# How to Strengthen Local Health Care Safety Net Systems:

# Lessons from Healthy San Francisco

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## INTRODUCTION

On July 25, 2006, by a unanimous vote, the San Francisco Board of Supervisors adopted the San Francisco Health Care Security Ordinance (HCSO), an ambitious law to provide health care to all uninsured residents and workers of San Francisco. The HCSO created two new city programs. First, it established Healthy San Francisco, a new health access program designed to provide comprehensive health services to uninsured San Francisco residents with a focus on prevention. Second, it created a requirement that San Francisco's medium and large-sized businesses spend a minimum amount on health care for their employees. One way employers may meet the requirement is to contribute to the new public health program.

Healthy San Francisco is a comprehensive medical care program for uninsured San Francisco adults operated by the San Francisco Department of Public Health (SFDPH). Healthy San Francisco is not health insurance. Instead, it provides access to basic and ongoing medical services, though a network structured around the public hospital and clinics, with private hospitals providing specialty services. Services include preventive and primary care, specialty, urgent and emergency care, behavioral health, laboratory, inpatient hospitalization, x-rays and pharmaceuticals. The program is open to uninsured residents regardless of health, employment or immigration status. Enrollment in Healthy San Francisco began in July 2007. To date, more than 52,000 of the city's estimated 60,000 uninsured adult residents participate in the program.[i] [ii]

While several localities in California and throughout the country have developed coverage expansion initiatives, San Francisco is the first local government to provide universal health care to its residents. San Francisco's experience offers important lessons about how to strengthen health care safety net systems to improve access and deliver appropriate care to the uninsured. Even with recently enacted federal health reform, which expands health insurance coverage to most uninsured Americans, tens of millions of individuals will remain uninsured or underinsured because of eligibility restrictions, insufficient subsidies or other social, geographic or language barriers.[iii] These individuals will

continue to rely on the health care safety net for their vital health needs. San Francisco's health reforms offer a model for bolstering local health delivery systems to complement public and private expansions of health insurance at the national level.

This policy brief examines the key design features of Healthy San Francisco that can be replicated in other communities. It is intended for a broad audience of local policymakers, health services planners, public administrators, community and government partners and advocacy organizations in communities like San Francisco that are committed to addressing the health care needs of the uninsured population. Information for this analysis was drawn from interviews with leaders involved in the planning, development and implementation of Healthy San Francisco, including city government officials, health care providers, program staff, members of Mayor Gavin Newsom's Universal Healthcare Council (UHC), consultants and other public health leaders in California. Part I describes the program's major improvements to the health care delivery system and offers guidance about how they were accomplished. Part II examines the combination of factors that contributed to the development of the program in San Francisco, including the political, institutional, and cultural context. Finally, Part III considers the implications of federal health reform for the future of health care safety nets.

# I. LESSONS FROM HEALTHY SAN FRANCISCO

Healthy San Francisco is designed to improve access to health services and deliver appropriate care to uninsured adult residents of San Francisco. To accomplish these twin objectives, the program strengthened the local health care safety net via three notable reforms. First, by simplifying and clarifying access to services for patients, Healthy San Francisco created a more transparent, patient-centered system of care. Second, the program restructured the county indigent health system in order to encourage preventive care and continuity in primary care. Third, the program expanded access to care to all uninsured San Francisco residents.

This section describes how San Francisco accomplished each type of reform. In each case, San Francisco's experience offers important lessons about opportunities to create greater public value from the existing health care delivery system. Although these reforms are sometimes related, local implementers will need to decide which of these goals to pursue given the needs of their community.

## Patient-Centered Reform

One of the major ways Healthy San Francisco improved access to care was by reducing barriers uninsured individuals experience when they try to obtain services. Before the program, many low-income uninsured residents had no way of knowing where to go when they needed care. They were forced to navigate a complex array of entitlement programs, specialty services, hospital-based programs and emergency services provided by safety net and traditional providers within the public and non-profit sectors.[iv] Oftentimes, patients would access multiple safety net options, including community health centers, public hospitals and clinics, non-profit hospitals and private providers to meet their vital health needs.[v] Still others would delay seeking care out of fear of the cost, or because they could not get an appointment. The public safety net system left many patients confused and with less than optimal care.

Healthy San Francisco provided coherence to the city's fragmented and opaque delivery system. By clearly communicating with patients about how they could obtain needed care, the program reduced barriers to desired services and made life easier for service recipients. It is worth emphasizing that this type of system reform involved no change to the actual provision of care. Instead, Healthy San Francisco took advantage of opportunities to rationalize existing service arrangements to make them more accessible and transparent. The San Francisco experience offers several important lessons about how to create a patient-centered system of care.

## LESSON 1: Effective program communication encourages participation and creates a sense of membership in an organized health program.

Through a variety of written program materials and a program website, Healthy San Francisco provides timely and relevant information to facilitate participation in the program. All participants receive an enrollment identification card and a participant handbook at the time they enroll in the program. Participants present their ID card, which includes their name, identification number and medical home information, when accessing medical services at their clinic or pharmacy. The participant handbook helps enrollees understand program rules and how to access the program's services.[vi] Healthy San Francisco also publishes a medical home directory with information about participating providers, such as practitioners' language/cultural competencies, location and clinical specialty.[vii]

The program launched a participant communications and outreach effort that was more extensive than anything the city's public health system had offered before. Participants now receive a number of materials by mail, including a quarterly newsletter, direct mail brochures encouraging them to seek preventive care and annual renewal reminder notices. All materials for applicants and participants are available in English, Chinese, and Spanish. The program, however, has no formal marketing or advertising aimed at identifying people who are eligible but not enrolled. Information is made publicly available through the Healthy San Francisco website (www.healthysanfrancisco.org) – the program's most accessible and versatile communications tool – and through the "311" calling system operated by the city.

These communications features – the participant ID card, handbook, website, mailings, etc. – have enabled Healthy San Francisco to create a system of care that is both transparent and accessible to patients. But not only do such materials help safety net users make sense of the health delivery system; they also contribute to a sense of membership to an organized health care program, creating expectations for access and quality. Because of these and other factors described below, participants generally do not think of Healthy San Francisco as being a charity care program.[viii]

## LESSON 2: Offering basic customer service is a simple but important way to help safety net users navigate the local health system.

