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

DEPT: Health Services Agency **BOARD AGENDA #** B-19

Urgent ☐ **Routine** ☒ **AGENDA DATE** March 18, 2008

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

SUBJECT:

Acceptance of the HFS Consultants' Final Report on the Health Services Agency Strategic Planning and Financial Evaluation Project and Approval of the Recommended Reduction in Force of Five Full-time Filled Positions and Five Vacant Positions Effective April 18, 2008

STAFF RECOMMENDATIONS:

1. Accept the final report from HFS Consultants on the Health Services Agency Strategic Planning and Financial Evaluation Project.

2. Approve the reduction-in-force and deletion of five filled full-time positions and the deletion of five vacant full-time positions, effective April 18, 2008, as outlined in Table 2 of this report.

3. Amend the Salary and Position Allocation Resolution to reflect the recommended changes as outlined in Table 2 of this report.

Continued on page 2

FISCAL IMPACT:

As the Health Services Agency entered the third year of the Board-approved three-year Strategic Plan, it faced a significant financial challenge, both in its operating budget and in its cash position. The 2007-2008 Proposed Budget for the Clinics and Ancillary Services Division reflected an unfunded shortfall of $12.6 million for which funding was not identified.

Continued on Page 2

BOARD ACTION AS FOLLOWS:

No. 2008-189

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

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

Christine Ferraro

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

STAFF RECOMMENDATIONS (Continued):

4. Approve an additional 5% license pay for registered nurses in a Management job classification to recognize the ability to provide back-up nursing care to patients.

5. Authorize the Chief Executive Office and the Managing Director of the Health Services Agency to fulfill the operational activities associated with implementation of the above recommendations.

FISCAL IMPACT (Continued):

The final approval of the County's application for Federally Qualified Health Center Look-Alike (FQHC-LA) was received on September 24, 2007. The cost report provided by HFS Consultants estimates that FQHC-LA status will provide additional revenue of $6.4 million annually in increased reimbursements for primary care and urgent care clinic services. In addition, initiatives presented and approved by the Board of Supervisors on September 11, 2007 and October 16, 2007 are estimated to increase revenues and reduce costs by over $6 million annually. The Health Services Agency budget was adjusted as part of the First Quarter Financial Review to reflect the impacts of receipt of FQHC-LA designation and approved initiatives. The following table (Table 1) includes initial annualized projections as well as the projected impacts assuming the actual effective dates of initiatives and FQHC-LA enhanced reimbursement, which all began after the first of the fiscal year, and reflects the additional General Fund contribution authorized by the Board as part of the First Quarter Financial Report for 2007-2008.

Table 1

Clinic & Ancillary budget (includes MIA)	**2007-2008 Annualized Projections**	**2007-2008 Projections – Prorated Improvements**
Estimated shortfall	$17.0 million	$17.0 million
Planned General Fund contribution	(4.4 million)	(4.4 million)
Adjusted shortfall	12.6 million	12.6 million
FQHC-LA Net impact	(6.4 million)	(4.9 million)
Efficiency Improvements through Initiatives	(6.2 million)	(3.5 million)
Necessary Additional General Fund Contribution	0	$4.2 million

Although the current estimated amount of additional General Fund contribution is less than previously projected, the Health Services Agency budget was not adjusted in the mid-year budget proposal, as the projections are based on a relatively short period of experience in the fiscal year. Initiatives that are contributing to this optimistic projection have been implemented between September and December. Additionally, these projections do not include the impact of approved or proposed State budget cuts that could potentially affect this Fiscal Year.

Cost savings from initiatives contained in this report that were not previously recommended, are estimated to further reduce the operating loss by approximately $600,000 annually. However, given timing of implementation of the new initiatives, it is anticipated that any additional savings to be realized in this fiscal year will be minimal.

In future years, the on-going General Fund contribution authorized by the Board on September 13, 2005 along with the additional revenues from FQHC-LA and the annual savings associated with the recommended efficiencies should allow the Agency to submit balanced budgets annually.

DISCUSSION:

Background

In September 2005, the Board of Supervisors adopted the recommended three-year Strategic Plan for the Health Services Agency. This plan infused $16.7 million from the County's General Fund into the Agency and recommended several strategies for change to the clinic system and Medically Indigent Adult program in order to continue to provide access to residents who rely on the Agency for their health care needs, primarily those who are underserved and uninsured.

While some of the 2005 strategic plan initiatives have been achieved the Agency has continued to struggle financially and required $9.5 million in addition to the $16.7 million planned contribution in order to balance the budget through the 2006-2007 fiscal year-end.

The most significant initiative within the Health Services Agency's Clinics and Ancillary Services Division Strategic Plan to achieve financial sustainability, was the pursuit of the Federally Qualified Health Center Look-Alike (FQHC-LA) designation. The application for that designation was submitted to the federal Health Resources and Services Administration (HRSA) in August of 2006. On September 24, 2007, final approval was received with an effective date of September 20, 2007.

For Fiscal Year 2007-2008, the financial goal of the Agency's Clinics and Ancillary Services Division was to achieve a break-even position with a planned general fund contribution of approximately $4.4 million. Projections submitted with the Proposed Budget in June 2007 indicated that without the FQHC-LA designation or other significant system changes, the Clinics and Ancillary Services Division would require approximately $12.6 million in additional funding to achieve a break-even position. Having received the FQHC-LA designation, the Agency estimated that the corresponding net improvement would be $6.4 million annually, leaving a remaining annual operational shortfall of approximately $6.2 million.

Based on the urgency and level of complexity regarding the Agency's shortfall, the Board authorized the engagement of external experts, HFS Consultants. These experts have assisted the Chief Executive Office and Health Services Agency staff in the development of policy recommendations to resolve the current fiscal crisis and to implement sustainable solutions that seek to preserve services for the community within limited available resources. The Board's Health Executive Committee, comprised of Supervisors Mayfield and Grover, has been deeply involved in these efforts through regular meetings and continues to provide focus and direction to the Agency and HFS Consultants as the initiatives are developed and brought to the full Board.

Given that both the FQHC-LA designation and the deficit-reducing initiatives approved on September 11, 2007 and October 16, 2007, were not effective at the start of the fiscal year however, the Agency will not have the full annual benefit of these changes in the current fiscal year. A projected $4.189 million of additional General Fund was projected to balance the Agency's budget during this fiscal year, and was approved as part of the First Quarter Financial Report for 2007-2008. For clarification, some of the initiatives required a hearing and/or where a reduction-in-force was applicable, notice periods were required in accordance with the County's labor agreements. A public hearing took place on October 16, 2007 and the related initiatives, including staff reductions, were implemented effective December 1, 2007.

The Strategic Planning and Financial Evaluation Project Final Report

The attached final report provided by the HFS Consultants reflects a focused effort at identifying and implementing change in the Health Services Agency's Clinics and Ancillary Services Division. Both the Health Services Agency and the Chief Executive Office have worked in collaboration with HFS Consultants on this effort and have greatly benefited from their expertise. The recommendations contained in the initial report presented on September 11, 2007 and this final report are expected to allow the County and the Health Services Agency to continue to provide clinical services to the community, within available resources.

This final report includes a summary of the scope of work provided by the consultants, an update of the implementation progress on the initiatives approved in the initial report, as well as an update and recommendation on additional initiatives. Work on additional initiatives provided in the HFS Final Report has produced recommendations that are projected to save an estimated additional $1.2 million annually. Two of these recommendations require that a public hearing be conducted prior to Board consideration that is scheduled for March 18, 2008 at 6:35 p.m. Other recommendations would require notice periods pursuant to labor agreements, such that if approved, the financial impact will be more important for the Agency's Fiscal Year 2008-2009 budget.

