THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
ACTION AGENDA SUMMARY

DEPT: Chief Executive Office **BOARD AGENDA #** B-10

Urgent ☐ **Routine** ☑ **AGENDA DATE** September 13, 2005

CEO Concurs with Recommendation YES ☑ **NO** ☐ **4/5 Vote Required YES** ☐ **NO** ☑
(Information Attached)

SUBJECT:

Approval of the Health Services Agency Strategic Plan and Related Recommendations and Schedule of a Public Hearing for October 18, 2005, 6:40 PM, to Consider Program Changes Outlined in the Report

STAFF RECOMMENDATIONS:

1. Accept the Health Services Agency Strategic Plan Report.

2. Adopt a three-year service delivery plan, which includes:
Year One: Remodel and expansion of outlying clinics to accommodate patient volume from the Family Practice Center, Specialty Clinics and Urgent Care facilities at County Center II. Prepare site selection analysis and cost estimates to build replacement facilities for Public Health, Behavioral Health & Recovery Services & Central Services. Issue Request for Qualifications and/or Request for Proposals to evaluate Community Partnerships for the delivery of some health services.

(Continued on Page 2)

FISCAL IMPACT:

Since the closure of Stanislaus Medical Center in November 1997, the Health Services Agency has experienced over $52 million in operating losses, prior to the consideration of one-time funding sources. The pre-audit operating results for the year close on June 30, 2005 indicate a net loss of over $9.3 million, prior to the consideration of one-time funding sources. The 2005-2006 Proposed Budget for the Health Services Agency - Clinic and Ancillary Services budget reflected an operating deficit of $8,672,857.

(Continued on Page 3)

BOARD ACTION AS FOLLOWS:

No. 2005-720

On motion of Supervisor Mayfield , **Seconded by Supervisor** Simon
and approved by the following vote,
Ayes: Supervisors: O'Brien, Mayfield, Simon, DeMartini, and Chairman Grover
Noes: Supervisors: None
Excused or Absent: Supervisors: None
Abstaining: Supervisor: None

1) X **Approved as recommended**
2) _____ **Denied**
3) _____ **Approved as amended**
4) _____ **Other:**
MOTION:

Christine Ferraro

ATTEST: **CHRISTINE FERRARO TALLMAN, Clerk** **File No.**

STAFF RECOMMENDATIONS: (Continued from Page 1)

Year Two: Pursue Community Partnerships where feasible
Year Three: Evaluate success of new model. If the new model is unable to achieve significant improvement in reducing the deficit to a more sustainable additional General Fund contribution level of $3.75 million, consider only providing benefits to Medically Indigent Adults.

3. Schedule a Public Hearing, Pursuant to Section 1442.5 of the Health and Safety Code, on October 18, 2005, at 6:40 P.M., to consider:
   A. The elimination of the direct provision of mammography services.
   B. The elimination of the direct provision of speech therapy services.
   C. The elimination of the direct provision of dental services.
   D. Amend the eligibility requirements of the Medically Indigent Adult program to allow only those Stanislaus County residents who are United States citizens or legal permanent residents and who meet all other eligibility criteria to be granted program eligibility.
   E. Provide for patient volumes at 1997 levels (minimum 207,000 patient visits) while insuring the preservation of the Omnibus Agreement with Tenet Health Systems/Doctors' Medical Center.

4. Direct the Chief Executive Officer to finalize a detailed facilities implementation plan and return to the Board of Supervisors at a future date to present the plan and/or schedule a public hearing if required by law.

5. Approve the three-year funding plan outlined in the report and direct the Health Services Agency to submit budgets consistent with this plan.

6. Approve the change in the terms of the secured note from the Tobacco Securitization Fund to include the 2003-2004 cash deficit of $3,236,112 and authorize the Treasurer-Tax Collector and Chairman of the Board of Supervisors to sign the revised loan agreement.

7. Direct the Chief Executive Officer and Health Services Agency Managing Director to continue to pursue legislation to allow Stanislaus County to qualify for Certified Public Expenditures.

8. Direct the Health Services Agency Managing Director to submit an application for status as a Federal Qualified Health Center.

9. Direct the Health Services Agency Managing Director to explore alternative Medi-Cal Managed Care delivery options.

10. Authorize the continuation of the Residency Program and direct the Health Services Agency Managing Director and Residency Program Director to seek additional financial sponsors and improvements in the overall efficiency of the Program.

11. Direct the Chief Executive Officer and Health Services Agency Managing Director to continue to pursue contributions from other health agencies and medical providers.

12. Direct the Health Services Agency Managing Director, or her designee, to renegotiate the current Blue Cross contract.

13. Direct the Health Services Agency Managing Director to implement the efficiency improvements outlined in the Strategic Plan Report.

14. Approve the increase in the cash payment to $90 for Primary Care visits and the deposit to $100 for Urgent Care and Specialty Care visits, from current levels of $45 and $40 respectively, to more accurately reflect costs of providing care.

15. Authorize the Chief Executive Office to negotiate an amendment to the Paradise Medical Office and McHenry Medical Office clinic leases with the building owners for clinical space renovations, and return to the Board of Supervisors for final approval.

16. Authorize the Purchasing Agent to negotiate a two-year extension to the Turlock Medical Office lease.

17. Authorize the Purchasing Agent to execute leases for new leased space for offices being relocated from the present use at Paradise Medical Office, including the Community Services Agency, Children and Families Commission and Women, Infant and Children Programs.

18. Authorize the Chief Executive Officer to obtain design and engineering services to plan for the remodel of the Medical Arts Building.

19. Authorize the Chief Executive Officer to develop a phasing plan to relocate Public Health, Behavioral Health & Recovery Services, Central Services and other programs currently located at County Center II, and to proceed to plan for the marketing and sale of County Center II.

FISCAL IMPACT: (Continued from Page 1)

The Health Services Agency Strategic Plan report recommends a three-year funding plan that will require the Health Services Agency to reduce the operating deficit to $7,440,000 in Fiscal Year 2005-2006, $5,600,000 in Fiscal Year 2006-2007, and $3,750,000 in Fiscal Year 2007-2008. The plan also includes a total of $1,599,500 for one-time costs related primarily to facility changes, and $1,839,000 for contingencies, including potential employee cashout costs. Funding for this $20,228,500 three-year plan includes the use of $3.5 million from the Community Health Services Trust Fund and $16,728,500 from the General Fund. The ongoing General Fund contribution thereafter would be the current $161,075 County Match plus an additional General Fund match of $3,750,000 for a total of $3,911,075.

The Health Services Agency will be expected to submit budgets consistent with this plan. Any additional fund balance created by the Agency through efficiency improvements, additional revenue sources, or other sources can be retained by the Agency to address ongoing operational issues. Conversely, any future cash deficits are expected to be made up through the following year's HSA budget.

The Strategic Plan also contains recommendations to deal with prior operating deficits. First, it is recommended that the note between the Treasury and Health Services Agency, secured by the Tobacco Securitization Fund, be amended to include the Fiscal Year 2003-2004 cash deficit of $3,236,112. Secondly, it is recommended that all but $3.5 million of the Community Health Services Trust Fund cash ($1,771,629) be transferred to the Clinics and Ancillary Services enterprise fund to address the $1,770,398 cash deficit from the 2004-2005 Fiscal Year.

To manage to an operating deficit level of $7,440,000 for Fiscal Year 2005-2006, it will be necessary for the Agency to reduce their operating budget by $1,232,857. It is anticipated that this reduction can be made up through efficiency improvements, lower costs and losses from a decrease in overall patient visits, revenue increases as a result of the change in the cash discount and cash deposit, and overall reductions in administrative overhead costs. These changes are reflected in the Fiscal Year 2005-2006 Final Budget Addendum, to be presented to the Board of Supervisors in the same meeting as this report.

A more detailed discussion about various fiscal impacts is included in the Health Services Agency Strategic Plan Report.

DISCUSSION:

The attached 62 page Health Services Agency Strategic Plan Report is the culmination of over ten months of intensive effort by staff from the Health Services Agency, Chief Executive Office, Scenic Faculty Medical Group and Stanislaus Medical Society representatives, with assistance from The Camden Group. The report outlines the history behind the challenges facing the Health Services Agency clinic system, efforts undertaken to analyze the situation and develop recommendations, community involvement, major factors influencing the final recommendation and a discussion of the recommendations.

The recommendations contained in the report attempt to provide a model that will allow the County to provide the greatest level of services to the most residents at the lowest cost possible. Even still, the funding of these recommendations will require an additional General Fund contribution of over $16.7 million over the next three years. This use of this level of discretionary funding is unprecedented and reflects the Board of Supervisors' commitment to maintaining "a healthy community."

Some of the recommendations contained in this report are subject to a public hearing, pursuant to Section 1442.5 of the Health and Safety Code. The Health Services Agency Strategic Plan Report recommended that this public "Beilensen" hearing be conducted on September 27, 2005. Due to scheduling conflicts, it is now requested that the Board of Supervisors schedule that public hearing for October 18, 2005, at which time those recommendations can be discussed. Should the Board of Supervisors approve the recommendations at the hearing on October 18th, the recommended effective date for the program changes would be October 27, 2005.

A draft of the Recommendations was presented to the Health Executive Committee at their August 23, 2005 meeting. The Committee recommended that the Report and Recommendations be forwarded to the entire Board of Supervisors and authorized the Chief

Executive Officer and HSA Managing Director to begin meeting with employees, unions and other interested parties to discuss the recommendations.

POLICY ISSUE:

The basic policy question before the Board of Supervisors, which this report attempts to grapple with, is: "Should the County stay in the business of providing non-mandated health services or focus on providing only those services mandated by law, that of serving the medically indigent and providing public health services?" Although the recommendations contained in the report will undoubtedly result in the Health Services Agency being able to serve fewer of the uninsured/underinsured constituents of Stanislaus County, it attempts to develop a sustainable, long-term plan to insure that the Agency can continue to be a major "safety net provider" in this community, consistent with the Board of Supervisors' priority of "a healthy community".

STAFFING IMPACT:

Should the Board of Supervisors, after conducting the required Beilenson Public Hearing on October 18, 2005, choose to eliminate the direct provision of mammography, speech therapy and dental services, as well as provide services at 1997 patient visit levels, there will be a need for fewer staff. Currently there are 3.5 full-time positions in the mammography, speech therapy and dental services programs, of which 2.5 of these positions are currently filled. The subsequent recommended clinic changes may result in further staffing impacts. Some staffing reductions may be accommodated through normal attrition and through the use of fewer part-time and temporary help. It is our goal to place the remaining affected employees in other county jobs wherever possible.

HEALTH SERVICES AGENCY

"leading the way to a healthy community"

Strategic Plan Report

2005

Stanislaus County

Striving to be the Best

Stanislaus County Board of Supervisors
District One: William O'Brien
District Two: Thomas W. Mayfield
District Three: Jeff Grover
District Four: Raymond C. Simon
District Five: Jim DeMartini

Health Services Agency Strategic Plan Report

I. Introduction

Table of Contents

Healthcare in the United States is a patchwork of uncoordinated systems. There are entitlement programs for some segments of the population, such as Medicare for seniors, and Medicaid (called Medi-Cal in California) for certain persons based on either income, disability or age. Most working age individuals rely upon employer-sponsored health care, purchase individual coverage, or do without insurance at all.

The situation in California is no better, but adds the additional complication of indigent care responsibilities, imposed on counties as provider of last resort, under Welfare and Institution Code Section 17000. It states "Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions". Counties are allowed to set individual standards of indigency based on income, assets and residency. Counties are not legally obligated to serve uninsured persons who do not meet indigency requirements, nor legally obligated to provide or contract for health care services for any other payer or insurance.

Historically, Stanislaus County had met the indigent mandate through a county hospital, and later through a network of outpatient clinics. The county also provided services on a fee for service basis to other non-mandated populations, including the uninsured and Medi-Cal. These services were provided by the county as there was a lack of capacity, obligation and/or desire by the private medical community to serve these populations. Therefore, the county system has served a "safety net" function in the community, providing access to health care for those patients.

The Health Services Agency (HSA) is Stanislaus County's largest "safety net" provider, serving over 80,000 unique patients with over 260,000 patient visits annually. In addition, the Agency has a broad scope of responsibilities including the management of the Section 17000 mandate through the Indigent Health Care Program (IHCP), and the provision of mandated Public Health services under California Code Title 17. The Clinic and Ancillary branch provides direct medical services including primary, specialty and urgent care, as well as laboratory, radiology, pharmacy and rehabilitative services.

This report is the culmination of years of effort in trying to develop a long-range strategic plan for the HSA that balances financial resources with the Board of Supervisors' priority for a healthy community. This has been a difficult and arduous journey and the leadership and the staff of the HSA are to be commended for their suggestions, patience, flexibility and dedication to the task at hand, while strategic options were being crafted.

In reading the report, unless otherwise stated, most of the data related to visit volume, operating income or losses, staffing and various ratios are for the fiscal year ending June 30, 2004.

II. History

In the early and mid-1990's the County hospital, Stanislaus Medical Center (SMC), was able to operate in a marginally profitable manner. Like other area hospitals though, SMC had begun to experience a reduction in average daily census and a reduction in the average length of stay. Dramatic changes were occurring within the health care system, which were anticipated to have a significant impact on the County's health care delivery system. These changes included an increasing role by managed care programs which was fundamentally changing how health care services were delivered, declining reimbursements, significant costs for seismic retrofitting of existing inpatient facilities, and an increasing focus on prevention and education. In order to respond to these changes, it was recommended that the County seek partnerships with local hospitals and other providers in the County for acute medical services. Concern was voiced at the time regarding the potential loss of Disproportionate Share (DSH) funding, a State/Federal matching program which provides subsidies for inpatient care based upon the hospital having a disproportionately large share of inpatient days for Medi-Cal and indigent patients. This DSH money was bringing in over $4.5 million for SMC at that time, as well as up to $1.6 million for the Stanislaus Behavioral Health Center (SBHC).

On January 28, 1997, the Board of Supervisors directed the Chief Executive Office to enter into exclusive negotiations with Doctors Medical Center (DMC) and return the negotiated agreement to the Board. The DMC proposal offered an allotment, at its cost, of 2,200 inpatient care days per year for County qualified indigents and a $12 million one-time payment to the County for support of the outpatient clinic network.

On October 28, 1997, the Board of Supervisors unanimously approved the DMC agreement and the closure of Stanislaus Medical Center, effective 11/30/97. A reduction in DSH funding was projected, but it was hoped that this loss would be offset to some extent by a reduction in operating expenses. In addition, the County would pursue a Section 1115 waiver, which would allow the County to continue to receive DSH funding for five years, and was optimistic about its potential success. Neither State nor Federal support for this waiver was achieved, which resulted in a $4.6 million loss of revenue for the Stanislaus Medical Center.

In addition to the loss of DSH funding, several other factors contributed to the Agency's operating deficit. First, the State denied Medi-Cal treatment room charges, which totaled $2 million annually. These charges are additional Medi-Cal fee-for-service reimbursement given to county hospital-based ambulatory clinics to cover the higher cost of service delivery. Fortunately, in October 2001, AB963 (Assemblyman Cardoza) was passed which reinstated this funding retroactive to January 2002. Over $5 million of funding was lost however during the period of March 1998 through January 2002.

Other factors contributing to the deficit included rising labor costs of almost $2 million per year agency wide for cost-of-living adjustments, step increases, and increases in health insurance, Workers' Compensation and retirement. Also, State formulas for the distribution of Realignment revenue, which funds indigent and public health services, have not kept pace with Stanislaus County's growing population resulting in our "under

equity" position as a county and the cumulative loss of approximately $10 million of funding for health services.

The following chart shows the annual operating loss for the Clinics and Ancillary Services system prior to the use of one-time funding, commencing with the 1996-1997 Fiscal Year.

Fiscal Year End	Profit/(Loss)
June 30, 1997	($1,105,534)
June 30, 1998	($4,321,088)
June 30, 1999	($8,201,092)
June 30, 2000	($7,150,380)
June 30, 2001	($7,825,976)
June 30, 2002	($2,417,613)
June 30, 2003	($5,520,693)
June 30, 2004	($6,433,011)
June 30, 2005	($9,330,196)1

1 reflects pre-audited operating results

These annual operating losses accumulated over time creating a serious deficit in both cash and retained earnings. To begin addressing this accumulated deficit, the Board of Supervisors established a repayment plan as part of the 2003-2004 Final Budget that consisted of two parts. The first part was to allow the Department to consider $7.4 million provided from a fund established at the time of the hospital closure as revenue. The second part dedicates discretionary revenue interest, generated from 80% of the tobacco endowment funds earnings, to go towards the accumulated deficit.

The following chart shows the cash position for the Clinics and Ancillary enterprise fund.

Fiscal Year End	Accumulated Cash Deficit
June 30, 1998	($ 6,359,774)
June 30, 1999	($13,687,839)
June 30, 2000	($10,869,394) 1
June 30, 2001	($15,065,700)
June 30, 2002	($19,491,450)
June 30, 2003	($20,489,032)
June 30, 2004	($23,725,144) 2
June 30, 2005	($22,259,891) 3

1 $8,201,092 cash advanced from Community Health Services Trust Fund

2 In County financial statements, accumulated cash deficit reflected as $3,236,112 for cash proceeds from long-term note of $20,489,032 secured by Tobacco Endowment Fund

3 Reflects pre-audited numbers for '04/05 cash deficit of $1,770,398, '03/04 cash deficit of $3,236,112, and remaining balance due on note from the Treasury of $17,253,381.

As part of the June 30, 2004 closing of the County's financial books, the County's external auditors recommended that the accumulated cash deficit be recorded as a long-term loan against the Treasury's pooled investment funds. After considerable discussion between the Chief Executive Office, Auditor-Controller's office and our outside auditors, it was determined that a formal note would be recorded with the County's Treasury to secure the payment in the amount of $20,489,032, the amount of the accumulated cash deficit as of June 30, 2003. Consequently, the County's financial statements reflected an accumulated cash deficit of $3,236,112 for June 30, 2004.

Operating losses over the years have been offset with the use of one-time funding from the Community Health Services Trust Fund, Tobacco Settlement Funds, Public Health and Managed Care fund balances, litigation revenue and the use of interest earnings from the Tobacco Securitization fund. Unfortunately, these one-time funding sources have dwindled or become obligated and are no longer an option for balancing future deficits beyond Fiscal Year 2005-2006.

The Health Services Agency (HSA) is the largest outpatient "safety net" provider in Stanislaus County. The County is only mandated to serve medically indigent adults, which represent just over 8% of patients seen and 11% of total charges. Based on percent of revenue, approximately 50% of patients seen are on Medi-Cal and another 13% are on Medicare. While not mandated to provide health services to these populations, given the current low Medi-Cal reimbursement rates, it would be difficult for these patients to find access to health care services from other providers were they not seen by the HSA. Failure to provide services to this population would most likely seriously impact already over-burdened emergency rooms, contributing to a health care crisis in this County.

The Health Services Agency has worked closely with the Chief Executive Office over the past several years to come up with strategies to address this deficit. Several scenarios have been developed ranging from increasing services to providing mandated services only. Virtually every scenario analyzed included some level of operating deficit as well as drastic service implications. Unfortunately, those scenarios with the least amount of operating deficit, such as providing mandated services only, carried with them devastating impacts that would cripple access to health care in our community. Before asking the Board of Supervisors to make a decision that might carry serious negative consequences to our community, it was decided that it would be prudent to seek an independent review from a third party.

After meeting with the Health Executive Committee on October 12, 2004, the Chief Executive Office entered into a contract with The Camden Group to assist in addressing this issue. The Camden Group has considerable experience in the health care arena, most recently working with the County of San Luis Obispo to restructure their health care service delivery system. The contract with The Camden Group to prepare the Health Services Agency – Strategic Assessment Report was for a not to exceed amount of $34,650. The final cost for this engagement was $33,000.

The scope of The Camden Group engagement with Stanislaus County included:

- A review and analysis of the current performance of the Agency, especially as it relates to recommendations contained in the 1998 review by Camden.
- A review of the strategies identified by HSA for alternative structuring of the Clinic and Ancillary Services.
- Providing a strategic overview of what other health agencies in California are doing to fund/reduce operating losses in their outpatient services.
- Identifying other innovative strategic options, and/or variations of these options to enhance reimbursement/reduce operating losses.
- Conducting an all day strategic planning session to develop a series of recommended strategies.

In late November/early December 2004, Camden conducted a two-day site visit to review Clinic operations and meet with HSA and CEO senior staff. Ms. Mary Witt, a senior manager with Camden who also worked on the 1998 report and recommendations, noted that the Agency had "improved dramatically" having established performance targets for productivity, staffing and accounts receivable, streamlined processes and strengthened the overall financial management. It seemed apparent from early in the engagement that while the HSA has made considerable progress in addressing revenue and expense issues at the Clinic sites, with rising health care costs it would not be able to significantly impact its losses without systemic changes. The balance of the engagement was spent focusing on strategic options that could provide these systemic changes.

On January 18, 2005, Ms. Laura Jacobs, senior vice president for Camden and Ms. Witt, met with the Health Executive Committee to share some of their preliminary findings, observations and scenarios for consideration. The balance of the day was spent in a strategic planning session with HSA senior staff and representatives from the Chief Executive Office.

The "Health Services Agency – Strategic Assessment" prepared by The Camden Group outlined "Opportunities for Improvement" that, if determined legal and feasible and if implemented, could result in an estimated $750,000 in savings and increased revenue. While these savings/increased revenue are significant, it became clear that merely improving current performance by implementing these recommendations without addressing systemic change would fall far short in addressing the current level of operating loss. Accordingly, the report contained some strategic options that, if implemented, were projected to significantly improve the Agency's financial performance and even potentially eliminate the operating deficit.

