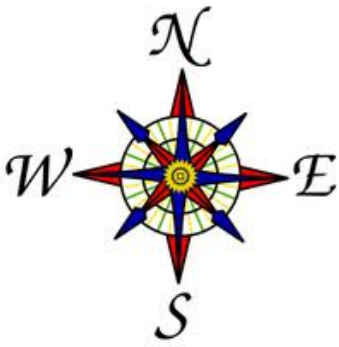
San Diegans for Healthcare Coverage
A Coalition for Health

San Diego Roadmap to Coverage and Care

Planning for Success under Health Reform



Task Force Report and Recommendations

June 23, 2011

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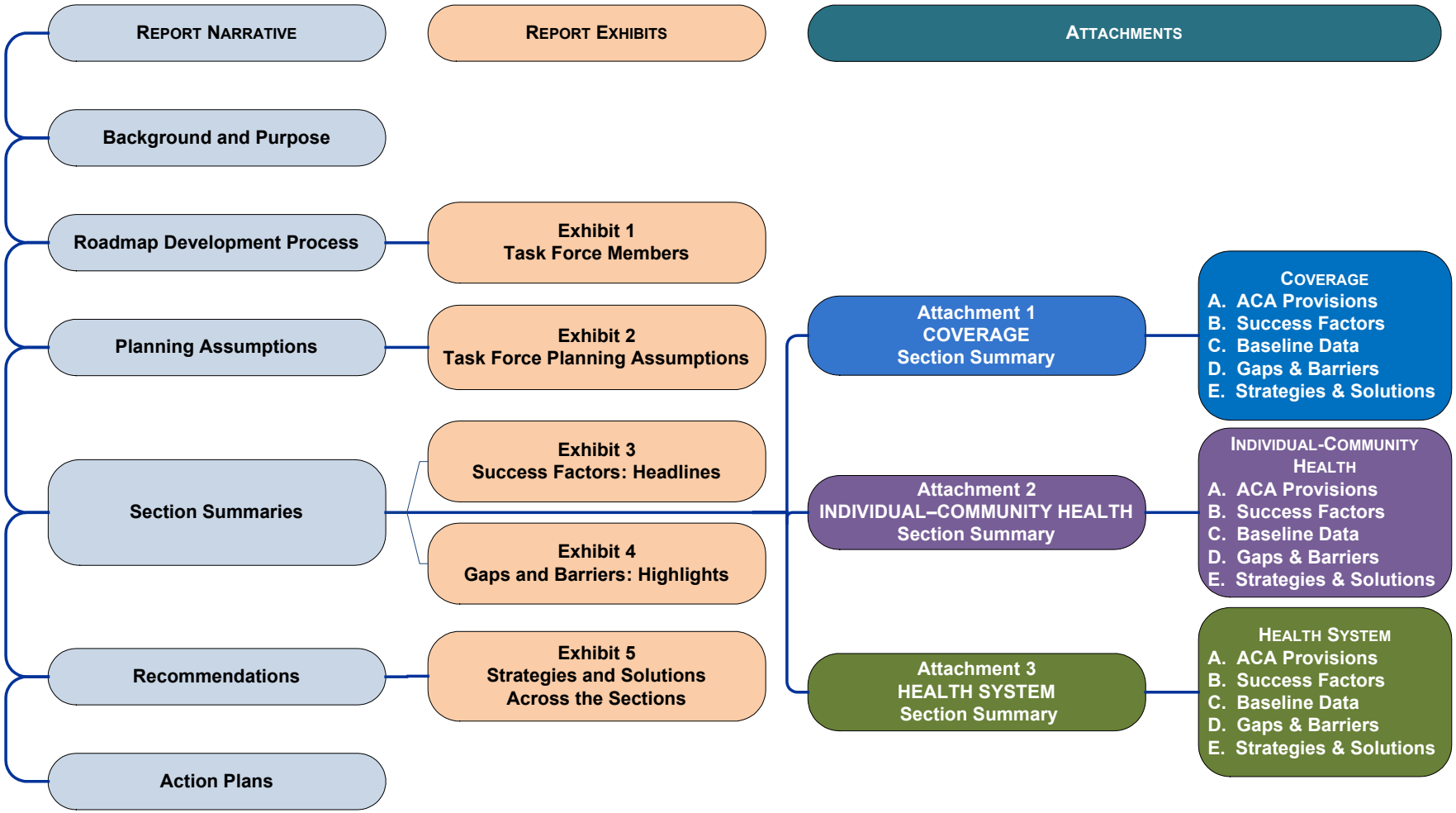


SAN DIEGANS FOR HEALTHCARE COVERAGE
A COALITION FOR HEALTH

San Diego Roadmap to Coverage and Care
Planning for Success under Health Reform
Task Force Report and Recommendations
June 23, 2011

This Report summarizes the work of the San Diego Roadmap to Coverage and Care Task Force, charged with collaborative planning for successful implementation of health reform in the region. This document incorporates input from the San Diegans for Healthcare Coverage (SDHCC) coalition, local constituency leaders and community groups to the draft Task Force report published in March 2011; input addresses both the relative importance and feasibility of key recommendations identified by the Task Force, as well as leaders, participants and strategies essential to their implementation.

Background and Purpose

Background

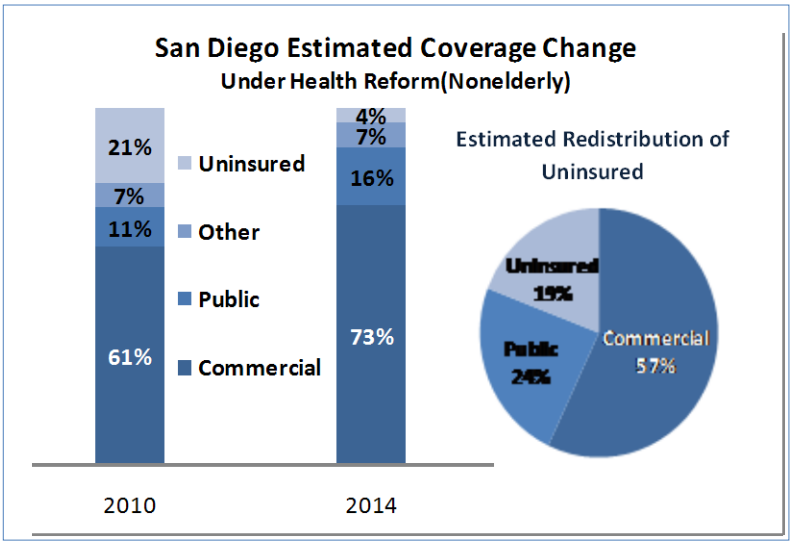
The Patient Protection and Affordable Care Act of 2010 (ACA) provides new opportunities to expand coverage and care and improve the health of all San Diegans. Passage of the ACA and the availability of coverage alone do not assure access to care and health improvements. The San Diegans for Healthcare Coverage Board and Coalition recognized that we cannot successfully maximize coverage and provide access to care for all San Diegans without a clear plan of action do so. Achieving success will require the San Diego community to work collaboratively to implement health reform and to ensure that the resources are in place to enroll and to care for the newly insured, while focusing on improving health outcomes and reducing costs.

The overarching goal of the ACA is to expand access to affordable coverage and access to care to all Americans, while working to improve health status and outcomes, make the healthcare system more efficient and reduce costs. Currently, one in five non-elderly San Diegans go without healthcare coverage. The number of under-insured, those with high deductibles and co-payments documented to be a barrier to recommended care, continues to increase as businesses and individuals struggle with double digit premium increases.

Table 1 summarizes the estimated impact on coverage in San Diego from 2010 to 2014, with implementation of the ACA. It is estimated that the ACA has the potential to dramatically expand coverage and reduce the nonelderly uninsured rate in San Diego from close to 21% to 4% or less.

These estimates assume that approximately 57% of the *currently uninsured* would enroll in private coverage with most eligible for premium assistance through the Health Insurance Exchange, 24% would enroll in public coverage, and 19% would remain uninsured (based on current ACA assumptions).

Table 1



According to a January 2011 article published in Health Affairs, the authors estimated that 96% of Californians would have healthcare coverage by 2016 and that San Diego would experience the largest decrease in the percent of uninsured in the State.

Health reform will have a positive economic impact on San Diego. Using the estimated increase in San Diego insured, and conservative financial assumptions regarding healthcare funding related to new coverage, *Table 2* provides a relatively conservative San Diego economic impact perspective of coverage expansion.

Table 2

Coverage Type	Estimated Redistribu-tion of Uninsured	Incremental Economic Impacts		
		Direct Funds ($000)[1]	Business Activity ($000)[2]	Jobs[2]
Private	347,752	$ 1,367,457	$ 3,445,992	27,130
Public	145,202	$ 298,432	$ 752,048	5,921
Uninsured	117,138	-	-	-
Total	610,092	$ 1,665,889	$ 4,198,040	33,051

[1] Private premiums/spending to 80% of premiums (melded to $328)

[1] Public premiums/spending at average of $150/mo

[2] Business Activity/Jobs estimated using Families USA Economic Calculator

An econometric model developed by Families USA was used to make these economic impact estimates. Based on incremental revenue assumptions, covering San Diego's uninsured would conservatively yield more than $1.6 billion in new annual direct funding to the region, representing estimated annual business activity of close to $4.2 billion and close to 33,000 new jobs.

Maximizing the potential of health reform for all San Diegans, and ensuring adequate resources to provide access to coverage and to care, will be extremely challenging. These estimates of potential coverage expansion amplify the need to identify the barriers and develop strategies to maximize the possibilities for our region.

Purpose

The purpose of this Report is to provide a San Diego Roadmap for working to successfully implement and maximize the benefits of the ACA to the region. The Report identifies key recommendations, implementation leaders and participants and a process for monitoring progress and impacts. It is intended to be a living document.

The San Diegans for Healthcare Coverage (SDHCC) Task Force on the *Roadmap to Coverage and Care* was formed to identify strategies and recommendations to maximize healthcare coverage, access to care and funding to the San Diego region, to address local planning to facilitate the smooth transition and implementation of regulations, policies and programs under health reforms, and to identify strategies to assist our communities with navigating health reform implementation. The Task Force charge included, identifying:

- Optimal success factors/imperatives for maximizing health coverage and care
- Potential gaps and barriers to achieving imperatives and success factors
- Current status, programs and activities related to success factors
- Recommendations and strategies and solutions for overcoming gaps and barriers to maximize success

An initial draft *Report* was published in March 2011 to communicate the work of the Task Force and the strategies and solutions identified and to seek input from constituency groups. This document incorporates that input.

Roadmap Development Process

The Task Force was formed in late 2009, and includes representatives from a broad range of key constituency groups (***Exhibit 1***). For over a year, the Task Force held regular meetings. We want to thank the Task Force members who dedicated hundreds of hours, both at meetings and between meetings, working on this effort. The report, recommendations and community ownership would not have been possible without their dedication and commitment.

From the start, the Task Force identified a number of information needs and activity steps necessary to proceed. ACA provisions and potential impacts on the San Diego region were researched, summarized, presented to and reviewed with the Task Force. Imperatives and success factors were developed to reflect the best case scenario for San Diego. Metrics were established to identify progress towards achieving success (how to know if we are making progress). The Task Force then held a number of brainstorming sessions to identify the Gaps and Barriers to achieving success, followed by many sessions to identify Strategies and Solutions to overcome Gaps and Barriers.

A draft Task Force report was published in March 2011 and subsequently presented to constituency and community groups. In June 2011, a coalition and community forum was held to secure input into the report and finalize recommendations, as well as to identify the relative importance and feasibility of each recommendation and a clear path forward by defining leadership, participation and key elements essential to implementation.

Planning Assumptions

The Task Force began its work before passage of the Patient Protection and Affordable Care Act of 2010 (ACA); therefore, due the uncertainties regarding the ACA, the underlying Task Force scope and planning assumptions were in a state of flux and revision until passage. A consistent set of assumptions within a constantly shifting healthcare environment was challenging, but essential, to Task Force focus and progress. The Task Force Planning Assumptions (***Exhibit 2***) provide the fundamental understandings that guided the Task Force in its efforts.

While there is ongoing judicial review and continued congressional activity surrounding the ACA, federal, state, and local governments, as well as healthcare providers, business and consumers are operating under the assumption that the law's fundamental provisions and timelines will remain substantially unchanged. Accordingly, SDHCC and its coalition is forging ahead in order to ensure that San Diego is well positioned to maximize the benefits and opportunities afforded by the ACA to our region.

Section Summaries

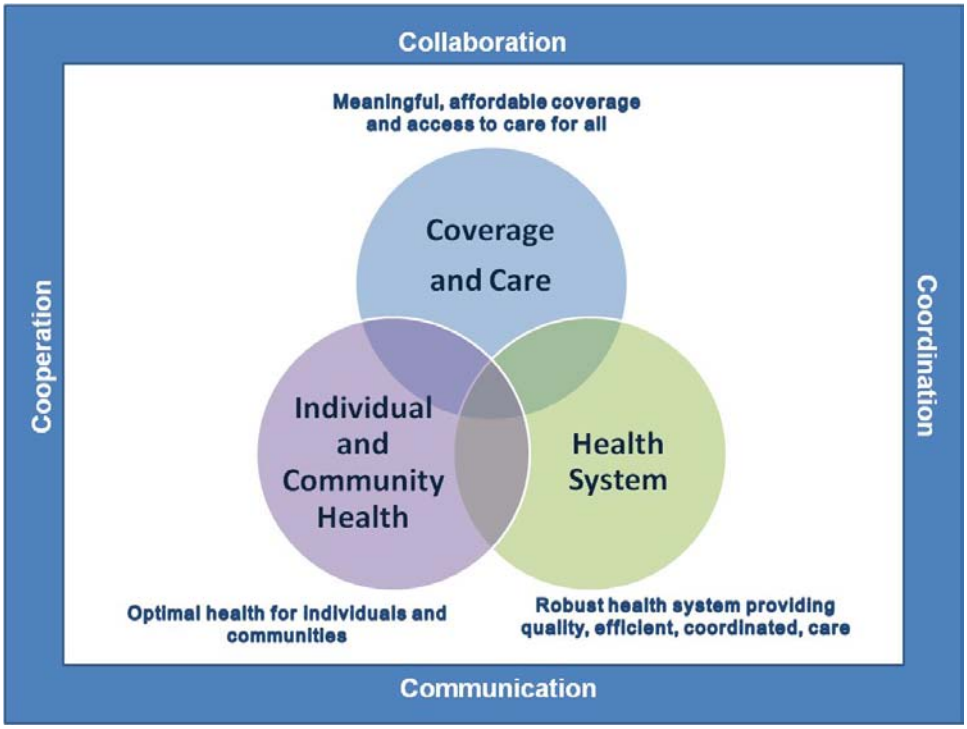
After reviewing the ACA and potential impacts, the Task Force determined that efforts would best be focused and organized into three (3) broad Sections:

- Coverage and Care
- Individual and Community Health
- Health System

The ACA addresses a great deal more than expansion of healthcare coverage and insurance reforms. ACA provisions address quality and efficiency within the healthcare system, new models of care and payment, community and workplace health initiatives, coordination of care and alternative level of care pilots and other pilots.

