those employees with respect to program eligibility:

Table H1

City Option Eligible Employees by Program (Unduplicated Count) as of June 30, 2011[11]

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.	33,356
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.	41,352
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.	(5,242)
Total City Option Employees	Employees with HSF contributions + employees with MRA contributions - employees with both HSF & MRA contributions.	69,466

[11] The table reflects all employees whose employers have submitted rosters with payments.

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 33,404 employees designated as potentially eligible for HSF enrollment. 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 33,404 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.)

Table H2
Potential City Option HSF Eligible Employees by Disposition[12]

HSF Eligibility Disposition	Number	Percentage
Known	14,105	40%
Unknown	8,139	24%
Inadequate Data/Unresponsive	11,160	34%
All Dispositions	33,404	100%

Of those employees with a known disposition (14,105):

- 50% (7,036) are or have been enrolled in HSF,
- 44% (6,146) were determined ineligible for HSF and were sent a MRA Transfer Request Form and
- 6% (923) indicated that they were not interested in HSF or MRA (if ineligible for HSF).

[12] The table reflects all employees whose employers have submitted rosters with or without payment. There were 48 employees for whom payment had not been received as of June 30, 2011.

Of those employees with an unknown disposition (8,139), 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 6% (508) 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 46% (3,747) 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 48% (3,884) 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 approximately 50% (4,070) 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 (11,160) 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% (3,460) 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% (7,700) 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 (145 out of 1,265), the data indicate that:

- the majority of employers who have elected the City Option are either in the other services (23%), retail trade (14%) or professional/scientific/technical services (12%),
- 2% have fewer than 20 employees, 15% have 20 – 49, 11% have 50 – 99, 22% have 100 – 499 and 40% have 500 or more employees, and
- 78% are for profit and 10% are non- profit.

Table H3
City Option Employers (1,265) by Industry Type

Count by Industry (North American Industry Classification System code)	Number	Percent
Accommodation and Food Services (72)	82	6%
Administrative & Support and Waste Management & Remediation Services (56)	6	0%
Agriculture, Forestry, Fishing and Hunting (11)	2	0%
Arts, Entertainment, and Recreation (71)	53	4%
Construction (23)	20	2%
Educational Services (61)	38	3%
Finance and Insurance (52)	92	7%
Health Care and Social Assistance (62)	73	6%
Information (51)	26	2%
Management of Companies and Enterprises (55)	6	0%
Manufacturing (31-33)	24	2%
Mining, Quarrying, and Oil and Gas Extraction (21)	2	0%
Other Services (except Public Administration) (81)	296	23%
Professional, Scientific, and Technical Services (54)	146	12%
Public Administration (92)	3	0%
Real Estate and Rental and Leasing (53)	29	2%
Retail Trade (44-45)	181	14%
Transportation and Warehousing (48-49)	18	1%
Utilities (22)	3	0%
Wholesale Trade (42)	20	2%
Unreported	145	11%

Table H4
City Option Employers by Company Size

Count by Company Size	Number	Percent
0-19 employees	20	2%
20-49 employees	189	15%
50-99 employees	138	11%
100-499 employees	272	22%
500+ employees	501	40%
Not reported	145	11%

Table H5
City Option Employers by Tax Status

Count by Tax Status	Number	Percent
For-profit	989	78%
Non-profit	127	10%
Public (Publicly-traded)	4	0%
Not reported	145	11%

I. EVALUATION

This section discusses the findings from the independent two-year Healthy San Francisco program evaluation conducted by Mathematica Policy Research, Inc. ("Mathematica"). Appendix C is the summary brief of the final evaluation report.

The evaluation was designed to help determine if HSF was achieving its goals to improve access to health services for uninsured adults through a non-health insurance model. The evaluation was structured to provide formative findings that could be used to guide development of any program improvements or modifications, in addition to a summative analysis.

Overall, Mathematica's analyses found that:

> *"HSF is providing access to timely and coordinated primary care services to a population that greatly needs them. In general, HSF participants are very satisfied with their access to health care services. Overall, the results suggest that, even though the majority of these HSF participants were established patients in the HSF medical homes prior to enrolling, participating in the program alleviated financial and nonfinancial barriers to medical care for a large portion of enrollees. Most HSF participants are regularly receiving outpatient care at their medical homes, including recommended preventive services, and are using fewer ED services over time, both emergent and non-emergent, which suggests both improved care-seeking behavior and health status."*

Data Sources and Reports

Mathematica relied on a number of data sources – both quantitative and qualitative – for this evaluation. They included:

- HSF enrollment and encounter data for 95,580 unique enrollees covering the period from July 2007 through March 2011,
- encounter and enrollment data for 1,256 enrollees in the Healthy Workers (HW) program for the same time period,
- the 2009 American Community Survey (ACS),
- a 2009 survey of early HSF participants conducted by the Kaiser Family Foundation,
- five focus groups of HSF participants and four focus groups of adults eligible for but not enrolled in HSF,
- the Health Access Questionnaire (HAQ) conducted by HSF at enrollment, renewal, and re-enrollment covering the period December 2008 through March 2011,
- inpatient and ED discharges occurring in California hospitals from 2005 through 2009 from the California Office of Statewide Health Planning and Development (OSHPD),
- a 2010 survey of health care providers participating in HSF, and
- three site visits that included in-depth interviews with HSF key informants.

From this data, Mathematica produced the following reports for this evaluation:

1. Understanding the Healthy San Francisco Medical Home and How It Functions for Different Patient Populations,
2. Participation in Healthy San Francisco: Trends in Enrollment and Retention,
3. Healthy San Francisco: Changes in Access to and Utilization of Health Care Services and
4. Evaluation of Healthy San Francisco.

In addition, it produced a "Provider Satisfaction and Their Perspectives on Healthy San Francisco" assessment for provider/medical home use and review.

Enrollment

This component of the evaluation focused on who enrolls, which eligible individuals did not enroll, who remains enrolled and for how long and why individuals leave HSF and who returns.

The key findings were that:

- HSF appears to have enrolled a large portion of working-age uninsured adults in San Francisco.
- HSF enrollees are less likely to be younger uninsured adults and those from households with incomes above 300 percent of the FPL.
- More than 85 percent of HSF enrollees remain in the program for at least 12 months, and more than half (56 percent) of these participants renew enrollment at the first opportunity.
- Most frequently, the reason that an HSF participant exits the program remains unknown. Virtually all those exiting the program at month 13 did so for failure to complete re-screening.
- Factors predicting retention, renewal, and re-enrollment are consistent with expectations that individuals for whom HSF represents a high-value or long-term solution, those with closer relationships to the medical home, and those who likely have more stability in their work and residency situations are more likely to remain in or return to HSF.

Changes in Access to and Utilization of Health Care Services

This component of the evaluation focused on how HSF changed access to health care services, to what extent HSF participants utilized primary care services and to what extent HSF led to a decrease in emergent and non-emergent emergency department visits and in potentially avoidable hospitalizations.

The key findings were that:

- In general, HSF participants were satisfied with their access to needed health care services.
- More than forty percent of participants felt that access to care was easier now that they were in HSF, while over one-third felt that access did not change with participation in HSF.
- One in three participants felt that the quality of their care improved with participation in HSF.
- For those enrolled for at least 12 continuous months, 80 percent received at least one service.
- For preventive services, older individuals, non-whites, higher income groups, Chinese speakers, individuals with greater chronic disease burdens, and those enrolled with SFDPH medical homes all were more likely to receive at least one specified preventive service.
- Most HSF participants had between one and six physician visits per year, and a small percentage had monthly, or more frequent, visits.
- Most participants with ED visits or inpatient admissions received prompt outpatient follow-up.
- HSF participants show steadily declining ED use over time.

