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

DEPT: Chief Executive Office

BOARD AGENDA:7.3
AGENDA DATE: July 17, 2018

SUBJECT:
Approval of the Health Services Agency (HSA) Strategic Visioning Business and Facility Plan as Recommended by Pacific Health Consulting Group and Related Actions to Implement the Plan Regarding Future Scope of HSA Programs and Future Facility Plans

BOARD ACTION AS FOLLOWS: **RESOLUTION NO. 2018-0377**

On motion of Supervisor Withrow **, Seconded by Supervisor** Olsen
and approved by the following vote,
Ayes: Supervisors: Olsen, Chiesa, Withrow, Monteith, and Chairman DeMartini
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:

Elizabeth A King

ATTEST: **ELIZABETH A. KING, Clerk of the Board of Supervisors** **File No**

THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
AGENDA ITEM

DEPT: Chief Executive Office BOARD AGENDA:7.3
AGENDA DATE: July 17, 2018

CONSENT ☐

CEO CONCURRENCE: YES 4/5 Vote Required: No

SUBJECT:

Approval of the Health Services Agency (HSA) Strategic Visioning Business and Facility Plan as Recommended by Pacific Health Consulting Group and Related Actions to Implement the Plan Regarding Future Scope of HSA Programs and Future Facility Plans

STAFF RECOMMENDATION:

1. Approve the Health Services Agency Strategic Visioning Business and Facility Plan as recommended by Pacific Health Consulting Group regarding the future scope of programs to be provided by the County's Health Services Agency as summarized below:
    a. Implement a Community-Wide Population Health Initiative Focus for the Health Services Agency; and expand the Data and Quality Foundation for Public Health Services
    b. Public Health: Pursue Community Clinical Services and Other Programming Integration Initiative including Coordinated Public Health and Clinical Service Interventions; and Pursue Health Services Agency/Behavioral Health and Recovery Services Coordination
    c. Explore Regional Public Lab Partnership Opportunities to be returned to the Board of Supervisors for future recommended actions
    d. Public Health: Emergency Medical Services (EMS) – Continue to participate in the Mountain Valley Emergency Medical Services Agency (MVEMSA) including seeking additional support for EMS Service Delivery in Stanislaus County
    e. For Primary Care, Specialty and Physical Rehabilitation Clinics: Explore options for alternative service providers with the goal of preserving and potentially expanding access to clinical services for low-income residents
    f. Physician Training: Continue the County's Commitment and partnership in the Physician Training Residency Program: Valley Consortium for Medical Education (VCME) in partnership with Doctors Medical Center and Memorial Medical Center
    g. Approve the HSA Facility Plan and Direct the Finalization of an Implementation Plan to relocate future Health Services Agency Programs

2. Approve an Amendment to the Contract with Pacific Health Consulting Group to facilitate a Request for Qualifications/Proposals process related to County Clinical

Services to ensure access to and operations of primary care clinics and specialty care in an amount not to exceed $85,500.

3. Authorize staff to return to the Board of Supervisors with a Request for Qualifications/Proposals for the provision of continued access to primary and specialty clinical care for County residents

4. Direct the staff to finalize the facilities and funding plan needed to implement the Master Facilities Plan including a recommendation to relocate the Health Services Agency from County Center II (Scenic Drive) to New Facilities at County Owned Property at County Center III (Scenic Drive and Oakdale Road, Modesto)

5. Authorize staff to prepare and return to the Board of Supervisors with a Request for Qualifications/Proposals for Professional Planning and Design Services for new facilities needed by the Health Services Agency for future Board of Supervisors' consideration.

DISCUSSION:

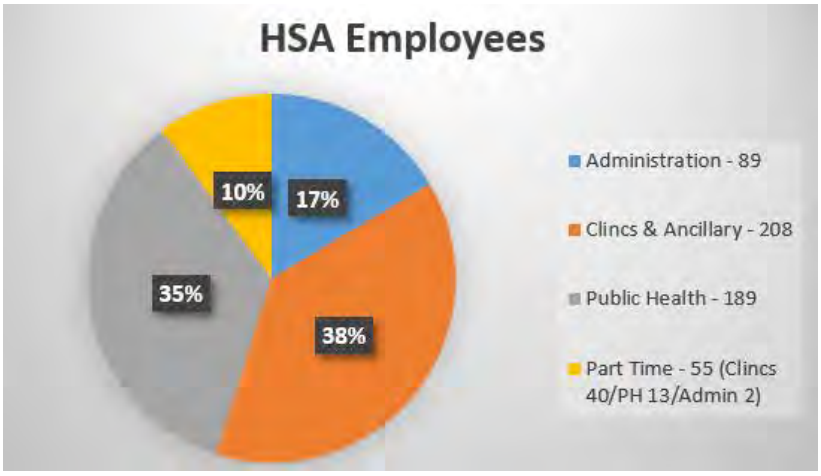
The County has a proud 100+ year history of addressing the health needs of the County, which has included providing healthcare services for the underserved in Stanislaus County. The Health Services Agency (HSA) serves as the local Public Health Department and in some cases the HSA's services go well beyond its mandated responsibilities. In more recent years, many external and internal circumstances have impacted the Health Services Agency, such as the Affordable Care Act, the expiration of the twenty-year Inpatient Agreement with Doctors Medical Center which is being replaced by a significantly different agreement, and an aging facility infrastructure.

Because of the changing healthcare environment and need to address the aging facilities, the Board of Supervisors approved the development of a Comprehensive Health Services Agency (HSA) Strategic Visioning, Business and Facility Plan on March 22, 2016 which was intended to assess and define the future scope of the HSA and inform a developed Master Facility Plan.

Subsequently, the County issued a Request for Qualifications and Proposals (RFP/Q) for the development of the Plans. On February 28, 2017, the Board of Supervisors awarded the project contract to Pacific Health Consulting Group and work began with Chief Executive Office and Health Services Agency staff. The outcomes of the planning process are summarized below.

<u>Strategic Visioning Report</u>

The HSA is essentially comprised of two service divisions: Public Health and the Clinic System, with an Administration division supporting the agency needs. As illustrated in the chart below, the majority of the employees are within the two larger divisions and the remainder of employees are part of the Administration division.



The Public Health division fulfills county responsibilities under the federally required Ten Essential Services. The division is responsible for delivering services and programs which help to protect and improve the lives of County residents including preventing illnesses and injury, promoting healthy lifestyles and behaviors and to protect the community from health threats.

The Clinic division is deliberately a safety net provider and provides primary care, including obstetrics and after hour urgent care, specialty care and physical rehabilitation services. The six primary care clinics which are situated in Modesto, Ceres, Hughson and Turlock, are designated as Federally Qualified Health Center Look-Alike (FQHC-LA) clinics by the federal Health Resources and Services Administration and primarily care for the underserved community. The FQHC-LA designation was achieved in 2007 after receiving Board of Supervisors approval to apply on September 13, 2005, and to establish the federally required Community Health Center Board with specific delegated responsibilities. Approximately 90% of the patients served are enrolled in one of two Medi-Cal Health Plans.

The comprehensive visioning process approved by the Board of Supervisors and facilitated by Pacific Health Consulting Group (PHCG) examined key elements of the services provided by the Health Services Agency divisions. PHCG has worked over the last 20 years with many counties, most of the state's local public Medi-Cal managed care plans and with many of the state's largest safety net providers. PHCG has extensive experience working with Central Valley safety-net providers and has knowledge of the regional health care environment. The consultant teams' background and experience includes facilitation and strategic planning, county health department leadership, FQHC operations and management, program planning and policy development.

Specifically, the expert consultants conducted an extensive strategic visioning and planning process with Health Services Agency and County Chief Executive Office (CEO) staff to identify a long-term agency vision and articulate specific strategic directions for the future. Assisted by PHCG, the CEO and HSA staff identified six strategic topical/program areas, chosen because these were determined to have the most opportunity for change and/or which addressed an identified weakness/exposure now and in the future They are: Health Data Analytics and Culture of Quality Improvement, Public Health integration with community clinical services and other programs, Public Health Laboratory, Emergency Medical Services Agency (EMS), Primary Specialty and Physical Rehabilitation clinics, and Valley Family Medicine Residency Program. The PHCG report is attached and includes the following:

- Health Environmental Scan and SWOC Analysis Findings – this document provides an overview of the planning process, discusses the methodology and shares the Strengths, Weaknesses, Opportunities and Constraints (SWOC) findings;
- Strategic Visioning Report – this document includes the summary of the SWOC and a health environmental scan identifying opportunities and gaps within the community and health delivery system along with the strategic recommendations for each topic area.
- Topical Memos – there are a total of six topical memos included in the PHCG report including one topical memo for each topic area.
- Health Services Agency Facility Plan - summarizes an assessment of the HSA facilities including their efficiency, sustainability and suitability for current and future use.

Topical Memo #1: Public Health: Health Data Analytics and the Culture of Quality Improvement

The development of a data and quality-driven organization encompasses the development of several important elements, such as data infrastructure/capabilities, organizational culture of quality, level of agency integration and the scope and reach of a quality framework. The PHCG review found that the Public Health and clinical operations data systems are fragmented and limited. Barriers included difficulty recruiting Epidemiologists, limited staff capacity, capability of databases and access by staff, lack of integration between databases, lack of timely data or clear understanding of what information is available throughout the department, and systems that do not allow real-time or user-generated reports. There is a lack of dedicated staff to support quality and improvement and data reporting for outcomes based management

To build a data and quality-driven organization, PHCG recommended a phased approach.

Phase I: Build the Foundation. HSA would prioritize establishing a quality and data foundation for the future including the key elements of staffing, data/reporting systems, culture of quality improvement and leadership exchange.

Phase II: Institute an Agency-Wide Population Health Initiative. Within this option the agency would move beyond establishing a foundation and would see to establish an agency-wide initiative articulating over-arching population health goals, metrics and targets that would inform the development of department/program-specific initiatives and cross-agency initiatives.

Phase III: Implement a Community-Wide Population Health Initiative. Within this phase, HSA would engage other community providers and stakeholders in the identification of population health priorities and development and execution of shared strategies and interventions to address these priorities.

HSA staff and the Public Health divisions have initiated Phase I and support the recommendations from PCHG:

1. Implement a Community-Wide Population Health Initiative. Focusing on the required Population/Public Health role of HSA, complete the new Community Health Assessment (CHA) with increased community partner engagement and use to inform a Community Health Improvement Plan (CHIP) in FY18-19. In partnership with community partners, utilize the CHA and CHIP to inform development of a community-wide population health initiative in FY 19-20.

2. Expand Data and Quality Foundation. Strengthen HSA's health and organizational information gathering capabilities and systems, including the Epidemiology team, to expand data gathering and analysis with a focus on developing a culture of quality improvement, dedicating resources based on areas of need and with effective and measurable methods for outcomes-based management. Become a consistent resource of health and health indicator data for County and community stakeholders.

Topical Memo #2: Public Health: Community Clinical Services and Other Programming Integration

Public Health departments are charged with assuring that community members can access services through linkage to community providers, support of the delivery system or direct delivery of care. The integration of public health with Department, County and community partners is key to improving the health of the citizens of Stanislaus County. Multiple factors, such as access to services, health behaviors, living environments and other social determinants of health impact community health outcomes. Coordination

and improved integration with service providers are essential to improving population health and reducing health care costs.

To achieve integration and improved population health, PHCG provided the following future options:

Option 1: Internal HSA – Clinical Operations Coordination/Integration
Option 2: Coordination/Integration between HSA Public Health and Community Healthcare Providers
Option 3: Coordination/Integration between HSA and BHRS

When considering these options, staff and PHCG determined a combination of the options serve to provide the recommendation for the future.

1. Coordinated Public Health and Clinical Service Interventions. Based on findings from the Community Health Assessment (CHA) and priorities established in the Community Health Improvement Plan (CHIP) develop a coordinated intervention between Public Health and community clinical providers (FY 19-20).

2. HSA-BHRS Collaboration. Work with County Behavioral Health and Recovery Services to develop a population health framework for collaboration between the agencies to improve health outcomes and create efficiencies.

Topical Memo #3: Public Health Laboratory Services

Public health laboratory services play an important role in achieving the mission of public health agencies to protect and promote the health of the population. Public health laboratories perform laboratory tests on samples collected from both humans and animals, and select sources where infectious diseases and harm agents pose a potential threat to the population. The Stanislaus County Public Health Laboratory (SCPHL) facility is located at 820 Scenic Drive, Modesto in a multi-building campus housing numerous HSA Programs. Staffing for the Public Health lab is limited and has been further reduced through attrition during this project. The required Lab Director function is fulfilled through a part-time and soon retiring independent contractor. Currently SCPHL refers some testing to an outside public health lab, San Joaquin County Public Health Lab.

As outlined in the topical memo, small and mid-sized Public health labs, like Stanislaus County's, are trending toward contracting out or regionalizing public health lab services. The challenges of maintaining a public health lab including the cost of equipment retention and maintenance, recruiting and finding a qualified public health lab director in light of the statewide shortage, retention of public health lab staff and the overall cost to maintain the lab with low test volumes has contributed to counties looking for innovative ways to provide the mandated service. Many counties have in recent years opted for a multi-county approach to meeting this critical need. The options PHCG provide for consideration are:

Option 1: Retain Current SCPHL Model

Option 2: Retain Current Stanislaus PHL Model with Modifications

Option 3: Seek Partner County to form Regional Public Health Lab and Close Stanislaus County Public Health Lab

After review of the pros/cons for each option, county staff agree the following recommendation is the best option for continuing to efficiently and effectively provide mandated public health lab services:

1. Regional Lab Partnership: Explore regional Public Health Laboratory partnership in FY18-19 with partner county(ies) while maintaining local intake.

As part of this strategic recommendation, HSA staff have a team working on identifying partnerships and best practices for the continued public health lab service. A proposal for the continuity of public health lab services would be planned for the Board of Supervisors' review and consideration by the end of the calendar year.

Topical Memo #4: Public Health: Emergency Medical Services (EMS) Agency

Under the Health and Safety Code, Division 2.5, Chapter 4, Article 1, Section 1797.200, "Each county may develop an emergency medical services (EMS) program. Each county developing such a program shall designate a local EMS agency (LEMSA), which shall be the county health department, an agency established and operated by the county, an entity with which the county contracts for the purposes of local emergency medical services administration, or a joint powers agency created for the administration of emergency medical services by agreement between counties or cities and counties pursuant to the provisions." Stanislaus County has designated Mountain Valley Emergency Medical Services Agency (MVEMSA) as the LEMSA and participates in Joint Powers Agency (JPA) for the unified planning and coordination of the emergency medical system.

PHCG examined the current JPA model Stanislaus County is participating in along with other options for the provision of EMS services. Four options were suggested in the topical memo and the pros/cons of each model were reviewed. The options included:

Option 1: Continue as a Member County of Mountain Valley EMS Agency and develop a plan to address current issues related to Stanislaus-specific capacity needs and JPA governance.

Option 2: Form a Single-County Stanislaus EMS Agency.

Option 3: Form a Stanislaus County-operated EMS Agency and contract with the other four JPA counties to provide their EMS Services.

Option 4: New Partnership with One Other County.

After reviewing the options, county staff concur with the PHCG recommendations to:

1. Continue in Regional EMS Agency. Continue membership in regional Mountain Valley Emergency Medical Services (EMS) Agency.
2. Additional Support for EMS Services Delivery in Stanislaus County. As needed consider supplementing MVEMSA with staffing to ensure optimal delivery of EMS Services in Stanislaus County.

The one concern with staying within the current system was the limited staffing resources to focus on Stanislaus County EMS issues and the availability of staff to address Stanislaus County needs. Under recommendation No. 2, HSA staff may be assigned to focus on and provide support to EMS requirements and projects specific to Stanislaus County. This position would coordinate closely with Mountain Valley EMS Agency, the Chief Executive Office and the HSA Managing Director to ensure County priorities and needs are being addressed through the current JPA structure.

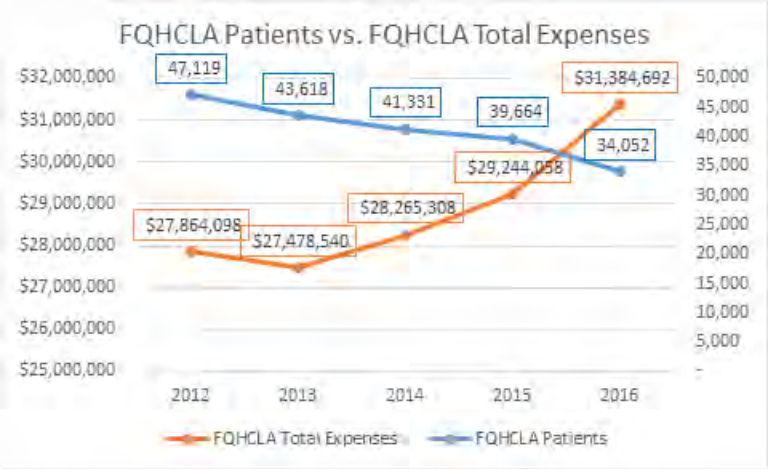
Topical Memo #5: Primary Care, Specialty and Physical Rehabilitation Clinics

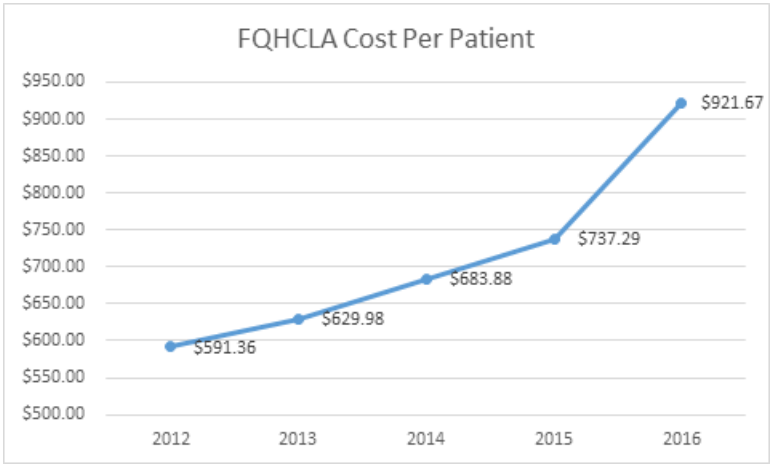
The HSA's clinic system has long existed as a safety net provider, and in 1982 while the State transitioned the responsibility for healthcare of medically indigent adults from State Medi-Cal to county responsibility, the HSA's outpatient and inpatient services became the "network" of healthcare services for the medically indigent of Stanislaus County. In 1997, the County hospital closed and the County continued to meet its mandate to serve the medically indigent adults through its clinic systems and contracts with Doctors Medical Center and others. For decades, the County - through the Health Services Agency - has provided direct clinical services as a provider and beyond the mandates required by law.

While all counties continue to have Medically Indigent Adult (MIA) program responsibility under Welfare and Institutions Section 17000, due to the State of California's decision to implement the federal Affordable Care Act's State optional Medicaid (Medi-Cal) expansion and to implement the "Covered CA" Exchange program, the demand for the MIA program has been limited to an occasional temporary need until the effective date of other program eligibility. Since January of 2014 when both new programs began, the HSA has enrolled less than 15 unique individuals and has incurred relatively nominal costs. This enrollment compares to pre-ACA and recession-era level of approximately 9,000 unique individuals in a fiscal year period. Note: The State diverted funding for County MIA programs to other state programs.

The impacts of the ACA and the significant reduction to the MIA program is fully discussed in the clinical services topical memo.

Other impacts to the HSA clinic system have included the growth of other safety net providers throughout the State and specifically within Stanislaus County including Golden Valley Health Centers and Livingston Community Health Centers. Both are non-profit organizations designated as Federally Qualified Health Centers. With growing safety net providers and community-wide increased competition for physicians and other providers, there has been a declining patient volume for the HSA clinics and an increase in total expenses as shown on the charts below.





For many years, the County General Fund contributed $3,113,397 annually which is not a mandated match requirement. This amount includes a varying annual contribution of $800,000 to $1.5 million supporting the Residency program. In addition to the County General Fund contribution, the Fiscal Year 2018-2019 proposed budget includes using $1.5 million in fund balance to offset an anticipated increase of staffing and operational costs for clinic support. The Clinic system unmet need is approximately $4.5 million per year and without change will likely continue to require a significant increase in general fund support beginning in the next fiscal year.

Physician full time equivalent (FTE) positions declined from 26.7 to 23.0 between 2010 and 2016. The number of patients seen and the provider staffing levels have decreased, but the cost of providing patient care has increased. Part of the increase has been personnel costs.

Health Services Agency provides Specialty Care and Physical Rehabilitation services, which are not part of the FQHC-LA designation. The specialty services have been offered for many years to provide needed access for the safety net population and to provide for particular curricular experiences (rotations) for the Family Medicine physician residency program. The Specialty clinic's health care and teaching services are provided by local community physicians who contract to provide limited time at the HSA operated clinic. Specialty and Physical Rehabilitation services have generally been as follows:

Specialty Care Clinic Services	
Orthopedics	24-28 hours per week
ENT	4 hours per week
Sports Medicine	4 hours per week
Urology	4-5 hours per week
Podiatry	12 hours per month
Neurosurgery	8-16 hours per month
Neurology	8-16 hours per month
Gastroenterology	8-12 hours per month
Hep C	8 hours per month
Minor Procedures	4 hours per week
Special Procedures	4 hours per month
Physical Rehabilitation Services	
Physical Therapy	40 hours per week
Occupational Therapy	24 hours per week
Wound Care	25 hours per week
EMG	8 hours per month
Audiology	16 hours per month

With the other options for clinical services available to Stanislaus County residents, the role and services provided by HSA was re-examined through the visioning process. With current trends in patient distribution, it is possible that Stanislaus County's clinic operations will continue to downsize due to reductions in patient volume, attrition of clinicians to other health providers and increased need for County funds to support the County clinics.

The options provided by PHCG in the topical memo included:

Option 1: Retain Current Clinics with System Improvements

Option 2: Strategically and Immediately Consolidate the Number of Stanislaus County Clinic Sites (with Improvements) and Explore Strategic Partnerships/Approaches to Maintain Access to Care and Optimize Resources

Option 3: Eliminate or Limit Stanislaus County Role as a Direct Clinical Provider in the future

With the other options for clinical services available to Stanislaus County residents, the role and services provided by HSA was re-examined through the visioning process. After careful review and thorough analysis of the options, PCHG made the following recommendation specific to the clinical services:

1. Clinical Services Access: With the goal of preserving and expanding clinical services for low-income residents, explore clinical care alternatives by other mission-driven safety net providers that may be better positioned than HSA in the future to provide sustainable, high-quality clinical services in multiple community locations.

Preserving capacity of clinical services for low-income residents in the community and ensuring continuance of the residency program are important community needs. There are other local providers dedicated to providing services to the safety net population. The County's MIA population numbers have declined to almost zero. Therefore, the resources of HSA agency may better serve the community by focusing on community health promotion and protection; the county's mandated Public Health role. To that end, it is recommended that a subsequent effort be made to assess the interest and ability of others to directly provide the current level or greater of patient care services. The Board of Supervisors could consider a Request for Qualifications/Proposals process to explore potential possibilities which could be considered in future policy decisions about any potential change in HSA's role in the direct delivery of care. The RFP/Q development and process is a complex undertaking. Therefore, staff is asking the Board of Supervisors to support PHCG's facilitation of the RFP/Q development and process to explore alternatives to ensure access to care. This will require an amendment to the PHCG Agreement for an amount not to exceed $85,500, which would be absorbed in the current HSA budget.

Topical Memo #6: Valley Family Medicine Residency Program

In 2010 based on changing federal requirements and as approved by the Board of Supervisors on May 5, 2009, residency training underwent a significant transition that produced a progressive non-profit consortium model of sponsorship, which involves the County, Doctors Medical Center and Memorial Medical Center: Valley Consortium for Medical Education (VCME). Since the VCME establishment and accreditation achievement for Family Medicine, and based upon the continuing and serious physician workforce shortage in the area, an Orthopedics residency program began in 2013. This program leverages the infrastructure of the consortium, although unlike the financial "unmet need" sharing of the Family Medicine program, Doctors Medical Center solely underwrites the financial shortfall of the Orthopedic program. The outpatient training of the Orthopedics program occurs in the HSA's Specialty clinic and other locations.

PHCG evaluated two options in the topical memo for consideration.

Option 1: Retain Current Valley Family Medicine Residency for Stanislaus County.
Option 2: Retain and Expand Valley Family Medicine Residency for Stanislaus County with New Partners.

Due to the importance of the program for attracting new physicians to Stanislaus County, both options look to strengthen the residency program. After thorough analysis of the program, local support and trends the recommendations include:

1. Continued HSA Residency Leadership: Continue support for the family medicine residency program and participation in the Valley Consortium for Medical Education.

2. Expanded Residency Partnerships. Supported by the Valley Consortium for Medical Education (VCME) Board, seek additional partners in FY18-19 to support future sustainability and growth of the VCME.

The VCME Board of Directors developed its strategic plan this year which is supportive of expansion, including a recent decision to resume discussions with Golden Valley Health Centers, which proposed participation to the VCME Board in 2017.

<u>HSA Facility Plan</u>

The HSA Facility Plan was developed in coordination with the visioning process. The need for a Facility Plan was supported by multiple factors including:

- The 830 Scenic Drive main campus (County Center II) for the Health Services Agency is aging with the oldest and still occupied buildings constructed in the early 1940s and the newest in the 1970s.
- The workflow operations are designed as workarounds such as administrative space operating in floor plans designed for a hospital, impacting efficiency.
- The aged buildings require frequent repair such as elevators, chiller and boiler, leaking pipes, a generator failure in 2015 and several flooding incidents with significant impacts to the Central Unit in 2016 and a separate incident with lessor impacts to 1030 Scenic Drive in 2017, also on the County Center II campus.
- There are security deficiencies due to the layout and numerous access points to and within the buildings.
- The buildings are not designed to meet current disability accessibility requirements.

As part of the visioning process, PHCG retained INDE Architecture to support the completion of the Facility Plan. The Facility Plan summarizes an assessment of HSA facilities. The facility assessment includes evaluation of the following elements:

- How much space is required to support the existing HSA divisions, functions and programs in the near future.

- How the actual needs of each division compare to the existing facility size and condition.
- The relative costs for potential new facilities based on the programming effort.

INDE Architecture evaluated division and facility sites within the HSA department including facility tours of the County Center II campus (830 Scenic, 820 Scenic & 1030 Scenic and Family and Pediatrics Health Center), 1533 Lakewood, Paradise Medical Office, Turlock Medical Office, Ceres Medical Office, Ceres WIC and Specialty Clinic and Physical Rehabilitation. Floor plans, lease documents, maintenance information and department programming were reviewed. Specifically examined were the needs of each area including

- Does the existing space meet the requirements of the program for project growth now and in the foreseeable future?
- Is each existing location sized appropriately for its staff and programs?
- Are there existing conditions, such as code compliance or building age, which might inform a decision to remodel or relocate the program?

The summary of conclusions outlined in the HSA Facility Plan are:

- The total existing space occupied by HSA divisions significantly exceeds the amount of space that is required for the current functions by more than 100,000 square feet. The difference is largely due to the use of existing owned and leased buildings that are not efficient for the HSA uses.
- The existing Public Health Building at 820 Scenic Drive is no longer suited for its current programs and the long-term needs for that division; the existing buildings' age and configuration limit its reuse, and therefore renovations will not achieve sufficient efficiency and compliance with current codes.
- The age of the old Scenic hospital buildings has compromised the efficiency and long term operational viability for HSA's use. Therefore, based on the condition and inefficiency of the existing buildings at County Center II (Scenic Campus), relocation of the HSA support and Administrative services and Public Health programs currently located at this site is recommended.
- No matter what policy decisions are made by the Board of Supervisors in the future related to Clinical Services, the County will remain in the mandated provision of Public Health Services and Health Services Agency functions long term, therefore a long-term facility change is needed to correct existing inefficiencies, compliance concerns and meet projected programming needs for the future HSA.

Ongoing facility exposures and the conclusions of the PCHG's HSA Facility Assessment support the staff recommendation to relocate the Health Services Agency from County Center II (Scenic Drive) to New Facilities at County Owned Property at County Center III (Scenic Drive and Oakdale Road, Modesto). With the Board of Supervisors' adoption of this recommendation, the Project Team will prepare for future consideration by the Board of Supervisors an Implementation and Funding Plan and a Request for Qualifications/Proposals for Professional Planning and Design Services for new future facilities needed by the HSA.

A companion Board of Supervisors Agenda Item on the July 17 Board of Supervisors Agenda, recommends the relocation of vacant County modular buildings currently located at 530 S. Santa Cruz Avenue to the County Center III Site for more immediate use by the HSA to better meet current demands and needs. It is important to note that several programs provided by the Agency were already relocated to the County Center III location near the new Coroner's facility when the 2016 flooding occurred at the Center II Scenic location. With the completion of the new Coroner's facility at that location at Oakdale Road and Scenic Avenue in Modesto, the County has a considerable long-term investment at that site. The finalization of the Plan will also include the development of options for the future of the old hospital site on Scenic Drive.

A full presentation of the Recommended Plans will be presented to the Board of Supervisors at the Board meeting on July 17, 2018.

POLICY ISSUE:

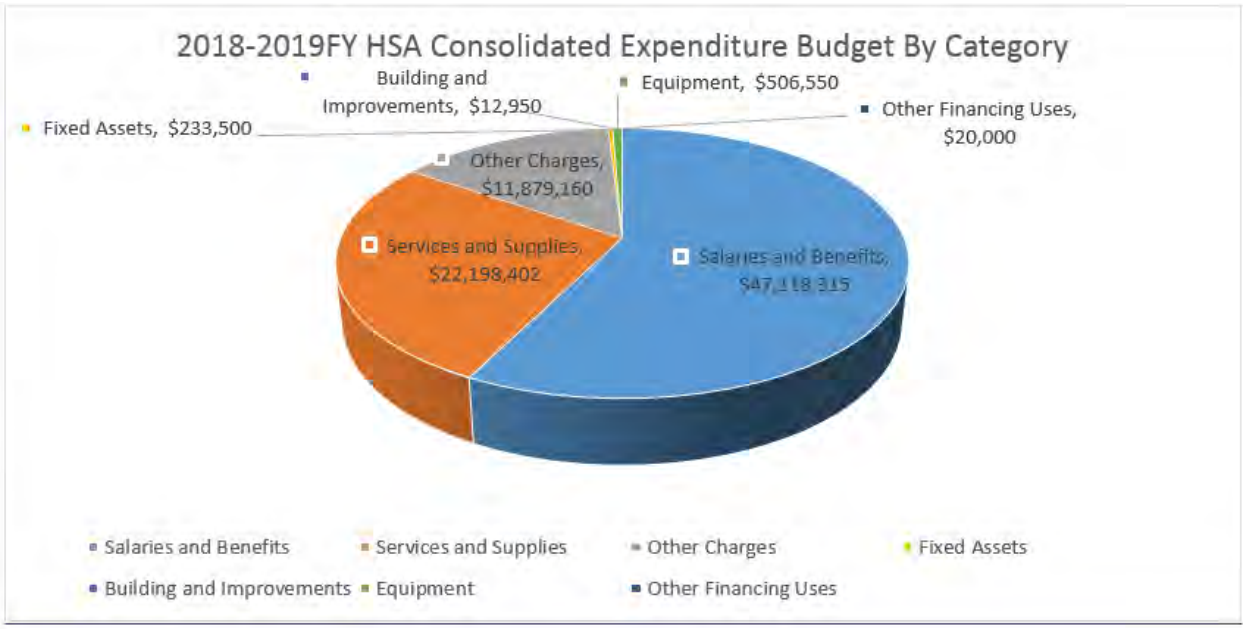
The scope of the Health Services Agency includes both mandated and non-mandated services. The Board of Supervisors consideration and action will direct the future scope and priorities of the HSA, while the policy and financial support will enable the implementation of the intended actions.

FISCAL IMPACT:

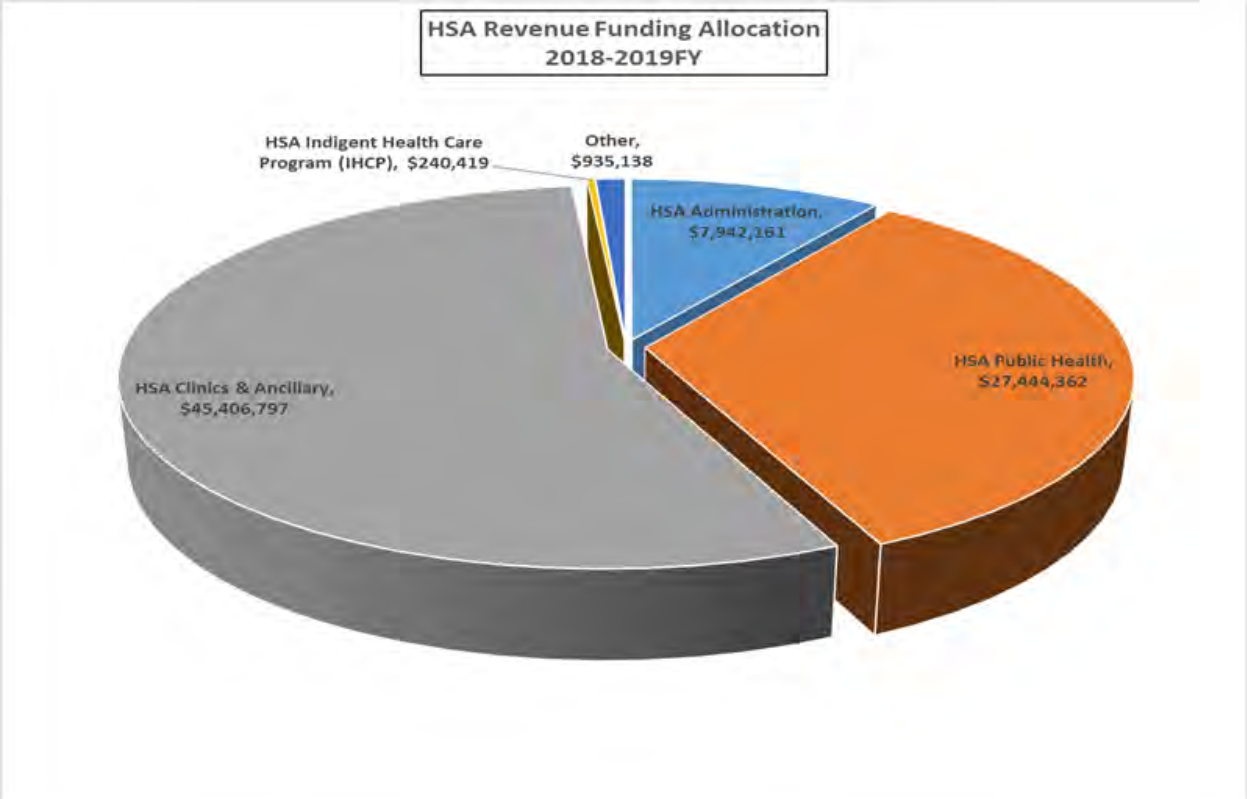
The Health Services Agency Fiscal Year 2018-2019 budget totals $81,968,877. The details by individual legal budget units and category are outlined below as follows:

Health Services Agency (HSA) Legal Budget Summary
2018-2019FY

	HSA Administration	HSA Public Health	HSA Clinics & Ancillary	HSA Indigent Health Care Program (IHCP)	HSA IHCP Emergency Medical Services Hospital	HSA IHCP Emergency Medical Services Physicians	HSA IHCP Emergency Medical Services Discretionary Fund	HSA Public Health Vital and Health Statistics	Consolidated Total
Taxes									$ -
Licenses, Permits, Franchises		15,000							$ 15,000
Fines, Forfeitures, Penalties					209,617	406,306	101,143		$ 717,066
Revenue from Use of Assets	200	50	42,925		3,911	1,393	300		$ 48,779
Intergovernmental Revenue	315,000	16,339,130	39,400						$ 16,693,530
Charges for Service	7,612,486	4,452,897	32,127,610	232,900				63,000	$ 44,488,893
Miscellaneous Revenue	14,475	200	8,001,032	750					$ 8,016,457
Other Financing Sources		4,286,433	549,625						$ 4,836,058
Total Revenue	**$ 7,942,161**	**$ 25,093,710**	**$ 40,760,592**	**$ 233,650**	**$ 213,528**	**$ 407,699**	**$ 101,443**	**$ 63,000**	**$ 74,815,783**
Use of Fund Balance/ Retained Earnings		$ (3,326)	$ 1,532,808	$ (293,231)	$ 167,022	$ 23,011	$ 2,435	$ (43,000)	$ 1,385,719
Total Funding Sources	**$ 7,942,161**	**$ 25,090,384**	**$ 42,293,400**	**$ (59,581)**	**$ 380,550**	**$ 430,710**	**$ 103,878**	**$ 20,000**	**$ 76,201,502**
Salaries and Benefits	$ 8,486,990	$ 16,545,515	$ 22,057,104	$ 28,706					$ 47,118,315
Services and Supplies	2,233,325	4,800,409	14,125,780	123,750	380,550	430,710	103,878		$ 22,198,402
Other Charges	2,049,836	844,219	8,904,413	80,692					$ 11,879,160
Fixed Assets		233,500							$ 233,500
Building and Improvements			12,950						$ 12,950
Equipment	200,000		306,550						$ 506,550
Other Financing Uses								20,000	$ 20,000
Equity									$ -
Intrafund	(5,027,990)	5,020,719		7,271					$ -
Contingencies									$ -
Gross Costs	**$ 7,942,161**	**$ 27,444,362**	**$ 45,406,797**	**$ 240,419**	**$ 380,550**	**$ 430,710**	**$ 103,878**	**$ 20,000**	**$ 81,968,877**
General Fund Contribution	**$ -**	**$ 2,353,978**	**$ 3,113,397**	**$ 300,000**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 5,767,375**
Total Allocated Positions	**90**	**174**	**208**						**472**



The primary funding sources for the Health Services Agency operations consist of patient revenues, Realignment, Federal, State grants and other local County match contribution. As a result of the projected decline in patient revenue and increased operating expenditure budget in 2018-2019FY, the department had to request approximately $1.5 million from its Fund Balance to balance the Clinic and Ancillary division budget.



The Fiscal Year 2018-2019 clinic and ancillary budget will absorb the cost of $85,500 for the PHCG contract amendment to support the Clinical Services RFP process.

The fiscal impact of subsequent related policy considerations will be included in future agenda items.

BOARD OF SUPERVISORS' PRIORITY:

The recommended actions are consistent with the Boards' priorities of *Supporting Community Health* and *Delivering Efficient Public Services and Community Infrastructure* by approving the Health Services Agency Strategic Visioning Business and Facility Plan.

STAFFING IMPACT:

Assisted by the Pacific Health Consulting Group, existing staff would carry out the actions associated with the recommendations. While the subsequent result of some of the recommendations would likely prompt staffing impacts, staff will return to the Board of Supervisors for such consideration.

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ATTACHMENT(S):

1. Health Environmental Scan and SWOC Analysis Findings
2. Strategic Visioning Report
3. Topical Memo #1, Public Health: Health Data Analytics and the Culture of Quality Improvement
4. Topical Memo #2, Public Health: Community Clinical Services and Other Programming Integration
5. Topical Memo #3, Public Health Laboratory
6. Topical Memo #4, Public Health: Emergency Medical Services
7. Topical Memo #5, Primary Care Specialty and Physical Rehabilitation Clinics
8. Topical Memo #6, Family Risidency Program Options
9. HSA Facility Plan

Pacific Health Consulting Group

Stanislaus County Health Services Agency

Health Environmental Scan and SWOC Analysis Findings

Strategic Visioning Deliverables – Part I

Prepared by Pacific Health Consulting Group
7-5-2018

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A. Overview and Methodology

The Stanislaus County Health Services Agency (HSA) engaged Pacific Health Consulting Group (PHCG) to facilitate an intensive strategic visioning process for the agency. As part of the engagement, PHCG conducted a health environmental scan identifying community health needs/outcomes, social/economic factors impacting resident health, access to care in the community and delivery system capacity and gaps. Additionally, PHCG completed a Strengths, Weaknesses, Opportunities and Constraints (SWOC) analysis of the Health Services Agency (HSA) that solicited internal perspectives, external perspectives and analysis of available internal data and programs.

To complete both the Health Environmental Scan and SWOC Analysis, Pacific Health Consulting Group (PHCG) designed and completed an integrated approach that included analysis of internal data, collection and review of community/secondary data, external community stakeholder interviews and internal facilitated discussions with HSA executive leadership and managers/supervisors within the organization.

The enclosed report summarizes findings from the Health Environmental Scan and SWOC Analysis. Additionally, it provides detailed findings from each of the data collection activities completed as part of the analysis.

A listing of the data collection activities completed by PHCG as a part of the strategic visioning process is included below:

1) **Key Informant Interviews (15 participants):** Conducted telephone interviews solicit perspectives on community health issues and unmet needs, delivery system gaps, HSA strengths/weaknesses and opportunities/roles for HSA in the future:
   - Aurora Licudine, Chair, School Nurses, City of Modesto Schools
   - Warren Kirk, CEO, Doctors Medical Center
   - Tony Weber, CEO, Golden Valley Health Centers
   - Terri Howell, Provider Relations Manager, Health Net
   - Amy Shin, CEO, Health Plan of San Joaquin
   - Richard Murdock, ED, Mountain Valley Emergency Medical Services
   - John McCormick, CEO and President, Oak Valley Hospital
   - George Kilian, Business Manager, Scenic Faculty Medical Group
   - Susan Rich, Assistant Superintendent, Stanislaus County Office of Education
   - Daryn Kumar, CEO, Sutter Health Memorial Medical Center
   - Francine DiCiano, ED, United Way
   - Dr. Kate Keams, MD, Valley Consortium for Medical Education
   - Cle Moore, ED, West Modesto King Kennedy Collaborative
   - Stan Risen, CEO, Stanislaus County

- Jeffrey Lewis, President and CEO, Legacy Health Endowment

2) **Community Data Profile – Analysis of Secondary Data and Community Reports:** Analyzed secondary data to assess community health outcomes and behaviors, social/economic characteristics and factors impacting resident well-being, access to health care and delivery system gaps

3) **HSA Management Team Focus Group (23 participants)**: Conducted a focus group of HSA managers to identify priority community health issues, HSA organizational improvement opportunities, barriers and challenges impacting the organization, and opportunities for internal/external integration

4) **Stanislaus County HSA FQHC Look-Alike Board of Directors Focus Group**: HSA staff facilitated a planning exercise with HSA's Federally Qualified Health Center Look-Alike (FQHCLA) board of directors to solicit feedback on primary care clinic performance, opportunities for the future and constraints impacting the organization. The board of directors includes community members and patients of the HSA primary care/FQHCLA clinics.

5) **HSA Visioning Team Planning Sessions with HSA Senior Leadership (3 sessions)**: Facilitated 3 SWOC sessions with HSA senior leadership (known as the "Visioning Team") to solicit senior staff perspectives on organizational strengths, weaknesses, constraints and opportunities for the future.

6) **Analysis of HSA Service Performance and Future Options in Targeted Services/Functions (6 memos completed):** Completed intensive analyses of 6 key topical/program areas within HSA to assess current performance and characteristics, potential future options and evaluation of each option against key criteria. Topical areas included the following:
    - Public Health: Health Data Analytics and the Culture of Quality Improvement
    - Public Health: Community Clinical Services and Other Programming Integration
    - Public Health Laboratory
    - Public Health: Emergency Medical Services (EMS)
    - Primary Care, Specialty and Rehabilitation Clinics
    - Valley Family Medicine Residency Program

B. Health Environmental Scan Summary of Findings

The enclosed summary describes key community health issues, health care service needs/gaps, and other economic/social factors impacting the health of residents in Stanislaus County. The summary was informed by several data collection activities, including analysis of secondary community data, HSA Visioning Team meetings, HSA manager focus group feedback, key informant interviews with community leaders, and topical memo findings.

Health Environmental Scan findings include the following:

Need for and Lack of Access to Behavioral Health Services. Community data, Visioning Team and Management Team perspectives, and overwhelming feedback by key informants all pointed to substance use and mental health as key community health issues, and highlighted the lack of sufficient or coordinated mental health and substance use services in the community. This was the most significant community health issue identified through the Health Environmental Scan. Major data points included the following:

- According to the California Opioid Surveillance dashboard, the 2015 Stanislaus County rate of opioid prescriptions, as well as overdose ED visits and hospitalizations was about twice the rate for California overall;

- According to the 2017 California Health Status Profile, Stanislaus County had an age-adjusted death rate of 17.0 per 100,000 residents for "drug-induced" deaths compared to a California state average of 11.8 per 100,000.

- Emergency Medical Services (EMS) officials noted that the rate of ambulance transport for mental health crises is high in Stanislaus County and is related to the lack of psychiatric beds and community behavioral health services available in the community;

- According to the most recent Office of Statewide Health Planning and Development (OSHPD), there is a significant shortage of psychiatrists in most Stanislaus communities, including a ratio of 71,252 residents to 1 psychiatrist in Turlock, 28,901 to 1 in Ceres/Modesto South Central and no psychiatrists in Hughson or Oakdale/Riverbank.

- Key informants, HSA managers and the HSA visioning team all identified mental health and substance abuse as a high priority community health issues, as well as, highlighted the lack of available services as a major gap in the community.

KEY INFORMANT INTERVIEWS: What are the most pressing community health issues affecting the health of Stanislaus County Residents?