As depicted in **Table 3**, all of these provisions are synergistic and ultimately focus on improving access to care and health status while slowing the growth in healthcare costs through collaboration, coordination and improved outcomes.

Table 3
A Healthy Future for San Diego



As work progressed, it became clear that the strategies and solutions for each of these broad Sections fell naturally into five (5) Categories:

- Communication (information and strategies)
- Resources and Funding
- Systems Change
- Information Technology
- Policy and Advocacy

The Strategies and Solutions were further summarized across both Sections and Categories to identify overlaps and common themes, and to establish an overall Planning Framework to communicate and guide continued work.

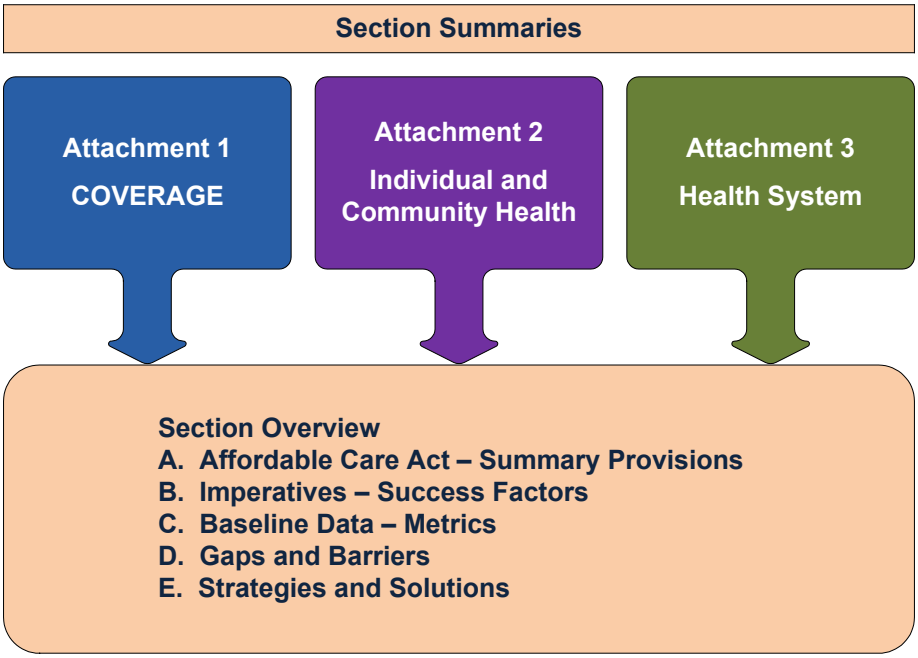
The Task Force reviewed the ACA, developed imperatives and success factors, identified gaps and barriers to achieving success and then developed strategies and solutions for overcoming the gaps and barriers; this process focused on each of the broad Sections in turn – Coverage, Individual and Community Health, and Health System.

A high level summary of the Imperatives and Success Factors adopted by the Task Force are provided in ***Exhibit 3***. Similarly, a summary of key gaps and barriers are provided in ***Exhibit 4***.

The issues of cost, affordability and funding are extremely important and cross-cutting; therefore, the Task Force determined that these issues should be incorporated into each section. The results of Task Force brainstorming sessions were quite extensive and detailed; the information included in this Framework Report summarizes those results. Appendices with the detailed work of the Task Force will be made available on the SDHCC website.

As outlined in ***Table 4,*** each Section Summary (Attachment) includes a compilation of information and data, as well as the Task Force efforts, related to that Section's area of focus.

Table 4



Recommendations

While the Task Force focused on each Section in turn, as work progressed it became increasingly evident that there were overlaps and interdependencies between these broad Sections. The Task Force spent many meetings and hours brainstorming strategies and solutions to overcoming the gaps and barriers identified. No limitations were placed on the difficulty, feasibility or the number of solutions identified during this process; as a result, hundreds of potential strategies and solutions were identified. This large list of strategies and solutions was summarized into five categories by Section to make them more manageable, and then summarized further for this report.

The *Strategies and Solutions Framework: Across the Sections* (***Exhibit 3***) arrays key strategies and solutions by Sections and Categories to clearly display overlaps and common efforts, as well as to establish an overall planning framework for moving forward.

The Framework was utilized to further develop and transform the strategies and solutions into overarching Recommendations. ***Table 5****,* on the following page, summarizes the Roadmap Recommendations emerging from these efforts.

Table 5

Summary of Recommendations by Section

Coverage and Care: *Meaningful, affordable coverage and access to care for all*

- Establish a REGIONAL COMMUNICATIONS COLLABORATIVE AND STRATEGIES to disseminate clear unbiased information through trusted sources across sectors and communities to maximize successful implementation of health reform
- Pursue establishment of a LOCAL NAVIGATOR to conduct education, outreach, and provide unbiased information and assistance with enrollment to diverse San Diego businesses and individuals; healthcare and relationships are local, and local targeted efforts are essential to maximizing the potential and success of health reform in the region (SDHCC pursuing Navigator designation)
- Pursue ADEQUATE ELIGIBILITY AND ENROLLMENT RESOURCES AND SIMPLIFIED PROCESSES and information systems to successfully inform, enroll and retain those eligible for coverage
- Pursue expanded LOCAL CONSUMER ADVOCACY CENTER support to assist with accurate policy interpretation, denials, access and dispute resolution in an efficient, timely and culturally competent manner

Individual and Community Health: *Optimal health for individuals and communities*

- Establish a REGIONAL COMMUNICATIONS COLLABORATIVE AND STRATEGIES to disseminate clear unbiased health improvement information through trusted sources across sectors and communities
- Implement COMMUNITY HEALTH AND WORKPLACE WELLNESS PROGRAMS based on proven strategies to promote healthy behaviors and establish a community-wide "*culture of health"*

Health System*: Robust health system providing quality, efficient coordinated care*

- Pursue improved QUALITY, EFFICIENCY AND COORDINATION OF CARE ACROSS THE HEALTH SYSTEM through continuous, targeted, and collaborative efforts to improve outcomes and reduce costs
- Pursue provider and payer ADOPTION OF A PATIENT CENTERED MEDICAL HOME (PCMH) MODEL that embraces a physician-led, team approach to care, integration of behavioral health, and evidence-based care and health improvement strategies to expand physician capacity, reduce health disparities, improve health outcomes and lower costs
- Pursue HEALTH INFORMATION TECHNOLOGY AND COLLABORATION across the health system to achieve integrated healthcare delivery, improved outcomes, cost effectiveness, and personal responsibility
- Adopt, monitor and report PERFORMANCE METRICS AND MEASURES to allow for course changes and to measure progress and the effects of health reform and implementation strategies

Cross Cutting: Pursue COLLABORATIVE ADVOCACY across sectors to maximize collective influence in addressing local, state and federal issues related to health coverage, care, incentives and resources

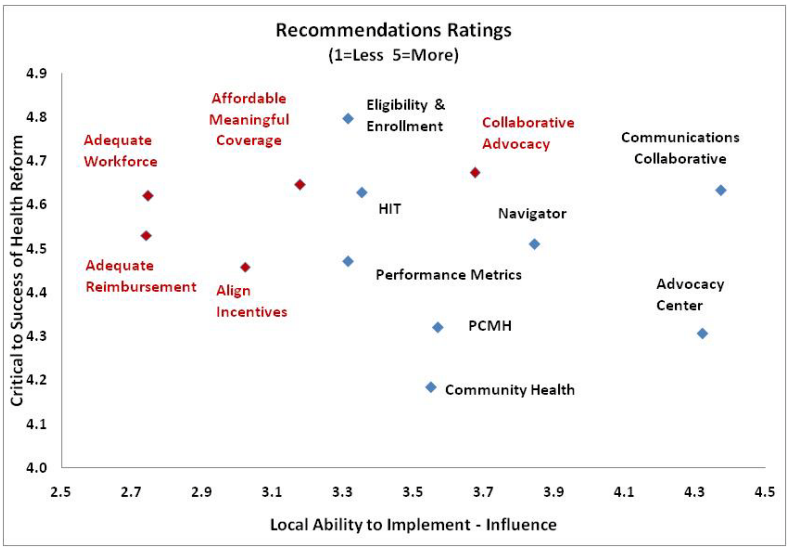
- Implementation of all ROADMAP RECOMMENDATIONS
- AFFORDABLE, MEANINGFUL HEALTH COVERAGE that assures access to care and incentivizes appropriate behaviors, while controlling costs, is crucial to the short- and long-term success of health reforms
- Strategies to INCREASE THE PHYSICIAN AND HEALTH PROFESSIONS WORKFORCE are needed to address current shortages and access limitations, and to meet the future healthcare needs of all San Diego communities
- APPROPRIATE AND EQUITABLE REIMBURSEMENT to San Diego providers and adequate funding for essential resources, including the healthcare safety net, are critical to the success of health reform; without these investments, the potential success of health reform is jeopardized
- ALIGN INCENTIVES AND DISINCENTIVES WITH GOALS AND DESIRED OUTCOMES for individuals, business, providers and communities (e.g., workplace wellness, healthy behaviors, health education, healthy options)

Action Plans

After presentation and discussion of the Report and recommendations, more than 40 local constituency leaders were asked to rate: 1) How critical is each recommendation to successful implementation of health reform; and, 2) Our local ability to implement or influence implementation of the recommendation.

Table 6 summarizes combined Task Force and constituency leader ratings; the chart clearly demonstrates that the Task Force successfully identified recommendations felt to be critical to maximizing the opportunity afforded by health reform to improve the health of our community through coverage and systems change.

Table 6



As the chart clearly demonstrates, local leaders are most skeptical about our local ability to influence those recommendations that require advocacy and over which there is little local control (e.g., meaningful coverage, adequate reimbursement). One additional recommendation was added as a result of constituency input: *Pursue improved QUALITY, EFFICIENCY AND COORDINATION OF CARE ACROSS THE HEALTH SYSTEM through continuous, targeted, and collaborative efforts to improve outcomes and reduce costs.* Several strategies and solutions related to this recommendation were identified during the Task Force process.

Through self-identification of constituency leader roles in implementation of recommendations, as well as individual meetings and discussions, recommendation leaders, partners, participants and working forums were identified. To the extent possible, existing forums were identified to avoid duplication. It should be noted that some efforts are new, but there are many related activities underway. For example, the Beacon Collaborative involves all San Diego health systems and community clinics, the county and medical society in pursuing a health information exchange (HIE) for the region. The Hospital Association intends to take a leadership role (ownership) of specific recommendations and strategies from the Roadmap through its non-profit subsidiary.

Table 7 summarizes the Recommendations and identifies the Leaders, Partners, Participants and working forums associated with them. Leaders will work with SDHCC to refine the measures and metrics associated with each recommendation and a regular process of reporting them; SDHCC, in turn, will provide status reports to the coalition and the community.

The Roadmap is one key step on the path to using the opportunity afforded by health reform to improve coverage and access to care, efficiency, quality and the health status of all San Diegans. If all recommendations are pursued and advanced, we will have made great strides towards achieving that goal.

Table 7

San Diego Roadmap to Coverage and Care: *Planning for Success under Health Reform*

Implementing Recommendations: Leaders – Partners – Forums

Recommendations	Leader(s) *Convener/Primary Lead*	Partners *Steering/ Planning/ Implementation*	Involved *Planning/ Implementation*	Working Forum(s)
1. Regional Communications Collaborative and Strategies	SDHCC	CCHEA HHSA 2-1-1 CHIP SDOP	Provider Associations Business Associations CBOs Health Plans	Commun Collaborative Navigator Workgroup
2. Local Navigator (Linked to Exchange)				
3. Adequate Eligibility and Enrollment Resources – Simplified Processes	HHSA CCHEA	SDHCC HASDIC 211 CCC Health Plans	Business Associations CBOs	Enrollment Workgroup
4. Local Consumer Advocacy Center	CCHEA	SDHCC HHSA	Provider Associations Business Associations	CCHEA HCA Consortium
5. Community Health & Workplace Wellness	HHSA CHIP	Price Charities Business Associations HASDIC Health Plans	SDHCC Coalition Schools (K-12)	Healthy Works CHIP Workgroups CPPW Steering
6. Improving Quality, Efficiency and Coordination of Care	HASDIC CCC SDCMS	HHSA Health Plans	Providers Beacon Collaborative	PRN/Patient Safety First Beacon QI Committee (Cty)
7. Patient Centered Medical Home (PCMH) Payer and Provider Adoption	CCC SDCMS	HHSA	Health Plans	Workgroup
8. Health Information Technology and Collaboration	Beacon Collaborative LEC HHSA	HASDIC CCC SDCMS Providers	Technology Partners Communications Partners	Beacon Collaborative LEC Workgroup
9. Performance Metrics and Measures	SDHCC	HHSA CHIP CCHEA	HASDIC CCC SDCMS	SDHCC Task Force
10. Collaborative Advocacy Strategies	SDHCC	SDHCC Coalition Members	Legislative Delegation	Workgroup
a. Pursue Support for Recommendations b. Affordable - Meaningful Health Coverage c. Increase the Physician and Health Professions Workforce d. Appropriate & Equitable Reimbursement e. Align incentives with Goals and Desired Outcomes				

See Legend on Page 9

Table 7: Legend

Implementing Recommendations: Leaders-Participants-Forums

Abbreviation	Description
2-1-1	211-San Diego
Beacon Collaborative	Hospital Systems, Clinics, County and Provider Collaboration for a San Diego Health Information Exchange (HIE)
Business Associations	Chambers of Commerce, Industry Associations, Business Improvement Districts and others
CBOs	Community-based organizations
CCC	Council of Community Clinics
CCHEA	Consumer Center for Health Education and Advocacy
CHIP	Community Health Improvement Partners
Communications Partners	Media and Marketing Representatives
CPPW	Communities Putting Prevention To Work
HASDIC	Hospital Association of San Diego and Imperial Counties
HCA	Health Consumer Alliance
Health Plans	Commercial, Medi-Cal and Medicare health plans
Healthy Works	San Diego's CPPW Program
HHSA	County of San Diego, Health and Human Services Agency
LEC	Local Extension Center for Electronic Health Records Implementation in Physician and Clinic Practices
PRN	Preventing Re-hospitalization Network (HASDIC Led)
Provider Associations	SDCMS, CCC, HASDIC, Dental Society, others
Schools (K-12)	Elementary, Middle and High Schools and School Districts
SDCMS	San Diego County Medical Society
SDHCC	San Diegans for Healthcare Coverage and its members
SDOP	San Diego Organizing Project, A PICO Affiliate
Technology Partners	High-tech and communications companies

Exhibit 1

San Diegans for Healthcare Coverage

Roadmap to Coverage and Care

Task Force Members*

Kitty Bailey, Executive Director, San Diego County Medical Society Foundation*

Michael Bardin, Senior Director, Government and Public Affairs, Scripps Health

Karma H. Bass, Vice President, ACCORD Ltd.