- HSF may be associated with a decrease in the number of non-emergent ED visits to SFGH made by uninsured adults.

- HSF may be associated with a decrease in potentially avoidable hospitalizations made by uninsured adults in San Francisco.

Lessons Learned

Mathematica found that HSF has helped San Francisco prepare for federal health reform implementation by:

- creating a centralized system for enrolling and tracking uninsured residents that will gives the county a substantial lead in identifying and enrolling people who become eligible for reform programs,

- leveraging existing resources for the uninsured and organizing the delivery system,

- organizing and expanding the delivery system for uninsured and low income adult populations,

- strengthening the position of its providers to compete successfully in a more competitive health care landscape and

- connecting each person with one specific medical home and increasing providers' accountability for a set of patients, HSF has demonstrated that it is possible to generate important access and quality improvements for low-income adults with multiple health problems.

In the area of costs, Mathematica found that HSF had demonstrated that some long-term cost savings are possible, through fewer ED visits and potentially avoidable hospitalizations. But, it also noted that short-term costs of preventive and primary care services could increase as uninsured people become more connected with a medical home.

Ongoing Monitoring

Over the course of this independent evaluation, the Department used interim findings from the formative evaluation reports, along with other program information and data, to make any needed modifications in the program. These included, but are not limited to:

- addition of a new question in the Health Access Question designed to ascertain reasons why participants renew on time,

- strengthened communication strategies with providers and

- targeted case management strategies to renew HSF populations with low retention rates.

While this formal independent evaluation has ended, the Department will continue with this approach moving forward with the final evaluation report. It will also use administrative data and data from Health Access Questionnaire to monitor the program on an ongoing basis.

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 FY2010-11 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 $177.7 million in FY 2010-11. Department HSF expenditures totaled $149.6 million in FY2010-11. Of that amount, $49.9 million in expenses were covered by revenue and $99.7 million was covered by a City and County General Fund subsidy. Private HSF medical homes and non-profit hospitals incurred $28.1 million in HSF net expenditures.

With a total of 654,129 participant months in FY2010-11, the estimated total per participant per month expenditure was $272 ($177.7 million divided by 654,129) 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 $229 ($149.6 million divided by 654,129).

From FY2009-10 to FY2010-11 when examining Department expenditures and revenue, there was a:

- 10% increase (60,000) in HSF participant months,
- 23% increase ($9.5 million) in Department revenue,
- 6.7% increase ($9.37 million) in Department expenditures,
- Less than 1% decrease ($109,000) in City and County General Fund and
- 3.1% decrease ($7) in Department per participant per month expenditures.

Overall, Department expenditures for uninsured individuals (those enrolled in HSF and those not enrolled in HSF) in FY2010-11 is estimated at $210.86 million.

Estimated Private HSF Provider Costs and Revenue of Serving HSF Participants

There are 18 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. 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. For FY2010-11, the HSF program Department developed a financial expenditure and revenue form for private medical home delivery systems to provide this information to the Department in a more consistent manner. The HSF program relied on charity care expenditure data self-reported by hospitals and collected by the Department as part of the annual hospital charity care report. Data was obtained for the following entities:

Table J1
Requested Expenditure and Revenue Information from Private HSF Providers

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

It is estimated that health services to HSF participants cost private HSF providers $28.141 million:

- $16.328 million by medical homes when revenues of $21.7 million are deducted and
- $11.813 million in hospital charity care expenses.

Table J2
Estimated Expenditures and Revenue for Private HSF Medical Homes

Medical Home	HSF Expenditures	HSF Funding and Other Revenues	Net Expenditures
BAART (< 12 months of HSF participation)	($36,617)	$5,685	($30,932)
Brown & Toland Physicians (< 12 months of HSF participation)	($101,902)	$21,196	($80,706)
CCHCA & Chinese Hospital	($2,414,544)	$2,331,479	($83,065)
Glide Health Services (affiliation with Saint Francis Memorial Hospital)	($2,245,985)	$575,000	($1,670,985)
Kaiser Permanente	($10,940,891)	$4,566,058	($6,374,832)
North East Medical Services (SFCCC affiliated)	($12,016,382)	$5,245,533	($6,770,849)
San Francisco Comm. Clinic Consortium Affiliated Clinics (7)[13]	($7,819,824)	$7,819,824	$0
Sister Mary Philippa Clinic (affiliation with St. Mary's Medical Center)	($2,469,647)	$1,152,631	($1,317,016)
All Non-DPH Medical Home Health Systems	($38,045,792)	$21,717,406	($16,328,385)

Of the $21.71 million in revenues available to medical homes, $14.15 million (65%) was funding from the Department. 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

[13] Note that on its financial data submission, SFCCC noted that the difference between HSF expenditures and reimbursement from the Department represented contributions from the participating clinics. It noted that "revenues sources include government and foundation grants, private donations and patient fees as reported to OSHPD. These revenues support all uninsured and underinsured patients and are not specifically designated for HSF participants."

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. 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. [14]

Charity care services by non-profit hospitals are estimated at $11.8 million. Hospitals count these expenses in different ways. As a result, the costs may include any of the following:

- services to HSF participants affiliated with the medical home the hospital partners with or
- services to HSF participants not affiliated with the medical home the hospital partners with.

Costs included in Table J3 are not included in the Table J2 cost calculations to avoid double counting.

Table J3
Estimated HSF Charity Care Expenditures by Non-Profit Hospital

Hospital Charity Care	HSF Expenditures
California Pacific Medical Center	($2,944,863)
Chinese Hospital	($121,220)
Kaiser Permanente	($1,998,457)
Saint Francis Memorial Hospital	($3,834,320)
St. Mary's Medical Center	($2,163,997)
UCSF Medical Center	($749,825)
All Non-Profit Hospital Charity Care	($11,812,682)

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, in the area of charity care, some hospitals providers report costs on a calendar year, not fiscal year basis.

Total Estimated HSF Expenditures and Revenues

System-wide estimated HSF expenditures for FY2010-11 are estimated at $177.8 million (Table J4). It includes estimated HSF expenditures for private medical homes 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 net HSF expenditure for private medical homes is used. Expenditure detail follows in Table J5.

Table J4
Summary of Estimated System-wide FY2010-11 HSF Expenditures (All HSF Providers)

Delivery System	Estimated Cost
Total Department HSF Expenditures	$149,633,780
Private Provider Net HSF Expenditures	$16,328,385
Non-Profit Hospital Charity Care Expenditures	$11,812,682
All HSF Provider Expenditures	$177,774,847

[14] Prior to HSF, 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 J5
Estimated Total Department and Non-Department HSF Expenditures (Fiscal Year 2010-11)