- Mental health, trauma (9)
- Obesity and chronic disease (8)
- Asthma and poor air quality (6)
- Drugs/Substance abuse (5)

Primary and Specialty Care Access for Medi-Cal and Uninsured Residents. Another critical community health or delivery system identified through the planning process was access to primary and specialty care in the community with a focus on lack of access among Medi-Cal enrollees and the uninsured. Available data and stakeholder perspectives highlight a significant shortage of specialist providers, especially specialists willing to see Medi-Cal enrollees. Additionally, several stakeholders pointed to primary care access as a challenge for Medi-Cal enrollees and other low-income residents. Although available data indicates some level of primary care access challenges and provider shortages, it also shows a meaningful and growing presence of FQHC and Look-Alike primary care providers in the community. Key findings included the following:

- 2015 data on community provider supply indicated that there were far fewer active specialty physicians in Stanislaus County than statewide – 82 specialty physicians per 100,000 residents in Stanislaus County compared to 104 per 100,000 in California overall;

- According to key informants, many Medi-Cal enrollees have to travel out of the county for specialty services. Qualitatively, HSA officials noted that HSA is the only resource for certain specialties for Medi-Cal enrollees within the county. Additionally, over 50% of specialty referrals to the HSA specialty clinic come from non-HSA providers indicating a lack of other local options;

- The HSA Visioning Team and HSA managers described a shortage of primary care providers to serve low-income residents and significant challenges recruiting primary care providers for HSA FQHCLA clinics. Several community informants additionally highlighted challenges training, recruiting and retaining primary care providers to serve low-income residents;

- 2015 data indicates that Stanislaus County had an estimated 52 active primary care providers per 100,000 residents compared to 64 per 100,000 for California overall;

- A higher percentage of Stanislaus County low-income residents get care at FQCHCs or Look-Alikes (FQHCLA) than low-income Californians overall. As

of 2016, an estimated 45% of low-income residents in Stanislaus County received care at an FQHCLAs (including HSA) compared to just 34% of all Californians.

- That said, the number of primary care patients served by Stanislaus County FQHCLA clinics has declined by 13,000 patients, or 28%, over the previous five years. During that time period, independent FQHCLA clinics have increased the number of patients they serve by a similar number. Overall, the total number of patients served by all FQHCLAs (HSA and independent) has remained steady over the prior 5 years;

- Since 2011, the Valley Family Medicine Residency (VFMR) program has graduated 72 residents, of which 17 went on to practice in safety-net settings, but only 6 were retained by the Scenic Faculty Medical Group (SFMG).

HSA VISIONING TEAM: What are the community health outcomes and the social/ economic factors impacting the health of Stanislaus County residents?

TIER 1

- Children in poverty
- Obesity
- Access to care / provider shortage
- Behavioral health

TIER 2

- Housing
- Violent crime
- Smoking
- Education

Chronic Disease Prevalence, Prevention and Health Behaviors. Stanislaus County experiences a high community prevalence and impact of chronic disease, as well as, faces challenges creating healthy community environments and impacting health behaviors. Participating stakeholders, including the HSA Visioning Team, HSA managers and community informants also described this as a priority community health issue.

- According to the 2017 California Health Status Profile, Stanislaus County had higher mortality rates than 75% of California counties for 8 of 11 chronic disease-specific mortality indicators, including coronary heart disease, chronic lower respiratory disease, stroke, diabetes, colorectal cancer and lung cancer;

- According to the 2017 County Health Rankings prepared by Robert Wood Johnson Foundation, Stanislaus County ranked 47 of 57 participating California counties in "health behaviors", which considered factors such as

adult smoking, adult obesity, physical activity, excessive drinking and food environment;

- While the HSA Visioning Team highlighted issues of childhood obesity, HSA managers pointed to high rates of preventable chronic conditions and poor health behaviors among the client population. Key informants indicated that chronic disease, including obesity, diabetes, and heart disease are significant health issues in the community.

Impact of Poverty and the Built Environment on Community and Children's Health. Findings from multiple data sources and feedback from internal/external stakeholders highlighted the impact of community factors, such as poverty, education and the physical environment, on community health, and in particular children's health outcomes. Community informants, HSA Visioning Team members and HSA managers all highlighted this as a priority community health issue.

- Many community informants highlighted the impact of the community environment, poverty, violence and trauma on children's health behaviors and outcomes. HSA Visioning Team members and HSA managers additionally prioritized children's poverty as a key community health priority for Stanislaus County;

- According to the 2017 County Health Rankings prepared by Robert Wood Johnson Foundation, Stanislaus County ranked 48 of 57 counties in "physical environment", which considered air pollution, drinking water violations and housing problems. It also ranked 46 of 57 in "social/economic factors", which considered education, unemployment, childhood poverty, income inequality, prevalence of single-parent households, violent crime and injury deaths;

- 44% of all Stanislaus County residents are below 200% of the Federal Poverty Level (FPL) compared to 36.1% of Californians overall. Additionally, 23.8% of all Stanislaus County children fell below the federal poverty level compared to just 18.2% statewide. Notable income disparities exist for Latinos, African-Americans and Native Americans/Alaska Natives;

- Only 16.5% of Stanislaus County adults have a bachelor's degree compared to 31.4% of all California adults;

- The violent crime rate is notably higher than California overall – 527 incidents per 100,000 compared to 406 per 100,000 statewide in 2013;

- According to the American Lung Association Spare the Air 2016 report, the metropolitan area between Modesto and Merced ranked 7th worst in the United States for ozone pollution, 4th worst for short-term particulate pollution and 6th worst for annual particulate pollution.

HSA MANAGER FOCUS GROUP: What do you see as the 3-5 most pressing community health issues in Stanislaus County?

- **Lack of access to care,** including inadequate primary care and specialty care provider capacity, and contributing issues such as transportation challenges

- **High rates of community poverty, unemployment and poor education** with a correlating challenge including poor quality housing and associated mental trauma for children and families living in poverty

- **Substance use, mental illness and homelessness among complex populations.** Participants described high rates of substance use (opioids), untreated mental health issues and homelessness among the population

- **Diabetes/Chronic disease resulting from poor health behaviors.** Participants described a lack of focus and resources for prevention, health education/literacy and unsupportive community environments

C. Strengths, Weaknesses, Opportunities and Constraints (SWOC) Summary of Findings

As part of the strategic visioning process, Pacific Health Consulting Group additionally conducted a strengths, weaknesses, opportunities and constraints (SWOC) analysis of the Stanislaus County Health Services Agency. In order to complete the SWOC, PHCG facilitated multiple planning discussions and individual interviews with HSA leadership (Visioning Team), an in-person focus group with HSA program and department managers, and key informant interviews with other service providers, county agencies and community leaders. Additionally, PHCG incorporated findings from the 6 topical memos examining HSA performance and opportunities within key areas, such as clinical services, Emergency Medical Services, Public Health Lab, internal service integration, and data systems. The following section summarizes findings from the SWOC Analysis.

Strengths

Public Health Role (and Crisis Response). External stakeholders, Visioning Team members and HSA managers all affirmed that the HSA has played a historically strong role in fulfilling core public health department responsibilities, particularly responding to public health crises, such as disease outbreaks or public health emergencies. External stakeholders representing schools, community-based agencies and other county departments repeatedly described this as a core strength of HSA.

Broad Scope of Services. Despite challenges coordinating and maximizing impact of services, HSA provides a very broad scope of public health services, as well as direct primary care, specialty, rehabilitation and other direct clinical services. With service locations across the County, HSA exhibits a broad reach both in breadth of services and geographic reach.

Weaknesses

Community Health Leadership. Although external stakeholders, the HSA Visioning Team and HSA managers voiced shared community health priorities, each group noted that the HSA has not played a leadership role in elevating community health priorities or facilitating community responses. Further, stakeholders highlighted a lack of awareness about what HSA's community health priorities or strategies are.

Internal Strategic Direction and Focus. Although staff gave the agency high marks for fulfilling core Public Health responsibilities and responding to community health crises, HSA managers and the Visioning Team described the agency's approach as largely responsive, rather than pro-active or strategic. Managers encouraged leadership to develop clear community health priorities, articulate tangible and specific strategies/ resources to address them, and communicate clearly and consistently about strategic directions. They additionally emphasized the importance of accountability and consistency.

Internal and External Service Integration. External stakeholders generally could not comment on HSA integration. However, HSA managers and the Visioning Team confirmed that there is minimal coordination, integration or co-location of HSA public health programs and clinical services, despite supporting programs/services that serve similar populations and address parallel health issues. Additionally, multiple stakeholders, including County, HSA, hospital and other community stakeholders, described a lack of integration between HSA and Behavioral Health and Recovery Services (BHRS). There appears to be a lack of understanding about the roles and responsibilities of each entity and of how services could be better coordinated/ integrated to serve clients more effectively. For example, a couple of provider stakeholders were not aware that BHRS was not encompassed in HSA. Other stakeholders indicated that because of the division of responsibilities between HSA and BHRS there is no one that takes an over-arching leadership role to address behavioral health service gaps and challenges in the community.

Data System. HSA Visioning Team and Management feedback, as well as an assessment of staffing and infrastructure in clinical operations, public health and administration, highlighted under-developed data collection and reporting capabilities within HSA. This includes inadequate data and reporting systems, staffing levels and capabilities, and still developing emphasis on data to prioritize needs, manage performance, evaluate outcomes and inform decision-making.

Opportunities

Leadership in Defining and Addressing Community Health Priorities. HSA Managers highlighted an opportunity for HSA to play a more explicit role in defining and leading community responses to shared community health priorities, such as mental health, substance use, access to care, chronic disease and early childhood prevention and education. External stakeholders echoed similar themes with a parallel focus on strengthening behavioral health services (mental health, substance use), improving access to specialty and primary care for low-income residents and addressing/preventing chronic disease. Potential roles for HSA included tracking and reporting on community health issues, convening community providers and stakeholders, and pursuing complementary local policy, among others. However, a few external stakeholders encouraged HSA to continue to focus on providing direct clinical services (e.g. primary care).

Prevention, Population Health and Social Determinants of Health: Given the community health issues, disparities and inequities in Stanislaus, the HSA Visioning Team, Management Team and external stakeholders all promoted a stronger HSA focus on population health, prevention/early intervention and a more sustained focus on the social determinants of health. Stakeholders, linked this focus to multiple HSA strategies/functions, such as enhanced (and innovative) prevention services, school and community-based partnerships, health assessments, data monitoring/ epidemiology for

major initiatives (e.g. Focus on Prevention), utilization of local policy options to impact the built environment and health behaviors, and sustained HSA leadership on selected issues.

Greater Internal and External Integration. Given the depth and diversity of HSA services, HSA managers and the Visioning Team described opportunities for targeted integration of programs and services, including the co-location of services where appropriate. Managers highlighted several tangible steps that could be taken to advance internal integration, including purposefully scheduling required county trainings together (across programs), physical co-location of services targeting the same client population, providing more ongoing forums to promote coordination by clinical and public health programs serving the same populations, piloting interdisciplinary care teams, and empowering departments/ programs to develop informal partnerships. The Visioning Team additionally identified opportunities for Public Health and Clinical Services coordination at the leadership and service levels. As stated earlier, internal and external stakeholders discussed opportunities to strengthen external partnerships to address community health priorities, such as partnerships between HSA, BHRS, Emergency Medical Services and hospitals to address behavioral health issues.

Constraints

Direct Clinical Service Focus. Several Visioning Team participants acknowledged that the delivery and funding of direct clinical services at HSA clinics dominates organizational attention and limits its ability to develop other aspects of the agency or establish a broader strategy/role in addressing public health priorities. While HSA has been able to provide an important service to the community, it has not been successful in building other infrastructure or capabilities within the organization.

Workforce/Recruitment. Challenges recruiting and retaining staff/providers, was noted consistently by the Visioning Team and others as a key constraint that has limited the ability of the organization to move forward. As indicated by dramatic declines in primary care providers (and faculty), HSA has experienced persistent and significant challenges recruiting and retaining primary care providers at its primary care clinics. Thus far, the system has been unable to reverse this trend. Outside of direct clinical services, the Visioning Team described additional challenges effectively recruiting for skilled staffing positions and multiple long-term vacancies.

Facilities. Many HSA programs and services are currently housed in aging facilities designed for other historic County functions and service delivery models. Consistent and recurring facility emergencies at these aging HSA buildings have frequently diverted leadership focus and HSA resources from other HSA priorities and have pulled HSA back to a responsive, rather than pro-active role. Additionally, facility restrictions have also represented a barrier to integration/co-location of HSA services and programs.

D. Key Informant Interviews

Pacific Health Consulting Group (PHCG) conducted telephone and in-person interviews with 15 community stakeholders between April and June 2017 to solicit perspectives on community health issues and unmet needs, delivery system gaps, HSA strengths/weaknesses and opportunities/roles for HSA in the future. Interviews were conducted with the following individuals:

- Aurora Licudine, Chair, School Nurses, City of Modesto Schools
- Warren Kirk, CEO, Doctors Medical Center
- Tony Weber, CEO, Golden Valley Health Centers
- Terri Howell, Provider Relations Manager, Health Net
- Amy Shin, CEO, Health Plan of San Joaquin
- Richard Murdock, ED, Mountain Valley Emergency Medical Services
- John McCormick, CEO and President, Oak Valley Hospital
- George Kilian, Business Manager, Scenic Faculty Medical Group
- Susan Rich, Assistant Superintendent, Stanislaus County Office of Education
- Daryn Kumar, CEO, Sutter Health Memorial Medical Center
- Francine DiCiano, ED, United Way
- Dr. Kate Keams, MD, Valley Consortium for Medical Education

A summary of key findings is included below:

Community Health Needs and Social/Economic Factors

Behavioral Health, Asthma/Air Quality, and Obesity and Other Chronic Disease. When asked to describe the most pressing community health needs impacting Stanislaus County residents, key informants most commonly highlighted mental health and trauma issues, as well as drug/substance abuse. In addition, several key informants highlighted asthma and poor air quality as a significant issue impacting residents, and particularly children. Third, multiple key informants discussed obesity and related chronic diseases (diabetes, heart disease) as central community health issues. Some key informants noted that the built environment is not conducive for residents to access healthy foods or to be able to exercise regularly.

Environmental Impact on Children. Key informants additionally highlighted widespread community poverty, crime, lack of reliable public transportation and poorly developed "built" environments as significant contributing factors impacting community health and well-being. In particular, many key informants highlighted concerns about the disproportionate impact of the social/economic environment on the health of low-income children and youth. They highlighted the impact of the community environment, poverty, violence and trauma on children's health behaviors and outcomes, while encouraging more targeted prevention services and partnership with organizations serving children and youth.

Delivery System Gaps and Unmet Needs

Behavioral Health Services. Key informants were additionally asked to describe critical gaps within the health care delivery system in Stanislaus County, particularly for low-income residents. Overwhelmingly, key informants identified mental health services as by far the most critical gap. Multiple key informants described inadequate outpatient treatment options for patients with serious mental health issues, which contributes to preventable mental health crises addressed through emergency department visits and psychiatric hospitalizations. Key informants additionally highlighted the need for more programs and services for individuals needing substance use treatment. As a secondary theme, key informants described a lack of coordination and integration between behavioral health and primary care services in the county clinics.

Primary and Specialty Care Access for Medi-Cal/Low-Income Residents. Secondly, key informants also described a lack of primary and specialty care access/capacity to serve Medi-Cal and other low-income residents in the community. Multiple key informants noted that specialty access for Medi-Cal members is extremely limited and that many residents have to travel out of the County for services. A couple of key informants noted that access to HSA clinics has become more difficult with a perception that this was due to continued challenges recruiting sufficient providers. Key informants voiced mixed perspectives about the level of access for commercially insured or Medicare enrollees. While some felt that access was "fine" for these residents, others felt that access to care was a challenge regardless of insurance coverage. Lastly, a couple of key informants pointed to a lack of timely access to **dental services** for low-income residents.

Role and Impact of the Stanislaus County Health Services Agency

Key informants shared perspectives about the historical role of the Stanislaus County HSA, organizational strengths and weaknesses, and recommended future role to impact community health going forward.

Public Health Leadership. In terms of HSA strengths, multiple external key informants representing schools, community-based agencies and other county departments applauded HSA's leadership in responding to public health crises, such as disease outbreaks and other community health emergencies. Overall, key informants viewed this as a core strength of HSA.

Lack of Community Health Leadership and Visibility on Broader Population Health Issues. As stated above, key informants highlighted several common delivery system and community health challenges, including poverty, chronic disease, transportation, lack of primary/specialty care access, and inadequate behavioral health services, among others. Despite these common issues, most key informants, and particularly health care provider systems and funders, indicated that the HSA has not played a leadership role either in defining community health priorities or as service partners to address these issues. Key informants reported a limited understanding about what HSA's priorities and initiatives are, concerns about lack of responsiveness to

stakeholder overtures or attempts at partnership, and a limited role/presence by HSA leadership in existing initiatives like Focus on Prevention. Importantly, several key informants commented on HSA's lack of visibility in the community, both in terms of services offered and as an "issues" leader. This appears to have contributed to less partnership and engagement with HSA and an ambivalence about their leadership role.

Defined Community Health Priorities. When asked about the potential future role of HSA, several key informants encouraged HSA to prioritize 1-3 community health or delivery system issues for sustained focus and investment. Most commonly, this included expanding and improving behavioral health services (mental health, substance use), improving access to specialty and primary care for Medi-Cal and other low-income resident and addressing/preventing chronic disease (particularly among children).

Prevention, Population and Social Determinants of Health. In that vein, several key informants urged a more sustained focus on population health, prevention/early intervention and the social determinants of health. Key informants linked this focus to multiple HSA strategies/functions, such as enhanced prevention services, school and community-based partnerships, health assessments, data monitoring/epidemiology, utilization of local policy options to impact the built environment and health behavior, and sustained leadership on selected community health issues.

HSA Role in Direct Clinical Services. Several key informants, including county, hospital and other key informants, openly questioned whether it is necessary for HSA to continue to play a significant role in providing primary care and other direct medical services, given the emergence of other independent FQHCs and the decline in uninsured patients. While all noted the need for this primary care capacity to remain in the community, some recommended exploring the transition of these clinics to other providers. Some also suggested that these resources could be re-allocated to other community health services and needs. That said, a couple of key informants emphasized that HSA plays a necessary role as a safety-net provider and that other entities, including independent FQHCs, may not maintain the same level of commitment to the patient population.

E. Community Data Profile

Pacific Health Consulting Group (PHCG) compiled and analyzed publicly available data describing community health outcomes/behaviors, social/economic factors and characteristics and access to health care services in Stanislaus County. A summary of data findings is included in this profile.

Community Health Outcomes and Behaviors

Overall Community Health Outcomes and Mortality

- According to the 2017 California Department of Health Services County Health Status Profile, Stanislaus County had a higher age-adjusted death rate than 50 of 58 California counties placing it among the bottom 11% among all California counties. Stanislaus County had an age-adjusted death rate of 793.3/100,000 residents compared to 616.2/100,000 for California overall.[1]

- According to the 2017 County Health Rankings prepared by the Robert Wood Johnson Foundation, Stanislaus County ranked in the bottom quartile (lowest 25%) among California counties in "quality of life" and "health factors", which included health behaviors, social/economic factors, physical environment and clinical care.[2]
    - Life Expectancy: 41 (3rd quartile)
    - Quality of Life: 45 (bottom quartile)
    - Health Factors: 47 (bottom quartile)
        - Health Behaviors: 53 (bottom quartile)
        - Clinical Care: 35 (3rd quartile)
        - Social and Economic Factors: 46 (bottom quartile)
        - Physical Environment: 48 (bottom quartile)

- The top 5 leading causes of death in Stanislaus County (excluding "all cancers"), include coronary heart disease, chronic lower respiratory disease, stroke, alzheimer's and accidents. This largely mirrors the leading causes for Californians statewide but the death rate is notably higher in Stanislaus County for each of these causes.[3]

- According to the 2017 County Health Status Profile, Stanislaus County had a higher age-adjusted death rate than 75% of other California counties in 9 of 18 mortality indicators with the poorest performance among chronic disease mortality indicators. Stanislaus County had a higher age-adjusted death rate than 75% of California counties for: colorectal cancer, lung cancer, diabetes, alzheimer's, coronary heart disease, stroke, influenza/pneumonia, chronic

[1] California Department of Health Services, County Health Status Profile, 2017
[2] County Health and Rankings Roadmaps, Robert Wood Johnson Foundation, 2017
[3] California Department of Health Services, County Health Status Profile, 2017

lower respiratory disease and infant mortality. It also ranked 54 of 58 counties in deaths from "all cancer".[4]

Leading Causes of Death (Age-Adjusted Rate)

Rank	Stanislaus County		California	
	Indicator	Age-Adj. Death Rate	Indicator	Age-Adj. Death Rate
--	All Causes	793.3	All Causes	616.2
--	All Cancers	174.1	All Cancers	143.8
1	Coronary Heart Disease	141.7	Coronary Heart Disease	93.2
2	Chronic Lower Resp. Dis.	48.4	Chronic Lower Resp. Dis.	33.3
3	Stroke	43.6	Alzheimer's	32.1
4	Alzheimer's	41.6	Accidents	29.1
5	Accidents	39.9	Stroke	34.7

Source: California Department of Health Services, County Health Status Profiles, 2017.

Chronic Disease and Related Health Behaviors

- In 2017 Stanislaus County had higher mortality rates than 75% of California counties for 8 of 11 chronic disease-specific mortality indicators, including having a higher mortality rate than 90% of counties for colorectal cancer, coronary heart disease and stroke.[5]

- The 2014 California Health Interview Survey (CHIS) indicated that Stanislaus County had a higher adult diabetes rate than California overall (14.4% vs. 8.8%), as well as a higher adult obesity rates (35.9% vs. 25.9%).[6]

- According to the Sutter Health Memorial Medical Center 2016 Community Health Needs Assessment, the Stanislaus county obesity rate is 10% higher than the statewide average and diabetes-related hospitalizations are also above the statewide average.[7]

- The Sutter needs assessment also found that asthma prevalence and asthma related hospitalizations are higher in Stanislaus County than in California overall. Key informants participating in the assessment also highlighted asthma as a major concern.[8]

- Compared to California students, more Stanislaus County students at every grade level measured have identified health risks in the areas of aerobic capacity and body composition.[9]

[4] Ibid.
[5] Ibid.
[6] Adult Health Profile, California Health Interview Survey, 2014
[7] Community Health Needs Assessment, Sutter Health Memorial Medical Center, 2016.
[8] Ibid.
[9] 2015-16 California Physical Fitness Report

- According to the 2017 County Health Rankings prepared by Robert Wood Johnson Foundation, Stanislaus County ranked 47 of 57 participating counties in "health behaviors". This considered factors, such as adult smoking, adult obesity, physical activity, excessive drinking, and food environment, among others. Additionally, Stanislaus County ranked 48 of 57 counties in "physical environment", which considered air pollution, drinking water violations, housing problems and commuting.[10]

County Health Profile and Statewide Comparison: 2017

	Indicator		Stanislaus County		CA	National objective
			Rank	*Rate*	Rate	Rate
Chronic Disease	All Causes	Age-Adj. Death Rate	51	793.3	616.2	a
	All Cancers	Age-Adj. Death Rate	54	174.1	143.8	161.4
	Colorectral Cancer	Age-Adj. Death Rate	55	16.4	13.2	14.5
	Lung Cancer	Age-Adj. Death Rate	51	39.5	30.6	45.5
	Female Breast Cancer	Age-Adj. Death Rate	39	21.2	19.8	20.7
	Prostate Cancer	Age-Adj. Death Rate	42	21.9	19.3	21.8
	Diabetes	Age-Adj. Death Rate	47	24.9	20.6	b
	Alzheimer's	Age-Adj. Death Rate	50	41.6	32.1	a
	Coronary Heart Disease	Age-Adj. Death Rate	58	141.7	93.2	103.4
	Stroke	Age-Adj. Death Rate	53	43.6	34.7	34.8
	Influenza/Pneumonia	Age-Adj. Death Rate	46	18.0	15.2	a
	Chronic Lower Resp. Dis.	Age-Adj. Death Rate	46	48.4	33.3	a
	Chronic Liver Dis. and Cirrh.	Age-Adj. Death Rate	37	15.1	12.1	8.2
Injury	Accidents	Age-Adj. Death Rate	30	39.9	29.1	36.4
	Motor Vehicle Treffic Crashes	Age-Adj. Death Rate	34	12.5	8.3	12.4
	Suicide	Age-Adj. Death Rate	18	10.6	10.3	10.2
	Homicide	Age-Adj. Death Rate	35	5.7	4.8	5.5
	Firearm-Related	Age-Adj. Death Rate	27	9.2	7.6	9.3
	Drug-Induced	Age-Adj. Death Rate	34	17.0	11.8	11.3
STD	AIDS	Case Rate	30	3.0	6.5	a
	Chlamydia	Case Rate	44	413.6	460.2	c
	Gonorrhea – Female 15-44	Case Rate	47	252.4	192.2	251.9
	Gonorrhea – Male 15-44	Case Rate	50	310.1	307.3	194.8
	Tuberculosis	Case Rate	32	2.6	5.6	1.0
Maternal and Child Health	Infant Mortality: All Races	Rate	49	6.3	4.6	6.0
	Infant Mortality: Asian	Rate	51	6.3	3.3	6.0
	Infant Mortality: Black	Rate	50	15.2	10.2	6.0
	Infant Mortality: Latino	Rate	48	5.8	3.8	6.0
	Infant Mortality: White	Rate	49	6.3	4.5	6.0
	Low Birth Weight	Percent	19	6.2	6.8	7.8
	1st Trimester Prenatal Care	Percent	27	78.6	83.3	77.9
	Adequate Plus Care	Percent	47	68.4	78.3	77.6
	Teen Births (age 15-19)	Age-Specific Birth Rate	42	27.7	21.0	a
	Breastfeeding Initiation	Percent	53	88.7	93.5	81.9

Source: State of California Department of Health Services, County Health Status Profiles, 2017

[10] County Health and Rankings Roadmaps, Robert Wood Johnson Foundation, 2017

County Health Rankings and Roadmaps: Stanislaus County (2017)

	Stanislaus County	Error Margin	Top U.S. Performers *	California	Rank (of 57)
Health Outcomes					41
Length of Life					43
Premature death	7,100	6,800-7,300	5,200	5,200	
Quality of Life					43
Poor or fair health **	20%	19-20%	12%	18%	
Poor physical health days **	4.6	4.4-4.7	3.0	3.6	
Poor mental health days **	4.1	4.0-4.2	3.0	3.6	
Low birthweight	8%	8-8%	6%	7%	
Health Factors					47
Health Behaviors					53
Adult smoking **	14%	14-15%	14%	12%	
Adult obesity	32%	28-37%	26%	25%	
Food environment index	7.3		8.4	7.8	
Physical inactivity	20%	17-24%	19%	17%	
Access to exercise opportunities	93%		91%	94%	
Excessive drinking **	18%	17-18%	12%	18%	
Alcohol-impaired driving deaths	28%	25-31%	19%	30%	
Sexually transmitted infections	459.2		145.5	459.0	
Teen births	37	36-38	17	20	
Clinical Care					35
Uninsured	13%	12-14%	8%	14%	
Primary care physicians	1,490:1		1,040:1	1,280:1	
Dentists	1,670:1		1,320:1	1,350:1	
Mental health providers	580:1		360:1	350:1	
Preventable hospital stays	48	46-51	36	36	
Diabetes monitoring	83%	80-86%	91%	82%	
Mammography screening	61%	58-64%	71%	66%	
Social & Economic Factors					46
High school graduation	85%		95%	82%	
Some college	50%	49-52%	73%	63%	
Unemployment	9.3%		3.3%	6.2%	
Children in poverty	27%	23-30%	12%	21%	
Income inequality	4.6	4.5-4.8	3.7	5.2	
Children in single-parent households	35%	33-37%	21%	32%	
Social associations	5.6		22.1	5.8	
Violent crime	533		62	407	
Injury deaths	57	54-60	53	47	
Physical Environment					48
Air pollution - particulate matter **	10.0		6.7	8.0	
Drinking water violations	Yes				
Severe housing problems	27%	26-28%	9%	28%	
Driving alone to work	80%	80-81%	72%	73%	
Long commute - driving alone	31%	29-32%	15%	39%	

Areas to Explore Areas of Strength

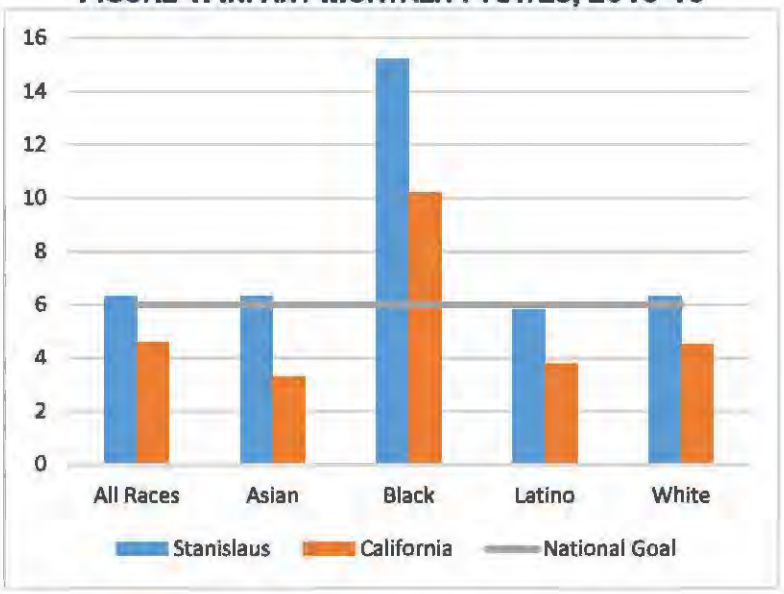
* 10th/90th percentile, i.e., only 10% are better.
Note: Blank values reflect unreliable or missing data
** Data should not be compared with prior years

2017

Maternal and Child Health

- In 2017, Stanislaus County ranked 49th worst out of 58 counties in infant mortality, including consistently high infant mortality rates for all major races (Asian, Black, Latino and White). Overall, the County exhibited a very high infant mortality rate compared to California overall.[11]

FIGURE 1. INFANT MORTALITY RATES, 2015-16



- Additionally, Stanislaus County exhibited low rates of adequate prenatal care and breastfeeding initiation, as well as high teen birth rates. However, the County ranked among the top half of counties in 1st trimester prenatal care and a low percent of low birth weight babies.[12]

Stanislaus County Maternal and Child Health Indicators

Indicator		Stanislaus County		CA	National objective
		Rank	*Rate*	Rate	Rate
Infant Mortality: All Races	Rate	49	6.3	4.6	6.0
Infant Mortality: Asian	Rate	51	6.3	3.3	6.0
Infant Mortality: Black	Rate	50	15.2	10.2	6.0
Infant Mortality: Latino	Rate	48	5.8	3.8	6.0
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Adequate Plus Care	Percent	47	68.4	78.3	77.6
Teen Births (age 15-19)	Age-Specific Birth Rate	42	27.7	21.0	a
Breastfeeding Initiation	Percent	53	88.7	93.5	81.9

Source: State of California Department of Health Services, County Health Status Profiles, 2017

[11] California Department of Health Services, County Health Status Profile, 2017
[12] Ibid.

Communicable Disease

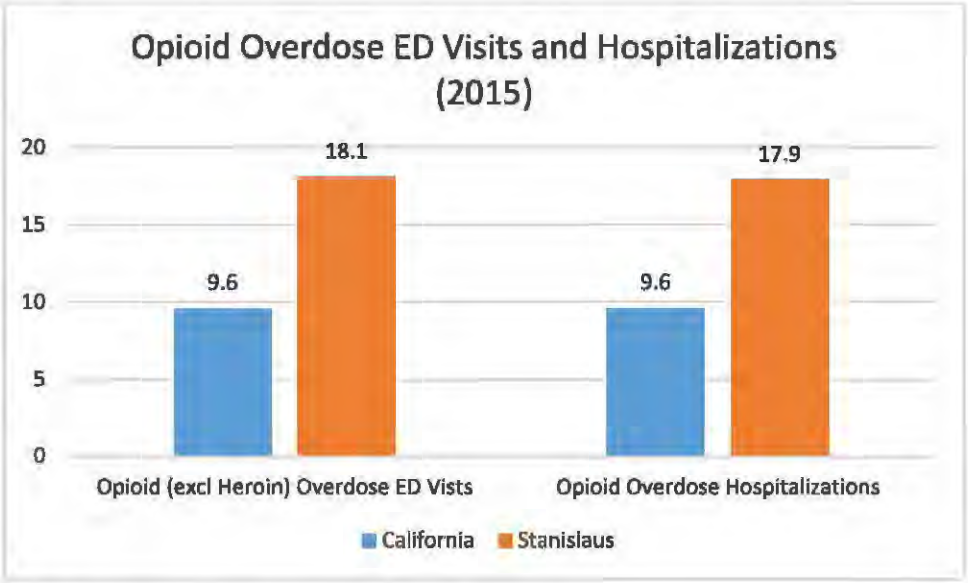
- In 2017, Stanislaus County exhibited a lower rate of AIDS, chlamydia and tuberculosis than California overall. However, rates of male gonorrhea and particularly female gonorrhea were higher than California overall.[13]

Substance Abuse

- According to the 2017 health status profile, Stanislaus County ranked 34th out of 58 counties in drug-induced deaths. It averaged 17.0 deaths per 100,000 compared to a California rate of 11.8.[14]

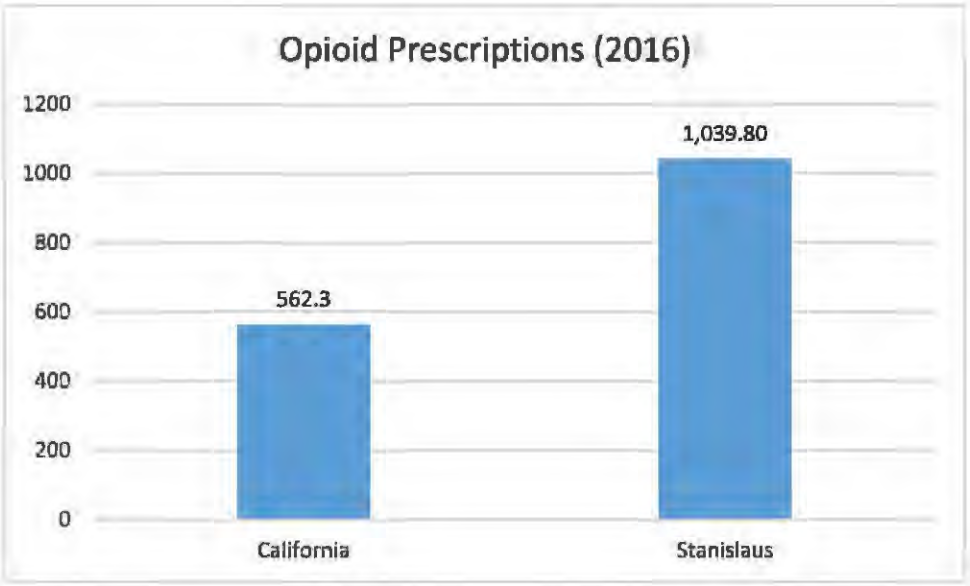
- According to the California Opioid Surveillance dashboard, exhibited a rate of opioid overdose ED visits and hospitalizations (excluding heroin) that was about twice the California rank.[15]

- Additionally, the rate of opioid prescriptions was also twice the California rate in 2015.[16]



Source: California Opioid Surveillance Dashboard

[13] Ibid.
[14] Ibid.
[15] California Opioid Surveillance Dashboard
[16] Ibid.



- Community stakeholders participating in the 2016 Sutter Health Memorial Medical Center needs assessment described methamphetamine and heroin use as major problems in the area. They additionally cited a high prevalence of drugs in local parks, particularly among the homeless population where substance use, poverty and mental illness appear to often intersect.[17]

Mental Health

- In 2017, Stanislaus County had the 18th lowest suicide age-adjusted death rate among 58 California counties. The rate is comparable to California overall. However, the suicide rate increased between 2005 and 2017.[18]

- In the 2014 California Health Interview Survey, 13% of Stanislaus adult respondents reported "serious psychological distress" in the past year compared to 8% of all Californians.[19]

[17] Community Health Needs Assessment, Sutter Health Memorial Medical Center, 2016.
[18] California Department of Health Services, County Health Status Profile, 2005-2017
[19] Adult Health Profile, California Health Interview Survey, 2014

Social/Economic Factors

- According to the 2017 County Health Rankings prepared by the Robert Wood Johnson Foundation, Stanislaus County ranked 46 of 57 participating California counties in "social/economic factors". This considered elements such as, education, unemployment, childhood poverty, income inequality, prevalence of single-parent households, violent crime and injury deaths.[20]

Income, Poverty and Education

The 2011-2015 American Community Survey highlighted the following income, poverty and education characteristics in Stanislaus County:[21]

- In 2015, the median income in Stanislaus County was $50,125, which was 15% lower than the California median;
- 44% of Stanislaus County residents are below 200% of the Federal Poverty Level (FPL) compared to 36.1% of all Californians;
- 23.8% of Stanislaus County children under 18 fell below the federal poverty level compared to 18.2% of all California children;
- Data also indicates notable income disparities for African-Americans, Native American/Alaska Natives and Hispanic/Latinos.

Selected Income, Poverty and Education Characteristics

	California	Stanislaus County	Ceres city	Modesto city	Turlock city
Educational Attainment					
High school diploma/GED or above	81.8%	77.2%	67.9%	81.2%	81.2%
Bachelor's degree or higher	31.4%	16.5%	8.6%	18.6%	23.5%
Poverty Level					
Population under 100% FPL	16.3%	20.3%	17.9%	20.5%	17.5%
Population under 200% FPL	36.1%	44.0%	49.6%	43.7%	38.2%
Families Below Poverty Level in Last 12 months					
Overall	12.2%	16.1%	15.8%	16.4%	12.4%
With children <18	18.2%	23.8%	21.0%	24.8%	18.9%
With children <5	15.5%	22.7%	25.8%	25.2%	18.4%
Income					
Median Income	61,818	50,125	47,858	48,577	51,401

Source: American Community Survey 2011-2015 five-year estimates

[20] County Health and Rankings Roadmaps, Robert Wood Johnson Foundation, 2017
[21] American Community Survey 2011-15 five-year estimates

Education

- Only 16.5% of Stanislaus County adults have a bachelor's degree or higher compared to 31.4% of all California adults. Education rates appear to be lowest in Ceres.[22]

- Although overall graduation and dropout rates are similar for California as a whole, there are marked disparities within sub-populations. For example, 26% of English Language Learners drop out before completing high school.[23]

- Only 38% of 3- and 4-year-olds attend preschool. Only 39% of 3rd grade students scored proficient or higher in reading, although this rate has been increasing.[24]

- Reading proficiency is highest among White students (51%), and lowest among Latinos (32%), socioeconomically disadvantaged students (32%) and English Language Learners (26%).[25]

- 61% of children from low-income households have no children's books at home.[26]

Safety, Crime and Violence

- The rate of violent crime is consistently higher in Stanislaus than California as a whole. In 2013, there were 527 incidents per 100,000 persons versus 406 for California.[27] While violent crime has been decreasing in California, it has been increasing in Stanislaus County.[28]

- The Sutter needs assessment found that ethnic/racial groups are disproportionately affected by violence/injury. The homicide rate for African-Americans is over three times the rate for Stanislaus County as a whole. In surveys, community residents identify unsafe parks, homelessness, drugs and stray dogs as barriers to safety.[29]

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[22] Ibid.

[23] Stanislaus County Health Services Agency, 2013-14 Community Health Needs Assessment

[24] California Department of Education, Standardized Testing and Reporting (STAR) Results. Nov. 2013. (kidsdata.org)

[25] Stanislaus Reads 2015 Community Report

[26] Stanislaus Reads 2015 Community Report

[27] California Department of Justice, Office of the Attorney General, 2013, http://org.ca.gov/crime/cjsc/stats/crimes-clearance

[28] US Department of Justice, Federal Bureau of Investigation, Criminal Justice Information Services Division, Crime in the United States 2012

[29] Sutter Health Memorial Medical Center – 2016 Community Health Needs Assessment.

- In 2002 there were 60% more substantiated cases of child abuse per child than in California. This rate has been increasing in Stanislaus while it declines in the state overall.[30]

Physical Environment

- According to the 2017 County Health Rankings prepared by the Robert Wood Johnson Foundation, Stanislaus County ranked 48 of 57 participating California counties in "physical environment". This considered elements such as, air pollution, drinking water violations, severe housing problems and commuting.[31]

- Air pollution is a serious health burden for San Joaquin Valley residents. Residents face more than 100 unhealthy ozone days per year. In 2016 the metropolitan area between Modesto and Merced ranked 7th worst in the United States for Ozone pollution, 4th worst for short-term particulate pollution, and 6th worst area in the United States for annual particulate pollution[32]

[30] Citation from infographic (UCB publication).
[31] County Health and Rankings Roadmaps, Robert Wood Johnson Foundation, 2017
[32] American Lung Association Spare the Air 2016 Report

Access to Care

- According to the 2017 County Health Rankings prepared by the Robert Wood Johnson Foundation, Stanislaus County ranked 35 of 57 participating California counties in "clinical care". This considered elements such as, uninsured rate, number of primary care physicians, dentists and mental health providers, preventable hospital stays, diabetes monitoring and mammography screening.[33]

Provider Supply

- According to a 2015 data on practicing physicians in California, there were a comparable number of active primary care providers per 100,000 residents in Stanislaus County as in California overall (52 vs. 50 per 100,000). This rate is lower than the national benchmark (60-80) but significantly higher than neighboring Merced County, which had only 33 active primary care physicians per 100,000 residents. The data indicates that Stanislaus County does have a shortage of primary care physicians, but is fundamentally better positioned than many of its Central Valley neighbors to the south.[34]

- In contrast, 2015 data showed that Stanislaus County had fewer active specialty physicians per 100,000 residents than California overall (82 vs. 104 per 100,000).[35]

Active Primary Care and Specialty Care Providers
Per 100,000 Residents: 2015

	Primary Care Providers	Specialists
COGME Benchmark	60-80	85-105
California	50	104
Stanislaus County	52	82

Source: "California Physicians: Who They Are, How They Practice". California HealthCare Foundation, August 2017

- According to available data on Federally Qualified Health Center / Look-Alike (FQHCLA) presence, an estimated 45% of Stanislaus County low-income residents (<200% FPL) were served by FQHCs or Look-Alikes in 2016. As a point of comparison, about 34% of all low-income Californians receive care from FQHCs or Look-Alikes (including Stanislaus County FQHCLA clinics).

- Between 2014 and 2016, the number of low-income residents served by FQHCs and Look-Alikes remained essentially unchanged. Given the decline in Stanislaus FQHCLA clinic patients (-7,000) this suggests that other

[33] County Health and Rankings Roadmaps, Robert Wood Johnson Foundation, 2017
[34] "California Physicians: Who They Are, How They Practice." California HealthCare Foundation, August 2017.
[35] Ibid.

FQHCLA providers increased patient numbers/capacity during that time period.[36]

- An estimated 48% of low-income Modesto residents and 47% of southern county residents (Ceres, Turlock, Waterford) received care from FQHCLAs in 2016. In contrast, only 25% of low-income residents accessed care at FQHCLAs in northern Stanislaus County. The size of the population is much smaller in northern Stanislaus county.[37]

- California OSHPD data provides provider to population ratios for primary care, dental care and psychiatry services in different Stanislaus County geographic areas. The most recent data highlights disparities in different parts of the county and areas where sever provider shortages exist:

    - While Modesto-West, Modesto-East and Turlock all have primary care population to provider ratios well below the common goal of 1,500:1, Oakdale/Riverbank, Hughson and to Ceres/Modesto South Central exhibit a greater shortage of primary care providers.

    - Hughson, Oakdale/Riverbank and Ceres/Modesto South Central also have fewer dental providers to meet community needs.

    - Most significantly, each of the Stanislaus County MSSAs exhibit a severe shortage of psychiatrist providers. Oakdale/Riverbank and Hughson both had no psychiatrists in the community during the last reporting period, while the population to psychiatrist ratio was 71,252:1 in Denair/Turlock and 28,901:1 in Ceres/Modesto South Central

Provider to Population Ratios in Stanislaus County Medical Service Study Areas (MSSAs)

Medical Service Study Area (MSSA)	**211**	**212.1**	**214**	**215a**	**215b**	**215c**
Population Center Name	Oakdale/ Riverbank	Denair/ Turlock	Hughson	Modesto - West	Modesto - East	Ceres/ Modesto So. Central
Population to Provider Ratio						
Primary Care Providers	3,172	1,188	3,960	453	877	1,927
Dental Providers	3,851	1,188	7,260	886	1,177	3,211
Psychiatrist Providers	0	71,252	0	7,977	8,947	28,901

Source: OSHPD Medical Service Study Areas Final Configuration

- According to the Sutter Health Memorial Medical Center 2016 needs assessment, Stanislaus County had an average of 62 mental health providers per 100,000 residents compared to a California average of 157.[38]

[36] Uniform Data Set Mapper (UDS Mapper).
[37] Ibid.
[38] Sutter Health Memorial Medical Center – 2016 Community Health Needs Assessment.

F. Stanislaus County Health Services Agency Manager Focus Group Summary

On April 27, 2017, Pacific Health Consulting Group facilitated a focus group discussion with the HSA Management team excluding department leads or any other staff participating in Visioning Team meetings. Participants included the following:

Name	Title	Dept
Adams, Janice	Clinic Manager	Hughson and Turlock Medical Office
Bhatia, Anuj	Division Manager	Public Health - Emergency Preparedness/WIC
Blanco, Maria	Manager	Administration
Bunch, Cindy	Manager	HR
Cadeaux, Lili	Manager	Public Health - Medical Therapy Unit
Collett, Cheri	Clinic Manager	Family & Pediatric Health Center
Duvall, Heather	Manager	Public Health WIC/Nutrition
Eldridge, Beverly	Manager	PH CA Childrens Services
Falkenstein, Julie	Manager	PH Community Health Services
Ferrera, James	Manager	PH Emergency Preparedness
Forrette, Pam	Clinic Manager	Specialty Clinics
Gomez, Reyna	Clinic Manager	Ceres Medical Office
Halliday, Ann	Clinic Manager	McHenry Medical Office
Machado, Nancy	Manager	Central Business Office
Markum, Lorrie	Manager	Materials Management
Mixon, Willie	Manager	Health Care Quality Services
Montgomery, Aurora	Pt. Mgr.	PMO, Assistant Clinic Manager
Plascencia, Ev	Manager	Information Technology
Semone, Mark	EMR Manager	IT/EMR
Thompson, Lucas	Manager	Administration
Trevizo, Patricia	Clinic Manager	Paradise Medical Office
Tresenriter, Matt	Manager	Rehabilitation/Physical Therapy
Vassell, Barbara	Manager	Communicable Disease/HIV

Following introductions and a review of the strategic visioning process, participants broke into groups to respond to four questions. Each group recorded key themes/responses onto flip charts. The flip chart responses for each question were grouped together. Following the small group discussions, participants did a "café walk" to read the responses of the other groups. As a full group we then discussed themes for each question.
Community Health Issues

1. **COMMUNITY HEALTH ISSUES: What do you see as the 3-5 most pressing community health issues in Stanislaus County?**

Overall, the groups highlighted four over-arching community health issues:

1. **Lack of access to care**, including inadequate primary care and specialty provider capacity/supply, and contributing issues such as transportation challenges

2. **High rates of community poverty, unemployment and poor education** with a correlating challenge including poor quality housing and associated mental trauma for children and families living in poverty.