James Beaubeaux, COO/CFO, San Diego County Medical Society

Janya Bowman, Assistant Deputy Director, Health and Human Services Agency

Kate Bartkiewicz, Former Director, ICAN at Work, San Diego*

Kristin Garrett, Executive Director, Community Health Improvement Partners

Gabriel Kendall, 2-1-1 San Diego

Michael Nagy, Policy Coordinator, San Diego Regional Chamber of Commerce

Carol Neidenberg, Director of Policy, Training and Development, Consumer Center for Health Education and Advocacy

Hannah Gravette, San Diego Organizing Project

Gary Rotto, Director of Health Policy and Fund Development, San Diego Council of Community Clinics

Sara Steinhoffer, Vice President of Government Relations, Sharp Healthcare

Ann Warren, Chief Government and Provider Relations Officer, Community Health Group

Jan Spencley, Executive Director, San Diegans for Healthcare Coverage

Kamal Muilenburg, Associate Director, San Diegans for Healthcare Coverage

* Members as of December 2010; membership has changed over the course of the Task Force deliberations due to job/role changes.

Exhibit 2

San Diego Roadmap to Coverage and Care Task Force

Planning Assumptions

While there is ongoing judicial review and continued congressional activity surrounding the ACA, federal, state, and local governments, as well as healthcare providers, business and consumers are operating under the assumption that the law's fundamental provisions and timelines will remain substantially unchanged. Accordingly, SDHCC is forging ahead in order to ensure that San Diego is well positioned to take advantage of the benefits afforded by the ACA.

- Federal Health Reform legislation has passed and will require implementing legislation, appropriations and regulations at the national and state levels
- Health care is local. Therefore, San Diegans can best plan for, inform and implement health reform in San Diego
- Gaps and barriers to coverage and care will best be understood and addressed collectively, not individually
- SDHCC planning efforts will help inform our advocacy for transition and implementation at federal, state and local levels
- New public and private coverage options will be established (timing may differ)
- Health plans/insurers requirements will be established (guaranteed issue, rate banding)
- Health plans/insurers will be required to offer plans with standardized benefits
- There will be new pressures for healthcare providers, e.g., care delivery models, health information technology, bundled reimbursement, incentives and disincentives, etc.
- There will be new imperatives impacting how technology is used to support quality, care coordination, continuity, health records, etc.
- There will be individuals/groups/consumers that are new to the system under health reform
- There will be an increased demand for healthcare services under health reform
- There will be mandates for individual coverage
- There will be specific requirements for business contributions to health coverage
- Certain populations will remain uninsured (e.g., undocumented residents, those who choose to remain uninsured)
- Individuals will require information, education and assistance to understand, choose and enroll in their new coverage options
- Businesses, particularly small and medium size business, will require information, education and assistance to understand and choose their new coverage options
- The State of California will continue to have significant financial problems and federal entitlement and discretionary funding will be constrained due to deficit reduction efforts

Exhibit 3

Task Force on San Diego Roadmap to Health Coverage and Care

Imperatives – Success Factors: Headlines

COVERAGE – Access and Maintain Stable Coverage and Care

- All individuals have meaningful, affordable coverage and access to care
- Individuals aware of coverage requirements and options available
- Individuals enroll and maintain coverage and have assistance as needed
- Businesses are aware of coverage requirements and options available
- Businesses enroll in and maintain coverage and have assistance as needed
- Individuals and businesses have assistance with resolving coverage/care issues
- Cost of coverage is affordable, covers benefit levels and is in-line with inflation
- San Diego maximizes all funding sources available for coverage, care, outreach and assistance

INDIVIDUAL AND COMMUNITY HEALTH – Optimal Health Status for Individual and Community Health

- Identified medical home/routine source of care
- Personal responsibility/healthy behaviors
- Health promotion, education, wellness and prevention programs are available, affordable and accessible
- Screening and immunization services are available and accessible
- Improved health outcomes
- San Diego maximizes all funding sources available for individual and community health

HEALTH SYSTEM – Integrated, efficient, quality care

- Adequate number of providers (physicians, hospitals, etc)
- Workforce to meet demand/need
- Capacity/infrastructure to meet needs
- Payment rates are adequate to provide resources/access
- Integrated/coordinated healthcare delivery
- Integrated health information system
- Efficient, quality care and optimal outcomes
- San Diego maximizes all funding sources for health system infrastructure and technology

Exhibit 4

Task Force on San Diego Roadmap to Health Coverage and Care

KEY GAPS AND BARRIERS: HEADLINES

COVERAGE

- Challenges to dissemination of clear, accurate, unbiased information
- Overcoming trust, cultural and perceived value barriers
- Complex eligibility processes, limited resources and systems
- Lack of local influence and resources for assistance and information
- Short and long term affordability and accessibility of coverage

INDIVIDUAL AND COMMUNITY HEALTH

- Challenges to disseminating and raising awareness regarding healthy behaviors, prevention and other factors impacting health status
- Overcoming trust, cultural and perceived value and benefit barriers
- Public and workplace policies do not consistently support adoption of healthy lifestyles
- Lack of access or appropriate use of the health system results in poorer health status and increased costs
- Provider incentives are not always aligned with provision of preventive care, disease management and health education
- Funding for public health services has declined and remains unstable

HEALTH SYSTEM

- Inadequate number of physicians to meet increasing demands and needs
- Low reimbursement rates and payment policies limit provider participation in public programs and health system viability
- Inadequate health professions workforce to meet demand
- Health system is not integrated into public and land use policy as essential “critical infrastructure”
- Lack of clear definition and criteria for integrated and coordinated health care delivery to support efficiency, quality and optimal outcomes
- Slow adoption and lack of health information technology integration

Exhibit 5

San Diegans for Healthcare Coverage Task Force: San Diego Roadmap to Coverage and Care

Strategies and Solutions Framework: Across the Sections

Cat	COVERAGE	INDIVIDUAL AND COMMUNITY HEALTH	HEALTH SYSTEM
Communication and Education	**1. Form a regional communications collaborative and network of community agencies to establish communication channels within diverse communities and sectors**		
	▪ Clearly defined stakeholder benefits ▪ Needs for coverage and care	▪ Clearly defined stakeholder benefits ▪ Need for health home/behaviors	▪ Point of Service communication ▪ Defined/consistent messaging
	2. Develop a communications plan targeted to consumers (individuals, families and business) to address coverage, access, individual and community health, and healthy behaviors.		
	▪ Targeted strategies and tactics for specific groups/populations (language/culture) ▪ Maximize use of electronic/social media		
	▪ Unbiased information on coverage and care ▪ Roll-out well in advance of implementation	▪ Timely information on access and healthy behaviors ▪ Provider messaging resources and tools	▪ Point of Service communication ▪ Provider messaging and tools
	3. Develop and distribute targeted informational materials and tools		
	▪ Coverage options, rights and comparisons ▪ Assistance resources ▪ Targeted to group	▪ Health and healthy behaviors ▪ Medical Home and prevention	▪ Timely , up to date health reform information ▪ Engage/provide consumer education materials ▪ Healthcare system as critical infrastructure
Resources and Funding	**1. Pursue Local Navigator for local unbiased resource , partnerships (SDHCC)**	**1. Promote Workplace Wellness Programs (baseline standards, goals and strategies)**	**1. Support primary care patient centered medical home implementation**
	▪ Coverage options, helpline, assistance ▪ Common provider database/decision trees ▪ Retention program and strategies	▪ Educate business on benefits/incentives ▪ Mitigate barriers (flex hours, comp) ▪ Wellness Program access strategies	▪ Pursue resources to support PCPs ▪ Physician-led care teams
	2. Promote adequate access to local eligibility and enrollment resources	**2. Promote collaboration to maximize health improvement**	**2. Pursue resources to expand provider capacity to meet increased demand**
	▪ Geographically accessible capacity ▪ Telephonic and web based	▪ County Health Strategy with community ▪ Evidence based, proven models	
	3. Promote programs to care for uninsured		**3. Promote inclusion of Coordination of Care measures in health surveys**
			▪ Monitor impacts pre and post health reform
	4. Promote local designated Advocacy Center		
	▪ Assistance with eligibility denials/access ▪ Dispute resolution and grievances		

Exhibit 5

San Diegans for Healthcare Coverage Task Force: San Diego Roadmap to Coverage and Care

Strategies and Solutions Framework: Across the Sections

Cat	COVERAGE	INDIVIDUAL AND COMMUNITY HEALTH	HEALTH SYSTEM
Systems Change	**1. Pursue streamlined eligibility and enrollment processes (Public-Private)**	**1. Identify medical home models with proven health improvement/education strategies**	**1. Encourage integration and coordination of care across continuum**
	▪ One stop-no wrong door ▪ Web-based eligibility and enrollment ▪ Consolidated applications ▪ Self declaration with audit/verification	▪ Demonstrated/proven results ▪ Incorporate into accreditation/monitoring ▪ Incentivize individuals to use medical homes ▪ Provider processes for direct referral and linkage to appropriate medical homes	▪ Efficiency, cost, quality and outcomes ▪ Standardized definitions and evidence based protocols - automated decision support tools ▪ Invest portion of savings in health improvement
	2. Expand on proven projects to increase access to eligibility and enrollment	**2. Support organizations' efforts to adopt a culture of heath promotion and behavior**	**2. Encourage provider adoption of patient centered medical home model**
			▪ Collaboration to meet criteria/integration
		3. Promote use of evidence based public and community health improvement strategies	**3. Pursue collaborative solutions to increase specialty care capacity for clinic patients**
		▪ Maximize impact ▪ Improve return on investment	▪ Centralized FQHC specialty centers ▪ Reimbursement to specialists
			4. Promote physician recruitment and retention strategies to accommodate changing workforce
			▪ Flexible hours ▪ Job sharing -Predictability
Information Technology	**1. Establish local consumer, business and assistor accessible web-sites /systems**		**1. Promote HIT adoption to improve care, coordination, efficiency and outcomes**
	▪ Coverage options and information ▪ Decision making tools Applications (eligibility/enrollment) Electronic verifications		▪ Standardized definitions and interoperability ▪ EHR, HIE, MHealth, Telemedicine ▪ Protocols/decision support ▪ Hospital – medical home referral/linkage
	2. Establish standardized metrics and reporting to monitor effects of health reform		
	▪ Coverage status ▪ Process (enrollment/denials/opt out) ▪ Costs (premium)	▪ Public and community health interventions ▪ Health status , report cards, surveillance ▪ Effectiveness/course corrections	▪ Population to provider ratios ▪ Utilization rates/avoidable conditions
	3. Promote extensive use of proven technology and social media (internet, Texting, YouTube, smart phones, etc)		
	▪ Information dissemination ▪ Status, updates and reminders	▪ Engage individuals in health improvement ▪ Public and community education/prompts	▪ Improve efficiency, quality, outcomes ▪ Targeted information – reminders

Exhibit 5

San Diegans for Healthcare Coverage Task Force: San Diego Roadmap to Coverage and Care

Strategies and Solutions Framework: Across the Sections

Cat	COVERAGE	INDIVIDUAL AND COMMUNITY HEALTH	HEALTH SYSTEM
Policy and Advocacy	**1. Pursue collaborative advocacy strategies to maximize collective influence to address local, state and federal issues**		
	▪ Local Navigator, advocacy and outreach ▪ Meaningful coverage and care ▪ Healthy behavior incentives ▪ Cost and affordability strategies ▪ Business 1099 reporting requirement	▪ Reimbursement for education/prevention ▪ Local public/community health funding	▪ Adequacy/equity of reimbursement ▪ Payment for allied health "team" members ▪ Strengthen safety net ▪ Health system as "critical infrastructure" ▪ Tort reforms ▪ Improve local health shortage scores (MUA) ▪ Remove HIPAA barriers to coordination
	2. Pursue standardized criteria , incentives and disincentives to maximize coverage and health status/outcomes		
	▪ Individuals and businesses to secure and maintain coverage ▪ Stabilized health plan premium rates	▪ Adoption of healthy behaviors ▪ Compliance with recommended prevention, disease management and education	▪ Provider adoption of prevention, disease management and education services ▪ Incentives/payment for use of care teams ▪ Collaboration and communication among providers
	3. Advocate for funding/coverage for those not eligible under health reform	**3. Support/Pursue community health initiatives and funding**	**3. Pursue strategies to increase number of individuals exposed to, prepared for, and selecting health professions**
	▪ Over income limit for Medi-Cal or subsidy ▪ Opt out due to financial hardship (or penalty) ▪ Residency status/duration < 5 years	▪ Access to healthy foods ▪ School based initiatives/programs ▪ Built environment	▪ Pipeline programs for K-12 (diversity) ▪ Spokespersons ▪ Increased residency slots ▪ Increased health professions slots/interns ▪ Clinical time in training (preparation) ▪ Increased financial support and incentives
	4. Advocate for inclusion of all insurers under health insurance reforms		
	▪ Reinsurers ▪ Dental, LTC and Vision Plans		

Attachment 1

San Diegans for Healthcare Coverage

Task Force: San Diego Roadmap to Coverage and Care

Planning for Success under Health Reform

Section Summary: COVERAGE

The Coverage section addresses health coverage, insurance markets, public programs and individual and business requirements related to coverage and eligibility and enrollment processes.

Affordable Care Act Provisions (Attachment 1-A) Key provisions of the ACA related to coverage seek to address many barriers to coverage by creating purchasing pools (Exchanges), standardized minimum benefit plans, premium assistance programs through the Exchange, significant insurance reforms and consumer protections, Medicaid (Medi-Cal) expansion and simplifications, Medicare expansions, individual and business (over 50 employees) requirements to purchase or provide coverage, and tax credits for small businesses providing coverage.