The strategic options recommended in the report by Camden for consideration were:

- Option A – Consolidate clinics and seek recognition as a Federally Qualified Health Center (FQHC) for all clinics.
- Option B – Consolidate clinics and partner with a private provider for select clinics
- Option C – Privatize all clinics

All of the proposed options sought to meet the Board of Supervisors' priority of ensuring a healthy community, provide access to healthcare for the County's Medi-Cal, uninsured and underinsured citizens, and maximize the utilization of County resources.

Options A and B, both involved potential closure of the Medical Arts clinic, consolidation of the Ceres and Hughson clinics, a reduction in direct and indirect costs per patient visit and possible discontinuance of the residency training program. Option A was unique in that it assumed that Stanislaus County would be successful in obtaining FQHC status, where Option B assumed that the County would enter into a partnership with a private partner for select clinics and that the partnership relationship would result in referrals for specialty services. Option C would involve converting all of the clinics to a private operator.

While the recommended options appeared to increase financial performance while preserving our ability to provide essential services, all the options involved some major assumptions, risks and potential weaknesses. It should also be noted that while Camden reviewed a significant amount of data provided by HSA in completing their analysis, their focus was primarily on developing strategic options and as such their analysis was at a very high level. A more detailed and careful cost/benefit analysis needed to be completed to assess the feasibility, legality and other risks for each of the components recommended in the report before crafting final recommendations for consideration by the Board of Supervisors. When considering recommendations involving potential consolidation of clinics, all facilities were assessed in terms of lease costs, size, patient volumes and geographic areas served.

On March 1, 2005, the Health Executive Committee discussed the Health Services Agency – Strategic Assessment and recommended that the report be forwarded to the Board of Supervisors. The Committee also approved the proposed work plan that outlined the next steps in developing a specific recommendation for consideration by the Board of Supervisors. That work plan included the creation of five specialized workgroups. Participating in these workgroups were members of the Stanislaus Medical Society, members of the Scenic Faculty Medical Group (SFMG), HSA senior staff, County Counsel staff and Chief Executive Office staff. The five workgroups by topic were: Legal Issues, Improving Efficiency, Revenue Maximization, Facility Management and the Residency Program. These workgroups culminated their efforts in an intensive day and a half planning session on April 20-21, 2005. The Camden Group was brought back in to assist the workgroups in their analysis and to participate in this two-day retreat. The total cost of this second engagement was $6,193. Some of the detailed research performed by these workgroups supported Camden's report, while some of the research ruled out some of the options/assumptions contained in the report.

Chief Executive Office and HSA senior leadership continued to evaluate potential actions as well as scheduled meetings with community stakeholders to solicit their input relative to strategic options. Dozens of scenarios were discussed and countless hours were spent developing the recommendations contained in this report. It is our hope, that based on these recommendations, the HSA will have a sustainable strategic direction that will allow the Agency to continue to provide quality health care to this community for years to come.

III. Clinic/Service Profiles

To assist in understanding the recommendations contained in this report, a little background about the various clinics and services is being provided. A more complete breakdown of each of the clinic operations is provided in Appendix A of this report.

HSA Clinic and Ancillary services consist of primary care, specialty care, and the ancillary services that support this care (lab, radiology, retail pharmacy, and rehabilitation services) to approximately 20% of the County population. Clinic services provided at nine medical office locations include: family practice; pediatrics; prenatal care; obstetrical care; women's health care and family planning; immunizations; treatment of sexually transmitted diseases (STD's); well child check-ups; urgent care; and adult and pediatric specialty care including orthopedics, otolaryngology, neurology, cardiology, ophthalmology, general surgery, gastroenterology, spinal cord, HIV care, oncology, urology, podiatry and neurosurgery. Full service rehabilitation services including, physical therapy, occupational therapy, speech therapy, audiology, and wound care services are also provided.

In conjunction with the provision of patient care, the Agency maintains a family practice residency program, which is affiliated with the University of California, Davis. Through this three-year program, 27 family practice residents are trained and are an integral part of the County's primary care clinic system. Outpatient training is performed in the Agency medical offices and inpatient training occurs at Doctors Medical Center in Modesto.

The medical services of the teaching program are supported through Scenic Faculty Medical Group, a "core" medical staff representing primarily Family Practice, Pediatrics and Obstetrics/Gynecology. In addition, approximately 80 community physicians provide teaching and specialty services to HSA clients in the Agency's specialty clinics.

This budget unit is funded through charges for services to clients, residency program funds and one-time fund balance transfers.

Following is a profile of each of the various Clinic and Ancillary Services in operation today:

Family Practice Clinic (FPC):

Location: 830 Scenic Drive, Modesto
Year opened: 1977
Services provided: Family Practice and Internal Medicine

Number of Providers: 15.75
Non-Provider Full Time Equivalent: 41.55

Total Annual Patient Visits: 37,794

Net Profit/(Loss): ($2,022,080) *
*Includes Residency Program costs

Lease or Owned: Owned

Urgent Care (UC):

Location: 830 Scenic, Modesto
Year opened: 1997
Services provided: Episodic, Urgent Medical Care

Number of Providers: 3.5
Non-Provider Full Time Equivalent: 19.5

Total Annual Patient Visits: 26,365
Net Profit/(Loss): ($344,221)

Lease or Owned: Owned

Ceres Medical Offices (CMO):

Location: 3109 E Whitmore, Ceres
Year opened: 1999
Services provided: Family Practice, Family Planning and Primary Medical Care

Number of Providers: 7
Non-Provider Full Time Equivalent: 14.2

Total Annual Patient Visits: 20,015
Net Profit/(Loss): ($737,579)

Lease or Owned: Leased
Lease term: 15 years (no early termination or fiscal out clause)
Monthly lease cost: $12,956 (Clinic) $15,159 (entire facility)
Shared space with Women Infants Children (WIC) and American Medical Response (AMR)

Hughson Medical Office (HMO):

Location: 3rd & Elm Streets, Hughson
Year opened: 1998
Services provided: Family Practice, Family Planning and Primary Medical Care

Number of Providers: 5
Non-Provider Full Time Equivalent: 17

Total Annual Patient Visits: 25,207*
Net Profit/(Loss): ($744,191)*

Lease or Owned: Leased
Lease term: 10 years (no early termination or fiscal out clause)
Monthly lease cost: $6,250

*Figures include partial year operation for Empire Medical Office, closed October 2003

Paradise Medical Office (PMO):

Location: 401 Paradise Road, Modesto
Year opened: 2001
Services provided: Family Practice, Family Planning and Primary Medical Care

Number of Providers: 3
Non-Provider Full Time Equivalent: 14.5

Total Annual Patient Visits: 21,484
Net Profit/(Loss): ($867,590)

Lease or Owned: Leased
Lease term: 20 years (no early termination or fiscal out clause)
Monthly lease cost: $9,602 (Clinic), $43,451 (entire facility)
Shared facility: Women Infants Children (WIC), Prop 10 Commission, Behavioral Health Recovery Services (BHRS), Community Services Agency (CSA), Library and American Medical Response (AMR)

McHenry Medical Office (MMO):

Location: 1209 Woodrow Ave, Modesto
Year opened: 2003
Services provided: Family Practice, Family Planning, Obstetrics and Primary Medical Care

Number of Providers: 7.5
Non-Provider Full Time Equivalent: 21.57

Total Annual Patient Visits: 23,657

Net Profit/(Loss): ($641,981)

Lease or Owned: Leased
Lease term: 15 years (no early termination or fiscal out clause)
Monthly lease cost: $25,235

Medical Arts Building (MAB):

Location: 17th and G St, Modesto
Year opened: 1993 (purchase date, County leased prior to purchase)
Services provided: Dental services, Pediatrics, Women's Health, High Risk Obstetrics

Lease or Owned: Owned
Monthly financing cost: $16,823.75
Current balance owed: $1,320,192
Appraised value: $2,300,000

MAB Pediatrics:

Number of Providers: 6.5
Non-Provider Full Time Equivalent: 12.5

Total Annual Patient Visits: 22,903
Net Profit/(Loss): ($638,517)

MAB Women's Health:

Number of Providers: 4.5
Non-Provider Full Time Equivalent: 20.5

Total Annual Patient Visits: 17,235
Net Profit/(Loss): ($713,394)

MAB Dental:

Number of Providers: 2
Non-Provider Full Time Equivalent: 4

Total Annual Patient Visits: 4,246
Net Profit/(Loss): ($203,841)

Turlock Medical Office (TMO):

Location: 800 Delbon, Turlock
Year opened: 1996
Services provided: Family Practice, Family Planning and Primary Medical Care

Number of Providers: 6
Non-Provider Full Time Equivalent: 20.7

Total Annual Patient Visits: 26,037
Net Profit/(Loss): ($643,810)

Lease or Owned: Leased (current lease month to month)
Lease term: ends June 29, 2005
Monthly lease cost: $8,820

Specialty Clinics:

Location: 830 Scenic Drive, Modesto
Services provided: Orthopedics, Oncology, ENT, HIV, Ophthalmology, Cardiology and Specialty Services

Number of Providers: 5.5
Non-Provider Full Time Equivalent: 34

Total Annual Patient Visits: 22,618
Net Profit/(Loss): ($1,226,387)

Lease or Owned: Owned

Ancillary Services

Laboratory:

Location: 830 Scenic Drive, Modesto
Services Provided: Clinical Laboratory, diagnostic testing and blood bank

Number of Staff: 26
Total Annual Test Volume: 227,387
Net Profit/(Loss): ($113,705)

Radiology:

Location: 830 Scenic Drive, Modesto
Services provided: Plain Film, Ultrasound, Nuclear Medicine and CT Scan

Number of Staff: 14

Total Annual Studies: 25,300
Net Profit/(Loss): ($331,996)

Pharmacy:

Location: 830 Scenic Drive, Modesto
Services provided: Retail Pharmacy

Number of Staff: 17
Total Annual Prescriptions: 124,127

Net Profit/(Loss): $2,025,604

Rehabilitative Services:

Location: 830 Scenic Drive, Modesto
Services provided: Rehabilitative Services, Occupational Therapy, Physical Therapy and Wound Care

Number of Therapists: 3
Number of Non-Provider Staff: 10

Total Annual Patient Visits: 21,669

Net Profit/(Loss): $180,274

IV. Workgroups Summary

As discussed previously, five workgroups were assembled to evaluate and clearly identify the pros and cons, advantages and disadvantages, of various courses of actions that would assist in developing a strategic direction for the Health Services Agency. Workgroups attempted to identify likely outcomes as well as any incremental costs or savings associated with those actions, but were asked to stop short of developing recommendations. These workgroups began their efforts in March 2005 meeting weekly, and often twice a week, to discuss potential actions. They culminated their efforts in a day and a half planning retreat on April 20-21, 2005.

Following is a summary of some of the actions discussed by the various workgroups. A more complete summary can be found in Appendix B of this report.

Improving Efficiencies Workgroup

The Improving Efficiencies workgroup examined four basic areas. The first area looked at how the HSA clinic system performed compared to industry standards and benchmarks, factors contributing to variances, and program and staffing implications if changes were made to meet various benchmarks. The second area of examination involved researching what are some of the industry "best practices" that might result in improved efficiency of the clinic system as well as what practices, if any, are remnants of the former hospital based system. The third area looked at information management and its role in improving efficiency and the last area looked at the efficiency of our facilities, including their layout and size.

The group developed 35 potential actions that were discussed and evaluated. Many of these actions show great promise, such as migrating to an "Open Access" model of care, acquiring a clinically based electronic health records system and eliminating services that do not justify their cost. Other actions, though discussed and evaluated, were not deemed feasible in the final analysis.

Revenue Maximization Workgroup

This group explored the feasibility of Federally Qualified Health Center status, Certified Public Expenditures, enhancement of ancillary services, changes in payer mix, renegotiation of the Blue Cross contract, and alternative models for Medi-Cal Managed Care. In addition, this group reviewed other revenue strategies employed in other public sector health care such as the passage of a 1/2-cent sales tax, parcel taxes, use of the Tobacco Settlement funds, and general fund subsidies.

The most promising areas, in terms of the amount of revenue to be gained and likelihood of attainment, seem to be Certified Public Expenditures (CPE), and gaining Federally Qualified Health Center (FQHC) status. Both CPE and FQHC would provide enhanced federal funds for the services already provided to Medi-Cal recipients. Although we can pursue both concurrently, we cannot access both mechanisms

simultaneously, as they both draw down federal funds for the same function. It is likely that CPE may be available sooner than gaining FQHC status. Once CPE is obtained, it may be sufficient for our needs, and we would not need to pursue FQHC status further. FQHC may take as long as 18 months to achieve and has other operational and cost impacts. Other revenue opportunities listed in the workgroup report, such as renegotiation of the Blue Cross contract, and change in payer mix, will also be pursued, but would produce a lower impact on the Agency bottom line.

Facilities Management Workgroup

This workgroup examined the most efficient use or re-use of each existing Health Services Agency facility, the ability to use facilities for clinic purposes, and the potential for liquidation of marketable property or termination of leases. In general, outside of County Center II, the current decentralized clinic system has little room for capacity growth or shifting from facility to facility in order to close any one clinic, at the current volume level. However, the greatest re-use of existing leased clinics at Paradise Medical Office and McHenry Medical Office, plus the re-occupancy of the Medical Arts Building will enable the County to maximize existing and newer clinic investments and long-term leases.

Additionally, this workgroup looked at the clinics owned by the county versus those under lease. As the County Center II is a highly marketable, desirable site for other development purposes, the sale of that property would likely result in a benefit to the county to assist the Health Services Agency in a transition to a new model. The sale of the Medical Arts Building would probably not yield any substantial cashflow as over $1 million is still owed on it. Finally, current leased clinic spaces have several years left on the leases, resulting in limited ability to withdraw from those sites.

Residency Program

The workgroup evaluated three scenarios for the residency program. Each based on the assumption of preserving current clinic visit volumes.

1) Maintain the existing program with nine residents per year;
2) Retain the program at two-thirds its current level (six residents each year); and
3) Discontinue the program.

The workgroup focused on program costs of the Residency Program.

The positive and negative impacts for each scenario were analyzed and evaluated.

One of the benefits of maintaining the Residency Program in some form was the cost effectiveness of physician care the program provides for the County's medically indigent. The teaching incentive the program provides has attracted well-qualified physicians to work in County clinics. Additionally, the program has been an effective recruitment source of primary care physicians for our community, as approximately one-third of the graduates choose to remain in the area.

A fiscal benefit in discontinuing the Residency Program is the elimination of the Programs operating deficit of approximately $700,000 reflective of the County's annual share. Also, there is a level of inefficiency as a result of the lack of medical experience among the resident physicians.

A negative impact in the discontinuing of the Residency Program is the cost associated with replacing the resident physicians with practicing physicians. The community would lose its local resource of retaining one-third of the Residency Program graduates, continuing to practice in Stanislaus County.

Even though the workgroup recognized overall the benefit of maintaining the Residency Program, there are still opportunities to consider for improvement.

The opportunities primarily focused on additional outside funding to mitigate the Health Services Agency share of the programs operating deficit. The program should consider federal funding by adding rotations of visiting residents along with additional stipend support with Tuoro Osteopathic School of Medicine and UC Davis.

Legal Issues

The Legal Issues Workgroup explored various topics related to the Health Services Agency including Beilenson hearings, labor codes and contractual agreements. The workgroup discussed legal exposures that might exist under various strategic options. Findings and observations are not provided, given the potential for litigation that could arise when dealing with the variety of challenging issues contained in this report.

V. Community Involvement

To engage the local medical community and area policy makers in this dialogue, the first of two "Health Summits" was held on January 27, 2005. Co-hosted by the Health Services Agency Foundation and the Stanislaus Medical Society, this Summit provided an opportunity to discuss the challenges generally facing health care providers and facilities, specific challenges the County is facing in the delivery of health care services, and opportunities for collaboration and potential new models for health care delivery. This Summit was well attended by over 70 local legislators, medical doctors, medical center administrators, health care providers and representatives from several community based organizations.

A second Health Summit was held on May 11, 2005. At this meeting, the team leads from the various workgroups shared their respective workgroups' findings and observations. An opportunity was provided for those in attendance to ask questions and offer suggestions.

Over the past several months, the CEO and HSA Managing Director met with representatives from each of major hospitals in the area, including Doctor's Medical Center, Emanuel Medical Center, Kaiser, Memorial Medical Center and Oak Valley Hospital. Issues discussed included a status on HSA strategic planning efforts, current emergency room overcrowding, possible financial contributions to the HSA from other health agencies and the possibility of an Employer Provider Option (EPO) for health insurance to County employees. These providers made no commitments that would substantially alter the financial or operational assumptions being presented to the Board of Supervisors.

The CEO and HSA Managing Director also met several times with Michael Sullivan from Golden Valley Health Centers. An interest was expressed by Golden Valley in partnering with the County in four of the clinics: Ceres Medical Office, McHenry Medical Office, Paradise Medical Office and Turlock Medical Office.

Senior staff from the HSA and CEO's office attended several health forums hosted by the Congregations Building Communities (CBC). A wide variety of speakers offered their suggestions and ideas for tackling the fiscal crisis facing the HSA. Staff kept notes and discussed the various suggestions during strategic planning sessions.

On May 13, 2005, the CEO, HSA Managing Director and senior staff from HSA and the CEO's office, met with Assemblyman Dave Cogdill to discuss possible legislative changes to allow Stanislaus County to be eligible for Certified Public Expenditures (CPE). The Assemblyman was very helpful and there have been numerous follow-up conversations on this topic with Judith Reigel, the County Health Executives Association of California (CHEAC) Executive Officer and Don Peterson, our state lobbyist.

There have been numerous other meetings over the past several months with local community healthcare professionals, county department heads and staff and local media representatives.

VI. Major Factors Influencing the Final Recommendation

Several key factors had a significant effect on the preparation of the final recommendations presented to the Board of Supervisors in this report. Given their significance, this section provides some background on each of those key factors.

A. Omnibus Agreement with Doctor's Medical Center

On November 30, 1997, the County entered into a contractual agreement with Tenet Health System, Inc. dba Doctors Medical Center (DMC) of Modesto. That contract has several elements including: a Lease and Management Services Agreement for the operation of the Stanislaus Behavioral Health Center (SBHC); an Inpatient Hospital Services Agreement which designates DMC as the exclusive supplier of all inpatient services required by the County for the patients of the Clinics; an Affiliation Agreement for the operation of the family practice residency program; and a subcontract to provide certain services to inmates under the Hospital Services Agreement.

The agreement provides for the County to continue to operate health clinics, gives DMC exclusivity over ancillary services the County does not perform itself at the Medi-Cal rate, commits DMC and the County to pursue a fully integrated delivery system of health care, and provides for a dispute resolution process.

This agreement also provides for representation on the DMC Board of Governors. One position is appointed by the Board of Supervisors; the Health Services Agency Managing Director and the Mental Health Director of the County are to be appointed as the County's *Ex-Officio* Board Members.

The Inpatient Hospital Services Agreement provides for DMC to assume the County's obligation to provide inpatient care in an acute hospital setting in the same manner, and with services and quality standards that are equal to or better than those services provided by the County when previously operating Stanislaus Medical Center. The agreement provides for guaranteed access, at DMC's cost, for the first 2,200 Medically Indigent Adult (MIA) inpatient days, credit for MIA inpatient days below 2,200 days, coordination of activities between the County and DMC on admission and discharge policies, utilization review and quality management policies and compliance with all regulatory, reimbursement and accreditation approvals. Also, coordination of inpatient services will occur with the clinics, jail, coroner, and juvenile hall.

The agreements collectively provide for a twenty (20) year period commencing on December 1, 1997.

In reviewing strategic options to address HSA's fiscal challenges, two particular sections of the Agreement were given careful consideration. First, Recital "C" states, "County has also operated and will continue to operate those outpatient clinics (the "Clinics") and provide the ancillary services set forth in Exhibit A." Section 8.7 Clinic Operations states, "While this Agreement is in effect, County shall maintain, whether directly, through a joint venture or by contract, an outpatient clinic system which provides

substantially the same level of preventative care and urgent care as is currently provided by the Clinics. If new Clinics are opened using the subsidy provided by DMC under the terms of the Omnibus Agreement, the County will operate those Clinics during the term of this Agreement so long as there is sufficient patient demand."

On October 10, 2000, the Board of Supervisors approved an "Amended and Restated Affiliation Agreement". The closure of the Stanislaus Medical Center in 1997 and the ensuing transfer of the inpatient and emergency services training was judged by the Health Care Financing Administration as creating a new residency program. As a result of this classification change of the program to the status as a "new program", the per capita funding was reduced for each resident in the program. The Amended Agreement provided for the County and DMC to share equally in funding the direct overhead costs associated with the operation of the Residency Program.

The Affiliation Agreement portion of the Omnibus Agreement may be terminated by either party, without cause, at the end of each Fiscal Year, beginning with the Fiscal Year ending May 31, 2001, upon service of no less than one (1) year's written notice to the other party. The balance of the Agreement is subject to the twenty year term.

B. Impact on residents and the local health community

As stated earlier, HSA is the largest outpatient "safety net" provider in Stanislaus County. The County is only mandated to serve qualified medically indigent adults, which in the 2003-2004 Fiscal Year accounted for 21,559 visits for 6,603 unique patients. In contrast, during the same fiscal year the Agency had 132,933 visits for an estimated 41,500 unique Medi-Cal patients, and 27,739 visits for an estimated 9,000 unique Medicare patients. While not mandated to provide health services to these latter two populations, given the current low reimbursement rates, it would be difficult for these patients to find access to health care services from other providers were they not seen by the HSA. There is a serious need for other local providers in this community to begin to absorb some of this patient population.