	2006-07	2007-08	2008-09	2009-10	2010-11
Total Participant Months	0	126,268	421,058	594,102	654,129
REVENUE					
General Fund	$4,866,402	$0	$0	$0	$0
Health Care Coverage Initiative	$0	$8,136,224	$19,199,749	$22,855,381	$27,400,000
Participation Fees and DPH POS	$0	$836,493	$3,208,577	$5,046,830	$5,791,742
ESR (Employer Health Care Expenditures)	$0	$4,187,554	$18,236,251	$13,970,440	$12,966,266
Reserve for Unearned Rev. (Enrollee & ESR)	$0	($1,046,889)	($4,559,063)	($1,563,176)	$0
Transfer of Unused MRA Funds	--	--	--	--	$3,565,831
Philanthropic Grants (Evaluation)	$0	$0	$450,000	$140,000	$210,000
TOTAL REVENUE	$4,866,402	$12,113,382	$36,535,514	$40,449,475	$49,933,839
DPH EXPENDITURES					
Administration					
HSF Administration (including IT staff)	$277,000	$0	$752,122	$697,757	$788,742
Evaluation	--	--	--	--	$719,088
Third-Party Administrator (SFHP)	$2,306,311	$3,039,107	$5,132,291	$6,180,527	$6,567,316
Services					
Cost of Services (SFGH, Clinics, UCSF)	$0	$38,030,229	$91,431,700	$97,374,760	$106,295,039
Behavioral Health	$0	$2,183,284	$20,099,554	$23,440,070	$20,375,732
Non-DPH Provider Reimbursement	$885,000	$2,153,255	$6,683,671	$11,516,867	$14,396,117
Information Systems					
Eligibility/Enrollment System (One-E-App)	$693,091	$393,000	$240,702	$282,636	$267,810
Siemens Information Technology	$705,000	$200,000	$200,000	$203,578	$223,936
Capital					
Capital Projects	$0	$0	$0	$562,280	$0
TOTAL DPH EXPENDITURES	**$4,866,402**	**$45,998,875**	**$124,540,040**	**$140,258,475**	**$149,633,780**
NON-DPH EXPENDITURES					
Medical Homes Net HSF Expenditures	--	--	--	$23,629,093	$16,328,385
Non-Profit Charity Care Expenditures	--	--	--	--	$11,812,682
TOTAL EXPENDITURES	**$4,866,402**	**$45,998,875**	**$124,540,040**	**$163,887,568**	**$177,774,847**
ESTIMATED PER PARTICIPANT PER MONTH EXPENDITURE ($177.77M ÷ 654,129)	--	--	--	$276	$272
DPH REVENUE LESS DPH EXPENDITURES = GENERAL FUND SUBSIDY ($149.6M - $49.9M)	$0	($33,885,493)	($88,004,526)	($99,809,000)	($99,699,941)
DPH PER PARTICIPANT EXPENDITURE ($149.6M ÷ 654,129)	--	$364	$296	$236	$229
DPH PER PARTICIPANT REVENUE ($49.9M ÷ 654,129)	--	$96	$87	$68	$76
PER PARTICIPANT GF SUBSIDY ($99.7M ÷ 654,129)	--	($268)	($209)	($168)	($152)

Participant months totaled 654,129 in FY2010-11 (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 $272 ($1177.8 million in expenditures divided by 654,129 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 FY2010-11 per participant per month cost of $272 is slightly less than the FY2009-10 calculation of $276.

Department Expenditures

Department expenditures totaled an estimated $149.634 million in FY2010-11. 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 $141.067 million,
- administration (including the evaluation and information technology) was roughly 6% of total estimated Department expenditures at $8.567 million,

A portion of Department expenditures reflects reimbursement for non-Department medical homes and emergency ambulance transportation ($14.4 million), incremental UCSF reimbursement for services rendered at San Francisco General Hospital ($6.3 million), and incremental behavioral health provider funding ($1.4 million).[15] This totaled an estimated $22.1 million in FY2010-11 or 15% of Department service costs. In addition, as noted in Section C (Table C1) a portion of Department service costs at San Francisco General Hospital support hospital based specialty, urgent care, diagnostic, emergency care, home health, pharmacy, durable medical equipment and/or inpatient services to not only Department clinics, but several other private providers in the network.

Department Revenues

Non-General Fund revenues totaled $49.3 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, 2011, approximately 34% of participants were at or above 101% of FPL. For the fiscal year ending June 30, 2011, the participant payment rate was approximately 80% with quarterly participation fees of $5.17 million received from participants and forwarded to the Department.[16] 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, 2011, the Department collected an estimated $615,000 in HSF point-of-service fees. The amount of point-of-service fees paid by HSF participants to non-Departmental HSF providers is not known to the Department and is not included in the calculations. [17]

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[15] 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.

[16] 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.

[17] 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.

General Fund Subsidy

The difference between the expenditures and the revenue was covered by a City and County General Fund subsidy of approximately $99.7 million. It is represented as a negative number to show the shortfall between revenues and expenditures. The FY2010-11 General Fund subsidy was essentially the same as the FY2009-10 General Fund allocation at $99.8 million.

Department Per Participant Per Month Costs

As noted above, there was a total of 654,129 participant months in FY2010-11. The estimated total Department per participant per month expenditure was $229 ($149.6 million in expenditures divided by 654,129 participant months). Of the $229 per participant per month cost, $76 (33%) was covered by revenue and $152 (67%) was covered by General Fund subsidy.

From FY2009-10 to FY 2010-11, there was a 3.1% decrease in Department per participant per month expenditures (from $236 to $229 -- a $7 reduction). Department per participant per month expenditures decreased with an increase in expenditures because the percentage increase in participant months (10%) was greater than the percentage increase in expenditures (6.7%) 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 at San Francisco General Hospital and in Community Oriented Primary Care. It is estimated that the costs of providing services to this population was approximately $61.2 million in FY2010-11.[18] As a result, the Department's estimated cost of serving the indigent and uninsured in FY2010-11 is $210.86 million.

Table J6
Estimated Costs of Serving Indigent and Uninsured (Fiscal Year 2010-11)

Uninsured Patient Population	Estimated Cost
HSF Uninsured Population	$149,633,780
Non-HSF Uninsured Population	$61,227,007
Entire Uninsured Population	$210,860,787

[18] This does not include behavioral health costs through Community Behavioral Health Services or long-term care costs at Laguna Honda Hospital.

III. 2011-12 Program Activities

For FY2011-12, in addition to general operational oversight and continued operation of the program, the Department will focus on some of 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 using RelayCare product and
  - expansion of primary care enhancements within primary care settings.

- **Encounter Data Submission**: Continue to work with all HSF providers, in particular non-profit hospitals, on the submission of encounter data to the HSF Clinical Data Warehouse.

- **Evaluation**: Work to strength HSF program by disseminating evaluation findings and examining findings of independent evaluation for any potential program modifications.

- **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.

- **Jail Health Services:** Work with Community Behavioral Health Services and Jail Health Services to ensure that individuals who have been released from local jails or who are transferred from State prison to the County on parole are informed about and enrolled in HSF upon release from custody.

- **Low Income Health Program/SF PATH**: Ensure Department ongoing operation of California's health access program in preparation for federal health reform.

- **Program Renewals**: Continue to monitor and improve on-time participant renewals.

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

The Department will also use FY 2011-12 as an opportunity to examine which data source -- California Health Interview Survey or U.S. Census's American Community Survey – should be used to provide an estimate of the number of uninsured residents.

Appendix A – HSF Data Warehouse Data Collection Summary

	2009						2010												2011		
Submitting Medical Homes	July 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	Jun 10	July 10	Aug 10	Sept 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11
BAART																☺	☺	☺	☺	☺	☺
Brown & Toland																		☺	☺	☺	☺
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 Philippa Health Center			😐	😐	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺

Key

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

Gray: Program not yet started.

😐: Data potentially incomplete. Low volume of services reported.

☺: Data available for program.