Expansion of coverage under the ACA is expected to occur primarily through individuals and businesses purchasing commercial coverage through the Exchange and through Medi-Cal expansion. While many of these provisions are not direct coverage expansions, they do address barriers to coverage like affordability, pre-existing conditions, risk pooling and administrative complexity. Insurance reforms, consumer protections and risk pooling through the Exchange are direct trade-offs for the requirement that all Americans enroll in health coverage; no insurance system can work if enrollment occurs only when coverage is needed.

Imperatives - Success Factors (Attachment 1-B) The overarching success factor for this Section was identified as: All individuals have meaningful, affordable coverage and access to care. To provide clarity, meaningful coverage was defined by the Task Force as "Meaningful and affordable healthcare coverage promotes access to necessary and recommended health and medical services, including screenings, immunization, early intervention, disease monitoring, management and treatment; coverage that imposes financial or other access barriers does not meet this definition." ***Attachment 1-B*** summarizes the success factors identified to support achieving this overarching goal, as well as the metrics and indicators available to measure current status and future progress.

Baseline Data (Attachment 1-C) More than one in five non-elderly San Diegans currently go without healthcare coverage. The number of under-insured, those with high deductibles and co-payments documented to be a barrier to recommended care, continues to increase as businesses and individuals struggle with double digit premium increases.

There are numerous research reports and data sources on insurance status, benefit costs and cost sharing and the impacts on access to care. Most are state-level data, with some specific to San Diego, none are available in real-time but with a one to two year lag. Therefore, for the purposes of this report, the Task Force narrowed its baseline and key indicators for this Section to data expected to be available over time.

Gaps and Barriers (Attachment 1-D) identified related to coverage and care programs clearly document that transition of our fragmented, complex and limited system of coverage to a new system that offers not only more accessible coverage options, but new complexities and new rules, will be a challenge.

Strategies and Solutions (Attachment 1-E) related to coverage and care includes the need for clear, unbiased communication and information dissemination, ensuring adequate local resources to assist individuals and businesses with identifying options, enrolling in coverage, advocacy resources, easily accessible, streamlined eligibility and enrollment processes and systems, and data collection and monitoring of process and outcomes to monitor performance and progress and make adjustments as necessary.

Attachment 1-A

San Diego Roadmap to Coverage and Care:

Planning for Success Under Health Reform

Affordable Care Act Provisions: COVERAGE

OVERVIEW

Under the new health law, there are numerous provisions designed to significantly increase the population with health coverage. It is estimated that more than one in five non-elderly san Diegans are without currently without coverage (22%) and that increasing numbers are under-insured.

Under health reform, it is estimated that San Diego could reduce its uninsured rate to 4% or less with two-thirds of the currently uninsured gaining private coverage and one-third Medi-Cal or other public coverage.

Key provisions in the new health law designed to increase both coverage rates and access to care are summarized below.

INDIVIDUAL MANDATE (implementation date 2014)

- Requires all individuals to have health insurance with the following exceptions:
  - Individuals with a religious conscience exemption (applies only to certain faiths)
  - Incarcerated individuals
  - Undocumented immigrants
  - Individuals with a coverage gap of less than 3 months
  - Individuals in a hardship situation (as defined by the Secretary of Dept. of Health & Human Services)
  - Individuals with income below the tax filing threshold
  - Members of Indian Tribes
- Provides premium assistance for individuals and families earning less than 400% of the federal poverty level
- Individuals may opt out with modest penalty or or without penalty if costs exceed 8% of annual income
- Health insurance is available through employer sponsored coverage, private market or public programs; states have option of creating Basic Health Plan for those between 133%-200% FPL (under legislative consideration)

EMPLOYER OPTIONS AND REQUIREMENTS

- Employers with over 200 employees must automatically enroll employees in coverage
- Employers with 50-200 employees are subject to penalties if they do not offer coverage, and any of their employees receive premium assistance coverage through the Exchange
- Employers with fewer than 50 employees are exempt from employer requirements
- Employers with fewer than 25 full-time equivalent employees (FTE) earning an annual average wage less than $50,000 are eligible for tax credits beginning at 35% in 2010, increasing to 50% in 2014
- Employers with fewer than 100 employees are eligible to purchase coverage in the Exchange (See next section)

HEALTH BENEFIT EXCHANGES—INDIVIDUALS AND EMPLOYERS

- Health Benefit Exchanges (Exchange) will be created to allow US citizens, legal immigrants and businesses with fewer than 100 employees to research, purchase and enroll in insurance coverage
- The Exchange will be the only place to obtain individual/family premium assistance according to the following scale:
  - Up to 133% FPL – premium cost is 2% of income (most are Medicaid-eligible)
  - 133-150% FPL – premium cost 3-4% of income
  - 150-200% FPL – premium cost 4-6.3% of income
  - 200-250% FPL – Premium cost 6.3-8.05% of income
  - 250-300% FPL – Premium cost 8.05-9.5% of income
  - 300-400% FPL – Premium cost 9.5% of income
- Sets minimum set of standards, four levels of benefit plan coverage and catastrophic plan for young adults
- Exchanges must establish “Navigators” for outreach, education and enrollment assistance.

PRIVATE INSURANCE MARKET OUTSIDE THE EXCHANGE

- Individuals and employers may keep their existing coverage or continue to purchase insurance in the commercial market outside the Exchange.
- Health plans offering coverage options within the Exchange must offer the same coverage options in the commercial market
- Private market subject to insurance reforms under the new health law (see next section)

HEALTH INSURANCE REFORMS

- No denials of any applicants due to pre-existing conditions as of 1/1/2014
- No denials of children under 19 with pre-existing conditions as of 9/23/2010
- Established rules for comprehensive coverage with Essential Benefits 1/1/2014
- Caps out-of-pocket spending 1/1/1014
- No cost-sharing for preventive services effective for everyone as of 1/1/2011
- No annual caps as of 1/1/2014; no lifetime caps as of 9/23/2010
- Premiums may vary based on age (3:1), geographic area, tobacco use (1.5:1) and number of family members as of 1/1/2014
- Coverage of adult children up to age 26 as of 9/23/2010
- Waiting periods for coverage limited to 90 days
- Existing individual and employer-sponsored insurance plans will be allowed to remain essentially the same, except for dependent coverage to 26, annual and lifetime caps, rescission and waiting periods

MEDICAID (Medi-Cal in California)

- Medi-Cal is expanded to include childless adults (non-pregnant, non-Medicare eligible) who are citizens and legal residents with 5 or more years in US , and with an income below 138% as of 1/1/2014
- Income eligibility determination of those newly eligible (non-pregnant, non-Medicare eligible childless adults) under the expansion
    - No asset or resource test
    - Income based on modified adjusted gross income (MAGI) which includes total income plus tax exempt interest and foreign earned income. Applies 5 percentage points to bring effective income eligibility to 138% FPL
    - Medicaid benefits for newly eligible adults must meet the minimal essential health benefits (Benchmark Plan) available in the Exchange (includes Rx and mental health parity)
- Healthy Families eligible children from 100% - 133% transfer from Healthy Families to Medi-Cal as of 1/1/2014
- States must cover parents below State's July 1996 welfare level
- States must cover elderly and persons with disabilities receiving SSI, as well as certain low income Medicare eligibles
- Requires States to implement web-based eligibility process with electronic signature for applications and renewals
- Establishes procedures that allow individuals to apply for Medicaid, SCHIP or the Exchange through a state-run website
- Categorical and income eligibility determination for those eligible for Medi-Cal prior to 1/1/2014 remains the same under existing State rules (children, disabled, elderly, etc.)
- Establishes Medicaid coverage (with EPSDT benefits) for individuals under age 26 who were in foster care until 18.
- Permits all hospitals participating in Medicaid to make presumptive eligibility determinations; allows hospitals and other providers to make presumptive eligibility determinations for all Medicaid eligible populations
- Requires states to establish equivalent income thresholds to implement Maintenance of Effort requirements for children using MAGI that ensures that individuals eligible on Jan. 1, 2014 do not lose coverage
- Exempts states from MOE requirement for non-disabled adults with incomes above 133% FPL starting in Jan 2011 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year
- Requires smoking cessation for pregnant women with no cost sharing
- Requires coverage for free standing birth center services
- Encourages states to develop pilots to provide coordinated care through a health home for individuals with chronic conditions

HEALTHY FAMILIES/SCHIP

- Extends and funds SCHIP through 2015 and requires State MOE through 2019
- Children between 100 and 133% FPL will be transferred to Medicaid program
- Requires States to have a SCHIP comparable plan in the Exchange for those children who cannot enroll in SCHIP due to program limits, caps and are not eligible for Medicaid

MEDICARE

- Extends the Medicare Trust Fund through 2029
- Closes the prescription drug "Donut Hole" over several years
    - $250 rebate in 2010 for recipients reaching the "Donut Hole"
    - Beneficiaries who reach the "Donut Hole" over the next several years will be able to purchase brand-name medications at half price, beginning in 2011
    - "Donut Hole" disappears in 2020
- Eliminates copayments and deductibles for preventive care and covers an annual wellness exam
- Provides subsidizes for drug benefits for people whose incomes are at or below 150 percent of the federal poverty level and who have limited assets
- Imposes higher Part B premiums on higher income Medicare recipients
- Beginning in 2013, increases the Medicare payroll tax for individuals from 1.45 percent to 2.35 percent on wages earned over $200,000 for a single filer and over $250,000 for married couples filing jointly over $125,000 for a married individual filing separately). Also, a new 3.8 percent tax will apply to the net investment income of individuals with a modified adjusted gross income over $200,000 ($250,000 for joint filers).

Attachment 1-B

San Diego Roadmap to Coverage and Care:

Planning for Success Under Health Reform

Imperatives - Success Factors: Definition and Metrics

1. COVERAGE: Access and Maintain Stable Coverage and Care		
Success Factors	**Further defined by:**	**Metric/Indicator**
All individuals have meaningful, affordable coverage and access to care	• Meaningful coverage is available for, at a minimum, a standard basic benefit package • Programs are available for those unable to afford the cost of coverage and care	• Insured/uninsured/underinsured rates • CMS/CI Enrollment • Eligible but not enrolled (ESI and public programs) • Coverage costs (premium/OOP) • Employer coverage rates • Outreach & communication • Centralized information resources • New funding, grants and contracts
Individuals aware of coverage requirements and options available	• Private and public coverage and enrollment information is widely promoted and easily available to all • Private and public coverage and enrollment information and referral is provided to individuals through points of care and community agencies	
Individuals enroll and maintain coverage and have assistance as needed	• Individuals and families have access to timely assistance with enrolling in coverage • Individuals and families enroll in coverage available to them • Individuals and families maintain coverage	
Businesses are aware of coverage requirements and options available	• Businesses are actively informed about coverage options available • Businesses have easy access to information about coverage choices	
Businesses enroll in and maintain coverage and have assistance as needed	• Employer sponsored coverage is affordable to business • Employers contribute equitably to the cost of employee coverage • Businesses offer meaningful coverage to their employees and dependents • Businesses have assistance with enrolling in coverage • Employers maintain coverage	
Individuals and businesses have assistance with resolving coverage/care issues	• Advocacy/ombudsman available to employers/business • Advocacy/ombudsman available to individuals for timely resolution • Escalation process in place for coverage/care issue resolution	
Cost of coverage is affordable, covers benefit levels and is in-line with inflation	• Cost of coverage is affordable relative to income and family size • Premiums are actuarially sound • Cost of coverage increases at the same rate as inflation/wages	
San Diego maximizes all funding sources available for coverage, care, outreach and assistance	• Private and public funding for coverage and care • Funding for implementation, outreach and education • Funding for local innovation and pilot projects	

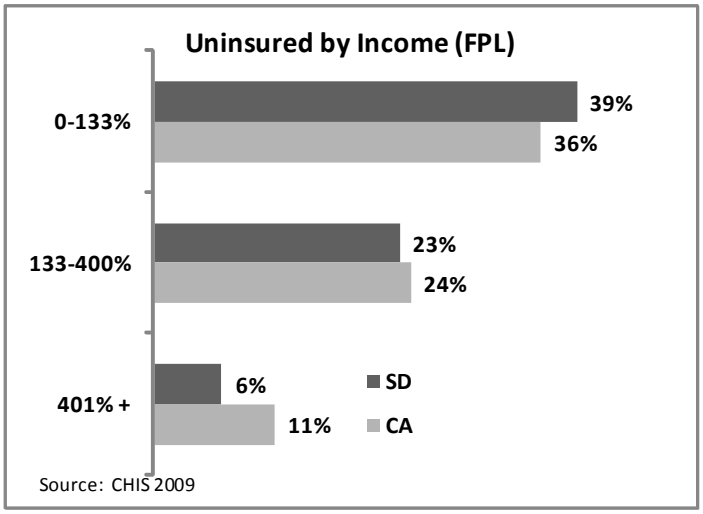
Attachment 1-C

San Diegans for Healthcare Coverage

Baseline Data: Key Indicators

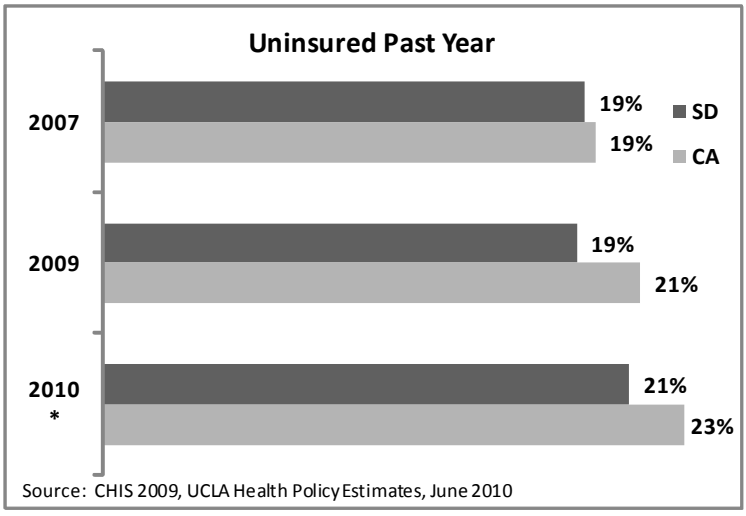
COVERAGE

Uninsured by Income (FPL)



