Healthcare Reform With a Safety Net: Lessons From San Francisco

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Public hospital safety net systems face constant financial constraints, hindering their ability to provide adequate healthcare services. Many healthcare reform proposals would further weaken these systems by redirecting current safety net resources toward private insurance. Despite or perhaps because of this challenging environment, many successes in improving care for poor and vulnerable populations have been pioneered in safety net systems. San Francisco, California, is implementing several innovative programs to strengthen the financial viability of its healthcare safety net while also attempting to improve the access to and the quality of healthcare services.

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San Francisco's Healthcare Safety Net

San Francisco, California, is implementing several innovative programs to strengthen the financial viability of its healthcare safety net while also attempting to improve the access to and the quality of healthcare services (Table). San Francisco's healthcare safety net is composed largely of 2 networks, namely, the San Francisco Department of Public Health's Community Health Network and the San Francisco Community Clinic Consortium. Combined, they care for more than 150,000 patients per year, including most of the city's 73,000 uninsured residents.[1-3] The Community Health Network includes an acute care hospital (San Francisco General Hospital) with on-site primary and specialty care clinics, as well as 11 community-based primary care clinics. The San Francisco Community Clinic Consortium is a private not-for-profit partnership of 10 nonprofit primary care community health centers. Providers in these clinics rely on San Francisco General Hospital for a significant portion of their specialty referrals and inpatient care. All of the clinics have access to the San Francisco Department of Public Health's electronic health information system to assist in shared patient care.

The San Francisco Health Plan: Catalyst for Change

The San Francisco Health Plan, the local Medicaid managed care plan, has been a catalyst for health insurance expansions and quality improvement in San Francisco's healthcare safety net. One early example was the creation of the *Healthy Workers* program. *Healthy Workers* provides health insurance for workers who provide In-Home Supportive Services to nursing home–eligible Medicaid beneficiaries. The San Francisco Department of Public Health uses local government funds to provide 60% of the cost of these workers' insurance through the San Francisco Health Plan, with the remaining 40% coming from federal matching funds as a part of the cost of providing Medicaid-sponsored In-Home Supportive Services.

The provider group for this insurance is limited to the public providers in the San Francisco Department of Public Health's Community Health Network, including those at San Francisco General Hospital. Therefore, the program provides health insurance to a previously uninsured group and brings millions of US dollars a year to support San Francisco General Hospital and its af-

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San Francisco's experience has shown that healthcare safety nets can serve as laboratories for change.

- The local Medicaid managed care plan has been a catalyst for health insurance expansions and quality improvement in the healthcare safety net.
- Public delivery systems, like capitated health maintenance organizations, can develop innovative care strategies such as electronic referral and chronic care teams with financial subsidies that are not tied to specific visits.
- San Francisco is implementing a pay or play employer mandate that maintains the employer-based insurance system while supporting the healthcare safety net as an alternative provider.

filiated clinics. This strategy of expanding access to care in concert with strengthening the resources of the healthcare safety net informed the approach that is now being used in a subsequent citywide project, Healthy San Francisco, which is described herein.

eReferral

The San Francisco Health Plan has also stimulated quality improvement in San Francisco's healthcare safety net by providing technical assistance and grants for innovative programs. For example, the plan was an early supporter of eReferral, a Web-based system developed at San Francisco General Hospital for managing requests for ambulatory specialty consultation. This innovative system permits referring clinicians to electronically submit specialty consultation requests that are reviewed online within 48 to 72 hours by a designated specialty clinician who responds to the request by replying to the referring clinician or by scheduling the patient for a regular or urgent specialty clinic appointment. In 2007, there were approximately 6500 eReferrals submitted to 12 specialty clinics at San Francisco General Hospital by 744 different referring providers.

One benefit of eReferral is that it allows systematic allocation of ambulatory specialty care services on the basis of need as judged by the specialist reviewers, who through the process come to understand the total population needs for the services. Demand for specialty visits can be reduced by providing referring physicians with an opportunity to obtain electronic communications from a specialist, which may enable them to care for the patient in their own setting. During 2007, approximately 25% of medical specialty and 20% of surgical specialty eReferral requests were never scheduled because the specialist alternatively recommended a primary care–based treatment plan. The specialist can also guide the referring provider's preconsultation evaluation and management, so that specialty clinic appointments are used optimally. This can lower the number of unneeded specialty visits by ensuring that critical information (such as the reason for the referral or the results of diagnostic tests) is included in the request for consultation.

The eReferral process also permits specialist reviewers to identify patients who are in need of more immediate care. Specialists who review the eReferrals can move higher-urgency patients to the front of the clinic waiting line by overbooking them into earlier clinic sessions.