3. **Substance use, mental illness and homelessness among complex populations**. Participants described high rates of substance use (opioids), untreated mental health issues and homelessness among the population.

4. **Diabetes/Chronic disease resulting from poor health behaviors**. Participants described a lack of focus and resources for prevention, health education/literacy and unsupportive community environments.

2. **HSA IMPROVEMENT OPPORTUNITIES: How could HSA be more effective at addressing these issues? What could we do more of or differently?**

Participants highlighted several themes:

Pro-Active prevention and education to impact community health priorities

- Substance use prevention, school partnerships for parent and child education, life course interventions

Alternative models to treat and manage targeted conditions/patient populations

- Care management, group disease management, non-MD centric care teams, health education to impact patient behaviors

More service integration and co-location to impact community health priorities (especially mental health)

- Co-location of health, social and mental health services
- Targeted collaboration with EMS and BHRS to address mental health issues

Maximize clinical capacity and system performance

- New strategies to maintain a full provider/clinical staff workforce through loan repayment and other incentives
- SFMG arrangement not conducive to productivity, innovation or efficiency
- Clinical model that is less dependent on physicians

Build facilities that facilitate the above goals

- Service co-location, preventive services and alternative models, AND staff retention

3. BARRIERS/CHALLENGES What holds us back? What are the biggest challenges or barriers?

In addition to reinforcing some of the themes above, participants highlighted the following issues:

Significant opportunities to strengthen the organizational culture

- More communication and transparency from leadership. Be clear about decisions and direction to staff
- Need to clearly articulate priorities (e.g. community health priorities) and stick with them. Reputation for lots of planning and starting many initiatives but does not follow through. Finish what we start.
- Similarly, a need to translate priorities into specific choices, workplans and tangible actions. If substance use/mental health is a priority than provide specific guidance to departments/programs about how each program/department will contribute to meeting the objectives
- Less top down, more flexibility. Provide more opportunity for programs/ departments to make recommendations, test new ideas and contribute their expertise. Right now staff are not empowered.
- Trust needs to be rebuilt

Unable to recruit and retain staff

- Salaries and benefits do not compete, and facilities do not instill pride and a positive work environment

4. **INTEGRATION: What specific steps could HSA take to integrate services and coordinate efforts across the Agency *and* outside of the Agency?**

Participants were also asked about what HAS could do to strengthen integration and coordination. Themes included the following:

Integration is easier to envision and execute when organized around clear community health priorities. What we want to achieve drives steps to coordinate HSA programs, co-locate services and partner with other groups.

Take concrete steps to build more awareness and coordination between programs and departments (public health, clinical)

- Regular trainings together (even if standard trainings)
- Ongoing meetings/forums to facilitate coordination by clinical and public health programs serving the same population
- Physical co-location of services (and facilities that are conducive to co-location)
- Care team/Service models that incorporate multiple disciplines
- Empower departments and staff to work together

Develop and invest in targeted external partnerships focused on the outcomes we want to impact

- EMS community paramedicine, BHRS partnerships to impact mental health
- FRC, school partnerships to enhance prevention and education
- UCD, Stanford, USF, Madera to impact the workforce

Build standard, integrated systems to support reporting and service delivery

- Referral systems, viewing client information across programs, information sharing, data on health outcomes

5. **FUTURE PRIORITIES: What do you see as the biggest priorities for HSA over the next 3 years?**

Participants wrote their responses on post-it notes and placed them on the wall. The responses or themes were not discussed as a group. Overall, participant priorities echoed many of the themes discussed above, including enhanced integration, investment in staff to ensure full and stable staffing (compensation, training), strengthening organizational trust and culture, better facilities, more focus on prevention and addressing the social determinants of health, modifying the care team/model to be less reliant on physicians, and targeted partnerships with other departments and agencies.

G. Topical Memos: Key Findings

Between September 2017 and May 2018, Pacific Health Consulting Group (PHCG) developed six topical memos addressing key strategic topics and decision-points facing the Stanislaus County Health Services Agency (HSA). The memos examined the characteristics and outcomes of the current HSA arrangements, described potential future options or pathways, evaluated options against key criteria and highlights pros/cons and trade-offs, and presented a summary of key findings and considerations. The purpose of the memos was to provide detailed analysis to inform HSA leadership decisions about the strategic direction and steps for the next 2 years.

PHCG completed memos on the following topics:

1. Public Health: Health Data Analytics and the Culture of Quality Improvement
2. Public Health: Community Clinical Services and Other Programming Integration
3. Public Health Laboratory
4. Public Health: Emergency Medical Services
5. Primary Care, Specialty and Rehabilitation Clinics
6. Valley Family Medicine Program

Draft memos were submitted to Stanislaus County Health Services Agency Leadership in January 2018 to enable review and assessment of strategic visioning options. A chart summarizing findings from each of the memos related to the health environment and organizational strengths/weaknesses/opportunities/constraints are included on the following page.

Topical Memo Findings Related to Health Needs/Delivery System and HSA Organizational Strengths, Weaknesses, Opportunities and Constraints

Health Needs and Health Care Delivery Environment	HSA Organizational Strengths, Weaknesses, Opportunities and Constraints
Memo #3: Public Health Laboratory (PHL) • Significant decline in PHL testing volume between 2011 and 2016 *Memo #4. Public Health: Emergency Medical Services (EMS)* • Increased 911 call volume correlated with Medi-Cal coverage expansion (>30% increase from 2011-2016) • Significant use of ambulance transport for non-medical conditions, particularly mental health crises – lack of psychiatric beds, inadequate behavioral health services in community • High Medi-Cal payer mix impacts EMS financial sustainability • Paramedic shortage underpins EMS workforce challenges *Memo #5. Primary Care, Specialty and Rehabilitation Clinics* • Higher percentage of Stanislaus low-income residents served by FQHCs/Look-Alikes than California overall (45% vs. 34%) • Medi-Cal managed care enrollment growth +109,076 since 2013 (68,000 = newly eligible) • HSA only Medi-Cal specialty resource for many offered specialties – 50% of referrals from non-HSA primary care providers *Memo #6. Valley Family Medicine Program* • Community data and stakeholder input highlights moderate primary care provider shortage and significant specialty care provider shortage, particularly for Medi-Cal/uninsured • Primary care providers per 100,000 residents o Stanislaus: 52 o San Joaquin Valley: 39 o California: 64	*Memo #1. Public Health: Health Data Analytics and Culture of Quality Improvement* • Public Health and Clinical Operations data systems are fragmented, limited • Staffing to support quality and data/reporting is limited and unable to move beyond basic responsibilities • Quality improvement efforts siloed by department/program, not linked • Quality initiatives compete with other priorities for resources and attention • No agency-wide data or quality strategies in place *Memo #2. Public Health: Community Clinical Services and Other Programming Integration* • Clinical Operations and Public Health Services operate independently (in silos), though recent development of cross-unit leadership meetings • Currently, limited coordination between HSA and other health care system stakeholders to address community health/access issues *Memo #3. Public Health Laboratory (PHL)* • $600,000 in County subsidy in 2015/16 due to declining volume and revenue compared to no County subsidy in 2011/12 *Memo #5. Primary Care, Specialty and Rehabilitation Clinics* • 28% decline in HSA FQHCLA patients since 2012 while County personnel expense increased by $2.59M • HSA FQHCLA cost per patient increased from $591.36 in 2012 to $921.67 in 2016 • HSA FQHCLA clinical productivity above average, but support staffing levels also high • Negative HSA FHCLA financial performance due to very high operating expenses / cost per visit. Specialty clinic annual net loss of $2.9M, expected to increase in coming years • Uneven operational and clinical quality performance, inadequate infrastructure systems to manage quality or operations *Memo #6. Valley Family Medicine Residency Program* • 28% of family practice residents retained in County since 2011 – only 8% stayed with HSA clinics (6)

H. FQHC Look-Alike Board of Directors SWOC Planning Exercise

On March 30, 2017, Stanislaus County Health Services Agency senior staff facilitated a strategic visioning exercise with the agency's Federally Qualified Health Center Look-Alike (FQHCLA) board of directors to solicit feedback on primary care clinic performance, opportunities for the future and constraints impacting the organization. The board of directors includes community members and patients of the HSA primary care/FQHCLA clinics.

HSA facilitators listed the four SWOC (Strengths, Weaknesses, Opportunities and Constraints) on separate flip charts and facilitated a full-group discussion with the Board. Comments were recorded under the appropriate flip charts. A few comments were duplicated and listed under more than one category.

Following the discussion, Board members were given a set of red (critical), green (very important) and yellow (important) dots. Board members were each asked to individually prioritize the importance of the various comments by placing a dot by each of the comments. To establish a value of the issues identified, a value of 5 was given to the red dots, 3 for the green dots and 1 for the yellow dots.

- In terms of STRENGTHS, Board member participants ranked the residency program (21 points), ability to have the same doctor (18 points), access to care (15) and better access to County services (15 points) as the greatest strengths of the HSA FQHCLA/primary care clinics.

STRENGTHS	RANKING	TOTAL POINTS
Access to care	🔴🔴🔴	**15**
340b Special Pricing	🔴	5
Excellent high quality physicians	🔴🔴🔴	**15**
Residency program	🔴🔴🔴🟢🟢	**21**
Ability to have same doctor (1 on 1) relationship	🔴🔴🔴🟢	**18**
Geographic locations	🔴🟢🟢	11
Responsiveness/consistency/reliability	🔴	5
Nice facilities	🔴🟢🟢	11
Passionate staff with longevity	🔴🔴	10
Coordination of care (go the extra mile)	🔴🔴🟢	13
Better access to County services (BHRS/CSA)	🔴🔴🔴	15
Increased communication between staff and patients	🔴🔴	10
Urgent Care	🔴🔴🟢	13
Co-location with CSA and connection with Public Health		
Government option more stable		
Specialty Care		
🔴 *5 pts - critical importance*		
🟢 *3 pts - very important*		
🟡 *1 pt - important*		

- When asked to rank WEAKNESSES, Board members highlighted long waiting times at the clinics (21 points), recruiting and retaining physicians (20 points), and too many patients assigned to physicians (20 points).

WEAKNESSES	RANKING	TOTAL POINTS
Recruiting and retaining physicians/staff (lack of PCPs)	🔴🔴🔴🔴	**20**
Competition for clients	🟢🟡	4
Facility on Scenic	🔴🟢🟢	11
County do more to recruit faculty	🔴🔴🔴	15
Waiting time at clinics (has improved)	🔴🔴🔴🟢🟡🟡🟡	**21**
Too many patients for doctors	🔴🔴🔴🔴	**20**
Clinical support staff recruitment (Medical Assistants)	🔴🟢🟢🟡	12
🔴 *5 pts - critical importonce*		
🟢 *3 pts - very important*		
🟡 *1 pt - importont*		

- Lastly, Board members discussed OPPORTUNITIES and CONSTRAINTS. Following this discussion, Board members prioritized the following items: addressing the Scenic facility (23 points), more efficiently coordinating County services (22 points), expanding urgent care (21 points) and increasing the number of mid-level providers (19 points).

OPPORTUNITIES AND CONSTRAINTS	RANKING	TOTAL POINTS
Opportunity to more efficiently coordinate County services	🔴🔴🔴🟢🟢🟡	**22**
Scenic facility	🔴🔴🔴🔴🟢	**23**
Uncertainty regarding health care at federal level	🔴🟡🟡	7
Attract Staff with change in county perception regarding expansion	🔴🔴🔴	15
Clinical support staff recruitment (Medical Assistants)	🔴🟢🟢	11
EMR - Look at improving outcomes (health indicators)	🟢🟢🟢	9
Increase number of mid-level providers	🔴🔴🟢🟢🟢	**19**
🔴 *5 pts - critical importance*		
🟢 *3 pts - very important*		
🟡 *1 pt - important*		

ATTACHMENT 2

Stanislaus County Health Services Agency

Strategic Visioning Report

Strategic Visioning Deliverable – Part II

Prepared by Pacific Health Consulting Group
7-12-2018

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I. INTRODUCTION

Between March 2017 and May 2018, the Stanislaus County Health Services Agency (HSA) conducted an extensive strategic visioning and planning process to identify a long-term agency vision and articulate specific strategic steps for the next two years. Pacific Health Consulting Group (PHCG) was engaged to support the planning process. To inform the planning process, PHCG additionally completed the following activities:

- Developed a Health Environmental Scan report outlining community health needs/outcomes, social/economic factors impacting resident health, access to care in the community;
- Conducted a Strengths, Weaknesses, Opportunities and Constraints (SWOC) analysis of the Stanislaus County Health Services Agency;
- Completed intensive analysis of several topical/program areas within HSA to assess current performance and characteristics, potential future options and evaluation of each option against key criteria. Topical areas included the following: direct clinical services, including primary care, specialty care and rehabilitative care; residency program; emergency medical services; public health laboratory; clinical service, public health and other programming integration, and health data analytics, and;
- Engaged an independent architecture firm to develop a Facility Master Plan.

A summary of key findings from the Health Environmental Scan and Strengths, Weaknesses, Opportunities and Constraints (SWOC) are included in this report and detailed findings are available as a separate report.

In addition to reviewing key findings from the environmental scan and SWOC analysis, the enclosed report outlines the 10-year strategic vision for the Stanislaus County Health Services Agency and presents 2-year strategic recommendations for six specific service/topic areas, including: Emergency Medical Services; Public Health Laboratory; Valley Family Medicine Residency Program; Clinical Services (including primary, specialty and physical rehabilitative care); Clinical Service, Public Health and Other Programming Integration, and; Health Data Analytics and the Culture of Quality.

APPENDIX I includes six memos reviewing detailed analysis of each of the above topic areas, including performance and characteristics of the current system, review of alternatives/options for HSA moving forward, and evaluation of the trade-offs of each option.

II. HEALTH ENVIRONMENTAL SCAN AND SWOC FINDINGS

Pacific Health Consulting Group (PHCG) conducted a health environmental scan identifying community health needs/outcomes, social/economic factors impacting resident health, access to care in the community and delivery system capacity and gaps. Additionally, PHCG completed a Strengths, Weaknesses, Opportunities and Constraints (SWOC) analysis of the Health Services Agency (HSA) that solicited internal perspectives, external perspectives and analysis of available internal data and programs.

Key findings from the Health Environmental Scan included the following:

- Quantitative and qualitative evaluation highlighted substance use and mental health as key community health issues, as well as, highlighted the lack of sufficient or coordinated mental health and substance use services in the community. This was the most significant community health issues identified in the Health Environmental Scan;

- Access to timely health care services remains a challenge for low-income residents. This particularly includes a significant shortage of specialist providers, especially those willing to see Medi-Cal enrollees. Although available data indicates some level of primary care access challenges and provider shortages, it also shows a meaningful and rapidly growing presence of independent FQHC primary care providers in the community;

- Stanislaus County experiences a high community prevalence and impact of chronic disease, as well as, faces challenges creating healthy community environments and shifting resident health behaviors and self-management, and;

- Community health is significantly impacted by community factors, such as poverty, education, community safety and the physical/built environment. This is particularly true among Stanislaus County children, who experience high rates of poverty and are impacted disproportionately by the above factors.

Key findings from the HSA Strengths, Weaknesses, Opportunities and Constraints (SWOC) analysis included the following:

- The HSA is well-regarded for its historically strong role in fulfilling core public health department responsibilities, particularly in response to public health crises, such as disease outbreaks and public health emergencies;

- Internal and external stakeholders highlighted a lack of awareness about HSA's community health priorities and strategic direction, and highlighted opportunities for HSA to play a broader public health/community health leadership role in defining community health priorities and engaging partners;

- Similarly, stakeholders highlighted an interest in and opportunity to more directly focus on prevention/early intervention, population health and the social determinants of health as strategies to impact community health;

- While stakeholders recognized the importance of retaining and building primary care capacity in Stanislaus County, some stakeholders questioned the appropriate role of HSA as a direct clinical service provider given the rapidly growing presence of independent FQHC systems, HSA challenges recruiting and retaining primary care providers, reduction in the number of “indigent” patients in the community, and fact that direct clinical services are not a mandated requirement for the agency. Some suggested that HSA may create more positive impacts by focusing efforts more explicitly on public health strategies and partnerships;

- There appears to be a lack of integration both within HSA (e.g. between clinical services and public health), as well as, between HSA services and other county agencies (e.g. Behavioral Health and Recovery Services). Internal and external stakeholders see opportunities for targeted integration and coordination between programs, departments and agencies in order to impact community health priorities;

- Limitations on data systems and staffing have impacted the ability of HSA to promote integration, quality and efficiency across the organization;

- Challenges recruiting and retaining staff and medical providers, was highlighted as a persistent and significant challenge impacting the ability of HSA to provide direct clinical services and advance its public health strategic initiatives. Additionally, reliance on aging facilities has affected service quality, led to unexpected costs and redirected senior staff attention from delivering services and advancing community health.

III. 10-YEAR STRATEGIC VISION

The below Long-Term Vision Statement and Desired Agency Characteristics provide the framework for and guide the 2-year strategic steps outlined in section IV of the Visioning Report.

A. Stanislaus County Health Services Agency Long-Term Vision Statement

Over the next ten years, the Health Services Agency (HSA) will invest in transformative change into a system that explicitly focuses on prevention and population health. While maintaining mandated and essential individual services and programs, HSA will prioritize efforts that address the socio-economic factors and individual behaviors that shape the health of community residents and can lead to meaningful improvement in the health of the community. This will require transformative change in the organizational mindset, practices, infrastructure, skill sets and resources of the agency.

B. Desired Agency Characteristics

In order to achieve its 10-year vision to meaningfully focus on and impact on population health, the HSA will seek to develop the following organizational components and characteristics that are essential to a successful transformation:

- **Population Health and Delivery System Priorities.** Periodically prioritize population health outcomes and delivery system issues to focus;
- **Collaborative Leadership.** Develop a collaborative leadership approach that explicitly outlines shared goals and promotes communication and coordination across HSA divisions, departments, services and programs, as well as, with behavioral health and other county agencies;
- **Service Integration.** Integrate the delivery of medical, public health, behavioral health, and other services/programs that address individual client clinical and social determinant needs;
- **Quality Improvement.** Adopt and consistently practice a standardized quality improvement and evaluation process across divisions, departments, programs and services;
- **Data-Driven Decision-Making.** Develop the organizational resources, tools and reporting structure to utilize data to inform all aspects of planning and operations, including service planning decisions and evaluation of program/ service impact and quality;
- **Community Leadership.** Prioritize the responsibility of HSA leadership to actively engage community providers and leaders on priority population health and delivery system issues.
- **Customer Service.** Maintain commitment to an optimal customer experience and prioritize customer service in the development, delivery and evaluation of services.

IV. TWO-YEAR STRATEGIC STEPS

The following section outlines the 2-year interim strategic steps recommended by the HSA to achieve its long-term vision. It outlines specific recommendations, rationale and timelines/phasing for recommendations in each of the following areas:

A. Public Health: Health Data Analytics and the Culture of Quality Improvement

B. Public Health: Community Clinical Services and Other Programming Integration

C. Public Health Laboratory

D. Public Health: Emergency Medical Services (EMS)

E. Primary Care, Specialty and Rehabilitation Clinics

F. Valley Family Medicine Residency Program

Table A on the following page summarizes recommendations for each of the topical areas. Additional discussion of analysis findings, rationale and the timeline and phases for implementation for each topical area then follow.

TABLE A. Summary of HSA 2-Year Strategic Recommendations

TOPIC AREA	RECOMMENDATIONS
Public Health: Health Data Analytics and the Culture of Quality Improvement	1. **Implement a Community-Wide Population Health Initiative.** Focusing on the required Population/Public Health role of HSA, complete the new Community Health Assessment (CHA) with increased community partner engagement and use to inform a Community Health Improvement Plan (CHIP) in FY18-19. In partnership with community partners, utilize the CHA and CHIP to inform development of a community-wide population health initiative in FY 19-20. 2. **Expand Data and Quality Foundation.** Strengthen HSA's health and organizational information gathering capabilities and systems, including the Epidemiology team, to expand data gathering and analysis with a focus on developing a culture of quality improvement, dedicating resources based on areas of need and with effective and measurable methods for outcomes-based management. Become a consistent resource of health and health indicator data for County and community stakeholders.
Public Health: Community Clinical Services and Other Programming Integration	1. **Coordinated Public Health and Clinical Service Interventions.** Based on findings from the upcoming Community Health Assessment (CHA) and priorities established in the Community Health Improvement Plan (CHIP), develop coordinated interventions between Public Health and community clinical providers (FY 19-20). 2. **HSA-BHRS Collaboration.** Work with the County Behavioral Health and Recovery Services to develop a population health framework for collaboration between the agencies to improve health outcomes and create efficiencies.
Public Health Laboratory	1. **Regional Lab Partnership.** Explore a regional Public Health Laboratory model in FY18-19 with partner county(ies) while maintaining local intake.
Public Health: Emergency Medical Services	1. **Continue in Regional EMS Agency.** Continue membership in the regional Mountain Valley Emergency Medical Services (EMS) Agency. 2. **Additional Support for EMS Service Delivery in Stanislaus County.** As needed, consider supplementing MVEMSA with staffing to ensure optimal delivery of EMS services in Stanislaus County.
Primary Care, Specialty and Physical Rehabilitation Clinics	1. **Clinical Services Access**. With the goal of preserving and expanding clinical services for low-income residents, explore clinical care alternatives by other mission-driven safety net providers that may be better positioned than HSA in the future to provide sustainable, high-quality clinical services in multiple community locations.
Valley Family Medicine Residency Program	1. **Continued HSA Residency Leadership.** Continue support for the family medicine residency program and participation in the Valley Consortium for Medical Education. 2. **Expanded Residency Partnerships.** Supported by the Valley Consortium for Medical Education (VCME) Board, seek additional partners in FY18-19 to support future sustainability and growth of the VCME.

A. Public Health: Health Data Analytics and the Culture of Quality Improvement

Recommendations

In order to further its capability and performance as a data-driven agency with an organizational focus on quality, the following steps are recommended:

1. **Implement a Community-Wide Population Health Initiative.** Focusing on the required Population/Public Health role of HSA, complete the new Community Health Assessment (CHA) with increased community partner engagement and use to inform a Community Health Improvement Plan (CHIP) in FY18-19. In partnership with community partners, utilize the CHA and CHIP to inform development of a community-wide population health initiative in FY 19-20.

2. **Expand Data and Quality Foundation.** Strengthen HSA's health and organizational information gathering capabilities and systems, including the Epidemiology team, to expand data gathering and analysis with a focus on developing a culture of quality improvement, dedicating resources based on areas of need and with effective and measurable methods for outcomes-based management. Become a consistent resource of health and health indicator data for County and community stakeholders.

Analysis and Rationale

Rather than examine distinct pathways, the options considered within this topic were outlined as steps or building blocks. A central question was how far and how quickly HSA could develop its capabilities in this arena. Options examined included the following:

1. Build a foundation by establishing a quality and data platform for the future;
2. Complete #1 above *and* institute an agency-wide Population Health Initiative, and;
3. Complete #1 and #2 above *and* implement a community wide Population Health Initiative.

The analysis produced the following key findings:

- **FINDING:** Current HSA data systems are fragmented and limited. HSA Quality and Data staff are often unable to move beyond executing basic responsibilities due to multiple competing demands and system limitations.

- **FINDING:** Similarly, current Quality initiatives often compete with other organizational priorities and mandates for resources and attention.

- **FINDING:** While HSA departments often articulate and pursue individual quality initiatives, these efforts are siloed and often unrelated. HSA as an agency has not yet developed either a shared understanding of quality or established forums to achieve an aligned agency-wide quality strategy.

B. Public Health: Community Clinical Services and Other Programming Integration

Recommendations

As part of the visioning planning process, HSA examined options for enhanced integration within HSA departments, with other county agencies and with other community partners and providers. Based on analysis and planning, the following steps are recommended:

1. **Coordinated Public Health and Clinical Service Interventions.** Based on findings from the upcoming Community Health Assessment (CHA) and priorities established in the Community Health Improvement Plan (CHIP), develop coordinated interventions between Public Health and community clinical providers (FY 19-20).

2. **HSA-BHRS Collaboration.** Work with the County Behavioral Health and Recovery Services to develop a population health framework for collaboration between the agencies to improve health outcomes and create efficiencies.

Analysis and Rationale

The planning process and related analysis highlighted the following findings:

- **FINDING:** Many other California counties and communities nationally are pursuing integrated clinical and public health strategies to address community health priorities. This includes both integration between clinical service and public health departments within county agencies, as well as, integration and coordination between county public health departments and community health and service providers.

- **FINDING:** Community health priorities like cardiovascular morbidity/mortality, diabetes prevention, smoking cessation, maternal child health and opioid overdose prevention are examples of community health priorities that can be effectively addressed through combined clinical and public health interventions.

- **FINDING:** Conversations have begun between Stanislaus County HSA and Behavioral Health and Recovery Services (BHRS) regarding coordination and leveraging opportunities. A framework should be considered including clinical and other integration models (e.g. health promotion, outreach and engagement, etc.) that improve health outcomes and create administrative and clinical efficiencies.

C. Public Health Laboratory

Recommendations

The following strategic step is recommended:

1. **Regional Lab Partnership.** Explore regional Public Health Laboratory model in FY18-19 with partner county(ies) while maintaining local intake.

Analysis and Rationale

An analysis during the strategic visioning process examined the current HSA arrangement for Public Health Laboratory (PHL) services and its performance, as well as, examined the following options for the future:

1. Retain local Stanislaus County Public Health Lab model;
2. Retain local Stanislaus County Public Health Lab model with increased testing; volumes and/or lowered costs, and;
3. Join a regional Public Health Lab model.

Major findings from the analysis included the following:

- **FINDING:** Rapid changes in lab technologies, coverage and reimbursement are having profound effects on many health service programs traditionally provided by local governments;

- **FINDING:** A critical shortage of qualified lab directors has hampered recruitment and retention of lab leadership;

  FINDING: Multiple factors are contributing to a more challenging environment for Stanislaus County lab services. Declining testing volumes and revenue are likely to continue under the current model. Current lab operations are also vulnerable to staffing changes and acquiring new technologies would be challenging and expensive to implement.

D. Public Health: Emergency Medical Services

Recommendations

The following strategic steps are recommended:

1. **Continue in Regional EMS Agency.** Continue membership in the regional Mountain Valley Emergency Medical Services (MVEMSA) Agency.

2. **Additional Support for EMS Service Delivery in Stanislaus County.** As needed, consider supplementing MVEMSA with staffing to ensure optimal delivery of EMS services in Stanislaus County.

Analysis and Rationale

An analysis during the strategic visioning process examined the current HSA arrangement for EMS services and its performance, as well as, examined the following options for the future:

1. Continue as a regional Mountain Valley Emergency Medical Services Agency (MVEMSA) member and address current concerns;
2. Form a single county EMS agency;
3. Form a new Stanislaus County-operated multi-county EMS agency, and;
4. Form a new 2-county EMS agency.

The analysis produced the following major findings, which informed the Visioning Plan recommendations outlined above. Key findings included the following:

- **FINDING:** The MVEMSA is an established EMS agency with strong institutional knowledge, expertise and clinical/staff leadership. Participation in the multi-county EMS agency provides important advantages in state funding, as well as, institutional expertise.

- **FINDING:** There are opportunities for Stanislaus County to work with MVEMSA and other community partners to address shared challenges facing the health care delivery system, such as management of mental health patients, EMS workforce, ambulance provider stability and health system access improvements.

- **FINDING:** Stanislaus County has the option, and opportunity, to ensure adequate leadership and resources to support effective EMS services within the current MVEMSA structure.

- **FINDING:** Shifting to a single-county, new 2-county or new multi-county agency presents important operational challenges and could result in increased net costs to Stanislaus County.

E. Primary Care, Specialty and Physical Rehabilitation Clinics

Recommendations

Based on an intensive review of current and anticipated system performance and analysis of options in consideration of community needs, the following strategic steps are recommended:

1. **Clinical Services Access**. With the goal of preserving and expanding clinical services for low-income residents, evaluate and pursue clinical care alternatives by other mission-driven safety net providers that are better positioned than HSA in the future to provide sustainable, high-quality clinical services in multiple community locations.

Analysis and Rationale

The HSA strategic visioning planning process included an intensive analysis of HSA clinical services, including FQHC Look-Alike primary care clinics and specialty/rehabilitative services. The analysis evaluated the historical role and justification for HSA provision of direct clinical services; performance and outcomes of current HSA clinical service delivery; trends and emerging practices related to delivery of clinical services by county health systems, and; an analysis of options and trade-offs for future delivery of clinical services by Stanislaus County HSA.

The analysis included an evaluation of the following strategic options:

1. Retain current FQHC Look-Alike/Other clinical services with system improvements.

2. Strategically consolidate clinic sites with improvements and explore strategic partnerships/approaches to maintain access to care and optimize HSA resources.

3. Phase out Stanislaus County HSA role as a direct clinic service provider.

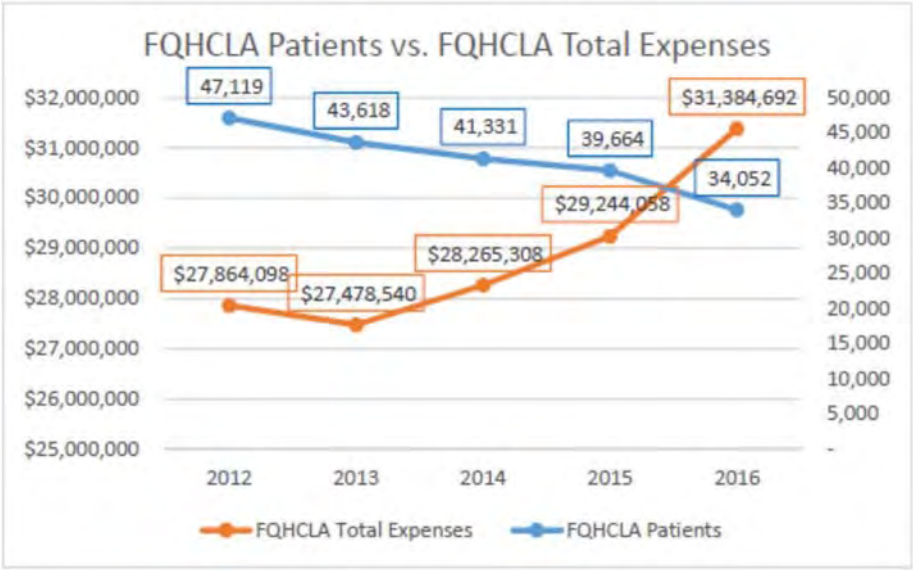
The analysis produced the following major findings, which informed the Visioning Plan recommendations outlined above. Key findings included the following:

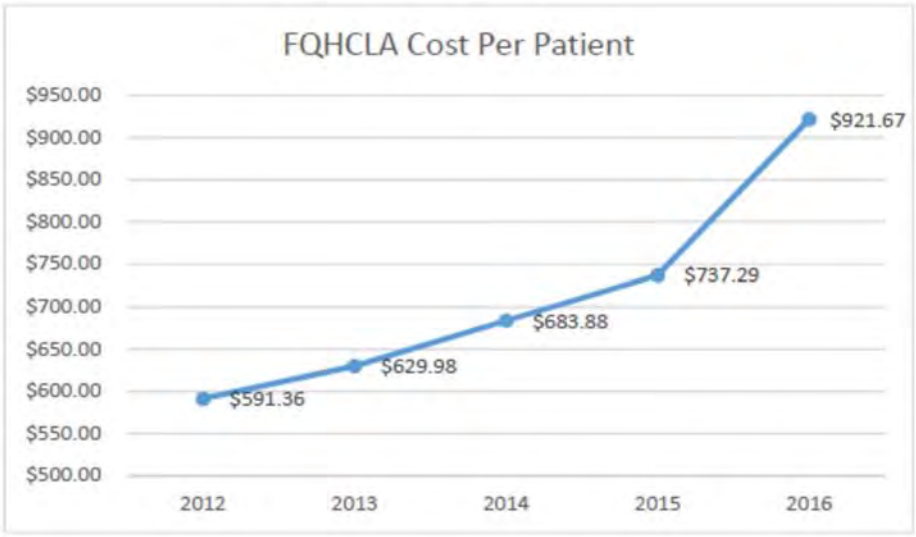
- **FINDING:** While ensuring adequate primary care capacity in the community remains a challenge, the historical role and rationale for HSA's role in the *direct* provision of primary care services is shifting. Independent FQHC service providers are growing in the community and now serve over 100,000 patients at 22 sites in Stanislaus County. Independent FQHCs now serve 75% of all low-income residents receiving care at FQHC/Look-Alike clinics in the County. Additionally, the Affordable Care Act / Medi-Cal expansion significantly

decreased the number of uninsured residents in the community and reduced the number of uninsured eligible for the Medically Indigent Adult (MIA) program.

- **FINDING:** Stanislaus County HSA has struggled to attract and retain medical providers in a highly competitive environment. Overall contracted and employed clinical provider staffing declined from 38.2 Full Time Equivalents (FTE) in 2010 to 33.4 FTE in 2016. Multiple vacancies remain unfilled and limited options exist to meaningfully strengthen the competitive position to attract new providers.

- **FINDING:** Dramatic declines in Stanislaus County FQHC Look-Alike clinic patients served and annual visits in parallel with continued increases in expenses have contributed to a growing cost per patient served and increasing challenges to retain current clinic facilities without enhancing General Fund contributions.





- **FINDING:** Specialty care access for Medi-Cal beneficiaries and other low-income residents remains severely limited. HSA specialty services remain one of the few local options for Medi-Cal enrolled residents to access specialty services. Other safety-net providers, including independent FQHCs, are not optimally positioned or incentivized to increase specialty care services.

- **FINDING:** Although HSA specialty and rehabilitative services meet an important community need opportunities do exist to more effectively partner with community providers and manage cost and service offerings to most effectively meet community needs.

F. Valley Medicine Family Residency Program

Recommendations

In recognition of the important role of the Valley Medicine Family Residency program in the community and the essential role of HSA in ensuring its continued success, the following is recommended:

1. **Continued HSA Residency Leadership.** Continue support for the family medicine residency program and participation in the Valley Consortium for Medical Education.

2. **Expanded Residency Partnerships.** Supported by the Valley Consortium for Medical Education (VCME) Board, seek additional partners in FY18-19 to support future sustainability and growth of the VCME.

Analysis and Rationale

As part of an analysis of community needs and the role of Stanislaus County in the residency, HSA reviewed two potential pathways moving forward:

1. Retain the current Valley Family Medicine Residency for Stanislaus County, and;
2. Retain and expand the Valley Family Medicine Residency for Stanislaus County with new partners.

The analysis highlighted several important findings about community needs and the role of HSA in the future. Key findings included the following:

- **FINDING:** A real and persistent challenge recruiting and retaining an adequate number of primary care providers exists across California and is particularly acute in the San Joaquin Region. This provider shortage is even more accentuated for service to low-income residents. The primary care provider to population ratio in the San Joaquin Region is 22% below the California average.

- **FINDING:** Stanislaus County plays a unique and essential role in maintaining and championing the residency program. Developing the local provider workforce falls appropriately within the role of the HSA to assure adequate services within the community and address system-level challenges. No other provider or system is adequately equipped or motivated to play this leadership and key funding role.

- **FINDING:** Challenges in administering, funding, growing and strengthening the impact of the residency program highlight the importance of new strategic partnerships within the program.

V. APPENDIX I – TOPICAL MEMOS

Between September 2017 and May 2018, Pacific Health Consulting Group (PHCG) developed six topical memos addressing key strategic topics and decision-points facing the Stanislaus County Health Services Agency (HSA). The memos examined the characteristics and outcomes of the current HSA arrangements, described potential future options or pathways, evaluated options against key criteria and highlights pros/cons and trade-offs, and presented a summary of key findings and considerations.

The purpose of the memos was to provide detailed analysis to inform HSA leadership decisions about the strategic direction and steps for the next 2 years. PHCG completed memos on the following topics:

1. Public Health: Health Data Analytics and the Culture of Quality Improvement
2. Public Health: Community Clinical Services and Other Programming Integration
3. Public Health Laboratory
4. Public Health: Emergency Medical Services (EMS)
5. Primary Care, Specialty and Physical Rehabilitation Clinics
6. Valley Family Medicine Residency Program

The completed memos are included on the following pages.

STANISLAUS COUNTY HEALTH SERVICES AGENCY
TOPICAL MEMO #1
Public Health: Health Data Analytics and the Culture of Quality Improvement
May 11, 2018

Overview

The Stanislaus County Health Services Agency (HSA) engaged Pacific Health Consulting Group (PHCG) to facilitate an intensive strategic planning process for the agency. As part of the engagement, PHCG was asked to evaluate several strategic topics/issues and present key findings to inform HSA strategic decisions.

The enclosed memo examines two key and inter-related topics: 1) development of a culture of quality, and 2) development of organizational capability and use of health-related data.

While the topics of "culture of quality" and "data-driven" organizations encompass a number of complex issues and questions, this memo seeks to frame the current HSA position and potential options for moving forward in a simple, unified framework to inform specific strategic decisions and commitments by the agency.

Methodology

This analysis relied primarily on extensive discussion and information exchange with HSA leadership. The PHCG team also utilized its understanding of health department/agency practices and developments across California and the nation. HSA leadership providing information for this analysis included:

- Mary Ann Lee, HSA Managing Director
- Alisa Bettis, HSA Director of Quality and Planning
- Dr. Del Morris, former HSA Medical Director
- Lori Williams, HSA Director of Public Health
- Karryn Unruh, former HSA Director of Clinical Operations
- Vijay Chand, HSA Chief Financial Officer

Current State and Characteristics

Public Health and Clinical Operations data systems are fragmented and limited. As an example, Public Health data is not available in a single database and access to data and reports is limited. The data used by CAPE are held in several different databases. Access to the databases is limited to CAPE personnel or IT. Division directors or managers do not have routine access to databases nor do they perform their own analyses. Requests for analysis are made through CAPE. The turnaround time is described as varying in relation to the size of the request but often takes several weeks to complete. The lack of timely data or clear understanding of what information is available inhibits the ability of the organization to be data-driven. Prior efforts to create a single database for all HSA data have stalled due to lack of available staff and competition by other priorities.

Similarly, Clinical Operations systems do not allow real-time or user-generated reports. Clinical quality and population health reports must be requested and can take several weeks to complete. HSA has purchased an EHR add-on that enables additional reporting and case management. Implementation of the add-on has been delayed over the previous two years due to lack of staffing, competing priorities and some internal resistance by clinic staff and providers. To that end, the clinics do not generate any clinic- or provider-level clinical quality dashboards or regular reports.

As a result of system and staffing limitations, Clinical Operations reporting is limited to required reporting elements and not used to identify or inform population health initiatives. According to staff, reporting efforts are directed to meeting HEDIS and UDS reporting requirements. Due to limitations of the EHR and lack of confidence in the completeness and accuracy of the data, reporting on some elements is augmented by the manual review of charts.

Staffing to support quality and data/reporting in both Public Health and Clinical Operations has historically been limited and unable to move beyond basic responsibilities. Clinical Operations staff resources and staffing to generate reports is extremely limited with only 0.5 FTE allocated systemwide for clinical quality reporting. In addition, although the system has 3.0 FTE technically allocated to QI, staff indicated that the vast majority of responsibilities relate to compliance, risk-management and other functions un-related to advancing a population health approach. Lastly, the Director of Quality, who oversees quality in both Public Health and Clinical Operations, is responsible for a wide array of functions beyond quality improvement, including contract compliance, risk management, facilities management, special projects, and grant writing and research, among others. The breadth of responsibilities limits the time and focus on quality improvement.

During the last couple of years, the CAPE unit has struggled to achieve full staffing and move beyond required reporting and basic program reporting. Within Public Health, CAPE is the principal group responsible for the collection and analysis of data. These open positions have significantly limited the role and contributions of CAPE. However, the unit, which is managed by a Chief Epidemiologist with 2.0 FTE additional epidemiology positions, has recently achieved full staffing. It also no longer has responsibility for vital statistics, which may enable it to focus more fully on its core responsibilities.

Quality improvement efforts are siloed by program/department and do not link to each other. The development of quality definitions, aims and priorities appear to be closely tied to sub-units within the agency. They, in turn, respond to quality mandates and initiatives related to their local functions. Therefore, there is a siloed, grass roots approach to quality within HSA.

This includes a siloed approach to educating staff about quality improvement, selecting measures/indicators, developing quality goals, reviewing data and designing interventions to meet goals.

HSA leadership have not developed a shared understanding of quality or forums to create an aligned agency-wide strategy. According to staff, Public Health and Clinical Operations staff have not yet invested in shared trainings, planning or the development of strategies to guide an agency-wide quality strategy and ensure a consistent understanding of quality concepts.

Quality initiatives compete with other priorities for resources and attention. According to staff, immediate needs and crises related to facilities, clinical operations and public health emergencies consistently deter the organization from advancing quality and data initiatives, as well as, developing a pro-active agency-wide quality and data strategy.

Placing Stanislaus County in Context

The development of a data and quality-driven organization encompasses the development of several important elements, such as data infrastructure/capabilities, organizational culture of quality, level of agency integration and the scope and reach of a quality framework. The below chart offers a simple framework for thinking about the evolution of a data and quality-driven organization by outlining characteristics of organizations with Developing, Established and Advanced quality and data capabilities.

Based on the analysis, it appears that Stanislaus County is a "Developing" agency in the early stages of establishing a culture of quality and data/reporting capabilities. The current state is characterized by under-developed data collection and reporting capabilities, limited quality and data-related staffing in both Public Health and Clinical Operations, siloed departmental/program approaches to quality, and as of yet a lack of shared quality training and competencies. The potential options for moving the HSA forward are outlined within this framwork.

Continuum of Development of Quality and Data-Driven Organizations

DEVELOPING

Quality Framework

Department-specific quality initiatives

Culture of Quality

Some shared executive leadership quality competency

Integration

No departmental integration, some leadership exchange

Data and Reporting

Focus on accurate data and real-time, user-end generated departmental reporting

ESTABLISHED

Quality Framework

Agency-wide population health goals, priority populations, metrics and interventions

Culture of Quality

Cross-agency quality training for executive and departmental leadership

Integration

Department/Program forums to promote integration, coordination and shared interventions

Data and Reporting

Agency-wide metrics, reporting and review

ADVANCED

Quality Framework

Community-wide population health goals, priority populations, metrics and interventions

Culture of Quality

Strong agency quality foundation and competency

Integration

Formal engagement of community providers and stakeholders in quality initiatives

Data and Reporting

Community-wide metrics, reporting and review

Analysis of Options

The proposed options are outlined as steps, or building blocks, rather than alternative pathways. The key question for HSA will be to determine how far, how quickly and with how large of an investment and focus the agency will want to develop its capabilities as a data and quality-driven organization.

Phase 1. Build the Foundation. Under this option, the HSA would prioritize establishing a quality and data foundation for the future. Key elements of this option would include:

- Staffing: Increasing base quality and data/reporting staff allocations, as well as consider redefining Director of Quality responsibilities to allow for more focused attention on quality,
- Data/Reporting Systems: Prioritizing the development of integrated data systems that enable real-time and user-generated reporting in both Public Health and Clinical Operations,
- Culture of Quality: Providing training to the HSA executive team to ensure a common understanding of quality concepts and frameworks (culture of quality), and,
- Leadership Exchange: Initiating some structured forums for HSA executive leadership to share quality priorities and begin to identify opportunities for integration and coordination both *across* Public Health programs (e.g. MCAH, WIC, PHN) and *between* Public Health and Clinical Operations – depending on the continued role of HSA in delivering direct clinical services.

Above all, this option would require additional full-time equivalent (FTE) investments, such as, filling the epidemiologist position, adding FTE to support Public Health and Clinical Operations quality initiatives, and expanding IT/data analytics staffing. Most likely, this would require at least 3-5 additional FTEs, but a detailed assessment of staffing gaps and needs would need to be completed by the agency. In terms of data systems, HSA would need to fully commit to implementing the expanded EHR reporting and case management functions and explore integrated system options for Public Health programs.

Lastly, strengthening the "culture of quality" represents more of an institutional commitment rather than a financial or systems investment. As a first step, HSA leadership could commit to shared quality training modules to develop a common understanding of quality concepts. Additionally, the HSA could institute regular, structured forums (e.g. monthly basis) for Public Health and Clinical Operations to share quality initiatives and progress and begin to identify opportunities for integration and collaboration. Each of these elements are essential building blocks to becoming a quality and data-driven organization.

Phase 2. Institute an Agency-Wide Population Health Initiative. Within this option, the agency would move beyond establishing a foundation and would seek to establish an agency-wide initiative articulating over-arching population health goals (e.g. reducing childhood obesity), metrics and targets that would inform the development of department/program-specific initiatives and cross-agency initiatives. This approach is also addressed in the memo examining Clinical Operations and Public Health integration. Key steps include the following:

- Agency-Wide Priorities. Identify agency-wide population health priorities,
- Agency-Wide Metrics. Identify metrics/indicators that measure progress along population health priorities and develop reporting structures/dashboards,

- Improvement Targets. Set improvement goals for each metric and hold the agency accountable for progress,
- Agency-Wide Quality Training. Invest in uniform departmental/program quality trainings to ensure a shared organizational understanding of quality concepts,
- Departmental/Program Initiatives Contribute Toward Agency Priorities. Use agency-wide priorities to inform departmental priorities, as well as, evaluation of cross-departmental/program projects and integration,
- Cross-Departmental/Program Exchange and Planning. Create structured cross-departmental/program forums to collaboratively review progress and develop and manage new initiatives, and
- Reporting and Communication. Communicate the results through community reports, agency-wide dashboards and departmental/program dashboards.