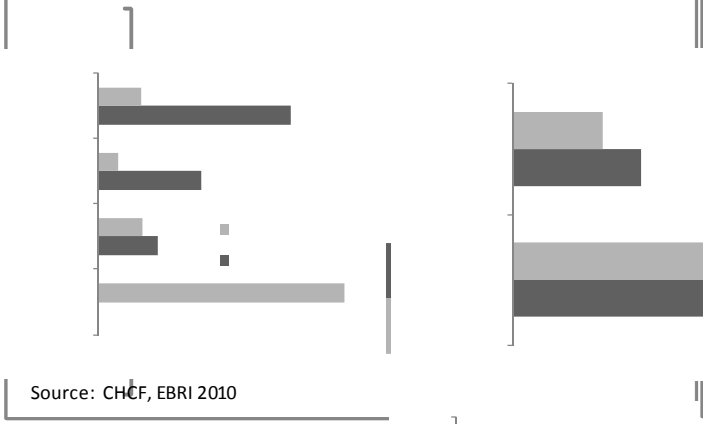
Source: CHIS 2009

Uninsured Past Year



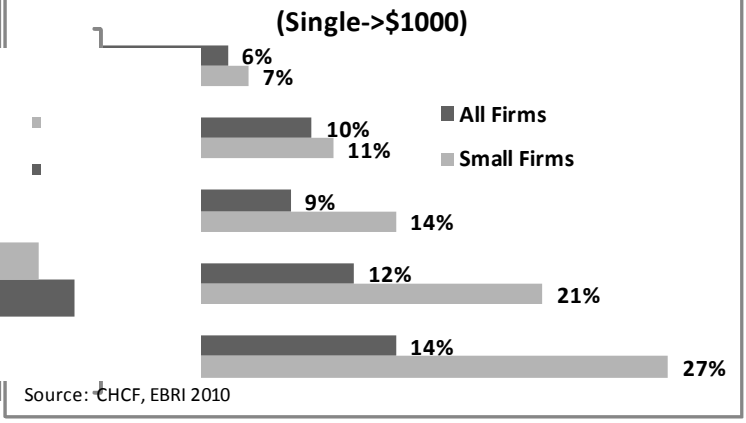
Source: CHIS 2009, UCLA Health Policy Estimates, June 2010

Monthly Premium (Employer Sponsored)



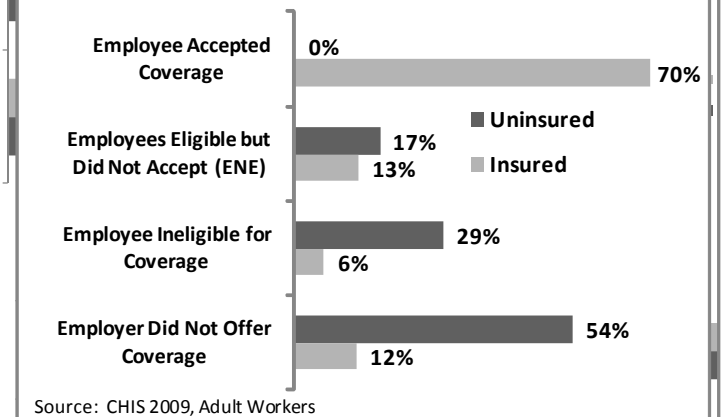
Source: CHCF, EBRI 2010

Underinsured: High Deductible Plans (Single->$1000)



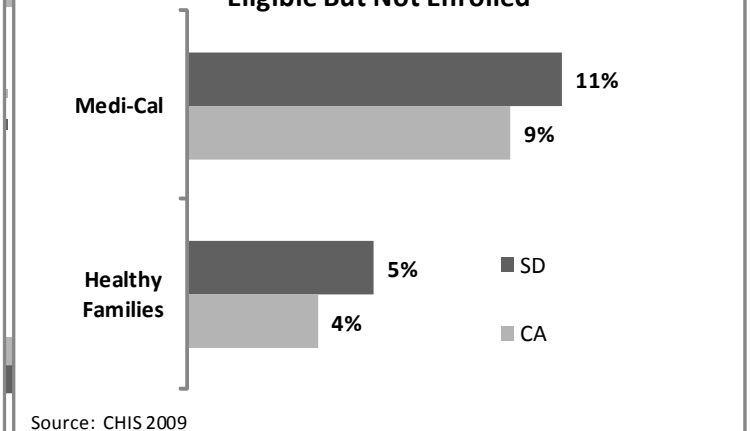
Source: CHCF, EBRI 2010

Employer Offered Coverage



Source: CHIS 2009, Adult Workers

Eligible But Not Enrolled



Source: CHIS 2009

Attachment 1-D

San Diegans for Healthcare Coverage

Task Force: San Diego Roadmap to Coverage and Care

Planning for Success under Health Reform

Gaps and Barriers Summary

COVERAGE

Challenges to dissemination of clear, accurate, unbiased information. A priority identified by the Task Force was the need for clear and accurate, unbiased information for business and consumers as key elements of Health Reform are implemented. The complexity, breadth and scope of the health law will require information resources that simplify and clarify coverage options, requirements and steps to take. To effectively reach our diverse communities, communication channels and outreach efforts need to be established that ensure that information is tailored to the audience, including culturally and linguistically appropriate materials delivered through trusted sources. These resources, characteristics and channels are not in place today.

Overcoming trust, cultural and perceived value barriers. Barriers to coverage related to perceived value, trust and culture were identified. Many businesses and individuals have a basic mistrust of government, some do not understand the value of health coverage and the consequences of going without, while others find coverage to be antithetical from a cultural perspective and believe in seeking only what one can pay for. Targeted education and messaging that address these concerns do not exist today, but will become increasingly important as health reform is implemented.

Complex eligibility processes, limited resources and systems. Eligibility requirements and many enrollment processes are complex and difficult, often present barriers to coverage and must be simplified to address the needs of diverse populations well in advance of health reform effective dates.

Limited eligibility and enrollment resources, processes and systems to support full implementation at the state and local level were also identified as potentially significant barriers. In San Diego, approximately one half million currently uninsured will become eligible for commercial coverage, with or without premium assistance, through the Health Insurance Exchange or for public program coverage, on January 1, 2014. In addition, many businesses and individuals with coverage will seek to take advantage of the new options available, and those in state high risk programs will be required to enroll through the Exchange in 2014.

Adequate lead time for planning and enrollment is critical to meeting this concentrated, high demand for coverage. Insufficient eligibility, enrollment, as well as assistance and advocacy resources could serve as barriers and further limit access to coverage. Currently individuals, business, providers, advocates and community agencies do not have access to standardized web-based systems for all programs, nor on-line applications and enrollment capability, all of which are critical to successful and timely implementation.

Lack of local influence and resources for assistance and information. Significant concerns were raised about the need and importance of local influence and resources for implementation, including eligibility, enrollment, advocacy and assistance. In light of historically poor performance when these functions are centralized at the state level, this was viewed as a major barrier. Health care and relationships are local, and the community looks to trusted local resources for assistance. Examples of programs that have been poorly implemented when a local resources and assistance were not available include Healthy Families, Medicare Part D Pharmacy Benefit and Low Income Tax Credits. These issues persist with Healthy Families eligibility and enrollment despite years of raising concerns; they continue to lead to gaps in coverage, excess costs and the inefficient use of resources to re-enroll children multiple times in the same program.

Short and long term affordability and accessibility of coverage. Apprehensions about the affordability of coverage for both business and individuals were raised, including the resistance of business to make a commitment to offer or

individuals to purchase coverage when faced with a lack of predictability of premium costs over time. The ability to opt out of coverage with minimal penalties is also a barrier to maximizing coverage for all eligible San Diegans. Furthermore, there is a lack of clarity regarding premium payment and portability provisions that may lead to gaps and disrupt continuity of coverage and care. Whether the as yet to be defined Essential Benefit options under ACA prove meaningful, and provide access to necessary care without payment barriers, looms as a real concern.

Options and barriers for legal immigrants and the undocumented will continue. A concern regarding being considered a "public charge" for enrolling in public coverage is a barrier for eligible legal immigrants and their families. While health coverage is not, in and of itself, a public charge issue for those seeking permanent legal residency and citizenship, it is considered if there are other elements of public charge, such as cash assistance. As a result, immigrants are reticent to seek any form of coverage for themselves or their family members that might place their future residency and citizenship position in jeopardy. Another concern raised by the Task Force is that there will be no state public program coverage for those legally resident for fewer than five years, most of whom are low income. While the need and demand for services and programs for the undocumented will continue, there are no provisions to adequately fund those services and programs. Specific ACA restrictions on coverage for the undocumented under Medicaid raise concerns regarding access to health and preventive care, increased uncompensated emergency services and public health impacts.

Attachment 1-E

San Diegans for Healthcare Coverage

Task Force: San Diego Roadmap to Coverage and Care

Planning for Success under Health Reform

Strategies and Solutions Summary
COVERAGE

Communication/Education

1. Form a regional communications collaborative and network of community agencies to establish communication channels:
   - **a.** Partner with key constituencies (e.g., government, consumer advocates, health providers, health plans, call centers, business organizations and other community based organizations)
   - **b.** Identify/define benefits to stakeholders to participate in the communications collaborative (e.g., standardized, unbiased resources, updates, media linkages, member perks, etc)
   - **c.** Identify communication needs and strategies to reach diverse San Diego groups with accurate and unbiased coverage and care options
2. Develop a communications plan targeted to consumers (individuals, families and business) to address coverage, access and healthy behaviors:
   - **a.** Strategies and tactics appropriate to specific groups/populations (identify best practices)
   - **b.** Communication and education well in advance of implementation
   - **c.** Unbiased, targeted messaging ,information materials and tools (youth, business, etc)
   - **d.** Outreach/educational strategies that optimize each "teachable moment"
   - **e.** Use of electronic media (e.g., text, email, Social media, etc) to push information out
   - **f.** Spokespersons and PSAs appropriate to group/messaging
3. Develop and distribute informational materials for consumer and business on coverage options that:
   - **a.** Clearly articulate coverage options, rights and comparisons
   - **b.** Identify assistance resources (coverage, dispute, grievance)
   - **c.** Information regarding the value of coverage and healthy behaviors
   - **d.** Targeted (culturally and linguistically) for diverse communities
   - **e.** Use simple and concise language
   - **f.** Easy to distribute widely in print and electronic format

Resources/Funding

1. Pursue SDHCC delegation by State Exchange as local Navigator, including unbiased resource center and partnerships for information, outreach, education, help-line and assistance where individuals and businesses can research and enroll in public and private coverage options (e.g., Private coverage, Exchange coverage, Medi-Cal, Healthy Families).
   - **a.** Establish and maintain a common provider resource database identifying:
     - **i)** Available services, programs provided and plan participation
     - **ii)** Common decision tree to maximize appropriate information and referral
   - **b.** Develop focused enrollment retention program and strategies with business, health plans, agents, case managers and others
2. Promote adequate access to local eligibility and enrollment resources (e.g., Family Resource Centers, provider sites, regional offices) and methods (e.g., telephonic and web-based information, application, eligibility and enrollment) for both public and private coverage options
3. Strengthen and increase existing/new programs to meet care needs of those remaining uninsured

4. Promote designation and publicize an Advocacy Center (ombudsman) for assistance with eligibility denials, access, dispute resolution and grievances

Systems Change

1. Advocate for streamlined eligibility and enrollment processes to eliminate barriers and maintain coverage for both public and private programs
   a. One stop – no wrong door access to eligibility and enrollment
   b. Web-based eligibility and enrollment systems (information, application, renewal, documentation/verification, decision, languages, status, payment, plan/provider selection)
   c. Consolidate applications for means tested coverage programs to eliminate duplication
   d. Self declaration with audit verification of applicant information (advocacy)
2. Pursue expansion of proven efforts (e.g., One-e-App in clinic setting) to increase eligibility and enrollment access and resources

Information Technology (IT)

1. Establish local consumer, business and assistor accessible web-based information systems for both public and private coverage programs linked to statewide systems, including:
   a. Information on coverage options (appropriate to audiences)
   b. Online decision-making tools to evaluate options/cost-benefit analysis
   c. Applications, changes and renewals
   d. Documentation/verification using available systems (e.g., social security, banking, tax files) with document submission only as back-up
   e. Eligibility determination/enrollment confirmation
   f. Enrollment status query
   g. Premium payment processing
   h. Plan/provider selection
2. Promote the establishment of standardized health coverage metrics/data and reporting (community) to monitor and evaluate the effects of health reform implementation, for example:
   a. Insurance Status
   b. Enrollment processes and outcomes
   c. Denials and Disenrollment by reason
   d. Demographic by program/coverage type
   e. Coverage opt out by business and individuals and reasons
   f. Cost of coverage/trends (plan and contract types)
3. Promote extensive use of technology, including social media, texting, YouTube, and smart phone applications to push information/education, send reminders, provide checklists, etc.

Policy/Advocacy

1. Pursue collaborative advocacy strategies to maximize collective strength and influence to address local, state and federal issues related to coverage and care, including but not limited to:
   a. Regional Navigator (coalition), consumer advocacy and outreach resources and funding
   b. Benefit packages that provide for access to meaningful, affordable care
   c. Promotion of evidence based health education and healthy behavior incentives
   d. Cost and affordability issues (e.g., government sponsored reinsurance pool to reduce premiums)

   e. Adequacy of provider reimbursement as a barrier to participation and enrollee access e.g., Medi-Cal, Disproportionate Share Hospital (DSH) payments, Federally Qualified Health Center (FQHC) payments, Medicare equity under Geographic Practice Cost Index(GPCI) and Sustainable Growth Rate (SGR) adjustments
   f. Legal/regulatory barriers to workplace wellness programs (e.g., workers comp, flex hours)
2. Pursue strategies to increase both incentives and disincentives for individuals and businesses to secure and maintain coverage
3. Propose that health plans offer stable premium rates in exchange for incentives (e.g., tax credits, eligibility for government employee contracts, use of multi-year contracts and rates) or penalties for non-participation in Exchange programs they are eligible for (e.g., non-contractor with State, local government, etc)
4. Advocate for funding for coverage and/or care for individuals not eligible for Medi-Cal or subsidy through the Exchange or who opt out due to financial hardships
5. Advocate/pursue inclusion of reinsurers in health coverage reforms (e.g., pre-existing conditions, limits, rates, etc.) through State of California

Section Summary:

INDIVIDUAL AND COMMUNITY HEALTH

The Individual and Community Health section addresses public, workplace and community policies, activities and resources directed to improving health status, including individual responsibility for adopting healthy behaviors.

Affordable Care Act Provisions (Attachment 2-A) Key provisions of the ACA support efforts to improve individual and community health by establishing a National Health Strategy for Wellness and Prevention to support the delivery of evidence based prevention and wellness services to reduce chronic disease rates and address disparities, including a National Prevention, Health Promotion and Public Health Council to coordinate federal efforts and a Fund to sustain prevention and public health programs. The ACA establishes a number of grant and pilot projects and funds targeted to community health improvement, prevention, chronic disease management and home and community based services. The ACA also requires coverage of recommended preventive services, screenings and immunizations without cost sharing (2010) and encourages adoption of medical home models providing comprehensive, community based coordinated care. Employer wellness programs are encouraged and allow employers to offer premium discounts, waiver of cost sharing or additional benefits for employee participation in a wellness program; employer grants for up to five (5) years are available to small employers that establish wellness programs.