Another way Healthy San Francisco facilitates participation is by providing multilingual customer service. The program's customer service center, which is managed by the program's third-party administrator, answers questions about the program, sends participants program materials and responds to problems and complaints. The call center provides telephone assistance to all Healthy San Francisco customers, including applicants, participants, employers and employees. It also manages communication with providers.[ix]

Before implementation of Healthy San Francisco, there was no one single phone number to call for information about accessing services through the public health system. Uninsured residents would have to contact each public and community clinic separately, and each clinic differed in terms of who answered the phone and the level of information that was provided.[x] Under the new health program, participants continue to contact their clinic directly for questions about medical services or to make an appointment. But now they can call customer service for a standard source of information about how the program works, for questions about billing, to request a new Participant ID card or to report a complaint or problem. Based on anecdotal reports, program participants widely value having a single, comprehensive customer service resource.[xi]

San Francisco's experience suggests that communities can go a long way toward reducing safety net users' difficulties in accessing services by providing basic customer assistance. The city's decision to offer centralized customer service is among the simplest but

most important changes as a result of the program to help users navigate the local health system.

## LESSON 3: Establishing predictable and affordable participation fees reduces anxiety about the cost of care and encourages patients to seek preventive care.

Individual participation fees may be structured in a variety of ways. Prior to Healthy San Francisco, the San Francisco Department of Public Health operated an indigent care program, which billed for services based on a sliding scale of income for only the months in which safety net users accessed county health services. The billing structure was costly to maintain, and patients rarely paid the bills.[xii] Healthy San Francisco presented an opportunity to simplify payment options for individuals participating in the new health program.

Similar to managed care, the program has two fee components: participation fees (i.e., premiums) and point-of-service fees (i.e., co-payments). The participation fee is paid quarterly based on a sliding scale of household income (See Table 1). Residents with income below the federal poverty level (FPL), those who are homeless or those who receive General Assistance do not pay a participation fee.

In addition, participants pay point-of-services fees which also slide with income when they access clinical and hospital services, with little or no cost sharing for individuals in families below 100 percent of FPL. Point-of-service fees are determined in advance but vary by medical home and type of service. Within the DPH network, the fees include $10 for a primary care visit, $20 for specialty and urgent care, $5 for formulary/$25 non-formulary drugs, $50 for ER (without a hospital admission) and $200 per hospital admission.[xiii] Healthy San Francisco does not provide or pay for care delivered outside the network for participants.

San Francisco's experience suggests individual participation fees for this type of program should – and can – be designed to provide incentives for appropriate utilization but not impede access to care. Fees that are too high, especially for those just above the poverty

line, may discourage enrollment or make it more likely that people will enroll only to obtain subsidized access to care but then drop their participation after receiving treatment, creating an administrative burden and depriving the program of a steady contribution toward its cost. The fee structure under Healthy San Francisco is designed to be both predictable and affordable for individuals, so that fees do not exceed 5 percent of family income for individuals with income below 500 percent of FPL. On average, participants can expect to spend 2.2 percent of their total annual income on health care expenses through the program, and cost sharing is within or below national benchmark standards for health care affordability.[xiv] [xv]

Making fees predictable and affordable makes it less likely individuals will delay seeking treatment when ill because of concern about the cost of care. Furthermore, by collecting payment prospectively, the program encourages participants to seek ongoing primary and preventive care. A fee structure that requires pre-payment, however, should be reviewed regularly to ensure individual expenditures do not impede access to care for the near-poor population.

**Table 1: Quarterly Participation Fees**

| Percent of Federal Poverty Level | 0-100% | 101-200% | 201-300% | 301-400% | 401-500% | 501%+ |
|---|---|---|---|---|---|---|
| Quarterly Fee[xvi] | $0 | $60 | $150 | $300 | $450 | $675 |
| Fees as a percent of income | 0% | 2.3% | 2.9% | 3.9% | 4.4% | 5.2% |

*The federal poverty level is $10,830 for an individual in 2009.
Source: Healthy San Francisco program in-depth.

## LESSON 4: A single, streamlined eligibility determination and enrollment system simplifies the enrollment process and maximizes coverage opportunities.

A key access innovation of Healthy San Francisco is the program's common eligibility and enrollment system shared by all provider sites countywide. The Department of Public Health implemented a web-based system, One-e-App, to screen and enroll uninsured

residents in Healthy San Francisco and to determine eligibility for multiple publicly funded health programs through a single application.[xvii]

Safety net users benefit in several ways from the program's centralized screening and enrollment process. Eligible individuals can enroll in Healthy San Francisco at over 30 sites across the city—including all primary care medical homes, an eligibility and enrollment unit within the SFDPH, San Francisco General Hospital, and the San Francisco Health Plan—an advantage for serving individuals in a safety net setting in which patients present at clinics when they need care.[xviii] The screening and enrollment process is smoother for applicants, because the system interfaces with other state and local eligibility systems and minimizes the need to collect the same information from the patient multiple times. Because applications and supporting documents (e.g., proof of income, rights and declarations, identity, residency, etc.) are submitted and stored electronically, participants are immediately enrolled in Healthy San Francisco, and their documents can be easily retrieved at the time of renewal, improving retention.

Furthermore, because the system screens patients for a broad range of health and social service programs before enrolling them in Healthy San Francisco, the city is able to increase coverage opportunities for individuals and families and maximize access to public funding. In FY 2008-09, for example, Healthy San Francisco helped reduce the number of uninsured by identifying approximately 5,200 uninsured residents eligible for, but not enrolled in, public health insurance (e.g., Medicaid) and facilitating their enrollment into the appropriate program.[xix]

A centralized eligibility and enrollment application also offers several system-wide benefits. It increases administrative efficiency by reducing time to process multiple applications for individuals and families seeking access to health care. An integrated eligibility determination system also ensures participants are routed to the correct program (e.g., Healthy San Francisco or Medi-Cal), with fewer opportunities to "fall through the cracks" and remain uninsured. Finally, because it is used consistently across provider sites, the centralized system of record creates a comprehensive database of the number of uninsured accessing services for planning and evaluation purposes.

Implementing a new system countywide requires significant time, training and resources, however. Counties often rededicate portions of existing staff time to implementation, and additional staff may be necessary – a significant challenge in the fiscal environment facing California and many local and state governments.[xx] Moreover, process change can be difficult at the clinic level; staff may not view the efficiency gains as worth the time investment. For these reasons, county agencies and community-based organizations should be involved early on in implementation planning in order to increase buy-in and facilitate the transition.

Despite the initial cost investment, San Francisco's experience suggests that simplifying the varied, confusing and often-conflicting eligibility and enrollment rules and procedures used by different safety net systems is an important way to reduce barriers to entry, increase system efficiency and preserve limited local resources by maximizing access to public funding streams.

## Delivery System Reform

The second major way Healthy San Francisco strengthened the health care safety net was by re-envisioning how the city delivers care to the uninsured. The program restructured the county indigent health system from a crisis delivery approach to a focus on prevention and continuity in primary care. Through the program, public and private providers are integrated into an organized care network, anchored by the county hospital and clinics.