The status of initiatives, financial progress and current recommendations were outlined for the Health Executive Committee of the Board of Supervisors at their meeting on February 5, 2008.

Staffing Related Recommendations

The entire list of initiatives calls for many changes and efforts to redesign the Agency's Clinic system. As part of the initial group of changes identified for consideration, a target goal of $500,000 was established based upon a general assumption that a 2.5% reduction in staffing could be achieved. What followed was a study by HFS Consultants, with input from Agency and Chief Executive Office staff, of the management organization structure, as well as a staffing ratio study within the clinics.

Regarding the clinic staffing, the consultants focused on the benchmarking of staffing ratios both internally and externally, based on the volume of clinic providers and scope of service. The consultants' review of the management organization considered factors such as span of control, program complexity, and current and emerging issues.

The resulting recommendation is for the deletion of 10 full-time positions (5 filled, 5 vacant) and 4.25 Full-Time Equivalent (FTE) positions. The 4.25 FTE reduction impacts eight individuals who work as extra help (2.55 FTE) or are Personal Services Contractors (1.7 FTE). The total proposed FTE reduction is then 14.25 positions.

These changes are projected to provide annual savings to the Agency in the amount of approximately $600,000. Not all of the 14.25 FTE positions contribute to this projected savings figure as the salary savings from some vacant positions has already been assumed by the Agency. The HFS Report provides additional detail on the work conducted from which these recommendations were formed, including benchmarking other county and non-county community clinic systems. One additional filled position is recommended for deletion in the Indigent Health Care Program (IHCP) This was not included in the scope of work of the HFS Consultants' staffing study which focused on

clinic staffing and the management organization structure. It is important to note that these recommended reductions are in addition to the reductions that occurred as a result of the public hearing held on October 16, 2007.

A separate issue regarding staffing and management that was not a subject of the HFS Consultants' review, is one impacting our clinical management staff. Several years ago, on February 25, 2003, the Board of Supervisors approved a 5% license pay for Clinic Nurse Managers who have a registered nurse license and the ability to provide nursing care to patients on a back-up basis. This Board approval was specific to the Manager IV job classification. Last year, to address the need in the Agency's Specialty clinics, a Manager II was added to support and provide back-up to the Clinic Nurse Manager (Manager IV). Although this Assistant Clinic Nurse Manager is a registered nurse and does provide direct patient care from time to time, the Agency was unable to offer the license pay, as the Board's prior approval was specific to the Manager IV job classification. Considering the present shortage of nurses and the Agency's need for succession planning, the capacity and flexibility that working nurse managers offer the clinic system, is valuable. If approved, this recommendation will achieve consistency and support the needs of the clinic. Although as requested, the policy would apply to any Management classification that serves in the capacity of Clinic Nurse Management, presently it would apply to just one individual.

POLICY ISSUE:

Approval of this item supports the Board of Supervisors' priorities of a healthy community and efficient delivery of public services, by strategically focusing efforts to preserve an effective clinic system within available resources.

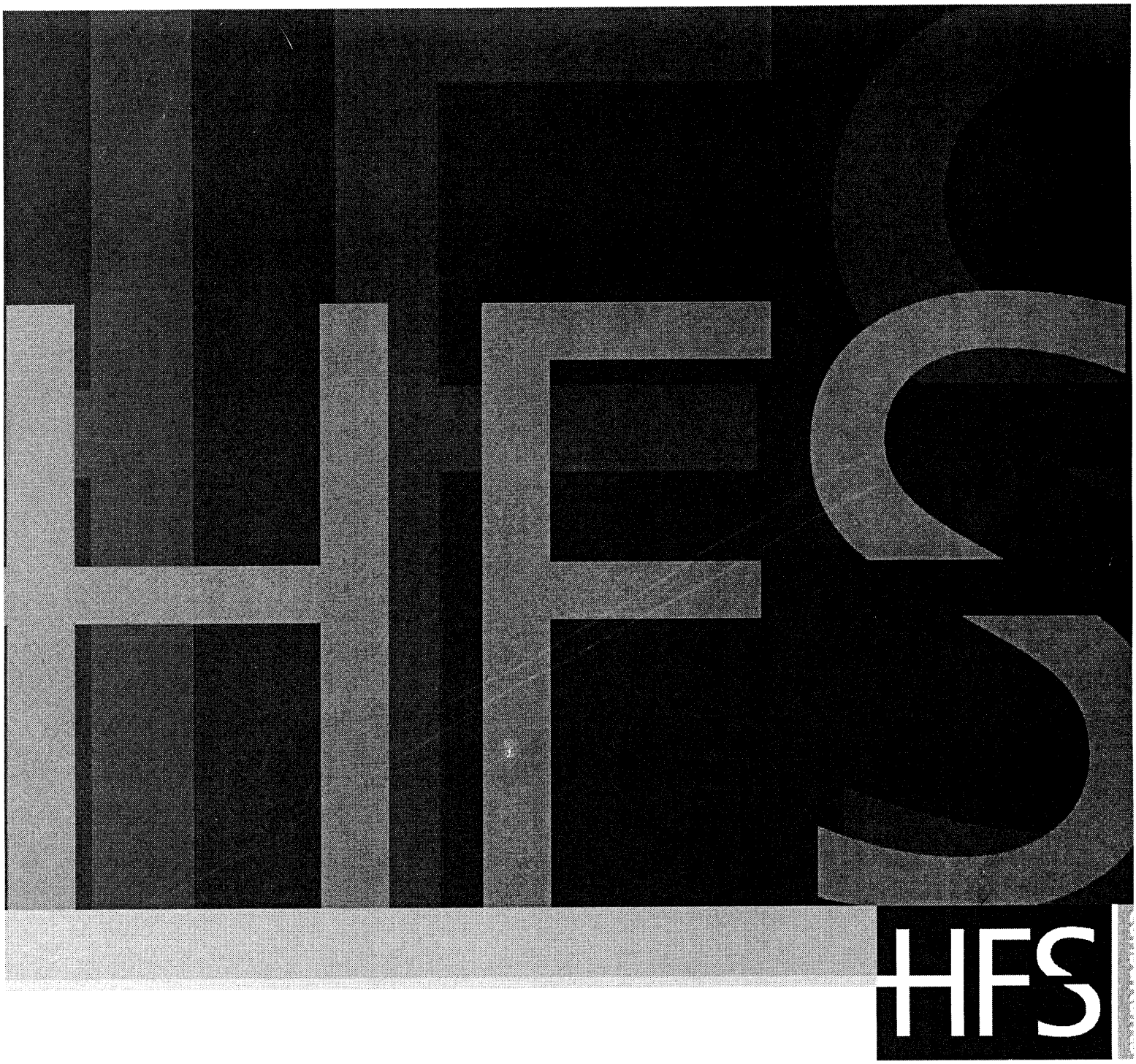
STAFFING IMPACT:

The recommendations in this agenda item will result in staffing impacts to existing contract, extra-help and full-time allocated positions in the Health Services Agency. It is noted that 37 positions were eliminated on December 1, 2007, based upon the initial phase of recommendations presented on September 11, 2007 and October 16, 2007. This subsequent phase of staffing impacts will include the elimination of 10 full-time allocated positions and 4.25 Full Time Equivalent (FTE) positions consisting of extra help and personal services contract staff. Unlike the December 1, 2007 reductions that were based upon the elimination of particular services, the reductions recommended herein are based upon workload and process efficiency and upon staffing ratios present in similar clinic systems.