Imperatives-Success Factors (Attachment 2-B) The overarching success factor for this section is to achieve optimal health status for all San Diegans. The success factors address linking all individuals to a medical home, getting recommended preventive and screening services, establishing incentives for healthy behaviors and personal responsibility, and health education and promotion strategies, all leading to improved health outcomes and health status.

Baseline Data (Attachment 2-C) It is estimated that in 2007, more than 50% of San Diego adults, 23% of teens and 22% of children are overweight or obese placing them at risk for diabetes, heart disease and other health conditions. Only 70% of San Diegans reported getting a flu shot in the past 12 months (2007). In 2007, there were 27,600 hospital admissions for ambulatory sensitive conditions (ASCs), generally used to represent avoidable hospitalizations if an individual is seen and managed in the outpatient setting before their conditions worsen. Using conservative estimates, these admissions would represent an average daily census of 378 patients costing an estimated $800,000 per day ($317 million per year). While San Diego morbidity and mortality measures are in line, or slightly better than statewide rates, most fall short of national targets.

Gaps and Barriers (Attachment 2-D) focus on barriers to communication, awareness and incentives for adoption of healthy behaviors, lack of a community-wide culture of health, lack of access and inappropriate use of the health system, provider incentives to integrate prevention and disease management into care, and the decline and instability of funding for public health services.

Strategies and Solutions (Attachment 2-E) include the need for healthy behavior communication and information dissemination, coupled with adopting community, public agency and workplace wellness programs and a “culture of health” (e.g., Building Better Health), adoption of proven medical home models that integrate comprehensive prevention, health improvement and disease management, integrating incentives and disincentives into coverage and care models and pursuing stable collaborative, community health initiatives and funding.

Attachment 2-A

San Diego Roadmap to Coverage and Care:
Planning for Success Under Health Reform

Affordable Care Act Provisions: INDIVIDUAL AND COMMUNITY HEALTH

OVERVIEW
Under the new health law, there are numerous provisions for wellness, prevention and health education programs designed to improve the overall health status in our communities. Key ACA provisions are summarized below.
NATIONAL STRATEGY AND FUNDING FOR WELLNESS AND PREVENTION
• Establishes a five year grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities, especially in rural and frontier areas. • Establishes the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities. • Creates a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs. • Creates task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. • Establishes a Prevention and Public Health Fund for prevention, wellness, and public health activities including prevention research and health screenings, the Education and Outreach Campaign for preventive benefits, and immunization programs. Appropriate $7 billion in funding for fiscal years 2010 through 2015 and $2 billion for each fiscal year after 2015.
PREVENTION SERVICES
• Requires qualified health plans to provide, at a minimum, coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. (Effective 9/23/2010) • Removes cost-sharing for preventive services and immunizations recommended by the U.S. Preventive Services Task Force under Medicare and Medicaid. • Provides a one percentage point increase in the federal Matching Assistance Program (FMAP) for provision of such services under Medicaid. • Authorizes Medicare coverage of personalized prevention plan services, including a comprehensive health risk assessment, annually. Reimburses providers at 100% of the physician fee schedule amount with no adjustment for deductible/coinsurance when these services are provided in an outpatient setting. (Effective January 1, 2011) • Provides incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. (Effective 1/1/2011) • Requires Medicaid coverage for tobacco cessation services for pregnant women. (Effective 10/1/2010)
EMPLOYER-BASED WELLNESS PROGRAMS
• Permits employers to offer employees rewards—in the form of premium discounts, waivers of cost sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate. (2014) • Establishes 10-state pilot programs by July 2014 to permit states to apply similar rewards for participating in wellness programs in the individual market and expand demonstrations in 2017 if effective. • Provides grants for up to five years to small employers that establish wellness programs. (FY 2011) • Conducts a national worksite health policies and programs survey.
NUTRITIONAL INFORMATION
Requires chain restaurants and food sold from vending machines to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment)

MEDICAID
• Special provisions and opportunities for pilot projects that stress the utilization of a medical home, coordinated care and long term care alternatives • Allows states to enroll Medicaid beneficiaries with chronic conditions, which include serious and persistent mental illness, into medical homes as part of pilot projects. Authorizes state grants of as much as $25 million (begins on January 1, 2011). • Allows states to provide more types of home- and community-based services (HCBS) to Medicaid beneficiaries with higher levels of need through a state plan amendment, rather than a waiver, and to extend full coverage to beneficiaries who receive HCBS under a state plan amendment. • Establishes the State Balancing Incentive Payments Program to increase the proportion of Medicaid beneficiaries who receive long-term care outside of institutional settings. For states that qualify, provides FMAP increases for medical assistance expenditures for long-term care services and supports provided to Medicaid beneficiaries outside of institutional settings.
MEDICARE
• Opportunities for new programs focused on medical homes, coordinated community health teams. • Establishes a program to create and fund the development of community health teams to support the creation of medical homes through increased access to comprehensive, community-based, and coordinated care • Eliminates cost sharing for preventive services • Authorizes Medicare coverage of personalized prevention plan services • Provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs
SPECIAL POPULATIONS
• Authorizes competitive grants to eligible entities for programs that promote individual and community health and prevent the incidence of chronic disease. Includes programs to prevent or reduce the incidence of mental illness. • Authorizes grants to eligible entities to promote positive health behaviors/outcomes for populations in underserved communities through the use of community health workers. • Funding to integrate primary care and mental health services (see Health System)

Attachment 2-B

San Diego Roadmap to Coverage and Care:

Planning for Success Under Health Reform

Imperatives - Success Factors: Definition and Metrics

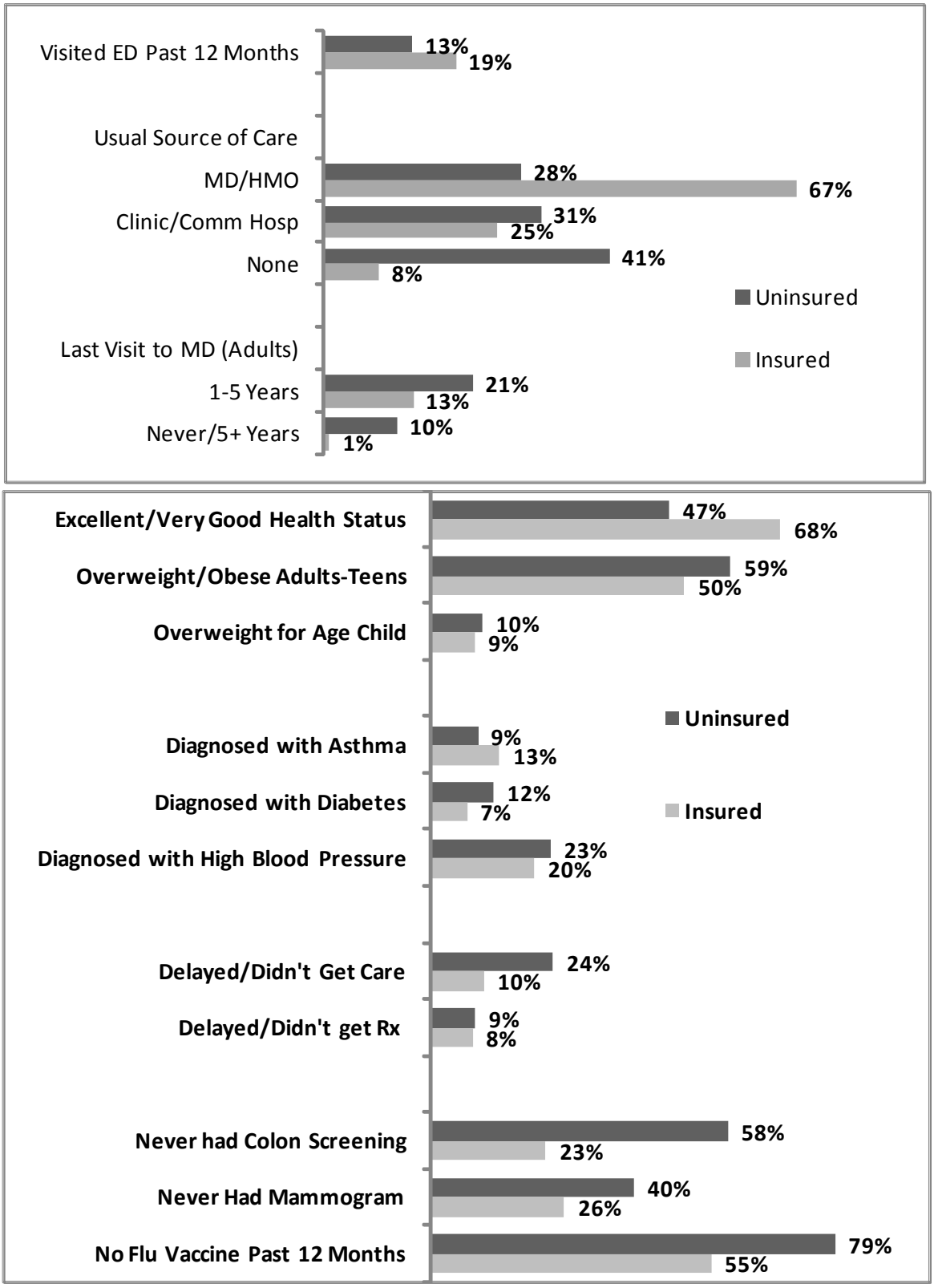
2. INDIVIDUAL AND COMMUNITY HEALTH CARE – Optimal Health Status for Individual and Community Health		
Success Factors	**Further defined by:**	**Metric/Indicator**
Identified medical home/Routine source of care	• Individuals select/are assigned to one primary care provider/medical home • Individual receives routine preventive/screening services • Individual care is coordinated through PCP/medical home	• Health status data • Morbidity/Mortality data • Medical Home – Source of care • Programs available for health education, disease management • Screening and immunization services locations/cost • Screening and immunization rates • Employee Wellness Programs* • Ambulatory Sensitive Conditions data** *If available: SDRCC Survey of Workplace Employee Wellness Programs *ICANATWORK **OSHPD (2 year lag)
Personal responsibility/healthy behaviors	• Incentives support individual healthy behaviors • Incentives support decisions/personal responsibility for healthy behaviors • Individuals practice healthy behaviors • Individuals comply with medical decisions	
Health promotion, education, wellness and prevention programs are available, accessible and affordable	• Individuals aware of lifestyle and behaviors to achieve optimal health • Individuals have access to affordable health education, prevention and wellness programs to improve their health and health outcomes • Health promotion and outreach programs are available for a diversity of health issues throughout the county • Physicians actively provide healthy lifestyle counseling	
Screening and immunization services are available and accessible	• Affordable screening and immunization services are available throughout the community	
Improved health outcomes	• Decreased rates of communicable disease • Early identification and treatment of illness • Reduced ED encounters and admissions for avoidable conditions	
San Diego maximizes all funding sources available for individual and community health	• Public and private funding for local innovation and pilot projects • Public and private funding for local, state and federal initiatives	

Attachment 2-C

San Diegans for Healthcare Coverage

Baseline Data: Key Indicators

INDIVIDUAL AND COMMUNITY HEALTH



Source: CHIS 2009

Gaps and Barriers Summary Statements
INDIVIDUAL AND COMMUNITY HEALTH

Challenges to disseminating and raising awareness regarding healthy behaviors, prevention and other factors impacting health status. A priority issue identified by the Task Force was not just the difficulty of reaching and educating very diverse communities about healthy behaviors and a healthy environment, but raising that awareness to the level that it results in modified behavior. There was a strong feeling that there are no consistent, reliable definitions and messaging about health, healthy behaviors and recommendations, as well as the corresponding consequences of unhealthy behaviors or failure to pursue recommended screenings or lifestyle changes. While there are communication strategies highlighting the importance of healthy lifestyle, messaging from many sources with differing motivations may be conflicting and confusing to the general public (e.g., fiber in cereal ads versus limiting sugar and salt intake).

Overcoming trust, cultural and perceived value and benefit barriers. San Diego is an extremely diverse community. There are significant socio-economic, cultural and language barriers to raising awareness and changing behaviors. In some cases there is a lack of trust in, and cultural competency of, those delivering the messages. Awareness does not always translate to acceptance with many not identifying the need to adopt healthy behaviors or having a perspective of "if it is not broken, why fix it?"

Public and workplace policies do not consistently support adoption of healthy lifestyles. The importance and support for adopting a healthy lifestyle is not always reflected in policies and practices. Healthy choices are not always available in our schools, our workplaces or our communities. As a region where close to 95% of businesses and 50% of workers are employed by small businesses, adoption of workplace wellness programs and supportive policies are less likely. As a community, many are trying, but we have not yet adopted a culture of health.

Lack of access or appropriate use of the health system results in poorer health status and increased costs. Studies show that having a regular medical home improves health outcomes and reduces overall costs. Unfortunately, rather than establishing and using a routine medical home where education and preventive services can be provided, many turn to convenience and availability of emergency departments for episodic treatment. This may be due to a lack of timely access to primary care (uninsured, cannot get a timely appointment, no established medical home), an inability to take time from work for medical appointments without loss of pay or consequences, or simple convenience. For many, there are no strong disincentives for use of the emergency department for care that could be managed by their primary care provider, even for those with health coverage.

Provider incentives are not always aligned with provision of preventive care, disease management and health education. With some exceptions, our system of healthcare financing is designed to respond to illness and injury, not to prevention. Physicians are paid by the visit or procedure and are not incentivized to spend time working with a patient on management of their disease or health; on the contrary, payment systems are structured so that the visit should be problem oriented and as short as possible. Despite evidence that a team approach to care is more effective, especially for those at risk for or with chronic conditions, most payers, including most public programs, do not pay for visits to nurse specialists, nutritionists or health educators. There are real operational and financial barriers to individual physicians and small groups establishing a team approach to care, especially without a method to pay for those services.

Funding for public health services has declined and remains unstable. Over the years, funding for public health programs dedicated to community education, immunization and prevention have declined, resulting in a slow reduction and elimination of programs. For example, the funding and resources to provide public health nurse home visits to new

mothers have declined despite the recognition that these home visits are important to assessing needs, providing education and averting infant illness or injury. Public health is critical to effective immunization and vaccination programs which, in turn, are essential to individual and broader community health. As a region, we must look to public health to convene and partner with the community, business and schools in shifting to a culture of health. While grants and other funding may be made available for specific programs or services on a time-limited basis, they do not provide for stable, long-term health improvement programs and services. The poor economy increases the need; however, the fiscal crisis at the state level and federal deficit reduction initiatives can only be expected to further reduce both support and public and community health services.