By linking existing service delivery systems, Healthy San Francisco took advantage of potential synergies between providers and the gains that come from better care coordination. The resulting safety net is designed to provide a more organized and efficient model of health care delivery, which improves access, utilization, quality and cost-effectiveness of care and ultimately results in better health outcomes. The San Francisco experience offers several lessons about how communities can redesign their safety net systems to create a more appropriate model of health care delivery for the uninsured.

## LESSON 5: Providing access to care, rather than insurance, results in lower costs and allows counties to leverage federal and state funding.

Policymakers confront a choice between two options when attempting to expand health care to the uninsured: access or insurance. Health insurance is often considered the most likely way of making health care services accessible and affordable to those lacking coverage, and an insurance coverage model is preferable, because it offers better choice and flexibility. But because substantial subsidies are required to help low-income uninsured persons afford coverage, many communities may find it difficult to publicly fund comprehensive coverage while ensuring that provider rates are adequate, a challenge Medi-Cal continues to face.

San Francisco focused on increasing access to subsidized health care services, rather than providing insurance. Healthy San Francisco is not an insurance plan but instead provides access to care through a network structured around the county hospital and clinics (public and non-profit), with non-profit hospitals providing inpatient and/or specialty services. The program is not licensed as an insurance product and is not regulated by state insurance agencies. Health services are available only within the local network of the City and County of San Francisco.

By providing access to care using the public and non-profit networks, San Francisco could achieve a greater level of coverage for uninsured individuals than through a publicly funded insurance product. In FY 2008-09, monthly expenditures per participant were $298 ($3,580 annually), which is less than the cost of commercial health insurance.[xxi] [xxii] Furthermore, because county residents enrolled in the program are still uninsured, the county continues to leverage state and federal resources that benefit the uninsured, and enrollees continue to qualify for certain federal and state benefits (e.g., the AIDS Drug Assistance Program) that are unavailable to insured patients.[xxiii]

An access model, in comparison with an insurance coverage model, also reduces concerns that individuals or employers will drop their existing health insurance coverage in order to take advantage of a publicly funded program. Such "crowd out" has the potential to significantly increase the number of individuals participating in the public coverage initiative,

draining program funding. Because services are available only through a restricted network of local clinics and because the range of services is not as comprehensive as health insurance, insured individuals are less likely to place the same value on Healthy San Francisco as they would on private health insurance. Thus far, the program has not observed a shift away from private coverage. Of the more than 52,000 individuals enrolled in the program to date, less than 2 percent have income above 300 percent of the FPL.[xxiv] [xxv]

Some of the disadvantages of a non-insurance based system have already been mentioned. Healthy San Francisco is a safety net program that does not reduce the number of uninsured or provide a legal entitlement to a defined set of benefits, as in the Medicaid program. The program does not cover certain services, such as vision or dental, among others. As noted above, services are only available within the local network, and participants lose their benefits if they move outside San Francisco.

Yet, despite these limitations, San Francisco's experience shows that a model guaranteeing access to care through a well-structured delivery system provides an affordable alternative to health insurance. Program costs are lower than health insurance and the program continues to leverage state and federal funding sources that support services to the uninsured.

## LESSON 6: Linking patients to a primary care medical home reduces duplication of services and improves coordination of care.

A key feature of Healthy San Francisco is the use of medical homes to reduce episodic care and improve the quality and continuity of care enrollees receive. Upon enrollment, participants select a primary care medical home from among the participating clinics as their usual source of care. The medical home is then responsible for assigning patients their own physician (either a primary care physician, nurse practitioner, or physician assistant), delivering routine primary and preventive care services, conducting chronic disease management and coordinating care across conditions, episodes, providers and service settings.[xxvi]

Thirty-one medical homes across five delivery systems currently participate in Healthy San Francisco. They include the city's 14 public health clinics, 8 private non-profit community clinics (with 13 sites), a private hospital-based clinic, a private physicians association (2 sites) and a non-profit health plan (See Tables 2 and 3). All provider sites share a common system of record (One-e-App), which allows them to direct participants to their proper medical home if a patient arrives at the wrong clinical site.

Healthy San Francisco participants respond favorably to having one location for their medical needs. This allows individuals to develop a relationship with a primary care provider and increases patient access to specialty services. In surveys of program enrollees, participants indicate that they have more established relationships with a medical home, better access, fewer delays in seeking care and perceived better quality of care.[xxvii] [xxviii]

At the same time, providers become accountable for the quality and efficiency of care delivered to their assigned patients. Medical homes reduce the duplication of services, so providers can better coordinate care, manage chronic conditions and monitor patient compliance with treatment. Patients are less likely to rely on costly emergency room visits for conditions that could be treated in a primary care setting, and they are less likely to incur avoidable emergency department and hospitals stays.[xxix] Program data from FY 2008-09 showed 78 percent of participants utilized primary care services within a 12-month period. The program also witnessed a 27 percent decrease in SFGH hospital emergency department visits per 1,000 participants (216 to 157) between the first to second year, as well as lower rates of hospital utilization and avoidable emergency department visits at SFGH than occurred in Medi-Cal.[xxx]

San Francisco's experience thus far is consistent with preliminary evidence from other demonstration programs suggesting that a focus on primary care through the use of medical homes can help control costs, improve quality and better meet the needs of patients as well as providers.[xxxi]

## LESSON 7: Collaboration between existing public and private safety net providers maximizes available resources to care for the uninsured, increasing access.

Healthy San Francisco takes advantage of a public-private partnership to improve access to health care services for the uninsured. The program relies on existing safety net providers for the core of the health network. In San Francisco, this group of health care providers consists largely of two networks: the public hospital and clinics operated by the San Francisco Department of Public Health (SFDPH) and a consortium of private non-profit community-based health centers affiliated with the San Francisco Community Clinic Consortium (SFCCC). The two provider networks have long been partners in caring for the city's uninsured population. Healthy San Francisco presented an opportunity to formalize their common mission under the new health program.

The program also brought with it additional funding to care for the uninsured. The Department of Public Health entered into grant agreements with the non-profit consortium clinics for their participation as medical homes in Healthy San Francisco. Medical homes receive negotiated payments based on their number of enrollees and the range of administrative and/or clinical services offered.[xxxii] The provider organizations participated in the program's planning process.