☹: No data available for program

Pharmacy Services Data Submissions

	2009						2010												2011		
Submitting Entity	July 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	Jun 10	July 10	Aug 10	Sept 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11
CBHS	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
DPH	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
NEMS	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺

SFGH Hospital Data Submissions

	2009						2010												2011		
Submitting Entity	July 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	Jun 10	July 10	Aug 10	Sept 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11
SFGH	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺

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

	2009						2010												2011		
Submitting Entity	July 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	Jun 10	July 10	Aug 10	Sept 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11
Chinese - CCHCA	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
CPMC - NEMS	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
Kaiser	☺	☺	☺	☺	☺	☺	☹	☹	☹	☹	☹	☹	☹	☹	☹	☺	☺	☺	☺	☺	☺
St Francis - Glide	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
St Mary's – Sr Mary Philippa	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
UCSF -- Radiology	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☹

Charity Care Hospital Submissions – Incomplete Submissions

	2008						2009												2010		
Submitting Entity	July 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	Jun 10	July 10	Aug 10	Sept 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11
Chinese	☺	☺	☺	☺	☺	☺	☹	☹	☹	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
CPMC	☺	☺	☺	☺	☺	☺	☺	☺	☺	😐	😐	😐	😐	😐	😐	😐	😐	😐	😐	😐	😐
Kaiser	☺	☺	☺	☺	☺	☺	☹	☹	☹	😐	😐	😐	😐	😐	😐	😐	😐	😐	😐	😐	😐
St. Francis	☺	☺	☺	☺	☺	☺	☺	☺	☺	😐	😐	😐	😐	😐	😐	😐	😐	😐	😐	😐	😐
St. Mary's	☺	☺	☺	☺	☺	☺	☺	☺	☺	😐	😐	😐	😐	😐	😐	😐	😐	😐	😐	😐	😐
UCSF	☺	☺	☺	☺	☺	☺	☺	☹	☹	😐	😐	😐	😐	😐	😐	😐	😐	😐	😐	😐	😐

APPENDIX B

Summary of FY 2010-11 Health Access Questionnaire Responses (New Applicants and Continuing Participants)

No.	Question	Key 2010-2011 Responses	Key 2009-2010 Responses	Key 2008-2009 Responses
1	Would you say that in general your health is excellent, very good, fair, or poor?	58% of all respondents indicated their health was Excellent, Very Good, or Good.	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?	49% 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.	53% of all respondents indicated that they did not have health insurance for some time in the past 12 months.
3	What is the main reason why you did not have health insurance?	The most common reason noted was "enrollment in Healthy San Francisco." Twenty-nine percent (29%) cited HSF as the reason they 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?	10% of all respondents stated that they had visited a hospital emergency room in the previous 12 months.	12% of all respondents stated that they had visited a hospital emergency room in the previous 12 months.	14% of all respondents stated that they 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?	63% of all respondents most often receive care at a clinic, health center, doctor's office or hospital clinic and 2% of all respondents most often receive care in an emergency room.	71% of all respondents most often receive care at a clinic, health center, doctor's office, 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, doctor's office 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?	45% of all respondents said it was Not At All Difficult or Not Too Difficult to access care when they needed it.	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.

No.	Question	Key 2010-2011 Responses	Key 2009-2010 Responses	Key 2008-2009 Responses
7	How do you rate the medical care that you received in the past 12 months – excellent, very good, good, fair, or poor?	23% rated the medical care they received in the past 12 months as Excellent or Very Good.	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?	8% of all respondents said they had delayed getting care or did not get a medicine prescribed to them during the past 12 months.	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, 10% 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.	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, 11% of respondents smoked (either every day or some days).	Overall, 14% of respondents smoked (either every day or some days).	Overall, 16% of respondents smoked (either every day or some days).
11	Which of the following had the greatest influence in your decision to come in today to renew? Gift card lottery, phone call from HSF, reminded when visited medical home, reminded when called medical home, or you remembered?	Thirty-five percent (35%) of respondents stated the lottery offer as the reason for coming in for renewal.	Not Available – question was not asked	Not Available – question was not asked

Evaluation of Healthy San Francisco

Summary Brief

August 26, 2011

Catherine McLaughlin
Margaret Colby
Erin Taylor
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Tricia Higgins
Vivian Byrd
Laurie Felland

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Policy Research

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Evaluation of Healthy San Francisco

Summary Brief

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EVALUATION OF HEALTHY SAN FRANCISCO

Healthy San Francisco (HSF) is a health care access program for uninsured adults ages 18 to 64 who reside in the City and County of San Francisco. It offers enrollment in a subsidized system of health care, rather than covering the uninsured individual through a health insurance product. HSF provides many of its services through a network of established clinics in San Francisco that historically have served several different populations and neighborhoods.

The HSF program includes delivery system changes intended to improve both the quality of health care for HSF participants and efficiencies within the resource-constrained safety-net environment. HSF participants are required to choose one of the participating clinics as their point of first contact for all of their basic medical care. This approach of selecting and seeking care at a specific medical home is expected to alter the experience for both the provider and the patient, change utilization patterns, and ultimately improve the quality of care and control costs by reducing non-emergent emergency department (ED) visits, potentially avoidable hospital admissions, system inefficiency, and redundancy.

This brief summarizes findings from a comprehensive report on HSF.[1] The study of the HSF program relied on a large number of data sources and included a rich set of quantitative and qualitative data. Data sources informing this report include:

- HSF enrollment and encounter data for 95,580 unique enrollees covering the period from July 2007 through March 2011
- Encounter and enrollment data for 1,256 enrollees in the Healthy Workers (HW) program for the same time period
- The 2009 American Community Survey (ACS)
- A 2009 survey of early HSF participants conducted by the Kaiser Family Foundation
- Five focus groups of HSF participants and four focus groups of adults eligible for but not enrolled in HSF[2]
- The Health Access Questionnaire (HAQ) conducted by HSF at enrollment, renewal, and re-enrollment covering the period December 2008 through March 2011
- Inpatient and ED discharges occurring in California hospitals from 2005 through 2009 from the California Office of Statewide Health Planning and Development (OSHPD)
- A 2010 survey of health care providers participating in HSF[3]
- Three site visits that included in-depth interviews with HSF key informants

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[1] This brief was completed as part of Mathematica's evaluation of HSF. For the complete report on which this brief is based, see [http://www.healthysanfrancisco.org/about_us/Reports.aspx].

[2] Conducted in 2010 and 2011 by Corey, Canapary, and Galanis Research (CCG).

[3] Administered by CCG.

Basic Design of HSF

The HSF program, launched in two pilot clinics in July 2007, provides primary care (including preventive and routine care), as well as specialty, hospital, and behavioral health care and prescription drugs. Dental, vision, acupuncture, and long-term care services are some of the services not included. People apply for HSF at participating clinics (San Francisco Department of Public Health [SFDPH], San Francisco Community Clinic Consortium [SFCCC], Sister Mary Philippa, and others), at a central enrollment unit located at San Francisco General Hospital (SFGH) or the San Francisco Health Plan (SFHP).

Participants with household incomes over 100 percent of the federal poverty level (FPL) pay a quarterly fee to participate in the program and, in some cases, a point-of-service (POS) fee for some doctor visits, prescriptions, and certain ED visits. Both of these fees vary by family income and household size. Those with incomes below 100 percent of the FPL—the majority of HSF participants—pay no participant fees and may pay no POS fees (depending on the medical home). Income-related eligibility limits were phased in over time, starting with people with incomes below 100 percent of the FPL and gradually increasing to the current threshold of 500 percent of the FPL.

The City uses the One-e-App system, a commercially available web-based enrollment product that had been effective in enrolling participants into a range of local and state health and social service programs. The One-e-App software first screens applicants to rule out possible eligibility for other public insurance programs, including Medi-Cal, the State's Medicaid program. At the end of the enrollment year, HSF participants renew their eligibility by completing a re-enrollment interview, providing updated proof of income and residency status.