Reductions in full-time allocated positions include five unclassified positions in three budget units (Administration, Clinics and Ancillary, and Health Coverage and Quality Services), one classified position in IHCP, and four classified positions in the clinics. Of the ten full-time positions, five are currently vacant. Table 2 reflects the details of the positions recommended for deletion, as part of this item. It is recommended that the Salary and Position Allocation Resolution be amended to reflect these changes effective April 18, 2008. Staffs from the Chief Executive Office and the Health Services Agency have initiated discussions with designated labor representatives regarding the projected impacts of these recommendations on existing County employees. It is anticipated that some of the impacted employees will maintain employment through transferring to vacant positions within the Agency.

Table 2

Allocated Budget Unit	**Position Number**	**Allocated Classification**	**Vacant/Filled**	**Filled Classification**	**Recommendation**
Clinic and Ancillary	3642	Account Clerk II	Filled	Account Clerk II	Delete
Clinic and Ancillary	3729	Medical Records Clerk	Filled	Medical Records Clerk	Delete
Clinic and Ancillary	6266	Licensed Vocational Nurse II	Vacant	-	Delete
Clinic and Ancillary	1049	Nursing Assistant	Vacant	-	Delete
Clinic and Ancillary	1571	Manager IV	Vacant	-	Delete
Clinic and Ancillary	10443	Manager IV	Vacant	-	Delete
Clinic and Ancillary	6616	Manager IV	Filled	Manager IV	Delete
Health Coverage and Quality Services	8074	Associate Director	Vacant	-	Delete
Administration	1663	Manager III	Filled	Manager II	Delete
Indigent Health Care Program	0838	Family Services Specialist II	Filled	Family Services Specialist II	Delete



Stanislaus County Health Service Agency

Strategic Planning and Financial Evaluation Project

HFS Consultants

February 14, 2008

Phase 2

Final Report

Table of Contents

HFS Consultants

Stanislaus County HSA

Final Engagement Report

February 14, 2008

I. Introduction

Since the issuance of our first HFS Strategic Planning and Financial Evaluation Project Report in September, 2007, we have continued to work on the two primary goals of the project which can be summarized as:

1) Obtaining FQHC-LA designation and implementing the program throughout the FQHC-LA approved clinics &
2) Implementing Revenue Enhancement and Cost Reduction Initiatives

In addition to these two goals twenty key objectives to be achieved during our work engagement were articulated in the Scope of Service section of the Engagement Agreement between HFS and HSA. In light of these goals and objectives HFS has prepared this final report that will cover the following items:

- Provide a status report on FQHC-LA implementation efforts.
- Document Completion of Scope of Service Objectives.
- Provide Observations and Recommendations for the future.
- Present an Update on the High Priority Initiatives (Appendix 1).
- Present the HFS Staffing Study (Appendix 2).
- Present our Organizational Structure Proposal Report (Appendix 3).

It is our desire that this report provide both goal and objective status information and represent the completion of our current engagement. Your satisfaction is important to us here at HFS so we stand ready to answer any questions you may have upon your review of the document. We hope you are satisfied with our efforts to date and look forward to working with the HSA again.

II. Status Report on FQHC-LA Implementation Efforts

Since the submittal of the first Strategic Planning and Financial Evaluation Project Report, implementation of FQHC-LA related procedures across the designated clinics has gone forward. With help from HFS, the HSA Administration has submitted the data, documents and forms necessary to get enhanced interim FQHC-LA reimbursement. Sliding Fee scale adjustments have also been made and implemented. At the February 5th meeting of the Health Executive Committee of the Board of Supervisors, HSA's Chief Financial Officer was able to report a significant increase in our per clinic revenues as a result of these and other efforts. The next steps in the FQHC-LA process are to a) submit a recertification application for the next year of operation and b) strategize about how to approach the "base year" calculations that will go into the determination of the final FQHC-LA reimbursement rate. Key considerations include: programmatic changes, clinic site increases or decreases and capital expenditures (i.e. implementation of Electronic Medical Records).

III. Progress meeting the Scope of Service Objectives

There are twenty Scope of Service Objectives listed as part of the Engagement Agreement between HFS and HSA. HFS efforts to address each objective are listed below:

1) All day planning session with key staff.

As part of our Phase One Activities, HFS conducted an Initial Project Strategic Planning Meeting with key members of HSA's Administrative Team and with members of the CEO's Office. This initial effort led to the chartering of a Strategic Planning Team whose mission was to work with HFS in obtaining Federally Qualified Health Center–Look Alike (FQHC-LA) status; preparing for and implementing FQHC-LA throughout the selected clinics and developing and implementing Revenue Enhancement and Cost Reduction Initiatives (commonly referred to as the "High Priority Initiatives").

2) Briefings/Discussions with the Health Executive Committee of the Board of Supervisors, The Board of Supervisors, the Community Health Center Board, and as applicable community meetings.

On numerous occasions during the course of this engagement HFS has provided updates, reports and briefings to both the Health Executive Committee of the Board of Supervisors, the full Board of Supervisors and the Community Health Center Board (CHCB). HFS has also participated with HSA in making presentations at a Community Health Summit and a meeting of community groups from the community around the Paradise Medical Office.

3) Discussion with Behavioral Health and Recovery Services for appropriate coordination of community building.

HFS has participated with HSA Administration in meeting with Behavioral Health and Recovery Services to discuss issues of common concern.

4) Assist, comment or otherwise advise on the process management of the clinic system, to include implementing new processes based on our findings and the findings of the County's internal audit team, review of financial statements, billing processes and receivable and denial patterns, reimbursement arrangements, professional and support staffing levels and arrangements to improve efficiencies and maximize revenues.

A number of activities have been conducted by HFS in addressing these items. First, as part of the FQHC-LA implementation and the High Priority Initiatives effort we have helped HSA initiate various changes with financial and billing operations (ex. Sliding Fee Scale changes;

Eligibility changes; FQHC-LA Reimbursement adjustment, etc.,). Additionally, HFS has made recommendations that have had a significant impact on overall staffing levels (i.e. Closing Laboratory and Radiology Services; prepared a Staffing Study with recommendations for adjusting clinic staffing levels). HFS has also directed the development and implementation of

numerous "High Priority Initiatives" that have improved efficiencies and maximized revenues (i.e. Urgent Care Hours/Staffing changes; Organizational Structure Proposals, etc.,).

5) Explore opportunities to partner with other health care providers.

HFS helped HSA initiate a dialog with physicians and other healthcare providers at the HSA sponsored Community Health Care Summit. HFS encouraged HSA and the Community Health Center Board in its effort to start a dialog with the Board of Golden Valley Health Care.

6) Explore opportunities to substitute services using other, more cost-effective strategies, or eliminate or reduce services.

As part of the High Priority Initiatives process HFS has made recommendations that have resulted in the elimination of some services (i.e. Laboratory and Radiology services), and the reduction of others (i.e. Urgent Care). These actions have reduced overall cost to the clinic system while leveraging services within the community to provide for discontinued HSA provided services.

7) Conduct a review of the organization chart and determine gaps in positions, leadership and management.

An Organizational Structure Proposal has been developed and presented as part of this report that addresses this item (See Appendix 3).

8) Explore the possibility of streamlining supervision of sites and staff using existing positions.

As part of the Organizational Structure Proposal, the concept and implementation of the two clinic, one manager concept has been refined and supported (See Appendix 3).

