LAYING THE FOUNDATION FOR HEALTH CARE REFORM: LOCAL INITIATIVES TO INTEGRATE THE HEALTH CARE SAFETY NET

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EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) provides an opportunity to transform local health care safety nets into seamless systems of care. An assessment of safety net integration activities underway in five study counties—Contra Costa, Humboldt, San Diego, San Joaquin, and San Mateo—suggests much progress has been made to this end. All are focusing on systems-wide integration (e.g., launch of their Medi-Cal Waiver Low Income Health Programs), cross-provider integration (e.g., mental health and primary care integration, e-referral systems), and patient-level integration (e.g., Nurse Advice lines, Certified Application Assistors). Most are considering Accountable Care Organizations (ACOs), consumer ePortals, and Health Information Exchanges (HIE). In addition to undertaking diverse integration initiatives, their information technology (IT) infrastructures continue to evolve albeit in a piecemeal fashion. There is evidence that many of these initiatives are resulting in coordinated care and strengthened partnerships between providers and county agencies, facilitating implementation of health care reform. Though there are differences in capacity and the resources that counties bring to bear, there are specific strategies and models that can be adopted by others, particularly in the areas of specialty care access, mental health and primary care integration, patient care coordination, and outreach and enrollment.

The comparison of five counties that have made great strides toward creating integrated delivery systems corroborates earlier UCSF findings that great capacity and willingness to reengineer health care for the medically underserved resides at the county level. These counties have the partnerships and shared commitment to create seamless systems of care. The presence of safety net collaboratives and/or nimble organizations, such as Medi-Cal managed care organizations and clinic consortia,

afford counties the ability to secure resources and implement integration initiatives individual stakeholders might not otherwise undertake. The analysis of the 30 safety net integration "best practices" points to several common factors for success, including leadership support at the top, shared leadership among organizations, perseverance of effort, open communications, and buy-in at all levels.

However, delivery system gaps and financial challenges loom large. Funding for these efforts varies by safety net stakeholder, and is piecemeal and project driven. While the high capacity to meet the needs of the newly insured and remaining uninsured bodes well for continued progress in all five counties, these counties nonetheless face significant challenges, be it the erosion of county funding or gaps in access to primary care. Key strategies to expand safety net integration include targeted support for some types of integration activities (e.g., safety net ACOs), IT infrastructure, and broad-based networks, as well as state policymaking that is sensitive to county safety net variation and leverages ACA provisions and policies to support integration (e.g., the Health Benefit Exchange).

Safety Net Integration Best Practice: Health Care Coverage Initiative (HCCI)

San Diego County Health and Human Services Agency, San Diego County

Under the 2005 HCCI, San Diego County made a significant investment in disease management for chronic disease, and extended coverage to 3,700 uninsured adults with incomes under 200% FPL with diabetes and/or hypertension and/or hyperlipidemia. The acute care benefit package covered inpatient, emergency, outpatient, dental, and pharmaceutical services. Enrollees were encouraged to participate in Project Dulce, which combines culturally specific diabetes and hypertension case management using a disease management team and a self-management training program comprised of classes taught by promotoras. The program outcomes were encouraging. The county was able to prove that upstream prevention could achieve financial savings in ER use as well as decrease hospitalization and length of stay. Annual inpatient/emergency costs were $1,324 lower and outpatient/pharmacy costs were $542 higher among program participants who participated in disease management compared to enrollees who did not participate in disease management. The county has been able to build on its efforts and it started enrolling patients as of July 2011 under its LIHP. For more information, please contact Janya Bowman, HHSA Health Care Policy Administration, at Janya.bowman@sdcounty.ca.gov.

Safety Net Integration Best Practice: Specialty Care Access Project

Community Clinic Consortium, Contra Costa County

Funded by Kaiser Permanente Community Benefit Programs, this initiative was launched in 2008 to increase access to diagnostic specialty care services in Contra Costa County, specifically GI care, breast care, and gynecological care. The Community Clinic Consortium led a specialty care access coalition comprised of Operation Access, safety net providers, Contra Costa Health Services, and Alameda Contra Costa Medical Association. It worked with Operation Access to develop a referral system to expand access to free surgeries, and held multiple trainings and shared referral protocols. It also worked with health centers to create the Specialty Care Provider Database to help Referral Coordinators share information about specialty care providers. Project achievements included an 88% increase in referrals to diagnostic breast care services, and a 100% increase in GYN procedures (21) and colonoscopies (20), all between 2008 and 2010. Additionally, community health centers in Contra Costa County referred 361 patients to Operation Access—up 429% from 2008. Operation Access also had enough volunteers to provide free surgeries. The initiative has made significant progress in increasing access to specialty care services and resulted in a lasting collaborative network. For more information, please contact Alvaro Fuentes, Community Clinic Consortium, at afuentes@clinicconsortium.org.

INTRODUCTION

There is a growing consensus that the US health care system should address patient needs in a "comprehensive, continuous, coordinated, culturally competent and consumer-centered" manner, and that coordination of health care services is necessary to this end.[1] Several provisions in the Patient Protection and Affordable Care Act (ACA) strengthen coordination and integration of care among health care providers, with the goal of ensuring that patients get the care they need when they need it. These provisions include the establishment of Accountable Care Organizations (ACOs), adoption of the Patient-Centered Medical Home (PCMH) model of care, testing of payment reforms, (e.g., bundled payments), and community-based collaborative demonstration projects.

Importantly, successful implementation of federal and state health care reform will depend in large part on the ability of *local* health care safety nets to transform themselves into integrated systems of care. They will need to be able to provide patients with a full continuum of care and coordinate care across numerous providers. Local safety net systems must also assist patients in obtaining health insurance (where feasible) as well as help patients transition among Medi-Cal, the health insurance exchange, and other forms of coverage.

Counties in California are integral partners in enacting various provisions of federal reform. California counties have led the implementation of the Section 1115 Medicaid Waiver Low Income Health Program (LIHP), which is providing coverage for uninsured non-elderly adults up to 200% FPL and laying the foundation for anticipated expansions under the Affordable Care Act.[2] Counties will also be involved with implementing ACA provisions in 2014, when an estimated 4.7 million Californians will be newly eligible for coverage through Medi-Cal or the subsidized Health Benefit Exchange.[3] Many of these Californians currently obtain care from county and non-county safety net providers. These same

safety net providers also serve many Californians who are likely to remain uninsured, including an estimated 1.1 million undocumented immigrants.

Some counties have made great strides in creating integrated health care safety net delivery systems, particularly the original ten Health Care Coverage Initiative (HCCI) counties: Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura.[4] These ten counties developed provider networks, shifted the management of chronic care to outpatient settings, and facilitated adoption of the Patient-Centered Medical Home (PCMH).[5, 6] Additionally, the Specialty Care Access Initiative—a partnership of Kaiser Permanente Community Benefit Programs, California Association of Public Hospitals and Health Systems, California Primary Care Association, and California HealthCare Foundation—supported adoption of diverse strategies in 28 county-level safety net coalitions to increase access to specialty care as well as improve communication and coordination between primary care and specialty care.[7] The current Section 1115 Waiver Delivery Systems Reform Incentive Program (DSRIP) also provides a significant opportunity for California's 21 public hospital systems to expand their infrastructure and pilot, test, and replicate new care models.[8]

However, many county safety nets are struggling or are just launching initiatives. As Ku et al. (2011) point out, safety net providers face significant challenges in coordinating care, particularly given the gaps in access to care, state cuts in Medicaid spending, and the lack of a coordinated, sustainable funding base that could create incentives for providers to coordinate care.

Moreover, there is no "one-size-fits-all" approach to integration; strategies have to be adapted to local conditions.[9] Consequently, safety net integration will be shaped by conditions at the county level, such as provider mix, demographics, income levels, geography, and historical responsibility for medically indigent adults (MIAs). Additionally, different models of county health care safety net systems may require different integration strategies. The 24 largest counties in California provide services to the medically indigent using one of three models: "provider counties," which operate public hospitals and outpatient clinics (e.g., Santa Clara and Alameda), "payor counties," which contract out services for low-income populations to private and non-profit providers (e.g., San Diego and Orange), and "hybrid counties," which contract with private hospitals but also operate public clinics (e.g., Sacramento and Santa Cruz).[10] A uniform approach to safety net integration would be unfeasible given the differences in the underlying structure of these three models.

To support implementation of health care reform, UCSF conducted a descriptive study of five diverse county health care systems that have launched safety net integration initiatives. The in-depth, case-study approach used in this study allowed us to delve deeply into the challenges, failures, and successes of some of the California counties that are blazing the trail in safety net integration. In this report we describe lessons learned on the ground from the implementation of these activities, consider how these lessons can be applied elsewhere, and provide recommendations for supporting local safety net initiatives more broadly.

STUDY OBJECTIVES AND TASKS

This study characterizes and assesses capacity to increase coordination of care in five counties that have a track record in provider-level integration and a strong commitment to increased access to care for its residents. The study objectives are:

- To describe a continuum of integration efforts among local safety net providers;
- To identify factors that affect a local safety net's ability to develop integrated delivery systems; and
- To develop recommendation for facilitating safety net integration.

Study Counties

The county is the unit of analysis because it plays a major role in the delivery of care to low-income persons and the administration of Medi-Cal. Counties that have different types of safety net systems and are in different regions of the state were included in the study, particularly counties with evidence of mature safety net provider integration activities, such as cross-provider (e.g., clinic/hospital) coordination, and public/private coordination, such as expanding the county safety net to include private providers.[11] Other criteria for selection of counties were:

- Representation of three safety net model types: a) county safety net provider system that relies primarily on a county-run public hospital and county clinics; b) hybrid or public/private safety net provider system that relies on a combination of a public hospital, county clinics, and

Safety Net Integration Best Practice: Specialty Care Access Initiative

Health Plan of San Joaquin and Community Medical Centers, San Joaquin County

Funded by Kaiser Permanente ($750,000), the initiative was launched in 2008 to increase access to specialty care for the uninsured and underinsured in San Joaquin County. In Year 1, the Specialty Care Access Coalition led by the Health Plan of San Joaquin (HPSJ) identified specialty care needs through focus groups with physicians, creating consensus and provider buy-in. Two specialty care services—dermatology and orthopedics—were identified as deficits for the underserved. Another identified problem was the difficulty getting Community Medical Centers (CMC) patients in to the hospital and patient reports back to CMC and its primary care providers for orthopedic and dermatology services. The Specialty Care Access Coalition launched a successful dermatology clinic at San Joaquin General Hospital's Family Medicine Clinic. Teledermatology services are still under development. In addition, the project has piloted the use of mid-level practitioners and primary care providers at San Joaquin General Hospital's Orthopedics Clinic while supporting the ability to recruit orthopedists to San Joaquin General. The initiative is just seeing the initial signs of success, including increased access to dermatology and orthopedic services. Additionally, the referral process was streamlined such that primary care providers are getting more timely reports from specialist services providers. There is now agreement that building up safety net capacity is a net gain. For more information, please contact Dale Bishop, Medical Director, Health Plan of San Joaquin, at 209-461-2281.