HSF first focused on improving coordination within the existing network of providers and creating one system of record for patients already visiting these clinics. Relatively early in implementation, the program added other providers with a mission of caring for the uninsured, such as Sister Mary Philippa Health Center with St. Mary's Medical Center. Over time, additional private providers joined the program as medical homes, including Chinese Community Health Care Association (CCHCA) with Chinese Hospital, Kaiser Permanente, Brown & Toland Physicians with California Pacific Medical Center (CMPC), and BAART Community HealthCare Programs. SFGH provides the bulk of the hospital care for HSF participants, although other hospitals—including CPMC, Chinese Hospital, St. Francis Memorial Hospital, St. Mary's Medical Center, Kaiser Permanente Medical Center, and the University of California at San Francisco (UCSF) Medical Center—also provide hospital care for HSF participants.[4]

A cornerstone of HSF is participants' selection of a medical home—that is, a place or provider, most typically a clinic—at the time of enrollment. HSF defines the medical home as the place where a participant goes for basic medical care, including routine and preventive care, acute care, and care

[4] For more information about the HSF medical homes, see Taylor, Erin, Tricia Higgins, Catherine McLaughlin, Diane Rittenhouse, Gregory Bee, and Kevin Bradway. "Understanding the Healthy San Francisco Medical Home Concept and How it Functions for Different Patient Populations." Mathematica Policy Research. September 30, 2010. Available at: [http://www.healthysanfrancisco.org/files/PDF/HSF_Medical_Homes_Report_Full_20100927.pdf].

for ongoing health problems, such as asthma or diabetes. The medical home is intended to serve as the usual source of care, although its providers may refer participants when needed to other providers in the HSF network. Participants can select any medical home (most choose the one where they received care in the past) and they can shift to a different one at the time of renewal, which occurs every 12 months. More than 30 medical homes are included in the HSF network of providers (although not all may be accepting new participants at any given time).

Trends in Enrollment and Retention

The HSF program has now been operational for four years, and has attracted more than 95,000 enrollees from July 2007 through March 2011. As of March 2011, there were more than 54,000 enrollees; almost one-quarter had been enrolled for at least 24 months. Enrollments of new clients have averaged about 2,100 each month. While almost all of the early enrollees were established patients within the SFDPH or SFCCC systems, most recent HSF enrollees had no prior contact with their chosen medical home in the previous two years. Because the network of clinics participating in HSF has a broad reach across the City, the population of HSF enrollees is ethnically and linguistically diverse; however, income eligibility expansions have not led to changes in the overall income distribution of enrollees.[5]

Who Enrolls in HSF?

The demographic composition of HSF enrollees has changed over time, although the income distribution of new enrollees has remained steady. The first cohort of enrollees was more likely to be near-elderly (55 to 64 years old), female, and ethnically and linguistically Chinese, reflecting the characteristics of populations served by the HSF pilot clinics: North East Medical Services (NEMS) and the Chinatown Public Health Center. The most recent group of new enrollees were more likely to be male, younger (18 to 44 years old), and English-speaking. The income distribution of new enrollees has remained steady since the expansion of eligibility to 500 percent of the FPL. Just under two-thirds of each cohort report household incomes of 0-100 percent of the FPL, and another quarter reports income between 101 and 200 percent of the FPL. The stable income distribution and continued strong enrollment in a program completing its fourth year suggest that HSF continues to reach new pockets of low-income uninsured San Franciscans.

While many new HSF enrollees were established patients, some reported weak prior connections to the health care system. More than 90 percent of enrollees since 2009 completed the HAQ upon enrollment. About half of respondents reported a clinic or doctor's office as their usual source of care prior to enrolling in HSF, a rate comparable to that of Medi-Cal or Healthy Family enrollees.[6] By comparison, only 26 percent of uninsured residents of California reported using a doctor's office or HMO as their usual source of care. Nevertheless, some new HSF enrollees lacked a strong prior connection to the medical care system. About 5 percent of respondents

[5] For a full description of HSF enrollment and retention patterns, see Colby, Margaret, Catherine McLaughlin, Gregory Bee, and Tricia Collins Higgins. "Participation in Healthy San Francisco: Trends in Enrollment and Retention." Washington, DC: Mathematica Policy Research, February 2011. Available at: [http://www.healthysanfrancisco.org/files/PDF/Trends_in_Enrollment_and_Retention.pdf].

[6] Exhibit 2.13A from *California Health Care Chartbook: Key Data and Trends*, Kaiser Family Foundation, 2004, available at http://www.kff.org/statepolicy/7086/upload/California-Chartbook-Section-2-PDF.pdf.

considered the ED their usual source for care; another 11 to 12 percent reported not having a usual source for care. Fewer than 30 percent reported that accessing medical care in the past year had been difficult.

Which Eligible Individuals Do Not Enroll in HSF?

HSF appears to have enrolled a large portion of working-age uninsured adults in San Francisco. According to the ACS, in 2009 there were an estimated 77,588 individuals in the HSF target population. As of December 2009, HSF enrollment was 49,556, or about 64 percent of the target population. HSF has been particularly effective in enrolling the older population (reaching about 87 percent of the target group ages 40 to 64), English speakers (reaching 76 percent of the target group), and Asian and Pacific Islanders (88 percent of the target group).

HSF enrollees are less likely to be younger uninsured adults or from households with incomes above 300 percent of the FPL. Enrollment rates for the youngest age groups lag those for older adults in the target population. For example, the program has reached just under half of the target group ages 18 to 24. Enrollment rates for those from higher-income households also lag those from lower-income households. For example, HSF appears to have enrolled about 14 percent of the target population with incomes above 200 percent of the FPL. Demographic characteristics of the most recent cohorts suggest that coverage of the youngest group may have improved since December 2009; however, continued slower enrollment of higher-income participants (at or above 300 percent of FPL) implies little change in coverage of this population group. Several explanations may account for the gap in HSF enrollment relative to the estimated target population. Younger adults who may not have current health issues may simply place a lower value on enrollment. Low enrollment among somewhat higher income groups may be due to personal preferences or to a reluctance to make required financial contributions for a service they do not want or believe they need. These individuals are also more likely to have had private coverage in the past and may expect to regain coverage relatively soon.

Who Remains Enrolled in HSF and for How Long?

More than 85 percent of HSF enrollees remain in the program for at least 12 months, and more than half (56 percent) of them renew enrollment at the first opportunity. Another 16 percent who either had a short first period (less than 12 months) or failed to renew at the end of the 12-month enrollment period, eventually re-enrolled in the program. Altogether, two-thirds of enrollees for whom we can observe renewal and re-enrollment decisions by March 2011 signaled the value they place on HSF enrollment by actively opting into the program for a second period. For participants who renewed or re-enrolled in HSF, 59 percent renewed at their second renewal opportunity. Nearly one-quarter (15,750 enrollees) have experienced at least 24 months of continuous enrollment.

Why Do Individuals Leave HSF and Who Returns?

In the majority of cases, the reason an HSF participant exits the program remains unknown. In cases where the reason is known, loss of HSF eligibility accounts for more than half of exits prior to renewal. For many that is a positive development; roughly three-quarters of these individuals became insured through either private or public coverage sources. The remainder who lost eligibility aged out of the program, moved out of San Francisco, or died. After loss of HSF eligibility, making an insufficient payment is the leading reason for exiting HSF prior to renewal.

However, insufficient payment does not necessarily reflect a financial burden to the enrollee; it may simply mean the enrollee did not make a payment. Some participants in the focus groups said cost was a reason for leaving the program, but they added that the costs were very reasonable, just not affordable for them at that time. These participants did not indicate that they contacted the HSF program to discuss their participation fee.