Importantly, moving forward with Phase 2 requires many of the components outlined in Phase 1 to be in place, such as adequate staffing, functional data/reporting systems, executive commitment and understanding of quality and at least some structured leadership communication *across* Public Health programs and *between* Public Health and Clinical Operations – to the extent that HSA remains a direct clinical service provider. While Phase 2 may require some additional planning resources and staffing support, the essential ingredient is executive leadership commitment to both developing an agency-wide focus and ensuring structured and regular communication and coordination between departments and programs.

Phase 3. Implement a Community-Wide Population Health Initiative. Within Phase 3, HSA would engage other community providers and stakeholders in the identification of population health priorities and development and execution of shared strategies and interventions to address these priorities. The clear value of engaging community partners is it presents the opportunity to identify the most appropriate role and contribution of each partner to a common problem, create a shared focus on a major community priority and potentially leverage or generate new resources or funding to address priorities.

Above all, this would place HSA in a leadership role in facilitating a planning process, compiling and presenting data, and establishing a structure to monitor progress. Although the agency currently lacks the staffing/resources and bandwidth to meet the planning, reporting and monitoring requirements, the organization may be better positioned after foundational investments are made. Previous initiatives, such as Focus on Prevention and The Framework for a Thriving Stanislaus, highlight the challenges that the HSA would face in fostering successful community-wide initiatives.

Key Takeaways

Based on HSA's current position along the quality/data continuum, it appears that the vast majority of its energy during the strategic planning period may need to be committed to building a strong foundation by enhancing core quality and data staffing, prioritizing data collection and reporting system improvements in all of its programs and departments, and initiating a culture of communication and coordination at the executive team level. Without these elements in place, efforts to create agency-wide or community-wide initiatives may falter at the execution and monitoring phase due to resource shortages, unavailability of data/reports and lack of established structures or practices around coordination and integration.

STANISLAUS COUNTY HEALTH SERVICES AGENCY
TOPICAL MEMO #2
Public Health: Community Clinical Services and Other Programming Integration
May 11, 2018

Overview

The Stanislaus County Health Services Agency (HSA) engaged Pacific Health Consulting Group (PHCG) to facilitate an intensive strategic planning process for the agency. As part of the engagement, PHCG was asked to evaluate several strategic topics/issues and present key findings to inform HSA strategic decisions.

The enclosed memo examines options for clinical services and other programming integration. The memo considers opportunities for integration both within Stanislaus County Health Services Agency and with other agencies and partners, such as community health providers or other county agencies. The enclosed analysis reviews the characteristics and outcomes of the current HSA arrangements, describes potential future options or pathways, evaluates each option against key criteria and highlights pros/cons and trade-offs, and presents a summary of key findings and considerations. The analysis also includes a review of key trends and promising practices among comparable organizations. Specific options evaluated include the following:

1. Internal HSA Public Health and Clinical Operations coordination and integration
2. Coordination and integration between HSA Public Health and community health care providers, and;
3. Coordination and integration between HSA and Behavioral Health and Recovery Services (BHRS).

Methodology

The enclosed analysis includes information from:

- Planning meeting with BHRS and HSA leadership (April 2017);
- Review of best practices from other local health departments, national organizations and public health and primary care literature, and;
- Interviews with:
    - Mary Ann Lee, Stanislaus HSA Managing Director
    - Dr. Rebecca Nanyonjo, former Stanislaus HSA Chief Deputy Director
    - Lori Williams, Stanislaus HSA Director of Public Health
    - Karryn Unruh, former Stanislaus HSA Director of Clinical Operations
    - Dr. Del Morris, former Stanislaus HSA Medical Director
    - Dr. Julie Vaishampayan;, Stanislaus County Public Health Officer
    - Dr. Marguerite Ro, Seattle- King County Public Health, Chief of Assessment, Policy Development, and Evaluation / Chronic Disease and Injury Prevention

- Dr. Karen Milman, Sonoma County Public Health Officer
- Srija Srinivasan, San Mateo County Health System, Deputy Chief

Current State Characteristics and Performance

HSA Clinical Operations and Public Health: The current structure of HSA provides opportunities to promote coordination of planning, operations and data analytics across Public Health Services and Clinical Operations. The HSA Chief Deputy Director oversees both Clinical Operations and Public Health Services. The Director of Clinical Operations and the Director of Public Health both report to the Chief Deputy Director. The Public Health Officer and the HSA Medical Director report to the HSA Managing Director and work directly with the Chief Deputy Director. In practice, coordination across the department has been challenging. In general, Clinical Operations and Public Health Services function independently, in silos, without coordination and programmatic integration. Significant focus within the agency is directed to the county FQHC-LA health centers that are facing serious challenges in terms of decreasing patient numbers, increased operational expenditures and provider discord and recruiting difficulties.

There have been recent efforts to strengthen understanding and coordination across Clinical Operations and Public Health Services through regular meetings of the leadership team from both units. The leadership from these two units have identified some specific opportunities for coordination between clinical services and public health. Examples include maternal child health and chronic disease and risk factors, including reduction of premature deaths from cardiovascular disease, diabetes and tobacco use. Dr. Julie V, Stanislaus Public Health Officer highlighted the importance of reducing cardiovascular mortality through coordination and leveraging of public health and clinical services interventions. Preventing deaths from cardiovascular disease is of special importance for Stanislaus County, which ranks 58th out of 58 California counties for coronary heart disease (primarily heart attacks) deaths and 54th out of 58 California counties for cerebrovascular disease (primarily strokes) deaths.[1]

Mountain Valley Emergency Medical Services Agency: HSA has collaborated with Mountain Valley Emergency Medical Services Agency (MVEMSA) in developing innovative community paramedicine programs to address access issues impacting the health of specific sub-populations in the county, particularly individuals with serious mental illness. MVEMSA and HSA have expressed interest in collaboratively exploring other innovative paramedicine models that bridge public health and clinical services, such as addressing the needs of the homeless population and direct observed therapy for tuberculosis and other public health communicable disease collaboration.

Behavioral Health and Recovery Services: HSA has also participated in several preliminary planning discussions with Behavioral Health and Recovery Services (BHRS), the Stanislaus County agency that administers county behavioral health and recovery services for eligible residents, (including specialty mental health and

[1] County Health Status Profiles 2017, California Department of Public Health https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/OHIRProfiles2017.pdf

alcohol/drug treatment and prevention), to identify potential opportunities for collaboration. The Health Environmental Scan and Strengths, Weaknesses, Opportunities and Constraints (SWOC) reports completed as a part of the Visioning Project both highlighted mental health and substance use as significant community health issues, as indicated by multiple factors, such as high rates of opioid and other drug use, high rates of ambulance and emergency room use due to mental health crises or substance use, limited supply of mental health providers, and shortage of mental health crises and substance use treatment options. All of these issues have implications for both HSA and BHRS.

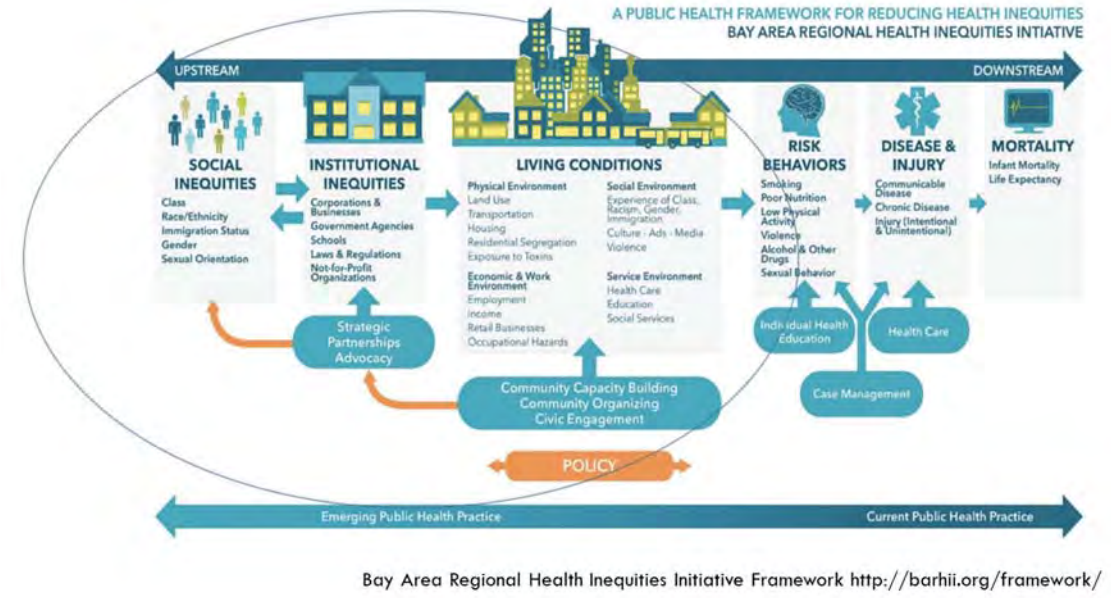
Community Healthcare Providers: To date there has been limited coordination of public health and clinical services coordination between HSA and other health care system stakeholders in the community. The County FQHC-LA clinics serve approximately 11% of the Medi-Cal population In Stanislaus County and about a third of the population served by community health centers. The County FQHC-LA clinics and the community FQHCs represent the principle primary care safety net providers for the county's medically underserved population. Community FQHCs, that were founded upon principles of equity, access, and reducing health disparities, are natural partners of Public Health in improving population health. Other healthcare partners, such as non-profit hospitals, have legal requirements to participate in assessing and impacting community health and can be strong clinical partners with public health. Additionally, community health workers from local community-based organizations can serve as a bridge between county residents, clinical services and public health in improving health through collaborative strategies.

External Trends and Promising Practices

In many ways, this is an opportune time to focus on improved integration within HSA (e.g. between primary care and public health) and across the broader health, public health, behavioral health and social services spectrum. Coverage expansion through the Affordable Care Act coupled with a parallel focus on generating greater value in the form of improved health outcomes and reduced cost, has propelled widespread interest among health, behavioral health and social service providers in a more integrated and coordinated approach to service delivery. This has included a recognition that multiple factors, such as access to services, health behaviors, living environments and other social determinants of health impact community health outcomes.

Perceptions about the role of Public Health departments have similarly evolved with many experts encouraging the development of Public Health departments as "chief health strategists" in their communities to work with other agencies and community partners to address community health, including a focus on "upstream" social determinants of health. The following two graphics illustrate the evolving view of public health and highlight the growing importance of increased partnership and integration.

Chart A: Public Health Framework for Reducing Health Inequities



Bay Area Regional Health Inequities Initiative Framework http://barhii.org/framework/

Chart B: Public Health Framework Evolution

Public Health-Primary Care Integration: Coordination and improved integration of primary care and public health priorities and strategies are essential to improving population health and reducing health care costs. The current transformation of primary care includes an increased focus on patient-centered care, population management, data analytics and social determinants of health. At the same time, Public Health has been transitioning to a new model of practice that emphasizes strong leadership and collaboration with community partners.

The Institute of Medicine, in their 2012 Issue Brief, *Primary Care and Public Health: Exploring Integration to Improve Population Health*[2], addressed the need to better

[2] Primary Care and Public Health: Exploring Integration to Improve Population Health, Institute of Medicine, Issue Brief, March 2012

integrate public health and clinical services to improve the health of populations across the nation and reduce the growth of healthcare expenditures. More recently, the Practical Playbook text and organization have provided important fundamentals and examples of public health and clinical services coordination at the local level to improve population health. [3]

There are various successful models and best practices for integrating clinical services and public health. Examples of collaboration between public health and primary care include:

- Reducing cardiovascular disease morbidity and mortality is as an area of special importance and interest for Stanislaus County, given the disproportionate levels mortality in the county from heart attacks and strokes. Several evidence-based strategies have been implemented that combine public health and primary care strategies to reduce cardiovascular disease (heart attacks and strokes). Kaiser Permanente implemented a highly successful population health strategy that reduced cardiovascular disease (CVD) morbidity by 60% among their members. They have supported the extension of this program to many community health centers in California, including some Golden Valley Health Center (GVHC) sites. The Million Hearts national initiative is co-led by the Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services (https://millionhearts.hhs.gov/). Million Hearts focuses on the 'ABC'S' of cardiovascular disease: **A**spirin for people at risk; **B**lood pressure control; **C**holesterol management and; **S**moking cessation. In November 2017 Million Hearts and CDC released their Guide to Best Practices for Cardiovascular Disease Prevention Programs (https://www.cdc.gov/dhdsp/pubs/docs/Best-Practices-Guide-508.pdf). The guide lays out best practices in the 4 domains of combined public health and clinical services interventions for the prevention of cardiovascular disease morbidity and mortality:

    - Epidemiology and Surveillance
    - Environmental and Policy Approaches
    - Health Care System Interventions
    - Community Programs linked to Clinical Services

- Examples of successful county-based Million Hearts initiatives in California that combine population-based public health and clinical systems interventions include Be There San Diego and Hearts of Sonoma and their It's Up to Us blood pressure campaign. (http://betheresandiego.org/ and https://www.checkyourbp.org/).

- Diabetes Prevention collaborative primary care/public health strategies focus largely on early detection of pre-diabetes in primary care and linking individuals with pre-diabetes to community-based prevention programs that emphasize physical activity and health eating. The YMCA Pre-Diabetes Prevention Program http://www.ymca.net/diabetes-prevention/ is an evidence-based example of this strategy.

[3] [3] Michener, J.L., et al The Practical Playbook Public Health and Primary Care Together, 2016

- Integrated initiatives for tobacco control include a combination of screening and smoking cessation support in primary care settings with the promotion of targeted public health policies and environmental approaches to reducing access to tobacco products.

- Another area of intense collaboration between primary care and public health is opioid overdose prevention. The California Department of Public Health and the California Health Care Foundation have provided important leadership in this area. There is a California Opioid Safety Network and multiple Opioid Safety Coalitions in counties throughout California. http://www.chcf.org/cosn The Opioid Safety Coalitions are made up of community partners from public health, primary care, hospitals, health plans, emergency response and others such as law enforcement. Collaboratively they have developed local plans, procedures and policies around safer prescribing practices, medication-assisted treatment and overdose prevention.

- In addition to specific models and best practices, the HSA leadership team emphasized the importance of having basic guiding principles for the public health and clinical services collaborative efforts. Guiding principles identified by the HSA workgroup included health equity and community engagement in the design and implementation of interventions. In addition, the group mentioned the importance of carrying out an initial environmental scan of existing local primary care and public health programs and interventions in Stanislaus and looking for 'natural connections' among them. This scan could be used to identify initial opportunities for primary care and public health collaboration and interventions with community partners.

Public Health, Medical and Behavioral Health integration: There are multiple recent examples of new initiatives promoting interdisciplinary and integrated approaches to improve community health and improve health and cost outcomes among our communities most complex and costly patients. Given the prevalence of medical, mental health and substance use issues among many of the highest risk patients, many of these initiatives emphasize partnership between Medi-Cal managed care, public health departments, county and non-profit medical providers and county behavioral health agencies. While a number of communities have launched individual county efforts, three statewide initiatives highlight the emphasis on public health, medical and behavioral health partnership. They include the Whole Person Care pilots, Health Homes Program and Drug Medi-Cal Organized Delivery System.

- **Whole Person Care Pilots (WPC):** The Medi-Cal 2020 Section 1115 waiver authorized the creation of "Whole Person Care" pilots, providing up to $1.5 billion for California counties to test county-based initiatives that coordinate health, behavioral health and social services for vulnerable Medi-Cal beneficiaries who are high users of multiple systems and have poor outcomes. The pilots, which require a governmental entity/authority to serve as the lead agency, explicitly focuses on increased integration, coordination and information sharing between county and non-county service providers to improve health outcomes and reduce costs for high-risk and high-cost populations. The first round of implementation is

scheduled to launch in July 2018. Stanislaus County has not submitted an application.

- **Health Homes Program (HHP):** Included as part of the Affordable Care Act, the Health Home Program (HHP) is an optional Medicaid state plan benefit covering health home service for beneficiaries with chronic conditions. The program, which is led by local Medi-Cal managed care plans (e.g. Health Plan of San Joaquin), includes development of a network of providers that will integrate and coordinate primary, acute and behavioral health services for the highest risk Medi-Cal enrollees. None of the Stanislaus County Medi-Cal managed care plans has submitted an application.

- **Drug Medi-Cal Organized Delivery System (DMC-ODS):** Also a part of the 1115 waiver, DMC-ODS is intended to demonstrate how organized substance use delivery (SUD) care can improve outcomes and reduce health care costs. Components of the DMC-ODS include increased local control/accountability for contracting, oversight and rate-setting; movement of beneficiaries into an "managed care" model; emphasis on coordination and integration with other systems of care; new evidence-based guidelines on the continuum of care and mechanisms for quality oversight, and; enhanced benefits/services for the Medi-Cal population. Counties have the opportunity to "opt-in" to the program. Stanislaus County has submitted a draft application that includes leadership by BHRS and participation by HSA.

Future Options

Listed below are 3 options for Stanislaus Health Services Agency (HSA) to integrate public health, clinical operations and/or behavioral health services (mental health, substance use treatment) to support community health objectives include:

Option 1: Internal HSA Public Health – Clinical Operations Coordination/Integration

One option for Stanislaus HSA to support community health objectives would be coordination of existing HSA programs in Public Health Services and Clinical Operations targeting the current service populations of those programs. The process to integrate and leverage the efforts of Public Health Services and Clinical Operations to support community health objects would include several steps. Public Health Services and Clinical Operations leadership and key staff would jointly:

1. Determine the specific community health objective/s they will address and the HSA service population they will target
2. Identify the most effective Clinical Operations and Public Health Services program interventions that they will coordinate and leverage to impact the selected community health objective/s
3. Develop robust processes for identification, referral and coordination of care and services for patients and clients from the HSA target population
4. Establish a joint group for ongoing monitoring, evaluation and quality improvement of their integrated intervention/s

5. Engage patients/target population in the design, implementation and evaluation of the collaborative strategies

Community health objectives that could be impacted by the coordination and leveraging of Public Health Services and Clinical Operations interventions include cardiovascular disease, diabetes prevention, smoking cessation and maternal child health. As an example, Public Health Services and Clinical Operations could focus on reducing cardiovascular disease morbidity and mortality among patients in the County FQHC-LA population. Integrated public health and clinical services strategies could include:

- Public Health epidemiology and surveillance of cardiovascular disease risk factors, morbidity and mortality trends among county clinic patients
- Public Health CVD policy, environmental and equity work to create the conditions for healthy choices and environments
- Health care systems interventions in the FQHC-LA clinics for improved detection and disease management of CVD and risk factors
- Link county clinic patients to community programs to improve chronic disease self-management

Option 2: **Coordination/Integration Between HSA Public Health and Community Healthcare Providers**

Stanislaus HSA could expand the focus of coordination of public health and clinical interventions objectives to a larger segment of the population and include additional stakeholders from the clinical care system of Stanislaus County, such as Federally Qualified Health Centers (FQHCs) or other healthcare providers serving low-income residents. This broader population health approach would expand the reach and impact of the public health and clinical services intervention/s. Community health priorities that could be effectively impacted by this broader approach include cardiovascular disease, maternal child health, obesity and diabetes prevention and opioid overdose prevention.

As an example, this type of broader coordination and leveraging of public health and clinical interventions could be used to reduce cardiovascular disease morbidity and mortality in Stanislaus County using a model such as the Million Hearts initiative, previously described in this memo. A Million Hearts safety net- or county-wide cardiovascular disease prevention initiative would include:

- Public Health epidemiology and surveillance of cardiovascular disease risk factors, morbidity and mortality trends across the county population;
- Public Health CVD county-wide policy, environmental and equity work to create the conditions for healthy choices and environments;
- Clinical interventions across major provider groups and health centers in the county for improved detection and disease management of CVD and risk factors;

- Linkage of patients throughout the county to community programs to improve chronic disease self-management.

Option 3. Coordination/Integration Between HSA and BHRS

HSA could additionally explore opportunities to coordinate and integrate Public Health and Clinical Operations services with Behavioral Health and Recovery Services (BHRS). Such a partnership could target a range of critical community health issues, including: opioid prescribing and abuse, ambulance and emergency room utilization related to mental health or substance use crises, behavioral health prevention and treatment options, collaborative management of shared clients with moderate to severe mental health diagnoses, community approaches to mental health trauma, adverse childhood experiences, and behavioral health provider supply, among other issues. Similar to Public Health – Clinical Services partnerships, HSA and BHRS would be tasked with several steps to jointly address issues:

1. Evaluate and identify shared community health objectives to address
2. Select effective program interventions to pilot and measure
3. Implement robust processes to identify, refer and coordinate services for clients
4. Establish a joint group for monitoring, evaluation and quality improvement, and
5. Engage patients/target populations in the design, implementation and evaluation of collaborative strategies.

Evaluation Dimensions

PHCG identified four broad evaluation dimensions to guide the analysis of potential impacts, benefits and challenges associated with each issue. These include:

- Impact on Community Health – Impact on population health, including magnitude and populations of focus
- Implementation and Operational Feasibility – Feasibility of initial implementation and implications for ongoing operations or management
- Financial Impact – Financial impact, including a review of one-time costs, new ongoing costs/resource requirements and implications for ongoing financial performance
- Political Feasibility – Key political considerations and factors

Analysis of Options

Option 1: Internal HSA Public Health – Clinical Operations Coordination/Integration

- By initially focusing on the county public health services and clinic patient population, HSA can develop internal capacity for collaboration and integration of strategies to address community health problems.

- On the other hand, limiting the scope of the public health/primary care coordination to existing HSA clinic patients and programs reduces the number of community members and providers participating in the intervention and limits the impact of the combined strategy on community health outcomes

- Public Health Services and Clinical Operations have been challenged to coordinate and integrate strategic priorities and programs to date. Changing the culture, practice and coordination of the HSA team and programs to a new more collaborative and integrated approach across units and programs will be difficult. The transformation will require leadership, accountability and persistence and would benefit from a framework, such as Results-based accountability, to provide a common language and shared goals across the organization.

- In Option 1, the public health and clinical services interventions would be developed internally without input from community partners and would be based on the characteristics of the County clinics. Because practice models differ among providers, this development of the model without community provider input could limit the ability to later expand the interventions to the larger community population and other healthcare system partners.

Option 2: **Coordination/Integration Between HSA Public Health and Community Healthcare Providers**

- A population health approach has the advantage of impacting a larger population than if the focus were exclusively on the patient population served by county clinics. For example, County clinics serve approximately 11% of the county Medi-Cal population. If HSA wants to impact a community health problem that disproportionately impacts the County Medi-Cal population, it is important to include the health care system partners that provide care to the other 89% of the County Medi-Cal population.

- A population health approach brings together a coalition of local primary care providers, other health care providers, community organizations and community members with their collective resources, expertise and perspectives that are needed to address complex community health issues.

- The Health Services Agency leadership has expressed the desire to move in the direction of population health in keeping with the CDC's model of Public Health 3.0 in which local health departments "serve as Chief Health Strategists, partnering across multiple sectors and leveraging data and resources to address social, environmental, and economic conditions that affect health and health equity." A public health/primary care collaborative with community partners positions HSA as the community health leader and convener in a manner consistent with the CDC Public Health 3.0 model.

Option 3: Coordination/Integration Between HSA and BHRS

- Stanislaus County community health data indicates that mental health and substance use issues clearly present some of the most critical community health outcomes and access challenges impacting the health of Stanislaus County residents. Similarly, collaboration between public health, medical and behavioral health service providers is likely essential to meaningfully addressing these issues.

- While collaboration is important, BHRS and HSA operate under vastly different funding and reimbursement structures, unique delivery system environments, different electronic health records systems, and distinct organizational and provider cultures. Any new collaboration should be approached thoughtfully and systematically.

Option Pros/Cons and Open Questions

	PROS	CONS
Option 1 Internal HSA Public Health – Clinical Operations Integration	• Moves HSA in direction of population health • May not require additional staffing	• Primary Care-Public Health Strategies to improve community health could be developed without input from community partners. This could negatively impact ability to expand interventions beyond HSA • Potential missed opportunities to improve access and community health collaboration with community partners
Option 2 HSA Public Health – Community Clinical Provider Integration	• Greater impact in terms of target population and collective impact of multiple provider organizations • Moves HSA in direction of population health • Can be done whether or not County has its own clinics	• Requires Department/County support and resources for HSA to take on a strong role as community leader and convener with health care partners • Requires dedicated HSA staff to perform leadership and possibly backbone organization functions • Doesn't specifically address improved coordination between HSA Public Health Services and Clinical Operations
Option 3 HSA and BHRS Integration/ Coordination	• Mental health and substance use issues among most critical impacting the community. Potential for significant impact on these issues • Moves HSA in the direction of population health • Better positions both HSA and BHRS for participation in value-based initiatives, such as WPC or HHP • Can be done whether or not County has its own clinics	• Organizational culture, siloed delivery and information systems, and lack of sustained history of partnership all create potential challenges for success • Requires sustained leadership and commitment to achieve outcomes

Evaluation of Options Against Key Evaluation Dimensions

Criteria	Option 1 Internal HSA Public Health – Clinical Operations Integration	Option 2 HSA Public Health – Community Clinical Provider Integration	Option 3 HSA and BHRS Integration / Coordination
Impact on Community Health	Impact limited to patients served by County Primary Care and Public Health Clinics	Greater impact on community health due to broader county target population and community primary care partner collaboration	Mental health and substance use issues among most critical community health issues in County. Collaboration necessary to impact these issues
Implementation and Operational Feasibility	County FQHC-LA has had challenges implementing changes such as the EHR, data analytics and Patient-Centered Medical Home. Implementing collaborative Public Health-Clinical Operations changes may also prove challenging May not require major operational changes, but will require significant changes in collaborative identification of joint priorities, planning and implementation strategies	Requires prioritization and support of the leadership role of Public Health in convening, leading an initiative with community primary care and other community members and partner organizations	Moderate first steps to establish information sharing, identification of shared issues/populations and small collaborative efforts would not present significant implementation issues. Higher level service integration and coordination would introduce significant complexity requiring close partnership and attention from both parties
Financial Impact	May require additional staffing	May require resources to support Public Health role in convening and providing backbone organization functions	Similarly, initial collaboration would not introduce significant new costs. More sustained coordination or integration could introduce new costs related to information sharing, project management and service delivery
Political Feasibility	Unlikely to generate political issues	Requires support from County for Public Health to take on this leadership role with community primary care and other health care partners	Likely to receive very positive support from external partners (e.g. hospitals). Would require open communication to manage different agency cultures in HSA and BHRS
Facilities Impacts	Unlikely to have facilities impacts	May require limited additional cubicle space for Public Health staff involved in supporting work with community partners	No initial impact. Potential for new costs/requirements if coordination leads to co-location of services

Key Findings and Take-Aways

1. Coordination and integration of primary care and public health priorities and strategies can improve population health and reduce health care costs. This is an opportune time to focus on integration of primary care and public health. The current transformation of primary care includes an increased focus on patient-centered care, population management, data analytics and social determinants of health. At the same time, Public Health has been transitioning to a new model of practice that emphasizes strong leadership and collaboration with community partners. There are successful evidence-based models and best practices for integrating clinical services and public health that Stanislaus County HSA can implement to support local community health priorities.

2. Community health priorities that can be effectively addressed through combined clinical and public health interventions include the disproportionally high rates of cardiovascular morbidity and mortality in Stanislaus County, diabetes prevention, smoking cessation, maternal child health and opioid overdose prevention.

3. Stanislaus Health Services Agency can approach integration of public health and clinical strategies to improve community health by focusing on the Department's internal programs, clinics and service populations. Alternatively, or additionally, HSA could increase the impact of coordinated public health and clinical interventions on community health by focusing on the broader county population in collaboration with other local health care system partners and community members.

4. Many of the most critical community health and access issues in Stanislaus County (and throughout California) link medical services, mental health and substance use. Shared issues include the opioid crisis and other drug abuse, treatment options to address mental health crises, substance use treatment services and mental health trauma/adverse childhood experiences among the population. While rife with challenges, sustained leadership and concerted partnership between the Health Services Agency and Behavioral Health and Recovery Services could represent an important strategy to address these issues.

STANISLAUS COUNTY HEALTH SERVICES AGENCY
Topical Memo #3
Public Health Laboratory
May 11, 2018

Overview

The Stanislaus County Health Services Agency (HSA) engaged Pacific Health Consulting Group (PHCG) to facilitate an intensive planning process for the agency. As part of that engagement, PHCG was asked to evaluate several strategic questions and present key finding to inform HSA decisions. The enclosed memo examines options regarding the provision of Public Health Laboratory services.

Specifically, the enclosed analysis reviews the characteristics and outcomes of the current HSA arrangement in this area, describes potential future options or pathways, evaluates each option against key criteria and highlights pros/cons and trade-offs, and presents a summary of key findings and considerations. The analysis also includes a review of key trends and promising practices among comparable organizations. The purpose of the memo is to provide detailed analysis that will enable the HSA to make strategic decisions for the future.

Context and History of PHL Services with a Focus on California

Public health laboratory services play an important role in achieving the mission of public health agencies to protect and promote the health of the population. Closely tied to their home agencies at local, state and national levels, public health laboratories (PHLs) perform laboratory tests on samples collected from both humans and animals, the environment and other select sources where infectious diseases and harmful agents pose a potential threat to the population.

While PHLs have been in existence in the United States for more than a century the diversity in their charters, organizational structures, and size between states and communities present a challenge to any brief summary. Recent efforts by the Association of Public Health Laboratories have however achieved a consensus defining core functions, capabilities and standards for the public health laboratory industry. These are articulated in 11 'core functions' for a PHL (MMRW Sept 20, 2002/51:1-8):

- disease prevention, control, and surveillance;
- integrated data management;
- reference and specialized testing;
- environmental health and protection;
- food safety;
- laboratory improvement and regulation;
- policy development;
- emergency response;

- public health-related research;
- training and education; and
- partnerships and communication.

The history of public health laboratory services in California has been shaped in several unique ways in comparison to other States. In the early 1900s California passed legislation requiring counties with populations over 50,000 to provide PHL services. Travel and communication technologies linking the far-flung counties at that time were rudimentary leaving each county largely on its own to provide laboratory services. Then in the late 1940's the Federal Hill-Burton Act spurred the construction of thousands of local hospitals and public health facilities. Many counties used Hill-Burton funding to build a public health laboratory. This combination of statutory requirement and funding opportunity resulted in California having a large number of local PHL each serving small-to-medium sized communities relative to PHL in many other states that elected a state-wide or regional approach.

Today roughly half of the State's 58 counties maintain their own laboratory while the remainder either refer testing to the California State Public Health Lab (counties with very small populations) or have arrangements with other counties to supply PHL services. California's legacy of distributing PHL functions to very small and local levels is illustrated in this recent three-way comparison: The State of Missouri had one State PHL and one branch facility serving a population of 6 million residents and a service area of 70,000 square miles. California's San Diego County had one PHL serving 3.0 million residents in a service area 4,500 miles. While Marin County, the fifth smallest County in California, maintained a PHL serving a population of 270,000 and a service area of 520 square miles.

Arguably, the need for access to public health laboratory testing to insure the public's safety were similar in these examples of a State, a large urban and a small semi-urban county but their contexts and histories led to very different outcomes. The consequences of those outcomes, particularly for smaller and semi-rural counties in California, inform much of the discussion it applies to the circumstances facing Stanislaus HSA and its laboratory. Those consequences derive from three interrelated areas: changing technologies, the economies of scale and the evolving environment of health care delivery systems and payments. The following with briefly summarize each area:

Changing technologies: Laboratory science is a rapidly changing field both at the 'bench' as to how tests are performed as well as how results are stored or relayed to providers. Many tests that have been standards for a generation or more are being replaced or sidelined by newer tests that leverage molecular technologies and advanced detection devices. These newer test platforms offer several advantages including speed, sensitivity and specificity. But small laboratories encounter challenges of large capital outlays to procure the equipment and experience high unit costs that arise from performing small numbers of tests. This issue of 'small volume testing' is especially magnified in an outbreak of a new or novel infectious agent affecting only a very small proportion of the population or when considering a new complex test such as gene sequencing.

Economies of Scale: New testing technologies have added further advantages over older techniques in the form of semi-automation and scale. Many common tests can now be performed on multiple samples in a single process and with only marginal additional inputs of materials or labor. The results have been to create advantages of scale for large volume of testing leaving small volume operations to cope with both high capital and operational costs per unit. Similar challenges for small volume laboratories exist when they attempt to adopt

advances in data storage and transfer. Prior methods of 'paper-rock-scissors' using paper reports /filing cabinets/FAX are rapidly being replaced with digital data/cloud/EMR interfaces in the laboratory industry. The high costs of acquiring and maintaining these digital systems can be manageable in high-volume laboratories become budget-breaking for small-volume operations.

Evolving environment of health care systems and payments: The landscape of health care systems in many communities has changed dramatically with the emergence of Federally Qualified Health Care Centers (FQHCs) in the 1980s. FQHCs have greatly increased the access to healthcare for millions of low-income and underserved Californians while opening the door for alternatives to County-provided clinical services. Many counties and communities have embraced the potential of the FHQH model to provide 'wrap around' primary care services that include some specialized services previously offered by County clinics such as tuberculosis, STD and family planning. These system-based changes in health care delivery have been accompanied by shifts in the contracting practices for laboratory services. Many of these newer arrangements (FQHC, managed Medicaid, non-County hospitals etc) engage single single-source, low-cost laboratory contracts that have reduced or ended their reliance or use of PHL services. A frequently observed net effect on many PHL has been lower volumes/demands from the clinics in their communities for testing and limited opportunities for them to expand their business.

Methodology

PHCG conducted interviews with the following Stanislaus HSA representatives:

- Lori Williams, Director of Public Health
- Julie Vaishampayan, MD, Public Health Officer
- Becky Nanyonjo, Chief Deputy Director
- Vijay Chand, Chief Financial Officer
- Jewel Warr, Chief Executive Office
- Steve Willis, Director, Stanislaus County Public Health Lab

PHCG conducted interviews with the following individuals outside of Stanislaus County:

- Paul Kimsey, PhD, Director California State Public Health Laboratory
- Anthony Gonzales PhD, Director, Sacramento County PHL
- Katya Ledin, Director, PhD, Solano Napa Yolo Marin Regional PHL

PHCG reviewed the following data/documents/summaries provided by Stanislaus HSA representatives:

- SCPHL Statements of Expenditures & Revenues
    - 2013, 2014, 2015, 2016, 2017 YTD
- SCPHL Budgeted Staff Positions, descriptions salaries
- SCPHL Water Test Summaries by Type/Volume
    - 2013, 2014, 2015, 2016, 2017 YTD
- SCPHL Current (2015) Lab Test Menu and Fee Schedule
- SPPHL Facilities Floor Plan
- Summary Description of PHL Services from HSA
- Draft Summary of Findings from HSA Lab Review (7/2017)
- PHCG also participated in a lab walk-thru

Current State Characteristics

Physical Plant

The Stanislaus County Public Health Laboratory (SCPHL) facility is located at 820 Scenic Drive, Modesto in a multi-building campus housing numerous HSA programs. Most of the buildings on the campus date from the 1930s and were constructed to house the Stanislaus County Hospital. The laboratory facility is housed in 'Building B', built in the early 1960's, and consists of a main work room of ~1,500 square feet and several small ancillary spaces for a total foot print of ~2,000 square feet. The laboratory has three Class BII Biological safety cabinets; an autoclave; a purified water system and a dedicated HVAC system. An electrical power generator located on the exterior of the building provides power backup if required.

Building B, which houses the laboratory, has been partially updated from the original hospital functions. The interior however remains dated and the environmental/support systems have been prone to repeated failures. While a major facilities plan has not yet been completed, the general assumption is that original hospital buildings are no longer cost effective to refurbish and that they will be replaced. No firm timeline for replacement has been set. Consequently, no architectural, engineering or cost assessments for a replacement laboratory facility are available for this review.

Staffing

Clinical Lab Scientist III	1.0 FTE
Clinical Lab Scientist II (vacant)	1.0 FTE
Clinical Lab Assistant II (vacant)	0.375 FTE
Lab Director (on contract)	0.1 FTE
	2.475 FTE
Admin Clerk II	0.5 FTE

The staffing of the SCPHL is remarkable for its extremely small size with only two full-time lab scientists and a part time assistant. The full-time lab director position has been unfilled for several years. The directorship duties have been performed by a contract for a few hours/week from an outside PHL laboratory. As will be discussed below, the very low staffing levels have had negative impacts on the laboratory's performance. It should be noted that despite the small size of the staff that its ability perform the volume of tests it does is commendable and reflects well on the staff.

It is unclear from discussions with stakeholders to what extent the low staffing levels are a consequence of a pervasive and long-term challenges to recruit qualified laboratory personnel. By report, they have interviewed one candidate for the Directorship position in four years! The compensation levels reported for these positions do not appear to be competitive.

Recent Performance History of the SCPHL

Several types of data including annual reports of test types, volumes of tests performed and financial data were reviewed in this analysis. The data show three interrelated trends: First, there has been a sharp decline in the total number of tests performed over the recent four-year period. Second, revenues from testing have declined as the volume of tests performed plummeted. Third, some offered tests have been curtailed or ended due to a combination of factors including a rare demand for the test and the limited availability of staff time to perform the test.

I. Declines in Test Volumes

The data in this analysis relevant to test volumes and the number of samples submitted/year were obtained from multiple sources including reports generated by the lab staff and summaries from a recent analysis by HSA management. Variances in the data are noted when comparing reported year-to-year volumes between the source documents. The trends that are described in the data from each source are consistent however. The data in the table below illustrate the ~53%% decline in test volumes over the recent four-year period.

	11/12 FY	12/13 FY	13/14 FY	14/15 FY	15/16 FY
# Lab Tests	13,990	11,550	8,694	7,902	6,506

Of note, the sharp decline in test volumes appear largely related to declines in testing performed under CPT codes 87941 and 87591. These are associated with testing for GC and chlamydia infections, common STDs.

II. Declines in Revenues

The data in the table below illustrate the declines in revenue from lab services over the same period (row 1). Consequent to declining revenues, County financing to support the laboratory budget rose sharply (row 2).

	11/12 FY	12/13 FY	13/14 FY	14/15 FY	15/16 FY
Lab Revenue from Services (exclude Misc)	$1,008,542	$839,206	$623,538	$553,257	$381,805
Health Realignment Funding	------NA	$0	$290K	$299K	$626K

III. Referrals of Tests to an Outside PHL

Over the observed time period the SCPHL has begun to refer some testing to an outside PHL, San Joaquin County PHL. Those include tests for ova and parasites, some types of tuberculosis tests as well as some tests for respiratory viruses. The net volumes and associated lost revenues are uncertain since they do not appear in the reports provided. Based upon historical data, however, they are unlikely to be significant contributors to the declines described. The elicited reasons prompting the referrals are multiple but seem related to either the very low volumes of requested tests making them inefficient and/or the demands on very limited staff time to perform them. Of note is that the practice of referring samples to outside PHL is not uncommon practice in other small PHL.

IV. Other Trends and Events

Laboratory Information Management System

Notable amongst other trends/events in the recent history of the SCPHL has been the stalled effort to fully launch its Laboratory Information Management system, LabWare. Licensed by HSA for the lab in 2015 its implementation has been significantly delayed necessitating continued reliance on manual interactions with data and reports. Root causes have included limited IT resources and the added costs of building interfaces with the data systems of recipient agencies/providers. In addition to the uncertainty about the future of the Public Health Lab, the timeline, additional costs and the current willingness to achieve full implementation are unclear.

HSA-Sponsored Evaluation of its PHL Services

Prompted by multiple factors including declining test volumes, an increasing requirement for County support and the challenges of maintaining staff the leadership of HSA completed an internal assessment of its PHL services in June, 2017. The assessment included cross-walk comparisons of the tests currently offered in the SCPHL and those potentially available in the San Joaquin PHL (SJPHL). Those comparisons suggest no loss of testing currently available through the SCPHL and the addition of several testing capabilities through the SJPHL. The assessment concludes with several recommendations:

- That Stanislaus County join San Joaquin County to form a regional PHL service with the laboratory operations located in the San Joaquin PHL (SJPHL).
- That Stanislaus HSA create and support a logistics system for receiving local samples and transporting them to SJPHL
- That the governance and financing of the regional model be administered under a JPA agreement between the Counties.
- That the timeline for implementation aims for a completion by June, 2018.

External Trends and Promising Practices

The circumstances facing the Stanislaus PHL have become common amongst small and mid-sized PHL as the trends described under the "Context and History" section of this memo describe. The strategies employed by other agencies supporting PHL services fall into three general schemes:

Lower input costs: In general PHL report few opportunities to substantively reduce input costs. In regards to supply/inventory costs, the fragmentation of the PHL network into multiple stand-alone operations at a small scale offers individual members scant leverage power to negotiate lower prices. Similar circumstances apply to the purchases of major equipment and technologies such as LIMs. In the area of labor costs several counties share a PHL director but they are principally motived by the challenge of recruiting PhD-qualified candidates. Measures that might reduce the labor costs of the larger staff are sharply limited by the need to have adequate staffing for surge events and the interests of organized labor.

Enhance revenues, find new purchasers: A few larger laboratories have found opportunities to provide some advanced testing capabilities to non-County clinical providers. For example, the Napa-Yolo-Solano-Marin PHL laboratory offers advanced TB and fungal ID testing for several hospitals in the region. Sacramento County PHL provides the TB testing for the UC Davis clinics.

Contracting out: Several counties have resorted to contracting some or all their PHL services to other counties. As mentioned above, some of smallest counties (<50,000 population) escape the statutory requirement of having a PHL service and rely upon the State PHL. Other counties have contract/refer out specialized or very low volume tests to other County PHL. Typically, these arrangements are limited in their impact on both costs and revenues to the parties involved and do not address the existential threats to the entire laboratory described above.

Regionalization: Regionalization of PHL services is a practice that has gained interest in California and across the United States in recent years. It has also raised concerns and debate given the unique role that PHL play in the defense of the public's health and safety. Reflecting those concerns at a national level, the Center for Disease Control (CDC) and the Association of Public Health Laboratories (APHL) developed extensive guidelines for agencies and governments contemplating service changes. Issued in 2012 and entitled *"A Practical Guide to Assessing and Planning Implementation of Public Health Laboratory Service Changes"*, the guidelines' authors acknowledge the need to "…achieve long-term sustainability by adopting management practices that can improve their operating efficiency and strengthen their resilience in the face of financial or other challenges." The guidelines specifically address service changes that include shared services across state and jurisdictions; contracting and the full merger of regional or sub-state laboratories.

The practice of regionalizing PHL services continues to unfold in California. Historically, regionalization of PHL services that resulted in closure of a local PHL was often and publically opposed by many leaders in public health including the unofficial organization of the Association of the Public Health Laboratory Directors. Those concerns and oppositions were most intense at the local level where changes in the service model and labor impacts were focused. The State, in its various agencies and positions, however took a neutral position demurring to the decisions of local governments providing that the outcomes continued the access to services. In that environment regionalization of PHL services in California has evolved from an 'ill

advised, last ditch counter measure' to a responsible option for public agencies if executed properly. Examples include the JPA-based Solano/Napa regional model in 1998 which evolved into the Solano/Napa/Yolo model in 2011 and, finally, the Solano/Napa/Yolo/Marin regional model in 2014. Other examples include the contract-based Sonoma/Mendocino/Lake PHL arrangement and the recent Sacramento/El Dorado PHL contract.

The performance of these examples of regionalized models with comparisons to stand-alone PHL models has not been systematically reviewed by the State or an independent agency. That said, the participants in these arrangements describe high levels of satisfaction with the service and economics of the regional model (private communication).

Future Options for SCPHL Service

The enclosed analysis examines three potential future options for Stanislaus County to consider:

- Option One: Retain Current Stanislaus PHL Model
- Option Two: Retain Current Stanislaus PHL Model with Modifications/Expansions
- Option Three: Seek Partner County to form Regional PHL and Close SCPHL

Evaluation Dimensions

PHCG identified four broad evaluation dimensions to guide the analysis of potential impacts, benefits and challenges associated with each issue:

- Impact on Community Health
- Implementation and Operational Feasibility
- Financial Impact
- Political Feasibility

Analysis of Options

Discussion of Option One: Retain Current SCPHL Model

Option One retains PHL services in the County. The County continues to operate its local PHL while adjusting operations and financing to keep the laboratory open and capable of servicing most/all of current demands. At its core, Option One reflects a judgement that local and integrated PHL services provide benefits that cannot be matched by alternatives at a similar cost.

Impact on Community. The impacts on the community in the short term (1-2 years) are predicted to be minimal insofar as current operations appear to meet most of community's immediate, non-surge needs. Gaps in the availability and long-turn-around times for some tests are currently being addressed by workarounds such as referring some tests to outside laboratories. Presumably this can continue or increase on a case-by-case basis.

Implementation and Operational Feasibility. The challenges facing the implementation and operational feasibility of Option One lay in its medium-to-long range future. Those challenges appear in four ways:

1) Substantial uncertainty is present around predictability and stability of a production process dependent on a very small staff. Losing a single FTE in a 2.5 FTE operation would have substantial impact on day-to-day operations and present a serious challenge in the event of a surge. Furthermore, recruitment of replacement staff would likely be a significant problem as noted across the organization.

2) Additional uncertainties arise from the laboratory's dependence on a very small number of tests to create a large proportion of its revenues. Any further losses in STD or lead testing would have significant impacts on revenue.

3) The low volumes of revenue-generating testing and the small size of the lab staff present financial and operational challenges to adding new testing or reporting technologies.

4) It seems likely that conditions in Building B will necessitate relocating the laboratory. Whether the relocation will involve repurposing existing County space or new construction is unknown. In either circumstance, extensive engineering and design features are required for laboratory functions. It is beyond the scope of this analysis to accurately project the costs of relocation/construction but similar new construction PHL projects have had multi-million dollar budgets.

Financial Impact. The financial impact of the Option One in the short-term is likely to be a continuation of the lab's dependence on a significant amount of County support. The circumstance of County support being required for a PHL service is not unusual. In fact, it is the norm in small-to-medium sized PHLs where operational costs are high relative to volume and where a substantial amount of testing is performed without a revenue expectation (contact tracing/epidemiology etc.) The amount of that dependence is likely to continue in the current range of ~$500-600K/year under the assumption that testing volumes continue at 2015-2016 levels. The non-quantitative costs of that County support lay in the opportunity costs when using County funds that have alternative uses in other program areas of unmet needs.