In addition to safety net providers, Healthy San Francisco has attracted traditional private providers who now serve the uninsured through the program. The Healthy San Francisco provider network has expanded to include a non-profit health plan, a private hospital-based clinic and a private physicians association, which serve as medical homes. These medical homes also receive negotiated payments. Additionally, four non-profit hospitals that are linked with primary care homes and a state-owned hospital providing radiological services have joined the provider network (See Table 2). San Francisco non-profit hospitals do not receive reimbursement through the program but instead participate through their provision of charity care (See Part II, "Existing Public Health Infrastructure).[xxxiii]

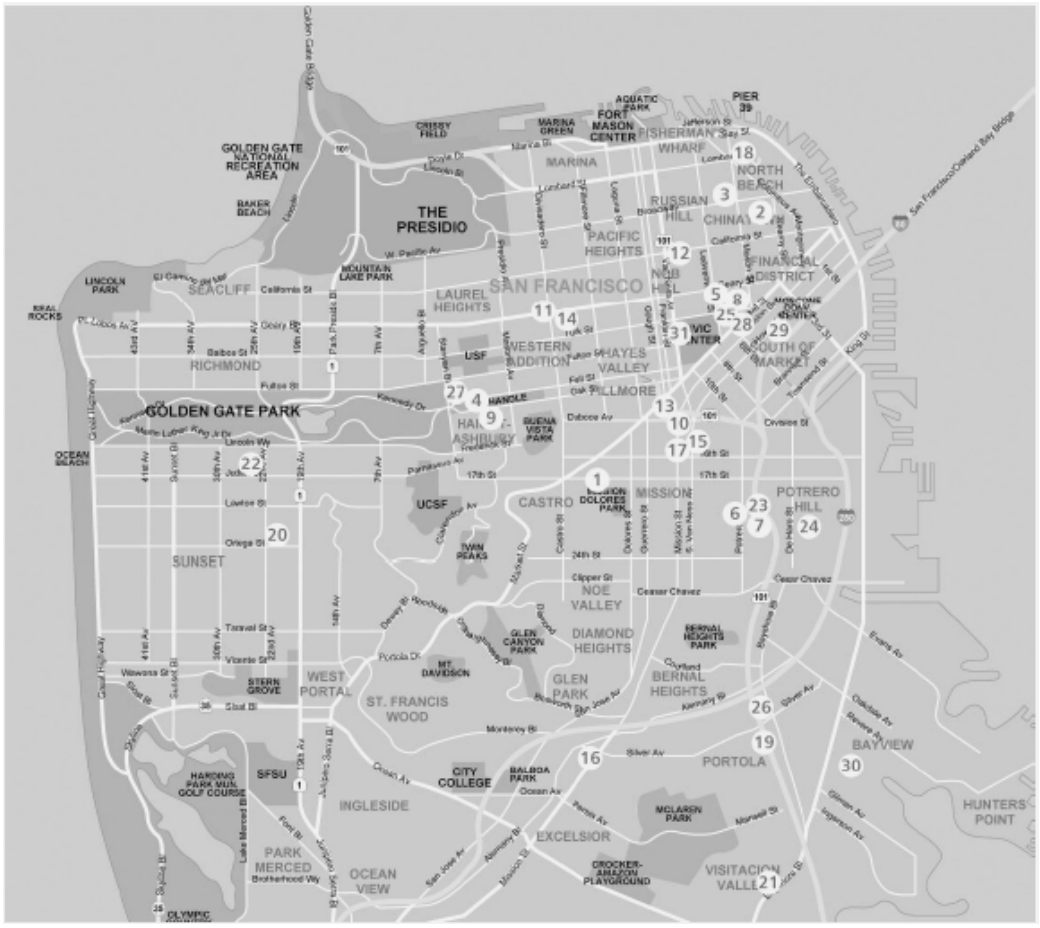
By linking public and private providers in an organized system, Healthy San Francisco created an integrated delivery network that optimizes the use of existing resources at the system level. The mix of public and private providers has allowed the program to achieve a broad-based health network, promoting choice for patients and ensuring access to comprehensives health services. Notably, the Healthy San Francisco program is not associated with any one provider; the choice of providers has contributed to perceptions among participants that Healthy San Francisco is not an indigent care program.[xxxiv]

**Table 2: Healthy San Francisco Provider Network**

| | Provider | Services | Description |
|---|---|---|---|
| **Medical Home** | San Francisco Department of Public Health (DPH) | primary, specialty, pharmacy | 14 public health clinics |
| | San Francisco Community Clinic Consortium (SFCCC) | primary (7 health centers)<br><br>primary, specialty pharmacy (1 health center) | 8 non-profit health centers with a total of 13 sites |
| | Sr. Mary Philippa Health Center (St. Mary's) | primary, specialty pharmacy | 1 non-profit hospital clinic |
| | Chinese Community Health Care Association (CCHA) | primary, diagnostic, specialty, pharmacy | 1 private physicians association (2 clinic sites and private officers) |
| | Kaiser Permanente San Francisco Medical Center | primary, emergency, specialty, diagnostic, pharmacy, inpatient | 1 non-profit health plan |
| **Hospital** | San Francisco General Hospital | inpatient, outpatient specialty, pharmacy, diagnostic, emergency | public |
| | Saint Francis Hospital (CHW) | in-patient | non-profit |
| | St. Mary's Medical Center (CHW) | in-patient | non-profit |
| | California Pacific Medical Center | in-patient | non-profit<br>(4 campuses) |
| | Chinese Community Hospital | Inpatient, emergency, specialty, diagnostic | non-profit |
| | UCSF Medical Center | radiological services | state-owned (academic) |

Source: Healthy San Francisco. (2009). Annual report to the San Francisco Health Commission (for fiscal year 2008-09).

## Table 3: Healthy San Francisco Clinic Network Map




Source: Healthy San Francisco medical home directory.

1. Castro Mission Health Center
2. CCHCA – Chinese Hospital
3. Chinatown Public Health Center
4. Cole Street Youth Clinic
5. Curry Senior Center
6. Family Health Center at SFGH
7. General Medicine Clinic at SFGH
8. Glide Health Services
9. Haight Ashbury Free Medical Clinic
10. Haight Ashbury Integrated Care Center
11. Kaiser Permanente San Francisco Med Ctr
12. Larkin Street Youth Clinic
13. Lyon-Martin Health Services
14. Maxine Hall Health Center
15. Mission Neighborhood Health Center
16. Mission Neighborhood Health Center - Excelsior
17. Native American Health Center
18. NEMS – Chinatown
19. NEMS – Portola
20. NEMS – Sunset
21. NEMS – Visitacion Valley
22. Ocean Park Health Center
23. Positive Health Program at SFGH
24. Potrero Hill Health Center
25. St. Anthony Free Medical Clinic
26. Silver Avenue Family Health Center
27. Sister Mary Philippa Health Center
28. South of Market Health Center
29. South of Market Senior Clinic
30. Southeast Health Center
31. Tom Waddell Health Center

## LESSON 8: An organized health delivery system provides a better framework for monitoring patterns of care and identifying opportunities for improving access, quality and efficiency.

Monitoring and improving the quality of care are essential to ensuring any health program meets its goal of improving health outcomes. By restructuring the city's fragmented health care safety net into an organized and coordinated system of care, Healthy San Francisco is better able to identify patterns of care and opportunities for clinical improvements.