The County currently has four emergency rooms operating in acute care hospitals. Federal law requires that emergency rooms treat patients regardless of ability to pay. Therefore, in addition to the crucial role emergency rooms play in life saving and trauma situations for all local residents, they are often a default primary or specialty medical service provider for patients who have no insurance, or who have insurance but cannot access a primary or specialty provider. True lack of medical access in the community, coupled with the legal inability of emergency rooms to deny service for lack of upfront payment, leads to inappropriate usage of emergency rooms for routine medical care. Highly specialized and expensive emergency resources are diverted from treating emergencies and trauma, and individuals and insurers are billed at high rates for services that could have been more appropriately and less expensively provided at a lower level of care. System wide, HSA serves 1,000 patients per day five days a week. Without access to this clinic system, a portion of those visits would impact the already overwhelmed emergency rooms. Some patients would opt to defer care, which could exacerbate chronic conditions, making them more expensive to treat later on, or lead to higher levels of communicable disease transmission.

The Residency program has played an integral role in the community by meeting the medical needs of the County's undeserved population. At the same time, it has provided a pool of trained medical physicians who have remained after graduation, and filled a shortfall of primary care physicians in this community.

C. Covering our Costs

An analysis was done for each of the clinics and ancillary services to determine whether reimbursements were at least covering variable expenses, let alone the fixed expenses. This analysis was important, because if reimbursements are not at least covering the variable costs, then any increase in patient visits will result in a larger operating loss. Conversely, any decrease in patient visits should drop the overall operating loss. Variable expenses include costs such as salaries and benefits, professional fees, pharmaceuticals and supplies, scheduling, transcription services and other expenses that could vary based upon the number of patient visits. Fixed expenses include costs such as rent, utilities, maintenance, administration and HSA and county overhead costs such as telecommunications, computer systems, personnel and payroll services.

The following tables provide a breakdown of net revenue, variable expenses, the contribution to fixed expenses, allocated fixed expenses and net income/(loss) for the 2003-2004 Fiscal Year, the fiscal baseline for this report. The first table is for clinic operations and the second is for ancillary services:

Clinic Operations	Net Revenue	Variable Expense	Contribution to Fixed Expense	Allocated Fixed Expense	Net Income /(Loss)
Ambulatory Support	$1,155,728	$272,900	$882,828	$47,091	$835,737
Ceres	$909,319	$1,098,604	($189,285)	$548,294	($737,579)
Family Practice*	$6,214,271	$6,823,724	($609,453)	$1,412,627	($2,022,080)
Hughson/EMO	$1,713,876	$1,899,317	($185,441)	$558,750	($744,191)
McHenry	$1,989,203	$1,766,458	$222,745	$864,726	($641,981)
Medical Arts – Dental	$687,753	$529,769	$157,984	$361,825	($203,841)
Medical Arts – Pediatrics	$1,067,018	$1,015,103	$51,915	$690,432	($638,517)
Medical Arts-Women's Health	$1,390,097	$1,228,578	$161,519	$874,913	($713,394)
Momobile**	$94,915	$103,056	($8,141)	$60,436	($68,577)
PMP**	$315,529	$281,949	$33,580	$210,337	($176,757)
Paradise	$1,072,642	$1,246,088	($173,446)	$694,144	($867,590)
Specialty	$3,828,133	$4,688,354	($860,221)	$366,166	($1,226,387)
Turlock	$1,357,233	$1,408,103	($50,870)	$592,940	($643,810)
Urgent Care	$2,248,625	$2,024,298	$224,327	$568,548	($344,221)
Total	**$24,044,342**	**$24,386,301**	**($341,959)**	**$7,851,229**	**($8,193,188)**

* Includes Residency Program

**Services transitioned to other providers or relocated

Ancillary Services	Net Revenue	Variable Expense	Contribution to Fixed Expense	Allocated Fixed Expense	Net Income /(Loss)
Laboratory	$4,137,249	$2,560,361	$1,576,888	$1,680,594	($113,705)
Pharmacy	$7,039,456	$4,227,847	$2,811,609	$786,005	$2,025,604
Physical Medicine (EEG/EMG)	$1,264,864	$764,184	$500,680	$320,406	$180,274
Radiology	$1,858,956	$985,064	$873,892	$1,205,888	($331,996)
Total	**$14,300,525**	**$8,537,456**	**$5,763,069**	**$3,992,893**	**$1,760,177**

As can be seen in these tables, reimbursements for clinic operations in total are $341,959 less than the variable expenses and $8.2 million less than total expenses. Ancillary services have a much better bottom line with a net income of $1.7 million.

D. One-time Funding

From the 1996-1997 Fiscal Year through the 2003-2004 Fiscal Year, the cumulative operating deficit for the Clinic and Ancillary Services budget was $42,975,387. The 2004-2005 Final Budget reflected a projected operating deficit of $7.8 million, bringing the total projected cumulative operating deficit to over $50 million.

To address this operating deficit, the County and the Agency have relied heavily on the use of one-time funding sources. Some of the one-time funding sources used and their cumulative respective amounts as of 6/30/04 are:

- Tobacco Settlement Funds - $1,500,000
- Public Health Fund Balance – $6,097,984
- Health Coverage & Quality Services Fund Balance - $3,100,000
- Community Health Services Trust Fund (loan forgiveness) - $7,390,482
- Litigation Revenue - $3,261,693
- A note for $20,489,032 secured by interest from the Tobacco Securitization Fund over a projected 15 year amortization period

The 2004-2005 Final Budget relied on the use of $500,000 in Tobacco Settlement Funds, $3.5 million of Public Health fund balance, one-time savings of $1 million as a result of Professional Liability using retained earnings, $500,000 of fund balance from Health Coverage and Quality Services, and $2.3 million from "one of the Agency budgets, or if necessary, the possible use of fund balance from the Community Health Services Trust Fund."

The 2005-2006 Proposed Budget contained an operating deficit of $8,672,857, funding for which was not identified. Much of the one-time funding sources identified above have been significantly depleted and no longer are viable funding sources for funding future operating deficits. The Community Health Services Trust Fund has a fund balance of approximately $5 million and some Tobacco Settlement Funding still remains,

although much of that was previously committed by the Board of Supervisors for infrastructure projects.

A critical component in the development of the final recommendations rested on the identification of additional one-time funding sources to carry us through the implementation of those recommendations.

E. Outside contributions

One of the areas the Workgroups determined to be noticeably absent from the budgets for the clinical services were additional funding sources besides patient revenue and realignment revenue for the Indigent Health Care Program. This is particularly significant in light of the fact that the HSA is the largest safety net provider in Stanislaus County. Given the overall poor reimbursement rates, the present need for the HSA to continue to operate as a provider, and the benefit to the local medical community from the Residency program and other services provided by the HSA, the ability to access other stable and long-term outside revenue sources is a key factor in developing the final recommendations.

Contributions are welcome, and the HSA Foundation (an IRS 501(c) 3 organization) has generated over $860,000 to offset Agency services since its inception. Yet, in order to undertake any long term or systemic planning, a regular, reliable and consistent stream of revenue is required to maintain an operation of this magnitude. Given the impact on local medical practices and hospital facilities, should the clinics close, one option may be to seek an operating offset from these entities. For non-profit medical groups, these contributions could be viewed as a significant aspect of a community benefit provided in exchange for the tax-free status of these organizations. However, only non-profit hospitals have a legal obligation under SB 697, to develop and implement a community benefit plan. Under these plans, hospitals determine the scope of services and level of the contribution that constitutes a community benefit.

F. Labor law and agreements

General law counties, such as Stanislaus County, are limited in their ability to contract out services when it involves the displacement of county employees. Pursuant to the memorandums of understanding with the unions representing Stanislaus County employees, the County has a meet and confer obligation before contracting out.

Section 31000 of the California Government Code provides authority for a Board of Supervisors to contract for 'special services' and the types of 'special services' specifically contemplated by the statute include financial, economic, accounting, engineering, legal, medical, therapeutic, administrative, architectural, airport or building security matters, laundry services or linen services.

California case decisions interpreting Government code section 31000 consistently show that 'special services' is intended to include attorneys but not paralegals, physicians but not nurses, engineers but not draftsmen, and essentially focus upon
individuals who might be classified as 'professionals'.

VII. Community Suggested Options:

A. Congregations Building Communities (CBC), a local affiliate of The Pacific Institute for Community Organization (PICO), became interested in the HSA fiscal concerns and offered suggestions for possible solutions. At their April 28, 2005 "Professional Health Symposium", they offered the following solutions to addressing the HSA deficit:

1. Cap administrative costs and pursue cost efficiencies; potential savings: $1-2 million.
2. Obtain status as a Federally Qualified Health Center (FQHC) and have Golden Valley Health Centers take over two of the HSA clinics; potential savings: $1.2-2.2 million.
3. Obtain contributions from Kaiser and other hospitals; potential savings: $1-2 million.
4. Solicit donations/voluntary contributions from patients; potential savings at $10-15 donation per visit: $5-8 million.

CBC suggested that together these recommendations would bring in $8 – 14.2 million allowing the County to completely offset the current operating deficit.

Options #1-3 closely mirror recommendations contained in the Camden Report and were already under consideration by the various workgroups. Option #4 was discussed by staff but poses several challenges. First, the contribution would have to be completely voluntary as there are current regulations severely limiting charges, especially as it relates to Medi-Cal patients. Secondly, a trial of the donation process was previously conducted in 2000 at the McHenry Medical Office, and indicated that a very small percent of the patients were willing to make a donation. Working with patients to collect money related to the portion of their services that they are responsible for presents its own challenge. Most often what is collected at the time of service is the extent of money received on the account, further indicating the unwillingness of patients to voluntarily make a donation.

B. There were also a series of meetings and exchange of correspondence between Golden Valley Health Centers (GVHC) and the County. Although there may be ways we can continue to work together, we were unable to reach a consensus on how we would pursue an encompassing mutually beneficial relationship between our organizations. GVHC has indicated their interest in taking over at least four of the existing county clinics, and would make an accommodation to hire any staff displaced by such an arrangement. However, GVHC has no interest in taking on any responsibilities for the Family Practice Residency program or the full range of specialty services. Nor would GVHC commit to a time period for continuous operation concurrent with the County's Omnibus Agreement with Tenet/Doctor's Medical Center. GVHC has indicated that their business interests and financial viability would determine when and for how long they would operate any site on behalf of the County. GVHC also expressed concerns that the County's pursuit of FQHC-Look-Alike status would negatively impact their financial status.

VIII. Final Recommendation

The development of a final recommendation regarding the future direction of the Health Services Agency has been an extremely complex and time-consuming task. In order to insure that we have completed our due diligence, county staff, clinic physicians and local health care professionals have contributed countless hours to assist in developing the recommendations contained in this report. The term "final" recommendation is in itself misleading, as the recommendations presented in this report are just a starting point and will undoubtedly need to be subsequently re-evaluated considering internal progress and environmental changes.

One of the major keys in developing the recommendations contained in this report hinged on the answer to one basic question: Should the County stay in the business of providing non-mandated health services or focus on providing only those services mandated by law, that of serving the medically indigent and Public Health services? From a fiscal perspective only, in many ways it would make more sense for the County to move towards a mandated services only model. Analysis by staff indicated that over a three-year period the additional General Fund contribution necessary to sustain operating costs for a mandated services only model would be approximately $11 million, compared to a three-year cost of $16.5 million for operating costs to fund the recommendations contained in this report. Unfortunately, as stated earlier in this report, such a model would have devastating impacts on our residents and the local health community. Providing mandated services only would leave over 70,000 patients in this county without a medical provider and would most likely cripple already heavily impacted local emergency rooms. While a mandated services only model might make sense financially, it is not consistent with the Board's priority of "a healthy community" and is not in our communities overall best interests. To that end, staff began pursuing strategic options that would allow the County to provide the greatest level of services to the most residents at the lowest cost possible. The key elements of the Final Recommendation are:

A. Provide for patient volumes at 1997 levels (minimum 207,000 patient visits) while insuring the preservation of the Omnibus Agreement with Tenet Health Systems/Doctors' Medical Center.

Critical to maintaining a model that optimizes health services to our community, while minimizing the fiscal impact on the County, is the preservation of the Omnibus Agreement with Doctor's Medical Center, entered into in November 1997. Among other benefits, that Agreement provides for 2,200 MIA inpatient days, significantly reducing the costs of running the MIA program. At the time the Agreement was entered into, the County was providing approximately 207,000 patient visits on an annual basis. In order to meet the intent of the contract which stated that the "County shall maintain…an outpatient clinic system *which provides substantially the same level of preventative care and urgent care as is currently provided by the Clinics",* it is recommended that patient volume be maintained at a minimum of this 207,000 threshold.

Reduction of patient volumes can be achieved in various ways, by payer source, by site, by provider, and/or by service. Limiting factors include the number of providers, exam rooms and hours of operation. All mechanisms are being explored to assure reductions without negatively impacting continuity of care for patients in a course of treatment. Limits on accepting new patients will be imposed, which may impact access for patients seen in local Emergency Rooms who need follow up care and who do not have a regular medical provider, newly arrived members of the community, and others whose payment source may not be widely accepted elsewhere in the medical community. Access will always be retained for the Medically Indigent, our mandated population.

B. Adopt a three-year service delivery plan, which includes:

<u>Year One</u>: Remodel and expansion of outlying clinics to accommodate patient volume from Family Practice Center, Specialty Clinics and Urgent Care facilities at County Center II. Relocate County Center II facilities and issue Request for Proposals for the sale of County Center II. Prepare site selection analysis and cost estimates to build replacement facilities for Public Health, Behavioral Health & Recovery Services & Central Services. Issue Request for Qualifications and/or Request for Proposals to evaluate Community Partnerships for the delivery of some health services.

<u>Year Two</u>: Pursue Community Partnerships where feasible.

<u>Year Three</u>: Evaluate success of new model. If the new model is unable to achieve significant improvement in reducing deficit to a more sustainable additional General Fund contribution level of $3.75 million, consider only providing benefits to Medically Indigent Adults.

In 1998, the County began an effort to improve patient access to healthcare through the development of a more decentralized clinic system. At the high point, the HSA operated Family Practice clinics in Salida, Modesto (4), Empire, Hughson, Ceres and Turlock as well as the Urgent Care in Modesto and the MOMobile. Facing a significant deficit as part of the 2003-2004 budget, the Agency was forced to close the Salida Medical Office (606 visits per year), Empire Medical Office (1,927 visits per year) and cancel the contract with Doctors' Medical Center Foundation for the MOMobile (1,965 visits per year). Patients from Salida and Empire were absorbed by other HSA clinics while the operation of the MOMobile was eventually assumed by Golden Valley Health Centers.

In evaluating the HSA clinic system, it became apparent from early on in the process that improving efficiencies alone would not address the magnitude of the Agency's operating deficit and that a new model of service delivery would need to be explored. Dozens of scenarios were considered, but unfortunately, most required either significant impacts in service or large capital investments. This recommendation attempts to balance maintaining service delivery, minimizing capital outlay and establishing a sustainable General Fund contribution level.

The recommendation calls for a three-year phasing plan. Along with the other recommendations contained in this report, it is recommended that in Year One that the County remodel and expand outlying clinics to accommodate patient volume from the Family Practice Center, Specialty and Urgent Care facilities at County Center II, with the goal of relocating these services by the end of the fiscal year.

Recently, several developers have expressed interest in the County Center II site. With its size of 17+ acres, proximity to downtown Modesto and location on Dry Creek, the property has become fairly valuable. At the same time, the Family Practice Center and Urgent Care facilities are the oldest clinics in the HSA system and pose many functional and efficiency issues. As a result of these factors, the strategies contained in this report focused on whether the HSA clinic system could be capable of providing service delivery at 1997 levels, if these two facilities were removed from the clinic inventory. With some expansion/remodel of the Paradise Medical Office, McHenry Medical Office and Medical Arts Building, and some expanded hours, the HSA will be capable of providing services at the 1997 levels.

The main buildings where the Health Services Agency resides on the Scenic Drive County Center II property were constructed between 1930 and 1970. While many of the buildings have some limited remaining economic life, overall the intended use of the facilities has changed significantly over the years and they are not as efficient as they could be or as conducive to their current usage. The "Central Unit", 830 Scenic Drive is the largest building on the site and was designed as a hospital facility. With the closure of the Stanislaus Medical Center (SMC) in 1997, and limited remodeling, the facility currently houses the Urgent Care, specialty services, ancillary services, program eligibility, Child Health & Disability Prevention, California Children's' Services, administration, and the health education department. One of the considerations in closing SMC was that it would not meet proposed seismic safety standards for hospitals.

Appendix C shows the location of the various buildings on the County Center II site. Appendix D shows the year each facility was constructed, the net useable square footage, the original intended use and the current use.

By Year Two (Fiscal Year 2006-2007), it is anticipated that the recommendations contained in this report will be implemented, patient volume will be lower and efficiency improvements will be implemented, reducing the Agency's overall operating deficit. In addition, the Agency will be encouraged to continue to pursue FQHC status as well as seek out community partnerships where feasible. These partnerships could include, but are not limited to, private or not-for-profit hospitals and medical groups.

By Year Three (Fiscal Year 2007-2008) it will be necessary for the Clinic system to achieve a balanced budget with a General Fund contribution level of $3,911,075, which is the amount of the current General Fund county match of $161,075 as well as an additional $3,750,000 as outlined in this plan. This level of General Fund contribution was determined by evaluating available resources, reviewing long range modeling, and evaluating what the County's obligation would be if it had to fund its mandated requirements under the law.

The HSA strategic plan contained in this report is based on a number of assumptions including, but not limited to:

- The HSA can successfully obtain Certified Public Expenditures or gain FQHC status to improve reimbursements.
- The recommendations contained in this report are consistent with the Doctors Medical Center contractual agreement and current labor law.
- The HSA can successfully bring patient volumes into line with 1997 levels.
- The HSA can see savings as a result of efficiency improvements and reductions in administrative and cost allocation plan charges.

It is important to note that it is not the intent of this recommendation to move to a mandated services only model in Year Three. Hopefully, as a result of the recommendations contained in this report, other operating improvements yet to be identified, and increased reimbursements from Certified Public Expenditures or FQHC, the County will be able to continue to maintain health care delivery at 1997 levels. However, if the assumptions mentioned above do not materialize, and the Agency is not able to find a way to balance its budget at the sustainable General Fund contribution level of $3.9 million, it may be necessary for the County to consider moving to a mandated services only model. In doing so, the County would prepare a Request for Proposal for all of the currently leased clinic space, in the hopes that other community health providers could take over the space and provide ongoing health care to the patients served at those sites.

C. Approve the three-year funding plan outlined in the report and direct the HSA to submit budgets consistent with this plan.

It is recommended that a three-year funding plan be adopted that is modeled after the three-year service delivery recommendations contained in this report. This three-year plan reflects an additional $16,790,000 in General Fund contributions for operating costs, above the current county match levels, and $3,438,500 for one-time costs and contingencies. Funding at this level was possible only as a result of a significant fund balance in the General Fund as of the close of the 2004-2005 Fiscal Year. A review of the County's General Fund long-range model indicates that an additional $3,750,000, above the current county match level, is a more sustainable General Fund contribution level going forward and would need to be funded by increases in discretionary revenue.

The three-year funding plan, as recommended, would be funded from almost $13 million of 2004-2005 General Fund – fund balance, $3.5 million from the Community Health Trust Fund and $3.75 million from increases in discretionary revenue.

	Year 1	Year 2	Year 3
Funding Needed:			
- Ongoing Operating	$ 7,440,000	$ 5,600,000	$ 3,750,000
- One time	$ 1,221,500	$ 378,000	$ -
Total	$ 8,661,500	$ 5,978,000	$ 3,750,000
- 10% Contingency Reserve	$ 400,000	$ 400,000	1,039,000
Funding Sources:			
Discretionary Revenue	$ -		$ 3,750,000
Fund Balance	$ 5,561,500		
Community Trust Fund	$ 3,500,000		
Fund Balance (designation)*		$ 6,378,000	$ 1,039,000
* Total required designation =	$ 7,417,000		
Total use of fund balance from 2004/2005:		$ 12,978,500	

In addition, the HSA clinic system incurred a cash deficit of $1,770,398 during the 2004-2005 Fiscal Year. The 2004-2005 Final Budget identified the possible need to use the Community Health Services Trust Fund for this purpose. It is recommended that all but $3.5 million of the Community Health Services Trust Fund cash as of June 30, 2005 ($1,771,629) be transferred to the HSA – Clinics and Ancillary Services budget to address this cash deficit.

It is the intent of this funding plan to limit the County General Fund cost for HSA operational costs to the current county match level of $161,075 plus the additional $16,790,000 identified in the three-year plan, with an ongoing contribution of $3,911,075 per year thereafter. Any additional fund balance created by the Agency through efficiency improvements, additional revenue sources, or other sources can be retained by the Agency to address ongoing operational issues. Conversely, any future cash deficits are expected to be made up through the following year's HSA budget.

D. Change terms of the secured note from the Tobacco Securitization Fund to include the 2003-2004 cash deficit of $3,236,112.

As part of the 2004-2005 Final Budget, the Board of Supervisors authorized the Treasurer-Tax Collector and the Chairman of the Board of Supervisors to sign a loan agreement to formalize the repayment of the Health Services Agency's cash deficit of $20,489,032 and to direct the Auditor-Controller to establish an interest bearing agency fund to account for the internal borrowing. This note will be paid from discretionary interest posted to the General Fund generated from the Tobacco Securitization Endowment Fund. At that time, it was projected that the deficit would be retired by year 2017. In preparing the formal note and amortization schedule, the 2003-2004 cash deficit of $3,236,112 was not included, as it was not part of the focus of the County's external auditors.

It is now recommended that the note between the Health Services Agency and the County's Treasury be revised to include the 2003-2004 cash deficit. The revised estimated repayment schedule to include the additional $3,236,112 now projects final payment in the year 2020.