Safety Net Integration Best Practice: Pediatric Peer Group

Community Medical Centers and San Joaquin General Hospital, San Joaquin County

Launched in 2010, providers from San Joaquin General Hospital and Community Medical Centers (CMC) meet regularly to share best practices and consult with each other. For example, there were many children in the clinic system that landed in the emergency room (ER), but it was very difficult to get them admitted to the hospital due to its admissions processes. The group was able to facilitate direct hospital admissions without going through the ER. Participating providers now work as peers. There is better communication between providers and they can now just pick up the phone to get a consultation. For more information, please contact Thomas Mahoney, Medical Director, Community Medical Centers, at mahoney@communitymedicalcenters.org.

independent primary care clinics; and c) private provider safety net system that relies primarily on private providers;

- Presence of a public hospital in at least two sites;
- Representation of the four Medi-Cal model types: a) 2-Plan (the Local Initiative); b) County Organized Health System (COHS); c) Fee-For-Services (FFS); and d) Geographic Managed Care (GMC);
- Inclusion of at least one rural County Medical Services Program (CMSP) county; and
- Representation of the different geographic regions of the state (Northern and Southern California, Central Valley, Bay Area).

The following are short descriptions of the five study counties and their safety net health care systems (see **Table 1**).[12, 13]

- **Contra Costa County:**
  A Bay Area county with a population of 1,049,025 (2010), of which 9% is at or below the Federal Poverty Level. The percent of uninsured adults age 18 to 64 is 21%. The county has a public hospital and county-run clinics, and it contracts with independent clinics through its county-sponsored health plan.

- **Humboldt County:**
  A rural Northern California county with a population of 134,623, of which 18% is at or below the Federal Poverty Level. The percent of uninsured adults age 18 to 64 is 21%. It has a private health care safety net system whereby all safety net health care services are provided by non-county providers.

- **San Diego County:**
  A Southern California county with a population of 3,095,313, of which 12% is at or below the Federal Poverty Level. The percent of uninsured adults age 18 to 64 is 23%. It has a private health care safety net system. All safety net health care services are provided by non-county providers.

Table 1: Five Study Counties—Safety Net Description and Study Representatives

County	Safety Net System	Medi-Cal Model and Study Health Plan	Study Safety Net Hospital	Study Non-County Clinic and Clinic Consortium	Low Income Health Program (LIHP)
Contra Costa	Public/private (7 hospitals, 9 county clinics, 2 private FQHCs, and private physicians)	2-Plan (Contra Costa Health Plan)	Contra Costa Regional Medical Center (CCRMC)	La Clinica de La Raza; Community Clinic Consortium	One of 10 original HCCI counties; launched LIHP in 2010—MCE and HCCI.
Humboldt	Private (11 FQHCs, 4 hospitals and private providers)	FFS	St. Joseph Health System– Humboldt	Open Door Community Health Centers; North Coast Clinics Network	Participating in CMSP LIHP Program; launched in 2012—MCE only.
San Diego	Private (13 FQHCs and other primary care providers and 12 hospitals)	GMC (5 commercial health plans)	UC San Diego Medical Center	La Maestra Family Clinic; Council of Community Clinics	One of 10 original HCCI counties; LIHP launched in 2011—MCE only.
San Joaquin	Public/private (county hospital/Family Medicine and Primary Care Clinics, 1 private FQHC)	2-Plan (Health Plan of San Joaquin)	San Joaquin General Hospital	Community Medical Centers, Inc.	LIHP to be launched in 2012—MCE only.
San Mateo	Public/private (county hospital, 11 county clinics, 2 private FQHCs)	COHS (Health Plan of San Mateo)	San Mateo Medical Center	Ravenswood Family Health Center	One of 10 original HCCI counties; launched LIHP in 2011—MCE only.

- **San Joaquin County:**
  A Central Valley county with a population of 685,306, of which 16% is at or below the Federal Poverty Level. The percent of uninsured adults age 18 to 64 is 24%. The county has a public hospital and a non-hospital site where it if offers primary care and specialty care services. It contracts with non-county clinics.

- **San Mateo County:**
  A Bay Area county with a population of 718,451, of which 7% is at of below the Federal Poverty Level. The percent of uninsured adults age 18 to 64 is 16%. The county has a public hospital and county-run clinics. It contracts with an independent clinic and a range of specialty medical care providers.

Safety Net Integration Best Practice: Specialty Care Referrals

San Mateo Medical Center and Ravenswood Family Health Center, San Mateo County

Funded through the Kaiser Specialty Care Access Initiative ($750,000) in 2008, the San Mateo Medical Center (SMMC) worked with the Ravenswood Family Health Center to implement an interactive referral process. There is a standing committee that has established clear communications channels between all primary care and specialty care providers, and is a neutral ground. Ravenswood provided input on how it wanted to be involved and the data, as well as on the development of a mini-specialty training program. The second piece was to work with primary care providers so that they could work with specialists and do more of the care in a primary care setting and inform the development of the electronic referral system. The results have been encouraging. They have reduced wait times in some specialties and there is more transparency and detail on wait times. They didn't lose ground when they had provider shortages; they adopted new protocols to work down the backlog. They expanded access to cardiology services because they were able to maintain staffing levels. Also, in 2010, with the teledermatology launch, SMMC gave Ravenswood the equipment and now the clinic is indistinguishable from county clinics. There is also integration at the medical staff level and Ravenswood's providers are credentialed through the county primary care department. For more information, please contact Dr. CJ Kunnappilly, Chief Medical Officer, San Mateo Medical Center, at ckunnappilly@smcgov.org.

Study Tasks and Analyses

One-hour phone interviews were conducted with three to five informants in each study county, including: a county health agency representative; a senior manager at a public, academic, or private safety net hospital; a representative from a Medi-Cal managed care plan; a senior manager at a non-county primary care clinic; and a representative from the local clinic consortium (these will hereafter be referred to as "stakeholders"). Informants were asked similar questions about integration activities that encompass multiple approaches to achieving integration at three levels—system, provider, and patient—within safety net systems:

- **Level of integration activity:** 28 integration activities "underway" (i.e., operational), "proposed" (i.e., being considered),[14] or "no activity;"
- **Contextual factors important to planning and implementation of integration initiatives:** strengths, gaps, policy issues, safety net collaboratives;
- **Resources by stakeholder:** sources of funding, strategy to secure funding, perceptions of county safety net capacity;[15]
- **Information Technology (IT) systems, by stakeholder:** centralized data systems, enrollment systems; and
- **Identification and characterization of 30 safety net integration "best practices."**

The interview responses were recorded in Excel, coded by themes, and analyzed for similarities and differences by county and where applicable by stakeholder type (county health agency, safety net hospital, Medi-Cal managed care plan, non-county clinic, and clinic consortium). The responses to the capacity and level of integration questions were tabulated and analyzed by county and stakeholder type.

There are varying perspectives on what is meant by "integration" and what types of efforts should be included. As described in **Figure 1**, Konrad (1996) conceptualizes integration as a continuum from the sharing of information between organizations to a fully integrated activity or system where resources are combined into a single entity to address a client's complex needs (e.g., one-stop shops that include primary care, mental health, WIC, etc). The model is useful for characterizing a cross-organization partnership but striving for increased consolidation of partner organizations may not be applicable in all

Safety Net Integration Best Practice: Mental Health in Primary Care Settings

San Joaquin General Hospital, San Joaquin County

Using Prop 63 Prevention and Early Intervention (PEI) funding ($779,000), this initiative was launched in 2010 to expand patient access to behavioral services in a less stigmatized setting and expand the capacity of the county's Family Practice Clinic to conduct mental health screenings, care coordination, and short-term mental health services. Three clinicians were co-located at the Family Practice Clinic to provide short-term interventions to older adults as well as to provide staff and resident training. The expansions were well received and have helped to develop stronger relationships between mental health and primary care. An estimated 945 people were served directly and 5,000 indirectly through training and education. For more information, please contact Vic Singh, San Joaquin County Behavioral Health Services, at vsingh@sjcbhs.org.

Figure 1: Levels of Integration

Information Sharing and Communication	Cooperation and Coordination	Collaboration	Consolidation	Integration
Organizations share general information about programs, services, clients. May be episodic, e.g., brochures.	Loosely organized approaches to work together to change procedures or structure, e.g., reciprocal client referral.	Equal partners that have written agreements, goals, possibly joint funding, etc. To work together as a whole.	Umbrella organization with single leadership, centralized administration, but line authority and cross-program collaboration, e.g., county health systems.	Single authority that is comprehensive in scope, addresses individual client needs, activities are fully blended, and is multi-purpose, e.g., one-stop shops.

settings or for all types of problems. For example, Provider Peer Groups comprised of hospital and primary care clinic providers may function best when they are ad hoc and limited to sharing of provider practices. For this study, we used the Konrad framework to characterize the level of collaboration between safety net stakeholders.[16]

Safety Net Integration Best Practice: Primary and Behavioral Healthcare Integration

Council of Community Clinics, San Diego County

In December 2006, the Council of Community Clinics, Community Clinics Health Network (CCHN) signed a contract with the County of San Diego's Behavioral Health Administration to implement the Mental Health and Primary Care Integration Project (MH&PCIP). This unique project is funded by MHSA, the Mental Health Services Act (Prop 63). The MH&PCIP utilizes two treatment models to deliver services: Specialty Pool Services (SPS) for individuals with Serious Emotional Disability or with Serious Mental Illness (SED/SMI), and IMPACT (Improving Mood Promoting Access to Collaborative Care Treatment) to treat individuals who are suffering primarily from depression. In addition, Senior Peer Promotoras conduct outreach and work to maintain clinic patients in treatment. Nine clinic organizations participate in this program.