While we have some data on disenrollment reasons for early exiters, virtually all those exiting the program at month 13 did so for failure to complete re-screening. This blanket disenrollment reason masks several potential explanatory factors. Participants may have become ineligible without notifying HSF (for example, they may have moved out of the City or gained access to insurance), or they may be relatively healthy individuals who have already addressed an episodic health care need during the first enrollment period. In 2010 the HSF program increased its efforts to track individuals who had not renewed to obtain information on why they may made that choice. While followup with this group is challenging, data suggest that more than 25 percent of those contacted who did not intend to renew had relocated outside of San Francisco or obtained public or private coverage.

Factors predicting retention, renewal, and re-enrollment are consistent with expectations that individuals for whom HSF represents a high-value or long-term solution, those with closer relationships to the medical home, and those who likely have more stability in their residency situations are more likely to remain in or return to HSF. Controlling for other factors, retention has been relatively stable over time. The following factors were statistically significant predictors of remaining enrolled for 12 months:

- Individuals 45 to 64 years old were more likely to stay enrolled than 18- to 24-year-olds
- Whites (relative to blacks and Latinos) and ethnically Chinese and Chinese-speaking enrollees (relative to whites and English speakers) were more likely to stay enrolled
- Participants from households with incomes below the FPL were more likely to stay enrolled
- Those who were established patients at the medical home were more likely to stay enrolled
- Those with an ED visit during the first enrollment, with physician visits, and with one or more chronic conditions all were more likely to stay enrolled

Similar factors were positively associated with those staying enrolled then renewing at 12 months and for those who did not renew but came back and re-enrolled within 18 months of exiting. There were some differences, however. Enrollees from higher-income households who stayed enrolled were more likely to renew at 12 months than those from households below the FPL.[7] Although those who were homeless were less likely to stay enrolled, homeless participants

[7] Because those with incomes below 100 percent of the FPL do not pay a participation fee, we were initially concerned these results were due to measurement error; that is, there may not be a formal disenrollment signal because HSF does not contact participants under the FPL who do not pay a participant fee to determine whether they are using or planning to use services. However, we found that among those with incomes below the FPL who remained nominally enrolled to 12 months and then exited at month 13, 70 percent used services during the third and fourth quarter of their first enrollment year, a clear signal that they were still enrolled and engaged in the program.

who did were more likely to renew than those who were never homeless. Black and Latino participants were less likely than white participants to stay enrolled, and, among those who remained in the program, less likely to renew; however, black and Latino participants who left the program were more likely to re-enroll than white participants. Participants who disenrolled because they became ineligible were less likely to re-enroll, most likely reflecting continual ineligibility; those who disenrolled for failure to pay the fee were more likely to re-enroll.

Changes in Access to and Utilization of Health Care Services

Our analyses suggest that HSF is providing access to timely and coordinated primary care services to a population who greatly needs them. In general, HSF participants are very satisfied with their access to health care services. Even though the majority of these HSF participants were established patients in the HSF medical homes prior to enrolling, participating in the program alleviated financial and nonfinancial barriers to medical care for a large portion of them. Most HSF participants are regularly receiving outpatient care at their medical homes, including recommended preventive services, and are using fewer ED services over time, both emergent and non-emergent, which suggests both improved care-seeking behavior and health status.

How Did HSF Change Access to Health Care Services?

In general, HSF participants were satisfied with their access to needed health care services. In the HAQ, few of those responding at the time of renewal or re-enrollment stated that they had experienced delays in obtaining needed care during the previous 12 months in the program. Participants in the focus groups expressed satisfaction with access to primary care services in general and preventive services in particular. At the same time, many of them had concerns about the wait to see a specialist, and that was echoed by providers who participated in our survey.[8] Nonetheless, most participants rated the care they received from HSF clinics favorably. In both the HAQ and the focus groups, there was uniform agreement that the quality of care they were receiving was quite high.

In addition to looking at perceptions about access to and satisfaction with the care received during their first 12 months in the program, we also looked at changes in the responses to these questions for HSF enrollees who filled in the HAQ at time of enrollment and then again at time of renewal or re-enrollment after a gap of one to four months. The responses provided at enrollment reflect their access to care prior to joining HSF, while the responses at renewal or re-enrollment reflect their experience in the HSF program. Even though enrolling in HSF is not the only change that could affect perceived access (a participant could, for example, sustain an injury during the year), comparing responses from the second survey to responses from the first survey does provide some indication as to whether participants, on average, perceived a change in their access to health care services during enrollment in HSF.

[8] We do not know whether the perceptions of the one in four enrollees who responded either "don't know" or refused to answer this and other questions on the HAQ are similar to the perceptions of those who responded. Similarly, it is difficult to generalize from the comments of those who participated in the focus groups. We give more weight to opinions that are expressed in the HAQ, the focus groups, the provider survey, and site visit interviews.

More than 40 percent of participants felt access to care was easier now that they were in HSF; more than one-third felt access did not change with participation in HSF. The majority of participants did not report delaying care when they first enrolled in HSF and did not report a change in delays to care a year after enrolling (77 percent). Very few reported delays at both enrollment and one year later. A notable portion, however, reported some delays in seeking care at enrollment but no delays after participation in HSF (17 percent). The majority of participants reported visiting a clinic or doctor's office as their usual source of care both before and after enrolling in HSF (74 percent). Slightly more than 20 percent were able to transition from visiting EDs or not having a usual source of care to visiting a doctor's office or a clinic as their usual source of care.

One in three participants felt the quality of their care improved with participation in HSF. Although many participants felt their care before and after enrolling in HSF was the same (44 percent), 34 percent said it improved. Participants were most likely to report that their health status improved while receiving care from HSF clinics. Overall, 28 percent of respondents indicated improvements in self-reported health status during the year that they participated in HSF.

To What Extent Are HSF Participants Utilizing Primary Care Services?

Having HSF participants select a medical home is intended, in part, to provide a usual source of care that strengthens the connection to primary care, with the aim of improving timely access to needed primary care and increasing preventive care. By requiring participants to select a medical home, the HSF program establishes, or for those already seeking care in these settings, formalizes, a usual source of care for enrollees. We found that most HSF participants are visiting their medical homes and many are receiving recommended preventive services.

For those enrolled for at least 12 continuous months, 80 percent received at least one service. Few of those in the HSF program with service use during the first month of enrollment did not go on to use additional services, suggesting that enrollment in HSF for "one-time" care is rare. Nearly three-quarters of HSF participants had at least one physician visit in the first year of enrollment, and almost half received at least one recommended preventive service.

HSF participants and HW enrollees had similarly high utilization levels. Almost two-thirds of HW enrollees had at least one encounter during the first year of enrollment—even though, on average, HW enrollees are more likely to be female, a bit older, and have fewer chronic conditions than HSF participants, characteristics that may affect the need for and receipt of health care services. HW enrollees were less likely to have a physician visit during their first year of enrollment (60 percent versus 71 percent for HSF enrollees) or to receive any preventive service (44 percent versus 48 percent for HSF enrollees).

Nearly all individual characteristics that we examined were significant predictors of the likelihood of receiving primary care, controlling for an array of factors. Women were more likely to have any physician visits during the year when compared to men. Young adults (those younger than 25) were less likely to have a visit during the first two months than those older than 45, but there were no significant differences between the youngest and the oldest in the likelihood of having a visit during the first year. Those with higher chronic disease burden were more likely to have any visits, as were those with a mental health diagnosis; however, participants with a substance abuse diagnosis were less likely to have a physician visit. English speakers and those for whom an SFCCC clinic is their medical home were also more likely to have one or more physician visit during

the first year and during the first two months. However, those who were not previous users of their HSF medical home and the homeless were less likely.