FY Ending	Year-End Balance	Pool Earnings Rate	Pool Interest Charged	Total Outstanding	Transfer from County	Ending Balance
7/1/2003	-23,725,144.00	2.74%	-548,716.00	-24,273,860.00	1,216,766.28	-23,057,093.72
7/1/2004	-23,057,093.72	1.94%	-406,136.00	-23,463,229.72	1,661,121.06	-21,802,108.66
7/1/2005	-21,802,108.66	2.50%	-545,052.72	-22,347,161.38	1,911,668.26	-20,435,493.12
7/1/2006	-20,435,493.12	3.00%	-613,064.79	-21,048,557.92	1,509,272.93	-19,539,284.99
7/1/2007	-19,539,284.99	3.50%	-683,874.97	-20,223,159.97	1,739,846.67	-18,483,313.29
7/1/2008	-18,483,313.29	4.00%	-739,332.53	-19,222,645.83	1,753,797.44	-17,468,848.38
7/1/2009	-17,468,848.38	4.50%	-786,098.18	-18,254,946.56	1,991,342.30	-16,263,604.26
7/1/2010	-16,263,604.26	5.00%	-813,180.21	-17,076,784.47	2,009,300.38	-15,067,484.09
7/1/2011	-15,067,484.09	5.00%	-753,374.20	-15,820,858.29	2,027,420.09	-13,793,438.20
7/1/2012	-13,793,438.20	5.00%	-689,671.91	-14,483,110.11	2,045,702.87	-12,437,407.25
7/1/2013	-12,437,407.25	5.00%	-621,870.36	-13,059,277.61	2,064,150.19	-10,995,127.42
7/1/2014	-10,995,127.42	5.00%	-549,756.37	-11,544,883.79	2,082,763.54	-9,462,120.24
7/1/2015	-9,462,120.24	5.00%	-473,106.01	-9,935,226.25	2,101,544.42	-7,833,681.84
7/1/2016	-7,833,681.84	5.00%	-391,684.09	-8,225,365.93	2,120,494.32	-6,104,871.61
7/2/2017	-6,104,871.61	5.00%	-305,243.58	-6,410,115.19	2,139,614.77	-4,270,500.43
7/3/2018	-4,270,500.43	5.00%	-213,525.02	-4,484,025.45	2,158,907.30	-2,325,118.15
7/4/2019	-2,325,118.15	5.00%	-116,255.91	-2,441,374.06	2,178,373.46	-263,000.59
7/4/2020	-263,000.59	5.00%	-13,150.03	-276,150.62	276,150.62	0.00

This recommendation has been discussed and agreed upon by both the Auditor-Controller and Treasurer-Tax Collector.

E. Pursue Legislation to allow Stanislaus County to qualify for Certified Public Expenditures.

As part of 2005 County Legislative Platform, the Board approved seeking additional federal funds to offset the cost of serving the Medi-Cal population through the mechanism of Certified Public Expenditures (CPE).

Under this mechanism in Federal law, public entities that can certify that their cost to provide services to Medicaid (Medi-Cal) beneficiaries exceeds the reimbursement received can claim the difference and draw down the Federal portion. There are no State funds or match required.

Assemblyman Frommer authored AB 915 in 2002 that provided this mechanism for outpatient services operated by public hospitals. We are seeking a further expansion to allow this mechanism for outpatient services run by public entities, but not affiliated or licensed under a public hospital. This expansion would amend Section 14105.96 of the Welfare and Institution Code. We estimate CPE could draw down an additional $1.3 million in reimbursement annually for Stanislaus County.

Following State Legislative and Executive approval, the Department of Health Services (DHS) would include this expansion in the State Plan Amendment submitted to the Federal Government, which must also approve. Our County lobbyist, Don Peterson, and the County Health Executive Association of California (CHEAC) have been pursuing legislative vehicles for this expansion.

F. Direct the HSA to submit an application for status as a Federal Qualified Health Center.

Concurrently with the pursuit of CPE, it is recommended that the County pursue application for Federally Qualified Health Center (FQHC) status. This Federal designation allows for augmented funding for services to Medi-Cal patients. System-wide, if all clinics qualify, we estimate we could draw down an additional $1.3 million in reimbursement annually.

The Medical Arts Building (MAB) and Paradise Medical Office (PMO) are currently in statistical areas that qualify for the designation. Typically the FQHC application process takes between 12 and 18 months. The current scope of services provided in the clinics is consistent with medical services expected in an FQHC environment. Funding formulas can take into account the costs for the providers under a residency program.

Pursuing an FQHC can be a long- term process and the result is not assured. Prior to FQHC application, the county clinics must be organized and functioning as an FQHC relative to staffing, services and governance. Issues to consider include a requirement for the county to recruit and develop a governing board that is consumer driven and understands the county structure in which the clinics might reside, including a relationship with the Board of Supervisors. In addition, the existing FQHC in the County, Golden Valley Health Centers, has expressed concern with this recommendation.

As part of this recommendation, the County will need to estimate costs for legal work, a consultant well versed in the FQHC application process, accounting system changes to meet the Federal requirements for FQHC, infrastructure and governing board support, a patient case management system and expand or augment areas such as transportation (taxi vouchers, bus passes). The HSA will return to the Board of Supervisors in the near future with a complete report and recommended actions concerning FQHC.

The County would also need to finance a transition period to an FQHC, which could include the CPE. Alternatively, the County could opt to pursue only CPE, and forego the FQHC status. The financial benefit is similar and the additional governance issues are avoided.

G. Direct HSA to explore alternative Medi-Cal Managed Care delivery options.

In 1996, California developed a Medi-Cal Managed Care model and implemented it in thirteen counties, including Stanislaus. The California model builds on the existence of County Organized Health System (COHS), allowed under federal law, which acts as a capitated insurance models for all Medi-Cal recipients. The State added two other delivery models, the Two Plan Model, where Medi-Cal recipients choose between two different insurers, usually one commercial plan and one public, and Geographic Managed Care, where the recipients choose between multiple plans. In Stanislaus, the current model is the Two Plan, with Health Net and Blue Cross as the two plans. Stanislaus County opted to contract with Blue Cross to serve as the public plan in 1997.

We have a partnership with Blue Cross where we have a profit sharing relationship, in years when Blue Cross has made a profit.

California has determined to expand Medi-Cal Managed Care into thirteen additional counties this year. These geographic expansion counties may notify the State which option they would prefer; otherwise the State will impose an option, likely Geographic Managed Care. The State has indicated it will ask the Federal government to allow up to five additional COHS.

Merced County is exploring the development of a COHS and there have been discussions on a staff level whether or not Stanislaus would opt to join them in this effort, and create a two county COHS. Under this delivery option, a County Board of Supervisors appoints a Local Health Commission to develop and operate a single Health Plan to insure and arrange for the care of all Medi-Cal members in the County.

The benefits of a COHS model are that it provides the greatest amount of local control, at no risk to County. The capitated dollars stay in the County, and there may be enhanced opportunity for provider payment incentives, and for a broader array of services, including prevention. The risks include Federal approval, and start up cost requirements.

H. Maintain the Residency Program while seeking additional financial sponsors and improvements in the overall efficiency of the Program.

Staff is recommending maintaining the Residency Program. The Residency Program has provided access to medical care for the County's medically uninsured at a cost effective physician rate. It has provided a pool of primary care physicians to a community that experiences a low ratio of physicians per capita.

Staff is also recommending the Residency Program evaluate funding opportunities, including reviewing federal program funding by adding rotations of visiting residents, estimated at $4,600 per visiting resident per month. Other opportunities include considering medical student rotations with Tuoro Osteopathic School of Medicine and UC Davis could potentially offer additional stipend support.

It is also recommended that the County renegotiate the terms of the sharing of the Residency Program financial shortfall with Doctors Medical Center.

I. Pursue contributions from other health agencies.

One of the areas the Workgroups determined to be noticeably absent was additional funding sources besides patient revenue and realignment revenue for the clinic system. This is particularly significant in light of the fact that the HSA is the largest safety net provider in Stanislaus County. Other public systems rely on other funding sources such as increased Federal dollars or local sales tax initiatives or county general fund allocations above the maintenance of effort required under realignment. Given the overall poor reimbursement rates, the desire for the HSA to continue to operate as a provider, and the benefit to the local medical community from the Residency program and other

services provided by the HSA, the ability to determine other outside revenue sources may be a key factor in creating a sustainable long term model.

Contributions are welcome, and the HSA Foundation (an IRS 501(c) 3 organization) has generated over $860,000 to offset Agency services since its inception. The HSA Foundation continues to seek funding to provide services to the underserved through the Agency clinics. Yet, in order to undertake any long term or systemic planning, a regular, reliable and consistent stream of revenue is required to maintain an operation of this magnitude. Given the impact on local medical practices and hospital facilities, should the clinics close, one option may be to seek an operating offset from these entities. In January of 2005, the Agency received a donation of $150,000 from the Sutter Gould Foundation to offset the cost of medical care in the clinic system.

For non-profit medical groups, these contributions could be viewed as a significant aspect of a community benefit provided in exchange for the tax-free status of these organizations. However, only non-profit hospitals have a legal obligation under SB 697, to develop and implement a community benefit plan. Under these plans, hospitals choose what services and what level of contribution constitutes a community benefit.

J. Renegotiate Blue Cross contract.

While Medi-Cal represents HSA's single largest patient base, some Medi-Cal patients are contracted through a managed care health plan. Blue Cross Medi-Cal patient visits in Fiscal Year 2004-2005 represented 27,000 total visits, and 21% of total Medi-Cal visits. Under HSA's contract with Blue Cross, medical services are reimbursed in accordance with Blue Cross' reimbursement schedule, which is roughly equivalent to the State fee-for-service reimbursement schedule. That schedule has not been increased in multiple years, although HSA costs have certainly risen. Particularly burdensome is the variance between cost and reimbursement in the area of specialty care. HSA management is presently in negotiations with Blue Cross for the purpose of increasing that rate of reimbursement.

K. Direct the HSA to implement efficiency improvements, including:

Several improvements have been identified to reduce cost and improve the overall operating efficiency of the Health Services Agency. Below are several specific areas that have been identified by the work groups, that when implemented will contribute to the reduction of the annual operating deficit. Some of the solutions are focused on administrative cost such as the need to streamline support services, while others address patient throughput, technology improvements and changes to scope of services.

1) Elimination of duplication and overall reduction in administrative overhead.
2) Begin development of an "Open Access Model", whereby an additional number of appointments are available on a same-day only basis. It is intended that this model will reduce no show rates.
3) Increase patient throughput by adding two additional patients per day per physician.
4) Prepare an analysis of potential return on investment, through increased operating efficiencies, enabled by an electronic health record system.

5) Enhance data reporting at the clinic operational level as a management tool for monitoring productivity and staffing ratios.
6) Discontinue the direct provision of certain services, including dental, mammography, and speech therapy. The limited volume required by the Medically Indigent Adult Program patients would be provided under contractual arrangements in the community (see Recommendation M below).

L. Amend the eligibility requirements of the Medically Indigent Adult program to allow only those Stanislaus County residents who are U.S. citizens or legal permanent residents and who meet all other eligibility criteria to be granted program eligibility.

Currently, temporary non-citizen residents and undocumented immigrants who are Stanislaus County residents and meet the Medically Indigent Program (MIA) eligibility criteria are granted eligibility for emergency services benefits only. This staff recommendation to change the eligibility policies would make such Stanislaus County residents ineligible for the Medically Indigent Adult program. This recommendation is consistent with the eligibility policies of many counties, including the neighboring counties of Merced and San Joaquin.

Recently, the federal government established new funding for hospital and physician emergency services rendered to this population. Additionally, the Health Services Agency medical services could be available to such established patients in accordance with its Personal Pay policies.

M. Conduct Beilenson Hearings as required.

a. Approval to set September 27, 2005 at 9:25 a.m. as the date and time to conduct a public hearing pursuant to Section 1442.5 of the Health and Safety Code to consider the elimination of mammography services, speech therapy services, dental services and the elimination of eligibility for undocumented immigrants and temporary non-citizens under the Medically Indigent Adult program.

b. Certify the posting of the notice of the public hearing at all county medical facilities on September 12, 2005.

c. Establish October 13, 2005 as the proposed effective date of the elimination of mammography, speech therapy, dental services and the elimination of eligibility for undocumented immigrants and temporary non-citizens under the Medically Indigent Adult program.

<u>Mammography, Speech Therapy and Dental</u>
Among its ancillary scope of services, the Health Services Agency has provided mammography and speech therapy services on an outpatient basis. Elimination of these services is projected to save approximately $60,000 and $15,000, respectively. Although the contributing deficit by mammography and speech therapy services are relatively insignificant, staff recommends their elimination primarily due to staffing challenges. Mammography services were provided to 1,150 unique patients last fiscal year, while

speech therapy was provided to only 20. Each requires specialized, licensed personnel. Particular to mammography, the personnel needed are in short supply, causing recruitment to be difficult and relatively expensive. Considering these services are available in the community, staff recommends that the Health Services Agency discontinue the direct provision of this care. Due to staffing challenges, speech therapy services were placed in abeyance for the last several months. Unlike the HSA's medical clinics, the dental clinic serves primarily Medically Indigent Adult (MIA) enrollees. During the Fiscal Year 2004/2005, the dental clinic provided care to 1,218 patients, of which 93% were qualified MIA patients. The projected annual savings through the discontinuance of the dental clinic is approximately $180,000. Dental services are available in the community and as such staff recommends the discontinuance of this service.

To the extent these services are needed for the County qualified MIA patients, contractual arrangements either already exist or will be made with other community providers to provide these services.

Medically Indigent Adult Program

The Medically Indigent Adult program is based upon a county obligation found in Welfare and Institutions Code section 17000 which requires counties to provide and or arrange for medical care for indigents "lawfully resident therein". The existing program allows undocumented immigrants and temporary non-citizen residents who meet all other eligibility requirements to enroll in the program, however the scope of benefits is limited to emergency services only. (Prior to a Board of Supervisor approved change in 2003, this population was eligible for the full program scope of benefits). Following Medi-Cal and industry standards emergency services includes not only Emergency Room services, but also inpatient services for patients who are admitted with a condition, which threatens life and/ or limb. From a practical standpoint, this includes patients admitted through the county's contracted hospital, Doctors Medical Center, and who require transfer to a tertiary center such as University of California, San Francisco. The Medically Indigent Adult program's obligation ends when the emergency condition is resolved, generally upon discharge from the hospital setting.

Prior to the Fiscal Year 2004/2005, the County accepted Proposition 99 Tobacco Tax dollars, which among many other mandates, required the County to supplement programs through expansion activities. Medically Indigent Adult program coverage was provided to the non-citizen and non-legal permanent legal resident population under this expansion component. The County no longer participates in the Proposition 99 Tobacco Tax program and therefore does not have an obligation to, nor does it receive additional funding to provide services to this population.

Specific to emergency services coverage for the undocumented immigrants and temporary resident non-citizens, the Health Services Agency incurred a total of $103,871 during fiscal year 2004/2005 for the provision of services to 160 enrollees. It is projected that this policy change will save between $100,000 and $150,000 annually.

The federal government has recently appropriated funding for emergency services for the undocumented immigrant population. This funding is to be accessed directly by providers of emergency care including hospitals and physicians.

N. Increase cash discount to $90 and the deposit to $100, from current levels of $45 and $40 respectively, to more accurately reflect costs of providing care.

The Agency has a cash discount policy for uninsured patients whereby the patient pays $45 at the time of service to see a primary medical provider. This discounted amount only applies to the services rendered by the medical provider. Any ancillary (radiology, lab, etc.) service needs, resulting from the medical visit, are the patient's responsibility separate, and in addition to, the $45 cash discount payment. The $45 discount amount does not cover the cost for even our most basic patient visits. Therefore, the Agency has proposed that this cash discount for primary care services be raised to $90 to cover the cost for our most common visit types. We would propose that this cash discount be reviewed annually against cost and adjusted accordingly. This cash discount policy would not apply to urgent care, specialty and other services due to the higher and varied cost structure for those services.

In the Final Budget for Fiscal Year 2001-2002, the Board of Supervisors adopted a recommendation to establish $40 as the standardized deposit to be collected in primary care clinics and urgent care from personal pay patients (uninsured clients seeking services). The $40 deposit has not been adjusted since the 2001-2002 Fiscal Year and does not cover the Agency's cost for even the most basic patient visit. The Agency would like to propose that the deposit be increased to $100 effective 10/1/05 for urgent care services. Deposits would no longer be applicable to the primary care clinics (excluding Urgent Care) to eliminate the confusion with the Cash Discount policy, described above. Setting the deposit at the $100 level will cover the cost for our most common visit types. Visits which generate a charge greater than $100 will continue to result in a bill to the patient for the balance. Similar deposits exist within our Specialty and other services. It is proposed that the Agency routinely review the various deposits for all service types against cost and adjust them accordingly on an annual basis.

Facility Related Recommendations:

O. Authorize the Chief Executive office to negotiate an Amendment to the Paradise Medical Office and McHenry Medical Office Clinic Leases with the building owners for clinical space renovations and return to the Board for final approval.

P. Authorize the Purchasing Agent to negotiate a 2-year extension to the Turlock Medical Office lease.

Q. Authorize the Purchasing Agent to execute leases for new leased space for offices being relocated from the present use at Paradise Medical Offices, including Community Services Agency, Children and Families First Commission and WIC Programs.

R. Authorize the Chief Executive Officer to obtain design and engineering services to plan for the remodel of the Medical Arts Building.

S. Authorize the Chief Executive Officer to develop a plan to relocate Public Health, Behavioral Health & Recovery Services, Central Services and other programs currently located at County Center II, and to proceed to plan for the marketing and sale of County Center II.

T. Authorize Staff to develop a phasing plan for relocation of the HSA Clinics and Urgent Care, Public Health, Behavioral Health & Recovery Services, Central Services and other County programs and services currently located at County Center II.

The proposed changes in Health Services Agency service delivery system will require modification of existing owned and leased facilities. New spaces would be required to accommodate the Women, Infants and Children (WIC) program; the Children and Families Commission; the Urgent Care Center, Specialty Clinics, and other HSA administrative functions.

At the West Modesto Community center, current space occupied by WIC, the Community Services Agency, Children and Families Commission, the Library and other tenants would be vacated to allow for relocation of the clinical services from County Center II. Existing space within the new McHenry Medical Office would be converted from counseling offices to additional examination rooms. .

The existing Medical Arts Building at 17th and G Streets would be re-occupied with various clinical services. These functions would all be relocated from County Center II.

The existing Turlock Medical Office would remain at its present location, although an extension of the current lease would be required.

Ultimately the sale of County Center II property would also require the relocation of offices occupied by Behavioral Health and Recovery Services, Public Health, and Central Services.

Summary

For the past ten months, HSA and CEO senior staff, SFMG and Stanislaus Medical Society representatives, with assistance from The Camden Group, have undertaken a significant amount of time and effort to develop a sustainable, long-term strategic plan for the HSA clinics and ancillary services. While this plan will undoubtedly need to be updated and fine-tuned as time goes by, it is our hope that the twenty recommendations contained in this report will lay a solid foundation upon which the HSA clinic and ancillary services can build on. The recommendations addressing prior year operating deficits will give the HSA a fresh start, allowing focus on improving current operations without the burden of trying to resolve past accumulated deficits or loans. Further, the recommendations should provide a reasonable level of subsidy to allow the Agency to transition to a new model of care. It is important to note that the transition to a sustainable new model will not be easy, and it will be necessary for the HSA to continue to remain diligent and aggressive in seeking revenue and operating improvements. While the proposed General Fund contribution of approximately $16 million to fund the three-year plan is unprecedented, it is consistent with the Board of Supervisors' commitment to "a healthy community."

Glossary

Ambulatory: Medical services provided in an outpatient setting.

Ancillary: Services that aid in diagnosis or treatment of medical conditions, such as lab, radiology, pharmacy, or rehabilitative services.

Audiology: A medical specialty pertaining to hearing.

Benchmark: A measurement of like services based on accepted industry standards

Bielenson Hearing: A requirement of California law to hold a public hearing when health services are to be reduced or eliminated.

Cardiology: A medical specialty pertaining to the heart

Certified Public Expenditures: A mechanism in federal law to draw down the federal portion of unreimbursed costs incurred by a public entity in the delivery of Medi-Cal services.

Corpus: The principal of the securitized tobacco settlement fund

Cost Allocated Charges: Refers to overhead expenses allocated and shared by county departments.

County Organized Health Systems (COHS): A legal construct in federal law that allows a county to develop and run a risk-based medical delivery system for specific populations.

Disproportionate Share (DSH): A mechanism in federal law to allocate funding to hospitals that serve a disproportionate percentage of low-income and Medi-Cal patients.

Electronic Health Records: A technology designed to eliminate paper records and provide access to the record wherever a patient seeks care.

Exclusive Provider Option (EPO): A network of medical services to provide health benefits to employees under contract to the employer. Generally this network is limited to a small number of providers who have agreed to contract for a set rate.

Family Practice Clinic: A clinic that provides general medical services in an outpatient setting.

Federally Qualified Health Center (FQHC): A federal designation for clinics that meet certain criteria for range of services, population served and governance. These clinics receive an enhanced rate of reimbursement in exchange for meeting these criteria. Designed to serve underserved populations or regions.

Full Time Equivalents (FTE): A mechanism for allocating staff resources.

Gastroenterology: A medical specialty pertaining to the gastro-intestinal or digestive system.

Graduate Medical Education (GME): A mechanism to provide federal funds to hospitals that participate in medical residency training programs.

Health Executive Committee: A committee of the Board of Supervisors consisting of two Board members and supported by various staff from the Chief Executive Office, the Health Services Agency and the Behavioral Health and Recovery Services departments.