Political Feasibility. The political feasibility of Option One seems viable at least in the short term. This analysis has not detected significant public advocacy change the local laboratory services.

Discussion of Option Two: Retain Current Stanislaus PHL Model with Modifications

Option Two retains PHL services in the County as does Option One but it proposes to improve both efficiency and financial performance either by increasing test volumes + revenues or by reducing costs. There are not specific goals in terms of test volumes or financial performance in Option Two but presumably a successful Option Two would partially restore the declines in performance seen in the 2012-2016 period.

Impact on Community and Political Feasibility. A discussion of the community impacts and political feasibility of Option Two largely track those of Option One and will not be discussed further.

Implementation and Operational Feasibility. The fundamental point that distinguishes the Options One and Two is whether expanding services and/or lowering costs is feasible. To that end, the opportunities to substantially reduce costs seem severely limited as discussed under "External Trends and Best Practices." Expanding services as a means to enhance financial performance may however be possible if the expansion targeted tests requiring few additional marginal inputs (labor/materials) and having favorable levels of reimbursement. Tests in the current portfolio of PHL matching those criteria are few however with STD testing presenting itself as the strongest. Unfortunately, STD testing is also the source of the greatest declines in test volumes in the SCPHL in recent years. Reversing that trend would be key to the success of Option Two. No opportunities for significant expansion of STD testing in the Stanislaus PHL were identified in this analysis.

Financial Impact. The financial impact of Option Two would improve over that of Option One commensurate with increases in testing volumes.

Discussion of Option Three: Seek Partner County to form Regional PHL and Close SCPHL

Option Three proposes that Stanislaus County collaborate another County willing to form a regional PHL service capable of providing testing to both Counties. The local Stanislaus PHL would close and test samples from Stanislaus would be routed to the regional lab facility. Option Three is a fundamental change in the PHL service to Stanislaus and creates multiple potential impacts, trade-offs and opportunities. A detailed analysis of a specific County as a potential partner is beyond the scope of this analysis but the discussion below is relevant to any due diligence exploration of a candidate County.

Impact on Community. The impacts on the community from Option Three relate to the overall ability of the regional laboratory to perform tests but especially on how the logistical processes around specimens and results are managed in the new regional model. To minimize the negative impact on Stanislaus customers, careful consideration should be given to maintaining easy access for local specimen pick-ups/drop offs and to reduce any 'frictions' that Stanislaus users might experience in billing or in obtaining results. The motto "Make the Right Thing to do,

the Easy Thing to do." With a little design and planning, these features are feasible and will reduce or eliminate negative impacts on the community.

Implementation and Operational Feasibility. The implementation and operational feasibility of Option Three appear to be present with at least one County, San Joaquin, as described in HSA's due diligence earlier this year. As a potential regional partner, San Joaquin appears to offer several strengths including proximity, strong laboratory leadership, a portfolio of laboratory tests greater than that of Stanislaus PHL, pre-existing relationships between the laboratories as well as at HSA leadership levels and data management capabilities that should allow for easy access to results. Moreover, the advantages of a regional model for Stanislaus (efficiencies and economies of scale) work in the same direction for San Joaquin. For example, a Stanislaus/San Joaquin catchment area of ~1.3 million residents would place it on a level of a large metropolitan laboratory. Some areas of feasibility around San Joaquin, however, remain uncertain until further discussions and negotiations between the two Counties occur. These areas include the mechanism of sharing costs, governance, non-test related services and contract provisions required by local custom. It is likely however that solutions can be found. Finally, it should be noted that other Counties as potential regional partners may exist but identifying other candidates is beyond the scope of this work.

Financial Impact. The financial impact of Option Three and its regional model requires further discussions and agreements between the partnering Counties. Several options to determine the cost to the partnering Counties exist. For example, the Counties could agree to use a fee schedule by test type and applied to the service recipient. In most cases a fee schedule approach would minimize the costs to a low-volume County contracting for services. Alternatively, the Counties could agree to share the total costs of the regional model by a metric such as % of tests from each County or the % of total population within the catchment area. Without clarity as to which cost mechanism might be negotiated it is difficult to estimate a cost impact of Option Three. That said, the current operating losses of the Stanislaus PHL of ~$600K/year provide a sizeable target for the two Counties to find economics that are positive for both.

Political Feasibility. The political feasibility of a regional laboratory model would seem favorable if HSA can present a clear and compelling case to the community and other stakeholders. Fundamental changes in government services, particularly those that appear to 'end' a local service, are surprisingly difficult even on a small scale. The advantages of a regional model to promote sustainability and strengthen the laboratory's ability to adopt future technologies are key messages in the public discussion. Another consideration affecting political feasibility is the manner in which the County approaches the impacted laboratory personnel. Facing the loss of work or a major change of work environment are highly stressful to affected workers and can reverberate amongst non-affected workers as well. Careful and considerate attention should be paid to affected workers and their concerns throughout any transition process.

Option Pros/Cons and Open Questions

	Pros	Cons	Open Questions
Option One Retain Local SCPHL Model	• Location of laboratory remains in-County facilitating ease of access and local contacts. • Coordination w other HSA functions such as epi, PHN and HSA clinics is 'in house' • Full and unambiguous control over PHL	• Low volumes and revenues are likely to continue • Operations vulnerable to any staffing losses due to small size • Acquiring new tests/technologies (sequencing) in low-demand settings is costly • Financial dependency on County is likely to continue and may increase with rising input costs	• Recent significant losses in test volumes/revenues require substantial County support • Current facility needs to be re-located. Engineering requirements for laboratory facilities are extensive. Costs of new lab construction are very high • Maintenance of staffing & filling unfilled positions is required for long-term stability. Uncertain that County/ community can be competitive for these job classes.
Option Two Retain Local SCPHL Model Increase testing Volumes and/or Lower Costs	• Scalability of some lab tests allow greater thru-put (+revenue) with marginal increase in inputs (staffing + costs) • Location of physical plant remains in-County • Coordination w other HSA functions is 'in house' • Full and unambiguous control over PHL	• Opportunities to greatly expand testing volumes appears to be limited • PHL test portfolios are narrow with limited non-PHL market relevance. • Few opportunities to reduce costs • Required expansion to maximize scale is very large…i.e. ~1M population or comparable increase in test volumes • Cons from Option One	• Can previous STD testing requests be returned to the PHL? • Current facility needs to be re-located at anticipated high costs • Cost savings uncertain depending on volumes/partner agreements.
Option Three Join Regional PHL Model Close SCPHL	• Greater economies of scale by forming larger lab operation • Increase access to more complex, expensive testing • Potential to reduce costs/population for both Counties • Potential to improve recruitment of qualified staff • Enlarges opportunities for sharing epi data across counties during surveillance/outbreaks	• Reversing a regional model and restoring a local lab would be extremely difficult • Careful negotiations required to establish parameters of governance, cost sharing, and strategic planning for the future • Relocation of lab facility outside of County may reduce ease of access for some users and require work-arounds to replace face-to-face interactions	• What mechanisms of governance are needed to insure Stanislaus' interests? • What will be the mechanisms of cost-sharing? • What will be the processes to enable transportation of specimens and the reportage of results?

Evaluation Against Key Dimensions

Criteria	Option 1	Option 2	Option 3
Impact on Community	May align in short term	May align in short term	Aligns in short/long term
Implementation & Operational Feasibility	Limited alignment. Feasible in short term with numerous uncertainties. Increasing difficult in long term	Limited alignment. May be feasible in short term with numerous uncertainties. Increasingly difficult in long term.	Aligns in short/long term. Likely to strengthen sustainability and access to expanded testing capabilities.
Financial Impact	Limited Alignment Likely requires long term County support	Limited Alignment Likely requires long term County support	Aligns with potential for some cost savings to County.
Political Feasibility	Moderate Alignment, short term	Moderate Alignment, short term	Aligns with best management practices to achieve goals of public health

Key Findings and Take-Aways

- Advances in the technologies relevant to laboratory science have dramatically changed the type, volume and scale of work employed by state-of-the-art public health laboratories. The rapid speed of change will continue as additional technologies such as sequencing and point-of-care test platforms are adopted.

- Changes in the organization and reimbursement of health care delivery systems have had profound effects on many health service programs traditionally supplied by local governments.

- California's unique history of organizing PHL services at a County level is undergoing an evolution as pressures grow on small-medium sized laboratories to provide service.

- The Stanislaus PHL has experienced several inter-related changes in recent years manifested by lower testing volumes, reduced revenues, increased requirements for County support and an ongoing challenge to maintain staffing.

- The Stanislaus PHL staff is to be commended for its ability to maintain most services despite ongoing challenges.

- The current model of PHL services +/- modifications will likely serve the community's needs in the short term albeit with several uncertainties. Significant challenges to the current model appear in the medium-long term future.

- A regional model for PHL services offers numerous advantages over the current model including stability, greater access to advanced testing, and potentially favorable economics and efficiencies from scale. A regional model aligns well with all of the evaluation dimensions used in this analysis.

STANISLAUS COUNTY HEALTH SERVICES AGENCY
TOPICAL MEMO #4
Public Health: Emergency Medical Services
May 11, 2018

Overview

The Stanislaus County Health Services Agency (HSA) engaged Pacific Health Consulting Group (PHCG) to facilitate an intensive strategic planning process for the agency. As part of the engagement, PHCG was asked to evaluate several strategic topics/issues and present key findings to inform HSA strategic decisions.

The enclosed memo examines Emergency Medical Services (EMS) for Stanislaus County.

Specifically, the enclosed analysis reviews the characteristics and outcomes of the current HSA arrangement for EMS service, describes potential future options or pathways, evaluates each option against key criteria and highlights pros/cons and trade-offs, and presents a summary of key findings and considerations. The analysis also includes a review of key trends and promising practices among comparable organizations. The purpose of the memo is to provide detailed analysis that will enable the HSA to make strategic decisions for the future.

Methodology

The enclosed analysis included both quantitative and qualitative analysis.

- Qualitative Findings from
  - Individual interviews with
    - Vito Chiesa, Stanislaus County Supervisor, District 2, Board Chair
    - Jim DeMartini, Stanislaus County Supervisor, District 5, Mountain Valley EMS Agency JPA Board Member, Stanislaus County
    - Richard Murdoch, former Mountain Valley Emergency Medical Services Agency (MVEMSA) Administrator
    - Dr. Kevin Mackey, former MVEMSA Medical Director
    - Dr. John Walker, former Stanislaus County Health Officer
    - Bryan Cleaver, Coastal Valleys EMS Agency Administrator and Emergency Medical Services Administrators Association of California (EMSAAC) Liaison with the California Conference of Local Health Officers (CCLHO)

    - Conversations with Mary Ann Lee, Stanislaus County Health Services Agency Director and Patricia Hill Thomas, Stanislaus County Assistant Chief Executive Officer.
    - Literature Review of Best Practices from other EMS Agencies
- Stanislaus County EMS System Assessment July 2017 Mountain Valley EMS Agency and Stanislaus County Health Services Agency
- Review of California legislation regarding EMS
- Review of California EMS System Core Quality Measures Data Year 2016
    - http://www.emsa.ca.gov/Media/Default/PDF/CM_Manual_2016data.pdf

Current State Characteristics and Performance

Section 1797.200 of Division 2.5 of the California Health and Safety Code states that "Each county… shall designate a local EMS agency which shall be the county health department, an agency established and operated by the county, an entity with which the county contracts for the purposes of local emergency medical services administration, or a joint powers agency created for the administration of emergency medical services by agreement between counties or cities and counties". Stanislaus County established a Joint Powers Agency (JPA) with Alpine, Amador, Calaveras and Mariposa counties in 1981. The 5 JPA member counties contracted with MVEMSA to administer their local emergency medical services agency responsibilities. Funding of local EMS agencies is generally the responsibility of the county that establishes an EMS program. The State EMS Authority provides State General Fund matching funds to encourage regionalization through the establishment of multi-county EMS agencies. A multi-county EMS agency is defined as three (3) or more counties.

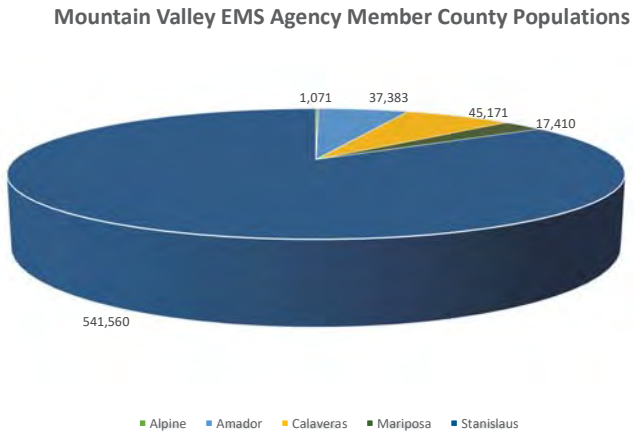
Map of EMS Agencies in California

Local EMS Agencies (LEMSA) are responsible for performing specific functions that include:

- Planning, implementing, evaluating, and continually improving local EMS systems including prehospital services and relevant hospital services such as trauma and pediatrics
- Collaborating with other health officials to ensure a unified, coordinated approach in the delivery of health care
- Serving as an advocate for patients
- Carrying out regulations relative to EMS systems (the State EMSA promulgates regulations but LEMSAs carry out those regulations)
- Certifying, accrediting, and authorizing EMS field personnel
- Authorizing and approving local EMS training programs
- Developing/approving medical treatment protocols and policies for local EMS service providers (EMTs, paramedics, dispatchers)
- Establishing and maintaining local EMS communication systems
- In collaboration with public health, developing local medical and health disaster plans and coordinating medical and health response to disasters (natural and man-made)
- Designating trauma centers and other specialty care centers
- Determining ambulance patient destinations based upon hospital resources
- Establishing policies for emergency department diversion and implementing mitigation strategies where diversion is excessive
- Coordinating activities and communications between various agencies that provide EMS system services so that care appears seamless to the patient (e.g., emergency medical dispatch, first responders, ground and air ambulance, receiving hospitals, trauma centers)
- Coordinating community education programs regarding injury prevention, CPR, public access defibrillation, etc.
- Collecting, analyzing, and reporting on EMS data and providing that data to EMSA electronically for statewide system evaluation
- Establishing exclusive operating areas for emergency ambulance service as appropriate, and then contracting for those services
- Providing oversight for EMS quality improvement and quality assurance activities
- Providing technical assistance to EMSA
- Mediating conflicts between various EMS stakeholders (e.g., ambulance, fire, hospitals, physicians)
- Resolving consumer complaints
- Providing information to public officials
- Advocating for sufficient and stable funding for emergency medical services[1]

[1] California Emergency Medical Services Administrators' Association of California (EMSAAC) website, accessed August 25, 2017 http://www.emsaac.org/about/lemsas

There are important differences in the size and characteristics of the member counties served by MVEMSA. Alpine, Amador Calaveras and Mariposa are rural mountain counties with populations ranging from 1,071 to 45,171 residents. Stanislaus has more than a half million residents and the population lives predominantly in urban areas, such as Modesto where approximately half of the county population resides. Eighty four percent of all 642,595 residents served by MVEMSA live in Stanislaus County. The main transportation corridors are in Stanislaus County, as are the main hospitals and specialty trauma, STEMI and stroke centers. The MVEMSA system, hospitals, trauma and other specialty centers serve a population that includes residents of the MVEMSA-member counties, as well as patients from other counties in the region and individuals traveling through the area requiring EMS response and resources.



American Community Survey 2016 Population Estimates

The total preliminary MVEMSA budget for fiscal year 2017-2018 is $1,524,612. Approximately 59% of the budget funds salaries and benefits, 8% contracted personnel, 8% data systems surveillance and 24% operating costs. Local revenues from the 5 JPA counties account for 48% of the budget, while State Multi-County grant funds make up 24% and Trauma, STEMI and Stroke Center fees represent 24% of the total agency budget. Stanislaus County contributes approximately $241,145 of county local funds to the total MVEMSA budget and this amount is matched dollar for dollar by the State of California General Fund Multi-County EMS Agency funding (based on a reimbursement rate of $0.44/resident).

MVEMSA is staffed to fulfill the full range of LEMSA responsibilities for the 5 JPA member counties. Agency personnel includes;

- 1.0 FTE Executive Director
- 1.0 FTE Deputy Director

- 1.0 FTE Trauma / Quality Improvement Coordinator
- 1.0 FTE Facilities & Critical Care / Disaster Coordinator
- 1.0 FTE Communications / Data Systems Coordinator
- 0.63 FTE Response & Transport Coordinator
- 1.0 FTE Management Services Assistant for Certifications / Data Registrar
- 1.0 FTE Financial Services Assistant / Executive Secretary
- 0.29 FTE Medical Director (Independent Contractor)

Mountain Valley EMS Agency oversees the delivery and quality of EMS services in the 5-county JPA region. MVEMSA has demonstrated a strong commitment to a high-performance, evidence-based EMS system. MVEMSA provides clinical oversight of the EMS system; monitors system performance and ambulance contract compliance; and engages in quality improvement efforts. MVEMSA is committed to quality. These oversight and performance monitoring activities include pre-hospital care, as well as regional Trauma, STEMI (ST elevation myocardial infarction) and Stroke Systems of Care.

Prehospital Monitoring

- Fire First Responders (BLS and ALS)
- Ambulance Providers
    - Ambulance deployment
    - EMS Response totals, levels of response and response-times
    - Ambulance transport
    - Emergency Department capacity and utilization
    - Economic sustainability, including emergency ambulance costs, payer mix, reimbursement, fines
    - MVEMSA is moving in the direction of monitoring and evaluating clinical benchmarks and standards but these efforts are currently hampered by limited access to data across the various components of the system involved in EMS response and medical care for individual patients
    - MVEMSA Quality Improvement Program defines key performance indicators, MVEMSA policies and procedures and expectation of EMS system participates. An annual formal QI review is done as required by California Code of Regulations, Title 22, Chapter 12

Specialty Care Centers

- 2 Level II Trauma Centers (Doctors Medical Center and Memorial Medical Center) have high level of local and national oversight and performance assessment. They participate in Total Quality Improvement Programs and are verified by American College of Surgeons)
- 3 STEMI receiving centers (Doctors Medical Center, Memorial Medical Center and Emmanuel Medical Center) are all accredited with the Society of Chest Pain Centers and have excellent benchmark times and quality measures.
- 3 Primary Stroke Centers (Doctors Medical Center, Memorial Medical Center and Kaiser Hospital Modesto) went live in 2017 and will be monitored for quality and outcomes.

External Trends and Promising Practices

Stanislaus County faces challenges shared by many counties in California and the rest of the country in assuring a strong and responsive EMS system. Some of these challenges include:

- **EMS 911 call volume and emergency response have increased over the past 3 years.** The increase has largely been attributed to the increased number of county residents with Medi-Cal since implementation of Medicaid expansion under the Affordable Care Act (ACA). The ACA expanded access to Medicaid insurance to more than 15 million Americans, including 64,400 residents of Stanislaus County. From 2014 to 2016, EMS calls increased by 5,841, adding 16 additional calls per day. [2]

- **Ambulance providers are facing challenges to their financial sustainability.** The increasing number of patients in Stanislaus County with Medicaid and high deductible health plans (HDHP) has shifted the payer mix for ambulance providers in a manner that jeopardizes their financial sustainability. Medicaid reimburses significantly less than the cost of ambulance transport services. Medicare pays much better than Medicaid, but still less than the true cost of ambulance transport. Commercial insurance has been decreasing their reimbursement rates and the percentage of individuals with high deductible health plans (HDHP)has increased with ACA. Many individuals are unable to pay the high deductibles of HDHP plans when they have a medical emergency. All these factors have combined to lower the per call revenue for ambulance providers. The lower per call revenue coupled with higher call volume result in inadequate revenue to cover the true cost of ambulance services.

- **There is a national shortage of paramedics and high turnover of existing Emergency Medical Technicians (EMTs) and Paramedics[3].** Ongoing difficulty in recruitment and retention of EMTs and Paramedics negatively impacts the local EMS system, making it difficult to maintain a stable workforce. The shortage also results in existing EMTs having to work longer assigned shifts which, in turn, can lead to burnout.

- **Excessive use of ambulance transports and emergency departments for individuals with non-emergency and/or non-medical conditions is seriously impacting EMS systems and emergency departments.** This trend is

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[2] Stanislaus County EMS System Assessment, July 2017, Mountain Valley EMS Agency and Stanislaus County Health Services Agency, p. 4.

[3] Based on interview with Richard Murdoch, MVEMS Agency Director and Emergency Medical Services in California: Wages, Working Conditions, and Industry Profile, UC Berkeley Labor Center, February 2017 http://laborcenter.berkeley.edu/pdf/2017/emergency-medical-services-in-california.pdf

impacting local emergency departments. Between 2011 and 2015, ED visits in Stanislaus County increased by 25% and there was an additional 5.5% increase between 2015 and 2016.[4] A major component of the avoidable use of emergency ambulance transport and emergency department visits is evaluation, clearance and placement of mental health patients in crisis. A decrease in the number of psychiatric beds, particularly for Medicaid patients, insufficient community behavioral health resources and regulatory issues have led to overuse of emergency ambulance transport and ED utilization. Long delays due to the lack of available psychiatric beds and other resources leads to patients staying for hours or even days in the emergency departments (ED) and decreases ED throughput. Throughput is also impacted by the need to provide medical clearance for mental health patients, even when psychiatric hospital beds are available. These situations can lead to delays in patient transfer of care (the time from ambulance arrival on hospital premises to documented transfer of care) and, in turn, a delay in ambulance crews returning to the field to be available to transfer other patients in need of emergency medical transport. The implementation of better systems for responding to the needs of mental health patients in crisis, such as community paramedicine, has been delayed by needed regulatory changes.

- **Coordination of medical and fire dispatch presents challenges.** Frequently both ambulance and fire providers are dispatched to provide EMS response for medical emergencies. In some communities both ambulance and fire providers are dispatched by a single entity and this can facilitate coordination. In other communities, including Stanislaus County, ambulance and fire providers are dispatched by separate entities and this can present challenges to effective coordination of medical response. Emergency dispatch for ambulances in Stanislaus County is provided by Valley Regional Emergency Communications Center (VRECC), which is a division of American Medical Response (AMR). Fire first response agencies are dispatched by SR9-1-1, the City of Ceres, and the City of Turlock. The County Board of Supervisors has set aside $1.5 million from the Stanislaus EMS System Enhancement Fund to address dispatch integration needs.

MVEMS and the Stanislaus Health Services agency are currently completing a strategic planning process. The initial EMS system assessment has identified promising practices to address EMS system challenges.

- Increased call volume, stretched emergency ambulance services and reduced per call revenue for ambulance providers could benefit from a **two-tier system for the deployment of ambulance transport**. In a two-tier system, Basic Life Support (BLS) ambulances are dispatched to respond to lower acuity calls as

[4] Stanislaus County EMS System Assessment, July 2017, Mountain Valley EMS Agency and Stanislaus County Health Services Agency, p. 4

determined by Emergency Medical Dispatch protocols that are defined by the EMS Agency.

- **Community Paramedicine** offers important opportunities to improve the efficiency of the health care delivery system and reduce excessive use of ambulance transport and emergency departments. Community paramedicine refers to paramedics functioning outside their traditional roles of emergency response and transport for the purposes of facilitating more appropriate use of emergency care services and better access to primary care for medically underserved populations. MVEMS and, specifically, EMS in Stanislaus County have been leaders in the development and evaluation of community paramedicine. The California EMS Authority (EMSA) Community Paramedicine Pilot implemented programs using paramedics to improve post-hospital discharge short-term follow-up; case management for frequent EMS users; directly observed therapy for tuberculosis patients, collaboration with public health departments, hospice support , alternate destination to urgent care centers for appropriate patients and; in Stanislaus County, piloting alternate destinations to mental health crisis centers rather than emergency departments. In the Stanislaus Community Paramedicine pilot, paramedics performed medical screening of patients to determine whether they could be safely transported directly to a mental health crisis center. Ninety five percent of patients enrolled in the program were evaluated by paramedics and obtained care at the behavioral health crisis center without having the delay of a preliminary ED visit. The program resulted in savings for payers, primarily Medi-Cal, due to reduced ED visits for medical clearance. Broader implementation of this successful model with require modifications to California regulations.[5]

Future Options

Based on these findings, Stanislaus County has several options for the provision of EMS services in compliance with Title 22:

OPTION 1. Continue as a Member County of Mountain Valley EMS Agency and develop a plan to address current issues related to Stanislaus-specific capacity needs and JPA governance

- Under this option, Stanislaus County would continue as a member of the current JPA with Alpine, Amador, Calaveras and Mariposa counties for the administration of Stanislaus County EMS services and the current JPA contract

[5] Overview of California' Community Paramedicine Pilot Projects, California Healthcare Foundation, January 2017 http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20S/PDF%20Sacto01232017PilotProjectOnePagers.pdf

with MVEMSA to administer local EMS Agency (LEMSA) responsibilities. At the same time, Stanislaus County would engage with the other JPA member counties and with MVEMSA to actively pursue solutions to any identified issues with the current EMS Agency.

- The current multi-county JPA EMS Agency model that is administered by MVEMSA provides several advantages to Stanislaus County.

    - **MVEMSA is an established EMS Agency with institutional knowledge, expertise, experience, competency and statewide reputation and established positive relationships with local and state stakeholders**.

    - **MVEMSA has strong administrative and clinical leadership and experienced staff**. The current MVEMSA Administrator, Richard Murdoch, is well respected by constituencies within County government, EMS and Fire. Dr. Kevin Mackey, the outgoing MVEMSA Medical Director is one of a small group of Board-certified EMS Emergency Medicine Physicians[6] in California and a respected EMS clinical leader and innovator. Dr. Mackey will continue to work with MVEMS as a consultant and his replacement is also a Board-certified EMS Emergency Medicine Physician.

    - **MVEMSA has demonstrated commitment to high performance of the EMS system and ongoing quality improvement.** MVEMSA has established methodologies and processes to monitor EMS system performance and ambulance contract compliance.

    - **MVEMSA has demonstrated a commitment to improving the efficiency of the larger health care delivery system in Stanislaus through innovation** in community paramedicine and community partnerships.

    - **As a member of a multi-county EMS agency, Stanislaus County receives California State Multi-County EMS Agency funding** annually of approximately $237,000. State Multi-County funding makes up 24%of the current MVEMSA budget. Stanislaus County would likely need to contribute a similar amount in county net costs, in addition to their current

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6 “The Emergency Medical Services (EMS) certification program, developed by the American Board of Emergency Medicine, is designed to standardize physician training and qualifications for EMS practice, to improve patient safety and enhance the quality of emergency medical care provided to patients in the prehospital environment, and to facilitate further integration of prehospital patient treatment into the continuum of patient care.” American Board of Emergency Medicine

$237,000 county contribution, if they decided to become a single county EMS Agency. Every local EMS agency (LEMSA) in California is responsible for a broad array of functions, most of which require qualified EMS staff with specialized knowledge. For this reason, it is unlikely that there would be major reductions in the staffing, operational costs or data systems surveillance costs for a single county EMS agency model.

- **A multi-county EMS Agency model can reduce some administrative and program costs across member counties.**

- **A multi-county EMS Agency can bring a regional focus to EMS concerns and standardize system coordination of EMS response and patient flow across counties and potentially have greater influence on a state level**

- **MVEMSA has demonstrated their commitment to collaboration with the County and with Health Services Agency**, both in the areas of Clinical Services and Public Health. This collaboration can be further strengthened without the need for structural integration with HSA.

- **MVEMSA provides essential high quality EMS services to the 4 smaller counties in the multi-county agency that would be difficult or impossible provide on their own without the participation of Stanislaus County.**

- The current multi-county JPA EMS model administered by MVEMSA has certain disadvantages for Stanislaus County.

    - **The current JPA governance structure provides an equal vote to each participating county**. Even though 84% of residents served by MVEMSA reside in Stanislaus County, Stanislaus only has I vote out of 5 in the JPA. While theoretically this could be problematic for Stanislaus, both County Supervisors and HSA leadership stated that the current governance structure has not presented issues of concern for Stanislaus.

    - **The multi-county EMS Agency model must address the EMS needs of all member counties and this can result in reduced availability of MVEMSA staff and resources for Stanislaus County**. EMS system needs vary importantly among the disparate member counties served by MVEMSA. The current staffing of MVEMSA does attempt to address these disparities. A larger percentage of staff time is focused on Stanislaus County which has a much larger population and higher concentration of regional hospital and other EMS-related resources. Despite attempts to balance the needs of Stanislaus and the other small rural member counties, there are occasions when MVEMSA staff is not available to the extent necessary to fully meet the EMS needs of Stanislaus. This is a

problem particularly when there is an emergency, such as large forest fires, in other MVEMSA member counties. Under these circumstances, MVEMSA personnel need to staff county emergency operations centers in the affected county as part of their EMS Agency responsibilities. In these circumstances, there are fewer available MVEMSA staff to address the EMS system needs of Stanislaus County.

Stanislaus County can pursue solutions to any identified issues of Stanislaus-specific EMS system capacity needs and/or JPA governance structure, if desired, within the current multi-county JPA LEMSA model with contracted MVEMS administration.

- If the current governance structure became problematic for Stanislaus at any point in the future, the county could work with the other JPA member counties to identify governance strategies or agreements that better reflect the distribution of the population served by MVEMSA and the location of EMS system resources, such as hospitals and trauma/STEMI/stroke centers.

- The current Stanislaus County EMS strategic planning process, including the recently released EMS System Assessment, can provide the foundation for identifying system gaps and developing a specific plan to assure that the EMS system needs of Stanislaus County are being met. This plan should include staffing, other necessary resources, a budget proposal and timeline. This plan needs to include specific measures to address surge capacity for emergencies that require deployment of MVEMSA staff to fulfill MHOAC responsibilities in other JPA-member counties. The plan also would also need to include an accountability mechanism for ongoing monitoring and evaluation of the improvement plan from the perspective of clinical performance, reliability, quality, cost, compliance and improvements in system efficiency. Such a plan to improve services for Stanislaus County would most likely include some additional staffing and resources with related increased costs. However, the cost to the county of continuing to contract with MVEMSA, even with some additional Stanislaus-specific staffing costs, would be less that the cost of the County establishing a single-county EMS agency with county employees. The County could explore use of some portion of the Stanislaus EMS System Enhancement Funds to offset some of the costs, particularly one-time costs, associated with the improvement plan. If, after implementation of the improvement plan, Stanislaus County determines that the Stanislaus-specific issues have not been adequately addressed, the County would have the option of pursuing a single-county EMS Agency model.

OPTION 2 Form a Single-County Stanislaus EMS Agency

Under this option, Stanislaus would terminate participation in the current multi-county JPA with Alpine, Amador, Calaveras and Mariposa counties for the administration of Stanislaus County EMS services and the contractual relationship with MVEMSA to administer local EMS Agency (LEMSA) responsibilities.

A single-county EMS Agency provides some advantages to Stanislaus County.

- **A single-county EMS Agency structures provides maximum autonomy to Stanislaus County in governance, setting of priorities, policies, administration and deployment of staff and other resources to meet the needs of the county.**

- **A single-county EMS Agency would have a singular focus on the needs of Stanislaus county without the need to share staffing and resources with other counties, other than in situations that require mutual aid.**

There are several potential disadvantages to Stanislaus transitioning to a single-county EMS model.

- **Stanislaus County would need to establish a de novo EMS Agency without existing county organizational EMS knowledge, expertise, experience or competency.** EMS is not the core business of Health Services Agency (HSA)

  and there would likely be a significant learning curve in designing, implementing, operating and managing a new County EMS agency that fulfills all the required functions of a LEMSA. Recruitment for qualified EMS Agency Administrator, Medical Director and EMS staff may be challenging.

- **The time, energy and resources required to design and implement a new EMS Agency may impact the ability of the Agency to move forward in a timely manner with needed system improvements identified in the recent Stanislaus County EMS System Assessment** (i.e. improvements to ambulance provider agreements, addressing the increase in EMS 911 call volume, frequent shortages of ambulances in 911 EMS System, excessive use of ambulances for non-emergency and non-medical conditions and impact on emergency department capacity, financial sustainability of ambulance providers).

- **To mitigate the potential disadvantages of establishing a de novo EMS Agency in the county and potential delay in implementation of needed system improvement, Stanislaus County could explore the option of contracting with MVEMSA or another existing EMS Agency to administer local emergency medical services agency (LEMSA) responsibilities**.

- **Stanislaus County net county costs would likely increase with a single-county EMS Agency model.** As a single-county EMS Agency, Stanislaus would lose approximately $237,000 annually in California State Multi-County EMS Agency funding. While income to fund EMS services would decrease significantly, the costs of administering a single county agency are likely to be similar to current MVEMSA operating costs. The range of EMS functions and services that a LEMSA must provide requires a similar staffing pattern of core EMS qualified leadership and staff regardless of whether the agency is single- or multi-county. Salaries and benefits for individual positions would likely be higher for County employees of a single-county agency.

OPTION 3. Form a Stanislaus County-operated EMS Agency and contract with the other 4 JPA counties to provide their EMS Services

- Under this option, Stanislaus would form its own EMS Agency and contract with the other 4 MVEMSA counties to administer their local emergency medical services agency (LEMSA) responsibilities. The Central California EMS Agency (CCEMSA) in Fresno County uses this model. CCEMSA is a Division of the Fresno County Department of Public Health and is the EMS Agency for Fresno, Kings, Madera and Tulare counties.
- Under this option, the current MVEMSA would be reduced to 4 counties or be dissolved

A Stanislaus County-operated EMS Agency that contracts with the other 4 JPA counties to provide their EMS services has several potential advantages.

- **A Stanislaus County- operated EMS Agency provides autonomy to Stanislaus County in governance.**

- **There is the possibility that the State EMS Authority would approve a new configuration of the multi-county agency that might qualify for regional multi-county EMS agency state general funds**. Access to these funds, however, is not assured and is dependent on approval from the State EMS Authority.

A Stanislaus County-operated EMS Agency that contracts with the other 4 JPA counties to provide their EMS services has potential disadvantages.

- **As a reconfigured multi-county agency, the County would still need to balance the needs of Stanislaus with those of the other member counties in the setting of priorities, policies, administration and hiring and deployment of staff.**

- **If the State EMS Authority were to deny approval of a reconfigured multi-county agency that would be eligible for regional multi-county**

agency state general funds, Stanislaus would not attain any financial benefit from this option.

OPTION 4. New Partnership with One Other County

Under this option, Stanislaus County could partner with another county and become a 2-county EMS Agency. An example of this model is the Coastal Valleys EMS that includes Sonoma and Mendocino counties.

Potential advantages of a 2-county Agency include reducing administrative and program costs, focusing on regional EMS concerns, standardizing system coordination of EMS response and patient flow and having a greater impact on a State level.

There are disadvantages of a 2-county EMS Agency.

- **A 2-county EMS Agency would not be eligible for State General Funds Multi-County EMS Agencies**, as agencies must include 3 or more counties to qualify for this funding.

- **Stanislaus could face similar challenges in partnering with another county that it already has with MVEMSA, including issues of governance, Agency focus and sharing of staff and other resources.** To minimize these challenges, it would be helpful for Stanislaus County to identify a county with similar size, volume demands and community characteristics and needs.

Evaluation Dimensions

PHCG identified four broad evaluation dimensions to guide the analysis of potential impacts, benefits and challenges associated with each issue. These include:

- Impact on Community Health – Impact on population health, including magnitude and populations of focus

- Implementation and Operational Feasibility – Feasibility of initial implementation and implications for ongoing operations or management

- Financial Impact – Financial impact, including a review of one-time costs, new ongoing costs/resource requirements and implications for ongoing financial performance

- Political Feasibility – Key political considerations and factors

Option Pros/Cons and Open Questions

	PROS	CONS	OPEN QUESTIONS
Option 1 Continue as Regional MVEMS Member and address current concerns	• Stay w/ established, high quality administrator with demonstrated EMS and emergency response expertise • Retain $234K state multi-county EMS contribution • MVEMS focus on health care system and innovation • Reduce administrative and program costs • Focus on regional EMS concerns • Standardize system coordination of EMS response and patient flow • Greater impact on a State level	• Limited representation in JPA governance structure relative to population and budgetary contribution • Limited ability to shape priorities or direct resources • Limited staffing and resources to address Stanislaus needs Ex. Limits flexibility • Availability of Agency staff to address Stanislaus needs reduced during emergencies in other member counties	• Are there modifications to the current governance structure that would improve representation based on population served? A bicameral model? • Can Stanislaus fund additional Stanislaus-specific MVEMSA staff and resources to provide desired level of service for Stanislaus and address surge capacity issues during emergencies in other MVEMSA counties? Are there other Innovative solutions to meet the baseline and surge capacity needs of Stanislaus during county emergencies of other MVEMS agencies? • What is the political likelihood that other MVEMSA counties would accept more representative governance model?
Option 2 Form Single County EMS Agency	• Gain full control of resources, decision-making and programmatic priorities	• Lose $234K state contribution without a commensurate reduction in budget • Need to establish a de novo EMS Agency without existing county institutional expertise or experience • Potential delay in addressing Stanislaus EMS system issues identified in EMS system assessment • Local fire districts may seek greater participation and funding in Advanced Life Support response, particularly given budgetary challenges	• Could Stanislaus contract with MVEMS to administer local emergency medicals services agency (LEMSA) responsibilities without being part of the JPA? • How would this change annual administration costs?
Option 3 Stanislaus County-operated Multi-county EMS Agency	• Governance autonomy for Stanislaus • Potential to retain multi-county EMS Agency funds from State general fund	• Still need to balance EMS capacity and staffing needs with those of the other member counties • If State EMSA doesn't approve reconfiguration, Stanislaus loses access to multi-county EMS Agency funds from State general fund	• Is there a way to determine the likelihood of EMSA approving this model of multi-county agency?
Option 4 New Partnership w/ One County	• Could enhance control and decision-making authority • May present some economies of scale if similar goals and priorities	• No partner identified – lots of uncertainty • Partnering with comparably sized and situated partners to ensure equal status would help • May present similar challenges as current arrangement	• What has worked best for other 2-county EMS Agencies, such as Coastal Valleys EMS Agency?

Evaluation of Options Against Key Evaluation Dimensions

Criteria	Option 1 Continue as Regional MVEMS Member	Option 2 Form Single County EMS Agency	Option 3 Stanislaus-operated Regional EMS Agency	Option 4 New Partnership w/ One County
Impact on Community Health	Demonstrated MVEMSA commitment and innovation in addressing health care delivery systems with a public health/social determinants approach. Limited Stanislaus-specific staff to target deficiencies and shortages	Greater autonomy to target resources and initiatives toward deficiencies – but requires resources	County has Greater autonomy to target resources and initiatives toward deficiencies – but this requires resources	Would need to identify community health priorities and resources with the other county
Implementation and Operational Feasibility	Presents no new operational demands Requires additional financial support and/or innovation to improve availability of staff and resources to consistently meet Stanislaus needs	Need to establish a new administrative structure and hire administrative and clinical leadership and staffing to address all State-required components of a local EMS Agency (LEMSA)	Need to establish a new administrative structure and hire administrative and clinical leadership and staffing to address all State-required components of a local EMS Agency (LEMSA) of all participating counties	Need to establish a new administrative structure and hire administrative and clinical leadership and staffing to address all State required components of a local EMS Agency Need to establish a governance structure
Financial Impact	Potential financial impact if additional staff resources added to meet Stanislaus-specific needs	Loss of State General Funds for Multi-County EMS Agencies- Minimum $235,000 increase in annual County responsibility. Anticipated additional increase in annual operating costs to ensure minimal staffing/resource requirements	Depends on whether the reconfigured regional EMS Agency is approved by State EMSA and becomes eligible for multi-county State General Funds . Loss of State General Funds for Multi-County EMS Agencies. Minimum $235,000 increase in annual County responsibility.	Loss of State General Funds for Multi-County EMS Agencies. Minimum $235,000 increase in annual County responsibility. Potential additional increase in annual operating costs to ensure minimal staffing/resource requirements
Political Feasibility	Addressing current concerns would increase political feasibility	Local jurisdictions may seek contracts to provide ALS and funding to support districts – not optimal provider or financial arrangement Modifying JPA governance structure may be unacceptable to other JPA members	Unclear	Unclear

Key Findings and Take-Aways

In consideration of the above analysis, key take-aways from the analysis include the following:

- Emergency Medical Services throughout the country are facing important challenges to the existing EMS system. The financial sustainability of ambulance providers is threatened due to a combination of increased call volume, reduced per call revenue, increased fees and penalties associated with ambulance contracts. There are shortages of EMS workforce. Many ambulance providers, particularly in rural areas, are struggling to maintain adequate coverage and this requires regular use of mutual aid from other areas to provide basic coverage, reducing the number of ambulances available in the larger EMS system and their ability to respond to emergencies. There is excessive use of ambulances and emergency departments for non-emergency and/or non-medical conditions that would be better addressed with alternative approaches and venues. This excessive use impacts the availability of ALS ambulance transport and emergency departments to meet emergency medical needs.

- MVEMS and Stanislaus Health Services Agency (HSA) are currently engaged in a strategic planning process and recently released a detailed EMS System Assessment. The Assessment identifies the major challenges to the EMS System in Stanislaus and provides specific opportunities for addressing these. The proposed solutions build upon the existing EMS system, local innovation and best practices from other communities. The next stages of the EMS strategic planning process will develop the strategic plan and implementation plan so that the county has a roadmap for addressing the major EMS system challenges and strengthening the system.

- While there are some relatively small challenges with Stanislaus being a member county of the JPA multi-county EMS agency, there are important advantages in state funding, as well as the institutional expertise, administrative and clinical leadership, and quality and innovation focus of MVEMSA.

- There are opportunities for Stanislaus to work with county, regional and state EMS and non-EMS partners to address shared challenges for the health care delivery system, such as management of mental health patients, EMS workforce, ambulance provider stability and health system access improvements, including improvements such as community paramedicine

- Shifting the EMS Agency model now to a single-county model within the county structure would be challenging given the lack of institutional experience with EMS, competing demands, loss of state funding and probable increased net county costs to fund a single-county agency. The time, energy and resources required to design and implement a new EMS Agency may impact the ability of the Agency to move forward in a timely manner with needed system improvements identified in the recent Stanislaus County EMS System Assessment. The option of a Stanislaus-operated EMS Agency that contracts with Alpine, Amador, Calaveras and Mariposa Counties

to administer their LEMSA responsibilities, could potentially be approved by the State EMS Authority as a multi-county agency that would be eligible for multi-county EMS Agency State general funds. Stanislaus County EMS System Assessment, July 2017, Mountain Valley EMS Agency and Stanislaus County Health Services Agency, p. 4

- Opportunities exist to expand collaboration between EMS and Public Health and Clinical to improve services to underserved populations, such as with community paramedicine. Increased collaboration would not require structural integration.

ATTACHMENT 7

STANISLAUS COUNTY HEALTH SERVICES AGENCY
TOPICAL MEMO #5
Primary Care, Specialty and Physical Rehabilitation Clinics
May 11, 2018/REVISED July 5, 2018

Overview

The Stanislaus County Health Services Agency (HSA) engaged Pacific Health Consulting Group (PHCG) to facilitate an intensive strategic planning process for the agency. As part of the engagement, PHCG was asked to evaluate several strategic topics/issues and present key findings to inform HSA strategic decisions. The enclosed memo examines potential future roles and strategic directions for the HSA in providing direct clinical services, including:

- **FQHCLA Clinical Services:** Management of FQHC Look-Alike clinics;
- **Specialty and Physical Rehabilitation Services:** Direct delivery of specialty and physical rehabilitation services.

The analysis examines potential future strategic directions or options for HSA to pursue and examines their potential impacts and trade-offs. To that end, it includes a review of the historical role and justification for HSA in providing clinical services; trends and emerging practices related both to the delivery of these services and role of county health systems, and; characteristics and outcomes of the current HSA arrangements with comparison to comparable programs when possible.

Specifically, the analysis is intended to assist the HSA in determining what role is most appropriate for Stanislaus County in delivering direct medical services and developing the local medical workforce in consideration of key criteria, such as:

- **Impact on Community Health:** How will different options impact community health?
- **Organizational Fit:** How effective is HSA in this role? Are there other entities that are better positioned or equipped to fulfill this role? What are the opportunity costs of playing this role?
- **Financial Impact:** What would be the one-time and ongoing costs associated with different options?
- **Implementation and Operational Feasibility:** How feasible are different options to implement and operate?
- **Political Feasibility:** How feasible are different options from a political standpoint?

The analysis evaluates three over-arching options against these criteria:

- ***OPTION 1.*** Retain Current Clinics with System Improvements
- ***OPTION 2.*** Strategically and Immediately Consolidate the Number of Stanislaus County Clinic Sites (with Improvements) and Explore Strategic Partnerships/Approaches to Maintain Access to Care and Optimize Resources
- ***OPTION 3.*** Transition or Limit Stanislaus County Role as a Direct Clinical Provider

Summary of Key Findings

The enclosed memo includes a detailed analysis of community needs, performance and characteristics of current Stanislaus systems and an analysis of future options. Key take-aways from the analysis are briefly summarized below.