Attachment 2-E

San Diegans for Healthcare Coverage

Task Force: San Diego Roadmap to Coverage and Care

Planning for Success under Health Reform

Strategies and Solutions Summary
INDIVIDUAL AND COMMUNITY HEALTH

Communication/Education

1. Form a regional communications collaborative and network of community agencies and organizations to establish channels
   - **a.** Partner with key constituencies (e.g., government, consumer advocates, health providers, health plans, call centers, business organizations) and other community based organizations
   - **b.** Identify benefits to stakeholders to participate in communications collaborative (e.g., standardized, unbiased, resources, media linkages, member perks, etc)
   - **c.** Identify communications plan needs and strategies to reach diverse San Diego groups with clear individual and community health improvement information
2. Develop a communications plan targeted to consumers (individuals, families and business) to address access, individual and community health and healthy behaviors:
   - **a.** Strategies and tactics appropriate to specific groups/populations (proven practices)
   - **b.** Targeted, timely messaging and information materials and tools
   - **c.** Engage and provide tools to providers for messaging/education on prevention and healthy behaviors
   - **d.** Outreach/educational strategies that optimize each "teachable moment"
   - **e.** Use of electronic media (e.g., text, email, Social media, etc)
   - **f.** Spokespersons (e.g., celebrity) and PSAs appropriate to message/group on prevention, healthy behaviors
3. Develop and distribute informational materials for consumers on
   - **a.** Health and healthy behaviors
   - **b.** Medical Home
   - **c.** Prevention and screening

Resources/Funding

1. Promote Workplace Wellness programs and baseline standards, goals and strategies:
   - **a.** Educate business associations and employers regarding potential benefits/incentives for workplace wellness programs
   - **b.** Clarify and work to mitigate barriers to workplace wellness programs (e.g., workers comp, flexible hours)
   - **c.** Develop strategies to ensure workplace wellness programs are available to small businesses (e.g., turnkey, leverage large employer programs, collaboration/economies of scale)
   - **d.** Encourage business associations to offer/support workplace wellness programs (e.g., as a member benefit)
2. Promote collaboration and integration of County Health Strategy (Building Better Health) with community plans and programs to maximize use of community based resources and opportunities for health improvement:
   - **a.** Stakeholder collaboration
   - **b.** Evidence based proven models
   - **c.** Collaborate to pursue and secure funding for community health improvement initiatives

Systems Change

1. Pursue integration of health promotion and education into medical home model accreditation and monitoring criteria; identify and utilize best practice medical home models that demonstrate good health improvement/education strategies
   a. Promote and provide incentives for individuals to adopt or default to, and appropriately utilize, medical homes
   b. Establish processes within hospitals, community based and other organizations that promote and provide individuals with direct referral/linkage with an appropriate medical home
2. Support health care organizations in adopting a culture of health promotion and healthy behaviors (i.e., walk the talk)
3. Promote evidence-based public and community health improvement strategies to maximize impact and return on investment of limited resources

Information Technology (IT)

1. Establish standardized metrics/data and reporting (community) to monitor and evaluate community and public health interventions and health status and to identify best practices/course corrections (e.g., surveillance reports/report cards, needs assessments, etc)
2. Promote extensive use of technology to engage individuals in taking action to improve health outcomes and self-monitoring (e.g., interactive websites, social media, texting, personal health records, etc.)
3. Promote extensive use of technology, including social media, texting , YouTube, and smart phone applications in public and community education initiatives

Policy/Advocacy

1. Pursue collaborative advocacy strategies to maximize collective strength and influence to address local, state and federal issues related to public and community health improvements, including but not limited to:
   a. Adequate reimbursement for prevention, screening and immunizations
   b. Adequate local public and community health funding
2. Pursue standardized criteria and incentives for individual adoption of healthy behaviors and compliance with recommended prevention, disease management and education programs
3. Support and promote environmental and institutional initiatives that will improve the health of our communities (e.g., access to healthy foods, school based programs)

Attachment 3

San Diegans for Healthcare Coverage

Task Force: San Diego Roadmap to Coverage and Care

Planning for Success under Health Reform

Section Summary: HEALTH SYSTEM

The Health System section addresses the health care delivery system, including provider capacity, workforce, delivery models and coordination of care, health information technology and provider reimbursement.

Affordable Care Act Provisions (Attachment 3-A) Key provisions of the act related to the health system include using payment incentives and disincentives to improve performance/outcomes and increase adoption and use of Electronic Health Record (EHR) and health information technology (HIT), expand primary care provider and clinic access and increase the health professions workforce, promote integrated and coordinated healthcare delivery, increased efficiencies and new payment models to reduce costs and improve outcomes.

Imperatives – Success Factors (Attachment 3-B) are based on the overarching goal of providing integrated, efficient, quality health care to all San Diegans. The success factors address the key elements identified as essential to achieving this goal with an emphasis on adequate provider resource and funding, integration of care and information systems and models of care.

Baseline Data (Attachment 3-C) show that San Diego physicians per 1000 population are well below statewide and national averages, with 58 primary care physicians compared to 80 and 79, and 124 specialists compared to 138 and 140 respectively – close to 27% fewer primary care physicians/population and 11% fewer specialists/population. Only 57% of physicians in California reported that they were accepting new Medi-Cal patients. Medi-Cal reimbursement per person is 40% less than the national average and ranks at the bottom of states. Medicare reimbursement to San Diego hospitals averages 14% less than the rest of California and outpatient service reimbursement is 5% less. While the average hospital stay is reimbursed at close the national average, the cost of living (wages and infrastructure) in San Diego is much higher.

Gaps and Barriers (Attachment 3-D) highlights the lack of adequate number and capacity of the physician workforce, especially primary care providers, and the fact that many will not take public program patients due to inadequate reimbursement rates. Inadequate public program reimbursement rates, coupled with ACA efforts to reduce costs, create barriers to health system expansion and viability. The trained health professions workforce and prospects for the future do not appear adequate to meet ongoing and future needs. The health system is not recognized or incorporated into public and land use policy, and face burdensome and bureaucratic processes and unfunded mandates that inhibit the ability to expand or restructure to meet community needs. The lack of clear definition and criteria for integrated and coordinated healthcare delivery and disease management , coupled with regulations and payer policies are barriers to integrated and coordinated healthcare delivery and physician-led team care models that expand physician capacity. Finally, better definition and less costly methods for adoption and use of health information technology are needed.

Strategies and Solutions (Attachment 3-E) include adoption of proven patient care models, including patient centered medical home, integrated and coordinated care across the continuum, adoption of EHR and HIT to support integration and outcomes, as well as decision support tools for providers. Many strategies and solutions related to expanding physician and healthcare workforce and training programs, including expanding physician capacity by securing payer acceptance of care team models. Finally, collaborative advocacy across sectors may be necessary to address many of these barriers.

Attachment 3-A

San Diego Roadmap to Coverage and Care:

Planning for Success under Health Reform

Affordable Care Act Provisions: HEALTH SYSTEM

OVERVIEW

The new health law has numerous provisions for health systems including physicians, facilities, workforce, operations, quality, efficiency and reimbursement. Key provisions are listed below.

QUALITY AND EFFICIENCY OF HEALTH CARE

- Establishes incentives and disincentives to drive provider behavior towards meeting performance standards and quality reporting (e.g., payment models, HIT adoption, etc)
- For hospitals:
    - Establishes program that links incentive payments to hospitals that meet performance standards, effective for claims for hospital discharges as of 10/1/12. Applies to specific conditions
    - Establishes special pilot programs to test value-based purchasing in inpatient, critical access hospitals
    - Establishes schedule for payment reductions for hospital acquired conditions (1% decrease)
- For physicians:
    - Effective 2015, if physicians do not comply with quality reporting, their reimbursement is decreased to 98.5% of fees in 2015, and 98% thereafter
    - Legislation requires a payment modification to reward physicians or physician groups based on quality of care beginning in 2013
    - Establishes and authorizes funds for a Primary Care Extension Program to educate primary care providers about preventive medicine; chronic disease management; mental and behavioral health services, which include substance abuse prevention and treatment services; and evidence-based and evidence-informed therapies and techniques
- For Long Term Care Hospitals/Inpatient Rehabilitation/Hospice, failure to provide quality reporting results in a decrease in payment
- For Skilled Nursing/Home Health, legislation requires a plan for value-based purchasing.

WORKFORCE

- Establishes competitive health care workforce development grant program (referred to in this section as the ''program'') for State partnerships to complete comprehensive planning workforce development strategies at the State and local levels
- Loan and loan repayment programs for medical and nursing students, pediatric specialists, public health workforce, and other areas
- Increased funding for the National Health Service Corps for fiscal year 2010, $320,461,632, for fiscal year 2011, $414,095,394, for fiscal year 2012, $535,087,442, for fiscal year 2013, $691,431,432, for fiscal year 2014, $893,456,433, for fiscal year 2015, $1,154,510,336. Increases in subsequent years will be adjusted by formulas specified in the law
- Funding to develop nurse-managed clinics (subject to State law)
- Funding for training and education of health professionals
- Capacity building grants for community health centers

ADEQUATE REIMBURSEMENT

- Medicare reimbursement to primary care physicians increased by 10% for years 2011-2016
- Payments to primary care providers under Medi-Cal (Medicaid) will be increased to the Medicare payment level, and will be adjusted as Medicare rates are adjusted annually. This increased reimbursement level is authorized for two years, 2013 and 2014.
- Reduction in rate of annual increase in Medicare reimbursement for certain providers, including hospitals, home health agencies, skilled nursing facilities, and hospices.
- Freezes extra payments to Medicare Advantage plans in 2011 and reduces payments in 2012.
- Requires Medicare Advantage plans to pay at least 85 percent of the premium dollars for medical claims.

INTEGRATED INFORMATION SYSTEMS
Both ARRA and regulations being developed for PPACA establish funding, as well as incentives and penalties, to encourage (require) providers to implement EHR and integrated information systems.
PROVIDER INFRASTRUCTURE
• Establishes a demonstration project for qualified pediatric providers to receive recognition and payments under Medicaid as ACOs, as well as permit ACOs that meet quality of care standards and reduce costs to share in a portion of their savings to the program (begins on January 1, 2012). • Requires HHS to establish a three-year Medicaid demonstration project to reimburse certain institutions for mental disease for services provided to beneficiaries aged 21 - 65 and require medical assistance to stabilize an emergency psychiatric condition. Authorizes $75 million for the project (begins on October 1, 2011) • Establishes a Medicare shared savings program that promotes accountability for a patient population and coordinates specific items and services specified in the law and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. • Authorizes $50 million in grants for coordinated and integrated services through the co-location of primary and specialty care in community-based mental and behavioral health settings.

Attachment 3-B

San Diego Roadmap to Coverage and Care:
Planning for Success Under Health Reform

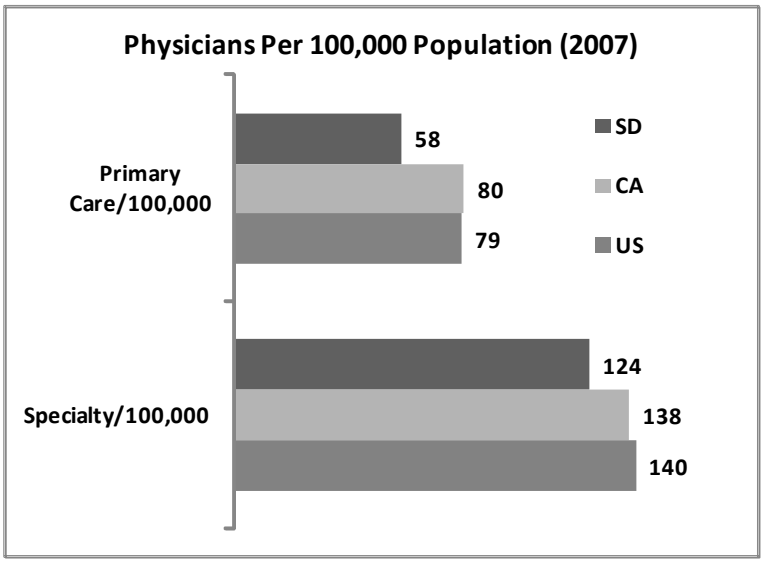
Imperatives - Success Factors: Definition and Metrics

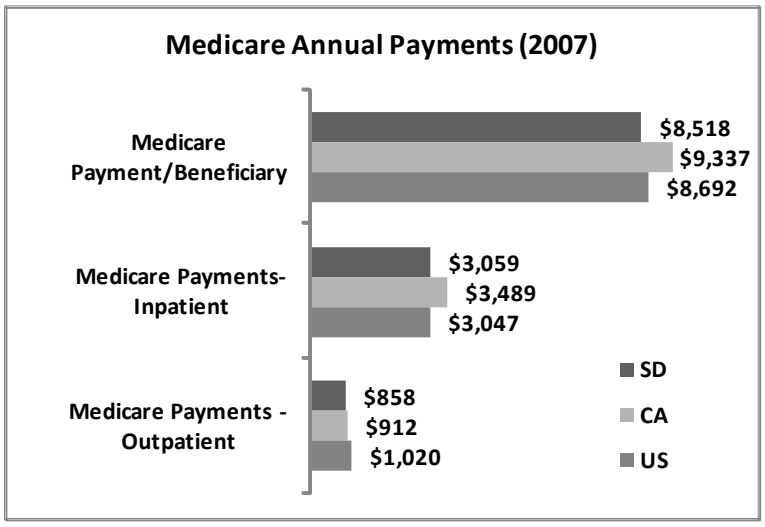
3. HEALTH SYSTEM – Integrated, efficient, quality care		
Success Factors	**Further defined by:**	**Metric/Indicator**
Adequate number of providers (physicians, hospitals, etc)	• Number of primary care providers meet community needs • Number of specialty and ancillary providers meet community needs • Hospital/facility providers meet community needs	• Providers/Population* • Provider Participation in public and private coverage programs** • Self reporting of integrated delivery systems • Self reporting of EMR/EHR/PHR • Provider payment levels • ED Utilization rates • Beacon clinical outcomes data • ED-Clinic IT connectivity • Readmission Rates *CHCF *OSHPD *Dartmouth Atlas **SDCMS physician participation survey results/CMAC Annual Report
Workforce to meet demand/need	• Number of healthcare professionals support provider/community needs • Programs to train health professionals are adequate	
Capacity/infrastructure to meet needs	• Provider organizations have capacity and infrastructure to support providers and community service needs	
Payment rates are adequate to provide resources/access	• Payment rates ensure adequate provider participation and access under coverage programs • Payment rates cover cost of providing efficient care	
Integrated/coordinated healthcare delivery	• Healthcare delivery systems are integrated across the continuum of care (e.g., primary, specialty, treatment, diagnostic, hospital) • Patient care/test data available to all providers across continuum • Physician-led patient center medical home model adopted • Incentives aligned to quality and efficiency across the continuum of care	
Integrated health information system	• Information systems support integrated/coordinated delivery across the continuum of care • Information systems support efficient, timely access , quality outcomes • Individual access to personal health record	
Efficient, quality care and optimal outcomes	• Services result in optimal outcomes and health status • Services provided in a timely and appropriate manner • Quality care is delivered in all settings • Disease management and case management services are available, accessible and utilized to improve outcomes • Practice standards are established	
San Diego maximizes all funding sources for health system infrastructure and technology	• Public and private funding for facility improvement/expansion and health information systems • Public and private funding for innovation/pilot programs	