Public hospitals, like capitated health maintenance organizations, have financial subsidies that are not tied to specific visits. Directing some of San Francisco General Hospital's specialty care financial support from the San Francisco Department of Public Health toward the actual referral process, not just the performance of the referred consultations, may be a more efficient way to meet the specialty needs of the patient population.

Chronic Care Teams: Leveraging Federally Qualified Health Centers

A second strategy being used to improve the delivery of specialty care services in San Francisco's healthcare safety net is to incorporate specialty physicians and nurse practitioners into chronic care management teams within high-volume primary care sites based at San Francisco General Hospital. Specialists are available on-site for complicated management decisions through direct patient visits and as back-up to other providers. In addition, a team of nurse practitioners with didactic and experiential training in the management of specific chronic diseases is available to provide more intensive interventions than are often feasible by primary care providers, particularly in circumstances where the patient needs frequent visits and the primary care provider is unable to provide them or needs assistance. Nurse practitioners are also able to implement other aspects of the chronic care model, such as supporting patient self-management and using population-based management tools. Having the entire healthcare team in the same clinic simplifies communication for providers and logistics for patients, who no longer need to travel between multiple clinics at multiple locations.

Introduction of this model into primary care clinics at San Francisco General Hospital that are federally qualified health centers (FQHCs) should enhance financial support for specialty care services. Federally qualified health centers are eligible for certain benefits, including enhanced Medicaid reimbursement for services. Although FQHCs traditionally have had a primary care–focused mission, bringing specialty care to these clinics is not entirely new to San Francisco's healthcare safety net. Northeast Medical Services, a San

Table. San Francisco's Healthcare Safety Net Strategies

Variable	Patient Benefits	Safety Net Benefits
Increase access to care		
• *Healthy Workers*	More people with health insurance coverage	Source of low-income patients with health insurance coverage
• *Healthy San Francisco*	Medical home for the uninsured	Increased financial support for care coordination
Improve coordination of care		
• eReferral	Reduced waiting times for specialty visits	More efficient use of resources
• Chronic care teams	Improved coordination of care and reduced administrative barriers to multiple providers	Improved reimbursement for specialty care

Francisco Community Clinic Consortium partner clinic with FQHC status, has organized the delivery of specialty services this way and has received enhanced Medicaid reimbursement for these services for several years.

The San Francisco Department of Public Health is implementing 5 primary care and specialty care collaboration projects in clinics based at San Francisco General Hospital in the areas of diabetes, heart failure, asthma and chronic obstructive pulmonary disease, back pain, and mental health. In addition to bringing specialist physicians into the primary care setting, the primary care and specialty care collaboration projects involve a combination of individual patient care, group care, and population-based medicine (registries, encouragement of referrals for patients with high-risk criteria, and clinical strategies designed to improve outcomes for the entire population with a given condition). As these projects evolve, increased collaboration is planned across the projects to improve care for patients with multiple diagnoses and to expand to other primary care clinics in the community.

Health Care Security Ordinance

Although San Francisco is actively pursuing approaches to ensure that the delivery of healthcare services in the safety net is of higher quality, more efficient, and better aligned with available funding, there ultimately needs to be a means to slow the demand for services from a growing number of uninsured residents and to infuse more resources into the system if it is to remain viable. To that end, the San Francisco Board of Supervisors in August 2006 passed the Health Care Security Ordinance.[4] The ordinance imposes what is called an Employer Spending Requirement on all employers with more than 20 employees who operate in San Francisco. These employers must spend a minimum amount of money, set forth in the ordinance, on healthcare services for each San Francisco employee. In 2008, employers with 20 to 99 employees were required to spend a minimum of $1.17 per hour (approximately $2400 per year), while those with 100 or more employees were required to spend $1.76 per hour (approximately $3600 per year). These amounts were scheduled to increase slightly in 2009.

Other employer pay or play efforts generally take money away from safety net hospitals to finance private insurance.[5] In contrast, the Health Care Security Ordinance maintains the employer-based insurance system while supporting the safety net as an alternative provider of care.

Employers who do not provide health insurance or other healthcare benefits and who meet the minimum spending limits may satisfy their healthcare spending obligation by contributing the required amount to the safety net through a newly created program called *Healthy San Francisco*. The program promises every uninsured person in San Francisco a medical home and access to a broad range of medical services at affordable prices. The network consists almost exclusively of healthcare safety net providers, with hospital and emergency services being covered only when provided at San Francisco General Hospital. Therefore, the Employer Spending Requirement has become a source of additional funds for the San Francisco healthcare safety net system. With this design, it is expected that the Employer Spending Requirement will keep the number of uninsured San Francisco employees from increasing, while providing funds to San Francisco's healthcare safety net to care for uninsured residents. Employers who do not contribute to their employees' health benefits at the required spending levels are subject to fines in excess of the amounts they would have had to pay for health benefits.