Health Professional Shortage Area (HPSA): A federal designation indicating a region has a less than optimal ratio of medical providers to population. Providers agreeing to serve in these areas may benefit from repayment assistance for education loans.

HIV: "Human Immunodeficiency Virus", the infectious agent that causes acquired immunodeficiency syndrome (AIDS).

Indigent: Legal residents with very limited income, assets and/or other support.

Inpatient: Medical services provided in a facility such as a hospital or skilled nursing facility, in which a patient is admitted and remains in the facility for more than 24 hours.

Managed Care: A mechanism for providing health care to a specified population, generally through a defined network of contracted providers and in accordance with rules. For example, a patient's condition and treatment must meet certain criteria before being approved for a non-emergent inpatient surgery.

Medi-Cal: The California term for the federal health care program Medicaid, which primarily serves poor, uninsured families, elderly and disabled persons.

Medically Indigent Adult (MIA): A health care access program established and operated by each County to serve uninsured poor adults between the ages of 21 and 64.

Medically Underserved Area (MUA): A federal statistical designation to determine and designate if a geographic area has a shortage of health care providers.

Medically Underserved Population (MUP): A federal statistical designation to determine and designate if a significant number of persons or groups of persons face economic, cultural or linguistic barriers to health care.

Medicare: A federally established and operated health care access program for the elderly and disabled.

Mid-Level Provider: A term that includes both Nurse Practitioners and Physician's Assistants. These licensed providers are not physicians, but under the supervision of a physician, can assess and treat patients.

Neurology: The medical specialty concerned with the diagnosis and treatment of disorders of the nervous system -- the brain, the spinal cord, and the nerves.

Neurosurgery: The surgical specialty pertaining to the nervous system -- the brain, the spinal cord, and the nerves.

Non-Provider – Refers to the staff required to operate a clinic that support the Physicians and Mid-Level providers; for example, Medical Assistants, Nurses, Registration and Billing clerks, Medical Records clerks, etc.

Obstetrical Care: Medical care related to the treatment of a pregnant woman for the primary purpose of ensuring the healthy development and delivery of the developing baby.

Omnibus Agreement: A collection of all of the agreements on a related subject.

Oncology: The field of medicine devoted the study and treatment of cancer.

Open Access: A general term that describes a health care delivery model where a clinic may not schedule appointments, provides care on a walk-in basis, or schedules appointments for only a limited future period, for instance, the same day. It is also philosophy of the physician to enhance access for the patient by being more available for questions, consults and treatment.

Ophthalmology: The practice of medicine pertaining to the eye.

Orthopedics: The practice of medicine pertaining to bones (skeleton).

Otolaryngology: The practice of medicine pertaining to the ears, nose and throat.

Outpatient: Refers to medical care provided in an ambulatory setting, in which the care is provided in less than 24 hours. For example, a doctor's appointment is an outpatient service. Also, a surgery in which a patient arrives for the procedure and goes home the same day is an example of an outpatient service.

Pediatrics: Branch of medicine pertaining to the development, diagnosis and treatment conditions and diseases affecting children.

Physician Assistant (PA): A mid-level medical practitioner who works under the supervision of a licensed doctor (an MD) or osteopathic physician (a DO).

Podiatry: The diagnosis and treatment of disorders of the feet.

Prenatal Care: Services for women during pregnancy, including: dietary and lifestyle advice, weighing to ensure proper weight gain, and examination for problems of pregnancy such as edema and preeclampsia (toxemia).

Provider: A licensed person or facility that renders medical care to a patient. In an outpatient environment, medical doctors, nurse practitioners and physician assistants are referred to as "Providers".

Registered Nurse (RN): A nurse who has completed a two- to four-year degree program in nursing, and provides direct patient care for acutely or chronically ill patients.

Residency Program: A program designed to train graduate medical students. Serving in a Residency Program is a prerequisite to Board Certification

Securitized: Refers to an entity (a state, county, or city) selling an expected stream of revenue to investors, for less than the total in exchange for receiving a lump sum at that time.

Specialty Services: Areas of specialized medical practice requiring additional study or certification. Examples include Oncology, Cardiology and Orthopedics.

Scenic Faculty Medical Group: SFMG is a private professional corporation made up of primary care physicians. Its mission is to excel in teaching the Family Practice Residents and provide quality medical care to the underserved population of Stanislaus County. SFMG has worked in a private-public partnership with Stanislaus County for over 25 years.

Stanislaus Medical Society: This is the name of the local medical society for Stanislaus County. Their mission is as follows:

> "The purpose of this society shall be to promote and develop the science and art of medicine, to conserve and protect the public health, to promote the betterment of the medical profession, to cooperate with organizations of like purposes, and to unite with similar societies from other counties of the state to form the California Medical Association."

Tobacco Endowment/Securitization Funds: Refers to the securitized tobacco dollars.

Tobacco Settlement Funds: Refers to the monies in the settlement agreement with the tobacco companies to be paid to the States. In California, those monies are allocated and to be paid over time to the counties.

Urgent Care: Treatment of illness and injuries of an acute or non-emergent nature that require immediate care

Urology: This specialty area deals with diseases of the urinary organs in females and the urinary tract and sex organs in males.

Appendix A

This Appendix consists of further information specific to each clinic. Data was collected from Fiscal Year 2003/2004 by HSA staff as well as summarized from the Camden report.

Medically Underserved Area (MUA) and Medically Underserved populations (MUP) are federally developed designations that establish initial eligibility for federal and state resources to improve access to health care in underserved areas. Medically Underserved Areas/Populations can be used to establish eligibility for programs or target resources from government or private funding agencies.

An area is designated as an MUA/MUP based on whether an area exceeds a score for an Index of Medical Underservice (IMU). The IMU is an index value based on the infant mortality rate, poverty rates, percentage of elderly, and primary care physician to population ratios.

The MUA or MUP designation, alone, does not directly afford any benefits to the County, community providers or its residents. However, having one of these designations is essential for gaining Federally Qualified Health Center (FQHC) status. FQHC status will allow for cost-based reimbursement for Medi-Cal and Medicare patient visits, qualification for California Physician Corps Loan Repayment Program with no county matching funds required, and participation in 340B drug "discount" pricing program.

Providers were calculated utilizing Medical Doctors, Dentists, Physician's Assistants, Residents and Nurse Practitioners. All other staff were considered non-providers and were calculated as full time equivalents. Actual allocated positions may be higher.

Family Practice Center

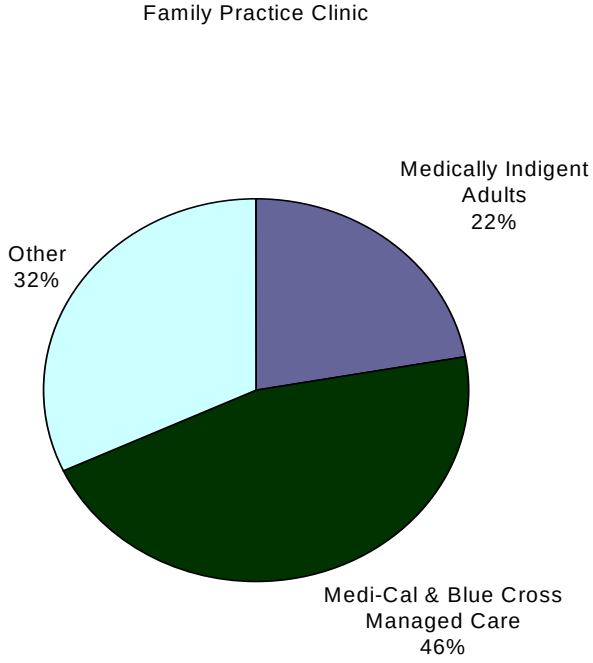
Is location within a Medically Underserved Area or Population (MUA/MUP)? No.

Providers/Provider Source

- Physicians: 1.5, Scenic Faculty Medical Group (SFMG)
- Residents: 12.25, Residency Program
- Mid-Levels: 2, Health Services Agency

Number of Non-Provider Staff: 41.55
Provider/Non-Provider ratio: 1:2.6

Position Title	Full Time Equivalents
Medical Doctor	1.5
Physician Assistants	2
Residents	12.25
Staff Nurse II-III	8
Supervising Account Administrative Clerk II	3.01
Community Health Worker III	1.9
Public Health Nurse	1.12
Administrative Clerk I - III	13.92
Medical Assistant	13.6



Total Visits: 37,794

Urgent Care Center

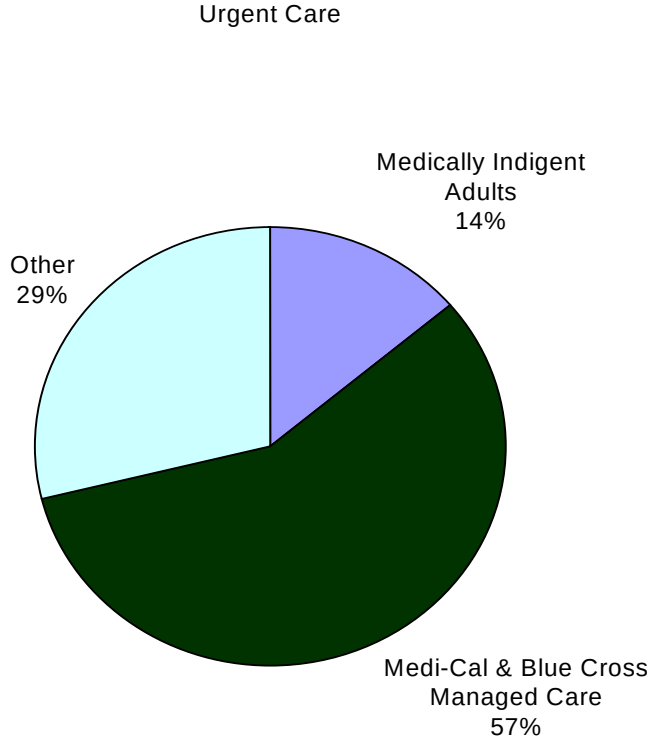
Is location within a MUA/MUP? No.

Providers/Provider Source

- Physicians: 3, contract with MedEx
- Residents: 0
- Mid-Levels: .5, Health Services Agency

Number of Non-Provider Staff: 19.5
Provider/Non-Provider ratio: 1.5:6.5

Position Title	Full Time Equivalents
Medical Doctor	3
Physician Assistants	.5
Clinic Manager	1
Staff Nurse II-III	4
Licensed Vocational Nurse	4
Staff Services Technician	1
Administrative Clerk I - III	4.5
Medical Assistant	5



Total Visits: 26,365

Ceres Medical Offices

Is location within a MUA/MUP? Pending application for designation.

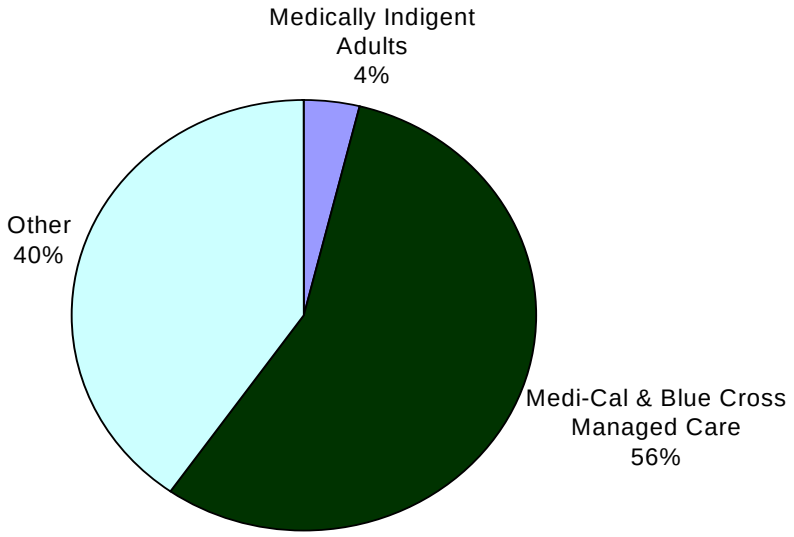
Providers/Provider Source

- Physicians: 3, SFMG
- Residents: 0
- Mid-Levels: 4, Health Services Agency

Number of Non-Provider Staff: 14.2
Provider/Non-Provider ratio: 1:2

Position Title	Full Time Equivalents
Medical Doctor	3
Physician Assistants	1
Nurse Practitioner	3
Supervising Account Administrative Clerk II	1.9
Staff Nurse II-III	2
Administrative Clerk I - III	5
Medical Assistant	5.3

Ceres Medical Office



Total Visits: 20,015

Hughson Medical Facility

Is location within a MUA/MUP? Pending application for designation.

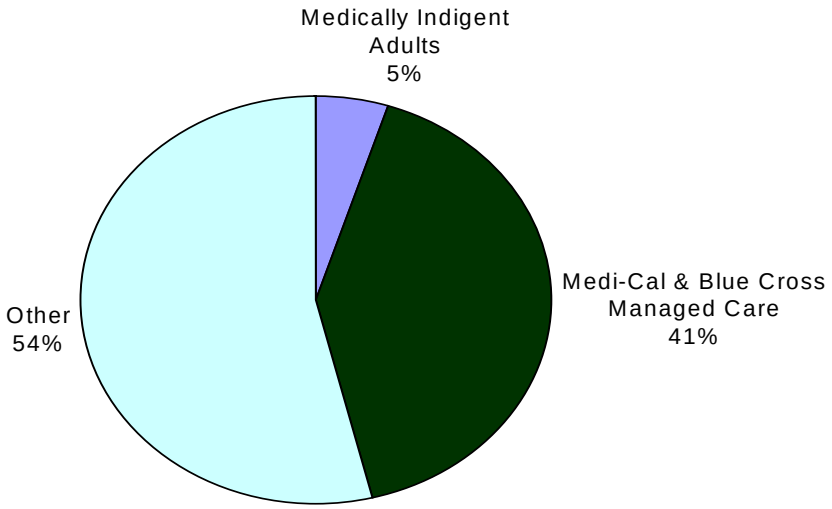
Providers/Provider Source

- Physicians: 2
- Residents: 0
- Mid-Levels: 3, Health Services Agency

Number of Non-Provider Staff: 17
Provider/Non-Provider ratio: 1:3.4

Position Title	Full Time Equivalents
Medical Doctor	2
Physician Assistants	1
Nurse Practitioner	2
Clinic Manager	1
Staff Nurse II-III	1.5
Licensed Vocational Nurse	1.5
Pharmacy Technician	.5
Supervising Account Administrative Clerk II	1.8
Community Health Worker I-III	.4
Administrative Clerk I - III	4.7
Medical Assistant	5.6

Hughson Health Facility



Total Visits: 24,915

Paradise Medical Offices

Is location within a MUA/MUP? Yes, location is within MUA and MUP.

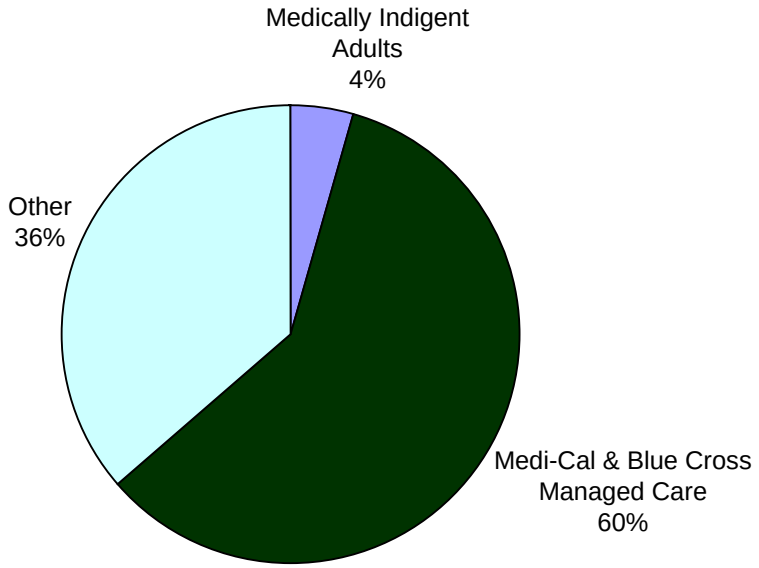
Providers/Provider Source

- Physicians: 2, SFMG
- Residents: 0
- Mid-Levels: 1

Number of Non-Provider Staff: 14.5
Provider/Non-Provider ratio: 1:2.1

Position Title	Full Time Equivalents
Medical Doctor	2
Nurse Practitioner	1
Clinic Manager	1
Staff Nurse III	1.2
Licensed Vocational Nurse	1
Staff Services Technician	1
Supervising Account Administrative Clerk II	.3
Community Health Worker III	1.1
Administrative Clerk I - III	2.5
Medical Assistant	6.4

Paradise Medical Office



Total Visits: 21,484

McHenry Medical Office

Is location within a MUA/MUP? No.

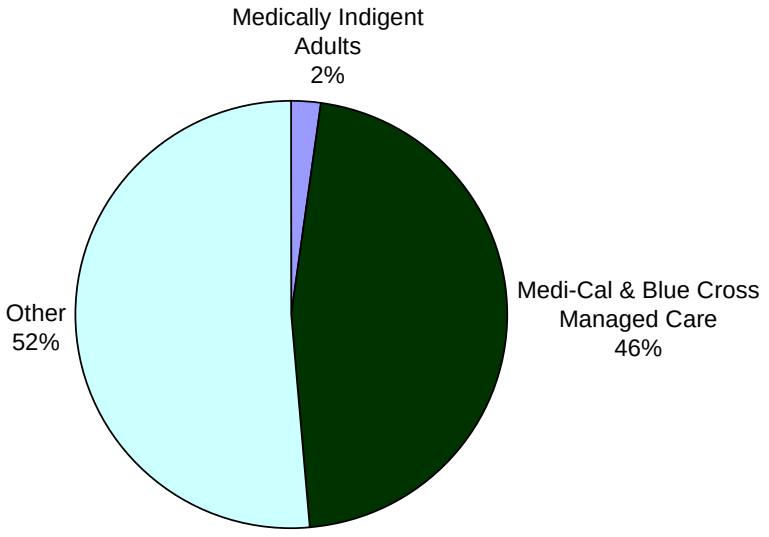
Providers/Provider Source

- Physicians: 3
- Residents: 0
- Mid-Levels: 4.5, Health Services Agency

Number of Non-Provider Staff: 21.57
Provider/Non-Provider ratio: 1:3.1

Position Title	Full Time Equivalents
Medical Doctor	3
Physician Assistants	2
Nurse Practitioner	2.5
Clinic Manager	.9
Staff Nurse II-III	2
Staff Services Coordinator	1
Community Health Worker II-III	5.6
Supervising Account/Administrative Clerk	1
Account Clerk	1
Administrative Clerk I - III	5.7
Medical Assistant	4.37

McHenry Medical Office



Total Visits: 23,657

Medical Arts Building: Pediatrics

Providers/Provider Source

- Physicians: 3, SFMG
- Residents: 1.5
- Mid-Levels: 2, Health Services Agency

Number of Non-Provider Staff: 12.5
Provider/Non-Provider ratio: 1:2.2

Position Title	Full Time Equivalents
Medical Doctor	3
Physician Assistants	2
Residents	1.5
Staff Nurse II-III	1.5
Licensed Vocational Nurse	2
Administrative Clerk I - III	2
Medical Assistant	7

Medical Arts Building: Women's Health

Providers/Provider Source

- Physicians: 1.5, SFMG
- Residents: 1
- Mid-Levels: 2

Number of Non-Provider Staff: 20.5
Provider/Non-Provider ratio: 1:5.1

Position Title	Full Time Equivalents
Medical Doctor	1.5
Nurse Practitioner	2
Residents	1
Clinic Manager	1
Staff Nurse II-III	2
Community Health Worker III	1.5
Administrative Clerk I - III	9
Medical Assistant	7

Medical Arts Building: Dental

Is location within a MUA/MUP? Yes, location is within MUA and MUP.

Providers/Provider Source
- Dentists: 2, Personal Services Contracts
- Residents: 0
- Mid-Levels: 0

Number of Non-Provider Staff: 4
Provider/Non-Provider ratio: 1:2

Position Title	Full Time Equivalents
Dentists	2
Dental Assistants	2
Community Health Worker III	1
Administrative Clerk II	1

Turlock Medical Office

Is location within a MUA/MUP? No.

Providers/Provider Source
- Physicians: 3, SFMG
- Residents: 0
- Mid-Levels: 3

Number of Non-Provider Staff: 20.7
Provider/Non-Provider ratio: 1:3.5

Position Title	Full Time Equivalents
Medical Doctor	3
Nurse Practitioner	3
Clinic Manager	1
Staff Nurse II-III	2
Account Clerk	.7
Community Health Worker II-III	2.7
Staff Services Technician	1.3
Administrative Clerk I - III	6.5
Medical Assistant	6.5

Specialty Clinics

Is location within a MUA/MUP? No.

Providers/Provider Source

- Physicians: 2, HSA; 3, Personal Services Contracts
- Residents: .5
- Mid-Levels: 0

Number of Non-Provider Staff: 34
Provider/Non-Provider ratio: 1:6

Position Title	Full Time Equivalents
Medical Doctor	2
Clinic Manager	1
Staff Nurse II-III	7
Orthopedic Assistant	1
Staff Services Technician	1
Medical Records Clerk	1
Administrative Clerk I - III	11
Medical Assistant	12

Laboratory

Number of Staff: 26

Position Title	Full Time Equivalents
Clinic Manager	1
Clinical Lab Scientist	14
Clinical Lab Assistants I-II	8
Administrative Clerk I-III	3

Radiology

Number of Staff: 14

Position Title	Full Time Equivalents
Radiology Technician's III	11
Administrative Clerk I-III	3

Pharmacy

Number of Staff: 17

Position Title	Full Time Equivalents
Pharmacy Manager	1
Pharmacists	5.5
Pharmacy Technicians	6.5
Administrative Clerk I-III	4

Rehabilitative Services

Number of Staff: 13

Position Title	Full Time Equivalents
Rehab Manager	1
Physical Therapists	2
Speech Therapist	1
Occupational Therapists	4
Audiologist	1
EEG Technician	1
Therapist Assistant	1
Therapist Aide	1
Administrative Clerk II	1

Appendix B

General Findings and Observations from Workgroups

The following is a summary of the general findings and observations that were compiled and shared with the local health community at the {date} Health Summit.