The second initiative was launched in 2009 and was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) ($500,000) to provide primary care to individuals with Serious Mental Illness (SMI) at behavioral health services organizations. This initiative paired two Federally Qualified Health Centers (FQHCs) with two county-contracted specialty mental health programs in two different areas of the county (North/South). A nurse care manager (RN) from the FQHC is placed in the specialty mental health setting and does basic health screenings. One of the FQHCs has also out-stationed a part-time nurse practitioner at a mental health program and the other FQHC has created specific appointment slots for the individuals referred from the mental health program. Primary care and mental health goals are shared to help persons with SMI improve their health status as well as improve provider decision-making. As of June 2011, 612 individuals have been enrolled and screened by the project. For more information, please contact Nicole Howard, Council of Community Clinics, at nhoward@ccc-sd.org.

FINDINGS

The five study counties, while being unique in history, culture, and economic base, share some important features, such as high stakeholder willingness to address the needs of the medically underserved. Their health care safety nets are strained but they continue to be reengineered in new and innovative ways. There is evidence that many of these initiatives are resulting in coordinated care and strengthened partnerships between providers and county agencies. The following describes the number and type of integration activities underway and proposed as well as facilitating factors and challenges.

County Safety Net Integration Initiatives Underway and Proposed

We asked safety net representatives in the five study counties to indicate the type of integration initiatives that were being undertaken in their county. As described in **Table 2** below, the five counties are making progress in nearly all of the 28 integration activity areas and there are modest differences by county. San Diego had 28 activities "underway," the most of the five counties. It was followed by Humboldt and San Mateo, each of which had 26 activities underway. Contra Costa and San Joaquin each had 25 activities underway. Three integration initiatives, ***Participation in an Accountable Care Organization (ACO), Participation in a Health Information Exchange, and Adoption of ePortals for patients to interact with the health system,*** were in the "proposed" stage for two or more counties.

Table 2: Activities Underway (U) and Proposed (P), by County

28 Integration Activities	Contra Costa (25 activities)	Humboldt (26 activities)	San Diego (28 activities)	San Joaquin (25 activities)	San Mateo (26 activities)
System-level Integration Activities					
Participation in an Accountable Care Organization (ACO)	P	P	U	P	U
Adoption of an integrated network of safety net providers (coordinate care across levels of care—primary clinic, specialty care, inpatient care)	U	U	U	U	U
Provider-level Integration Activities					
Adoption of panel management (multi-disciplinary primary care team plans and manages patients with chronic disease, e.g., Teamlet model)	U	U	U	U	U
Onsite specialty care at primary care sites:					
Mental health care	U	U	U	U	U
Dental health	U	U	U	U	U
Expanded communications between primary care and specialty care	U	U	U	U	U
Expanding provider scope of practice (e.g., trainings, mini-fellowships)	U	U	U	U	U
County contracts with community clinics to provide care to medically indigent	U	U	U	U	U
Adoption of patient centered medical home	U	U	U	U	U
Addition of new health care services (e.g., heart failure clinics)	U	U	U	U	U
Auto enrollment of Medi-Cal patients	U	P	U	U	U
Electronic eligibility and enrollment system (e.g., One-e-App)	U	U	U	U	U
Electronic prescribing system	U	U	U	U	U
Electronic health information systems, (e.g., EMR, HRE, LCR)	U	U	U	U	U
Electronic specialty care referral system	U	U	U	P	U
Electronic panel management system	U	U	U	U	U
Electronic disease registries (e.g., diabetes)	U	U	U	U	U
ER diversion programs	U	U	U	U	U
Health Information Exchange (HIE) between providers or providers and the county	P	U	U	U	P
Patient-level Integration Activities					
After hours and/or same day scheduling system	U	U	U	U	U
24/7 nurse advice line to redirect patients	U	U	U	U	U
ePortals for patients to interact with systems	P	U	U	P	P
Case management services or the coordination of treatment options	U	U	U	U	U
Certified Application Assistors (CAAs) who enroll the uninsured in health care insurance	U	U	U	U	U
Community Health Workers who facilitate access to health services	U	U	U	U	U
Patient Navigators who assist patients with medical treatment options and acts a liaison	U	U	U	U	U
Accessible telephone systems	U	U	U	U	U
Language access	U	U	U	U	U

Specific areas where there was high involvement by nearly all stakeholders in all counties included:

- Adoption of panel management (e.g., Teamlet model);
- Mental health primary care integration;
- Expanded communications between primary care and specialty care;
- Electronic disease registries (e.g., diabetes);
- After hours and/or same day scheduling;
- Case management services;
- Certified Application Assistors (CAAs);
- Community health workers who facilitate access to health care services
- Accessible telephone systems; and
- Language access.

(See **Appendix A**)

Stakeholder Findings

There are some differences in the type and number of safety net integration activities being undertaken and proposed by safety net stakeholders. For example, non-county clinics had more "proposed" activities than other stakeholders. However, no single category of stakeholder consistently engaged in more integration activities than others. Findings by stakeholder include (**Figures 2** and **3**):

County Health Agencies

There is a high level of involvement by *county health agencies* (25 to 28 activities) in diverse integration activities except in Humboldt, which does not provide health care services, and San Joaquin, which provides services primarily through its hospital. Interestingly, San Diego does not provide health care services but it is a key participant in all activities. Except for San Joaquin, which is considering eight additional activities, most of the county health agencies are considering two additional activities.

Safety Net Integration Best Practice:
Integrating Behavioral Health and Primary Care

San Mateo County Health System, San Mateo County

Launched in 2010 with support from a Substance Abuse and Mental Health Services Administration (SAMHSA) grant ($490,000 each year for four years), the Total Wellness project is a partnership between primary care and behavioral health and includes multiple components, grounded in the "four quadrant model." It builds on the location of two nurse practitioners in four outpatient behavioral health sites to provide accessible primary care to patients with Serious Mental Illness (SMI). Wellness groups run by peers and staff that target smoking cessation, physical activity, and nutrition, among other issues, have been developed and provide added support in targeting physical health issues not traditionally dealt with in behavioral health settings. The county also provides mental health consultative support in county and non-county primary care settings. This support is designed to address the more routine behavioral health issues like depression and anxiety, and to coordinate medication that requires calibration. Though it is too soon to see results from the grant, the county has seen high rates of initiation and engagement in behavioral health treatment, relative to national averages. In San Mateo County, substance abuse and mental health are combined in one division and there is shared leadership and ownership between primary care and behavioral health, with investment by both parts of the system. The county has had to be creative in the way it funds the program. For example, there are different requirements for each setting, e.g., what an exam room should be, what the ratio of support staff to provider staff should be, and FQHC requirements. For more information, please contact Chris Esguerra, MD, San Mateo County Behavioral Health and Recovery Services, at cesguerra@smcgov.org.

Safety Net Hospitals

There is high involvement (20 to 25 activities) by the *public hospitals* in Contra Costa and San Mateo and somewhat less involvement by the safety net hospitals in the three other counties. The number of activities being considered by safety net hospitals ranged from one additional activity in San Diego to upwards of eight additional activities in San Joaquin.

Medi-Cal Managed Care Plans

The three *Medi-Cal health plans* in Contra Costa, San Joaquin, and San Mateo had high levels of involvement (20 to 23 activities). The plans were involved in diverse activities, including provider-based IT activities, such as expanding communications between primary care and specialty care. The three Medi-Cal health plans were considering three to six additional activities.

Non-County Clinics

The five *non-county clinics* were very involved (13 to 25 activities), particularly in Humboldt where the non-county clinic is the key provider of primary care services for low-income populations. Except for Humboldt County, the clinics in the other four counties are considering five to twelve additional activities, more than the other stakeholders.

Clinic Consortia

Last, the three *clinic consortia* ranged in level of involvement, from 2 to 23 activities, suggesting differences in organizational focus. The number of activities being considered by each consortium ranged from one additional activity in Contra Costa to five additional activities in San Diego.

Some of the differences in number and type of integration activity underway by safety net stakeholders can be explained by differences in the five study counties (**Figures 4** and **5**):

Contra Costa

The county has many integration activities underway and proposed, with consistently high involvement by county and non-county stakeholders. The county's health agency, hospital, and Medi-Cal managed care plan function as an integrated enterprise to plan and adopt multiple integration initiatives. It also has developed partnerships with private safety net providers to undertake expansions or fill gaps in access.

Humboldt County

The county is very involved in safety net integration but private safety net providers are primarily engaged in these activities. The clinic consortium and safety net hospital are considering slightly more activities than the other stakeholders. Due in large part to geographic barriers, the county has developed a robust private safety net health care delivery system and relies heavily on IT, particularly telemedicine.