Healthy San Francisco maintains a clinical data warehouse through which it collects a range of administrative and clinical data across provider organizations. They include clinical encounter and utilization data, quality measures, application/enrollment trends, patient satisfaction and financial indicators.[xxxv] With this information, the program is in a position to develop data-driven, population-based interventions and quality improvement programs targeted to the specific health, access and utilization issues of participants.

For example, Healthy San Francisco launched an incentive program, "Strength in Numbers," to improve the quality of chronic care management within its provider network. Through seed funding and incentive payments to clinics, the program encourages medical home use of disease registries and rewards improvement in targeted chronic disease measures for diabetes, hypertension, chronic pain, HIV/AIDS, depression and high cholesterol.[xxxvi] [xxxvii] The program's initial focus on diabetes care shows promising early results: medical homes participating in the program have, on average, increased their blood glucose (A1C) screening rates by 8.7 percent and their cholesterol (LDL) screening rates by 7.1 percent.[xxxviii]

Setting process and outcome benchmarks is also critical to evaluating the program's performance. Healthy San Francisco uses the data it collects to compare performance against Healthcare Effectiveness Data and Information Set (HEDIS) benchmarks, recognized quality standards developed and maintained by the National Committee for Quality Assurance (NCQA) and widely used in the health care industry.[xxxix] HEDIS includes 71 measures spanning important dimensions of care and service, allowing comparison to other

health plans and to national and regional benchmarks and facilitating the trending of results from year to year. Using HEDIS benchmarking will begin in the 2010-11 program year.

The specific framework for monitoring, identifying and addressing the quality of care will depend on administrative capacity and the nature and extent of the provider network. San Francisco's experience suggests, however, the quality improvement (QI) framework should build on, rather than duplicate, existing systems. Instead of developing a separate and distinct QI structure for Healthy San Francisco participants, the program created a structure to complement providers' existing QI systems.[xl] The program's third-party administrator, the San Francisco Health Plan (SFHP), oversees the program's quality improvement activities. It collects and analyzes clinical and quality data from all Healthy San Francisco providers and monitors access and complaints. As issues are identified, SFHP works collaboratively with the appropriate QI structure for that provider system to address them—a benefit not only to Healthy San Francisco participants but also potentially to the provider's broader patient population.

The San Francisco experience shows that a safety net system which functions as a coordinated whole provides a better framework for measurement and improvement. By setting process and outcome benchmarks, measuring performance and developing appropriate clinical interventions, communities can continually strengthen the local health delivery system to improve access, quality and efficiency of care.

## Coverage Expansion

Finally, Healthy San Francisco strengthened the local health system by expanding access to care for the uninsured. All adult residents of San Francisco who have been uninsured for at least 90 days and who are ineligible for other public insurance program may apply, regardless of health, employment or immigration status.[xli] A resident may join either individually or through an employer. To date, more than 52,000 of the city's estimated 60,000 uninsured adult residents have enrolled in the program. About one-quarter of enrollees are new patients, meaning they had not used the health care system in the two years prior to joining.[xlii]

Several other counties in California and localities throughout the country have established innovative health care access programs. But few if any coverage expansion initiatives reach uninsured individuals with income above 300 percent of the federal poverty level (FPL). Most are available only to those at far lower income thresholds.[xliii] By contrast, Healthy San Francisco is open to uninsured individuals with household income up to 500 percent of FPL, or $110,250 for a family of four in 2009.[xliv] There is no income limit for individuals who join via the Employer Spending Requirement (see below). Healthy San Francisco represents the first time a local government has sought to provide health care services to all uninsured residents through a health care access model.

Limited funding is often the major barrier to expanding coverage at the local level. San Francisco's health reforms provided a financing mechanism that enabled San Francisco to take its safety net program to scale, achieving universal health care for its residents. The next section describes, for local adopters, how San Francisco was able to support its broad coverage expansion efforts.

## LESSON 9: A shared responsibility approach can provide a sustainable funding base to support coverage expansion efforts.

Healthy San Francisco's universal-access model is based on "shared responsibility" between government, individuals and employers. Uninsured individuals pay on a sliding scale of income with public subsidies for low- and moderate-income families, and employers are required to contribute to health benefits for their workers. In this way, all sectors of society play a role in addressing the health and well being of the uninsured. Shared responsibility is a common theme of many health reform proposals that build on the system of job-based coverage, including the recently enacted federal health reform legislation.

The program is financed by a combination of individual participant fees, employer contributions, and local and state resources. The primary source of funding comes from redirecting approximately $110 million in City and County funds to provide health care services to the uninsured.[xlv] San Francisco also receives federal funding in the form of a $73-million award over three years through the Federal Health Care Coverage Initiative, funded

as part of California's federal 2005 Medicaid Hospital Financing Waiver. Employer contributions and participant fees provide an additional source of financing for the program.

In FY 2008-09, total program costs were $126 million, or $298 per member per month, in health care services and administrative expenses. Table 4 summarizes the annual program finances of Healthy San Francisco.

**Table 4: Healthy San Francisco Finances for FY 2008-09**

| Funding Source | Amount (in millions) | Percent of Total Financing |
|---|---|---|
| City and County of San Francisco | $90 | 72% |
| Federal allocation (Health Care Coverage Initiative) | $19 | 15% |
| Employer contributions | $14 | 11% |
| Participant fees | $3 | <1% |
| Total | $126 | 100% |

Source: Healthy San Francisco. (2009). Annual report to the San Francisco Health Commission (for fiscal year 2008-09).

The infusion of federal funding has helped San Francisco support an expansion of its indigent health care program. These new revenues enabled the city to offer new administrative services – such as enhanced registration and health information systems, customer services and quality monitoring – and expand clinical capacity through the public health system. The Department of Public Health added new clinical staff (physicians, nurses, etc.) and hours for clinic operation (e.g., evenings and weekends) and increased hospital, ancillary, pharmacy and behavioral health services.[xlvi] Furthermore, the Department redesigned many of its primary care clinic facilities, creating additional exam rooms to reduce wait times for appointments and to meet the increase in the demand for care.

Employer participation has also been critical for supporting the city's broad program redesign. In San Francisco, employer responsibility has taken the form of an employer health spending requirement. Firms with 20 or workers are required to spend a minimum amount per hour on health care for their employees (See Table 5). Employers can satisfy the requirement by contributing toward health insurance, funding Health Savings Accounts, directly reimbursing for health care costs or paying into the city program (called the City Option). Non-profit organizations with less than 50 employees and small firms are exempt.

The requirement on employers is a "play-or-pay" health care law, in which employers that do not cover health care services on the job ("play") must contribute into a public pool ("pay"). The mandate on employers serves two critical functions. It discourages firms from dropping coverage, which would place a greater burden on the new public program, and it provides an important source of financing for the expansion of health services for uninsured workers.[xlvii] With the passage of federal health reform, though, which builds on the system of employer-sponsored coverage through an employer responsibility component, counties may see less of a need for an employer requirement at the local level.