- Overall, this analysis indicates that even with targeted system improvements, Stanislaus FQHCLA clinics will likely continue to experience decreases in patient volume, declining physician staffing, growing financial losses and increasing County general fund contributions.
- Stanislaus FQHCLA clinics have experienced a dramatic decline in patients over the previous 5 years (-13,067 patients) and have faced significant challenges competing for and retaining primary care physicians. This decline occurred in the context of the 2014 Medi-Cal expansion through the Affordable Care Act, during which the number of residents with Medi-Cal substantially increased and community health centers statewide experienced strong increases in number of patients served.
- Stanislaus FQHCLA clinics are experiencing worsening financial performance due to high and increasing expenses parallel to declining revenue. While patients/visits and associated revenue have continued to decline, personnel expenses have steadily increased. The cost per patient in Stanislaus FQHCLA clinics increased from $591.36 in 2012 to $921.67 in 2016.
- Other community providers appear increasingly well-positioned to meet safety net primary care needs in Stanislaus County. Non-county independent FQHCs have grown sites and patient numbers and now serve over 100,000 patients at 22 medical and dental sites compared to just over 32,000 patients served by Stanislaus FQHCLA clinics. Despite the decrease in Stanislaus FQHCLA patient volume, the overall number of patients served by all FQHCs and FQHCLAs has not declined in Stanislaus County, indicating the growing role of independent FQHCs.
- Stanislaus FQHCLA clinics and the SFMG provider contractor arrangement are performing sub-optimally and are not likely to improve substantially. The SFMG contracting model is fundamentally misaligned with the current provider employment environment and with the health improvement and innovation trends in primary care. HSA clinic staffing and operational structures face long-standing deficits that have long been recognized by leadership.
- Administration of the FQHCLA clinic system requires significant administrative attention and agency resources that could be redirected toward other public health priorities and investments. Reduction or elimination of FQHCLA sites could substantially reduce HSA and county general fund financial obligations. A portion of these savings could potentially be redirected to other priorities to improve community health, such as growing the health care workforce (e.g. nurse practitioner and physician assistant fellowships/ residencies), enhancing behavioral health services, and impacting targeted health status/disparity priorities (e.g. obesity, childhood poverty, integration of public health programs in community primary care settings).

Background

Why provide direct medical services?

Public health departments are not mandated to directly provide medical services. Instead, they are charged with assuring that community members can access services through linkage to community providers, support of the delivery system or direct delivery of care. Stanislaus County FQHCLA primary care clinics historically played an essential role in serving uninsured and other low-income residents by providing direct medical services for several reasons. Most importantly, uninsured and other low-income residents had nowhere else to go. Until recently there was an extremely limited presence of other FQHCs or community clinics in Stanislaus County to serve this population. In this environment, Stanislaus County determined that directly providing medical services was a cost-effective way to meet its county indigent care obligation and address an important community need.

As will be discussed in the Family Residency Program Options memo, the organization of Stanislaus FQHCLA/specialty clinics are also closely interwoven with the Valley Family Medicine Residency, which relies on Stanislaus clinics to serve as continuity clinics for medical residents and shares a physician/faculty staffing model through Scenic Faculty Medical Group (SFMG).

How has the environment changed?

Many of the factors that contributed to the growth and role of Stanislaus County FQHCLA clinics have changed notably in recent years, including growth in the size and number of independent FQHC clinics, significant growth in the number of residents with Medi-Cal, decrease in the number of uninsured residents, and decline in the number of residents eligible for and enrolled in the Stanislaus County Medically Indigent Adult (MIA) program to nearly zero.

- Medi-Cal Enrollment Growth. California Department of Health Care Services (DHCS) indicates that the number of Stanislaus residents enrolled in Medi-Cal managed care (Health Plan of San Joaquin or Health Net) grew from 94,839 in December 2013 to 203,915 in September 2017 (+109,076). An estimated 68,000 of these individuals became newly eligible under the Adult Medi-Cal Expansion (Affordable Care Act). Total Medi-Cal enrollment in Stanislaus County (including fee for service) is 249,000.

- Declining HSA Presence. Between 2012 and 2016, the number of patients served by Stanislaus County FQHCLA clinics decreased from 47,119 to 34,067 representing a decline of 13,067 patients (28%) over just 5 years. Further, available data indicates that Stanislaus County FQHCLA clinics serve just 11% of all Medi-Cal enrollees in Stanislaus County.

- Growing Independent FQHC Presence. As of 2016, independent FQHC clinic systems reported serving about 101,400 patients at 22 medical or dental sites in Stanislaus County compared to 34,052 patients served by Stanislaus County FQHCLA clinics. Although the number of patients served by Stanislaus County FQHCLA clinics decreased by 5,600 between 2015 and 2016, the total number of FQHC and Look-Alike patients in the county overall did not. This suggests that other FQHC clinic systems offset the HSA decline with increases in capacity and patients within their own systems. The table below highlights the locations and operators of different FQHCs and Look-Alikes in Stanislaus County.

Site	Operator	Site	Operator
MODESTO		**SOUTHERN STANISLAUS**	
Paradise Medical Office	HSA	Turlock	HSA
Family Pediatric Health Center	HSA	Hughson	HSA
McHenry Medical Office	HSA	Ceres	HSA
Hanshaw	GVHC	Ceres	GVHC
Hanshaw Dental	GVHC	Ceres East	GVHC
Robertson Road	GVHC	Ceres East Dental	GVHC
Robertson Road Dental	GVHC	Turlock	GVHC
West Modesto	GVHC	Turlock West	GVHC
Corner of Hope	GVHC	**OTHER**	
Tenaya	GVHC	Patterson	GVHC
Empire	GVHC	Riverbank	GVHC
Empire Dental	GVHC	Westley	GVHC
Florida Suites	GVHC	Waterford	LCH
Florida Suites Prompt Care	GVHC	Las Palmas	LCH
Florida Avenue North	GVHC		

What are other counties doing?

County-run clinics are extremely common among counties with public hospitals and somewhat less common among counties without public hospitals. Aside from Stanislaus County, four non-public hospital counties operate their own primary care clinics, including: Santa Cruz County (2 primary care clinics), Solano County (4 primary care clinics); Sacramento County (1 primary care/behavioral health clinic) and Santa Barbara County (5 primary care clinics).

Several non-public hospital counties have closed or transitioned county-run clinics to regional FQHCs over the last 10 years. Prior to that, a number of non-public health counties operated clinics. Counties moved away from direct operation of clinics for a few key reasons, including the rising cost and related deficits from these services, significant growth in size and capability of regional FQHC systems, and a growing complexity in delivering primary care services that pulled attention and resources away from other potential public health priorities.

- Placer County – Transitioned two primary care clinic sites to one regional FQHC with tapered grant funding in 2017. Utilized an RFP process to select the FQHC provider.
- Marin County – In 2017, it transitioned dental and STD clinics to a community FQHC and leased additional clinic sites.
- Sonoma County – Transitioned HIV clinical services and Family Planning Clinics to local FQHCs in 2010. The County Health Department and local community health centers engaged in a collaborative planning and implementation process. The majority of county clinical staff transitioned to the community health centers.
- San Luis Obispo – In 2003, San Luis Obispo closed the County hospital and, in 2004, transitioned the 2 county outpatient clinics associated with the hospital to Community Health Centers of the Central Coast (CCHC). CCHC took over the lease of 1 of the 2 county clinics and the County leased county clinic space to CHC for the other clinic. The county contracted with CHC for outpatient care for the medically indigent adult population. The current community health center-based system has improved both access and resulted in significant savings for the county.[1]

[1] Interview with Jeff Hamm, Director of San Luis Obispo Health Services Agency

What is the unmet need in the community?

Primary care is the foundation of health care nationally and in Stanislaus. Multiple studies have shown that strong systems of primary care are associated with better clinical outcomes and lower costs.[2][3] These studies have demonstrated that in geographic areas where primary care physician (PCP) density is higher, mortality is lower.[4] The same relationship is not seen with specialist physician density. Hospitalization rates are lower for diagnoses that could be addressed in ambulatory care settings in areas where there are more primary care physicians.[5] In states with a higher ratio of primary care physicians to Medicare population, expenditures per beneficiary are lower and scores on 24 common performance measures are higher than in states with fewer PCPs and more specialists per capita.[6] Over the next decade the demand for primary care will increase due to the growth and aging of our population and the increased number of insured individuals associated with the ACA.

Overall in the San Joaquin Valley, there are 39 primary care physicians for every 100,000 residents. This is 22 percent less than the state average of 64. Stanislaus County has a higher proportion of primary care providers—52 per 100,000 population. These ratios apply to the total county population. The number of primary care providers per population is lower for the Medi-Cal and uninsured population.

What are some evolving trends and practices?

Assuring an adequate supply of primary care physicians is necessary but not enough to meet the growing need for primary care capacity in Stanislaus County and the rest of the country. Increasing the number of primary care nurse practitioners (NP) and physician assistants (PA) and nurses[7] is also important. Primary Care Nurse Practitioner and Physician Assistant Residencies and Fellowships are increasing in number and are designed to increase the skills and comfort of NP and PA graduates in taking clinical responsibility for a panel of patients.

Primary care is further expanded when physician, NP and PA clinicians work in high functioning practice models with engaged leadership, data-driven improvement, team-based care, empanelment, patient-team partnership, population management, continuity of care and care coordination. Training residents in settings where these high performance primary care models are in place enhances their ability to better address the primary care needs of patients and populations.

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[2] B. Starfield, L. shi, and J. Macinko. Contribution of Primary Care to Health Systems and Health. Millbank Quarterly. 2005; 83 (no3):457-502.

[3] K. Baicker, A. Chandea. Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care. Health Affairs. 2004; 23:184-197.

[4] Starfield B, Shi L, Grover A, Macinko J. The effects of specialist supply on populations' health: assessing the evidence. Health Affairs. 2005; Jan-Jun:W5-97-W5-107.

[5] Bodenheimer, T. "Primary Care-Will It Survive?" 2006. New England Journal of Medicine 355: 861-864.

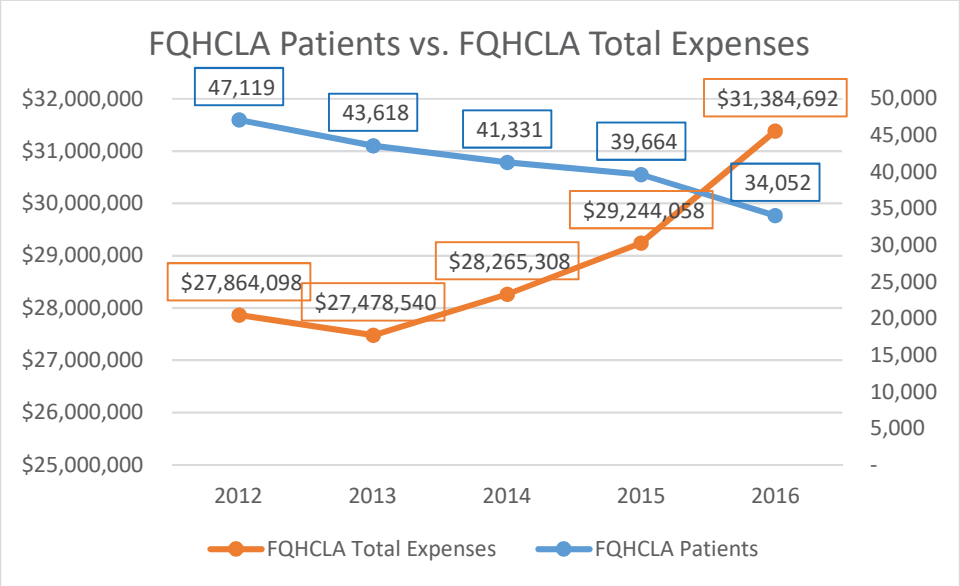
[6] Wennberg, JE, K Bronner, JS Skinner, E Fisher, Inpatient Care Intensity and Patient Experiences of their Health Care Experiences Health Affairs, Vol. 28 No. 1 pp 103-112.

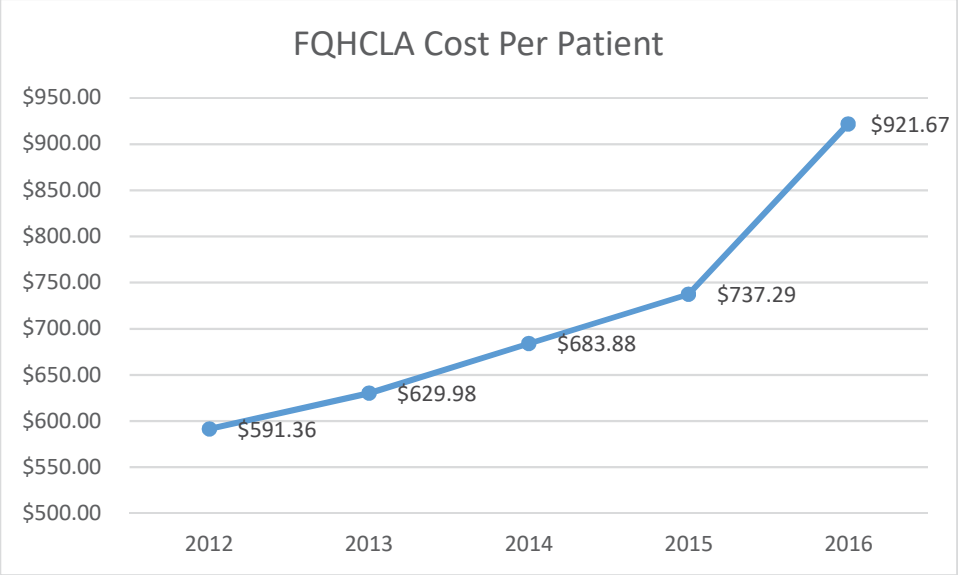
[7] Rethinking the Primary Care Workforce — An Expanded Role for Nurses. Bodenheimer, T., Bauer, M. New England Journal of Medicine; 375:1015-1017. September 15, 2016

Current State Characteristics and Performance

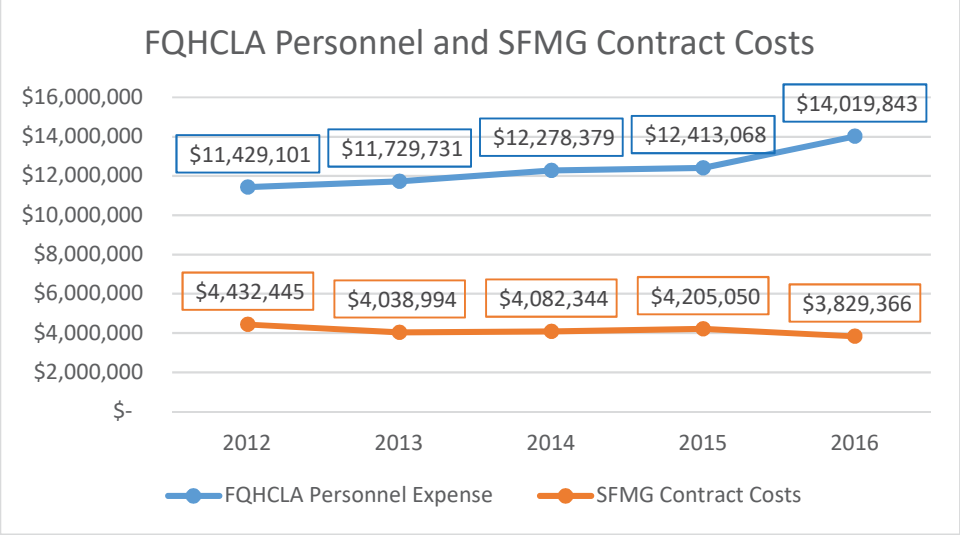
Stanislaus County FQHCLA Clinics

Declining Patients, Increasing Cost. In the context of a growing independent FQHC presence and significant growth in Medi-Cal enrollment, Stanislaus County FQHCLAs have experienced a dramatic decline in the number of patients it serves alongside steady growth in ongoing expenses. The chart below shows that since 2012 the number of patients declined by 28%, while total expenses increased by 12.6%, or $3.52 million. Consequently, the cost per patient has risen from $591.36 in 2012 to $921.67 in 2016.





Declining Provider Staffing Levels. Between 2010 and 2016, physician FTE declined from 26.7 to 23.0, while overall contracted and employed provider staffing declined from 38.2 to 33.4. The below chart shows that while SFMG contract costs have declined due to decreased provider staffing, Stanislaus County FQHCLA personnel expenses increased by $2.59 million, or 22.7%. This shows that though number of patients seen and provider staffing levels have decreased, this has not slowed growth in county staffing and personnel costs.



Provider Employment Model with Conflicting Incentives. SFMG and HSA representatives have conveyed significant concerns about the attractiveness of the current employment model to the current generation of providers and ability to compete with other systems. The working relationship between the two parties is also strained, which creates challenges to restructure employment arrangements, improve provider experience or develop shared workforce strategies (e.g. increase midlevel staffing and determine who employs). In addition, the use of a contracted provider staffing model primarily based on visits/productivity creates built-in incentives that run counter to the goals of the clinical system, including:

- Incentivizing volume over value for providers
- Limiting investments in mid-level provider staffing and creating competition between HSA and SFMG about who will employ those providers
- Segmenting physician and clinical support staffing supervision, while the industry is increasingly moving toward “team-based care” models
- Creating financial dis-incentives to participate in innovative or non-visit focused practices that may improve patient experience and quality outcomes, but reduce visits/productivity and thus impact provider income

While there are opportunities for Stanislaus HSA and SFMG to collaboratively address these issues (discussed later), the fundamental misalignment in incentives and operational structure are not possible to fully resolve under the current arrangement. Even with smart, targeted efforts, it is likely that physician staffing will continue to erode over time.

High Clinical Productivity. Clinical productivity, defined as annual visits per provider, or patients per provider, appears higher at Stanislaus clinics compared to the 2015 California FQHC median. Total annual visits per patient at Stanislaus clinics is 3.5 compared to 4.2 for the California FHCA/LA median.

	Stanislaus FQHCLA UDS (2016)	California FQHC Median (2016)
Annual Patients Per Provider	983	926
Annual Medical Visits Per Provider	3,483	3,023
Annual Physician Visits Per Physician FTE	3,622	3,162
Annual Mid-Level Visits Per Mid-Level FTE	2,765	2,922
Total Visits Per Patient	3.5	4.2

High Staffing Levels/Ratios. For the service model and service provided, staffing levels at Stanislaus FQHCLA clinics appear to be higher than other California FQHCs. This appears to be particularly true for clinical support staffing (e.g. nurses, MAs). For example, the clinical support staffing ratio at Stanislaus clinics in 2016 (clinical support to primary care provider) was 3.0 clinical support FTEs to 1.0 FTE primary care provider, which was notably higher than the California FQHC 2015 median (2.1).

	Stanislaus FQHCLA UDS (2016)	California FQHC Median (2016)
Clinical Support : Primary Care Provider Ratio	3.0	2.1
Non-Clinical Staff Ratio (as % of total FTE)	40%	37%
Total Patients to All Staff FTE	132	121
Total Visits to All Staff FTE	467	522

Negative Financial Performance. Stanislaus County FQHCLA clinics appear to generate comparable levels of per visit revenue as compared to other California FQHCs due to a high Medi-Cal payer mix (82%) and relatively competitive (though somewhat low compared to some county-run systems) Prospective Payment System reimbursement rates. However, expense per visit appears notably higher than the California FQHC median ($249 vs. $201) and the Stanislaus clinics revenue per visit ($214 per visit for a net loss of $35 per visit). This is likely predominantly due to higher overhead and staffing costs than other systems.

	Stanislaus FQHCLA	California FQHC Median (2015)
Operating Revenue Per Visit	$214	$218
Operating Expense Per Visit	$249	$201
Operating Revenue Per Patient	$822	$1,018
Operating Expense Per Patient	$958	$931

The below table highlights site-based financial performance. Overall, it appears that McHenry, Turlock and Ceres experience the largest negative per visit margins, while Paradise Medical Office nearly breaks even. McHenry, in particular, appears to have very high staffing levels compared to provider staffing and visit volume. This likely contributes to high expenses.

Site	Annual Visits	Average Revenue Per Visit	Average Expense Per Visit	Per Visit Difference
Ceres Medical Office	14,434	$ 194	$ 249	$ (56)
Family & Pediatric Health Center	16,334	$ 193	$ 236	$ (43)
Hughson Medical Office	10,935	$ 205	$ 233	$ (28)
McHenry Medical Office	27,795	$ 217	$ 276	$ (59)
Paradise Medical Office	42,955	$ 236	$ 241	$ (5)
Turlock Medical Office	13,872	$ 189	$ 248	$ (59)
TOTAL:	126,325	$ 214	$ 249	$ (35)

Clinic Facilities. All but one Stanislaus FQHCLA facility is leased and several site leases have recently ended. The below table outlines preliminary facility assessments. Potential consolidation of sites has been discussed to better match current demand with capacity, as well as, facility expansions and improvements.

Site	Own/Lease	Region	Facility Assessment
Ceres Medical Office	Lease	South	Lease term ended
Family & Pediatric Health Center	Own	Modesto	Recently refurbished
Hughson Medical Office	Lease	South	Lease term ends October 2018
McHenry Medical Office	Lease	Modesto	
Paradise Medical Office	Lease	Modesto	
Turlock Medical Office	Lease	South	Limited physical capacity/space

Uneven Performance and High Variation in Clinical Operations. Information and perspectives provided by HSA and SFMG representatives indicate that there is significant variation in clinic practices, staff roles and functionality/performance by site. Additionally, it appears that operational improvements have struggled to move forward in a timely manner. Some of the specific challenges highlighted include:

- Operations are site specific – lack of standardized clinic workflows or practices
- Standard schedule template but provider-specific customization is common
- Variation in staffing levels/ratios, roles by site

These issues contribute to lower physician satisfaction, uneven patient experience, higher costs and operational inefficiencies, and slower progress moving system improvement initiatives.

Inadequate Infrastructure/Systems to Manage Clinical Quality. Available clinical quality indicators suggest comparable quality of Stanislaus FQHCLA clinics compared to other FQHCs. However, HSA-provided information and staff insights on QI infrastructure, staffing, systems and reporting/technology suggest that QI systems and capability is under-developed. Some of the specific issues outlined by HSA include the following:

- Data validity concerns
- Mixed EMR and chart review for quality indicators
- No population/intervention-based reporting (IT module and modified workflow is current work-in progress)
- No end-user report generation capability
- Limited provider, clinic or system quality dashboards
- Limited management reports/dashboards
- Limited reporting and QI staffing and infrastructure; 0.5 FTE system wide FTE for clinical quality reporting/initiative; 3.0 Quality Division FTE also responsible for numerous other responsibilities

Specialty Clinic Physical Rehabilitation Services

Specialty Care Clinic and Physical Rehabilitation Services. Currently, the HSA Specialty Care Clinic (SCC) and Physical Rehabilitation Services (PRS) provide several services. Specialty services are available part-time, typically one or two half-day shifts per week. An exception is orthopedics, which is available up to 28 hours per week. Within PRS, physical therapy is available 40 hours per week, occupational therapy 24 hours per week, and wound care 25 hours per week. Many of these services have been provided for many years, including when the County operated the hospital and prior to the Medi-Cal expansion.

Specialty Care Clinic Services	
Orthopedics	24-28 hours per week
Ear, Nose and Throat (ENT)	4 hours per week
Sports Medicine	4 hours per week
Urology	4-5 hours per week
Podiatry	12 hours per month
Neurosurgery	8-16 hours per month
Neurology	8-16 hours per month
Gastroenterology	8-12 hours per month
Hep C	8 hours per month
Minor Procedures	4 hours per week
Special Procedures	4 hours per month
Physical Rehabilitation Services	
Physical Therapy	40 hours per week
Occupational Therapy	24 hours per week
Wound Care	25 hours per week
Electromyography (EMG)	8 hours per month
Audiology	16 hours per month

Family Medicine and Orthopedics Residency. The Accreditation Council for Medical Education (ACGME) accredits sponsoring Institutions, such as the Valley Consortium for Medical Education, and residency and programs, such as the Valley Family Medicine Residency Program and the Valley Orthopedic Surgery Residency (pending). As part of the accreditation process, ACGME establishes residency program requirements for education and training or residents, including specialty medicine rotations and physical medicine and physical rehabilitation rotations. The county medical specialty and physical medicine/physical rehabilitation clinics were established many years ago to provide ACGME-required specialty medicine training to family medicine residents and, later, orthopedic surgery residents and also to meet the needs of county hospital and medically indigent patients.

Valley Family Medicine Residents participate in regular ACGME-required specialty medicine clinical training with specialists at the HSA Specialty clinics. Family Medicine residents also are periodically participate in clinical training at the HSA Physical Rehabilitation clinic where they learn to appropriately utilize Physical Medicine/Physical rehabilitation Services, Occupational Health Therapy as well as outpatient wound care.

The Valley Orthopedic Surgery is engaged in required orthopedics and physical medicine and rehabilitation training at the HSA Ortho and Physical Rehab Clinics. In addition to resident training the orthopedics and physical rehabilitation clinics provide needed local access to these services. Although the Physical Rehab clinic is separate from the Ortho Teaching clinic, both are required training and are often complementary. For example, for many conditions Physical Rehab is required prior to any Orthopedic service authorization by the health plans. HSA manages the specialty care and physical rehabilitation clinics and contracts with specialists,

physical therapists and occupational therapists to staff the clinics. VCME reimburses HSA for 25% of the cost of specialist providers when they are precepting residents, while VCME reimburses HSA for 100% of the cost of family physician and orthopedist preceptors in family medicine and orthopedics residency clinics. The county operates the HSA Specialty Care and Physical Rehab clinics at significant net county cost.

High Demand for Services and Unmet Need. Available data and qualitative feedback indicate that there is an extremely high demand for specialty and physical rehabilitation services, both from HSA FQHCLA clinics and also from other Medi-Cal primary care providers. It also indicates that there is an overall community shortage in the number of specialists serving the community and more acute shortage of specialty providers serving Medi-Cal enrollees. Some key data points include the following:

- Available data on the number of specialty care providers in Stanislaus County, indicates that there are lower ratios of specialists to residents in Stanislaus County compared to California overall. According to 2015 data, Stanislaus County had 81.54 specialists per 100,000 residents compared to a California average of 104.06. This is consistent among the specialties provided by the SCC and PRS, but is also prevalent among other high need specialties, such as dermatology, endocrinology and ophthalmology;
- HSA clinics are an important resource available within Stanislaus County for these specialties for Medi-Cal members. There are inadequate resources for these services and many members are otherwise referred out-of-county. This is consistent with similar assessments completed in other central valley counties;
- More than 50% of specialty referrals come from non-HSA primary care providers. This indicates high community demand for the services and a degree of reliance by the health plans who have the responsibility to secure access for their Medi-Cal members;
- Appointment demand for specialty and physical rehabilitation services is very high with most services operating at capacity. Several specialties are currently not accepting referrals because they are at capacity.

Challenging Financial Model. Over 80% of visits at both SCC and PRS clinics are Medi-Cal, while the majority of remaining visits are Medicare. Whereas the FQHC Look-Alike clinics bill Medi-Cal and Medicare visits at an enhanced per visit rate that greatly increases revenue, SCC and PRS bill at standard rates which are significantly below costs. In the 2017/18 and 2018/19 fiscal years HSA is projecting increased operating losses for the SCC and PRS due to increased facility and operating expenses. The majority of SCC and PRS losses are funded through County general fund expenditures and Intergovernmental Transfers (IGTs), which are an important but uncertain source of revenue. It is also important to note that projected revenues for 2017/18 cover a small proportion of expenses. Based on first quarter performance, HSA projects only $875,000 in patient revenue from specialty services, representing just 22% of projected expenses. This highlights the fragility of the financial model supporting SCC and PRS services.

Specialist Contracts Represent a Small Portion of Total Costs. Also, it appears that the cost of contracting with specialty providers (plus malpractice insurance) is only about $750,000 out of $4.78 million in expenses. While there are certainly other essential expenses related to equipment, supplies, staffing and other justifiable expenses, it highlights the relatively low proportion of costs that are actually related to the professional service.

Future Options

The below section outlines potential future options or arrangements for the HSA to consider. Each of these options are evaluated against key criteria later in the analysis.

OPTION 1. Retain Current Clinics with System Improvements. Under this option, Stanislaus County would invest in specific initiatives, staffing and infrastructure to improve the cost-effectiveness, operational and quality performance of the FQHCLA system. FQHCLA clinic improvement strategies could include the following:

- Pursue reimbursement rate trigger events to strategically increase the reimbursement rate. A trigger may be providing an enhanced scope of service;
- Reduce and standardize clinical support staffing at the clinics to achieve comparable staffing ratios with other FQHCs and temper the growth in personnel costs;
- Standardize clinical operations across FQHCLA sites by implementing standardized policies and procedures, uniform clinical support staff roles/job descriptions, consistent site management structures and increased site accountability, and;
- Increase Quality Improvement staffing levels and data/reporting infrastructure to enable accurate, timely and user-driven quality reporting.

Under this option, HSA would also continue to provide and subsidize the provision of specialty and physical rehabilitation services. The agency could consider some strategic changes in service offerings and approaches to improve financial performance, increase access to care and respond to the most acute community needs. This could include:

- Re-evaluating which specialty services are provided by HSA based on key criteria, such as community need, impact on health, cost/loss to provide services, and availability and/or incentives for other providers to provide the service;
- Re-evaluate which patient/coverage populations to target services (e.g. Medicare, Medi-Cal) based on community need, reimbursement level and availability of other providers, and;
- Consider options to reduce operating costs and maximize reimbursement, such as, co-location of specialty services at Stanislaus County FQHCLA sites, administrative efficiencies and reductions in expenditures that are not directly related to patient care.

OPTION 2. Strategically and Immediately Consolidate the Number of Stanislaus County Clinic Sites (with Improvements) and Explore Strategic Partnerships/Approaches to Maintain Access to Care and Optimize Resources. Under this option, Stanislaus would strategically consolidate the number of clinic sites over a 2-3 year period based on community need/demand, operational/financial performance, facility considerations and other factors. Within this option, HSA could pursue two potential pathways for consolidating its clinic sites. These pathways are not mutually exclusive and could be pursued in tandem:

- Transition selected FQHCLA sites (and/or specialty services) to independent FQHCs through either a direct arrangement or RFP process, and/or;
- Shift FQHCLA and/or specialty and physical rehabilitation providers and patients to fewer facilities with some staff and capacity reduction. Informed by evaluation of clinic performance, presence/role of other independent FQHCs in region and facility master plan.

Development of a detailed clinic consolidation/transition plan is outside the scope of this analysis. However, some key steps associated with this option that would need to be completed include:

- Assess and prioritize Stanislaus FQHCLA clinics for consolidation or transition based on selected criteria, such as:
    - Is the clinic an essential location for residency training?
    - What is the level of unmet need for safety net primary care in this community?
    - Are there other independent FQHC systems with facilities in this community? Are they expanding capacity?
    - What is the facility condition/status and how attractive is the site for continued use? Are there opportunities to expand primary care capacity to absorb volume from other sites?
    - What is the financial and operational performance of the site and how likely is improvement?
    - Are independent FQHCs interested and capable of absorbing the clinic site?
    - Are potential FQHC partners capable and committed to participating as a service provider for a current or expanded Medically Indigent Adult (MIA) program?
- Determine the consolidation/transition approach (e.g. direct relationship with individual FQHC, RFP process, clinic consolidation, and/or combination);
- Outline staff and provider transition expectations (e.g. become FQHC staff, position transitions to other HSA departments, staff reductions);
- Develop a stakeholder engagement and communication strategy to address when and how to engage key constituencies, such as the Board of Supervisors, staff affected by the change, unions, SFMG, patients and the community at large;
- Outline a timeline and detailed logistical process for consolidation and transition steps.

OPTION 3. Transition or Limit Stanislaus County Role as a Direct Clinical Provider. Under this option, Stanislaus County would phase-out its role operating FQHCLA clinics over a period of 2-3 years. The FQHCLA phase-out would more than likely include both permanently closing a subset of clinics, as well as, transitioning some clinic sites to independent FQHCs. The analysis of which facilities to close and which to transfer would address similar criteria as in Option 2 and follow a similar process.

Under this option, HSA would additionally cease providing specialty and physical rehabilitation services or transition some/all specialty and physical rehabilitation services to independent local FQHCs and/or private specialty medical providers. Importantly, HSA would likely need to provide some level of bridge and/or ongoing funding to under-write these services, but funding levels would be notably lower than what is being spent today.

Evaluation Dimensions

PHCG identified four broad evaluation dimensions to guide the analysis of potential impacts, benefits and challenges associated with each issue. These include:

- **Impact on Community Health:** How will different options impact community health?
- **Organizational Fit:** How effective is HSA in this role? Are there other entities that are better positioned or equipped to fulfill this role? What are the opportunity costs of playing this role?
- **Financial Impact:** What would be the one-time and ongoing costs associated with different options?
- **Implementation and Operational Feasibility:** How feasible are different options to implement and operate?
- **Political Feasibility:** How feasible are different options from a political standpoint?

Analysis of Options

The following sections reviews the key trade-offs and considerations with each of the three options.

OPTION 1. Retain Current Clinics with System Improvements.

Some key considerations related to the FQHCLA clinics:

- The most important consideration is that this option is not likely to reverse Stanislaus FQHCLA patient volume, clinic operations and financial trends. HSA will likely continue to experience gradual declines in patient numbers and provider staffing, increasing financial losses and county general fund contributions and persistent clinic operational issues. As stated, multiple factors indicate that HSA may not be ideally suited to provide direct medical services in the current delivery system environment. These issues would additionally impact the successful functioning and sustainability of the residency program.
- The proposed FQHCLA clinic improvements would certainly require short-term financial investments and the likelihood of success are highly uncertain. Most of the issues identified through this analysis are well-known to HSA but have struggled with prior improvement efforts. The need for more consistency may be rejected by some current physicians resulting in lost provider staffing capacity.

Additional considerations related to the specialty (SCC) and physical rehabilitation (PRS) clinics include the following:

- SCC and PRS currently see Medi-Cal and Medicare patients only. Given access challenges, HSA could limit Medicare visits and prioritize Medi-Cal visits in order to increase access for Medi-Cal enrollees. Alternatively, HSA could increase Medicare volume given its higher reimbursement rates. Though it would not significantly affect financial performance, it would generate additional revenue.
- Co-locating services at HSA FQHCLA facilities would likely be manageable for those specialty services that are consultative, part-time and require minimal specialized equipment and space (e.g. neurology, podiatry). Further, those specialties that can be justified as incidental to primary care could be included under the scope of the FQHCLA clinics, which would provide enhanced reimbursement for Medi-Cal and Medicare. Co-location could also reduce facility rental expenses associated with current facilities. Community specialist physicians, however, may be less likely to participate if the location is not convenient and close to their private practice and/or hospital.
- Co-location may be less feasible for those services that are space and equipment intensive, such as physical therapy, occupational therapy, or orthopedics. Additionally, those services that cannot be justified as incidental to primary care could not be included in the FQHCLA scope. This does not preclude HSA from locating these services in the same/adjacent facilities, but would limit options for enhanced reimbursement.
- Staff indicated that HSA is only reimbursed for 25% of the cost of specialist providers when they are precepting with family medicine residents, despite being reimbursed for 100% of this time in orthopedics and in family medicine. Re-negotiation of this arrangement could generate some additional revenue for the program.
- Many of the specialty services currently provided are “legacy” services that continue to be provided because they have been provided for many years. It may benefit HSA to re-evaluate which specialty services it should provide based on 1) unmet community need, 2) impact on priority health conditions, 3) cost/loss to provide the service, and 4) appropriate role of HSA versus other providers in offering this service. In many primary care settings, county and FQHC clinics have prioritized delivery of cognitive specialties that can be delivered with minimal equipment, introduce limited advanced referral needs and relate to common patient health needs (e.g. cardiology, endocrinology, neurology, dermatology, podiatry).

OPTION 2. Strategically and Immediately Consolidate the Number of Stanislaus County Clinic Sites (with Improvements) and Explore Strategic Partnerships/Approaches to Maintain Access to Care and Optimize Resources.

- The decline in Stanislaus FQHCLA patients indicates that strategic consolidation of sites and staffing is an appropriate response to reduced demand. Thoughtful consolidation of sites, and reduction of staffing and expenses would likely have a minimal impact on overall capacity to meet the needs of existing patients.
- Available information strongly indicates that independent FQHCs are both playing an increasingly significant primary care delivery role in the community and that they likely have the capacity to absorb new sites and continue to expand primary care capacity over time.
- A thoughtful consolidation of Stanislaus FQHCLA facilities through transition of facilities to independent FQHCs and/or re-direction of some capacity to fewer FQHCLA facilities would likely result in the retention of most, though not all, of existing primary care services in the community. Within this option, HSA should anticipate the departure of a portion of the SFMG provider workforce to other systems. It should be noted that any transition to FQHCs would almost certainly require SFMG providers to either become employees of that FQHC or direct contractors. It is extremely unlikely that any FQHC would be willing to contract through SFMG.
- Although the HSA would certainly achieve ongoing operational savings due to reduced clinic obligations, there would likely be new costs for the first 3-5 years following any transitions to support clinic transitions to FQHCs and potential facility renovation / relocation costs for any remaining HSA facilities. Additionally, the level of savings would be dependent on HSA clinic staffing decisions.
- Political reaction to a reduced FQHCLA presence will likely include opposition from HSA clinic staff, unions and SFMG. One consideration may be whether HSA could temper the response by simply consolidating, rather than fully phasing out the clinics. If not, it may be a more attractive option to proceed with a full phase out rather than a stepped consolidation. Lastly, the Board of Supervisors will likely consider the balance and trade-offs between the financial, policy and political considerations.

OPTION 3. Transition or Limit Stanislaus County Role as a Direct Clinical Provider.

Many of the FQHCLA related considerations in Option 3 mirror those in Option 2. However, a couple of additional considerations exist. First, success of Option 3 in mitigating the negative impact on the amount of primary care services in the community becomes wholly dependent on the willingness of FQHC partners to take over operation of the largest and most essential Stanislaus FQHCLA clinics. Second, such a shift would imply the closure of SFMG since any FQHCLA partner would almost certainly require that providers either become employees or contract directly for services. Additionally, any new arrangement would necessitate that the FQHC partner(s) take on additional responsibilities for residency rotations/continuity clinics.

- There are multiple examples of FQHC clinics in California establishing specialty care centers or embedding specialty care within primary care settings. These arrangements tend to be successful when there are extremely limited alternatives for Medi-Cal specialty care services and when the systems develop strong systems to accept referrals from other primary care providers in the community.
- That said, it is unlikely that an independent FQHC would establish specialty services without transition, facility and some level of ongoing funding to support the programs. This is because it is much more difficult for FQHCs to achieve positive net income with specialty services and because these services require additional referral/scheduling management resources. However, given the relatively small proportion of current expenses that are attributed to specialty provider contracts, it

is likely that HSA could provide meaningful support for these services at a much lower cost to the County.

- Similar scope and space restrictions on which specialties could be off-loaded to independent FQHCs exist with this option as with option 2. Independent FQHCs would likely only be interested in housing those specialty services that could be included in their FQHC scope of services, addressed common patient needs and had limited space and equipment requirements.
- It is unlikely that this is a feasible option for either orthopedics or physical rehabilitation services. If Stanislaus County wishes to preserve access for the community, HSA would need to either maintain these clinics or establish similar arrangements with other private provider systems in the community.
- Under this option, it is feasible to continue support for the residency programs but the relationship of HSA with the Valley Family Medicine Residency and the Orthopedics Residency would change. Residency training would no longer occur in HSA clinics with specialist physicians and physical therapists hired through the county. Under this option, resident education and training for specialty medicine and physical medicine/physical rehabilitation would be provided at local FQHC/s and/or private specialty medical providers offices. The Valley Family Medicine Residency and the Orthopedics Residency would need to establish revised Program Letters of Agreement (PLA)[8] with each site for rotations where residents receive required training in specialty medicine and physical medicine and physical rehabilitation. The Accreditation Council for Graduate Medical Education (ACGME) requires Program Letters of Agreement which "provide details on faculty, supervision, evaluation, educational content, length of assignment, and policy and procedures for each required assignment that occurs outside of an accredited program's sponsoring institution."
- County financial support for education and training of Family Medicine and Orthopedics residents in ACGME-required specialty medicine and physical medicine/physical rehabilitation will likely be needed initially and possibly on an ongoing basis. However, this support would be significantly less than the County currently spending on specialty clinics and related residency training.

[8]Common Program Requirements Frequently Asked Questions ACGME
https://www.acgme.org/Portals/0/PDFs/FAQ/CommonProgramRequirementsFAQs.pdf

STANISLAUS COUNTY HEALTH SERVICES AGENCY
TOPICAL MEMO #6: Family Residency Program Options
May 11, 2018/REVISED July 5, 2018

Overview

The Stanislaus County Health Services Agency (HSA) engaged Pacific Health Consulting Group (PHCG) to facilitate an intensive strategic planning process for the agency. As part of the engagement, PHCG was asked to evaluate several strategic topics/issues and present key findings to inform HSA strategic decisions. The enclosed memo examines potential options for supporting the Valley Family Medicine Residency for Stanislaus County. The analysis examines potential future strategic directions or options for HSA to pursue and examines their potential impacts and trade-offs.

Specifically, the analysis is intended to assist the HSA in determining what role is most appropriate for Stanislaus County in developing the local medical workforce in consideration of key criteria, such as:

- **Impact on Community Health:** How will different options impact community health?
- **Organizational Fit:** How effective is HSA in this role? Are there other entities that are better positioned or equipped to fulfill this role? What are the opportunity costs of playing this role?
- **Financial Impact:** What would be the one-time and ongoing costs associated with different options?
- **Implementation and Operational Feasibility:** How feasible are different options to implement and operate?
- **Political Feasibility:** How feasible are different options from a political standpoint?

The analysis evaluates two options against these criteria:

- ***OPTION 1.*** Retain Current Valley Family Medicine Residency (VFMR) for Stanislaus County.
- ***OPTION 2.*** Retain and Expand Valley Family Medicine Residency for Stanislaus County with New Partners.

Summary of Key Findings

The enclosed memo includes a detailed analysis of community needs, performance and characteristics of current Stanislaus systems and an analysis of future options. Key take-aways from the analysis are briefly summarized below.

- Community data and stakeholder input indicates that there is a real and meaningful primary care provider shortage in Stanislaus County that impacts both safety net and non-safety net patients.
- While there may be opportunities for VFMR program improvement, the role of Stanislaus County HSA as a program champion, funder and board member of the Valley Consortium for Medical Education (VCME) is essential and appropriate. Developing the local provider workforce falls appropriately within the role of the HSA to assure adequate services within the community and address system-level challenges. No other provider or system is adequately equipped or motivated to play this leadership and key funding role.
- Assuring an adequate primary care physician workforce is a necessary but insufficient strategy to build primary care capacity in the community. Additional opportunities that could be explored include development of new nurse practitioner / physician assistant residencies and fellowships, as well as, other initiatives to promote local health care workforce pipelines.
- Retaining the residency program within Stanislaus FQHCLA clinics introduces the fewest short-term disruptions but may present significant long-term risks if the clinics continue to struggle with provider recruitment, patient decreases and financial losses. Transferring residency outpatient training to local community health centers represents a viable alternative.
- Building program relationships with UC Davis and other residencies, prioritizing local pipeline development, and cultivating a commitment to safety net practice through resident training rotations with community providers/FQHCs could meaningfully strengthen VFMR performance. A reduction in the HSA financial obligation, however, is not likely.
- The SFMG contracting arrangement, both for FQHCLA service delivery and as a VFMR faculty model present inherent barriers and counter-incentives to effective management and execution of these programs/services. Even with modifications, these arrangements are likely to inhibit long-term performance.

Background

What is the historical role and evolution of the residency?

Stanislaus County began residency training in the 1950's with general practice training at the County hospital. The county program became the Stanislaus Family Medicine Residency in 1975 and that same year the Scenic Faculty Medical Group was established. The County Hospital was the sponsoring organization for the Stanislaus Family Medicine Residency. Resident hospital training occurred at the County Hospital and outpatient training primarily at the continuity clinics of the Family Practice Center on the campus of the County Hospital. Historically, funding for the residency had been through a combination of Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) Medicare funding, plus patient fees and matched funding from the County. This combination of funding had been inadequate to meet the costs of the residency. The County Hospital closed in 1997, and the county transitioned hospital training of residents to Doctors Medical Center and resident continuity clinics and other outpatient training to county clinics. Several years later, the Centers for Medicare and Medicaid (CMS) determined that the Stanislaus Family Medicine Residency should not have continued operation after the closure of the county hospital. CMS denied Graduate Medical Education funding for 2 years, resulting in a $5 million deficit in funding and a $20 million prior years' disallowance that resulted in an equally shared refund to the federal government by Stanislaus County and Doctors Medical Center.

In 2009, Stanislaus County, in partnership with Doctors Medical Center (Tenet) and Memorial Medical Center (Sutter) established the Valley Consortium for Medical Education (VCME), a non-profit 501(c)(3) organization, to foster graduate and undergraduate medical education in the Central Valley. VCME became the sponsoring organization for the new Valley Family Medicine Residency (VFMR) in 2010 when Stanislaus Family Medicine Residency officially ceased operation. VFMR is accredited by the Accreditation Council for Graduate Medical Education (ACGME) and affiliated with UC Davis School of Medicine.

What is the unmet need in the community?

Primary care is the foundation of health care nationally and in Stanislaus. Multiple studies have shown that strong systems of primary care are associated with better clinical outcomes and lower costs.[1][2] These studies have demonstrated that in geographic areas where primary care physician (PCP) density is higher, mortality is lower.[3] The same relationship is not seen with specialist physician density. Hospitalization rates are lower for diagnoses that could be addressed in ambulatory care settings in areas where there are more primary care physicians.[4] In states with a higher ratio of primary care physicians to Medicare population, expenditures per beneficiary are lower and scores on 24 common performance measures are higher than in

[1] B. Starfield, L. shi, and J. Macinko. Contribution of Primary Care to Health Systems and Health. Millbank Quarterly. 2005; 83 (no3):457-502.

[2] K. Baicker, A. Chandea. Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care. Health Affairs. 2004; 23:184-197.

[3] Starfield B, Shi L, Grover A, Macinko J. The effects of specialist supply on populations' health: assessing the evidence. Health Affairs. 2005; Jan-Jun:W5-97-W5-107.

[4] Bodenheimer, T. "Primary Care-Will It Survive?" 2006. New England Journal of Medicine 355: 861-864.

states with fewer PCPs and more specialists per capita.[5] Over the next decade the demand for primary care will increase due to the growth and aging of our population and the increased number of insured individuals associated with the ACA.

Overall in the San Joaquin Valley, there are 39 primary care physicians for every 100,000 residents. This is 22 percent less than the state average of 64. Stanislaus County has a higher proportion of primary care providers—52 per 100,000 population. These ratios apply to the total county population. The number of primary care providers per population is lower for the Medi-Cal and uninsured population.

What are some evolving trends and practices?