Figure 2: Number of Safety Net Integration Activities "Underway" by Stakeholder

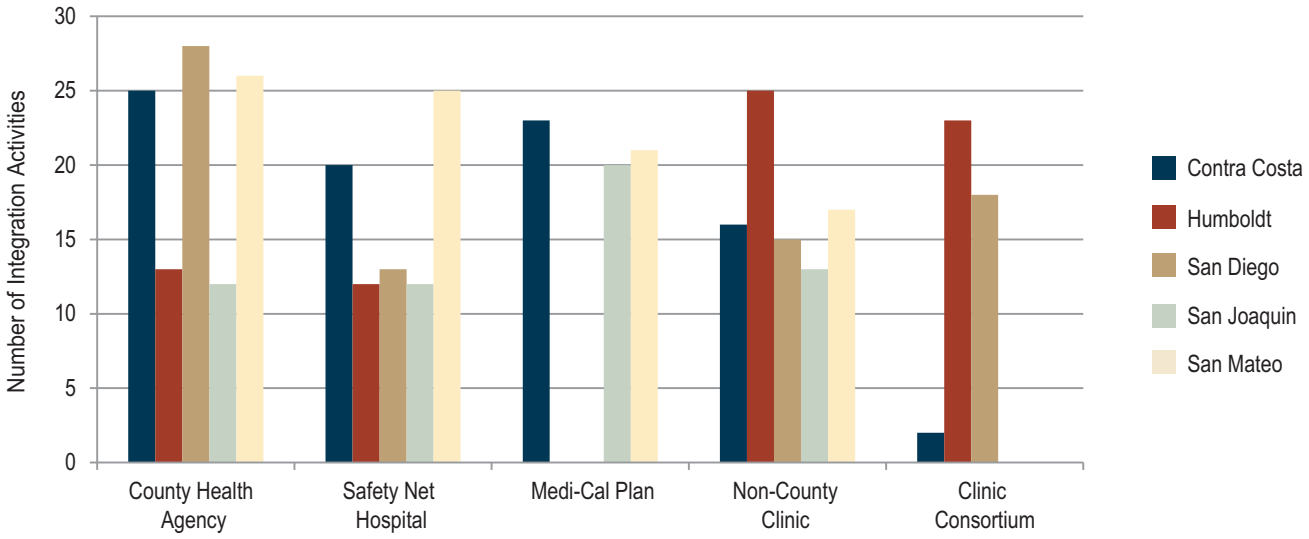
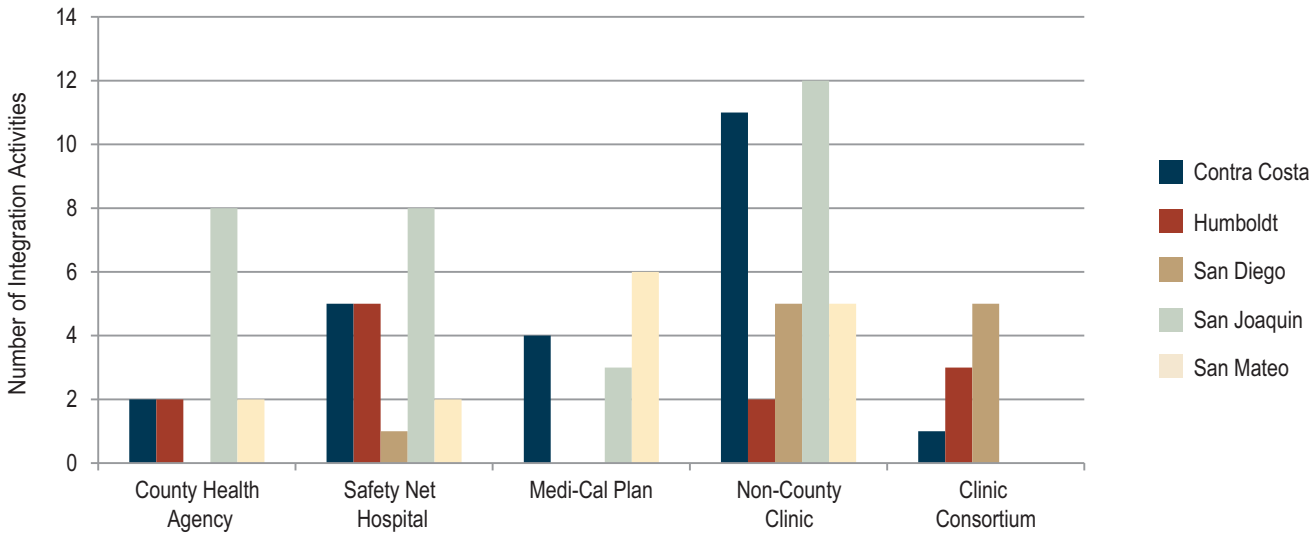


Figure 3: Number of "Proposed" Activities by Stakeholder



Safety Net Integration Best Practice: Medical Psychiatry Service

San Mateo Medical Center, San Mateo County

Largely self-sustaining with revenue from patient revenue for psychiatry and psychology services, the goal of this project is to embed a psychiatry/psychology team in the Medical Center's main campus general medical units. The effort also receives $300,000 in support from Mental Health Services Act (MHSA) funds. Launched in 2006 as part of the county's effort to integrate primary care and mental health throughout the county, this initiative provides mental health care for non-psychiatric patients. Program providers include four licensed clinical psychologists, four psychiatrists, and psychology interns/psychiatry residents. They address mental health issues that coincide with medical issues—e.g., patients with a history of psychiatric illness who have chronic medical problems—and provide holistic, comprehensive health care. Services include clinical and legal evaluations, psychotherapy, psychiatric services, and special services (palliative care, pain clinic, substance abuse treatment, AIDS care). The Medical Psychiatry Clinic provides therapy, medical management, psychological/neuropsychological testing, psychoeducation, and consultative evaluation. The results have been positive, including an increase in visits from 1,163 in 2006 to 3,984 in 2011, as well as high levels of patient satisfaction in multiple categories. They have seen a decrease in ER visits pre/post program implementation, from 76 to 44 patients. Finally, there have been several service expansions, including palliative care, substance abuse treatment, the Edison Clinic (which provides specialized primary care to clients with HIV), La Clinica Latina Groups, Hospital Consultation Liaison, LTC, and Psychology Training Program. For more information, please contact Dr. David Lin, Supervising Psychologist, San Mateo Medical Center, at DLin@smcgov.org.

San Diego

The county is very involved in safety net integration and has a high number of activities underway overall. The non-county clinic and clinic consortium are considering more activities than the other stakeholders. While it does not have county-run health care services and a Medi-Cal managed care organization (LI or COHS), the county health agency coordinates with the five Medi-Cal managed health care plans and has a long track record of supporting initiatives at the hospital and contracting with independent clinics to provide services for the uninsured.

San Joaquin

Except for the Medi-Cal health plan, the county's level of integration is lower than the other four counties, and it has more activities in the "proposed" stage than the other counties.[17] While similar to San Mateo and Contra Costa in that the county has a public hospital and Medi-Cal managed care plan, the San Joaquin is experiencing huge financial and economic pressures. For example, it has one of the highest foreclosure rates in the state and a large percent of the population under the poverty level (16%).

San Mateo

The county has many integration activities underway and there are limited differences by stakeholder type. With the exception of the non-county clinic and the Medi-Cal plan, very few activities are being proposed overall. In addition to being the primary health care provider of last resort, San Mateo's health agency, hospital, and Medi-Cal plan function as an integrated entity. This affords the county flexibility in planning, financing, and implementing integration activities.

Safety Net Integration Best Practices

UCSF asked study informants to describe integration activities they considered a "best practice" or an initiative that showed evidence of success. In addition, informants were also asked to describe initiatives that were done in partnership with the Medi-Cal health plan and/or a non-county clinic. Upwards of 30 integration initiatives were described, including many (ten) that were in the early stages of implementation. Using the three categories developed for the 28-activity survey, we clustered the 30 activities by five types and analyzed them for cross-cutting themes, particularly facilitating factors and challenges:

Figure 4: Number of Integration Activities "Underway" by County

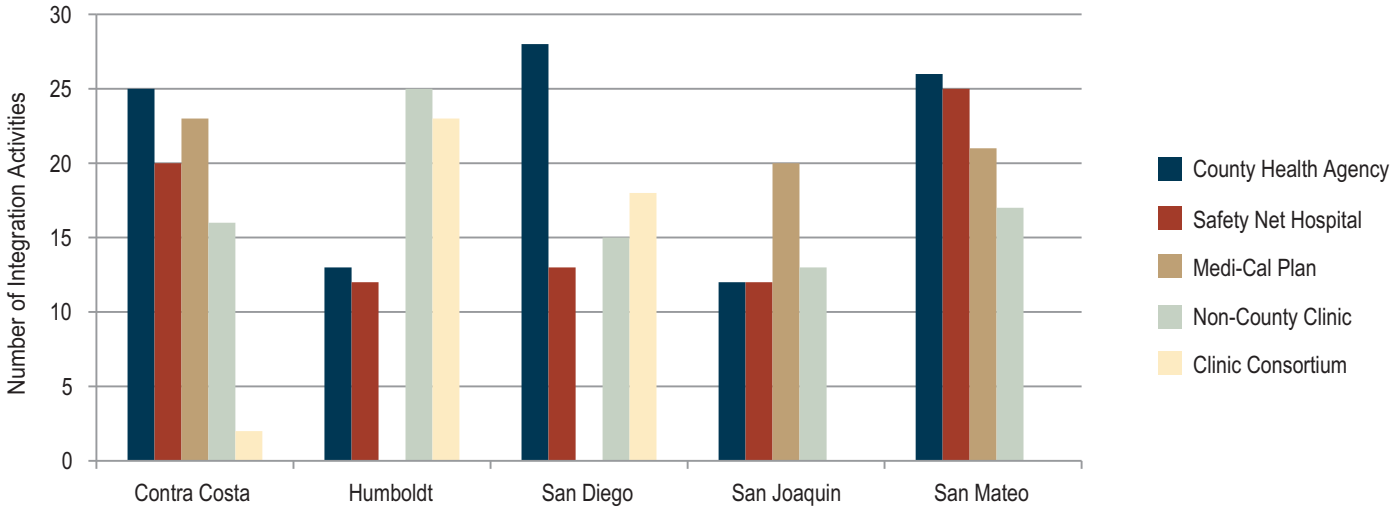
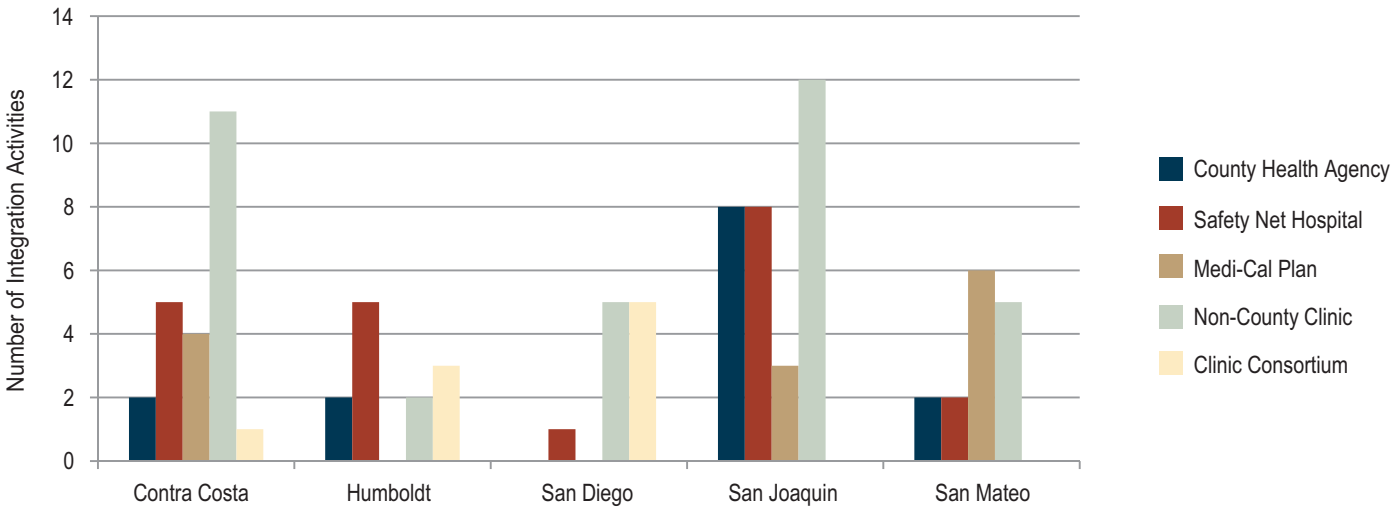


Figure 5: Number of "Proposed" Activities by County



System-Level Integration

HCCI/LIHP Integration Activities

Implemented as part of the 2005 Medi-Cal Waiver Health Care Coverage Initiative (HCCI), these activities include expanding chronic disease management, adoption of PCMH, and gearing up for LIHP implementation as part of the County Medical Services Program (CMSP) initiative. Advance preparation and inclusion of all stakeholders early on are musts. The partnership with non-county clinics is key to ensuring adequate capacity to treat the newly enrolled as well as do outreach and enrollment. The Medi-Cal plan plays an important role, such as the assignment of Seniors and Persons with Disabilities (SPD) to a non-county clinic and expanding the LIHP data system to include mental health data and primary care data to be able to look at costs and impacts.