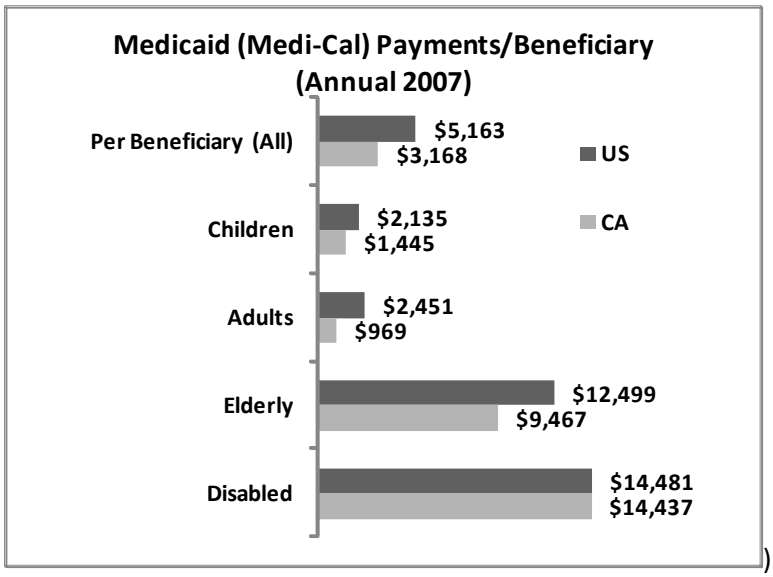
Attachment 3-C

Baseline Data: Key Metrics

HEALTH SYSTEM







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Gaps and Barriers Summary Statements

HEALTH SYSTEM

Inadequate number of physicians to meet increasing demands and needs. San Diego has a clear need for more primary care and specialty physicians, a need that will become critical as a high percentage of physicians retire over the next decade; the demand is expected to grow faster than physician supply due to population growth and aging, and an increased number of individuals with health coverage needing a primary care medical home. Today's physicians expect and have fewer hours of practice than previous generations and are poorly distributed across the region relative to the population. The physician community does not reflect the diversity of the populace and many young people of color do not view, and are not encouraged, to pursue health professions as an attainable career option. Medical schools are not expanding enrollment to keep pace with growing needs and most medical students are not selecting primary care specialties due to lower pay relative to workload. The cost of attending medical school leaves physicians with high debts that also influence their choices towards higher paid specialty practice. There are licensing and regulatory barriers to recruiting physicians to San Diego (and California) due to limited reciprocity with other states and an 8-12 month process for license approval.

Use of nurse practitioners and physician assistants could also help, however, the low payment rates for these services makes hiring prohibitive for physician practices. Payer payment policies are barriers to the creation of physician-led teams that may include nurse specialists, health educators and nutritionists; most payers will only pay for a physician visit and not care management and education visits to other team members, policies which would expand physician capacity and improve care.

Low reimbursement rates and payment policies limit provider participation in public programs and health system viability. California public programs (e.g. Medi-Cal) reimburse providers less than all but one other US state and already represent real access challenges for San Diego's 450,000 Medi-Cal beneficiaries. Because of a federal rural designation, it is reported that San Diego physicians make 8% less than Orange County under Medicare with a similar situation for hospitals. Under health reform, it is expected that San Diego will experience an increase in Medi-Cal of close to 150,000 enrollees, creating further challenges to access and provider viability. Low Medi-Cal reimbursement rates are a barrier to specialty care access, with long lead times for the small number of specialists who will take a limited number of Medi-Cal patients. While Community Health Centers will seek to expand primary care for increased numbers of Medi-Cal and those remaining uninsured, the need for specialty care remains to be addressed. As noted above, payer payment policies are a barrier to creation of patient care teams to expand physician capacity.

Low public program reimbursement rates negatively impact hospitals and other healthcare providers. Over the years, many hospitals and emergency departments have closed or been sold, primarily due to a high percentage of underfunded public program and uninsured patients. Hospitals must manage their mix of patients in order to continue to serve the community and cover the cost of unfunded care; unfunded care which leads to higher insurance premiums and taxes (disproportionate share payments). To the extent that new payment models and efforts under health reform reduce these sources without recognizing the continued burden, hospital services in many communities can be expected to erode and access to be diminished. San Diego is a highly advanced managed care market and has already achieved significant utilization reductions and savings, so may not benefit as much as other communities by the proposals under ACA.

Inadequate health professions workforce to meet demand. The inadequacy of the current and future health professions workforce is already an issue for the region. The health system needs more trained nurses, respiratory and

physical therapists, radiology technicians and other allied health professionals. As with physicians, a high proportion of nurses are close to retirement and, in fact, some retirees have only returned to work temporarily because of the recession. Nurses and other health professionals experience burn out, lose sight of purpose over administrative duties and often feel unappreciated for their roles. There are not enough students selecting a health professions career and not enough education slots at schools; as a result, the health professions "pipeline" is not adequate to meet growing needs. Even as the demand and shortages grow, the requirements for health professionals increase. Vocational school programs have all but disappeared. In addition, it is perceived that educational programs are not consistent with real world needs; schools do not have standardized criteria or include adequate clinical time so that graduates are prepared with the knowledge and experience needed to begin work in the health setting. Young students (K-12) are not exposed and encouraged to pursue the sciences; there is a perception that health professions are difficult to achieve, difficult and messy work environments and do not provide adequate pay.

Health system is not integrated into public and land use policy as essential critical infrastructure. As San Diego has and continues to expand or redevelop, policies and planning do not take health care into consideration as they do utilities, public safety or fire protection. And yet, the health system is expected to perform as a part of the critical community infrastructure and is the largest economic and employment sector in the region. The need to ensure locally accessible health services increases as communities grow and traffic increases; however, health care is generally not addressed or treated less favorably than a department store by planners and public policy makers. Regulatory barriers, extremely burdensome and bureaucratic building requirements and processes, and unfunded mandates make it difficult to expand healthcare capacity to meet community needs.

Lack of clear definition and criteria for integrated and coordinated health care delivery to support efficiency, quality and optimal outcomes. During Task Force deliberations, it became clear that there are no clear and standard definitions or criteria for integrated care or coordinated care. San Diego is considered quite advanced in health System integration; however, being in a hospital system with affiliated providers may not mean integrated or even coordinated care. Likewise, there is no standard criteria to define integration or disease management; in fact, there are disease management programs that provide different services and resources ranging from handing a patient a list of classes and a call center number to comprehensive programs providing case management, laboratory monitoring, nutrition, health education and periodic specialty check-ups.

The Accountable Care Organization (ACO) proposed under health reform has not yet eliminated legal concerns with regulations governing physician - hospital relationships and integrated delivery systems. It remains to be seen if these regulations will allow providers to align incentives and navigate regulatory barriers concerned with excessive referrals, kick-backs and other financial relationships.

Slow adoption and lack of health information technology integration. A critical component for integrated healthcare delivery is the ability to share and communicate patient information across providers using health information technology (HIT). San Diego hospitals are developing health information exchanges (HIEs) and are participating in the Beacon Collaborative; it is hoped that effort will serve as the basis for building further connectivity. In addition, for some time Beacon will be focused on specific disease outcomes and it can be expected that other ongoing local HIT efforts may not be consistent with the Beacon Collaborative.

Adoption of electronic medical records (EMR) and the interfaces required to create an EHR represents both cost and operational challenges to physicians and clinics, especially to smaller practices. Many individual health systems are working towards a single or linked electronic health record (EHR) across their system, but still face challenges with sharing information among providers due to privacy laws. There are local projects that link hospital emergency departments with community health centers allowing direct appointment-making for those needing a medical home (e.g., Safety Net Connect, ED Connect, etc.); however beneficial, current status is limited and fragmented. Further, an

uninsured individual referred from an ED to a Clinic may not be prepared or able to "pay" for services, even at a reduced rate, until coverage expansions are fully implemented.

Currently, there are no clear data standards, no standard outcome definitions or expectations and no plan of action to collect and assess performance and relate it to the cost of care. As the expectation that providers practice evidence-based medicine increases, that expectation creates a need for provider decision-support tools to support those expectations; however, there does not appear to be a plan to make a *standardized* set of decision-support tools available to providers, nor assurances that these will be the same across all payers and/or providers. Until such tools are deployed, it will be difficult to eliminate excess costs related to overutilization and defensive medicine.

Attachment 3-E

San Diegans for Healthcare Coverage

Task Force: San Diego Roadmap to Coverage and Care

Planning for Success under Health Reform

Strategies and Solutions Summary
HEALTH SYSTEM

Communication/Education

1. Provide timely, up-to-date information and education to providers on health reform
   - **a.** Coverage available to consumers/patients
   - **b.** Reimbursement incentives and disincentives
   - **c.** Funding/grants and resources for health system improvements (e.g., HIT, clinical outcomes)
2. Encourage engagement of providers in consumer education and distribution of information/materials
3. Pursue a communications and education strategy promoting healthcare system as a part of the critical infrastructure within the community(ies)

Resources/Funding

1. Pursue resources to support primary care providers in meeting patient centered medical home requirements
2. Pursue resources to expand provider capacity to meet demand created by newly eligible individuals
3. Promote inclusion of Coordination of Care Outcome Measures segment in future community health needs surveys to monitor the effect of health reforms

Systems Change

1. Encourage and support integration and coordination of care across the continuum to maximize efficiency, cost, quality and optimal patient outcomes
   - **a.** Promote use of standardized definitions, evidence-based protocols and automated decision-support tools for providers to improve efficiency and monitor outcomes relative to costs
   - **b.** Promote the concept that integrated delivery systems achieve and invest a portion of savings in health improvement strategies
2. Encourage and support primary care (clinics, medical groups and physicians) adoption and implementation of the patient centered medical home model
   - **a.** Promote collaboration to effectively/efficiently meet medical home criteria
   - **b.** Promote coordination and integration of behavioral health with primary care
3. Pursue regional and collaborative solutions for increasing the capacity of specialty care available to community health center patients (e.g., centralized FQHC specialty practice clinics)
4. Promote physician recruitment and retention strategies that accommodate a changing physician workforce (e.g., flexible hours, job sharing, and predictability)

Information Technology (IT)

1. Promote and support adoption of electronic health records, health information exchange and technology (e.g., MHealth*) to improve care, communication, collaboration, efficiency and outcomes
   - **a.** Promote Health Information Technology (HIT) standardized definitions and interoperability, including EMR, EHR, Health Information Exchange, MHealth*, telemedicine, etc.
   - **b.** Promote use of standardized definitions, evidence-based protocols and automated decision-support tools for providers to improve efficiency and monitor outcomes relative to costs

   c. Promote implementation/expansion of information system(s) for hospital patient referral and communication to clinics and physicians to establish a medical home and encourage appropriate use of the healthcare system
2. Establish standardized metrics to monitor effects of health reform on utilization, provider capacity, etc.
3. Encourage provider use of proven technology to improve efficiency, quality and health outcomes
4. Promote incorporation of HIT training in undergraduate, medical school and health professions curricula and clinical training time

*MHealth field has emerged as a sub-segment of EHealth. MHealth applications include the use of mobile devices in collecting community and clinical health data, delivery of healthcare information to practitioners, researchers and patients, real-time monitoring of patient vital signs and direct provision of patient care via mobile telemedicine.

Policy/Advocacy

1. Pursue collaborative advocacy strategies to maximize collective strength and influence to address local, state and federal issues related to achieving and maintaining a healthy healthcare infrastructure, including but not limited to:
   a. Reimbursement and funding to cover actual cost of care and/or mandates
   b. Payment equity and improvements (IGT, public/private, rural/urban, GPCI, SGR, etc)
   c. Reimbursement to physicians for allied health professional staff to provide case disease management, counseling and education (e.g., nurse specialists, nutritionists, health educators, etc) and for case management/care coordination team meeting
   d. Healthcare system as part of regional critical infrastructure and need to consider in land use/community planning and development, permit processes, regulatory exemptions, support, etc.
   e. Tort reforms to eliminate/minimize malpractice laws leading to excess utilization/defensive medicine
   f. Increase local health shortage area scores to improve reimbursement/funding
   g. Clarification and elimination of HIPAA barriers to coordination and collaboration among providers
2. Pursue standardized criteria and incentives for provider integration of prevention, disease management and education programs, including:
   a. Standardized definitions and criteria
   b. Payment for services and teams and incentives for use
   c. Incentives for collaboration and communication among providers (e.g., physicians, clinics, hospitals)
3. Support strategies to increase the number of individuals exposed to and selecting health professions, including:
   a. Programs and spokespersons to provide health system/professions exposure to K-12 students (e.g., job shadowing, internships, recruiters, biology/chemistry class programs/students, curricula, magnet schools)
   b. Targeted to reflect cultural and ethnic diversity of our area
   c. Increased California residency slots for impacted physician specialties
   d. Align local/regional educational capacity (faculty, programs, slots) for health professions training programs to meet future needs (e.g., nurses, respiratory therapy, physical therapy).
   e. Standardize and align educational programs and increase clinical time in training to improve student preparedness and potential for employment
   f. Financial incentives and support to pursue medical practice or health professions (e.g., expand Steve Thompson fund, FSDCMS scholarships, student loan reductions for years of service in community setting, primary care bonus program) in impacted areas or underserved areas

SAN DIEGANS FOR HEALTHCARE COVERAGE
A COALITION FOR HEALTH

Mission

The trusted community leader and unbiased resource. Convening the community, providing the voice, and serving as the navigator to achieve optimal health coverage and care for all San Diegans.

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