9) Assist with the provision of operational direction to the clinics.

In light of key upper level management positions being vacant at HSA during the time of this engagement, significant operational assistance has been given to HSA Administration in various areas (i.e. Project Management for proposed relocation of the Urgent Care Clinic to Paradise Medical Offices (PMO) and the development of a centralized Medically Indigent Adult Clinic (MIA) at PMO, etc.,).

10) Conduct productivity analysis for all providers, assess appropriateness of nursing support to providers.

Staffing support for providers was assessed as part of the Staffing Study HFS conducted as a part of this report (see Appendix Two). This report also looked at some provider productivity issues. In recognition of some data gaps in this area, HFS has assisted the HSA Medical Director with his focused efforts to develop additional data and appropriate productivity analysis tools.

11) Review all grants and contracts to determine the number of current positions can be supported from external sources, such as grants from the State, private foundations or federal programs.

Third Party Payor Contracts were evaluated as part of the "High Priority Initiatives" processes. Contracts that had a negative financial impact on HSA were recommended for termination. Most significantly, despite HSA efforts to negotiate better agreements, contracts with most others commercial carriers were eventually terminated. With regards to grants, the Title X Family Planning Grant was reviewed and renewed as part of the "High Priority Initiatives" processes.

12) Assess external factors impacting access, reimbursement rates, changes in demographics, etc. that affect financial performance expectations.

HFS has given advice and analysis about a number of external factors affecting HSA. Examples include (but are not limited to) changes in service area demographics (advise given in the first Strategic Planning and Financial Evaluation Project Report), and potential financial implications of the proposed state budget cutbacks.

13) Model an efficient clinic system without the FQHC-LA designation, which considers existing impacts and mandates, to project net income (loss).

Included in the first Strategic Planning and Financial Evaluation Project Report was an evaluation of several FQHC-LA Models including a no FQHC-LA designation model.

14) Model an efficient clinic system with the FQHC-LA designation, which considers existing impacts and mandates, to project net income (loss).

Included in the first Strategic Planning and Financial Evaluation Project Report was an evaluation of several FQHC-LA Models including an approved FQHC-LA designation model.

15) Model an alternative(s) that achieves only the Medically Indigent Adult (MIA) mandate.

Included in the first Strategic Planning and Financial Evaluation Project Report was an evaluation of several FQHC-LA Models including a Medically Indigent Adult (MIA) mandate model.

16) Review the 2005 Strategic Plan to determine status of objectives in plan.

The 2005 Strategic Plan contained twenty different recommendations (labeled A-T). Reviewing the recommendations and information available leads us to conclude that progress is being made on most of the recommendations. In some cases the task has been completed (i.e. pursuing FQHC-LA status). In other cases only preliminary work has began (i.e. exploratory meetings to investigate alternative Medi-Cal Managed Care delivery options. In at least one case, a different plan of action has been decided upon (i.e. It has been decided that the Medical Arts Building would be vacated and made available for sale or other County use. The services that were offered within the Medical Arts Building were absorbed into other existing sites to gain efficiencies).

17) Conduct a SWOT (Strengths, Weaknesses, Opportunities and Threats) for the clinic and ancillary system, including the MIA program.

As part of the Initial Strategic Planning Meetings between HFS, HSA Administration a SWOT analysis process was used to help develop the initial list of High Priority Initiatives.

18) Develop policy recommendations for Community Health Center Board (as applicable) and Board of Supervisors consideration.

On several occasions HFS has developed and presented recommendations in association with HSA Administration that have been presented to an/or adopted by both the CHCB and the Board of Supervisors. Key examples of recommendations made include the reduction in Urgent Care Hours and closing of both the Radiology and Laboratory Departments.

19) Create Action Plan based on policy decisions, for effective implementation, including action items, due dates, and person(s) responsible.

As part of the roll out of the High Priority Initiatives effort, individual initiative tracking grids were created to facilitate tracking the progress made addressing the various action plan items listed in each grid. Examples of these grids were provided as part of the Phase1 Final Report.

20) Participate in Implementation Team meetings

HFS served as the facilitator for the monthly Strategic Planning Group Meeting (a.k.a. Implementation Team). As part of the action plan tracking effort a summary grid of the first group of Initiatives to have work initiated and completed (i.e. the first twenty "High Priority Initiatives") was developed and shared regularly with HSA Administration and the Chief Executive Office.

IV. Observations and Recommendations

Significant progress has been made toward bringing the HSA to fiscal solvency. The two primary elements in this progress have been the ability of the HSA to obtain FQHC-LA status for its designated clinics and the effort of HSA Administration and staff to identify and implement cost reduction and revenue enhancement strategies. Currently, all indications are that HSA is on track with these two efforts toward balancing the agency's budget. In going forward several key actions will be needed to maintain the progress. These actions include:

1) Maintaining progress on implementing the various initiatives.
2) Supporting the efforts of HSA to redesign the patient care delivery process with an eye towards increasing efficiency and reducing cost.
3) Implementing the Organizational Restructuring effort in a timely manner.

Key recommendations in support of these observations include the following:

1) Identify one senior level executive to be responsible for overseeing the tracking and implementation of the various initiatives. Likewise, involve the HSA Chief Financial Officer (CFO) in monitoring the financial gains that are suppose to be captured with the implementation of the each initiative.

2) Support Clinic wide efforts to implement process redesign. Significant synergies can be created if improved means can identify ways for the clinics to work together more closely. As part of the redesign effort, the impact that the implementation of an Electronic Medical Record System will have on clinic processes and staffing needs to be taken into consideration.

3) Implement the proposed structural redesign as quickly as possible. The key benefit of the redesign project (besides administrative staff reductions) would be to optimize clinic decision making for general operations at a level below the Executive Director.