For preventive services, older individuals, non-whites, higher-income groups, Chinese speakers, individuals with greater chronic disease burdens, and those enrolled with SFDPH medical homes all were more likely to receive at least one specified preventive service. Older participants were more likely to receive preventive services. Also, for both care soon after enrollment (within the first two months) and preventive care, the higher levels increased with age; for example, participants 45 to 54 years of age were approximately twice as likely to receive preventive services as those under 25 years old, whereas those 55 years of age and older were almost three times as likely as the youngest group.

Most HSF participants had between one and 6 physician visits per year, and a small percentage had monthly, or more frequent, visits. About 29 percent of HSF participants had no physician visits, another 27 percent had just one or 2 visits, and 28 percent had between 3 and 6 visits during the first year. Five percent had 12 or more visits during the year. A larger percentage of HW enrollees (40 percent) had no physician visits during the first year of enrollment, but a higher percent (10 percent) had 12 or more visits during that time period. Physician office use increased with increasing chronic-disease burden. Those with two or more chronic conditions had notably more visits than those with no chronic conditions. This difference was greater for those in the HW program, explaining in part the higher percentage experiencing 12 or more visits. Age and health status are correlated with each other; however, while the differences in use diminished once various individual characteristics were controlled for, both age and the presence of chronic conditions remained significant determinants of use.

Most participants with ED visits or inpatient admissions received prompt outpatient followup. Eleven percent of HSF participants had an ED visit, while 3 percent had an inpatient hospitalization during their first year of enrollment. HW enrollees had experienced similar frequencies. While most HSF participants using hospital services received a follow-up physician visit within one month of discharge, about 44 percent of participants with ED visits and 29 percent of those with an inpatient admission did not obtain a follow-up outpatient visit within one month. Similar levels of followup were experienced by the HW enrollees.

To What Extent Has HSF Led to a Decrease in Emergent and Non-Emergent ED Visits and in Potentially Avoidable Hospitalizations?

HSF participants show steadily declining ED use over time. HSF participants who were enrolled for 24 months or more show declining use of the ED during their enrollment. Only 18 percent of participants who had an ED visit during their first year had another visit during their second year. The percentage of HSF participants who had at least one repeat ED visit was noticeably lower than that experienced by HW enrollees; almost 40 percent of those with an emergent ED visit during the first year had another during their second year, and almost one-fourth of those with a non-emergent ED visit repeated.

We note that non-emergent ED use will never reach zero because primary care clinics do not provide 24/7 access to care and some participants inevitably will develop urgent conditions during evening or weekend hours that would have been treatable in a primary care setting. Even so, over 90 percent of those with no chronic conditions who had a non-emergent ED visit during their first year did not have one during their second year. Declines in emergent care use may be due to health status

improvements that beneficiaries have realized as a result of improved primary care through their HSF medical home.[9]

Chronic disease burden and homelessness were the primary factors predicting both ED visits and inpatient hospitalizations in regressions controlling for individual characteristics. Household income also predicted ED use, and age predicted inpatient hospitalizations. Participants with one or more chronic conditions were more likely to have non-emergent ED visits, emergent ED visits, and inpatient hospitalizations, relative to those with no conditions. Those with substance abuse diagnoses also were more likely to use all hospital services, and those with mental health problems were more likely to have non-emergent ED visits but less likely to have an inpatient admission. Reflecting their increased exposure to health hazards (inconsistent nutrition and shelter) and likely reduced ability to connect with available primary care services to manage chronic conditions consistently, homeless individuals were about twice as likely to use the ED and 65 percent more likely to have a hospitalization.

To analyze the impact of HSF on ED use and potentially avoidable hospitalizations, we examined trends at SFGH, the primary hospital for HSF participants, compared to all other public hospitals in California (n=16). We compared trends for the HSF target population (uninsured or self-paying non-elderly adults) to three control groups: insured adults (Medi-Cal, Medicare, or private insurance), children, and the elderly. Because HSF has enrolled more than half of uninsured adults in the City, we would expect that changes in hospital utilization patterns among HSF participants may be sufficiently large to affect the utilization trends among uninsured patients using SFGH. Trends for insured adults, children, and the elderly illustrate whether there may be underlying citywide or statewide utilization trends driven by provider supply or accessibility. If HSF has had an impact on ED use or potentially avoidable hospitalizations, use among the uninsured or self-pay adult population at SFGH should have declined beginning in 2007 relative to the trends in use for other populations and at other hospitals.

HSF may be associated with a decrease in the number of non-emergent ED visits to SFGH made by uninsured adults. In 2005 and 2006, uninsured adults made about 6,600 non-emergent ED visits to SFGH. In 2007, the year during which HSF was launched, the number of non-emergent ED visits made by uninsured adults began to decline, reaching 4,500 visits by 2009.[10] Concurrent with this decline, HSF enrollment grew steadily, reaching more than 45,000 by the end of 2009. In contrast, the average number of non-emergent ED visits among uninsured adults at other public hospitals in California grew from 2005 to 2009. Insured adults and children made slightly more non-emergent ED visits to SFGH and other public hospitals in 2009 than in 2005, and

[9] Our data on ED utilization primarily reflect care delivered at SFGH. While some hospitals participating in HSF began reporting ED and inpatient use in 2009, others began submitting these data only recently. In addition, some HSF participants may receive care at hospitals that do not participate in HSF. As a result, we cannot rule out the possibility that at least some of the observed declines is due to participants shifting utilization to other emergency facilities in San Francisco. However, we have no evidence to suggest that this is occurring. Indeed, OSPHD patient discharge data suggest that SFGH provided a greater proportion of the City's charity care in 2009 relative to 2007.

[10] We present counts of ED visits rather than a rate—for example, the percentage of uninsured non-elderly adult residents with an ED visit—because we do not have accurate estimates of the appropriate denominator (the number of uninsured and insured non-elderly adults, elderly adults, and children) on an annual basis for San Francisco and the other counties in California.

use among the elderly remained steady. Because the decrease in non-emergent ED visits began in the year that HSF was launched, was seen only in the program's target population group, and was different from the general trend for California public hospitals, there is some evidence suggesting that the HSF program may have led to uninsured adults in San Francisco reducing their use of the SFGH ED for non-emergent care.

Uninsured adults in San Francisco made fewer emergent ED visits in 2009 than in 2007, but the decline is not necessarily attributable to the HSF program. From 2005 to 2009, the number of emergent ED visits to SFGH by uninsured adults declined steadily, reaching 1,985 in 2009. During the same period, the number of emergent ED visits for all other groups increased. Children and the elderly made slightly more emergent ED visits to SFGH and other public hospitals in 2009 compared to 2005 and insured adults at all public hospitals made many more visits. While we are certain that HSF's target population made fewer emergent ED visits during the program's operation (2007 to 2009), the decline was a continuation of the trend that began before the launch of HSF. Thus, while it is possible that HSF allowed this trend to persist or accelerate, we are uncertain whether the decline in emergent ED visits can be attributed solely to the HSF program.

HSF may be associated with a decrease in potentially avoidable hospitalizations made by uninsured adults in San Francisco. In 2005 and 2006, about 6.5 percent of hospitalizations for uninsured adults at SFGH were potentially avoidable. Beginning in 2007, the year of HSF's launch, potentially avoidable hospitalizations among the uninsured at SFGH began to decline, reaching 5.8 percent of all hospitalizations by 2009. In contrast, the percentage of potentially avoidable hospitalizations among insured adults at SFGH remained steady from 2007 to 2009, while the rate among the elderly grew from 14.6 to 15.8 percent. At all other public hospitals in California, the percentage of potentially avoidable hospitalizations among insured and uninsured adults rose over the period of 2007 to 2009 and remained steady for the elderly. As was the case with the observed trend in non-emergent ED visits, because the percentage of potentially avoidable hospitalizations (1) began to decline the year that HSF was launched, (2) was seen only in the program's target population group in San Francisco, and (3) was different from the trends for adults in other California public hospitals, there is some suggestive evidence that the HSF program has helped uninsured adults in San Francisco avoid hospitalizations for ambulatory care sensitive conditions.