Improving Efficiencies Workgroup

Participants:

Cindy Coit – Chief Financial Officer, Health Services Agency
Lawana Earl – Turlock Clinic Manager, Health Services Agency
John Emerson - Chief Information Officer, Stanislaus County
Larry Haugh – Auditor-Controller, Stanislaus County
George Killian – Business Manager, Scenic Faculty Medical Group
Dr. Steve Magee – Physician, Scenic Faculty Medical Group
Dr. Roland Nyegaard – Community Physician
Dr. Joseph Provenzano – Physician, Stanislaus Medical Society
Dr. Eric Ramos - Physician, Stanislaus Medical Society
Stan Risen – Assistant Executive Officer, Chief Executive Office
John Schaper – Ancillary/Specialty Services Manager, Health Services Agency
Margaret Szczepaniak – Managing Director, Health Services Agency

Findings and Observations:

- The Health Services Agency (HSA) has an adverse payer mix – Medi-Cal, Medically Indigent Adults and low-income populations. HSA will probably not be able to meet industry standard benchmarks through efficiency without also improving net revenue through payer mix adjustments or other contributions.

- There is a noted absence of other revenue sources beyond patient revenue. Other revenue sources need to be pursued such as voluntary community provider contributions to HSA, federal subsidies, potential grant opportunities and increased General Fund contributions.

- Patient acuity (complexity) is greater in our patient mix than the average commercially insured private practice.

- Specialty care had a $1.2 million operating loss in FY03/04. Provider payments exceed reimbursement. Specialty care is provided in our facilities primarily by community physicians, rather than at the offices of those specialist providers. Specialists require a subsidy to see Medi-Cal and Medically Indigent Adult (MIA) patients.

- We did compare operating costs to Camden benchmarks; general observations from the benchmarking analysis indicated:

- Since benchmarks provided were based as a percentage of net revenue, HSA's low reimbursement rate led to most of the percentages being over the recommended benchmark level.
- Many of the benchmarks appeared to be more reflective of private clinic structures as opposed to larger, more corporate structures.
- Administrative support, building and occupancy costs and benefits appeared to be higher than private practices.
- Non-provider full-time equivalents (FTEs) at the clinics ranged from 3.2 – 4.1, which was higher than the Camden recommended benchmark of 3.1. Some of this is due to higher State and Federal reporting requirements that HSA must meet compared to most private practices (Ex. Family Planning grant program); certification under the State's Department of Health Services requires an RN in each HSA clinic.
- "No show" rates of 15-20% are high; recommended benchmark is 5-7%.

Potential actions to improve performance against benchmarks could include developing and implementing an Open Access model, identifying the optimal number and role of mid-level providers and staffing to that level, reviewing administrative staff needs/ratios, bringing non-provider/provider ratios into line with benchmarks and using automated phone reminders.

- Cost Allocated charges for support services from both HSA and county administrative costs are high compared to the private sector. Potential actions include auditing all internal and external cost allocation plan charges and eliminating services that don't justify their cost.

- Eligibility screening and re-establishment of eligibility is very laborious.

- Current Information Technology (I.T.) system is hospital based and inconsistent with the County's financial system.

- Moving to a web-based Electronic Health Records (EHR) system in this distributed environment will contribute to overall I.T. efficiency, but will require corresponding cost reductions or increased revenue to produce a justifiable return on investment. EHR would enable standardized reporting per visit to find costs that are above/below the norm for clinic operations.

Revenue Maximization Workgroup

Participants:

Yulonda Bardney – Health Services Agency
Phoebe Leung – Health Services Agency
Kathy Passanisi – Health Services Agency
Linda Ruppel – Interim Assoc. Director Clinic Operations, Health Services Agency
John Schaper – Assistant Director, Ancillary Services, Health Services Agency
Margaret Szczepaniak – Managing Director, Health Services Agency

Findings and Observations:

- Federally Qualified Health Center (FQHC) status for some or all clinics is a viable option. FQHC status would provide enhanced federal reimbursement for patients seen in the clinic system. The Medical Arts Building and Paradise Medical Office are in areas that currently qualify for a Medically Underserved Area designation, a critical element in obtaining FQHC or FQHC "look-alike" designation. The County could apply for FQHC designation for the Paradise Medical Office (PMO) and Medical Arts Building (MAB) first, then eventually system wide. Alternatively, the County could partner with another existing FQHC organization.

- Most consultants indicate the FQHC process takes between 12 and 18 months.

- HSA's current scope is consistent with medical services expected in an FQHC environment.

- Issues that need to be considered relative to FQHC:
  - Recruitment and development of a governing board that is consumer driven and understands the county structure in which the clinics might reside.
  - Development of the relationship between the community board and the Board of Supervisors.
  - Prior to FQHC application, requesting entity must be organized and functioning as an FQHC relative to staffing, services, and governance.

- Factors of success relative to FQHC include:
  - Years of existence in serving this population.
  - Ability to retain a consultant well versed in obtaining designations.
  - Quality of our application.
  - Ability to demonstrate need to serve this population (i.e. survey data on availability of other providers who will take uninsured or Medi-Cal patients).

- Estimated costs that need to be considered relative to FQHC:
  - Legal work.
  - Consultant.
  - Accounting system changes.
  - Infrastructure.
  - Governing Board support.
  - Patient case management system.
  - Expand or augment areas such as transportation (taxi vouchers, bus passes).
  - Finance a transition period to an FQHC (Options could include County General Funds, loans or advances from public or private entities, transitional assistance grants from Foundations interested in health care access, such as Wellness or Endowment, non-profit hospital required community benefit (SB 697) funds.

- Revenue Maximization Workgroup conducted a make/buy analysis for each ancillary service (Lab, Radiology, Pharmacy and Rehabilitative Services). Determined that:

- For Radiology would need to move to digital imaging; provide professional radiology services satisfactory to providers; require use of our ancillary services by our facilities and providers.
- Negotiate for increased ancillary utilization with private partners.
- Improve processes for easy and accurate ordering (i.e. x-ray).
- Invest in an order entry system or electronic medical record.
- Examine discontinuation of some ancillary functions that are not cost effective or where sufficient capacity exists with providers in the community.

- The Revenue Maximization Workgroup identified a number of other revenue strategies:
  - Pursue legislation for Certified Public Expenditures to enhance federal match for Medi-Cal billed services.
  - Maximize use of Pharmacy Assistance Programs.
  - Augment our payer mix with more aggressive marketing for Medicare market share.
  - Affirmatively change our payer mix (reduce Medi-Cal, private pay; enhance commercial business).
  - Renegotiate current Blue Cross contract.
  - Pursue other revenue sources such as voluntary community provider contributions, Federal or State subsidies, non-profit hospital required community benefit (SB 697) funds allocations and evaluate potential grant opportunities to fund ongoing operational costs.
  - Change the current Medi-Cal Managed Care model. The State is willing to pursue additional designations of County Organized Health Systems (COHS).
  - Examine an increase in the primary care visit deposit and cash discount for self-pay/uninsured patients (NOT MIA).
  - Enhance collection percentages for share of cost and private pay patients.
  - Renegotiate SFMG administrative/overhead contractual arrangement.

- Other County or Public Models for Funding Health Care Services:
  - Sales and parcel taxes (subject to 2/3rds approval by voters).
  - Qualify clinics as FQHC.
  - Hospital –based funding for clinics (for those counties with public hospitals).
  - Alternate Medi-Cal Managed Care delivery models (county owned and operated Local Initiative or COHS).
  - Privatize the clinic network.
  - General Fund subsidy.

Facilities Management Workgroup

Participants:

Tim Fedorchak – Senior Management Consultant, Chief Executive Office
Dr. Chris Grover – Physician, Scenic Faculty Medical Group
David Jones – Public Information Officer, Health Services Agency
George Killian – Business Manager, Scenic Faculty Medical Group
Cle Moore – Associate Director, Public Health, Health Services Agency
Terry Rein – Attorney, Rein and Rein

Lina Ruppel – Interim Assoc. Director, Clinic Operations, Health Services Agency
Patty Hill Thomas – Assistant Executive Officer/Chief Operations Officer, Chief Executive Office

Findings and Observations:

- Except for the main campus (County Center II, Scenic Drive), there is little excess facility capacity or unused space. Currently there is some "temporary" space availability due to provider shortages in some locations.

- Given the recent investment and long-term leases executed at the newest clinic facilities, there are no immediate opportunities to cancel leases. Lease expirations are as follows:

  - Hughson Medical Office – lease expires 2008, $1.30/sqft
  - Ceres Medical Office – lease expires 2014, $1.65/sqft
  - McHenry Medical Office – lease expires 2018, $1.65/sqft
  - Paradise Medical Office – lease expires 2021, $1.60/sqft

- The current decentralized clinic system has little room for capacity growth or shifting from facility to facility in order to close any one clinic, at the current volume level.

- The County Center II site at Scenic Drive is owned wholly by the County. There are no facility related debt costs spread to HSA Clinics and Public Health users at this site. The sale or lease of some or all of County Center II would likely result in a benefit to the county to assist the Health Services Agency in a transition to a new model and create opportunity to manage that asset positively.

- Camden identified the Medical Arts Building as a building that could potentially be sold. Given that $1.3 million is still owed on the facility, it is unlikely that the sale of this building would yield any substantial cash flow. While the potential sale of this site is still being studied, the economics involved may not make the sale an immediately viable alternative.

- The Urgent Care facility, operated under contract, is not fully maximized and additional patient capacity is available. Effort should be given to explore ways to increase the utilization of urgent care, and seek partners to expand urgent care to relieve other emergency locations serving this patient load.

- The County securitized its Tobacco Settlement Funds in 2002. The "corpus" of the fund is $54 million and can only be used for capital investment. 80% of the interest earnings on the corpus are used for long-term debt relief to the accumulated HSA deficit of $20.5 million.

- Maintaining some form of a decentralized system will allow the County to maximize existing and newer clinic investments and long-term leases unless a decision is made to reduce access or services.

Residency Program

Participants:

Dr. Peter Broderick – Director of Residency Program, Health Services Agency
Dr. Thomas Gray – Physician, Family HealthCare Medical Group
Barbara Hill – Family Practice Center Clinic Manager, Health Services Agency
Mary Ann Lee – Associate Director, Health Coverage & Quality Services, Health Services Agency
Dr. Del Morris – Physician, Scenic Faculty Medical Group & Medical Director, Health Services Agency
Monica Nino-Reid – Assistant Executive Officer, Chief Executive Office
Dr. Joseph Provenzano – Physician, Sutter Gould Foundation & Stanislaus Medical Society
Dan Wirtz – Controller, Health Services Agency

- HSA has been the Institutional Sponsor of the UC Davis affiliated Family Medicine Residency Program since it was established in 1975; in 1997, DMC became an Institutional co-sponsor.

- Sixty of the Family Physicians graduated from the program practice family medicine in our county today.

- San Joaquin Valley currently lags the State average of primary care physicians per capita by 24%

- The entire medical community benefits from the Residency program. The County does not directly realize avoided monetary costs. Rather there is a positive impact to population in aggregate.

- Graduate Medical Education is funded by the federal government through the Medicare program via payments to the hospital institutional sponsor. Revenue flows through DMC to HSA, however inadequately covers all the program costs. Under the contractual arrangement with DMC, the County and DMC split the shortfall equally.

- The program provides the teaching incentive to attract well-qualified physicians to work in county clinics (both primary and specialty physicians).

- Program results in less efficient care/lower productivity per FTE physician (approx. 60% as productive – 1st year).

- There is the potential to add to federal program funding by adding rotations of visiting residents.

- Two potential actions are described below:

Scenario A

- Maintaining the Residency Program (9,9,9) – This scenario assumes current levels of visit volumes and maintaining the current number of 9 residents in each year of training (27 total Resident physicians).
- Program maintained - $1,947,178
- Provides inexpensive physician care ($52,000/FTE with benefits compared to ($180K & $260K for practicing FP & OBGyn)

Scenario B

- Discontinue the Residency Program (0,0,0) – This scenario is based on the absence of the residency program and includes a commensurate level of FTE physicians (12.82 FTE) to provide the current level of clinic visit volumes.
- Program eliminated - $3,038,817
- Eliminates the $700,000 Residency program shortfall burden.
- Adds cost of replacement physicians at HSA to backfill loss of 27 residents
- Loss of resource for future quality physicians for the county at large.
- Loss of many of the faculty group physicians (informal poll of SFMG=3/4s would leave.
- Possibility of retaining the Residency program in the community by transferring within the community. Potential interest unknown.

Legal Issues

Participants:

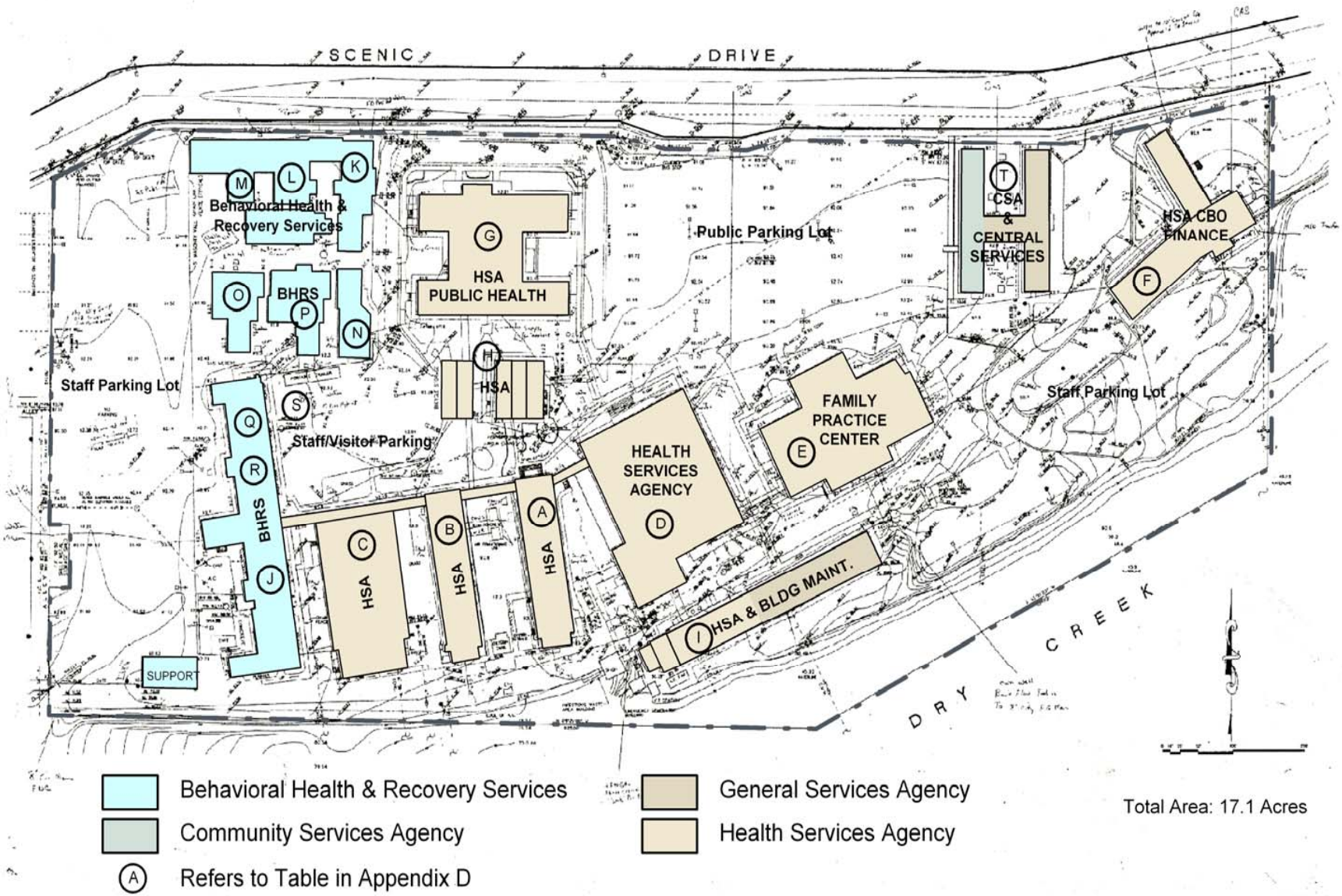
Richard Robinson – Chief Executive Officer, Stanislaus County
Mick Krausnick – County Counsel, Stanislaus County
Stan Risen – Assistant Executive Officer, Chief Executive Office
Margaret Szczepaniak – Managing Director, Health Services Agency
Dean Wright – Deputy County Counsel V, County Counsel

Findings and Observations:

The Legal Issues Workgroup explored various topics related to the Health Services Agency including Bielenson hearings, labor codes and contractual agreements. The workgroup discussed legal exposures that might exist under various strategic options. Findings and observations are not provided, given the potential for litigation that could arise when dealing with the variety of challenging issues contained in this report.

APPENDIX C

COUNTY CENTER II SITE PLAN



Appendix D
County Center II Facilities Description

HEALTH SERVICES AGENCY

Key	Building #	Square Footage	Date Constructed	Original Use	Current Use
A	Building #1	11,400	1930	Hospital	Rehab.; Oncology/GI
B	Building #2	12,282	1929	Hospital	Administration; Health Ed
C	Building #3	11,477	1930	Hospital	CHS: Public Health
D	Central Unit	81,091	1948	Hospital	Urgent Care, Specialty Clinics
E	Family Practice Center	15,667	1980	Outpatient clinic with Residency program	Family Practice Center
F	1020 Scenic Drive	9,400	c. 1940		Central Business Office; Finance
G	820 Scenic Drive	8,423	c. 1950		Public Health
H	Modulars	3,000	1990-1998		FPC Annex; HR/Safety
I	Support Building	5,000	1930		Materials Mgmt; Bldg Maint

OTHER DEPARTMENTS

Key	Building #	Square Footage	Date Constructed	Original Use	Current Use
J	Building #4	13,696	1936	Hospital	Behavioral Health & Recvy Svcs
K	800 Scenic Drive, Building A/H	3,200	1973		Behavioral Health & Recvy Svcs
L	800 Scenic Drive, Building B	2,452	1973		Behavioral Health & Recvy Svcs
M	800 Scenic Drive, Building C	3,129	1973		Behavioral Health & Recvy Svcs
N	800 Scenic Drive, Building D	3,004	1973		Behavioral Health & Recvy Svcs
O	800 Scenic Drive, Building E	2,856	1973		Behavioral Health & Recvy Svcs
P	800 Scenic Drive, Building F	3,617	1973		Behavioral Health & Recvy Svcs
Q	800 Scenic Drive, Building G	2,567	1970		Behavioral Health & Recvy Svcs
R	800 Scenic Drive, Building J	2,789	1973		Behavioral Health & Recvy Svcs
S	Modular	720	1989		Behavioral Health & Recvy Svcs
T	1018 Scenic Drive	7,752	1938		Central Services; Comm Svcs

Key refers to building locations denoted on map in Appendix C

PowerPoint

HEALTH SERVICES AGENCY

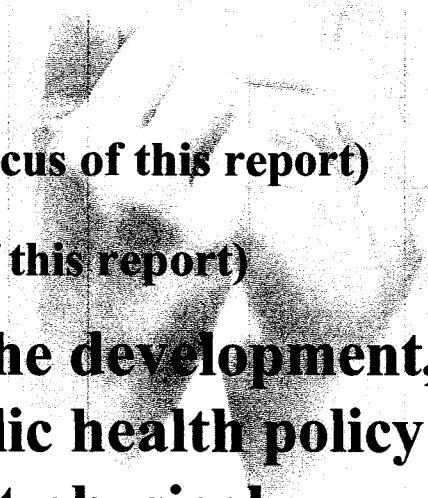
"leading the way to a healthy community"

Strategic Plan Report

2005

What is the HSA?