**Table 5: Employer Spending Requirement by Employer Size**

| Business | | Rate Schedule | | | |
|---|---|---|---|---|---|
| | | 1/9/08 | 4/1/08 | 1/1/09 | 1/1/10 |
| **Large** | 100+ Employees | $1.76/hour | | $1.85/hour | $1.96/hour |
| **Medium** | 50-99 Employees | $1.17/hour | | $1.23/hour | $1.31/hour |
| | 20-49 Employees | Not Applicable | $1.17/hour | $1.23/hour | $1.31/hour |
| **Small** | 1-19 Employees | Not Applicable | | | |

Source: San Francisco Department of Public Health

# II. CONTRIBUTING FACTORS

A set of local factors contributed to the development of San Francisco's health reforms. These conditions underlie the success of coverage expansion efforts and delivery system improvements in San Francisco and shed light on whether similar reforms might be achievable in other communities.

## Political Will and Leadership

> "With the passage of the San Francisco Health Care Security Ordinance by unanimous vote at the Board of Supervisors, our city sends a strong message to state and local governments across this nation. The message is that when the community speaks up, and the political will is there, no problem is too great. Even the question of universal health care can be surmounted."[xlviii]
>
> -- Tom Ammiano
> San Francisco Board of Supervisors

The San Francisco Health Care Security Ordinance (HCSO) was signed into law in August 2006, culminating a decade-long effort in San Francisco to expand health care coverage to the uninsured. Throughout this effort, political will to address the problem of the uninsured, strong leadership from the city's elected officials and strategic collaboration and compromise were crucial elements of success.

A vision for universal health care coverage first emerged under San Francisco Mayor Willie L. Brown, Jr. Shortly after taking office in 1996, Mayor Brown appointed a Blue Ribbon Committee on Universal Health Care Coverage comprised of a diverse group of stakeholders, including health care providers, labor, insurers, consumers, business, community-based organizations and health advocates charged with developing a framework for expanding health care coverage to the uninsured. In May 1998, the committee articulated its vision of access to affordable, comprehensive, continuous care with a focus on prevention, which would later become the guiding principles of Healthy San Francisco.[xlix]

At the time, there was overwhelming public support for universal health care in San Francisco. In November 1998, San Francisco voters approved Proposition J, a declaration of policy for the City and County to assist uninsured residents in obtaining affordable health care coverage. Proposition J passed with a 65 percent majority.[l] San Francisco voters have since supported expanded health care in a series of ballot propositions and bond measures, and the City and County of San Francisco has created a variety of incremental programs to address the health needs of the city's uninsured residents, including virtually all children, certain young low-income parents, In-Home Support Services workers and employees of City and County contractors. The passage of Proposition J marked a crucial moment in San Francisco's push for universal health care: it effectively laid the foundation of public support for comprehensive government action to expand coverage to uninsured San Francisco residents.

San Francisco's commitment, shared by community and political leaders, to addressing the uninsured problem resurfaced in 2004, after California's failed attempt at statewide health reform. *Senate Bill* 2 (SB 2), a statewide "play-or-pay" health care law requiring California employers to pay a fee to the state to provide health insurance unless the employer provided coverage directly, passed the California legislature in October 2003 and was signed into law by Governor Gray Davis shortly thereafter. The bill, however, was forced onto a referendum (Proposition 72) in November 2004, where it was overturned by less than a percentage point. While the referendum lost statewide, it received support from 69 percent of San Francisco voters. Tom Ammiano of the San Francisco Board of Supervisors seized on public support in San Francisco for universal health care and led an effort to craft similar legislation on a local level.[li]

Supervisor Ammiano worked with labor leaders and community organizations on the initial legislation. In November 2005, he introduced a proposal to require businesses in San Francisco with 20 or more employees to contribute to employee health benefits. The proposed legislation would provide coverage for an estimated 40,000 uninsured but working San Franciscans.[lii]

A majority of the Board of Supervisors endorsed Supervisor Ammiano's Worker Health Care Security Ordinance. It also had the full support of organized labor, including the

San Francisco Labor Council and the Service Employees International Union Local 790, and community organizations, such as Health Access California, ACORN, and the Senior Action Network.[liii]

The main opposition came from the business community, led by the Golden Gate Restaurant Association and the San Francisco Chamber of Commerce. The chamber assembled a coalition of large and small business leaders, members of theater and dance nonprofit organizations, restaurateurs and health insurance experts to oppose the legislation. The Golden Gate Restaurant Association and other employer groups heavily lobbied the Mayor to oppose the requirement on employers. Supervisor Ammiano vowed ultimately to take the issue directly to voters if the city's political leaders failed to act.[liv]

Amidst the public campaign to pass Supervisor Ammiano's ordinance, Mayor Gavin Newsom was also advancing a vision for universal health care. He had pledged during the State of the City address in October 2005 to provide "universal access" to care to an estimated 82,000 San Francisco residents who lacked coverage at the time.[lv] The Mayor's office began negotiations with Supervisor Ammiano. In February 2006, Mayor Newsom and Supervisor Ammiano announced the formation of a multi-disciplinary Universal Healthcare Council (UHC) made up of health care providers, labor, business and other community stakeholders charged with developing a proposal for universal health care in San Francisco.

Convening a task force proved to be politically shrewd. The UHC played an important role in bringing all the stakeholders to the table, building consensus among diverse interests and reaching an agreement with broad public support. The Council coalesced around a proposal from Mitchell Katz M.D., Director of Health, to reorganize the public health system, and it presented its recommendation for a citywide health access program in June 2006. By that time, eight out of 11 members of the Board of Supervisors had signed on to Ammiano's proposal, giving the Board a veto-proof majority. That the Board of Supervisors had the votes to take action also helped to focus attention and to facilitate good-faith negotiations.

After months of working with labor leaders, the business community and local advocates and negotiating with the Mayor, Supervisor Ammiano announced compromise

legislation that incorporated the Mayor's framework for Healthy San Francisco and Supervisor Ammiano's proposal for an employer health spending requirement. The San Francisco Health Care Security Ordinance (HCSO) was signed into law in August with unanimous support of the Board.

## Existing Public Health Infrastructure

San Francisco's health system is composed of an extensive network of public and community clinics serving the city's underserved, uninsured, and at-risk populations. San Francisco was able to build on this strong existing public health infrastructure for the core of the integrated delivery network.