Appendix 1

Projections and Initiatives	Conservative estimates	Aggressive Estimates	Revised Conservative estimates - 1/14/08	Indirects	Original Target Date	Revised Target Date	Comments	Months	Original Projection For Remainder of 07-08	Revised 2007-2008 Projection
Fiscal Year 2007-2008 Projected Operational Shortfall	**($17,000,000)**	**($17,000,000)**	**($17,000,000)**						**(17,000,000)**	**(17,000,000)**
Board of Supervisor General Fund Contribution	**$ 4,400,000**	**$ 4,400,000**	**$ 4,400,000**						**4,400,000**	**4,400,000**
Minimum Amount of Necessary Improvement	**($12,600,000)**	**($12,600,000)**	**($12,600,000)**						**(12,600,000)**	**(12,600,000)**
Phase 1 - High Priority Initiatives - Implemented										
Pharmacy-Staffing	$ 520,000	$ 770,000	$ 396,000		Nov 1	Nov 1	Implementing savings tracking, however, needed to add back an Admin position due to workload created by the e-recovery program	8	303,333	264,000
Pharmacy-MIA formulary	$ 1,000,000	$ 1,000,000	$ 1,600,000		Sep 1	Sep 1	Implementing savings tracking - savings tracking above original estimates	10	833,333	1,333,333
Pharmacy-Access 340B discounts (once FQHC-LA) & e-recovery	$ 500,000	$ 750,000	$ 432,000		Oct 1	Oct 1	Implementing savings tracking - Updated Fiscal analysis @ 36,000 per month	9	375,000	324,000
Review personal pay cash amounts and sliding scale; institute annual review per Strategic Plan	$ (60,000)	$ 150,000	$ (60,000)		Oct 1	Oct 1	Implementing savings tracking.	9	(45,000)	(300,000)
Add copay to zero share of cost MIA	$ 90,000	$ 90,000	$ 90,000		Nov 1	Nov 1	Implementing savings tracking.	8	60,000	60,000
Change maximum eligibility for MIA from 250% of FPL to 200%	$ 256,000	$ 256,000	$ 262,490		Dec 1	Dec 1	Implementing savings tracking - updated fiscal analysis @ 262,490 for 07-08	7	149,333	149,333
Reduce Urgent Care hours	$ 846,000	$ 846,000	$ 846,000		Dec 1	Dec 1		7	493,500	600,000
Changing classification in Urgent Care	$ 120,000	$ 150,000	$ 140,000		Dec 1	Dec 1	updated fiscal analysis	7	70,000	70,000
Eliminate Lab (buy for MIA)	$ 203,530	$ 718,864	$ 203,530	$ 450,000	Dec 1	Dec 1	RFQ. Potential additional savings of $173-203K; Future one time savings: Sale of equipment.	7	118,726	(96,000)
Eliminate Radiology (buy for MIA)	$ 315,000	$ 415,000	$ 315,000	$ 98,500	Dec 1	Dec 1	Decommissioning nearly complete; Future one time savings:Sale of equipment.	7	183,750	250,000
Eliminate biller position(s)	$ 50,000	$ 100,000	$ 140,000		Feb 1		**Admin Fund** - already implemented	4	16,667	140,000
Partially implemented or significantly underway									-	
MIA- Faster transition to Medi-Cal	$ 200,000	$ 200,000	$ 200,000		Oct 1	Oct 1	Provider training ongoing (Ortho; Oncology);	7	116,667	173,145
Implement Open Access/Same Day scheduling/Schedule Management	$ 1,000,000	$ 1,000,000	$ 1,000,000		Mar 1	Apr 1	PMO faculty & resident operations are implemented; Resolving operating issues before rolling out to remaining clinics.	4	333,333	250,000
Eliminate duplication of input into two accounting systems	$ 100,000	$ 100,000	$ 100,000		Dec 1	Jul 1	**Admin Fund** - Accountant retiring 3/08; 2 vacancies that will not be filling; current est svgs @ 27,000	7	57,940	30,000
Staffing efficiencies	$ 500,000	$ 500,000	$ 500,000		Jan 1	May 1	Proposal in March	2	250,000	83,333
Designate a clinic to serve all MIA patients-consider different physician compensation	$ -	$ -	$ -		Jan 1	Feb 1	Implementation underway. Provider base difficult.		-	
Renegotiate/Terminate commercial contracts	$ 360,000	$ 550,000	$ 360,000		Feb 1			4	120,000	
Indirect savings	$ 69,000	$ 69,000	$ 70,000		Jan 1	Feb 1		6	34,500	35,000
Planning/implementation efforts in progress									-	
Change Medical Transcription services to be consistent with more efficient sites to reduce direct costs	$ 150,000	$ 150,000	$ 150,000		Dec 1		Review indicates possible negative financial impact if transcription services discontinued.	7	87,500	0
Subtotal of Projected Savings from Phase 1 Initiatives	**$ 6,219,530**	**$ 7,814,864**	**$ 6,745,020**	$ 548,500					**3,558,583**	**3,366,145**
Projected Shortfall after Phase 1 Initiatives	**$ (6,380,470)**	**$ (4,785,136)**	**$ (5,854,980)**						**$ (9,041,417)**	**$ (9,233,855)**
FQHC-LA Net Impact	**$6,400,000**	**$6,400,000**	**$6,400,000**		20-Sep	20-Sep		9	**$4,851,762**	**6,351,762**
Projected Annualized Need	**$ 19,530**	**$ 1,614,864**	**$ 545,020**						**$ (4,189,655)**	**$ (2,882,093)**
Phase 2 - Under Consideration or Analysis Underway										
Revisit Dental Services, scope, delivery model, consider relocation of dental services			400,000		Spring 08	May 1	Proposal to BOS in March	2		66,667
Review High Risk OB, including CPSP							CPSP chart audit completed; Operational review.			
Change/Redefine Scope of Benefits - MIA Program			280,000			May 1	Proposal to BOS in March: elim mental health drugs	2		46,667
Schedule Management/Provider Scheduling to maximize resource effectiveness and revenue generation							Combined with Open Access Initiative; Tracking tools developed and being refined			
Evaluate all Specialty clinics by specialty, patient mix by specialty, contract arrangements										
Evaluate what/where programs are provided					Feb 08					
Develop a case management program for MIA patients					Mar 08		TAR reviews occuring; Med Dir data analysis			
Analyze MIA utilization, implement clinical protocols, review/revise auth req'ts, identify contract needs					Mar 08					
Pharmacy - Chemo Drugs Savings	-		600,000			Feb 1	estimated savings - $50,000 per month	5	-	250,000
Conduct a Make/Buy analysis of Pharmacy for MIA					Feb 08					
Subtotal of Projected Savings from Phase 2 Initiatives	**-**	**-**	**1,280,000**						**-**	**363,333**
Projected Annualized Need	**$ 19,530**	**$ 1,614,864**	**$ 1,825,020**						**$ (4,189,655)**	**$ (2,518,760)**

Appendix 2

HFS Consultants
Stanislaus County HSA
Staffing Efficiency Study
February 14, 2008

Table of Contents

I. Introduction

The purpose of the Staffing Efficiency Study is to identify appropriate levels of staffing for each of the Stanislaus County Health Service Agency (HSA) clinics and make recommendations on how to improve efficiency, productivity and reduce overall system staffing cost. To conduct the study, we reviewed information from external sources for general benchmarking purposes and reviewed internal site-by-site information to consider variables which impact appropriate staffing levels.

II. External Review

In order to develop baseline information, we gathered information on Community Health Centers. Community Health Centers are clinics that generally provide care to underserved populations in their services area, so this statistical source was considered to offer a better comparative model than national medical group statistics. We reviewed both National and California Community Health Center statistics. We attribute the 13% variation between the National and California statistics to marketplace differences (regulations, payor rules, cultural diversity, health trends, etc.) that contribute to the demand on manpower to operate a health clinic. We also gathered statistics from four California County clinic systems, as well as from two Family Medicine Residency programs. It is important to note that our review did not compare program scope, financial performance, productivity statistics or quality indicators, so the information is used as benchmark information, but should not be considered best practice information. A comparison of these statistics is provided in Table 1.

Table 1 Stanislaus County HSA
HFS Staffing Study
Staffing per Provider Comparison 2/14/08

Primary Care Clinics Comparison	Staffing per Provider FTE (Full Time Equivalent)
National	2.93
California	3.37
Counties	3.63
HSA	
Ceres Medical Office	3.2
Hughson Medical Office	3.6
McHenry Medical Office	3.2
Paradise Medical Office *	4.3
Turlock Medical Office	3
Pediatric Center	3.5
Urgent Care Center	2.2

Source: Information from National Association of Community Health Centers, Solano, Santa Cruz, Monterey and Santa Barbara Counties respective Health Departments.