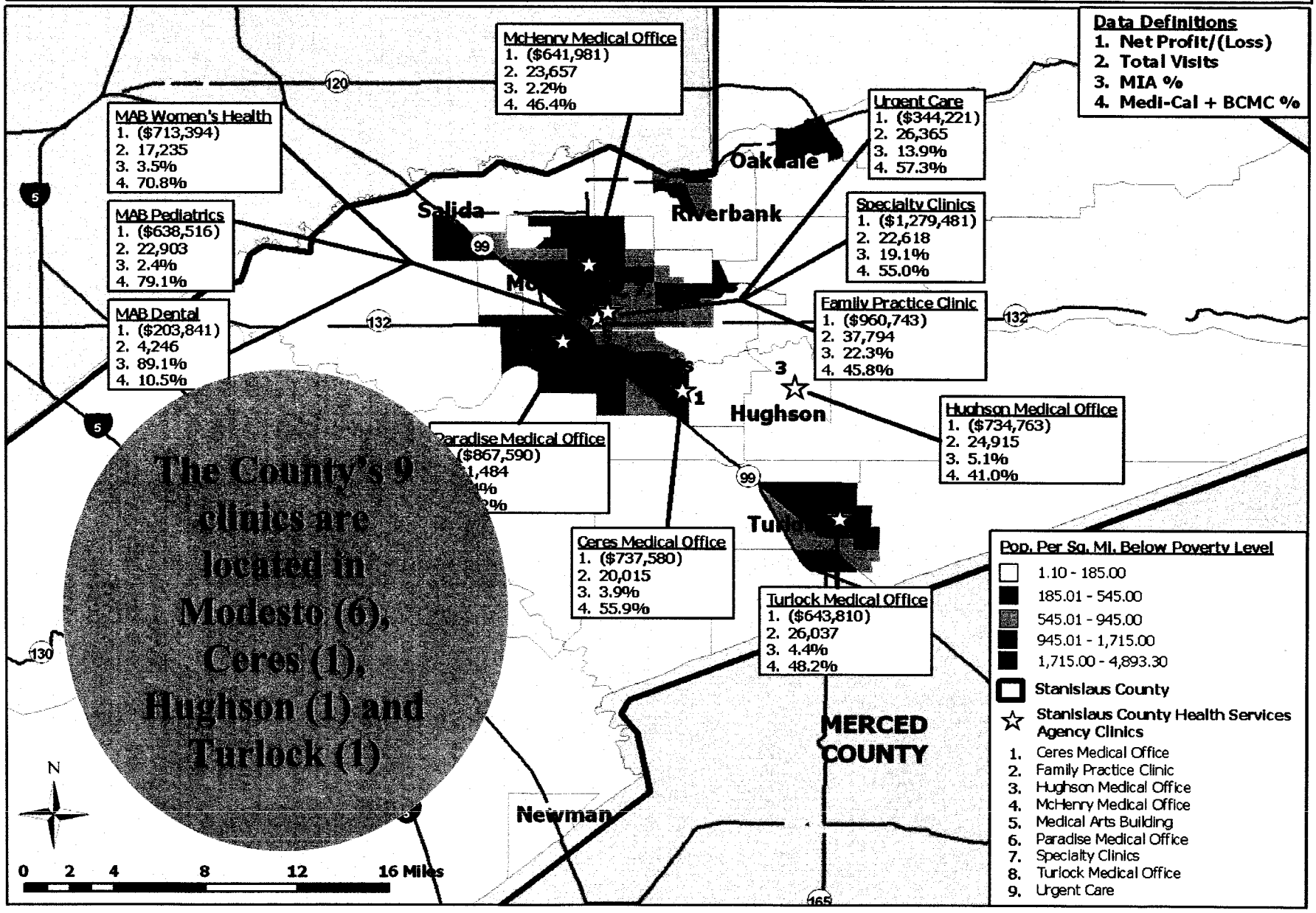
- The Health Services Agency (HSA) is a department of Stanislaus County that consists of the following major functions:
  - Clinics and Ancillary Services
  - Indigent Health Program
  - Public Health Services (not part of the focus of this report)
  - Health Promotion (not part of the focus of this report)
- The mission of the Agency is "to lead the development, implementation and promotion of public health policy and health care services to achieve excellent physical, psychological and social well-being."



Background

- **The Health Services Agency (HSA) is Stanislaus County's largest health provider to the underserved population**
- **The HSA Clinics and Ancillary Services division operates at 9 clinic locations throughout the County**
- **Clinic services currently provided include:**
  - **Primary Care**
  - **Specialty Care**
  - **Ancillary Services including lab, radiology, retail pharmacy and rehabilitative services**
  - **Urgent Care**

STANISLAUS COUNTY HEALTH SERVICES AGENCY CLINICS

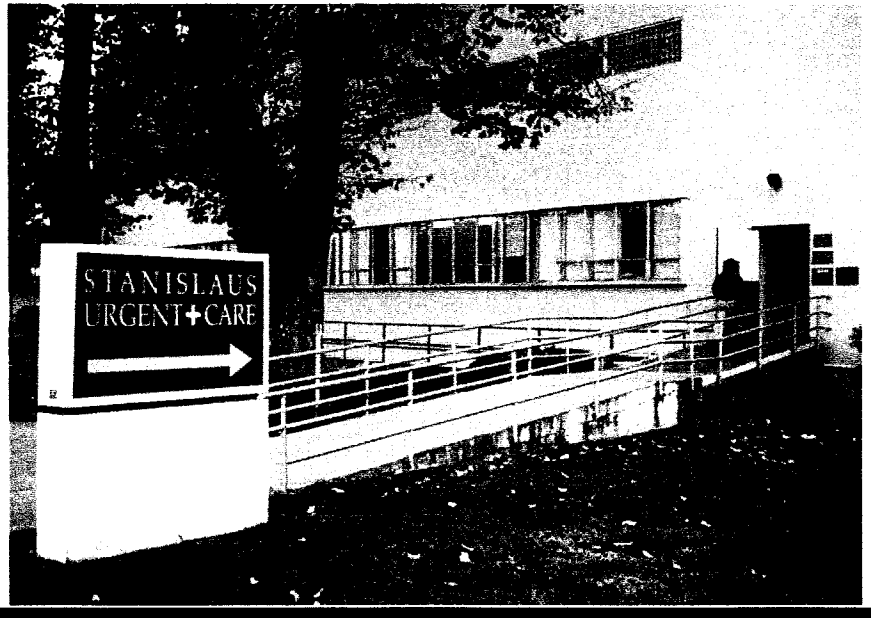


Background - Current Clinic Locations

- Family Practice Center (FPC), 830 Scenic Drive, Modesto
  - Opened in 1977
  - Family Practice and Internal Medicine Services
  - 37,794 Patient visits in 2003/2004

Background - Current Clinic Locations

- Urgent Care (UC), 830 Scenic Drive, Modesto
  - Opened in 1997
  - Episodic and Urgent Medical Care services
  - 26,365 Patient visits in 2003/2004



Background - Current Clinic Locations

- Ceres Medical Office (CMO), 3109 E. Whitmore, Ceres
  - Opened in 1999
  - Family Practice, Family Planning and Primary Medical Care
  - 20,015 Patient visits in 2003/2004

Background - Current Clinic Locations

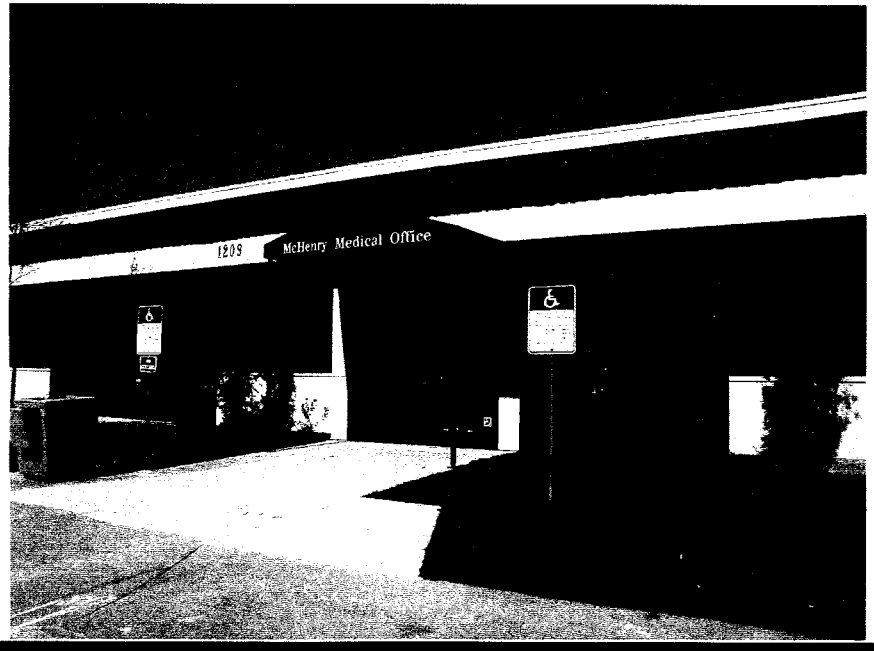
- Hughson Medical Office (HMO), 3rd & Elm Streets, Hughson
  - Opened in 1998
  - Family Practice, Family Planning and Primary Medical Care
  - 25,207 Patient visits in 2003/2004

Background - Current Clinic Locations

- Paradise Medical Office (PMO), 401 Paradise Rd, Modesto
  - Opened in 2001
  - Family Practice, Family Planning and Primary Medical Care
  - 21,484 Patient visits in 2003/2004

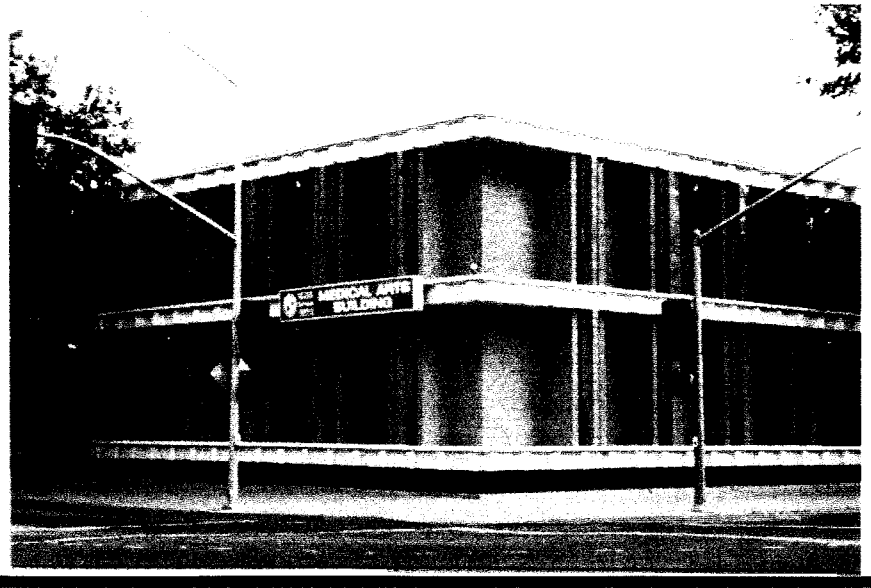
Background - Current Clinic Locations

- McHenry Medical Office (MMO), 1209 Woodrow, Modesto
  - Opened in 2003
  - Family Practice, Family Planning, Obstetrics and Primary Medical Care
  - 23,657 Patient visits in 2003/2004



Background - Current Clinic Locations

- Medical Arts Building (MAB), 17th & G St, Modesto
  - Opened in 1993
  - Dental, Pediatric, Women's Health and High Risk Obstetrics services



- 2003/2004 patient visits:
  - Dental - 4,246
  - Pediatrics - 22,903
  - Women's Health - 17,235

Background - Current Clinic Locations

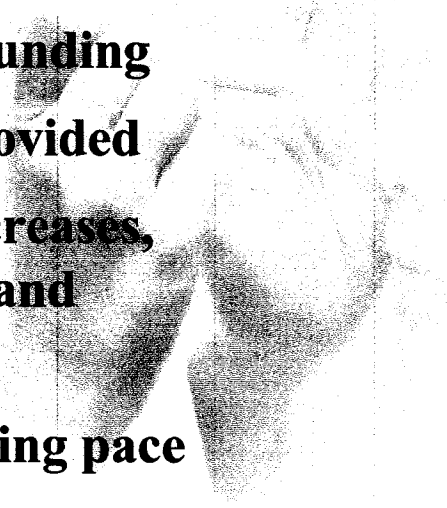
- Turlock Medical Office (TMO), 800 Delbon, Turlock
  - Opened in 1996
  - Family Practice, Family Planning and Primary Medical Care
  - 26,037 Patient visits in 2003/2004

Background - Current Clinic Locations

- Specialty Services, 830 Scenic Drive
  - Laboratory - annual test volume of 227,387
  - Radiology - annual studies of 25,300
  - Pharmacy - annual scripts of 124,127
  - Rehabilitative Services - annual patients of 21,669

Background

- **Ever since the closure of Stanislaus Medical Center in 1997, the Health Services Agency (HSA) has been faced with an annual operating deficit**
  - **This operating deficit is the result of several factors:**
    - **Loss of Disproportionate Share Hospital funding**
    - **Poor reimbursement levels for services provided**
    - **Rising labor costs including negotiated increases, workers' compensation, health insurance and retirement**
    - **Growth in Realignment Revenue not keeping pace with costs of providing services**

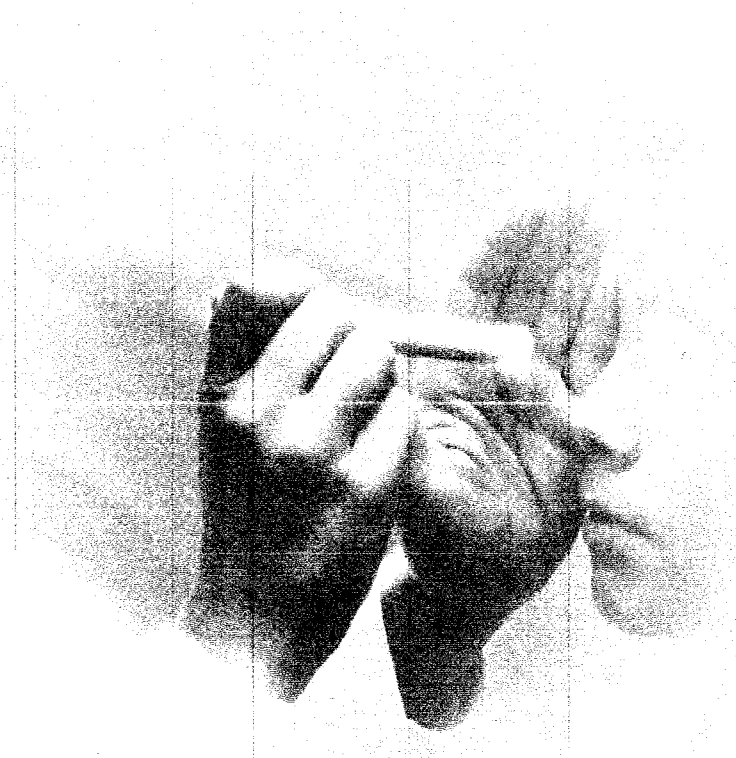


Annual Operating Deficits

Fiscal Year End	Profit/(Loss)
June 30, 1997	($1,105,534)
June 30, 1998	($4,321,088)
June 30, 1999	($8,201,092)
June 30, 2000	($7,150,380)
June 30, 2001	($7,825,976)
June 30, 2002	($2,417,613)
June 30, 2003	($5,520,693)
June 30, 2004	($6,433,011)
June 30, 2005	($9,330,196)
	($52,305,583)
2005-2006 Adopted Proposed Budget	($8,672,857)

Without the use of 1x funding, the clinic system has had a net loss of over $52 million from '96/97 to '04/05

Our Mandated Service



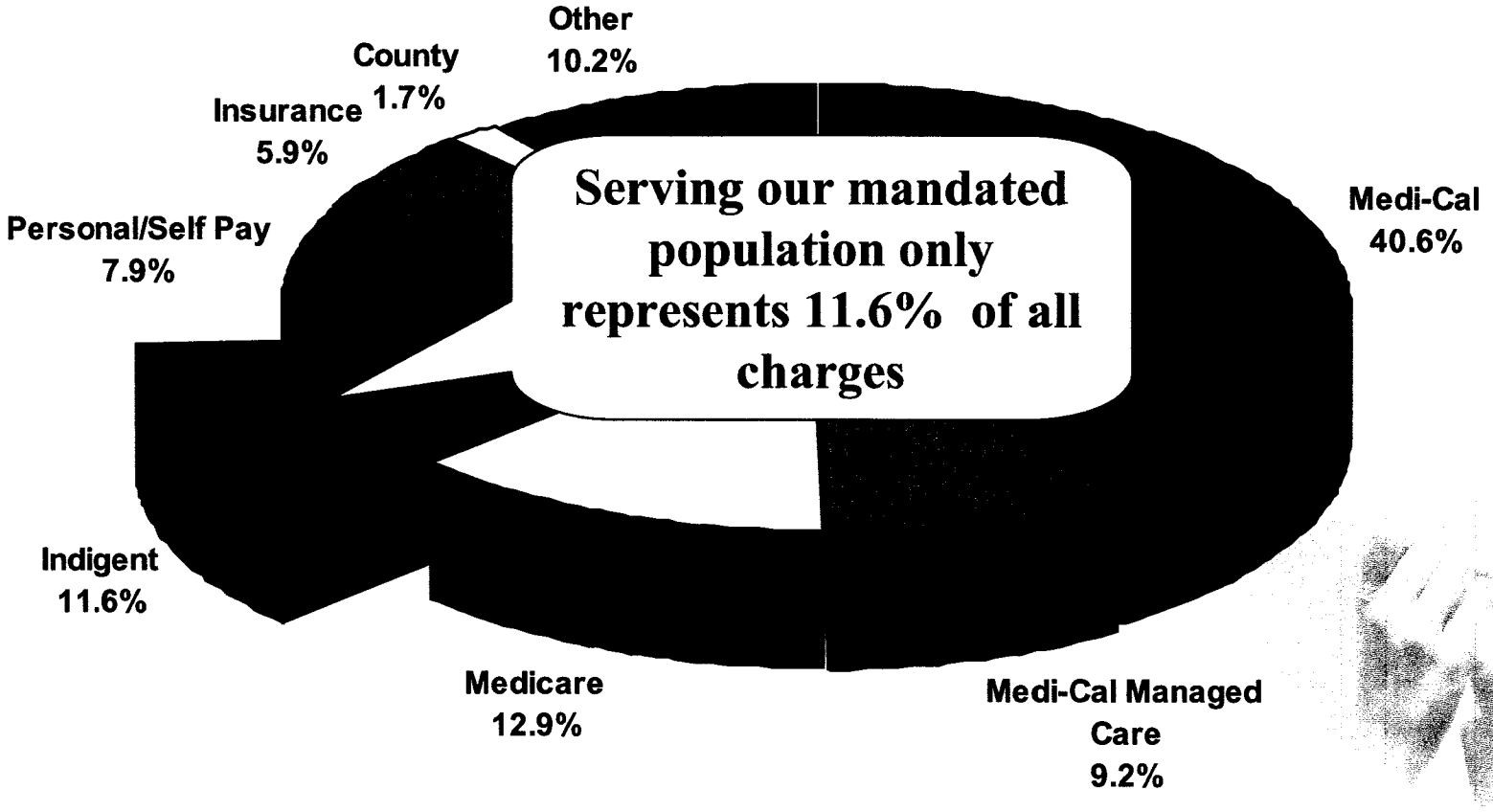
Section 17000 of the Welfare & Institutions Code states "Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions."

Strategic Plan Report
2005

HEALTH SERVICES AGENCY

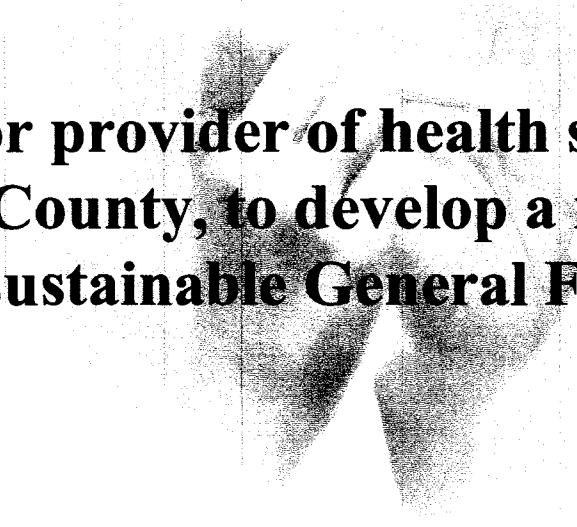
"leading the way to a healthy community"

Payer Mix Based on Charges (Fiscal Year 2003-2004)



The Challenge

- **To determine whether the County should stay in the business of providing non-mandated health services or focus on providing only those services mandated by law, that of serving the medically indigent and providing public health services**
- **If the County is to remain a major provider of health services to the underserved in Stanislaus County, to develop a model that can be maintained within a sustainable General Fund allocation**



The Strategic Planning Process

Camden Group prepares HSA Strategic Assessment

→

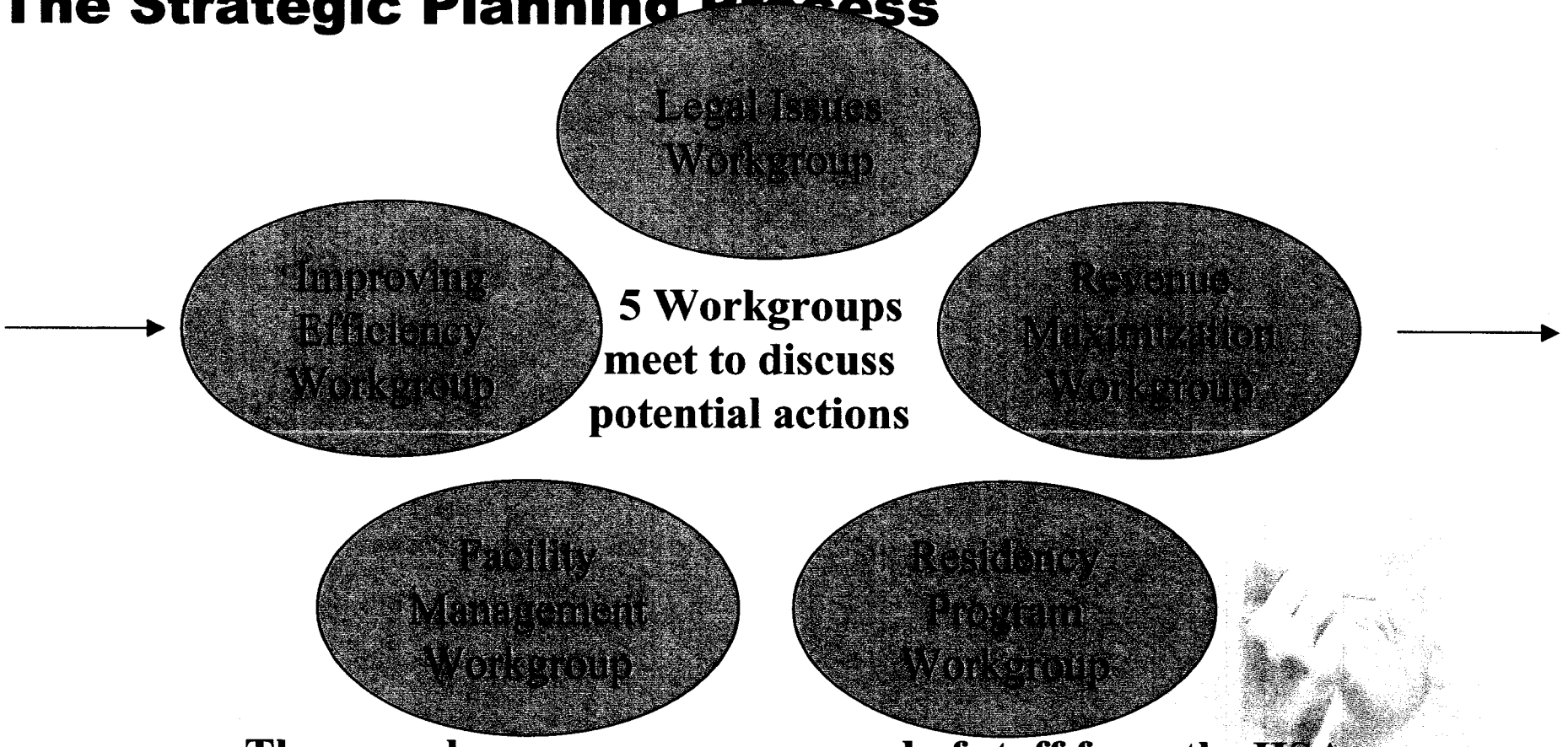
Health Summit held to discuss challenges & opportunities (Jan 27, 2005)