Unlike many other communities, which provide mainly traditional public health programs and services, San Francisco's Department of Public Health is also a direct provider of health care services. The San Francisco Department of Public Health (SFDPH) operates a network anchored by the county hospital (San Francisco General Hospital) and 18 primary care clinics located throughout the city. It is the city's primary provider of health services to the poor and uninsured. Through the public health system, the city delivers a broad range of primary care, acute, emergency, long-term and behavioral health services.[lvi]

To support a strong public health system, San Francisco spends more on public health than other cities and commits financial resources above its legal obligation to care for the indigent and uninsured.[lvii] Even before implementation of Healthy San Francisco, SFDPH operated a robust health care program for medically indigent residents with income up to 500 percent of the federal poverty level. The program served over 50,000 uninsured individuals each year, and the budget for indigent care services exceeded $100 million annually.[lviii] San Francisco, therefore, started with many resources in the system that could be redirected toward the new health program.

Healthy San Francisco also relies on a willing provider community outside of the public health system, which has traditionally provided services to low-income uninsured residents. Ten private non-profit community health centers are critical partners in supporting

San Francisco's health care safety net. The public and non-profit clinic networks combined deliver care to most of the city's uninsured population.[lix]

Finally, non-profit hospitals support San Francisco's safety net infrastructure through their provision of charity care, which includes emergency, inpatient or outpatient medical services provided without expectation of reimbursement. As a condition of licensure under California's Hospital Fair Pricing law, general and psychiatric acute care hospitals and specialty hospitals are required to provide free and discounted care to uninsured and underinsured patients with income at or below 350 percent of the federal poverty level.[lx] Through such in-kind contributions, a network of five non-profit hospitals currently participates in Healthy San Francisco (See Table 6). Coordination on a city level of private hospitals' contribution to charity care has helped ensure access to a continuum of specialty and diagnostic services for participants.

In summary, San Francisco had the advantage of both a large public health system and a large private non-profit delivery system that could be part of the health network. A functioning and willing provider network is critical to optimizing use of existing resources at the system level to improve and expand access to care.

**Table 6: Hospital Charity Care Policies**

| | MONTHLY INDIVIDUAL ADJUSTED INCOME AND ASSETS | | | | | |
|---|---|---|---|---|---|---|
| | $0 - $904 | $905 - $1,806 | $1,807 - $2,708 | $2,709 - $3,159 | $3,160 - $3,610 | $3,611 - $4,515 |
| **SF General Hospital** | NO FEE emergency care is provided at no cost | | | REDUCED FEE emergency care is provided at a discounted cost based on income and assets | | |
| **St. Francis Hospital** | | | | | | |
| **St. Mary's Hospital** | | | | | | |
| **UCSF** | | | | | | |
| **Chinese Hospital** | | | | | | |
| **Kaiser Permanente** | | | | | | |
| **California Pacific Medical Center** | | | | | | |

Source: Healthy San Francisco participant handbook.

## Unified City-County Government

San Francisco has an unusual local government structure. As its name implies, the City and County of San Francisco is a consolidated city-county, a status it has had since 1856.[lxi] City and county government functions are unified under one legal jurisdiction: the Mayor also serves as the County Executive, and the County Board of Supervisors acts as the City Council. San Francisco is the only such consolidation in California. Nationwide, there are 33 city-county consolidated governments out of a total of 3,069 county governments.[lxii]

Because of its consolidated city-county status, San Francisco assumes the powers and responsibilities of both types of entities. As a city, a municipal corporation, it employs broad powers of self-government. As a county, an administrative subdivision of the state, it is vested by the Legislature with mandatory duties under state law to provide for the health and welfare of the people within its borders. Counties in California, for example, as well as most other places throughout the county, bear a statutory obligation to provide medical treatment to low-income uninsured residents who would otherwise go without care.[lxiii] San Francisco fulfils this obligation through its county-run indigent health system.

To strengthen the local health system, San Francisco's health reforms took advantage of the City and County's overlapping local government structure. Using the city's broad revenue generating authority, San Francisco could set a minimum employer health spending requirement and put a floor under the employer-based system. Using the county-operated public health system, San Francisco could create a new local public health access program for the uninsured.[lxiv] These two components of the HCSO—the Employer Spending Requirement and Healthy San Francisco—work in tandem to address the health needs of San Francisco's uninsured residents and workers.

Communities like San Francisco that have a strong public health infrastructure may be able to move to a coordinated care model and implement some of the aforementioned patient-centered and delivery system reforms without relying on insurance. But, passing a similar ordinance with an employer mandate may present a larger challenge. Not only would the law have to be passed in the county; it would have to be ratified by multiple different cities.

## Strong Administrative Partnerships

To develop and implement the new health program, San Francisco took advantage of a licensed community health plan with extensive experience serving the city's underserved population. The San Francisco Department of Public Health partnered with the San Francisco Health Plan (SFHP) to administer program operations for Healthy San Francisco. SFHP is a City-sponsored health plan providing health insurance to more than 55,000 San Francisco residents, including most of the city's Medi-Cal (Medicaid) managed care population and beneficiaries of several other publicly funded programs.[lxv] The health plan was created by the City and County of San Francisco in 1994 to manage public insurance programs for San Francisco's low and moderate-income families. While SFHP is a governmental entity, it is separate from local government.

Because Healthy San Francisco shares many features of managed care systems, the program benefited from partnering with an HMO with expertise serving low-income populations in public insurance settings. SFHP performs an array of third-party administrative functions for the program, including customer services, enrollment, utilization tracking and monitoring, billing and communications with participants. It also manages contractual relationships with non-public providers. Lastly, the health plan is responsible for a variety of quality improvement activities, such as completing an annual service report, tracking and reporting complaints and overseeing the collection and analysis of clinical and quality data from all the network providers.[lxvi] Collaboration with SFHP is central to the program's ability to support participant outreach and to monitor and improve the quality of care.

In addition, the program identified a strong health information systems vendor, the Center to Promote Health Care Access, to support the city's new eligibility and enrollment system. These administrative partnerships have been instrumental in the start-up and ongoing operation of the program.

## III. IMPLICATIONS OF FEDERAL HEALTH REFORM

In March 2010, President Obama signed comprehensive health reform into law. The new health care legislation, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, will make sweeping changes to the U.S. health care system and provide health insurance to an estimated 32 million individuals who are currently uninsured.[lxvii] Under the new law, U.S. citizens and legal residents will be required to have health insurance starting in 2014. The legislation helps individuals meet this requirement in a number of ways: it expands eligibility for Medicaid; it provides federal subsidies and tax credits for individuals and small business to purchase coverage through new health insurance exchanges; and it imposes new requirements on private insurers to make health insurance more accessible and affordable to enrollees.

Yet, even with health reform, approximately 23 million non-elderly residents will remain uninsured.[lxviii] They include undocumented immigrants, who will be ineligible for coverage through the program, individuals exempt from the coverage requirement, those who will choose to pay the penalty rather than purchase insurance and those who will not be able to afford coverage even with federal subsidies.[lxix] Still others will be eligible for public programs such as Medicaid but won't sign up. Lastly, because insurance does not guarantee access, some newly insured individuals may still have difficulty accessing services. For these individuals who are otherwise unable to afford or access care, local safety nets will continue to be a vital part of the nation's health care delivery system.