*Principal Family Medicine Residency Program Site

III. Internal Review

In order to better understand the variability and contributing factors to staffing patterns, much information was gathered on programs, staffing classifications, providers, and general operating conditions. Not all programs create a significant staffing differential, while others do. For instance, the Residency Program that accounts for approximately 35% of the patient visits at the Paradise Medical Office (PMO) certainly is a contributing factor to the support staffing required. For a summary of the program variability, see Table 2. It is important to note that the volume of programs can vary widely from clinic to clinic. For instance, while approximately 35% of the PMO visits involve a Resident Physician, less than 10% of the visits at the McHenry Medical Office (MMO) involve a Resident Physician. The variation of programs is sometimes attributable to the scope of the providers practicing at a given clinic. For instance, the only clinic site with Pediatricians is the Pediatric Center (PEDS), so one would expect that the more seriously ill children which qualify for the California Children's Services Program (a payor and case management program jointly paid by the State and the County) would be part of the PEDS. Where the existence of a program required support staffing job classifications not required in the absence of that program, we excluded that staffing in our comparisons. For example, the peer provider counselors required in the Teen Clinic that operates at MMO and PMO only, were excluded in the staffing statistics captured in Table 1.

The study captured the provider staffing variations to generally assess the possible impact to staffing. These variations included the number of providers per clinic site, the percentage of providers working full-time vs. part-time, and the frequency of clinic scheduling changes such as when a provider will be unavailable for a clinic time with already scheduled patients. The study did not include a review of productivity by provider due to a data integrity concern.

The study also reviewed clinic size in terms of patient visit volumes, program variations and provider staffing levels. Each of these factors was a significant contributing cause of clinic staffing ratio variations.

Table 2 Stanislaus County HSA
HFS Staffing Study
Clinic Program Listings 2/14/08

Programs	CMO	HMO	TMO	PEDS	MMO	PMO	URGENT CARE
Comprehensive Primary Care	X	X	X	X	X	X	
Low Risk OB	X	X	X		X	X	
Perinatal Education(CPSP)	X	X	X		X	X	
Family Planning	X	X	X		X	X	
Well Child Care (CHDP)	X	X	X	X	X	X	
Cancer Detection Program (CDS)	X	X	X		X	X	
Cervical Cancer Program	X				X		
Immunizations	X	X	X	X	X	X	
Resident Training				X	X	X	
California Children's Services (CCS)				X			
High Risk Pediatrics				X			
Teen Clinic					X	X	
Geriatric Clinic						X	
Acute Care							X
Wound Care Medications							X
Occupational Health							X
Colposcopy		X	X		X		
High Risk OB					X		
Dermatology Clinic					X	X	
BCCCP						X	
Breast Cancer Early Detection Program (BCEDP)	X	X	X	X	X	X	

Source: Stanislaus County Health Service Agency-Primary Care Clinics-November 2007

The study also included process and programmatic discussions with each of the clinic managers, including not only the primary care clinics but also Specialty and Rehabilitation clinics. Data was captured to assess the types of support staffing used and additional review was done by subtotaling clinical support staffing volumes to clerical support staffing volumes by clinic. This was useful to identify potential process variations and create an opportunity to mirror best practices within the HSA system. Further it suggests that in order to achieve a best practice goal in each clinic, a process redesign is necessary to ensure that the most appropriate level of staff is providing the most appropriate function. For instance, if a licensed Registered Nurse is performing a clerical task, a process workflow redesign should be done to consider a more appropriate assignment to the extent clerical capacity exists. This additional assessment could indicate the need for job reclassification, which may result in incremental cost savings. To force consistency without a process redesign could save staffing costs, while creating revenue loss or a separate unforeseen operational expense. See Table 3 for the internal comparison by staffing type.

This review did however suggest efficiency reductions that could be made before or in the absence of an extensive process redesign. In some cases, the efficiency had been contemplated previously and was the intended result of a process redesign that was already underway.

Table 3 Clinical and Clerical Staffing Ratios Per Provider FTE

Clinics	Clinical Staffing per Provider FTE	Clerical Staffing per Provider FTE
Ceres Medical Office	1.7	1.5
Hughson Medical Office	1.9	1.7
McHenry Medical Office (includes OB/GYN)	2.1	1.1
Paradise Medical Office (includes Residency)	2.4	1.9
Turlock Medical Office	1.6	1.4
Pediatric Center	1.9	1.6
Urgent Care Center	1	.8
Specialty Clinics	4.9	1.4

Source: Data based on FY2006-7 clinic staffing numbers

IV. Recommendations

Based upon the scope of this review and discussions with HSA Management including Clinic Managers, the following actions are recommended. Where position reductions are recommended, the corresponding clinic manager has been part of the research and findings.

1. Consider the following reductions:

Clinic Site	Position Classification	Quantity or Percent of FTE
Hughson Medical Office	Account Clerk II	1
Paradise Medical Office	Clerical Community Aid I	.8
Pediatric Center	Licensed Vocational Nurse (reclassify this FT position to a PT RN for a .5 reduction of an LVN)	.5
McHenry Medical Office	Community Health Worker III	.5
Specialty Clinic	Registered Nurse III Registered Nurse II Medical Assistant Medical Assistant Medical Records Clerk	.2 .45 .75 .5 1
Rehabilitation	Physical Therapy Assistant Occupational Therapy Assistant Admin Clerk (Temporary)	.20 .85 .30
Total Staffing Reductions		7.05 FTEs

2. Examine process workflow in the best practice clinics, as defined by the most efficient staffing patterns, and compare that work process to the clinics with higher staffing patterns to understand the contributing factors and isolate controllable from

uncontrollable variables. Create transition plans to resolve the controllable variables and consider staff reductions and/or reclassifications as a result, that will not have a resulting negative impact to revenue, quality or compliance (Note: Given the intended implementation and transition to an Electronic Medical Record, this recommendation is a longer-term activity).

3. Continue the internal effort to generate reliable, accurate and timely productivity reports by provider. Add that data to a matrix that captures and compares staffing patterns against productivity and financial performance measures. The outcome of this matrix will be a more complex and comprehensive best practices model, to be used for on-going quality improvement purposes, and budget and staffing management purposes.

Appendix 3

HFS Consultants
Stanislaus County HSA
Organizational Restructuring Proposal Report
February 14, 2008

Table of Contents

HFS Consultants

Stanislaus County HSA

Organizational Restructuring Proposal Report

February 11, 2008

I. Introduction

HFS Consultants (HFS), working Stanislaus County Health Service Agency (HSA) Administration and Staff from the Stanislaus County CEO's Office (SCCEO), have developed the following Organizational Restructuring Proposal Report. The purpose of this report is to identify the Organizational Restructuring Opportunities for the (HSA) [excluding Public Health], and make a recommendation regarding which proposal we believe best meets the agencies needs.

The report will be presented in four sections. In section two, we present an Executive Summary of the report along with key findings and recommendations. In section three (Organizational Structure Redesign), we discuss the key considerations necessary to construct a sound Organizational Structure. In section four (Proposed Organizational Structures Discussion) we provide brief highlights of the proposals presented to the joint HFS, HSA, SCCEO team but ultimately not selected for implementation. In section five (Selected Organizational Structure and Recommendations), we'll discuss the selected proposal and review ways to maintain the momentum necessary to carry the initiative effort through to completion.

II. Executive Summary

Starting in September of 2007, an executive level team made up of representatives from HFS, HSA and SCCEO (hereafter referred to as "The Team"), started meeting together to discuss how to redesign HSA's organizational structure. The purpose of this effort was to identify an organizational structure for HSA that would be both a functional improvement over the existing organizational structure and more efficient. Over the course of several weeks The Team developed several different potential organizational structures (see Appendix 1). Ultimately HFS made recommendations to the representatives from HSA and SCCEO who then met and selected one proposal for implementation across HSA. The selected proposal provides several key advantages including:

- Reduction of reporting relationships to the HSA Executive Director
- Reduction in HSA managerial positions
- Reorganization of service lines
- Provides clear senior management structure for the clinical service line

The key observations and recommendations are as follows:

- Given that most of the clinic managers may be retiring in three to five years, it is essential to develop the RN III's within the system as potential managers for the future.
- Given the new roles being undertaken by key members of the Management Team having a retreat to focus on team building and planning could be helpful.