In addition to bringing new funds from employers, *Healthy San Francisco* can help San Francisco General Hospital and the healthcare safety net in other ways. First, the program should increase revenue by getting more patients into publicly supported insurance programs. With *Healthy San Francisco*, each uninsured person in San Francisco must undergo computer-based screening to determine if he or she might be eligible for

a federally or state-funded program (such as Medicaid) before enrollment in *Healthy San Francisco*. By creating an enrollment system that integrates the necessary information for the major public insurance options, more people should become enrolled in Medicaid and other publicly financed programs. This provides a benefit to the uninsured, while increasing federal and state healthcare US dollars for the San Francisco Department of Health and other healthcare safety net providers.

Second, the program requires all enrollees to choose a medical home. A person who does not qualify for state or federal programs must enroll in *Healthy San Francisco* if he or she does not want to pay full charges for services. As part of that enrollment, he or she must select a medical home clinic.

Before implementation of *Healthy San Francisco*, patients were free to go to any clinic for services, with some patients receiving care from multiple sites within and outside of the San Francisco Department of Public Health. Although there had been previous efforts to assign patients to clinics, there were no clear benefits in doing so and no consequences for failing to do so. Therefore, a clinic at which a patient presented had no incentive to redirect the individual to the previously assigned clinic.

The lack of a consistent enforceable primary care site assignment had numerous negative consequences. Services were duplicated, worsening already distressingly long waiting times. Patients' compliance with treatment was difficult to monitor. The health of some patients was almost certainly compromised by their receiving diagnoses, prescriptions, and treatment regimens from multiple providers.

Perhaps a more insidious consequence was the difficulty in making providers or clinics perceive themselves responsible for the quality or efficiency of care provided to their assigned patients. Because of the potential for multiple providers to be involved in the care of a patient, it was hard to develop, institutionalize, and monitor programs to assure that patients were getting the right treatment at the right time. In addition, the lack of complete service data undercut efforts to set benchmarks and make quality or efficiency comparisons among clinics and providers, thereby eliminating a powerful motivator for behavior change among clinicians. In 2009, there were 38,000 patients enrolled in the *Healthy San Francisco* program.[6] Once the program is fully subscribed, more rational and effective healthcare planning may be performed based on the service data that all *Healthy San Francisco* providers must submit. The long-standing investment in the development of a shared information system with centralized support has minimized the administrative burden for this reporting among healthcare safety net providers.

Conclusions

The challenges facing the US healthcare system are being manifest most acutely at urban safety net hospitals and healthcare systems. Therefore, some of the most innovative projects are being implemented in these systems as committed providers and administrators respond to the pressure. Urban safety net hospitals and their safety net partners should not be seen as relics of the past doomed to an obsolescence that should be hastened by healthcare reform. San Francisco's experience has shown that, when public policy leaders support these institutions and give them flexibility, urban safety net hospitals can serve as laboratories for change. Evaluations of these policies and programs are under way. Results from these studies, including patient and provider satisfaction surveys and safety net healthcare utilization patterns and costs, will be relevant for determining the sustainability of these programs in San Francisco, as well as their applicability to other public delivery systems and private nonprofit institutions that serve a wider range of clients.

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REFERENCES

1. California Health Interview Survey. March 2005. http://www.chis.ucla.edu/. Accessed September 5, 2008.

2. San Francisco Department of Public Health. Annual report: fiscal year 2004-2005. http://www.sfdph.org/dph/files/reports/PolicyProcOfc/2004-05AnnlRpt/FnlAnnlRpt2005n01.pdf. Accessed April 6, 2009.

3. San Francisco Community Clinic Consortium. Annual report 2005. http://www.sfccc.org/resource/AR2005.pdf. Accessed April 6, 2009.

4. City and County of San Francisco. Health care security ordinance., administrative code chapter 14. http://www.municode.com/content/4201/14131/HTML/ch014.html. Accessed May 6, 2008.

5. Nardin R, Himmelstein D, Woolhandler S. Massachusetts' plan: a failed model for health care reform. http://www.pnhp.org/mass_report/mass_report_Final.pdf. Accessed April 6, 2009.

6. Healthy San Francisco. Program stats. March 29, 2009. http://www.healthysanfrancisco.org/about_us/Stats.aspx##. Accessed April 6, 2009. ■