Federal health reform does not wholly depart from the traditional safety net model of care but instead supports local health delivery systems through critical investments in community and federally qualified health centers, the health care workforce and primary care. Notably, the legislation supports consortiums of health care providers to coordinate and integrate health care services for low-income uninsured and underinsured populations; it promotes training programs that focus on primary care models, such as medical homes, team management of chronic disease and those that integrate physical and mental health services; and it increases reimbursement for primary care physicians in Medicaid, which in theory will

expand the pool of private providers serving low-income populations.[lxx] These enhancements to the public health infrastructure and workforce present a unique opportunity to re-envision health care at the local level.

But at the same time, reform may also increase the strain on counties, as safety net resources are redirected toward covering the newly insured. Alongside expansions in Medicaid eligibility and private health insurance, health reform calls for annual reductions in federal disproportionate share hospital (DSH) payments, which currently help about half (2,700) the nation's hospitals provide uncompensated care to low-income patients. San Francisco General Hospital, for example, may lose $105 million in Medicaid DSH payments between 2014 – 2020, according to a preliminary estimate by SFDPH.[lxxi]

For this reason, it will be critically important for county safety net programs to facilitate the transition to health insurance coverage for the uninsured. Counties will play an essential role in identifying and enrolling newly eligible beneficiaries into the Medicaid program and coordinating their enrollment into state health insurance exchanges. To facilitate this process, states to will be required to develop a single form for applying for state health subsidy programs that can be filed online, in person, by mail or by phone. Healthy San Francisco provides one model for how the eligibility determination and enrollment process can be streamlined for multiple health programs.

Further, the San Francisco experience suggests how communities can take advantage of the new resources under health reform to create adequate safety net systems, which complement federal coverage expansion efforts. Indeed, many counties may decide to create integrated systems of care structured around the community health clinics and hospitals and supported by private providers, which will then be offered on the exchange. Models of coordinated care, as in San Francisco, have already taken root in several places around the nation. National health reform is likely to hasten the movement toward coordinated care as the mechanism for serving the medically indigent population.

# CONCLUSION

Healthy San Francisco offers a model for improving access and the delivery of care to low-income uninsured individuals through the health care safety net. San Francisco's experience illuminates three important ways of strengthening the local health system. The new health program created a simpler, more transparent system of care to reduce barriers to needed services ("patient-centered reform"). It restructured the county indigent health system to emphasize preventive care and continuity in primary care, rather than costly episodic and emergency care ("delivery system reform"). And it expanded access to care to all uninsured adult residents of San Francisco ("coverage expansion"). Policymakers will need to decide which of these health reforms is most important to pursue based on the local health needs, political will and resources of their communities.

This policy brief describes the essential design functions and features of Healthy San Francisco that achieve each type of reform:

Patient-centered reform

1. **By providing information and materials to facilitate program participation, communities can reduce difficulties patients experience in accessing services and create a sense of membership in an organized health care program that is less likely be perceived as charity care by participants.** Program materials may take a variety of forms, including a program website, enrollment identification cards, a participant handbook, preventive health care mailers, educational materials, newsletters, renewal reminder notices, etc.

2. **Offering customer service for personal inquiries and complaints is a simple but important way to help safety net users navigate the health delivery system.** Similarly, health insurance exchanges will be required to maintain a call center for customer service under the new health reform law.

3. **Participation fees should be both predictable and affordable to reduce anxiety about the cost of care and to provide incentives for appropriate utilization of primary and preventive health care services.** The fee structure should be within recognized health care affordability standards, and it should be evaluated regularly to ensure individual contributions do not impede access to care for the near-poor population.

4. **A single, streamlined eligibility determination and enrollment system for multiple health programs simplifies the screening and enrollment process, maximizes access to public funding streams and creates a comprehensive database for planning and evaluation.** This is also a stated goal of the reform legislation.

Delivery system reform

5. **Although insurance coverage is preferable, an access model provides an affordable alternative to health insurance and allows counties to continue to leverage state and federal funds to support the uninsured.**

6. **Assigning participants to a primary care medical home reduces duplication and improves care coordination.** As opposed to a crisis delivery approach, the medical home model provides a more appropriate setting for delivering routine primary and preventive care services, managing chronic conditions and coordinating access to care across providers and service settings.

7. **Cooperation between public and private providers maximizes available resources to care for the uninsured.** To start, communities should integrate existing public and non-profit/private providers serving the safety net population into a coordinated health network. Bringing relevant entities, including public hospitals and clinics, community-based groups, charitable hospitals, physicians organizations and others, into the program's planning process increases buy-in.

8. **An organized health delivery system provides a better framework for monitoring patterns of care and identifying opportunities for improving access and quality.** To assess areas for clinical and administrative improvement, safety net programs should examine utilization patterns, access and clinical data for participants and compare performance to recognized quality standards.

Coverage expansion

9. **Through a shared responsibility approach, communities can achieve a sustainable funding base for expanding access to care.**

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

National health care reform presents a tremendous opportunity to re-envision local health care delivery to better serve low-income individuals who will remain uninsured or underinsured after implementation of the new law. The San Francisco experience offers important lessons for how that might be achieved. By creating well-structured safety net systems that complement public and private expansions of health insurance coverage, truly then would all Americans have access to affordable, quality care.

# APPENDIX:

# LIST OF INTERVIEWEES

Lindsey Angelats, Senior Health Care Program Planner, San Francisco Department of Public Health

Tangerine Brigham, Director of Healthy San Francisco, San Francisco Department of Public Health

Danice Cook, Health Program Planner, San Francisco Department of Public Health

Catherine Dodd, Interim Director, San Francisco Health Service System

William Dow, Associate Professor of Health Economics, University of California, Berkeley

Jean Fraser, Chief, San Mateo County Health Systems (formerly CEO, San Francisco Health Plan)

Rafael Gomez, Manager of Programs and Access Initiatives, San Francisco Health Plan

Ken Jacobs, Chair, UC Berkeley Labor Center

Mitchell Katz, Director of Health, San Francisco Department of Public Health

Rachel Metz, Coverage Initiative Administrator, Alameda County Health Care Services Agency

Allen Meyer, Vice President of Programs, San Francisco Community Clinic Consortium

Catherine Moller Spaulding, City Performance Deputy Director, San Francisco Controller's Office

Nalini Pande, Senior Director of Strategic Partnerships, National Quality Forum (formerly Senior Manager, The Lewin Group)

Jim Soos, Assistant Director of Policy and Planning, San Francisco Department of Public Health

Melissa Stafford Jones, President & CEO, California Association of Public Hospitals & Health Systems

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