III. Organizational Structure Redesign

1). Organizational Structure Basics

For any business enterprise its organizational structure is the means by which management, employees and resources are linked together to achieve the business's mission and goals. An organization chart is the graphical manifestation of these linkages. Typically, the organization chart will have boxes which represent individuals or groups of individuals tied together as a business unit. These boxes are then usually organized into various groupings of boxes. These groupings represent a higher level of control and management. Ultimately, a final set of boxes is used to represent the top decision making authority within the business enterprise.

There are several different types of organizational structures. The different types allow for organizations to exercises the flow of resources, communication, finances and decision making in different ways. In the past, many organizations used a hierarchical organizational structure as their model for operations. This structure is used to express different levels/layers of a business in a vertical fashion with more power/authority located in each successively higher box/grouping. Typically, this structure is used when authority is centralized and power flows from the "top down". HSA's current organizational structure is a good example of a hierarchical organization (see Exhibit 1). Other types of business entities have found a "flat" organizational structure reduces the layers of management necessary to make decisions. This structure is typically found in businesses that are decentralized with a "bottoms up" orientation for information flow. Matrix Organizational Structures represent situations where cross functional responsibility requires dual reporting relationships. Deciding to use a hierarchical structure, flat structure, matrix structure or something in between depends upon the Chief Executive Officer and the organization's Board of Directors determining how much authority they wish to delegate to subordinate managers.

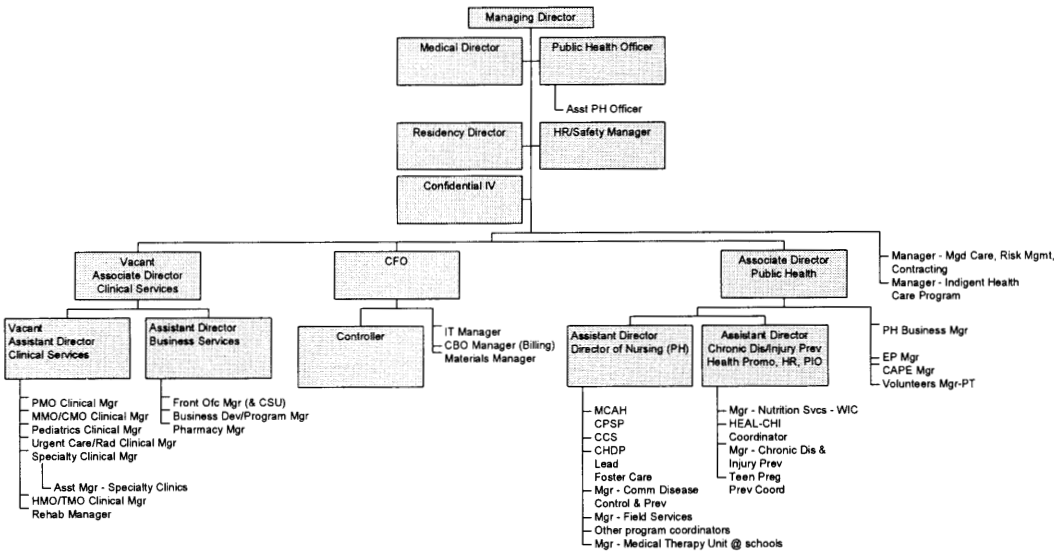
2). Key Redesign Considerations

During The Teams discussions several criteria were selected for use in determining the utility of a particular organizational structure to HSA executive management. Key factors included:

- Does the proposed organizational structure improve decision making within the organization?
- Does the proposed organizational structure address span of control issues for upper level management?
- Does the reassignment of individual managers improve the efficiency and effectiveness of the organization?
- Does the complement of managers identified as being needed in a particular organizational structure represents the best "mix" of talent necessary to run the organization?

Exhibit 1

Health Services Agency
Management Structure
December 2007



Utilizing these criteria, the team reviewed each proposal with a bias towards achieving the best combination of attributes possible. As the review went forward the team took pains to try to make decisions based on the positions under consideration and not on the individuals working in them.

IV. Proposed Organizational Structures

Appendix 1 contains examples of the non selected proposed organizational structure proposals. Three different models of organizational structure were considered with two minor variations on two of the models also considered. The primary services lines (Clinical, Financial/Support and Public Health) remained the same in each of the models. The number of positions deleted was also the same (four positions) except for one model where five positions were reduced. The key

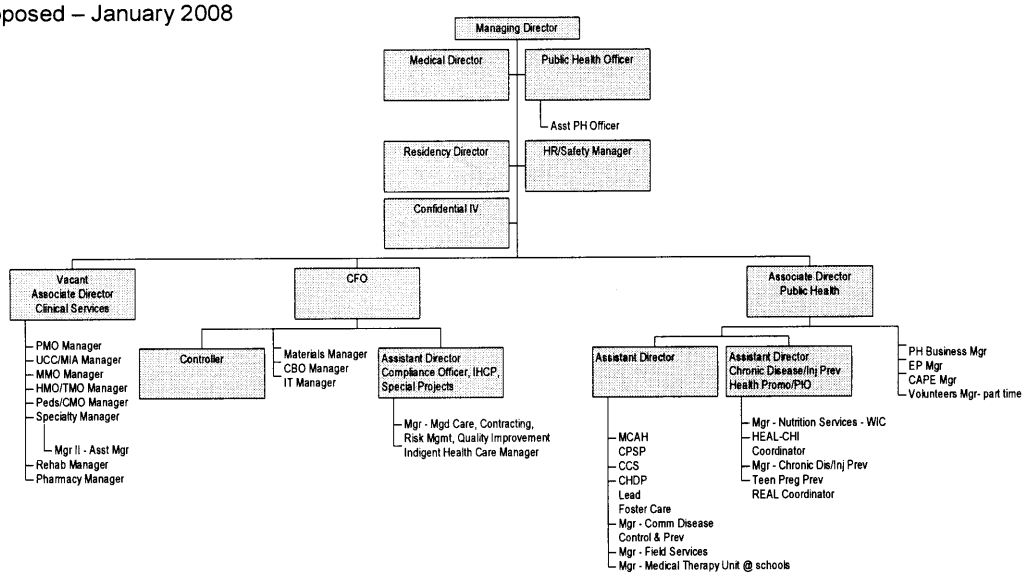
differences in the models was the number of positions that reported directly to the Executive Director (Range 6-9), whether the Safety and Risk Management functions were reassigned to another executive and whether a COO role was created. This last consideration was extensively discussed but ultimately rejected because of a concern that the agency needed more individual focus on each service line. Other considerations that were discussed as part of the review of each model included funding sources, regulations, skill sets and opportunities for collaboration.