Provider-Level Integration

Specialty Care Access

Most of the initiatives described by informants were funded under the Specialty Care Access Initiative discussed above. Informants described advances in specialty care referrals, data sharing between the

Information Technology

Respondents in the five study counties reported working with multiple IT systems as well as adopting new systems to facilitate integration. These included Safety Net Connect, which allows for seamless scheduling between different delivery systems, Apixio for mental health/primary care data integration, IRIS to facilitate appropriate specialty care referrals among different agencies, and some homegrown IT systems, such as a bidirectional provider data sharing systems.

In addition to characterizing the adoption of eight electronic integration activities (out of the 28 integration activities) we asked study informants to describe the IT initiatives underway in their county, specifically *presence of a centralized electronic data system for archiving health information* and *use of IT to facilitate continuous enrollment in a single public program and/or to help facilitate continuous coverage for persons who transition back and forth between Medi-Cal, Healthy Families, and the Health Benefits Exchange as their income fluctuates.* With respect to the former, there is considerable diversity between counties. Two counties appear to be further along in having a centralized system: Contra Costa has a centralized system through its health plan, county hospital, and Federally Qualified Health Centers (FQHCs), and San Diego is developing a community information system that builds on its Beacon Health Information Exchange initiative. The other three counties have separate stakeholder-based data systems. The safety net hospitals have or are implementing electronic medical record (EMR) systems. The Medi-Cal health plans have HEDIS and claims data they use for analysis, as well as IT systems to share data between providers. The non-county clinics have electronic practice management systems that provide some useful data, as well as EMRs, disease registries, and population management systems.

With respect to the latter, all counties are working with One-e-App or a similar system to do front-end enrollment in Healthy Families and Healthy Kids, and to screen and serve as the system of record for the HCCI and indigent populations. This function typically is undertaken by the non-county clinics. Further developments are on hold as the state determines its IT infrastructure for the Health Benefits Exchange. Other IT systems that might facilitate continuous coverage include C4Yourself and piggybacking on the 211 Call System.

The next round of IT applications include: electronic systems or ePortals that patients can use to connect with the health care systems, for example, C4Yourself, development of a Health Information Exchange (HIE), and continued efforts to enhance data sharing between systems. However, connectivity issues are a significant barrier. Many respondents noted the difficulty in having systems talk to each other as well as getting useful information out of the electronic systems.

non-county clinic and hospital, and launching Provider Peer Groups to facilitate the sharing of information and solving of problems. These activities can be time-consuming and slow due to provider recruitment delays, as well as barriers to undertaking expansions in some areas, such as adult dental care, which is not covered by Medi-Cal. Initiatives succeed when there is open communication and stakeholders develop meaningful relationships with equal investment and commitment.

Mental Health and Primary Care Integration

Supported by Mental Health Services Act (MHSA) funding (Prop 63) and federal Substance Abuse and Mental Health Services Administration (SAMHSA) grants, the initiatives described by informants speak to the different models of embedding primary care services in mental health, such as placing a nurse care manager in mental health settings, and the reverse, such as locating psychologists and psychiatrists in a hospital medical unit. Key facilitating factors include finding the middle ground and having shared leadership and ownership by mental health and primary care stakeholders. Initiatives are resource intensive and skilled staffing expertise—providers and support staff—is important to project success.

Adoption of Information Technology (IT) Systems

Study informants described different IT initiatives in different stages of adoption, such as the launch of a Health Information Exchange (HIE) and data sharing between a non-county clinic and safety net

Safety Net Integration Best Practice: Telehealth (TH)

Open Door Community Health Centers, Humboldt County

Open Door has been using Telehealth (TH), which allows clinic and community patients to tie in to specialists and other providers, for nearly 15 years. The clinic has its own internal virtual private network and all sites have telehealth connections. In 2006, it opened the Telehealth and Visiting Specialist Center in Eureka, CA. It has four full exam rooms and two office exam rooms equipped with video conferencing equipment, on-site specialty care providers (Allergy, Behavioral Health, Cardiology, Dermatology, Diabetes Education, Gynecology, HIV/Hepatic C Management, Nephrology, Orthopedics, Pediatrics, Psychiatry, Pulmonology, and Retinal screening), and has links to 22 clinics as well as providers at UCSF and UCD. By 2009, Open Door was conducting nearly 1,000 telehealth visits annually, and currently averages nearly 1,200 visits. And there are likely to be significant expansions in the future. A new generation of practitioners is coming into this field and TH is perceived to be cutting edge. A critical mass has developed in academic centers to advance the field and training is underway. The Federal Communications Communication (FCC) is providing funding to facilitate TH. The field is moving very quickly and the next quantum leap is with TH going to phones and iPads. For example, the clinic can now arrange consults and visits between patients/providers in multiple sites; this could never have happened in the past due to geographic barriers. For more information, please contact Frank Anderson, RN, BSN, Telehealth Development Director, at fanderson@opendoorhealth.com.

Safety Net Integration Best Practice: IMPACT-ED

University of California, San Diego Health System, San Diego County

With funding ($25,000) from the Alliance Healthcare Foundation, an electronic scheduling system, Improving Medical home and Primary care Access to the Community clinics Through the ED (IMPACT-ED), was launched in 2008. It linked three local FQHCs and the Emergency Department (ED) at UC San Diego (UCSD). The referral system created a Web interface between the ED electronic medical record (EMR) system and the clinic appointment system. ED providers received an automatic computer notification through the ED electronic medical record when a patient stated they didn't have a primary care physician or clinic. Available clinic appointment times were embedded in the system and physicians could select a specific appointment time if they thought the patient would benefit from a follow-up appointment at a clinic within two weeks of the ED visit. The clinic received an electronic notification of the appointment time through the system as well as the patient's demographic, registration, and contact information. The results were encouraging although there is room for improvement, e.g., most patients (75 percent) did not adhere to their appointments. The system did not increase the administrative burden on ED physicians: the referral rate remained the same pre and post implementation. There was a 23.8 percentage point increase (from 1.0 percent to 24.8 percent) in the number of patients who followed up at the clinic as directed. For more information, please contact Ted Chan, MD, UCSD Emergency Department, at tcchan@ucsd.edu.

hospital. These initiatives can be difficult and costly, and there are many possible points of failure (e.g., incorrect data entry). Gaps can be countywide (e.g., lack of infrastructure) as well as at specific providers. They require leadership support as well as representation and buy-in by all partners and end-users.

Patient-Level Integration

Care Coordination, Outreach and Enrollment

These initiatives range from behind-the-scenes coordination of providers to ensure a warm handoff of patients, to enrolling patients in public insurance. There are limited resources to support these services. These initiatives require individuals who are knowledgeable about the county safety net and can work as a part of a cross-organizational team.

Last, the analysis of "best practices" by partner organizations suggests certain types of organizations are more likely to pursue certain types of initiatives:

County Health Agency/Non-County Clinic Partnerships

- Mental health and primary care integration
- HCCI/LIHP-supported integration activities

Safety Net Hospital/Non-County Clinic Partnerships

- Coordination of patient care
- Provider peer groups
- Adoption of IT systems
- Specialty care access initiatives

Medi-Cal Health Plan/Non-County Clinic Partnerships

- Contracting to provide primary care services
- Data sharing
- Outreach and enrollment

In sum, all counties are active on multiple fronts and are very involved in implementing diverse integration initiatives. There are some differences in the number and type of initiatives being undertaken by safety net stakeholders and counties. All stakeholders are more involved in some activities than others, particularly integration of specialty care and primary care (e.g., mental health in primary care settings), adoption of IT systems to facilitate communications between safety net providers, and patient-level initiatives to increase access to care and coordinate services. All stakeholders are also considering similar activities: participation in an Accountable Care Organization, adoption of a Health Information Exchange, and adoption of ePortals.

Facilitating Factors

Although the five counties vary in size and population, they share some of the same facilitating factors and barriers to planning and implementing integration activities. Strong leadership commitment at the top (e.g., provider CEOs, Boards of Supervisors) is critical to improving the health of the community. Respondents repeatedly mentioned four facilitating factors for the "best practice" integration initiatives:

- New models of leadership (e.g., joint leadership of mental health and primary care integration projects)
- Open communications
- Buy-in at all levels early on
- Perseverance in the face of delays

Factors that are unique to a county include the presence of a Medi-Cal managed care organization (San Mateo, Contra Costa, and San Joaquin) and strong IT infrastructure (Humboldt).

Safety Net Integration Best Practice: Data Sharing Between Clinic and The County

Ravenswood Family Health Center, San Mateo County

Launched in 2006 and funded by Kaiser Permanente, this initiative focused on improving the specialty care referral process between Ravenswood and the San Mateo County Specialty Clinic. Partners met monthly for a year to plan and implement the project, including working with different county specialty clinics to identify the forms they required. They had to work out courtesy privileges for clinic providers as well as address legal issues. Ravenswood's providers are able to look at the county's Lifetime Clinical Record, including the dictated notes from the county specialty clinic. In addition, the clinic providers can indicate whether or not they are the primary care provider (PCP) in the patient's record. If county staff see that the clinic is the PCP, they can redirect the patient to the clinic, thereby attaching the patient to a provider. Over 3,000 patients were referred from Ravenswood in 2010. For more information, please contact Luisa Buada, CEO, Ravenswood Family Health Center, at lbuada@RavenswoodFHC.org.

While the county health agency plays a leadership role in all five counties, this role may be shared with the Medi-Cal plan and the community clinic consortium. Moreover, all counties have *safety net collaboratives* for convening stakeholders, such as the Community Health Network for the Underserved in San Mateo, the Access to Care Stakeholders Group in Contra Costa, and the San Diegans for Health Care Coverage. Study informants described these networks of safety net stakeholders as "mature," having long-standing relationships built on trust and goodwill and providing opportunities for collaboration. When asked what contributed to the success of these networks or collaboratives, study respondents repeatedly mentioned *"commitment,"* be it a shared commitment to vulnerable populations, senior leadership commitment, or commitment to providing high-quality care. Additionally, ongoing relationships that can be leveraged and good communications are important. A unifying vision was perceived as important but respondents indicated that there might be multiple visions such as one for providers and one for the county. Or there might be overlapping visions, such as a population health vision and fulfilling county Welfare and Institutions Code Section17000 obligations in the broadest sense.