Assuring an adequate supply of primary care physicians is necessary but not enough to meet the growing need for primary care capacity in Stanislaus County and the rest of the country. Increasing the number of primary care nurse practitioners (NP) and physician assistants (PA) and nurses[6] is also important. Primary Care Nurse Practitioner and Physician Assistant Residencies and Fellowships are increasing in number and are designed to increase the skills and comfort of NP and PA graduates in taking clinical responsibility for a panel of patients.

Primary care is further expanded when physician, NP and PA clinicians work in high functioning practice models with engaged leadership, data-driven improvement, team-based care, empanelment, patient-team partnership, population management, continuity of care and care coordination. Training residents in settings where these high performance primary care models are in place enhances their ability to better address the primary care needs of patients and populations.

[5] Wennberg, JE, K Bronner, JS Skinner, E Fisher, Inpatient Care Intensity and Patient Experiences of their Health Care Experiences Health Affairs, Vol. 28 No. 1 pp 103-112.

[6] Rethinking the Primary Care Workforce — An Expanded Role for Nurses. Bodenheimer, T., Bauer, M. New England Journal of Medicine; 375:1015-1017. September 15, 2016

Current State Characteristics and Performance

Resident Examination Scores. VFMR resident scores for the American Board of Family Medicine Residency Program Performance Examination improved from 2012 to 2016. In 2015 and 2016 one-hundred percent of residency graduates passed the exam on their first attempt. However, program graduate average examination scores are consistently below the national average.

Graduate Retention and Practice Settings. VFMR tracks Residency Graduate Placement. Data from 72 residents who graduated from the Valley Family Medicine Residency between 2011 and 2017, indicates that 28% of graduates remained in Stanislaus County to practice medicine. Of this group that remained in Stanislaus, 30% went to work with SFMG, 25% with Kaiser Permanente and 15% with Family Health Care Medical Group. The remaining 30% of residents worked in a variety of settings such as Sutter and Turlock Family Practice. Overall 36% of resident graduates practice in the Central Valley (28% in Stanislaus and 8% in other Central Valley locations). The remaining 64% of graduates practice in areas outside the Central Valley. Overall, 93% of graduates remained in California to practice medicine and 23% practice in a safety net medical setting.

VFMR Retention and Practice Settings	
Total Graduates 2011 – 2017	72
Practice in Safety Net Setting	17
Stayed in Stanislaus County	20
SFMG	*6*
Kaiser Permanente	*5*
Family Health Care Medical Group	*3*
Other	*6*

Funding Environment. The DMC cost report is the basis for Graduate Medical Education funding for the residency. The Clinic budget includes a contribution to the consortium of approximately $800,000 and $1.5 million annually. The family medicine resident continuity clinics are at the Paradise Medical Clinic and that facility has a net loss of $1.6 million, including some costs associated with the residency. Federal Teaching Health Center GME (THCGME) Funds initially contributed $2.5 million to the residency budget, but federal THCGME funding declined in 2016 to $500,000. Congress did not extend funding for the THC program by the September 30, 2017 fiscal deadline. On November 4, 2017, the House of Representatives passed HR 3922 (Championing Healthy Kids Bill) that would extend funding for the Teaching Health Center Graduate Medical Education program through FY2019. The bill will next be considered by the Senate.

Fluctuating Family Medicine Residency Slots. Uncertainty about the future of THC GME funding caused VCME to decrease the number of Family Medicine Residency slots in 2017 from 12 to 9 residents. However, the VCME Board voted in 2018 to raise the number of slots back to 12 in 2018 due to the award of a new state grant. Maintaining resident slots is important as reductions in slots could negatively impact the ability of the residency to attract qualified medical students to the program.

Faculty Retention and Satisfaction Challenges. Scenic Faculty Medical Group (SFMG) is a professional physician corporation. Previously, SFMG had 22 physicians, but their number will be reduced to 18 by September 2017. SFMG has a teaching agreement with VCME wherein the

Consortium funds 5 core faculty positions and the associate residency director. SFMG also has a Facilities and Services Agreement with the County. Core faculty members have their practices at the county clinics. Malpractice insurance is paid by VCME when faculty members are training residents and by the County when faculty are seeing their own patients in clinic.

SFMG has had difficulty retaining and recruiting core faculty members. Reasons cited included inability to meet higher salaries and signing bonuses available to physicians through other employers, particularly Kaiser Permanente and an increased preference, particularly among younger physicians, to be salaried employees.

Several interviewees referred to increased stress and dissatisfaction among faculty members. Factors mentioned as contributing to increased stress included increased faculty workload associated with recent loss of several faculty members over the last few years and inability to recruit new faculty; recent difficult implementation of electronic health record in county health center where faculty members practice; strained working relationship between faculty and County clinic management and support staff and; faculty reimbursement model that includes a stipend for faculty work and is based on productivity for clinical work.

Family Medicine and Orthopedics Residency. The Accreditation Council for Medical Education (ACGME) accredits sponsoring Institutions, such as the Valley Consortia for Medical Education, and residency and programs, such as the Valley Family Medicine Residency Program and the Valley Orthopedic Surgery Residency (pending). As part of the accreditation process, ACGME establishes residency program requirements for education and training or residents, including specialty medicine rotations and physical medicine and rehabilitation rotations. The county medical specialty and physical medicine/rehabilitation clinics were established many years ago to provide ACGME-required specialty medicine training to family medicine residents and, later, orthopedic surgery residents and also to meet the needs of county hospital and medically indigent patients.

Valley Family Medicine Residents participate in regular ACGME-required specialty medicine clinical training with specialists at the HSA Specialty clinics. Family Medicine residents also are periodically participate in clinical training at the HSA Physical Rehabilitation clinic where they learn to appropriately utilize Physical Medicine/Rehabilitation Services, Occupational Health Therapy as well as outpatient wound care.

The Valley Orthopedic Surgery is engaged in required orthopedics and physical medicine and rehabilitation training at the HSA Ortho and Physical Rehab Clinics. In addition to resident training the orthopedics and physical rehabilitation clinics provide needed local access to these services. Although the Physical Rehab clinic is separate from the Ortho Teaching clinic, both are required training and are often complementary. For example, for many conditions Physical Rehab is required prior to any orthopedic service authorization by the health plans. HSA manages the specialty care and physical rehabilitation clinics and contracts with specialists, physical therapists and occupational therapists to staff the clinics. VCME reimburses HSA for 25% of the cost of specialist providers when they are precepting residents, while VCME reimburses HSA for 100% of the cost of family physician and orthopedist preceptors in family medicine and orthopedics residency clinics. The county operates the HSA Specialty Care and Physical Rehab clinics at significant net county cost

Future Options

The below section outlines potential future options or arrangements for the HSA and the VCME partner organizations to consider. Each of these options are evaluated against key criteria later in the analysis.

OPTION 1. Retain Current Valley Family Medicine Residency (VFMR) for Stanislaus County. Under this option, Stanislaus County would pursue new strategies to strengthen the performance of VFMR.

VFMR Residency Improvement Strategies:

- Prioritize recruitment and retention of local health care professional by investing in the local pipeline for physicians, nurse practitioners, physician assistants and other health care professionals. Program examples include Mi Mentor and Puente;
- Expand the membership of the Valley Consortium for Medical Education (VCME) to include greater primary care representation;
- Consider expanding the number of resident training rotations through partner organizations, which could reduce county facility and cost requirements, as well as, expose residents to a greater variety of practice settings;
- Strengthen VFMR relationship with UC Davis by building working relationships with the UC Family Medicine Residency Network, UC Davis Center for Health Disparities, and/or other Central Valley Initiatives;
- Strengthen working relationships with other Central Valley residencies, such as other members of the UC Davis network, San Joaquin General Hospital Family Medicine Residency Program, Stockton Family Medicine Residency and Mercy Medical Center Merced Family Medicine Residency Program, and;
- Collaborate with local partners to systematically identify safety net primary care capacity needs and build a multi-faceted approach to building the local workforce that could include the residency, mid-level fellowship and training programs and other pipeline development initiatives, among others.

OPTION 2. Retain and Expand Valley Family Medicine Residency for Stanislaus County with New Partners.

- Consider partnering with non-county FQHC system for resident outpatient training, and particularly resident continuity clinics VFMR;
- Continue to partner with VCME as the sponsor for the VFMR. Inpatient residency training could potentially continue at Doctors Medical Center and university affiliation could continue with University of California Davis. Resident continuity clinics would be located at a local FQHC, as would the Residency faculty clinics.

The core faculty of the Valley Family Medicine Residency are members of the Scenic Faculty Medical Group, a professional physician corporation. SFMG has a teaching agreement with VCME wherein the Consortium funds five core faculty positions and the associate residency director. Core faculty members have their practices at the county clinics and the SFMG members are paid for their clinic practice time through the Facilities and Services Agreement with the County. Malpractice insurance is paid by VCME when faculty members are training residents and by the County when faculty are seeing their own patients in clinic.

If outpatient training were to transition from county clinics to another local FQHC system, VCME could continue to fund faculty positions for resident training, theoretically through a contract with SFMG or with the new residency outpatient training health center entity. Core faculty members would have their practices at the new residency outpatient training health center entity and would likely need to be employed by the health centers for their clinical time. Malpractice insurance could be paid by VCME when faculty members are training residents and by the health center when faculty are seeing their own patients in clinic.

The transition of outpatient training to a new site and entity would need to be approved by the Accreditation Council for Graduate Medical Education (ACGME). There are several examples in California and elsewhere of residencies that have successfully transitioned outpatient residency training to community federally qualified health centers. One example, the Santa Rosa Family Medicine Residency, transitioned outpatient training from clinics that were once part of the County Hospital. The County Hospital was leased under a Health Care Access Agreement that included outpatient clinics. In 2010, the hospital-associated clinics were closed and resident outpatient training was successfully transferred to Santa Rosa Community Health Center (SRCH). Existing faculty members also transitioned their teaching and clinical practices to SRCH but remained employees of Sutter Medical Group of the Redwoods.

Evaluation Dimensions

PHCG identified four broad evaluation dimensions to guide the analysis of potential impacts, benefits and challenges associated with each issue. These include:

- **Impact on Community Health:** How will different options impact community health?
- **Organizational Fit:** How effective is HSA in this role? Are there other entities that are better positioned or equipped to fulfill this role? What are the opportunity costs of playing this role?
- **Financial Impact:** What would be the one-time and ongoing costs associated with different options?
- **Implementation and Operational Feasibility:** How feasible are different options to implement and operate?
- **Political Feasibility:** How feasible are different options from a political standpoint?

Analysis of Options

The following sections reviews the key trade-offs and considerations with each of the three options. The table on the following page outlines specific considerations for each evaluation dimension.

OPTION 1. Retain Current Valley Family Medicine Residency (VFMR) for Stanislaus County.

- The proposed improvements and strategic directions outlined for VFMR, though not likely to affect funding obligations, could generate improvements in local provider retention in the community and in safety net settings. Importantly, these strategies could be pursued within any of the three options.

OPTION 2. Retain and Expand Valley Family Medicine Residency for Stanislaus County with New Partners.

- Support among the VCME board for transition of the residency program into a community setting is unknown. Further, it is unknown what level of commitment to the VFMR board members and other stakeholders would maintain following a transition. While a few members have expressed interest in exploring community partnerships, the full extent of support is unknown.

Evaluation of Options Against Key Evaluation Dimensions

	Option 1 Retain Current VFMR for Stanislaus County	**Option 2** Retain and Expand Valley Family Medicine Residency for Stanislaus County with New Partners
Impact on Community Health	Retains residency program in community System improvements could enhance local retention and focus on safety net population	Could enhance retention of providers in safety net system.
Organizational Fit	Strong organizational fit – no other entities equipped or motivated to play this role	Retains County interest/role in residency Enhances FQHC residency role, which may create strains/ challenges for FQHC systems
Implementation / Operational Feasibility	Improvements require 1) enhanced faculty competency and 2) execution of program improvements – may require additional funding	FQHCs may not have capacity/interest to incorporate residency program but could be a negotiating point to get clinics Requires change to faculty employment arrangements – SFMG resistance certain, faculty response unknown
Financial Impact	Does not address underlying financial sustainability issues – no real options to enhance revenue – future funding uncertainty	FQHC practice setting has more sustainable financial model Likely no/limited reduction of County VFMR obligation
Political Feasibility	VCME/VFMR stakeholder interest and openness to proposed directions and improvements may vary	VCME Board support uncertain Community stakeholder support also uncertain Same SFMG opposition expected

Stanislaus County
CALIFORNIA

HSA FACILITY PLAN

HEALTH SERVICES AGENCY
Facility Plan

July 12, 2018

INDE ARCHITECTURE

INDE ARCHITECTURE

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SECTION 01

Overview and Summary of Conclusions

Overview

The intent of this document is to summarize an assessment of the Health Services Agency (HSA) facilities that was conducted as part of a long term strategic visioning and planning effort performed by Pacific Health Consulting Group with County and Health Services Agency Leadership. The facility assessment effort specifically evaluated the programming needs for each existing HSA division for the future in order to understand:

- How much space is required to support the existing HSA divisions, functions and programs in the near future.
- How the actual needs of each division compare to the existing facility size and condition.
- The relative costs for potential new facilities based on the programming effort.

This report covers:

1. Recent facility history influencing the decision to undergo an assessment.
2. The process used to assess the programming and evaluate the existing facilities.
3. General findings of the assessment, including:
    - Comparison of Existing Space Requirements vs. Programmed Space Requirements.
    - Issues associated with the aging buildings
    - Code compliance issues and concerns
    - Current efficiency of the existing spaces
    - Co-location of programs for operational efficiency

This assessment provides information regarding projected programming for current HSA functions in order to assist the County and HSA with strategic facility decisions.

Summary of Conclusions

Below is a summary of the conclusions drawn from this assessment:

- The total existing space occupied by HSA divisions significantly exceeds the amount of space that is required for the current functions by more than 100,000 SF. The difference is largely due to the use of existing owned and leased buildings that are not efficient for the HSA uses.
- The existing Public Health Building at 820 Scenic Drive is no longer suited for its current programs and the long-term needs for that division; the existing building's age and configuration limit its reuse, and therefore renovations will not achieve sufficient efficiency and compliance with current codes.

- The age of the old Scenic hospital buildings has compromised the efficiency and long term operational viability for HSA's use. Therefore, based on the condition and inefficiency of the existing buildings at County Center II (Scenic Campus), relocation of the HSA support and Administrative services and Public Health programs currently located at this site is recommended.
- The County will remain in the mandated provision of Public Health Services and various other Health Services Agency functions long term, therefore a long-term facility change is needed to correct existing inefficiencies, compliance concerns, and meet projected programming needs for the future HSA.

SECTION 02

Reasons for Assessment

The Health Services Agency (HSA) occupies a wide range of buildings of varying age and condition. Most of the County owned facilities on the Scenic Campus were old converted hospital building built between early 1940's and the 1970's. and are now extremely aged and outdated. The remaining six clinic locations are not owned by the County and are leased on varying terms.

Some spaces have been built specifically for the HSA, while others are adapted and repurposed facilities originally designed for a different use. This diversity has evolved over time as space becomes available, functions grow, buildings require repairs, and programs begin or conclude.

Recently, HSA has been forced into a series of department moves due to issues with the condition of the facilities at the main campus located at 830 Scenic Drive in Modesto. Each of these events creates an immediate crisis in which the County has reacted quickly to maintain services and operations. Notable events such as water leaks at the former Hospital building at the Scenic Campus have caused significant disruption in productivity, and challenged resources to address the immediate remedies at a high financial cost. Other sites are faced with expiring leases, which require the County to make decisions on whether to extend the lease, remodel or relocate.

These events highlight the need for an overall assessment of the existing HSA facilities, so that the HSA has an understanding of each division's projected space requirements to act as a resource in making decisions related to future facility investments, needs and planning.

The intent of evaluating the needs of each division is to be able to answer the following questions:

- Does the existing space meet the requirements of the program for projected growth now and in the foreseeable future?
- Is each existing location sized appropriately for its staff and programs?
- Are there existing conditions, such as code compliance or building age, which might inform a decision to remodel or relocate program?

The facilities assessment supports an understanding of the space needed for HSA programs and potential costs so that decisions around space planning can be made strategically. It is intended to inform proactive decisions that will:

- Support productivity of work groups through co-location where HSA divisions have been separated over time.
- Reduce investment in facilities which have higher than normal maintenance costs and potential for ongoing failures.
- Right size inefficiently sized facilities to improve application of the County's resources.

SECTION 03

Process of Evaluation

As part of the Pacific Health Consulting Group Team, INDE Architecture met with Health Services Agency (HSA) personnel and the Chief Executive Office Capital Projects Team and reviewed the process for evaluating the existing facilities. The effort extended over several months and involved the following activities:

Document Review

HSA provided electronic copies of information related to the existing facilities. The documents included:

- **Floor Plans**: the floor plans vary in level of detail and accuracy due to age and availability of historic documents. They could not be used to determine program, use, specific square footage or code compliance as the department areas were not clearly defined.
- **Leasing information:** this information tracks lease terms, options, costs, expiration dates, square footage, etc.
- **Maintenance information:** These documents related to assessments of equipment maintenance including projected hours and systems types. The information did not have sufficient detail to determine code compliance.

Facility Tour

The evaluation process commenced with a hosted site tour of several facilities within the HSA system. The tour included most buildings at the Scenic Campus, including the Central Unit, Buildings 1, 2 and 3, 1030 Scenic, Family and Pediatrics Health Center and 820 Scenic; 1533 Lakewood; Paradise Medical Office; Turlock Medical Office; Ceres Medical Office; Ceres WIC; and Specialty Clinic and Physical Therapy.

The Facility Tour was limited to a walk-through of a portion of the spaces for each location combined with a discussion with HSA staff about the building's age, use, features and challenges. The tour did not assess existing functions, infrastructure or detailed code compliance.

Department Programming

Following the Facility Tour, INDE Architecture meet with the HSA Team to review programming for each individual program, function and division. The review took place over several meetings. The process involved reviewing: the division/program function, number of staff, number of visitors, need and ability to be co-located with other HSA programs, existing location, and types of spaces required based on function. Room sizes were estimated based on industry standards, and then adjusted to match established County Standards, where applicable.

The programming was based on a projection of likely staffing and space needs over the next five years, which was estimated by the HSA staff participating in the discussion. Co-locating opportunities were

identified during the review. Based on those assumptions, the team identified potential shared resources such as receptions, conference rooms, work rooms and breakrooms that could be used by co-located departments. This efficiency was incorporated into the programming in an effort to appropriately and efficiently size spaces to reflect actual needs.

Space Summary

Assumptions for shared resources are identified in the Notes column in the individual Space Summaries included in the Appendix Section B. Separating each division into distinct facilities would require additional space, which would be inefficient and not provide optimum adjacencies for productivity and communication.

In reviewing Administration and Public Health groups, each individual room was quantified and sized to determine the net space required. A Grossing Factor was then applied to provide a Gross Departmental Square Footage. This number is appropriate for planning tenant improvement construction.

FQHC Look-Alike Clinic Sites

The Clinical Sites were reviewed differently. The programming review process did not include data on current or projected patient volume, staff efficiencies, back logs or other relevant metrics. Therefore the assessment of potential clinical programming started with the size of the existing facilities, functionality, and lease terms. Based on the site tour and input from HSA staff, an estimated grossing factor was applied for correcting code compliance issues (such as toilet sizes, door clearance, etc.) and an expansion factor. The expansion factor was based on HSA input on potential growth, desire to expand services, and/or existing patient population. This was used to evaluate move vs stay leasing scenarios.

Women, Infants & Children (WIC)

For the Women, Infants & Children (WIC) facilities, the existing size varied based on the space available. The existing facilities are located in Modesto, Oakdale, Turlock, Patterson, Ceres, and Waterford. In discussion with HSA regarding their experience with a space size that works best, it was determined that approximately 3,000 SF was the ideal size for WIC facilities. We therefore noted that all the WICs should have a projected size of 3,000 SF if a new location is opened or an existing location is to be relocated.

Deliverables

The deliverables from the programming meetings were as follows; each is included in the Appendices:

- **Overall Summary of Total Square Footage** (SF). This compares SF by HSA Division to the existing SF and past assessments that were performed.
- **Division Summaries**. This lists all groups/clinics, their current location, existing SF and the current projected square footage. The square footage is totaled and estimated costs applied for

both tenant improvement and new construction. A few notes were added to clarify issues or discrepancies.

- **Space Summaries**. Each group has a space summary spreadsheet. These provide the specific program assumptions, such as number of staff, number of private offices, toilets, breakrooms, etc. The summaries are based on a five-year projection. Adjacencies were also noted in the Space Summaries.

Process Review

Upon completion of the programming effort, the Team reviewed the draft deliverables in several follow up meetings. These review sessions were used to identify potential adjustments, or concerns to be addressed. Some of the elements that were incorporated through this review were:

- Estimated construction costs for Tenant Improvement and New Construction projects. Square footage costs were established based on market rates, similar projects, and County experience. For New Construction Costs, the Departmental Square Footages were multiplied by a Whole Building Grossing Factor to capture exterior walls, vestibules, stairs, utilities, and services unique to whole buildings. The cost per SF was also increased to account for the structure, building systems and envelope.

- For the Clinics, existing lease information was included for additional context when evaluating the summary of the clinics.

Through the effort of the entire team, the programming assessment reflects the best information available at the time in order to establish square footage projections for each group. All spreadsheet and summaries can be found in the Appendices for reference.

SECTION 04

Summary of Findings

The following is a summary of findings associated with the Health Service Agency's facilities. The findings reflect the programming for maximum efficiency of HSA divisions, as well as observations about the existing buildings, cost factors and existing conditions which should be considered in evaluating long term facility decisions.

Programming

Through the process of reviewing and establishing a projected program for all facilities, several key elements were identified:

- The total existing space occupied by HSA departments significantly exceeds the amount of space that is required. The comparison of existing space versus current projections is in the first table of Appendix A.
- Many existing rooms or spaces are inefficient. This finding is based on a comparison of the existing floor plans against the programming space requirements, such as the re-use of former hospital patient rooms as offices on the Scenic Campus.
- Co-Location could improve inefficiencies, communication, managerial oversight and productivity.
- Direct and indirect costs associated with maintaining and repair of the older existing buildings for HSA programs will continue to rise, which may make a new modern facility a more cost effective solution for the long term programs of the Health Services Agency.

The existing space is over 100,000 SF greater than the programming established through the assessment process. The primary reason for this discrepancy is the use of existing facilities not designed for the HSA use, such as many of the buildings on the Scenic Campus. The initial re-use of existing buildings is often cost effective and the quickest way to secure operating capacity. However, since the rooms were not necessarily intended for the functions that now house them, the space is often larger than needed. Odd-shaped rooms contribute to this issue. Many rooms are larger than required, and some have semi-abandoned toilets. The additional square footage eventually translates into increased maintenance and repair costs. The condition of the existing facilities is also a factor and is addressed below.

There are many divisions of the HSA that could benefit from being co-located or in closer proximity. Part of the reason these functions are not currently co-located could be associated with the recent forced moves due to building failures. It is recommended that opportunities to co-locate related groups or groups within the same service chain should be pursued to improve communication, synergy, managerial oversight and benefit from capitalizing on shared resources.

It is worth noting that we compared the programming performed during this assessment with data from recent HSA moves, such as the Central Business Office/Central Scheduling Unit/Finance/Information

Technology move to leased space at 1533 Lakewood. Our process for reviewing needs was independent of existing room sizes or floor plans. In the case of Lakewood, this programming effort very closely matched the existing square footage for that move. This indicates that the work the HSA staff performed for that move was accurate, and consistent with industry standards.

In the instance of Turlock Medical Office, the observations during the site tour were that the existing use and volume exceed the current size of the facility. As such, staff has been creative in squeezing every last inch of efficiency out of the interior. However, the site is impacted and would benefit from an increase in available capacity, as well as improvements in patient and staff workflows. It is our assessment that modifications to achieve those improvements could not be done within the existing building. Even though the facility was pleasant, attractive and staff morale was high, the recommendation is to relocate this medical office.

Existing Facility Condition

Discussion of the existing facilities featured heavily in the assessment process. Several key elements discussed were:

- Due to age and current conditions, some existing buildings represent a significant concern for ongoing use by the HSA.
- Reacting to facility events or failures results in loss of productivity, staff uncertainty, and higher operational costs.
- Due to the age and condition, many buildings cannot efficiently be modified to meet current programming goals or code requirements.
- Due to the potential increasing costs associated with ongoing maintenance for the existing buildings, a new modern facility may prove to be more cost effective for future long-term programs of the HSA.

During the site tour of the Scenic Campus, the group walked through the Central Unit to observe the conditions and aftermath from the water leak and flooding. Much of the building was not being used or could not be used at the time of the tour. Given the age of the building, issues such as accessibility compliance, hazardous material abatement and failing infrastructure are not unexpected. During the tour, exposed chilled water lines were observed to have significant rusting and corrosion. In many cases, the pipe wall might be compromised with an increased possibility of rupture. Replacement of these systems would require a significant investment and require the building to be shut down for an extended period of time. Therefore, many of the spaces are no longer suitable for the current uses for the Health Services Agency and the HSA departments should be relocated into alternate facilities in a planned move. Restoration of the existing buildings could then be planned and coordinated with other potential uses. Other buildings, such as 1030 Scenic, have experienced similar water damage and are in a similar state.

The existing building conditions create an environment of uncertainty, with staff waiting for the next system to fail. This uncertainty and the group relocations that have occurred can cause staff fatigue,

reduced morale and loss of productivity. Addressing the facility issues with the aging buildings is recommended to be the highest priority. Barring this, ongoing efforts to patch and repair the buildings will continue to increase the operational costs.

Here is a brief summary of several HSA Owned Buildings:

County Center II – Scenic Campus:

The existing Scenic Campus is comprised of 12 buildings, totaling approximately 222,000 SF. The campus originally housed the Hospital with additional wards and support buildings. When the Hospital closed in 1997, some buildings began to be adapted for different functions. Health Services Agency now occupies several buildings on the campus. Five buildings have infrastructure that is connected and dependent on the Central Plant Operations. Although the age of the buildings vary, several are old and have experienced infrastructure failures which has impacted HSA programs and functions.

820 Scenic – Public Health: (Programs include PH Clinical Services, Immunizations, Communicable Disease Prevention and Control , Community Assessment Planning and Evaluation (CAPE), Vital Records and Public Health Administration) The existing square footage matches the programming square footage for the Public Health programs. However, the configuration of the existing building factors heavily into its ability to be reused. Many rooms are oversized, the existing toilets are not accessible, and the building configuration limits how it could be reused. Because the building's shape is not regular, it is very difficult to re-use or shift the extra SF to areas that need to be enlarged. Combined with the

building age, infrastructure, and code compliance, the recommendation is for these departments to be relocated into a new facility.

830 Scenic Central Unit, Buildings 1, 2 and 3: (Programs include Administration, Human Resources and Family Health Services) This was the former central unit of the County Hospital, reused over the years since the closure of the hospital in 1997 for offices, clinics, meeting rooms and storage. Because it was originally constructed as a hospital building, the adaptability has been inefficient for more current uses. As mentioned above, the building has experienced infrastructure failures that have forced relocation of several HSA programs. The areas requiring repair also limit the ability of HSA to collocate programs to achieve maximum efficiency and effectiveness. Given the age of the facility, existing configuration and programmatic needs for the HSA administration groups, the recommendation is that it is imperative for the functions and programs to be relocated into a facility that more closely matches the operational needs for program success.

830 Scenic – Family and Pediatrics Health Center: The location has been recently refurbished. It has some remaining code and compliance issues, however given the recent completion of the site or permitted construction, it is our recommendation to continue to use this facility at its current location.

1030 Scenic: Similar to the Central Unit, this building has experienced infrastructure failures which have forced portions of the building to be unused. The size and configuration of the existing building limits the ability to reconfigure the building to adapt to different layouts or uses. This inefficiency combined with the overall age of the facility and non-compliance with accessibility requirements for patient access supports the recommendation to collocate these HSA departments with others in a different facility.

Leased Locations

Other than Women, Infant and Children (WIC) locations, HSA occupies seven leased buildings totaling approximated 94,300 SF. The majority of the leased spaces house clinics.

1533 Lakewood: This location houses Information Technology, Finance, the Central Business Office and Central Scheduling Unit. The facility was leased recently in 2017 in response to the water pipe failures at the Scenic Campus, which forced the relocation. The projected programming completed by the Facility Assessment team closely matches the actual space provided at Lakewood. Combined with the recent buildout of the space, the recommendation is that these HSA functions operate efficiently within this leased space and do not need to be relocated at this time. However, these programs would benefit from a future centralized building that could co-locate other HSA Administrative programs, which could increase efficiency and productivity. The lease extends to 2020, with two additional 5-year options.

1209 Woodrow Ave, Modesto – McHenry Medical Office (Programs include Comprehensive Primary Care, High Risk Obstetrics, Teen Clinic, Integrated Behavioral Health, Family Planning, Medical Education of Family Medicine Residents): Based on the programming review and discussion with HSA staff, the recommendation was to remain in the existing location, with operational funding to support code compliance upgrades and programmatic improvements.

3109 Whitmore Ave, Ceres – Ceres Medical Office (Programs include Comprehensive Primary Care, Low Risk Obstetrics, HIV Clinic, Integrated Behavioral Health, Family Planning, Medical Education of Family Medicine Residents): Based on the programming discussion, the location could benefit from a small increase in space with which to make programmatic improvements, such as relocating behavioral health to a central building location at this site. This location has several hundred SF of space adjacent the clinic, which could be incorporated. A recommendation was not made on whether this facility should move or stay. This was due to two primary factors. The first is the lease status, as it is our understanding that lease negotiations with the existing landlord are ongoing. The second is the overall patient volume at this location. It was unknown if the facility is running below capacity. The recommendation is for HSA to study average patient volume/flow in order to determine if it is prudent to consolidate facilities.

2412 Third Street, Hughson – Hughson Medical Office (Programs include Comprehensive Primary Care, Low Risk Obstetrics, Family Planning, Integrated Behavioral Health): Similar to Ceres medical facility, the existing patient volume was not readily available to determine if the facility is at, near or below capacity. The recommendation is for HSA to study average patient volume/flow in order to determine if it is prudent to consolidate facilities.

401 Paradise Road, Modesto – Paradise Medical Office (Programs include Comprehensive Primary Care, Low Risk Obstetrics, Family Planning, Colposcopy, Geriatrics, Integrated Behavioral Health, Medical Education of Family Medicine Residents): This size of this facility allows the potential for the facility to adapt with future changes in healthcare delivery. Given the overall size of the interior spaces, this facility appears close to compliance. Therefore, this facility could stay in the existing location.

800 Delbon Ave, Turlock – Turlock Medical Office (Programs include Comprehensive Primary Care, Low Risk Obstetrics, Family Planning, Colposcopy, Integrated Behavioral Health): It was clear based on the walk-through that the Turlock program has outgrown the original intended capacity for the space. Staff was located in circulation paths which compromises patient privacy and HIPAA regulations. Rooms are undersized, and the facility has access compliance issues. Given the current patient volume, Turlock has outgrown the current facility size. As the building is leased and given the configuration of the street an parking, there is no room for an addition or remodel to alleviate the issues; therefore the recommendation is to relocate this facility.

1524 McHenry Ave, Modesto - Specialty Clinic and Physical Therapy (Programs include Orthopedics, Medical Education of Orthopedic Resident, ENT, Sports Medicine, Urology, Podiatry, Neurology, Hepatitis C, Lump and Bumps, Minor Procedures, Special Procedures, Physical Therapy, Occupational Therapy, Wound Care, Audiology, EMG): Based on the recent relocation into this location, and adequate exam room space at the time of the walk-through, it was the recommendation that this facility should not be relocated at this time.

Code Compliance

It is our understanding that the County has undertaken a full ADA Accessibility Survey of all the facilities. It was observed during the site tour that most facilities had some level of compliance issues. The

findings in the Accessibility Survey should be factored into the long term strategic facility decisions. The Health Services Agency addresses the issues of the entire population of Stanislaus County and the accessibility compliance issues in the older buildings create barriers for accessing those services.

Cost Factors

The following are some cost factors identified during the review process that will factor into the County's long-term facility decisions.

If a facility is to remain, HSA should consider:

- Cost of maintaining aging buildings. This category includes maintaining an excessive amount of square footage, upgrading failing systems and repairs after emergency events.
- Cost of relocating staff while upgrades or repairs are performed.
- Cost of code compliance upgrades. For many buildings, this will include path of travel modifications, accessible toilets, and barrier removal.

If a facility will be relocated, HSA should consider:

- Cost of design and construction.
- Cost of property acquisition or lease negotiation.
- Cost of utilities or infrastructure for new construction.

Although a detailed cost analysis was not performed, based on our experience, many of the HSA facilities, such as Specialty Clinic and Physical Rehabilitation, Paradise Medical Office and Family and Pediatrics Health Center, were constructed and/or remodeled recently or are configured in a way that upgrades can be reasonably achieved. Therefore, a future cost analysis or comparison may support reinvestment in the existing location. However, for the older buildings such as the Central Unit, the costs to remain are likely to far exceed the cost and benefits of relocating.

CONCLUSIONS

For each Health Services Agency division, the conclusions are unique and identified below separately:

Administration:

- The total existing space occupied by HSA departments significantly exceeds the amount of space that is required for the current functions by more than 100,000 SF. The difference is largely due to the use of existing buildings that are not efficient for the HSA uses.
- The infrastructure failures due to the age of the existing buildings is an ongoing concern for the stability of the functions and programs, and has led to operational inefficiencies.
- The age of the old hospital buildings has compromised the efficiency and long term operational viability for HSA's use. Therefore, based on the condition and inefficiency of the existing

buildings at County Center II (Scenic Campus), relocation of the HSA support and Administrative services is recommended.

Therefore, the recommendation is that the Administration division should be relocated into new facilities. If a new replacement building for all the current Administrative functions is constructed, then the building would be approximately 36,000 SF and could cost $10-13 million in construction costs.

Clinics:

- Many of clinics have code or access compliance issues that the County will need to address at some point.
- The majority of the clinics are located in leased facilities; therefore considerations, such as lease duration, options, lease costs, etc., will need to be factored into any decisions on facilities.
- Renovation of existing lease facilities may not be cost effective depending upon lease terms.
- The Turlock Medical Office is undersized for the patient volume and staffing, and renovation of the existing facility could not address those issues. Therefore, the recommendation is that this clinic be relocated.

For the clinic locations, the facility assessment provided potential SF sizes for each clinic, which can be used in evaluating decisions regarding relocation. It is our understanding that there are many factors outside of the facility assessment effort, such as patient volume, operational costs, lease negotiations, etc. that will determine next steps for each clinic location.

Public Health:

- The existing Public Health Building is no longer suited for the current program and the long-term needs for that division; and the existing building's age and configuration limit its reuse, and therefore renovations will not achieve sufficient efficiency and compliance with current codes.
- The County will remain in the mandated provision of Public Health Services and various other Health Services Agency functions long term; therefore a long-term facility change is needed to correct existing inefficiencies, compliance concerns, and match projected programming needs.

Therefore, the recommendation is that the Public Health division should be relocated into a facility which meet its programming requirements and complies with current code. If a new replacement building for Public Health is pursued, it could co-locate Public Health programs including; Communicable Disease Prevention and Control (CDPC), Epidemiology (Community Assessment Planning and Evaluation Unit), Family Health Services, Children's Medical Services, California Health and Disability Prevention Program and Health Promotion in order to improve operation and program efficiencies. If those programs provide similar functions as currently offered, then the building would be approximately 40,000 - 50,000 SF and could cost $14-16 million in construction costs.

APPENDIX A

Date: 7/12/18

HSA Facility Assessment Summary

(part of the HSA Strategic Master Planning Process)

Division	Existing SF	Previous Assessments for Reference: 2016 Projections	Previous Assessments for Reference: 2017 Co-Lo Projections		Facilities Assessment CURRENT 2018 Projections
Administrative/Support	*143,643.0*	*49,250.0*	*48,650.0*		**25,574.0**
Public Health	*44,408.0*	*21,545.0*	*21,545.0*		**49,276.3**
Clinical	*98,319.0*	*0.0*	*0.0*		**104,039.0**
Totals	286,370.0	70,795.0	70,195.0		178,889.3

Review Meetings:	Attendees	Notes:
September 22, 2017	Tim Fedorchak Alisa Bettis Jason Roberts Scott Peterson (INDE) Darren Raymond-Lombardo (INDE)	Reviewed Objectives, Public Health and Clinical Service Sites
October 6, 2017	Tim Fedorchak Alisa Bettis Jason Roberts Scott Peterson (INDE) Darren Raymond-Lombardo (INDE)	Notes: Reviewed Admin Departments, and reviewed key summary points for all departments
October 13, 2018	Tim Fedorchak Alisa Bettis Jason Roberts Deborah Thrasher Scott Peterson (INDE) Patricia Hill Thomas Kathy Passanis	Notes: Reviewed Draft document
April 6, 2018	Tim Fedorchak Alisa Bettis Jason Roberts Deborah Thrasher Scott Peterson (INDE)	Notes: Reviewed final requested revisions to be incorporated into programming.

HSA Division:
Administration

Group	Current Location	Existing SF	2016 Projections	2017 Co-Location Projections	(link from "HSA Admin Dept Detail") CURRENT 2018 T.I. Projections (Usable SF)	SF for New Construction	Notes	T.I ($/SF)	Est. Construction Cost Est.T.I. Construction Cost	New Construction ($/SF)	Est. New Construction Cost
Information Technology	1533 Lakewood	3000	4400	5800	2754	3856	1	190	$523,260	290	$1,118,124
Finance	1533 Lakewood	2400	4400	4400	2160	3024	1	190	$410,400	290	$876,960
Central Business Office	1533 Lakewood	4000	4400	4400	3850	5390	1	190	$731,538	290	$1,563,181
Central Scheduling Unit	1533 Lakewood	1300	4125	4125	1296	1814	1	190	$246,240	290	$526,176
Information Technology Training Room	CU, Basement	90337	2000	2000	900	1260	2	200	$180,000	300	$378,000
Payroll	1030 Scenic, 1st Floor	Incl	550	550	322	450		190	$61,104	290	$130,570
Human Resources/Safety	1030 Scenic, Basement	Incl	2475	2475	1505	2108		190	$286,026	290	$611,192
Scenic Faculty Medical Group	Building 2 1st Floor	18408	825	825	480	672	2	225	$108,000	325	$218,400
Administration	Building 2, 2nd Floor	Incl	3575	3575	5156	7218	5	190	$979,602	290	$2,093,255
Health Coverage and Quality Services	Building 2, 2nd Floor	Incl	1925	1925	936	1310	2	190	$177,840	290	$380,016
Stanislaus Health Foundation	Building 2, 2nd Floor	Incl	275	275	144	202		190	$27,360	290	$58,464
Volunteers	Building 2, 2nd Floor	Incl	550	550	0	0	6	190	$0	290	$0
Security	Building 2, 1st Floor	Incl	550	550	0	0	7	190	$0	290	$0
Environmental Services	Building 2, Basement	Incl	6400	6400	338	473	4	150	$50,700	250	$118,300
Information Technology Server Room	CU, Basement	Incl	2000	0	360	504		250	$90,000	350	$176,400
Materials Management	MM	15760	4475	4475	2160	3024	3	150	$324,000	250	$756,000
Community Services Agency	1030 Scenic, 1st Floor	8438	6325	6325	3213	4498	3	190	$610,470	290	$1,304,478
	Subtotal	143643	49250	48650	**25574**	**35803.6**					

Reasons for Programming Differences
1. Previous project appear to have been excessive. Current projections match recently completed tenant improvements at Lakewooc
2. Previous project appears to have been excessive.
3. Previous projections were modelled after existing space. However, existing space is inefficient
4. Sterilization Function no longer a service performed for clinics at this location
5. Previous projectsion appear to not have captured potential growth.
6. Volunteers are off site, and it was discussed that they do not need workspace in a central office
7. Security is a function that is incorproated to every individual facility. If the County creates another multi-building campus, then a dedicated security space may be appropriate.

HSA Division:
Public Health

Departments	Current Location	Existing SF	2016 Projections	2017 Co_Location Projections	(link from "HSA Admin Dept Detail") CURRENT 2018 T.I. Projections (Usable SF)	SF for New Construction	Notes	T.I ($/SF)	Est. Construction Cost Est.T.I. Construction Cost	New Construction ($/SF)	Est. New Construction Cost
Communicable Disease Prevention and Control	820 Scenic	15,922	9,900	9,900	*10,122*	*14,171*	*1, 3*	250	$2,530,500	350	$4,959,780
Public Health Lab		Incl			*2,520*	*3,528*	*1*	350	$882,000	450	$1,587,600
Epidemiology (Community Assessment, Planning and Evaluation Unit)	820 Scenic	Incl	2,475	2,475	*2,100*	*2,940*	*1, 4*	250	$525,000	350	$1,029,000
Community Health Services Maternal & Child Health	Building 3, 1st Floor	8,438	8,250	8,250	*5,037*	*7,052*	*2*	250	$1,259,213	350	$2,468,057
Emergency Preparedness		Incl			*1,180*	*1,653*	*5*	250	$295,100	350	$578,396
Emergency Preparedness - Storage		Incl	920	920	*920*	*1,288*		120	$110,400	220	$283,360
Children's Medical Services		10,880			*5,847*	*8,186*	*5*	200	$1,169,370	300	$2,455,677
Health Promotion/WIC					*6,550*	*9,170*	*5*	210	$1,375,542	310	$2,842,787
WIC - Oakdale	1407 West F Street, Oakdale, CA	643			*3,000*	*4,200*	*6*	210	$630,000	310	$1,302,000
WIC - Turlock	1125 N Golden State, Turlock, CA	3,000			*3,000*	*4,200*	*6*	210	$630,000	310	$1,302,000
WIC - Patterson	66 N El Circulo, Patterson, CA	1,085			*3,000*	*4,200*	*6*	210	$630,000	310	$1,302,000
WIC - Ceres	1424 Mitchell Road, Ceres, CA	3,000			*3,000*	*4,200*	*6*	210	$630,000	310	$1,302,000
WIC Waterford	325 D Street, Waterford, CA	1,440			3,000	*4,200*	6	210	$630,000	310	$1,302,000
	Subtotal	44,408.0	21,545.0	21,545.0	49,276.3	68,986.8					

Reasons for Programming Differences
1. Existing square footage incorporates PH CAPE unit.
2. Previous projections appears to have been excessive.
3. Previous projections appear to be to low.
4. Existing SF grouped with PH CD
5. Not tracked in previous projections
6. WIC Locations all budgeted at same square footage based on what has workd for HSA

HSA Division:
Clinical

Departments	Current Location	Existing SF	CURRENT 2018 Projections	NOTES	T.I ($/SF)	Est. Construction Cost Est.T.I. Construction Cost	New Construction ($/SF)	Est. New Construction Cost
McHenry Medical Office	1209 Woodrow Ave. Modesto, CA	15323	15294	1	250	$3,823,500	350	$7,494,060
Ceres Medical Office	3109 Whitmore Ave, Ceres, CA	10116	10940	2	250	$2,735,000	350	$5,360,600
Hughson Medical Office	2412 Third Street, Hughson, CA	5000	7000	3	250	$1,750,000	350	$3,430,000
Paradise Medical Office	401 Paradise Road, Modesto, CA	27500	27500	1	250	$6,875,000	350	$13,475,000
Turlock Medical Office	800 Delbon Ave. #A, Turlock, CA	5850	8775	3	250	$2,193,750	350	$4,299,750
Specialty Clinic and Physical Therapy	1524 Mchenry Ave, Modesto, CA	19990	19990	1	250	$4,997,500	350	$9,795,100
Family and Pediatrics Health Center	830 Scenic Drive, Modesto, CA	14540	14540	1	250	$3,635,000	350	$7,124,600
	Subtotal	98319	**104039**					

Notes
1. Current projection assumes that the clinic will stay at current location.
2. Current projection assumes that the clinic will stay at current location, however it will expand into the adjacent tenant space.
3. Assume that the site will change location.
4. Adjusted clinic sizes for Accessibility and Code compliance are located in the individual space assessment for the Clinic.

Typical Grossing Factors

Department Type	Net SF to Department Gross Factor
Primary Care / Family Practice	1.4
Pediatrics	1.35
Emergency and Ambulance Services	1.45
Women's Health Clinic	1.35
Occupational Therapy Clinic	1.3
Physical Therapy	1.35
Audiology / Hearing Conservation / Speech Pathology / ENT Clinic	1.4
General and Specialty Surgical Clinics	1.4
Orthopedics / Podiatry / Chiropractic / Sports Medicine	1.35
Ophthalmology / Optometry Clinic	1.35
Urology	1.35
Specialty Medical Clinics	1.4
Cardiology / Pulmonary Services	1.35
Behavioral Health	1.4
Preventive Medicine	1.35
Dental Clinic	1.4
Nursing Units	1.5
Labor and Delivery / Obstetric Unit	1.5
Nursery	1.45
Surgery (Inpatient and Ambulatory)	1.6
Psychiatric Units	1.5
Radiology and Nuclear Medicine	1.5
Central Sterile	1.3
Food Service	1.4
Pathology	1.3
General Administration	1.4
Pharmacy	1.25
Medical and Patient Libraries and Resource Centers	1.35
Education and Planning	1.35
Information Management	1.35
Medical Administration	1.35
Logistics	1.25

Other Grossing Factors

Dept Grossing SF to Building Grossing SF	1.4
(this is used to increase Tenant Improvement square footages to New Construction square footages)	

Example Breakdown of Grossing Factor

This itemizes the grosing factors into specific areas and the assumed distribution.