V. Selected Organizational Structure and Recommendations

The proposal that was selected for implementation at HSA offered a number of advantages over the current organizational structure (see Exhibit 3). First, the new organizational structure dramatically reduces the number of direct reports to the Executive Director. This will allow the HSA Director to spend less time dealing with lower level operating issues and instead concentrate on the strategic and external issues facing the HSA. The new structure also establishes a single designated leader for the clinical service line. This change results in the ability to eliminate a vacant Assistant Director position. Another advantage of this proposal is the realignment of several functions and departments. Within the clinics, the management of McHenry Medical Offices (MMO) is reestablished as requiring a full time manager. However, the concept of having some managers of smaller clinics serving as managers of two clinics at a time is also retained with the shift of the Pediatric Clinic Manager to shared status for both the Pediatric Clinic (PEDS) and Ceres Medical Offices (CMO). The new organizational structure also brings Managed Care Operations, Risk Management and the Indigent Health Program under finance under the guidance of an experienced Assistant Director. This Assistant Director will also absorb some additional functions that will result in the elimination of a Manager IV and a Manager II. Overall the new structure achieves all of the key criteria identified as important by HSA, HFS, and SCCEO and should promote more efficient operations.

Exhibit 3: New HSA Proposed Management Structure

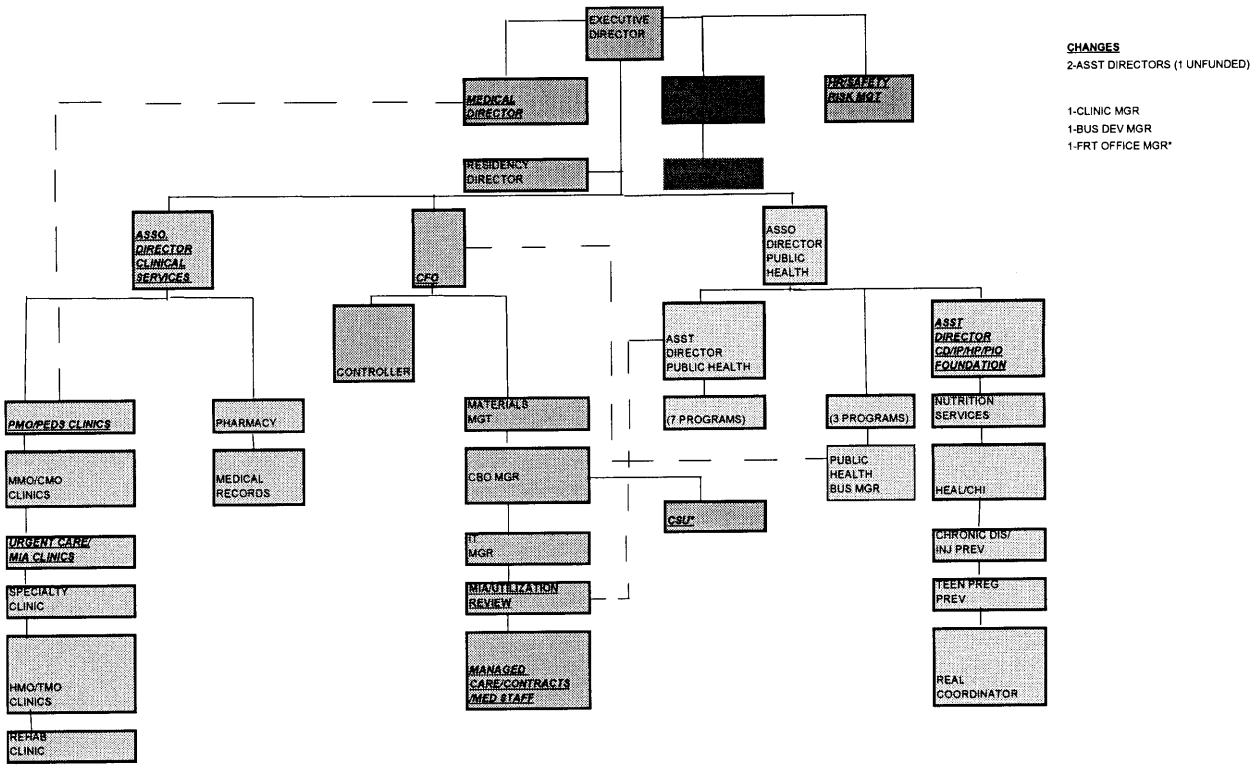
Health Services Agency
Management Structure
Proposed – January 2008



Appendix 1

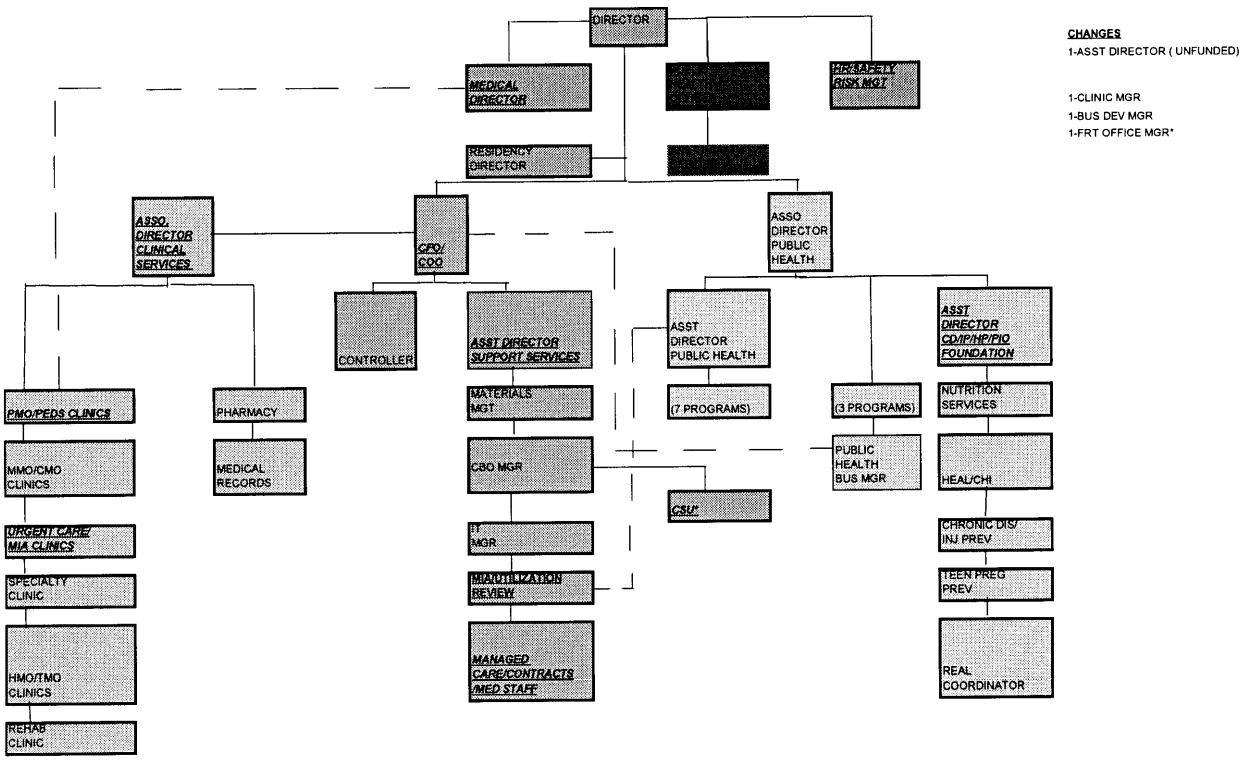
HSA Organizational Structure Proposal 1:

New Associate Director of Clinical Services; Nine Direct Reports to Executive Director; Five Position Reductions



HSA Organizational Structure Proposal 2:

New Associate Director of Clinical Services; Eight Direct Reports to Executive Director; New CFO/COO Role and 4 Position Reductions



HSA Organizational Structure Proposal 3:

New Chief Operating Officer; Six Direct Reports to Executive Director and 4 Position Reductions