UCSF measured the *level of collaboration between organizations* that work on initiatives to integrate the safety net. Overall, the level of integration between stakeholders is episodic and is on a project-

basis, with limited shared funding. There were minor differences between counties. The three public provider counties—San Mateo, Contra Costa, and San Joaquin—scored between 7.2 and 7.7 ("consolidation"). The two payor counties that contract out their health care services—San Diego and Humboldt—scored slightly lower at 6.3 and 6.7 ("collaboration") respectively. Not surprisingly, nearly all of the county health agencies and the safety net hospitals (public and private) and all Medi-Cal health plans rated the level of collaboration between organizations at 7.0 or higher. The majority of non-county clinics and clinic consortia rated the level of collaboration between 5.0 and 7.0. Respondents explained that partnerships among county entities scored higher, around 9.0, but partnerships with outside entities score around 6.0.

Challenges

All study counties are grappling with similar resource constraints, including low Medi-Cal provider reimbursement rates, competing priorities, and budget shortfalls at the state and county levels. However, study counties feel that the care is there if people need it. Specific safety net system access gaps common to all five county health care safety nets include:

- **Populations are at risk of not getting the care they need,** particularly the uninsured undocumented as well as some sub-populations (e.g., seniors, African Americans, and homeless);
- **Diseases or conditions that aren't getting the required treatment** include mental health and substance abuse, chronic disease, particularly diabetes/obesity, and HIV; and
- **Services where the need outpaces access include** primary care, mental health, dental care, and access to specialists.

Study counties mentioned several *gaps in capacity important to integrating health care services,* particularly the lack of coordination of specific providers (e.g., primary care, orthopedists) and coordination of needed services (e.g., health care and social services). Information Technology (IT) gaps were also mentioned by all study counties, including implementing electronic medical records (EMR) and "meaningful use" requirements, insufficient staff to analyze data, and interoperability issues (e.g., between the county hospital and non-county clinic IT systems).

Policy issues, particularly uncoordinated payment systems, stymie study counties' efforts. The fast enactment of federal reform provisions creates serious capacity problems for counties. At the state level, the 10% cuts in Medi-Cal reimbursement rates may jeopardize progress in expanding provider networks. Competing priorities are already a problem at the county level and are exacerbated by realignment and increased county responsibility for prisoners (AB 109) as well as the additional cost of including the Ryan White Population in the Low Income Health Program. Moreover, counties are experiencing shortfalls in county General Fund support, which, when combined with low provider reimbursement rates, compromise access (e.g., difficulties in recruiting providers) as well as undermine county commitment to the uninsured, particularly the undocumented.

The county safety net model may or may not be a barrier. While being a payor county that contracts out safety net health care services may contribute to marketplace competition and a piecemeal approach to providing care, it may also create an environment for novel solutions and public/private partnerships. Similarly, geographic barriers may force stakeholders to address access issues and focus on strengthening partnerships.

In sum, despite their relatively optimal position as high functioning, committed counties, the five study counties share some significant challenges and gaps in their safety nets. The gaps in primary care are noteworthy since the demand for these services will increase under the ACA.

Resources for Safety Net Integration Initiatives

As described above, there have been some *sources of funding* that have greatly facilitated local safety net integration in recent years. However, study informants described the funding for safety net integration activities as piecemeal, coming from many different sources (federal, state, local, public, and private). Moreover, funding varies by stakeholder. County health agencies tend to rely on a mix of public funds (matching federal funding, state Realignment and Prop 63 funds, county General Fund support) and some private foundation funding. Similarly, safety net hospitals listed a mix of public and private funding, including the Medi-Cal Waiver or Delivery System Reform Incentive Payments (DSRIP), Disproportionate Share Hospital (DSH) program funding, county General Fund support, and some private grants (e.g., Kaiser, the California Association of Public Hospitals). The Medi-Cal health plans cited fewer funding sources, including capitated member funds and private foundation grants. The non-county clinics and clinic consortia rely primarily on public and private grants, such as the Tides Foundation Community Clinics Initiative (CCI) and Specialty Care Access Initiative. None of this funding was considered sustainable although

Safety Net Integration Best Practice: Coordination of Care for the Medically Indigent

Contra Costa Health Plan, Contra Costa County

In 2009, for financial reasons, the county had to transition primary care for undocumented adults (16,000 adults) under its Basic Health Care (BHC) Program and it contracted with non-county Federally Qualified Health Centers (FQHCs) to provide services to this population. Contra Costa County continues to provide all ER and hospital care to this adult undocumented population as well as certain specialty care. All care is provided for undocumented children below 300% FPL. In addition to contracting with FQHCs, the Contra Costa County Health Plan supported two other initiatives—Rotocare and Operation Access—to facilitate access to care for this population. The Plan also works with the FQHCs and "free clinics" on referral patterns. It plays a lead role in coordinating care for these populations and it has been able to use a case management approach with 24/7 Advice Nurse Services to decrease inappropriate use of the ER. It also has a three-tier intervention approach that is described in a letter to patients. This letter states that patients should call an Advice Nurse and discuss how they should handle their care. Nurses triage patients appropriately and can authorize urgent care if needed. Also the nurses coordinate pregnancy care and communicate with providers. The Plan also has adopted a case management approach with three tiers of professionals to help with medical/social issues. Additionally, the Plan and Contra Costa Regional Medical Center (CCRMC) and Ambulatory Health Centers are adopting the EPIC electronic health record system so they can more easily share clinical information. The Plan has contracts with all FQHCs to serve documented uninsured adults in two programs under the LIHP program—Medicaid Coverage Expansion (MCE) (10,000 adults) and Health Care Coverage Initiative (HCCI) (1,750 adults). Plan administrators believe the program is making progress in educating populations on how to best use care. County financing and loss of revenue has forced them to look to the community, which requires coordination, e.g., communications and shifting of resources. For more information, please contact Patricia Tanquary, CEO, Contra Costa Health Plan, at Patricia.Tanquary@hsd.cccounty.us.

Safety Net Integration Best Practice: Care Transitions Program

St. Joseph Health System, Humboldt County

Launched in 2008 and funded by St. Joseph Health System in partnership with the Robert Wood Johnson Foundation, Aligning Forces for Quality initiative, the California HealthCare Foundation, and County Medical Services Program (CMSP), the Care Transitions Program supports individuals as they transition between health care settings. Community-based partners include the Public Health Department, the Department of Health and Human Services, the Eureka Community Health Center, and Humboldt State University. Coaches at St. Joseph and Redwood Memorial Hospital work with individuals to access care at the appropriate level of need. There are two levels of service and target populations: 1) Core Services, in which senior level nursing students coach people with chronic disease, such as COPD and heart failure; and 2) Intensive Transitional Services (ITS), in which a nurse with a social worker team work with high-risk indigent individuals who have had a recent hospital encounter to coordinate and ensure follow-up care with safety net providers, as well as provide supportive services such as respite housing, transportation to appointments, food, and clothing. The ITS team works closely with case managers at each safety net site to establish care, facilitate specialty care follow-up, and manage medications. The outcomes are promising. People who are enrolled in Core Services have an admission rate of 9% (vs. 12%). And with ITS, they've been able to show transition to stabilized housing for over 50 percent of the enrolled group, as well as improvement in maintaining sobriety for the high-risk medically indigent group (with 64 percent doing so over six months). For more information, please contact Sharon Hunter RN, PHN, Care Transitions Program Coordinator – St. Joseph Health System Humboldt County, at sharon.hunter@stjoe.org.

financing can be more readily shifted among county agencies, creating some flexibility in funding initiatives.

Interestingly, there were some differences in *strategies to secure funding* to undertake integration initiatives. Some safety net stakeholders are more entrepreneurial and use a "leave no stone unturned" approach while others are more cautious and are only willing to pursue funding that aligns with their mission and/or capacity. There were no discernible differences by stakeholder types. While being strategic in securing funding may prevent "mission creep," it raises important questions on whether increased economic pressures preclude taking full advantage of opportunities to expand or strengthen local safety nets.

Last, the *strategies to allocate funding* for integration initiatives vary by stakeholder type. The county health care delivery systems tend to have centralized decision making or cross-agency planning with decentralized responsibility for initiative implementation. Similarly the hospitals engage in centralized decision making and leave day-to-day decision making to the ground level. Last, the Medi-Cal plans, clinics, and clinic consortia have their own internal decision making guidelines and fund development capacity.

Additionally, we asked study informants to rate how strongly they agreed that their county *has the capacity to coordinate health care services to meet the needs of the newly insured as well as the remaining uninsured.* The stakeholders in three counties—Contra Costa, Humboldt, and San Mateo—indicated they "agree" to "strongly agree" that their county has this capacity, while there was a range of responses in the other two counties (e.g., "strongly disagree" to "strongly agree"). However the majority of respondents in these two counties "agreed" their counties had capacity. Anecdotal responses shed some light on these assessments, with the first three counties citing their existing capacity and collective commitment. Some of the respondents from the two other counties cited competing priorities, uneven provider capacity, and increase in the number of uninsured (see **Table 3** below).

In sum, the five counties have stable relationships and vehicles for ongoing collaboration. The three county-run delivery systems or

Table 3: Capacity Assessment by County

	Contra Costa	Humboldt	San Diego	San Joaquin	San Mateo
County has the capacity to coordinate health care services to meet the needs of the newly insured as well as the remaining uninsured	Agree to Strongly Agree	Agree to Strongly Agree	Strongly Disagree to Strongly Agree	Disagree to Agree	Agree to Strongly Agree
Anecdotal responses	"Gearing up for this and are well positioned"	"Already doing it; have the organizations, communications and networking capacity"	"The uninsured will persist under ACA" and "There is high commitment and resources"	"Pitting health care against other county issues" and "Uneven provider capacity"	"Are pursuing much of this" and "Have the will and many of the ingredients"

provider counties are characterized by a higher level of integration while the two payor counties are at a slightly lower level. While the integrated county system affords these counties greater flexibility and cross-entity coordination, the safety net collaboratives in the other two counties and presence of a clinic consortium may provide some continuity as well as stability. The high ratings of capacity to coordinate health care and meet the needs of the newly insured and remaining uninsured bode well for continued progress in all five counties.