Program Financing and Expenditures

HSF was designed to leverage existing resources so new funds would augment and not replace other charity care, sliding scale, and grant funding sources for the uninsured. The full cost of caring for HSF participants includes costs financed by these various other funding sources. This includes financial contributions from employers through the Employer Spending Requirement (ESR),[11] the City and County's general fund, and program participants. From 2007 to 2010, additional funding came from a 10-county California Medicaid waiver program, the Health Care Coverage Initiative (HCCI) that aims to move Medi-Cal to a system centered on primary and preventive services delivered through a medical home. HCCI funds supported delivery system improvements within the

[11] Under the ESR, employers who have more than 19 employees can choose to meet their spending requirement by contributing to the "City Option," through which employees can participate in HSF (if they meet eligibility criteria) or access funds in a medical reimbursement account administered by the SFHP.

SFDPH system and offset some of the costs of care for HSF participants with household incomes under 200 percent FPL who met other federal requirements and enrolled in an SFDPH medical home.

Private community clinics participating in HSF finance care for the uninsured with several funding sources, ranging from self-pay and third-party revenues to grants from federal, state, and local sources. HSF provides some compensation for costs associated with participation in HSF, including enrollment activities and provision of encounter data. Nonprofit hospitals in San Francisco serve uninsured patients through their charity care programs and receive no direct payments from HSF for the costs of such care to HSF participants.

The largest source of SFDPH revenue for the program has been the HCCI waiver, which brought in $50,191,354 during the three years of the waiver program, 53 percent of total SFDPH revenues. As of October 2010, an additional $2.15 million in HCCI funds were allocated for program administration but are not yet received because of State delays in developing an approved protocol for claiming these costs. The next largest source is revenue from ESR expenditures, totaling $36,394,245 (39 percent of total SFDPH revenue). Participation fees amounted to $9,091,900 and account for almost 10 percent of SFDPH revenue. SFDPH general funds financed program start-up costs during the first year, just over 5 percent of total SFDPH revenues. Remaining revenue came from various foundation sources, and covered primarily evaluation activities.

SFDPH expenditures for HSF through FY 2010 totaled $315,663,792. Almost all of this was for service delivery—86 percent for services provided at SFGH (for both SFDPH and private providers), SFDPH clinics, and contracted behavioral health services (for all HSF medical homes) and another 7 percent for services delivered by private clinics, hospitals, and other HSF providers.[12] The remaining 7 percent was for administration, information systems, and capital improvements. HSF-attributable expenditures by non-SFDPH providers were estimated at $35,077,479 in FY 2010; after subtracting SFDPH reimbursement, net expenditures amounted to $24,087,375, or roughly 15 percent of total expenditures for that program year. SFDPH expenditures that exceed available revenue are covered by City and County general funds. This substantial subsidy covered more than 70 percent of total SFDPH expenditures, amounting to $221,699,019 during the program's first four years.

SFDPH expenditures per person month averaged $276 from FY 2008 to FY 2010, starting out considerably higher the first year and declining by roughly $60 in each of the subsequent years. Notably, $276 was also the person month expenditure figure for FY 2010, when non-SFDPH expenditures were included.

[12] SFGH provides hospital based specialty, urgent care, diagnostic, emergency care, home health, pharmacy, durable medical equipment, and inpatient services to not only SFDPH clinics, but also to the seven participating SFCCC clinics and BAART Community HealthCare (excluding pharmacy). In addition, it provides specialty services not available at NEMS and to Sister Mary Philippa Health Center through its partnership with St. Mary's Medical Center. SFDPH provides all contracted behavioral health services for all HSF participants at all of the medical homes – both its own and all of the private providers.

Summary and Implications

HSF has attracted a large portion of the low-income uninsured working-age adults in San Francisco. For some of them, HSF is a stop-gap measure until they regain or obtain public or private insurance coverage; for others, especially those who have been without insurance for a long time and have no immediate prospects of obtaining coverage, it provides access to coordinated preventive and primary care services.

Our analyses suggest that HSF participants are regularly receiving outpatient care at their medical homes, including recommended preventive services, and are using fewer ED services over time, both emergent and non-emergent, which suggests both improved care-seeking behavior and health status. In the focus groups, HSF participants, particularly those who have renewed or re-enrolled in the program, expressed appreciation both for the improved access to primary care and the reduction in uncertainty in meeting their health care needs.

Our analyses also show that, while most participants access care early in their enrollment, many also have subsequent visits during the first year of enrollment, suggesting that, for the most part, participants are not just enrolling in the program when they seek care at SFGH's ED or at one of the medical homes, then disengaging soon thereafter. More than 60 percent of participants signaled the value they place on HSF enrollment by actively opting into the program for a second period.

In general, providers expressed satisfaction with the HSF program and intended to continue participating. Most had noticed either no change in access and utilization or improvements for those patients who had enrolled in the program and virtually all of them thought they were able to provide better, more coordinated care to their low-income uninsured patients. At the same time, many providers interviewed during site visits commented on increased pressures in the broader health care delivery system; problems of too few resources and too many patients, and general frustration with getting access to care for some patients.

Caring for Low-income People in a Reformed Health Care System. The passage of federal health reform legislation in March 2010 has led states and communities across the country to start preparing for the sweeping changes set to occur by January 2014. The Medicaid expansions and coverage subsidies authorized by this legislation will expand health insurance coverage to a large portion of the currently uninsured. Those who remain uninsured will include undocumented immigrants; those excluded from coverage mandates; and others eligible for coverage who remain uninsured by choice, often because insurance remains unaffordable. California is accelerating implementation of certain health reform components through a Medicaid waiver program called "Bridge to Reform." When reforms are fully in place, program staff estimate, roughly 60 percent of the HSF population will gain coverage, and the remaining 40 percent will remain uninsured and still need care through HSF.

HSF has helped San Francisco prepare for health reform in several important ways. Perhaps most important, its centralized system for enrolling and tracking the uninsured gives the City a substantial lead in identifying and enrolling people who become eligible for reform programs. By leveraging existing resources for the uninsured and organizing the delivery system, HSF was able to expand access to care for both new and existing uninsured adults with less additional funding than would have been required to provide insurance coverage.

HSF also helped to organize and expand the delivery system for uninsured and low-income adult populations and strengthened the position of its providers to compete successfully in a more competitive health care landscape. When health reform takes effect, safety-net providers will be competing with other providers for millions of newly insured people while also continuing to care for the remaining uninsured. Providing high quality care efficiently will be essential to survival in that environment. By connecting each person with one specific medical home and increasing providers' accountability for a set of patients, HSF has demonstrated that it is possible to generate important access and quality improvements for low-income adults with multiple health problems.

Lessons also emerged from HSF about how a program like this may influence the costs of caring for the uninsured. First, some long-term cost savings are possible, through fewer ED visits and potentially avoidable hospitalizations. Encouraging HSF participants to go to their medical homes for care they previously sought at the ED, and providing more consistent and better coordinated primary care in the medical homes should save the safety-net system money. At the same time, short-term costs of preventive and primary care services may increase as uninsured people become more connected with a medical home. Although HSF sought to use existing resources to maximize funding availability and to ensure stable funding, additional resources were required to cover new costs—not surprising, given the number of new people brought into the system. Other communities will have to think creatively about opportunities for reallocating available resources.

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