→

Camden Report presented to Board of Supervisors (Mar 22, 2005)

→

The Strategic Planning Process



•These workgroups were composed of staff from the HSA, CEO, Auditor-Controller, County Counsel and Scenic Faculty Medical Group, as well as 8 community physicians

The Strategic Planning Process

The Strategic Planning Process

CEO & HSA Managing Director meet with Hospitals & various Medical providers

Recommendations presented to Health Executive Committee
August 23, 2005

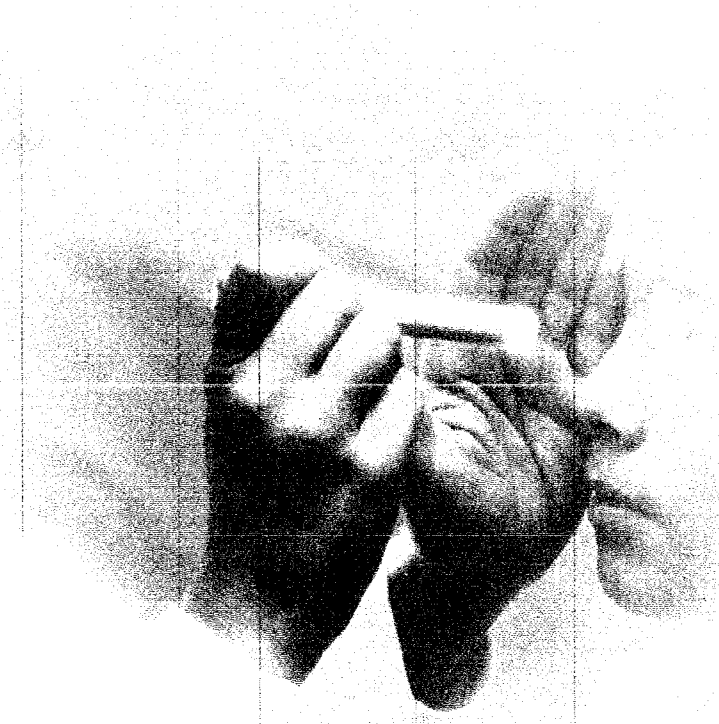
CEO & HSA Staff meet with union representatives
August 29, 2005

The Strategic Planning Process

HSA Strategic Plan Report & Recommendations to Board of Supervisors Sept. 13, 2005

Community Involvement

- Two local Health Summits
- CEO & HSA Managing Director meetings with hospitals & local medical providers
- CEO & HSA Senior staff attended several local health forums hosted by CBC
- CEO & HSA Senior staff met with Assemblyman Cogdill to discuss CPE
- Numerous other meetings with local health professionals, media, unions & County staff



Major Factors Influencing the Final Recommendation

- Omnibus Agreement with Doctor's Medical Center
- Impact on residents and the local health community
- Ability to cover our costs
- Availability of one-time funding
- Outside contributions
- Labor law and agreements
- Sustainability of a General Fund allocation

Strategic Plan Report
2005

HEALTH SERVICES AGENCY
"leading the way to a healthy community"

Recommendations

1 **Accept the Health Services Agency Strategic Plan Report**

2 **Adopt a three-year service delivery plan, which includes:**

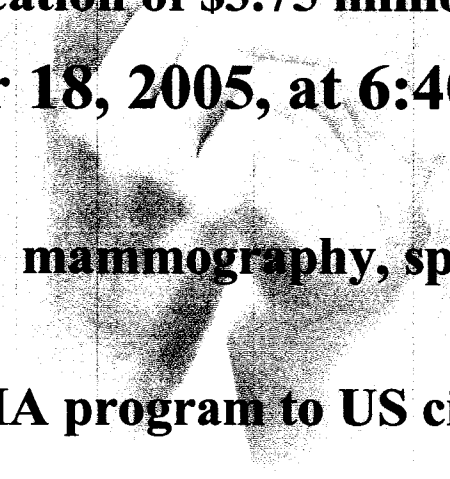
- **Year One:**
  - > **Remodel and expand outlying clinics to accommodate patient volume from Scenic Drive clinics**
  - > **Prepare site selection analysis and cost estimates to build replacement facilities for Public Health, BHRS & Central Services**
  - > **Issue RFQ/RFP to evaluate Community Partnerships for delivery of some health services**
- **Year Two: Pursue Community Partnerships where feasible**

Recommendations

- **Year Three:**
  - > **Evaluate success of new model**
  - > **Consider only providing benefits to Medically Indigent Adults if unable to achieve significant improvement in reducing the deficit to a more sustainable General Fund allocation of $3.75 million**

3 **Schedule a Public Hearing for October 18, 2005, at 6:40 PM to consider:**

- **The elimination of the direct provision of mammography, speech therapy and dental services**
- **Amending eligibility requirements for MIA program to US citizens or legal permanent residents**
- **Provide patient volumes at 1997 levels (minimum 207,000 visits)**



Recommendations

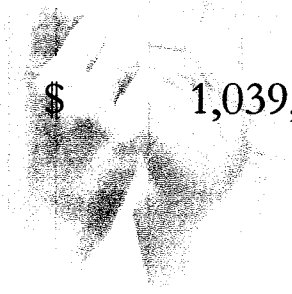
4 **Direct the CEO to finalize a detailed facilities implementation plan and return to the Board of Supervisors to present the plan and/or schedule a public hearing if required**

5 **Approve the three-year funding plan outlined in the report and direct the Health Services Agency to submit budgets consistent with this plan**

3-Year Funding Plan

	Year 1	Year 2	Year 3
Recommended Funding:			
- Increase in HSA County Match	$ 7,440,000	$ 5,600,000	$ 3,750,000
- One time costs	$ 1,221,500	$ 378,000	$ -
Total	$ 8,661,500	$ 5,978,000	$ 3,750,000
- 10% Contingency	$ 400,000	$ 400,000	1,039,000
Funding:			
General Fund	-		$ 3,750,000
Fund	5,561,500		
Co	3,500,000		
GF		$ 6,378,000	$ 1,039,000
* To	7,417,000		
Total	2005:	$ 12,978,500	

Funding for this $20.2 million three-year plan includes $3.5 million from Health Trust Fund and $16.7 million from the County General Fund



Recommendations

6 **Approve the change in terms of the secured note from the Tobacco Securitization Fund to include the 2003-2004 cash deficit of $3,236,112**

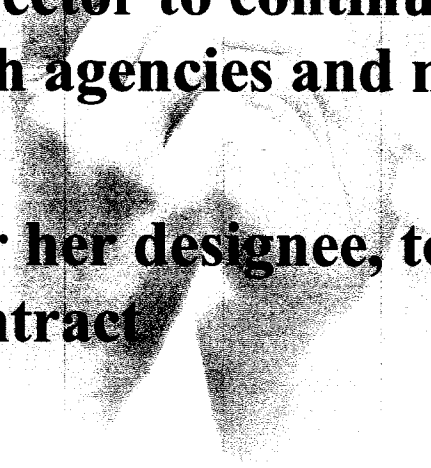
7 **Direct the CEO & HSA Managing Director to continue to pursue legislation to allow Stanislaus County to qualify for CPE**

8 **Direct the HSA Managing Director to submit an application for status as a Federally Qualified Health Center**

9 **Direct the HSA Managing Director to explore alternative Medi-Cal Managed Care delivery options**

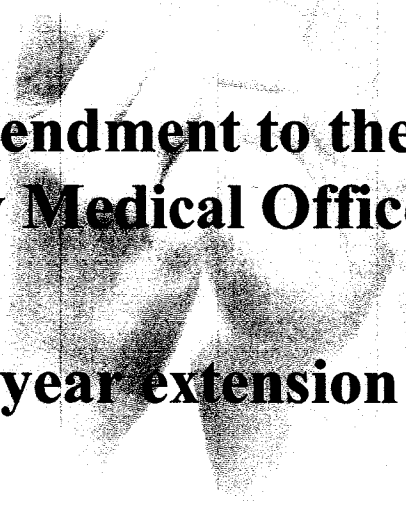
Recommendations

10. **Authorize the continuation of the Residency Program and direct the HSA Managing Director and Residency Program Director to seek additional financial sponsors and improvements in the overall efficiency of the Program**
11. **Direct the CEO & HSA Managing Director to continue to pursue contributions from other health agencies and medical providers**
12. **Direct the HSA Managing Director, or her designee, to renegotiate the current Blue Cross contract**



Recommendations

13. **Direct the HSA Managing Director to implement the efficiency improvements outlined in the Strategic Plan Report**
14. **Approve the increase in the cash payment to $90 for Primary Care visits and the deposit to $100 for Urgent Care and Specialty visits**
15. **Authorize the CEO to negotiate an amendment to the Paradise Medical Office and McHenry Medical Office clinic leases**
16. **Authorize the CEO to negotiate a two-year extension to the Turlock Medical Office lease**



Recommendations

17. **Authorize the Purchasing Agent to execute leases for new leased space for offices being relocated from the present use at Paradise Medical Office, including CSA, Children and Families Commission and WIC**

18. **Authorize the CEO to obtain design and engineering services to plan for the remodel of the Medical Arts Building**

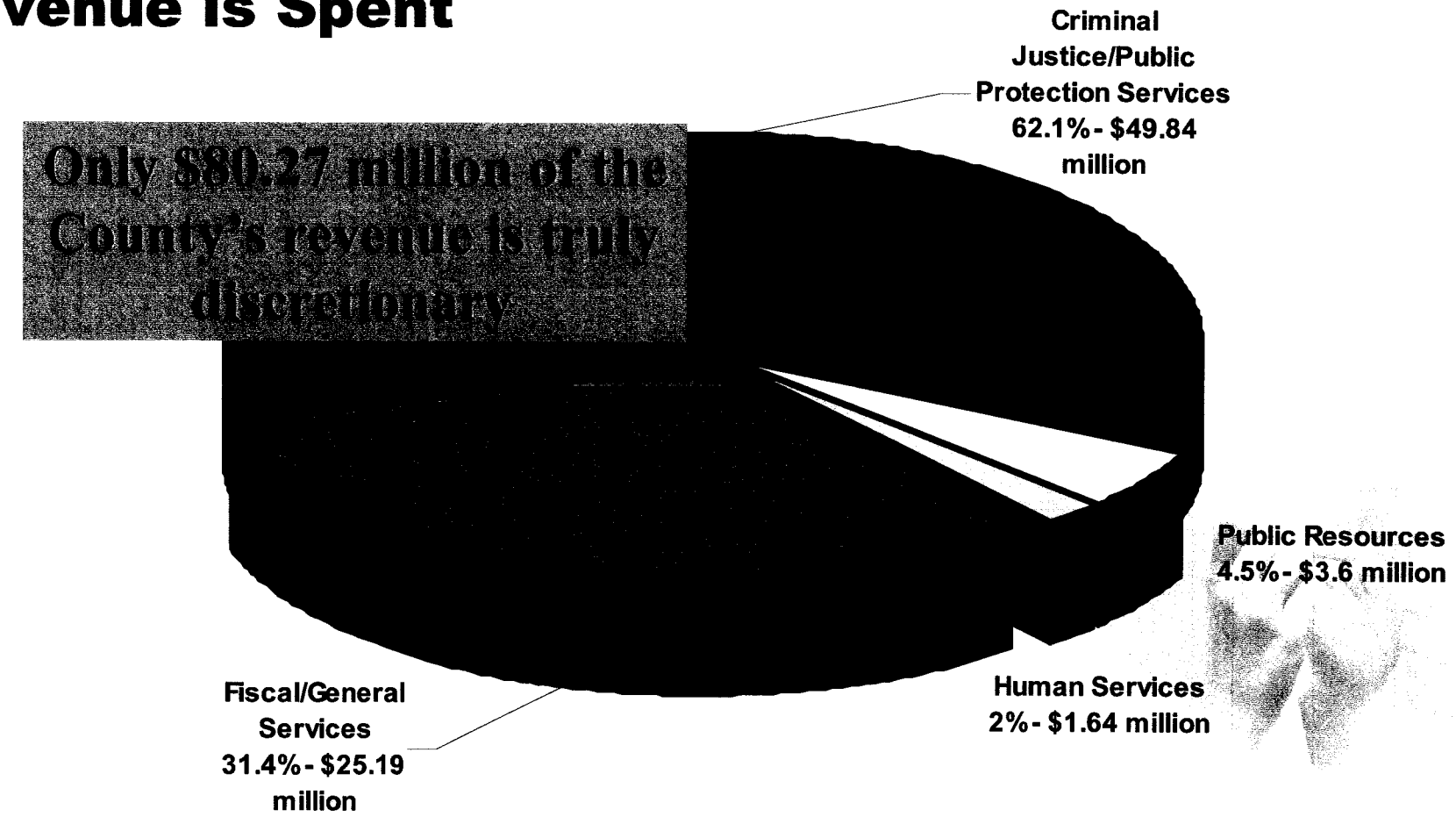
19. **Authorize the CEO to develop a phasing plan to relocate Public Health, BHRS and Central Services and other programs currently located at County Center II, and to proceed to plan for the marketing and sale of County Center II**

Frequently Asked Questions

Q. An $8.7 million deficit represents just over 1% of the County's total annual budget - why can't the County find the funding to address this need?

A. Only $80.27 million of the County's $797 million in revenue is available for funding programs at the Board of Supervisors' discretion. Of this $80.27 million, close to $50 million of it is used to support Public Safety programs, leaving only $30 million to support the remaining programs, many of which have some level of mandate (i.e. Animal Services, Assessor, Auditor-Controller, CEO, Elections, Office of Emergency Services, Parks & Recreation, Purchasing, Risk Mgmt, Tax Collector…)

Where the County's "Truly" Discretionary Revenue is Spent



Frequently Asked Questions

Q. If patient visits are reduced to 1997 levels, who will be affected and where will they go for care?

A. First, we will always remain open to serve our mandated population of the Medically Indigent. With the increase in the cash payment and cash deposit, we anticipate that there will be fewer private pay patients utilizing our services. Many Medi-Cal and MediCare patients may seek care at Federally Qualified Health Centers, such as Golden Valley Health Center, or at Rural Health Centers such as the Oakdale and Riverbank Community Clinics and the County-owned Hughson Medical Office

Frequently Asked Questions

Q. Why are the cash payment (previously referred to as a "cash discount") and the cash deposit going up?

A. These charges are for private pay patients, not Medi-Cal, MediCare or Medically Indigent. As there is no legal obligation to serve this population, these persons will need to cover the cost of their care. Even when these charges were established in 2001, they did not cover our costs. The new charges should cover our costs for most services

Frequently Asked Questions

Q. Why doesn't the County contract with Golden Valley to provide our clinic services?

A. There have been discussions with Golden Valley over the past several months, however, there are several significant challenges that would need to be addressed, including:

- ***A long-term commitment to providing health care to this population at these sites***
- ***Labor issues***
- ***Conformance with the Omnibus Agreement with Doctors Medical Center***

Frequently Asked Questions

Q. If we are moving clinical services off of County Center II (Scenic Drive site), where are the services going?

A. HSA and CEO senior staff are currently evaluating available square footage, remodeling costs and appropriate locations. We will return to the Board of Supervisors at a future date with a detailed relocation and phasing plan. It is anticipated at this point that all clinical services will be relocated off of the Scenic campus by the end of this fiscal year

Frequently Asked Questions

Q. What will happen to HSA Administration, Public Health, Behavioral Health & Recovery Services and Central Services when the clinics move off the Scenic campus?

A. These services will be relocated over time when replacement facilities are available.

Frequently Asked Questions

Q. How will core Public Health services be impacted and maintained?

A. Our Public Health mandate and mission is not changed as a result of these recommendations, nor is the County's commitment to those mandates. Although the Public Health division is interconnected with the clinic system, Public Health services will continue to meet its obligation to assess and assure specific health services

Frequently Asked Questions

Q. Will there be staff reductions?

A. There undoubtedly will be a need for fewer staff should the Board of Supervisors eventually adopt all of the recommendations contained in the report. Some staffing reductions may be accommodated through normal attrition and through the use of fewer part-time and temporary help. It is our goal to place the remaining affected employees in other county jobs wherever possible.

Next Steps

- Prepare a detailed Facilities Plan and bring it back to the Board of Supervisors for consideration
- Meet and confer with Unions
- Conduct October 18, 2005, 6:40pm Beilenson Public Hearing to consider recommended program changes

DECLARATION OF PUBLICATION
(C.C.P. S2015.5)

COUNTY OF STANISLAUS
STATE OF CALIFORNIA

I am a citizen of the United States and a resident Of the County aforesaid; I am over the age of Eighteen years, and not a party to or interested In the above entitle matter. I am a printer and Principal clerk of the publisher of **THE MODESTO BEE,** printed in the City of **MODESTO,** County of **STANISLAUS,** State of California, daily, for which said newspaper has been adjudged a newspaper of general circulation by the Superior Court of the County of **STANISLAUS,** State of California, Under the date of **February 25, 1951, Action No. 46453;** that the notice of which the annexed is a printed copy, has been published in each issue thereof on the following dates, to wit:

OCTOBER 7, 13, 2005

I certify (or declare) under penalty of perjury That the foregoing is true and correct and that This declaration was executed at **MODESTO,** California on

OCTOBER 13, 2005

Esther L. Jimenez
(Signature)

NOTICE OF PUBLIC HEARING

NOTICE IS HEREBY GIVEN that, pursuant to Section 1442.5 of the California Health and Safety Code and other applicable laws, th Board of Supervisors of the County of Stanislaus, State of California, will hold a public hearing regarding the reduction or eliminati certain health and medical services provided by the County. The public hearing will commence on Tuesday, October 18, 2005 at 6 p.m., or as soon thereafter as the matter may be heard, in the Board Chambers, 1010 10th Street, Modesto, California, at which tin place all interested persons may appear and be heard.

ADDITIONAL NOTICE IS GIVEN that the services proposed for reduction or elimination are as follows:

Reduction	Description of Reduction or Elimination
$2.7 Million	1. Patient Visit Volumes - The proposed level of clinical capacity represents a reduction of approximately 20% of existing capacity and is projected to impact approximately 16,000 - 19,000 patients. Those impacted may be a portion of patients currently accessing services at any of the existing facilities: Ceres Medical Office, Family Practice Center (Modesto), Hughson Medical Office, Medical Arts Building Pediatric and Obstetrical services (Modesto), McHenry Medical Office (Modesto), Paradise Medical Office (Modesto), Turlock Medical Office, and Specialty, Urgent Care and/or ancillary services at the Scenic Drive (Modesto) medical offices.
$ 60,000	2. Mammography - discontinue the direct provision of mammography services. Patients of the Health Services Agency will be referred to other community providers, based upon contractual arrangements of their health insurance or coverage program, to the extent applicable. Approximately 1,150 patients will be impacted by thi change.
$15,000	3. Speech Therapy - discontinue the direct provision of speech therapy services. Patients of the Health Services Agency will be referred to other community providers, based upon contractual arrangements of their health insurance or coverage program, to the extent applicable. Approximately 20 patients will be impacted by this change.
$180,000	4. Dental Services - discontinue the direct provision of dental services. Patients of the Health Services Agency will be referred to other community providers, based upon contractual arrangements of their health insurance or coverage program, to the extent applicable. Approximately 1,218 patients will be impacted by this change.
Between $100,000 - $150,000	5. Medically Indigent Adult Program Eligibility - Eliminate the provision of eligibility in the Medically Indigent Adult program for undocumented immigrants and temporary resident non-U.S. citizens. Approximately 160 patients w be impacted by this change.

NOTICE IS FURTHER GIVEN that at any time prior to the time fixed for the hearing, any interested person may file written comments o the proposed action with the Clerk of the Board of Supervisors of the County of Stanislaus. Both oral and written comments will be considered by the Board of Supervisors at the time and place fixed for hearing. Additional information regarding this hearing may be obtained by contacting the Stanislaus County Health Services Agency at (209) 558-7163, or by writing the Stanislaus County Health Services Agency, Attentio Administration, P.O. Box 3271, Modesto, CA 95353