Safety Net Integration Best Practice: Medically Trained Cultural Liaison (MTCL) Model

La Maestra Family Clinic, San Diego County

Implemented by La Maestra Family Clinic over 20 years ago, this program expands the promotoras function to include medical training. The clinic has over twenty languages at their seven sites and it hired and trained people from these populations to ensure cultural competency. MTCLs are a conduit between patients and staff and providers on culturally specific issues that can inform their treatment. Also, providers and staff who are informed about different cultural beliefs and experiences can deliver care in a way that is best understood by the patient, ensuring compliance with preventive screening and treatment instructions. This has been important as they integrate mental health and primary care. The MTCLs serve as peers and advocates in the mental health world. Patients wouldn't be able to be served if these MTCLs weren't there. Providers can't explain rights and procedures without assistance from these individuals. For example, hospital providers call the clinic about patient non-compliance. The clinic sends a MTLC and the process moves forward, e.g., paperwork processed. The clinic currently has 25 full-time MTCLs at its main site. The clinic selects people from their own community who are in good standing and are seen as neutral. For more information, please contact Zara Marselian, La Maestra Family Clinic, at zaramarselian@lamaestra.org.

RECOMMENDATIONS

The Commonwealth Fund Commission identified six attributes of an ideal health care delivery system that are useful for developing options to support and expand safety net integration:

- Patients' clinically relevant information is available to all providers at the point of care and to patients through electronic health record systems;
- Patient care is coordinated among multiple providers, and transitions across care settings are actively managed;
- Providers both within and across settings have accountability to each other, review each others' work, and collaborate to reliably deliver high-quality, high-value care;
- Patients have easy access to appropriate care and information, and there are multiple points of entry to the system. Providers are culturally competent and responsive to patients' needs;
- There is clear accountability for the total care of patients; and
- The system is continuously innovating and learning in order to improve the quality, value, and patients' experiences of health care delivery.[18]

The analysis of integration initiatives both underway and proposed indicates that progress is being made in many of these areas and that there is great potential for county safety nets to reduce the systemic barriers to care as well as achieve seamless coordination of care. Implementation of the ACA and the many provisions targeting payment reform as well as the emphasis on population health and prevention could move local health systems to greater integration. However, the current state budget

Safety Net Integration Best Practice: Working With CCRMC to Transition Patients

La Clinica de la Raza, Contra Costa County

In 2009, La Clinica participated in a series of meetings with Contra Costa Regional Medical Center (CCRMC) when the county decided not to include the undocumented uninsured in the Basic Health Care (BHC) Program. Clinic and hospital medical staff met to transition these patients, including medical records, follow-up, and coordination of care. The clinic worked out arrangements with the county to take on follow-up care after hospital discharge, medications, tests, etc. It focused on systemizing and coordinating care so care is less case-by-case. The clinic can now refine existing process and procedures. They have made progress and achieved a new level of coordination. Over the three years, they have strengthened relationships and established communications between hospital and clinic medical providers. For more information, please contact Viola Lujan, La Clinica de La Raza, at vlujan@laclinica.org

Safety Net Integration Best Practice: Nurse Advice Line

Health Plan of San Mateo, San Mateo County

Launched in 2008 and funded by Health Plan of San Mateo (HPSM), this initiative aims to reduce unnecessary emergency room visits. The Nurse Advice Line (NAL) is a safety net resource as well as source of advice. Nurse Response is the vendor. Any Plan member with San Mateo Medical Center (SMMC) as their primary care provider can use the NAL. Over one-third of HPSM's membership—40,000+ people—does so, including those in the county's uninsured program. After every call, the patient's clinic gets a triage report, so there is follow-up. Outside physicians often use the NAL to provide SMMC clinicians with information about their patients (e.g., admissions to outside hospitals). The NAL nurse makes referrals to community services (e.g., psychiatric assistance) as well. HPSM gets a daily summary of calls to make sure that no one falls through the cracks. The system reduced ER visits compared to non-users in one year. There is high utilization and positive reception by members, with about 20 to 30 calls/day. The Plan aggressively markets the service and the clinics give out reminder cards. There are also special projects jointly funded annually by Nurse Response and the Plan. The provision of fever kits (which include thermometers, instructions on taking temperatures, and dosing for antipyretics) is a popular special project. After the Plan provided fever kits to SMMC families with children under age nine, the number of calls to the Nurse Advice Line where families, which could not report their child's temperature, went to zero. For more information, please contact Daisy Liu, HPSM, at daisy.liu@hpsm.org.

shortfall and piecemeal approach to these initiatives could continue to stymie growth as well as result in uneven adoption. The following state and local strategies are recommended:

1) Targeted Support for Local Safety Net Integration Activities

The counties in this study have the commitment and wherewithal to undertake difficult initiatives. However, varying levels of stakeholder adoption of some types of integration activities, as well as the data on proposed activities and "best practices" initiatives, suggests *some integration activities need external support to achieve broader adoption, particularly: safety net ACOs, specialty care provider recruitment, and enrolling patients in public insurance.*

Additionally, providers have access to Medicaid and Medicare Electronic Health Records (EHR) Incentive Programs to adopt, upgrade, or demonstrate "meaningful use" of certified electronic health record technology. However, interoperability issues will persist. *Funding needs to be made available to continue IT infrastructure development as well as allow for sharing of data across safety net providers and for analysis of IT system data.*

Last, counties with long-standing partnerships between the county health agency and private providers, in addition to high stakeholder collaboration, are well positioned to plan and implement integration approaches. However, the extent of collaboration among stakeholders varies across California counties. *Supporting broad-based networks, such as safety net coalitions, joint leadership models, and open communications, will help create the foundation for safety net reforms.*

2) Informing State Policymaking

Study findings on differences in existing and proposed integration activities by county suggest that some counties might proceed more slowly in pursuing integration activities than others due to economic pressures and factors unique to each county. *Attention needs to be paid to county safety net variation and tailoring of strategies to meet individual county needs.*

The findings on competing priorities and challenges will assist with reassessing federal, state, and local relationships and developing sound policy options. Gaps in primary care capacity coupled with a state budget shortfall will continue to strain local health care safety nets. *There should be increased alignment of state and county program responsibilities, particularly expanding (or maintaining) county capacity and commitment to meet their Welfare and Institutions Code Section 17000 obligations.*

Federal health care reform has the potential to streamline financing of the health care safety net and increase coordination of care. *New payment models, including incentive payments and bundled payment approaches, should be considered to address gaps in resources as well as facilitate uniform progress by local health care safety nets.*

Last, the state can leverage provisions of the ACA and other policies over which it has discretion to support integration. In particular, the California Health Benefit Exchange can be used to transform health care financing and delivery by realigning incentives and rewarding coordinated, high-quality care.[19] Other opportunities include the California Duals Demonstration and the establishment of care coordination programs for Medicare-Medicaid enrollees to help alleviate fragmentation and enhance quality.

Safety Net Integration Best Practice: Outreach and Enrollment in Access and Care for Everyone (ACE)

Ravenswood Family Health Center, San Mateo County

Launched in 2007 with funding from The California Endowment, Ravenswood trained six Certified Application Assistors (CAAs) and adopted One-e-App. The clinic started enrolling medically indigent adults in ACE, the County's Health Care Coverage Initiative, in 2009. Prior to ACE, there was no method to pay for clinic uncompensated care patients other than sliding fee scale out-of-pocket patient payments averaging $18 per visit. Over 3,000 adult patients have been enrolled. The clinic received reimbursement for previously uninsured individuals and saw the number of uncompensated care patients decrease from 64% to 21%. The clinic has seen increased compliance for medications and the number of visits per patient went from 2.9 to 3.4. This has been a partnership with the Health Plan of San Mateo e.g., CAAs go to regular Plan meetings. The clinic has been able to secure funding from other sources such as private foundations to continue supporting the CAAs. San Mateo County has been extremely inclusive and has brought them to the table. The county made sure the work done by the clinic was valued and the clinic was considered an important player. There have been some little glitches along the way. The Plan changed its computer system in April 2011, and the clinic was not able to see where people were enrolled but this was fixed by September. For more information, please contact Luisa Buada, CEO, Ravenswood Family Health Center, at lbuada@RavenswoodFHC.org.

CONCLUSION

The Patient Protection and Affordable Care Act (ACA) provides an opportunity to transform local health care safety nets into seamless systems of care. An assessment of safety net integration activities underway in five study counties—Contra Costa, Humboldt, San Diego, San Joaquin, and San Mateo—suggests that much progress has been made to this end. All are focusing on systems-wide integration (e.g., launch of their Medi-Cal Waiver Low Income Health Programs), cross-provider integration, (e.g., mental health and primary care integration, e-referral systems), and patient-level integration (e.g., Nurse Advice lines, Certified Application Assistors). Most are considering Accountable Care Organizations, consumer ePortals, and Health Information Exchanges. In addition to undertaking diverse integration initiatives, their information technology infrastructures continue to evolve albeit in a piecemeal fashion. There is evidence that many of these initiatives are resulting in coordinated care and strengthened partnerships between providers and county agencies, facilitating implementation of health care reform. Though there are differences in the capacity and resources that counties bring to bear, there are specific strategies and models that can be adopted by others, particularly in the areas of specialty care access, mental health and primary care integration, patient care coordination, and outreach and enrollment.

The comparison of five counties that have made great strides toward creating integrated delivery systems corroborates earlier UCSF findings that great capacity and willingness to reengineer health care for the medically underserved resides at the county level. These counties have the partnerships and shared commitment to create seamless systems of care. The presence of safety net collaboratives and/or nimble organizations, such as Medi-Cal managed care organizations and clinic consortia, afford counties the ability to secure resources and implement integration initiatives individual

stakeholders might not otherwise undertake. The analysis of the 30 safety net integration "best practices" points to several common factors for success, including leadership support at the top and shared leadership among organizations, perseverance of effort, open communications, and buy-in at all levels.

However, delivery system gaps and financial challenges loom large. Funding for these efforts varies by safety net stakeholder, and is piecemeal and project driven. While the high capacity to meet the needs of the newly insured and remaining uninsured bodes well for continued progress in all five counties, these counties nonetheless face significant challenges, be it the erosion of county funding or gaps in access to primary care. Key strategies to expand safety net integration include targeted support for some types of integration activities (e.g., safety net ACOs), IT infrastructure, and broad-based networks, as well as state policymaking that is sensitive to county safety net variation and leverages ACA provisions and policies to support integration (e.g., the Health Benefit Exchange).

Safety Net Integration Best Practice: Prenatal Social Marketing Campaign

Health Plan of San Mateo, San Mateo County

In 2010, the Health Plan of San Mateo received a grant from UCSF's ACTION Program for $35,000 to develop a social marketing campaign targeting pregnant women of color (Latina, African American, Pacific Islander) who were entering prenatal care after the first trimester of their pregnancy. Modeled after the Health Plan of San Joaquin's "Go Before You Show" (GBYS) campaign, the county's safety net providers working with women in the target groups distributed GBYS posters, flyers, and brochures. The team developed a movie theater ad, launched a web site, created a toll-free number and placed numerous bus ads about the program. The results were very positive: the number of women who signed up for presumptive eligibility (temporary Medi-Cal) doubled. Thousands of flyers, posters, and brochures were distributed and HEDIS scores improved for these groups. The Health Plan acted as a liaison and connected this public health activity to multiple organizations that handed out flyers. It was a partnership of eligibility workers and pharmacies (e.g., Lucky and Safeway), as well as safety net agencies. For more information, please contact Liliana Ramirez, MPH, Health Plan of San Mateo, at Liliana.ramirez@hpsm.org.

Endnotes

[1] Institute of Medicine. Quality of Health Care in America. 1996.

[2] LIHP, also known as the Coverage Expansion and Enrollment Demonstration (CEED), includes the Medicaid Coverage Expansion (MCE; low-income adults up to 133% FPL) and the Health Coverage Initiative (HCI; between 134% and 200% FPL). Under the waiver, counties can receive federal funds (1:1 match) for providing coverage to uninsured "childless adults." The Department of Health Care Services has approved the LIHP applications for all counties. As of March 29. 2011, 27 applications had received a Letter of Initial Approval, including the original 10 HCI counties, 14 new counties, the County Medical Services Program (CMSP), the California Rural Health Indian Board (CRIHB), and the City of Pasadena.

[3] Kominski, G.F., et al., "Health Insurance Coverage in California under the Affordable Care Act." Presentation to the California Health Benefit Exchange Board. March 22, 2012. Available at http://www.healthexchange.ca.gov/BoardMeetings/Documents/UC%20Exchange%20Board%20Meeting%20Handouts%20for%203-22-12%20v5.pdf

[4] An integrated delivery system or IDS can be defined as: "…an organized, coordinated, and collaborative network that: 1) links various healthcare providers, via common ownership or contract, across 3 domains of integration—economic, noneconomic, and clinical—to provide coordinated, vertical continuum of services to a particular patient populations or community and 2) is accountable, both clinically and fiscally, for the clinic outcomes and health status of the population or community served, and has systems in place to manage and improve them." Enthovan, AC. "Integrated delivery systems: the cure for fragmentation." *The American Journal of Managed Care*. Dec 2009;15(10 Suppl):s284-290.

[5] Davis, C. "California's Health Care Coverage Initiative: County Innovations Enhance Indigent Care." Prepared for the California HealthCare Foundation. September 2009.

[6] Roby, D. et al., "Creation of Safety-Net-Based Provider Networks Under the California Health Care Initiative: Interim Findings." A publication of the UCLA Center for Health Policy Research. December 2009.

[7] Canin, L. and Wunsch, B., "Specialty Care in the Safety Net: Efforts to Expand Timely Access." Prepared for the California HealthCare Foundation. May 2009.

[8] "The Delivery System Reform Incentive Program: Transforming Care Across Public Hospitals." California Association of Public Hospitals and Health Systems. Policy Brief. June 2011.

[9] Ku, L., et al., "Promoting the Integration and Coordination of Safety-Net Health Care Providers Under Health Reform: Key Issues." Commonwealth Fund pub. 1552, Vol. 22, October 2011.

[10] Kelch, D., "The Crucial Role of Counties in the Health of Californians." Prepared for The California HealthCare Foundation. March 2011.

[11] Based on findings from the UCLA evaluation of the ten Health Coverage County Initiative counties and discussions with key stakeholders familiar with local safety net integration initiatives.

[12] QuickFacts from the US Census Bureau. http://quickfacts.census.gov. Accessed March 20, 2012.

[13] Health Profiles. UCLA Center for Health Policy Research. www.healthpolicy.ucla.edu/healthprofiles. Accessed March 28, 2012.

[14] By "proposed" we mean that an activity is in the early stages of discussion and has not been funded. It does not mean that a county is going to undertake a particular initiative. However, it is a fairly good predictor of activities a county is likely to undertake in the future.

[15] Cleary, J. and Cosgrove, K. "A Community Capacity Assessment Tool and Process for Natural Resource Management." Department of Water, Land and Biodiversity Conversation. December 2006.

[16] Konrad, E. "A Multidimensional Framework for Conceptualizing Human Services Integration Activities." *New Directions for Evaluation*. No. 69, Spring 1996.

[17] Note: San Joaquin County's activities for the county health agency and hospital are combined since the hospital is part of the county.

[18] Shih, K. et al., "Organizing the U.S. Health Care Delivery System for High Performance." The Commonwealth Fund, August 2008.

[19] California HealthCare Foundation. "Change Agent: The California Health Benefit Exchange as Catalyst of Finance and Delivery Reform." August 2011.

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Study Advisors

This project engaged representatives from safety net provider associations and research organizations to fine-tune the research approach, identify case study counties and informants, and review preliminary study findings. Representatives from the following organizations participated as Study Advisors:

- California Association of Public Hospitals–Safety Net Institute
- California Primary Care Association
- Insure the Uninsured Project (ITUP)
- UCLA Center for Health Policy Research

Investigator

The study was led by Annette L. Gardner, PhD, MPH, Assistant Professor in the UCSF Department of Social and Behavioral Sciences and Academic Specialist at the Philip R. Lee Institute for Health Policy Studies. Since 2002, Dr. Gardner has conducted several studies on county initiatives to expand coverage for the uninsured in California, including two statewide surveys on county access initiatives in 2002 and 2004 and numerous case studies on county health system redesign (e.g., implementation of Healthy Kids in Santa Clara County and Healthy San Francisco). She also served as an Independent Evaluator of the California HealthCare Foundation's Step by Step: Local Coverage Expansion Initiative, and conducted a three-year evaluation of child and adult coverage expansions in 30 counties, including technical assistance needs and gains. Her findings on county health care safety nets and local coverage expansions have been published in *Health Affairs* and the *Journal of Health Care for the Poor and Underserved.*

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Appendix A: Number of Stakeholders Involved with the 28 Integration Activities

28 Integration Activities	Health Agencies (5)	Safety Net Hospitals (5)	Medi-Cal Plans (3)	Non-County Clinics (5)	Clinic Consortium (3)
SYSTEM-LEVEL INTEGRATION ACTIVITIES					
Participation in an Accountable Care Organization (ACO)	2	1	0	0	0
Adoption of an integrated network of safety net providers (coordinate care across levels of care—primary clinic, specialty care, inpatient care)	3	3	3	4	1
PROVIDER-LEVEL INTEGRATION ACTIVITIES					
Adoption of panel management (multi-disciplinary primary care team plans and manages patients with chronic disease, e.g., Teamlet model)	**4**	**3**	**3**	**4**	**2**
Onsite specialty care at primary care sites:					
Mental health care	**5**	**3**	**3**	**5**	**2**
Dental health	3	2	2	5	2
Expanded communications between primary care and specialty care	**5**	**4**	**3**	**4**	**3**
Expanding provider scope of practice (e.g., trainings, mini-fellowships)	4	3	3	3	2
County contracts with community clinics to provide care to medically indigent	3	2	3	**5**	1
Adoption of patient centered medical home	4	2	3	3	2
Addition of new health care services (e.g., heart failure clinics)	3	3	1	2	1
Auto enrollment of Medi-Cal patients	3	2	3	0	0
Electronic eligibility and enrollment system (e.g., One-e-App)	5	3	3	1	1
Electronic prescribing system	3	3	2	2	2
Electronic health information systems, (e.g., EMR, HRE, LCR)	5	3	3	3	2
Electronic specialty care referral system	4	2	1	2	1
Electronic panel management system	4	3	1	2	0
Electronic disease registries (e.g., diabetes)	**5**	**4**	**2**	**3**	**2**
ER diversion programs	4	2	2	2	2
Health Information Exchange (HIE) between providers or providers and the county	3	2	1	2	2
PATIENT-LEVEL INTEGRATION ACTIVITIES					
After hours and/or same day scheduling system	**4**	**3**	**3**	**5**	**2**
24/7 nurse advice line to redirect patients	3	3	3	3	2
ePortals for patients to interact with systems	1	1	0	1	1
Case management services or the coordination of treatment options	**3**	**4**	**3**	**4**	**1**
Certified Application Assistors (CAAs) who enroll the uninsured in health care insurance	**4**	**4**	**3**	**5**	**2**
Community Health Workers who facilitate access to health services	**4**	**4**	**2**	**5**	**2**
Patient Navigators who assist patients with medical treatment options and acts a liaison	3	3	2	3	2
Accessible telephone systems	**5**	**4**	**3**	**3**	**1**
Language access	**5**	**5**	**3**	**5**	**2**

Appendix B: Study Informants

Contra Costa County

Alvaro Fuentes
Executive Director
Community Clinic Consortium

Viola Lujan
Director of Business and Community Relations
Contra Costa and Solano Counties
La Clinica de La Raza, Inc.

Patricia Tanquary
Chief Executive Officer
Contra Costa Health Plan

William Walker, MD
Director
Contra Costa Health Services

Shelly Whalon, RN, CPHQ
Chief Quality Officer
Contra Costa Regional Medical Center and Health Centers

Humboldt County

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Telehealth Development Director
Open Door Community Health Centers

Susan Buckley, RN, MPH
Public Health Branch Director
Humboldt County Department of Health and Human Services

Sharon M. Hunter, RN, PHN
Care Transitions Program Coordinator
St. Joseph Health System–Humboldt County

Tim Rine
Executive Director
North Coast Clinics Network

Herrmann Spetzler
Chief Executive Officer
Open Door Community Health Centers

Nancy Starck
Legislative Analyst
Humboldt County Department of Health and Human Services

San Diego County

Ted Chan, MD
Professor of Clinical Emergency Medicine
Medical Director, Emergency Department
University of California, San Diego Health System

Nicole Howard, MPH
Director of Programs and Fund Development
Council of Community Clinics &
Community Clinics Health Network

Zara Marselian
Chief Executive Officer
La Maestra Family Clinic

Nick Yphantides, MD, MPH
Chief Medical Officer
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Ken B. Cohen
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Margaret Szczepaniak
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