Total GSF:	35%	40%	45%
Circulation	15%	20	22
Mechanical	5	5.5	6
Electrical/Data	5	5	5
Structure/Walls	7	7	8.5
Public Toilets	1.5	1.5	2
Janitors Closets	0.2	0.5	0.5
Unassigned Storage	0.3	0.5	1

Example Programming Sheet for Non-Clinical Spaces

The County and Design Facility Team reviewed each department and modified the program spaces and sizes to reflect the specific uses. Spaces were added or deleted to reflect each department. The County Space standards for workstations and offices were used and the relevant standard is noted below. Space square footages were

Programming	Size	Qty	SF	Subtotal		Notes
Private Offices (Small)	9x12		108	0		Matches County Standard PO2
Private Office (extra chairs)	10x12		120	0		Matches County Standard PO3
Private Office (with meeting	10x14		140	0		Matches County Standard PO4
Shared Offices	10x16		160	0		No Matching Standard; Provides space for two cubicles
Open Office	8'x10' Cubical		80	0		Matches County Standard for SF3; used as average size for programming
Equipment Room	10x10		100	0		
Medium Conference Rm	15x20		300	0		
Large Conference Room	15x25		375	0		
Laboratory			1800	0		
Training Room	50SF / person		50	0		
Storage Rooms	10x10		100	0		
Break Room			350	0		
Waiting	35SF / person		35	0		
Reception			80	0		
exam			120	0		
procedure rm			150	0		
admin workroom			150	0		
				0		
			Subtotal	0		
			Grossing Factor (Percentage)	35		
			Total Estimate	**0**		

APPENDIX B

Date: 7/12/18

HSA Division:

Administration

		(link from individual spreadsheet)		Assumptions
				Location
Departments	**Co-Location**	**2017 Projections**	**NOTES**	**MOVE or STAY**
Information Technology (Lakewood)	Group 1	2754	Leased Building (3 year Term, with extension)	STAY (short term)
Finance (Lakewood)	Group 1	2160		STAY (short term)
Central Business Office (Lakewood)	Group 1	3850.2		STAY (short term)
Central Scheduling Unit (Lakewood)	Group 1	1296		STAY (short term)
Information Technology Training Room	Group 1/2	900	Function does not exist in this form; should be co-located at Lakewood, but there is not enough space at that site to add this function.	NEW
Payroll	Group 2	321.6	Currently at Scenic	MOVE
Human Resources/Safety	Group 2	1505.4	Currently at Scenic	MOVE
Scenic Faculty Medical Group	Group 2	480	Currently at Scenic	MOVE
Administration	Group 2	5155.8	Currently at Scenic	MOVE
Health Coverage and Quality Services	Group 2	936	Currently at Scenic	MOVE
Stanislaus Health Foundation	Group 2	144	Currently at Scenic	MOVE
Volunteers	Group 2	0	Space incorporated with Stanislaus Health Foundation	MOVE
Security	Group 2/3	0	Space needs integrated into other site/locations SF. A dedicated security space would need to be allocated if multiple sites are centralized into a campus (such as scenic).	
Environmental Services	Grou 2/3	338	Assume that Laundry Facility would be outsourced.	
Information Technology Server Room	Group 1/2/3	360		
Materials Management	Group 2/3	2160		
Community Services Agency	Group 2	3213	Strategic Master Plan consideration is whether this CSA locations should be co-located with a clinical site. If so, where? Issue relates to relocation of services from 1030 Scenic Bldg, as clinical services have migrated from 830 Scenic Central Unit.	MOVE
Subtotal		25574		

Space Summary

Information Technology (Lakewood)

Functional Description	Moved in August 2017;	
# of Employees	20	
# of Visitors/Day	5	
Co-Location?	Yes	Finance, CBO

Programming	Size	Qty	SF	Subtotal	Notes
Private Offices (Small)	9x12		108	0	
Private Office (extra chairs)	10x12	3	120	360	
Private Office (with meeting	10x14		140	0	
Shared Offices	10x16		160	0	
Open Office	8'x10' Cubi	17	80	1360	
Computer Lab	10x12	1	120	120	
Medium Conference Rm	15x20		300	0	Shared with CBO
Large Conference Room	15x25		375	0	
Laboratory			1800	0	
Training Room	50SF / person		50	0	
Storage Rooms	10x10	1	100	100	
Break Room			350	0	Shared with CBO
Waiting	35SF / person		35	0	
Reception			80	0	
Server Room		1	100	100	
procedure rm			150	0	
admin workroom			150	0	Shared with CBO
				0	
				0	
				0	
				0	
				0	

Subtotal	2040
Grossing Factor (Percentage)	35
Total Estimate	2754 (Linked to Admin Space List)

Space Summary

Finance (Lakewood)

Functional Description
# of Employees 16
# of Visitors/Day 2 in-house visitors
Co-Location IT/CBO

Programming	Size	Qty	SF	Subtotal	Notes
Private Offices (Small)	9x12		108	0	
Private Office (extra chairs)	10x12	3	120	360	
Private Office (with meeting	10x14		140	0	
Shared Offices	10x16		160	0	
Open Office	8'x10' Cubi	13	80	1040	
Computer Lab	10x12		120	0	
Medium Conference Rm	15x20		300	0	Shared with CBO
Large Conference Room	15x25		375	0	
Laboratory			1800	0	
Training Room	50SF / person		50	0	
Storage Rooms	10x10	2	100	200	
Break Room			350	0	Shared with CBO
Waiting	35SF / person		35	0	
Reception			80	0	
exam			120	0	
procedure rm			150	0	
admin workroom			150	0	Shared with CBO
X				0	
X				0	
				0	
				0	
				0	
				0	
				0	
			Subtotal	1600	
			Grossing Factor (Percentage)	35	
			Total Estimate	2160	(Linked to Admin Space List)

Space Summary

Central Business Office (Lakewood)

Functional Description		
# of Employees	16	
# of Visitors/Day	20	External
Co-Location	Yes	

Programming	Size	Qty	SF	Subtotal	Notes
Private Offices (Small)	9x12	4	108	432	Interview/Talking
Private Office (extra chairs)	10x12	1	120	120	
Private Office (with meeting	10x14		140	0	
Shared Offices	10x16		160	0	
Open Office	8'x10' Cubi	15	80	1200	
Computer Lab	10x12		120	0	
Medium Conference Rm	15x20	1	300	300	Shared with other departments
Large Conference Room	15x25		375	0	
Building Entry		1	80	80	Security
Training Room	50SF / person		50	0	
Storage Rooms	10x10	2	100	200	
Break Room			350	0	
Waiting	35SF / pers	4	35	140	
Reception		1	80	80	
Cashier		1	150	150	Protected Space; 2 staff
procedure rm			150	0	
admin workroom		1	150	150	Shared
X				0	
X				0	
				0	
				0	
				0	
				0	
			Subtotal	2852	
			Grossing Factor (Percentage)	35	
			Total Estimate	3850.2	(Linked to Admin Space List)

Space Summary

Central Scheduling Unit (Lakewood)

Functional Description		
# of Employees	15	
# of Visitors/Day	0	
Co-Location	Yes	

Programming	Size	Qty	SF	Subtotal	Notes
Private Offices (Small)	9x12		108	0	
Private Office (extra chairs)	10x12		120	0	
Private Office (with meeting	10x14		140	0	
Shared Offices	10x16		160	0	
Open Office	8'x8' Cubica	15	64	960	
Computer Lab	10x12		120	0	
Medium Conference Rm	15x20		300	0	
Large Conference Room	15x25		375	0	
Building Entry			80	0	
Training Room	50SF / person		50	0	
Storage Rooms	10x10		100	0	
Break Room			350	0	
Waiting	35SF / person		35	0	
Reception			80	0	
Cashier			150	0	
procedure rm			150	0	
admin workroom			150	0	
X				0	
X				0	
				0	
				0	
				0	
				0	
				0	
			Subtotal	960	
			Grossing Factor (Percentage)	35	
			Total Estimate	1296	(Linked to Admin Space List)

Space Summary

Information Technology Training Room

Functional Description	EMR training for 12-15 staff
# of Employees	0
# of Visitors/Day	0
Co-Location	Locate Near EMR Trainers; needs to be co-located in facility to share restrooms, etc.

Programming	Size	Qty	SF	Subtotal	Notes
Private Offices	9x12	0	108	0	
Private Offices (Small)	10x12		120	0	
Private Office (extra chairs)	10x14		140	0	
Private Office (with meeting	10x16		160	0	
Small Conference Rm	10x10		100	0	
Open Office	8'x10' Cubical		100	0	
Medium Conference Rm	15x15		225	0	
Large Conference Room	15x20		300	0	
Storage Rooms	15x25		375	0	
Group Room	20x20		400	0	
Training Room	25SF / pers	15	50	750	
Break Room				0	
Waiting				0	
Reception	35SF / person			0	
				0	
Special Rooms:				0	
X				0	
X				0	
X				0	
				0	
				0	
				0	
				0	
			Subtotal	750	
			Grossing Factor (Percentage)	20	
			Total Estimate	900	(Linked to Admin Space List)

Space Summary

Payroll

Functional Description
# of Employees 2
# of Visitors/Day 20 In-house
Co-Location Yes

Programming	Size	Qty	SF	Subtotal	Notes
Private Offices (Small)	9x12	1	108	108	
Private Office (extra chairs)	10x12		120	0	
Private Office (with meeting	10x14		140	0	
Shared Offices	10x16	1	160	160	
Open Office	8'x10' Cubical		80	0	
Equipment Room	10x10		100	0	
Medium Conference Rm	15x20		300	0	Shared, see Administration
Large Conference Room	15x25		375	0	
Laboratory			1800	0	
Training Room	50SF / person		50	0	
Storage Rooms	10x10		100	0	
Break Room			350	0	Shared, see Administration
Waiting	35SF / person		35	0	
Reception			80	0	
exam			120	0	
procedure rm			150	0	
admin workroom			150	0	Shared, see Administration
X				0	
X				0	
				0	
				0	
				0	
				0	
				0	
			Subtotal	268	
			Grossing Factor (Percentage)	20	
			Total Estimate	321.6	(Linked to Admin Space List)

Space Summary

Human Resources/Safety

Functional Description	HR functions, recruitment, safety officer (workplace injury, work comp, safety assesment, OSHA, etc)	
# of Employees	9	
# of Visitors/Day	35	In-house with external Recruitment
Co-Location	Yes	

Programming	Size	Qty	SF	Subtotal	Notes
Private Offices (Small)	9x12	1	108	108	Interview
Private Office (extra chairs)	10x12	2	120	240	
Private Office (with meeting	10x14		140	0	
Shared Offices	10x16		160	0	
Open Office	8'x10' Cubi	7	80	560	
Equipment Room	10x10		100	0	
Medium Conference Rm	15x20		300	0	Shared, see Administration
Large Conference Room	15x25		375	0	
Laboratory			1800	0	
Training Room	50SF / person		50	0	
Storage Rooms	10x10	1	100	100	
Break Room			350	0	Shared, see Administration
Waiting	35SF / person		35	0	Shared, see Administration
Reception			80	0	Shared, see Administration
exam			120	0	
procedure rm			150	0	
admin workroom		1	150	150	
X				0	
X				0	
				0	
				0	
				0	
				0	
			Subtotal	1158	
			Grossing Factor (Percentage)	30	
			Total Estimate	1505.4	(Linked to Admin Space List)

Space Summary

Scenic Faculty Medical Group

Functional Description	Contracted Physician Group; requires space for admin.
# of Employees	3
# of Visitors/Day	10
Co-Location	

Programming	Size	Qty	SF	Subtotal	Notes
Private Offices (Small)	9x12		108	0	
Private Office (extra chairs)	10x12		120	0	
Private Office (with meeting	10x14		140	0	
Shared Offices	10x16		160	0	
Open Office	8'x10' Cubical		80	0	
Equipment Room	10x10		100	0	
Medium Conference Rm	15x20		300	0	Shared, see Administration
Large Conference Room	15x25		375	0	
Laboratory			1800	0	
Training Room	50SF / person		50	0	
Storage Rooms	10x10		100	0	
Break Room			350	0	Shared, see Administration
Waiting	35SF / person		35	0	Shared, see Administration
Reception			80	0	Shared, see Administration
exam			120	0	
procedure rm			150	0	
admin workroom			150	0	Shared, see Administration
Contracted Space		1	400	400	
X				0	
				0	
				0	
				0	
				0	
			Subtotal	400	
			Grossing Factor (Percentage)	20	
			Total Estimate	480	(Linked to Admin Space List)

Space Summary

Administration

Functional Description	Overall Admin of H.S.A
# of Employees	13
# of Visitors/Day	10
Co-Location	

Programming	Size	Qty	SF	Subtotal	Notes
Interview Room	9x12	2	108	216	
Private Office (extra chairs)	10x12	9	120	1080	
Private Office (with meeting	10x14		140	0	
Shared Offices	10x16		160	0	
Open Office	8'x10' Cubi	2	80	160	
Equipment Room	10x10		100	0	
Medium Conference Rm	15x20	2	300	600	
Large Conference Room		1	900	900	
Laboratory			1800	0	
Training Room	50SF / person		50	0	
Storage Rooms		1	50	50	
Break Room		1	350	350	
Waiting/Lobby	25SF / pers	10	25	250	
Reception		2	80	160	
exam			120	0	
procedure rm			150	0	
admin workroom		1	200	200	
X				0	
X				0	
				0	
				0	
				0	
				0	
			Subtotal	3966	
			Grossing Factor (Percentage)	30	
			Total Estimate	5155.8	(Linked to Admin Space List)

Space Summary

Health Coverage and Quality Services

Functional Description	Contract Management; Health Plan Management; Clinical Quality Review/Oversight; Manage IHCP; Risk Managemen				
# of Employees	7				
# of Visitors/Day	3				
Co-Location					
Programming	Size	Qty	SF	Subtotal	Notes
Private Offices (Small)	9x12		108	0	
Private Office (extra chairs)	10x12	4	120	480	
Private Office (with meeting	10x14		140	0	
Shared Offices	10x16		160	0	
Open Office	8'x10' Cubi	3	80	240	
Equipment Room	10x10		100	0	
Medium Conference Rm	15x20		300	0	Shared, see Administration
Large Conference Room	15x25		375	0	
Laboratory			1800	0	
Training Room	50SF / person		50	0	
Storage Rooms	10x10		100	0	
Break Room			350	0	Shared, see Administration
Waiting	35SF / person		35	0	Shared, see Administration
Reception			80	0	Shared, see Administration
exam			120	0	
procedure rm			150	0	
admin workroom			150	0	Shared, see Administration
X				0	
X				0	
				0	
				0	
				0	
				0	
				0	
			Subtotal	720	
			Grossing Factor (Percentage)	30	
			Total Estimate	936	(Linked to Admin Space List)

Space Summary

Stanislaus Health Foundation

Functional Description	Community Partnership (separate 501c3); focusing on braod determinants of health	
# of Employees	1	Shared with Volunteer Services
# of Visitors/Day	2	
Co-Location		

Programming	Size	Qty	SF	Subtotal	Notes
Private Offices (Small)	9x12		108	0	
Private Office (extra chairs)	10x12	1	120	120	
Private Office (with meeting	10x14		140	0	
Shared Offices	10x16		160	0	
Open Office	8'x10' Cubical		80	0	
Equipment Room	10x10		100	0	
Medium Conference Rm	15x20		300	0	
Large Conference Room	15x25		375	0	
Laboratory			1800	0	
Training Room	50SF / person		50	0	
Storage Rooms	10x10		100	0	
Break Room			350	0	
Waiting	35SF / person		35	0	
Reception			80	0	
exam			120	0	
procedure rm			150	0	
admin workroom			150	0	
X				0	
X				0	
				0	
				0	
				0	
				0	
				0	
			Subtotal	120	
			Grossing Factor (Percentage)	20	
			Total Estimate	144	(Linked to Admin Space List)

Space Summary

Volunteers

Functional Description
# of Employees 16 (manager is shared with SHF; volunteers have no space needs)
# of Visitors/Day 0
Co-Location

Programming	Size	Qty	SF	Subtotal	Notes
Private Offices (Small)	9x12		108	0	
Private Office (extra chairs)	10x12		120	0	
Private Office (with meeting	10x14		140	0	
Shared Offices	10x16		160	0	
Open Office	8'x10' Cubical		80	0	
Equipment Room	10x10		100	0	
Medium Conference Rm	15x20		300	0	
Large Conference Room	15x25		375	0	
Laboratory			1800	0	
Training Room	50SF / person		50	0	
Storage Rooms	10x10		100	0	
Break Room			350	0	
Waiting	35SF / person		35	0	
Reception			80	0	
exam			120	0	
procedure rm			150	0	
admin workroom			150	0	
X				0	
X				0	
				0	
				0	
				0	
				0	
				0	
			Subtotal	0	
			Grossing Factor (Percentage)	35	
			Total Estimate	0	(Linked to Admin Space List)

Space Summary

Security

Functional Description
# of Employees 2
# of Visitors/Day 20
Co-Location

Programming	Size	Qty	SF	Subtotal	Notes
Private Offices (Small)	9x12		108	0	
Private Office (extra chairs)	10x12		120	0	
Private Office (with meeting	10x14		140	0	
Shared Offices	10x16		160	0	
Open Office	8'x10' Cubical		80	0	
Equipment Room	10x10		100	0	
Medium Conference Rm	15x20		300	0	
Large Conference Room	15x25		375	0	
Laboratory			1800	0	
Training Room	50SF / person		50	0	
Storage Rooms	10x10		100	0	
Break Room			350	0	
Waiting	35SF / person		35	0	
Reception			80	0	
exam			120	0	
procedure rm			150	0	
admin workroom			150	0	
X				0	
X				0	
				0	
				0	
				0	
				0	
				0	
			Subtotal	0	
			Grossing Factor (Percentage)	35	

Total Estimate 0 (Linked to Admin Space List)

Space Summary

Environmental Services

Functional Description
# of Employees 16
# of Visitors/Day 0
Co-Location

Programming	Size	Qty	SF	Subtotal	Notes
Private Offices (Small)	9x12		108	0	
Private Office (extra chairs)	10x12		120	0	
Private Office (with meeting	10x14		140	0	
Shared Offices	10x16	1	160	160	
Open Office	8'x10' Cubical		80	0	
Equipment Room	10x10		100	0	
Medium Conference Rm	15x20		300	0	
Large Conference Room	15x25		375	0	
Laboratory			1800	0	
Training Room	50SF / person		50	0	
Storage Rooms	10x10	1	100	100	
Break Room			350	0	
Waiting	35SF / person		35	0	
Reception			80	0	
exam			120	0	
procedure rm			150	0	
admin workroom			150	0	
X				0	
X				0	
				0	
				0	
				0	
				0	
				0	
			Subtotal	260	
			Grossing Factor (Percentage)	30	
			Total Estimate	338	(Linked to Admin Space List)

Space Summary

Information Technology Server Room

Functional Description	
# of Employees	***
# of Visitors/Day	***
Co-Location	No

Programming	Size	Qty	SF	Subtotal	Notes
Private Offices (Small)	9x12		108	0	
Private Office (extra chairs)	10x12		120	0	
Private Office (with meeting	10x14		140	0	
Shared Offices	10x16		160	0	
Open Office	8'x10' Cubical		80	0	
Equipment Room	10x10		100	0	
Medium Conference Rm	15x20		300	0	
Large Conference Room	15x25		375	0	
Laboratory			1800	0	
Training Room	50SF / person		50	0	
Storage Rooms	10x10		100	0	
Break Room			350	0	
Waiting	35SF / person		35	0	
Reception			80	0	
Server Room		1	300	300	
procedure rm			150	0	
admin workroom			150	0	
X				0	
X				0	
				0	
				0	
				0	
				0	
				0	
			Subtotal	300	
			Grossing Factor (Percentage)	20	
			Total Estimate	360	(Linked to Admin Space List)

Space Summary

Materials Management

Functional Description
# of Employees 9 (1 manager, 3 purchasers, 3 couriers, 2 stockroom)
# of Visitors/Day 35
Co-Location No

Programming	Size	Qty	SF	Subtotal	Notes
Private Offices (Small)	9x12		108	0	
Private Office (extra chairs)	10x12	1	120	120	Manager also oversees Housekeeping
Private Office (with meeting	10x14		140	0	
Shared Offices	10x16		160	0	
Open Office	8'x10' Cubi	6	80	480	
Equipment Room	10x10		100	0	
Medium Conference Rm	15x20		300	0	
Large Conference Room	15x25		375	0	
Stockroom		1	1000	1000	Includes two desk spaces for stock room staff
Training Room	50SF / person		50	0	
Storage Rooms	10x10		100	0	
Break Room			350	0	
Waiting	35SF / person		35	0	
Reception			80	0	
exam			120	0	
procedure rm			150	0	
admin workroom			150	0	
X				0	
X				0	
				0	
				0	
				0	
				0	
				0	
			Subtotal	1600	
			Grossing Factor (Percentage)	35	
			Total Estimate	2160	(Linked to Admin Space List)

NOTES:
Existing MM has central sterilization function, laundry service functions. Based on discussion, sterilization functions should be integrated into each site location (not centralized), and linen service can be outsourced. Therefore, these services do not need to be allocated space in future projections.
Stockroom is for accessory items and not for operational disposable supplies for clinical sites.
Functional Area should be reviewed after strategic operational decisions are made.

Space Summary

Community Services Agency

Functional Description	CSA is county department that leases space from H.S.A. ; intent is co-location o complimentary services.
# of Employees	23
# of Visitors/Day	
Co-Location	

Programming	Size	Qty	SF	Subtotal	Notes
Private Offices (Small)	9x12		108	0	
Private Office (extra chairs)	10x12	6	120	720	
Private Office (with meeting	10x14		140	0	
Shared Offices	10x16		160	0	
Open Office	8'x10' Cubi	17	80	1360	
Equipment Room	10x10		100	0	
Medium Conference Rm	15x20		300	0	
Large Conference Room	15x25		375	0	
Laboratory			1800	0	
Training Room	50SF / person		50	0	
Storage Rooms	10x10	3	100	300	
Break Room			350	0	
Waiting	35SF / person		35	0	
Reception			80	0	
exam			120	0	
procedure rm			150	0	
admin workroom			150	0	
X				0	
X				0	
				0	
				0	
				0	
				0	
				0	
			Subtotal	2380	
			Grossing Factor (Percentage)	35	
			Total Estimate	3213	(Linked to Admin Space List)

NOTES:

Master Planning decisions need to address where CSA would be co-located if relocated from the Scenic campus; consideration of de-centralization to co-locate with clinical services might be considered.

APPENDIX C

Date: 7/12/18

HSA Division:

Public Health

Departments	Co-Location	2017 Projections (link from individual spreadsheet)	NOTES	Assumptions: Location MOVE or STAY
Communicable Disease Prevention and Control		10,122.0	Existing Building has ADA compliance issues; Is Older; and layout has efficiency issues; If Lab is relocated then department might be able to stay in current location; otherwise departments should be relocated to achieve improved use/efficiency	MOVE (see note)
Epidemiology (Community Assessment, Planning and Evaluation Unit)		2,100.0	See CD Above	
Community Health Services Maternal & Child Health		5,036.9	On Scenic	MOVE
Emergency Preparedness		1,180.4	At CC III - Temporary	MOVE
Emergency Preparedness - Storage		920.0	At CC III - Temporary	MOVE
Children's Medical Services		5,846.9	At CC III - Temporary	MOVE
Health Promotion/WIC		6,550.2	Currently, located at CSF Hacket Rd; would like to be co-located; CSF currently impacted. Program can move to different location if necessary.	STAY
WIC - Oakdale		3,000.0		Stay or Move should be based on business decisions and lease terms
WIC - Turlock		3,000.0		Stay or Move should be based on business decisions and lease terms
WIC - Patterson		3,000.0		Stay or Move should be based on business decisions and lease terms
WIC - Ceres		3,000.0		Stay or Move should be based on business decisions and lease terms
WIC Waterford		3,000.0		Stay or Move should be based on business decisions and lease terms
Public Health Lab		2,520.0		
	Subtotal	49,276.3	(linked to HSA Summary spreadsheet)	

Alternates

Departments		2017 Projections (link from individual spreadsheet)	NOTES	Assumptions: Location MOVE or STAY
Reduced Public Health Lab (due to Regionalization)		518.0	This would replace the larger Public Health Lab (2,520 SF) above	
	Subtotal	518.0	(linked to HSA Summary spreadsheet)	

Space Summary

Communicable Disease Prevention and Control

Functional Description	STD Clinic; TB Clinic; IZ Cliinic; Prevention & Outreach;	
# of Employees	36	
# of Visitors/Day	50	
Co-Location	yes	CAPE

Programming	Size	Qty	SF	Subtotal		Notes
Private Offices (Small)	9x12	5	108	540		Interview Rooms
Private Office (extra chairs)	10x12	10	120	1200		
Private Office (with meeting table)	10x14		140	0		
Shared Offices	10x16	15	160	2400		Shared Office Plus Providers shared office
Open Office	8'x10' Cubical		100	0		
Equipment Room	10x10	1	100	100		
Medium Conference Rm	15x20	1	300	300		
Large Conference Room	15x25		375	0		
Laboratory			1800	0		In separate category
Training Room	50SF / person		50	0		
Storage Rooms	10x10	3	100	300		
Break Room		1	350	350		
Waiting	35SF / person	35	20	700		
Reception		1	150	150		
exam		8	120	960		
procedure rm		1	150	150		
med storage		1	80	80		
				0		
			Subtotal	7230		
			Grossing Factor (Percentage)	40		
			Total Estimate	**10122**		(Linked to "HSA PH" List)

Space Summary

Epidemiology (Community Assessment, Planning and Evaluation Unit)

Functional Description	Epedimiologist; vital records	
# of Employees	9	
# of Visitors/Day	40	
Co-Location	yes	PH CD

Programming	Size	Qty	SF	Subtotal		Notes
Private Offices (Small)	9x12		108	0		
Private Office (extra chairs)	10x12	2	120	240		
Private Office (with meeting table)	10x14		140	0		
Shared Offices	10x16	1	160	160		
Open Office	8'x10' Cubical	7	100	700		
Equipment Room	10x10		100	0		
Medium Conference Rm	15x20		300	0		
Large Conference Room	15x25		375	0		
Laboratory			1800	0		
Training Room	50SF / person		50	0		
Storage Rooms	10x10		100	0		
Break Room			350	0		
Waiting	35SF / person	10	25	250		
Reception			150	0		
exam			120	0		
procedure rm			150	0		
Admin Workroom		1	150	150		
				0		
			Subtotal	1500		
			Grossing Factor (Percentage)	40		

Total Estimate **2100** (Linked to "HSA PH" List)

Space Summary

Community Health Services Maternal & Child Health

Functional Description	Support Program services; Community Outreach; Case Management	
# of Employees	30	
# of Visitors/Day	1	
Co-Location	Possibly	CHDP and CCS; health promotion

Programming	Size	Qty	SF	Subtotal		Notes
Private Offices (Small)	9x12	2	108	216		
Private Office (extra chairs)	10x12	2	120	240		
Private Office (with meeting t	10x14		140	0		
Shared Offices	10x16		160	0		
Open Office	8'x10' Cubical	28	80	2240		
Equipment Room	10x10	1	100	100		
Medium Conference Rm	15x20	1	300	300		
Large Conference Room	15x25		375	0		
Laboratory			1800	0		
Training Room	50SF / person		50	0		
Storage Rooms	10x10	3	100	300		
Break Room			350	0		
Waiting	35SF / person	3	35	105		
Reception		1	80	80		
exam			120	0		
procedure rm			150	0		
admin workroom		1	150	150		
				0		
			Subtotal	3731		
			Grossing Factor (Percentage)	35		
			Total Estimate	**5036.85**	(Linked to "HSA PH" List)	

Space Summary

Emergency Preparedness

Functional Description
# of Employees 6
# of Visitors/Day 5
Co-Location NO

Programming	Size	Qty	SF	Subtotal		Notes	
Private Offices (Small)	9x12	1	108	108			
Private Office (extra chairs)	10x12	1	120	120			
Private Office (with meeting t	10x14		140	0			
Shared Offices	10x16		160	0			
Open Office	8'x10' Cubical	5	80	400			
Equipment Room	10x10		100	0			
Medium Conference Rm	15x20		300	0			
Large Conference Room	15x25		375	0			
Laboratory			1800	0			
Training Room	50SF / person		50	0			
Storage Rooms	10x10	1	100	100			
Break Room			350	0			
Waiting	35SF / person		35	0			
Reception			80	0			
Coffee Bar		1	80	80		Microwave/Refrigerator	
procedure rm			150	0			
admin workroom		1	100	100			
				0			
			Subtotal	908			
			Grossing Factor (Percentage)	30			
			Total Estimate	**1180.4**	(Linked to "HSA PH" List)		

Space Summary

Emergency Preparedness - External Storage

Functional Description
# of Employees 0
# of Visitors/Day 0
Co-Location NO

Programming	Size	Qty	SF	Subtotal		Notes
Centralized Storage	20x40	1	800	800		Does not include decentralized storage
				0		
			Subtotal	800		
			Grossing Factor (Percentage)	15		

Total Estimate 920 (Linked to "HSA PH" List)

Space Summary

Children's Medical Services

Functional Description	CCS: medical casemanagement (special needs); CHDP: Health screening for peds (well-child)
# of Employees	31
# of Visitors/Day	20
Co-Location	

Programming	Size	Qty	SF	Subtotal		Notes
Private Offices (Small)	9x12	2	108	216		
Private Office (extra chairs)	10x12	2	120	240		
Private Office (with meeting t	10x14		140	0		
Shared Offices	10x16		160	0		
Open Office	8'x10' Cubical	29	80	2320		
Equipment Room	10x10		100	0		
Medium Conference Rm	15x20	1	300	300		
Large Conference Room	15x25		375	0		
Laboratory			1800	0		
Training Room	50SF / person		50	0		
Storage Rooms	10x10	5	100	500		
Break Room		1	350	350		
Waiting	35SF / person	5	35	175		
Reception		1	80	80		
exam			120	0		
procedure rm			150	0		
admin workroom		1	150	150		
				0		
			Subtotal	4331		
			Grossing Factor (Percentage)	35		
			Total Estimate	5846.85		(Linked to "HSA PH" List)

Space Summary

Health Promotion/WIC

Functional Description	Tobacco Prevention; Nutrition; Obesoity prevention; oral health; teen pregnancy; car seats; no clients in the office, mostly outside engagement.	
# of Employees	14 (Projected 16 max)	
# of Visitors/Day	0	
Co-Location	YES	With WIC Management; with PH programs.

Programming	Size	Qty	SF	Subtotal		**Notes**
Private Offices (Small)	9x12	2	108	216		Interview/Talking Room
Private Office (extra chairs)	10x12	1	120	120		
Private Office (with meeting table)	10x14		140	0		
Shared Offices	10x16	6	160	960		
Open Office	8'x10' Cubical	3	80	240		
Equipment Room	10x10		100	0		
Medium Conference Rm	15x20		300	0		Needs access to shared conference space.
Large Conference Room	15x25		375	0		
Laboratory			1800	0		
Storage	10x10	1	100	100		
Storage Rooms (outside acces for outre	12x18	1	216	216		
Break Room			350	0		Shared with co-location
Waiting	35SF / person		35	0		
Reception			80	0		
exam			120	0		
procedure rm			150	0		
admin workroom			150	0		Shared with co-location
		1	3000	3000		
WIC Hackett						
				0		
			Subtotal	4852		
			Grossing Factor (Percentage)	35		
			Total Estimate	6550.2		(Linked to "HSA PH" List)

Space Summary

Public Health - Communicable Disease/Clinical Services

Functional Description	STD Clinic; TB Clinic; IZ Cliinic; Prevention & Outreach;	
# of Employees	36	
# of Visitors/Day	50	
Co-Location	yes	CAPE

Programming	Size	Qty	SF	Subtotal		Notes
Private Offices (Small)	9x12		108	0		Interview Rooms
Private Office (extra chairs)	10x12		120	0		
Private Office (with meeting table)	10x14		140	0		
Shared Offices	10x16		160	0		Shared Office Plus Providers shared office
Open Office	8'x10' Cubical		100	0		
Equipment Room	10x10		100	0		
Medium Conference Rm	15x20		300	0		
Large Conference Room	15x25		375	0		
Laboratory		1	1800	1800		
Training Room	50SF / person		50	0		
Storage Rooms	10x10		100	0		
Break Room			350	0		
Waiting	35SF / person		20	0		
Reception			150	0		
exam			120	0		
procedure rm			150	0		
med storage			80	0		
				0		
			Subtotal	1800		
			Grossing Factor (Percentage)	40		
			Total Estimate	**2520**		(Linked to "HSA PH" List)

Space Summary

Public Health - Communicable Disease/Clinical Services

Functional Description	STD Clinic; TB Clinic; IZ Cliinic; Prevention & Outreach;	
# of Employees	36	
# of Visitors/Day	50	
Co-Location	yes	CAPE

Programming	Size	Qty	SF	Subtotal		Notes
Private Offices (Small)	9x12		108	0		Interview Rooms
Private Office (extra chairs)	10x12		120	0		
Private Office (with meeting table)	10x14		140	0		
Shared Offices	10x16		160	0		Shared Office Plus Providers shared office
Open Office	8'x10' Cubical		100	0		
Equipment Room	10x10		100	0		
Medium Conference Rm	15x20		300	0		
Large Conference Room	15x25		375	0		
Laboratory		1	250	250		
Training Room	50SF / person		50	0		
Storage Rooms	10x10		100	0		
Break Room			350	0		
Waiting	35SF / person		20	0		
Reception			150	0		
exam		1	120	120		
procedure rm			150	0		
med storage			80	0		
				0		
			Subtotal	370		
			Grossing Factor (Percentage)	40		
			Total Estimate	**518**		(Linked to "HSA PH" List)

Space Summary

Women Infant Children

1407 West F Street, Oakdale, CA

Functional Description
# of FTEs
Max Staff on Site
of Visitors/Day
# of Exam Rooms
Patients Served
Age of Facility
General Condition

APPROACH

High Level Programming	Size	Qty	SF	Subtotal	Notes
General Size of WIC Space if New				3000	
				0	
				0	
				0	
				0	
			subtotal	3000	

Existing Clinic Size	Size	Qty	SF	Subtotal	Notes
Existing Clinic					
Expansion Factor					
Code Compliance Factor					
			subtotal	0	

Specific Programming	Size	Qty	SF	Subtotal	Notes
<Rolled UP>					
			subtotal	0	

Subtotal		3000
Grossing Factor (Percentage)		0
Total Estimate	3000	(Linked to "HSA Clinical")

Space Summary

Women Infant Children

1125 N Golden State, Turlock, CA

Functional Description
# of FTEs
Max Staff on Site
of Visitors/Day
# of Exam Rooms
Patients Served
Age of Facility
General Condition

APPROACH

High Level Programming	Size	Qty	SF	Subtotal	Notes
General Size of WIC Space if New				3000	
				0	
				0	
				0	
				0	
			subtotal	3000	

Existing Clinic Size	Size	Qty	SF	Subtotal	Notes
Existing Clinic					
Expansion Factor					
Code Compliance Factor					
			subtotal	0	

Specific Programming	Size	Qty	SF	Subtotal	Notes
<Rolled UP>					
			subtotal	0	
			Subtotal	3000	
			Grossing Factor (Percentage)	0	
			Total Estimate	3000	(Linked to "HSA Clinical")

Space Summary

Women Infant Children

66 N El Circulo, Patterson, CA

Functional Description
# of FTEs
Max Staff on Site
of Visitors/Day
# of Exam Rooms
Patients Served
Age of Facility
General Condition

APPROACH

High Level Programming	Size	Qty	SF	Subtotal	Notes
General Size of WIC Space if New				3000	
				0	
				0	
				0	
				0	
			subtotal	3000	

Existing Clinic Size	Size	Qty	SF	Subtotal	Notes
Existing Clinic					
Expansion Factor					
Code Compliance Factor					
			subtotal	0	

Specific Programming	Size	Qty	SF	Subtotal	Notes
<Rolled UP>					
			subtotal	0	

Subtotal		3000
Grossing Factor (Percentage)		0
Total Estimate	3000	(Linked to "HSA Clinical")

Space Summary

Women Infant Children

1424 Mitchell Road, Ceres, CA

Functional Description
# of FTEs
Max Staff on Site
of Visitors/Day
# of Exam Rooms
Patients Served
Age of Facility
General Condition

APPROACH

High Level Programming	Size	Qty	SF	Subtotal	Notes
General Size of WIC Space if New				3000	
				0	
				0	
				0	
				0	
			subtotal	3000	

Existing Clinic Size	Size	Qty	SF	Subtotal	Notes
Existing Clinic					
Expansion Factor					
Code Compliance Factor					
			subtotal	0	

Specific Programming	Size	Qty	SF	Subtotal	Notes
<Rolled UP>					
			subtotal	0	

Subtotal		3000
Grossing Factor (Percentage)		0
Total Estimate	3000	(Linked to "HSA Clinical")

Space Summary

Women Infant Children

325 D Street, Waterford, CA

Functional Description
# of FTEs
Max Staff on Site
of Visitors/Day
# of Exam Rooms
Patients Served
Age of Facility
General Condition

APPROACH

High Level Programming	Size	Qty	SF	Subtotal	Notes
General Size of WIC Space if New				3000	
				0	
				0	
				0	
				0	
			subtotal	3000	

Existing Clinic Size	Size	Qty	SF	Subtotal	Notes
Existing Clinic					
Expansion Factor					
Code Compliance Factor					
			subtotal	0	

Specific Programming	Size	Qty	SF	Subtotal	Notes
<Rolled UP>					
			subtotal	0	
			Subtotal	3000	
		Grossing Factor (Percentage)			
			Total Estimate	3000	(Linked to "HSA Clinical")

APPENDIX D

Date: 7/12/18

HSA Division:

Clinical Services

Departments	Location	Existing SF	2018 Projections (link from individual spreadsheet)	NOTES	Assumptions: Should this facility MOVE or STAY	Existing Leasing Information: Lease Start	Lease End	Max Lease End with Current Extentions	Annual Lease Costs	Lease Cost/SF
McHenry Medical Office	1209 Woodrow Ave. Modesto, CA	15323	15294	Facility to Remain; May need to allocate budget for future remodel due to process changes	STAY	2/8/2004	2/7/2019	2/7/2029		$1.99/SF
Ceres Medical Office	3109 Whitmore Ave, Ceres, CA	10016	10940	Current Leases is expired. Therefore, option to stay or move is tied to lease negotiation.	STAY/MOVE	4/16/1999	4/15/2014	4/15/2024*		$1.79/SF
Hughson Medical Office	2412 Third Street, Hughson, CA	5000	7000	This assumes relocation after the lease is up. If HMO stays then tthis number would be 5000 sf.	Move (See Note)	10/14/1997	10/14/2018	10/14/2028		$1.29/SF
Paradise Medical Office	401 Paradise Road, Modesto, CA	27500	27500	Assumes the location would stay; any work would be interior remodel only for changing process)	STAY	11/21/2000	11/20/2020	11/20/2030		$2.22/SF
Turlock Medical Office	800 Delbon Ave. #A, Turlock, CA	5850	8775	Facility is tight and at limit of capacity; there are accessiblility issues and dense work environment.	MOVE	4/1/2016	3/31/2018	3/31/2019		$1.63/SF
Specialty Clinic and Physical Therapy	1524 Mchenry Ave, Modesto, CA	19990	19990	New; will not be moved	STAY	2/21/2017	2/20/2027	2/20/2037		$2.10/SF
Family and Pediatrics Health Center	830 Scenic Drive, Modesto, CA	14540	14540	Recently refurbished location; if relocated then site should increase to approximately 16,400	STAY	County Owned				
	Subtotal	98219	104039	(linked to HSA Summary spreadsheet)						

Space Summary

McHenry Medical Office

Functional Description	Family Medicine, Family Planning and Woman's Health; Residency; IBH (one licensed Social Worker)
# of FTEs	
# Max Staff on Site	
# of Visitors/Day	
# of Exam Rooms	18 exam; 6 consult; 2 procedure
# Patients Served	
Age of Facility	
General Condition	Generally in good condition with functioning layout.

APPROACH

High Level Programming	Size	Qty	SF	Subtotal	Notes
				0	
				0	
				0	
				0	
				0	
			subtotal	0	

Existing Clinic Size	Size	Qty	SF	Subtotal	Notes
Existing Clinic		1	15294	15294	
Expansion Factor					Not Owned
Code Compliance Factor					Mostly ok; no expansion to accommodate improvements
			subtotal	15294	

Specific Programming	Size	Qty	SF	Subtotal	Notes
<Rolled UP>					
			subtotal	0	
			Subtotal	15294	
		Grossing Factor (Percentage)		0	EXISTING FACILItY TO REMAIN
			Total Estimate	15294	(Linked to "HSA Clinical")

Space Summary

Ceres Medical Office

Functional Description	Family Medicine; HIV Clinic
# of FTEs	
# Max Staff on Site	
# of Visitors/Day	
# of Exam Rooms	12 exam; 2 procedure (will repurpose two exam rooms for preventaive dental)
# Patients Served	
Age of Facility	End of Lease
General Condition	Good Condition; Inefficient pod layout; has vacant space that needs repurposing; LCSW is remote, and should be integrated

APPROACH

High Level Programming	Size	Qty	SF	Subtotal	Notes
				0	
				0	
				0	
				0	
				0	
			subtotal	0	

Existing Clinic Size	Size	Qty	SF	Subtotal	Notes
Existing Clinic		1	10116	10116	There is currently underutilized space on-site which could be used to increase exam rooms, or reconfigure for a change in delivery approach.
Expansion Factor		1	824	824	Take over the AMR space
Code Compliance Factor					
			subtotal	10940	

Specific Programming	Size	Qty	SF	Subtotal	Notes
<Rolled UP>					
			subtotal	0	

Subtotal	10940
Grossing Factor (Percentage)	0
Total Estimate	10940 (Linked to "HSA Clinical")

Space Summary

Hughson Medical Office

Functional Description
# of FTEs
Max Staff on Site
of Visitors/Day
# of Exam Rooms
Patients Served
Age of Facility
General Condition

APPROACH

High Level Programming	Size	Qty	SF	Subtotal	Notes
				0	
				0	
				0	
				0	
				0	
			subtotal	0	

Existing Clinic Size	Size	Qty	SF	Subtotal	Notes
Existing Clinic		1	5000	5000	
Expansion Factor				2000	
Code Compliance Factor					
			subtotal	7000	

Specific Programming	Size	Qty	SF	Subtotal	Notes
<Rolled UP>					
			subtotal	0	

Subtotal		7000
Grossing Factor (Percentage)		0
Total Estimate	7000	(Linked to "HSA Clinical")

Space Summary

Combine Ceres & Hughson

Functional Description	Family Medicine; HIV Clinic
# of FTEs	
# Max Staff on Site	
# of Visitors/Day	
# of Exam Rooms	12 exam; 2 procedure (will repurpose two exam rooms for preventaive dental)
# Patients Served	
Age of Facility	End of Lease
General Condition	Good Condition; Inefficent pod layout; has vacant space that needs repurposing; LCSW is remote, and should be integrated

APPROACH

High Level Programming	Size	Qty	SF	Subtotal	Notes
				0	
				0	
				0	
				0	
				0	
			subtotal	0	

Existing Clinic Size	Size	Qty	SF	Subtotal	Notes
Existing Clinic			13000	13000	
Expansion Factor					
Code Compliance Factor					
			subtotal	13000	

Specific Programming	Size	Qty	SF	Subtotal	Notes
<Rolled UP>					
			subtotal	0	

Subtotal		13000
Grossing Factor (Percentage)		0
Total Estimate	13000	(Linked to "HSA Clinical")

Space Summary

Paradise Medical Office

Functional Description
# of FTEs
Max Staff on Site
of Visitors/Day
# of Exam Rooms
Patients Served
Age of Facility
General Condition

APPROACH

High Level Programming	Size	Qty	SF	Subtotal	Notes
				0	
				0	
				0	
				0	
				0	
			subtotal	0	

Existing Clinic Size	Size	Qty	SF	Subtotal	Notes
Existing Clinic				27500	
Expansion Factor					
Code Compliance Factor					
			subtotal	27500	

Specific Programming	Size	Qty	SF	Subtotal	Notes
<Rolled UP>					
			subtotal	0	

Subtotal		27500
Grossing Factor (Percentage)		0
Total Estimate	27500	(Linked to "HSA Clinical")

Space Summary

Turlock Medical Office

Functional Description
# of FTEs
Max Staff on Site
of Visitors/Day
# of Exam Rooms
Patients Served
Age of Facility
General Condition

APPROACH

High Level Programming	Size	Qty	SF	Subtotal	Notes
				0	
				0	
				0	
				0	
				0	
			subtotal	0	

Existing Clinic Size	Size	Qty	SF	Subtotal	Notes
Existing Clinic				5850	
Expansion Factor		0.4	5850	2340	
Code Compliance Factor		0.1	5850	585	
			subtotal	8775	

Specific Programming	Size	Qty	SF	Subtotal	Notes
<Rolled UP>					
			subtotal	0	

Subtotal		8775
Grossing Factor (Percentage)		0
Total Estimate	8775	(Linked to "HSA Clinical")

Space Summary

Specialty Clinic and Physical Therapy

Functional Description	ortho; ortho residency; urology; cardio; PT/OT;
# of FTEs	
# Max Staff on Site	
# of Visitors/Day	
# of Exam Rooms	
# Patients Served	
Age of Facility	New; Up to code.
General Condition	Good

APPROACH

High Level Programming	Size	Qty	SF	Subtotal	Notes
				0	
				0	
				0	
				0	
				0	
			subtotal	0	

Existing Clinic Size	Size	Qty	SF	Subtotal	Notes
				19990	Recently constructed; Leased; unlikely to relocate or revise
Existing Clinic Expansion Factor					
Code Compliance Factor					
			subtotal	19990	

Specific Programming	Size	Qty	SF	Subtotal	Notes
<Rolled UP>					
			subtotal	0	

Subtotal	19990	
Grossing Factor (Percentage)	0	
Total Estimate	19990	(Linked to "HSA Clinical")

Space Summary

Family and Pediatrics Health Center

830 Scenic Drive, Modesto, CA

Functional Description	
# of FTEs	
# Max Staff on Site	
# of Visitors/Day	
# of Exam Rooms	26 exam; 1 IZ; 1 procedure
# Patients Served	
Age of Facility	Recently Remodeled; not connected to central plant
General Condition	Good

APPROACH

High Level Programming	Size	Qty	SF	Subtotal	Notes
				0	
				0	
				0	
				0	
				0	
			subtotal	0	

Existing Clinic Size	Size	Qty	SF	Subtotal	Notes
Existing Clinic				14540	If relocated, then size could be approximated 16,400 SF
Expansion Factor			400		
Code Compliance Factor	0.1	14540	1454		
			subtotal	14540	

Specific Programming	Size	Qty	SF	Subtotal	Notes
<Rolled UP>					
			subtotal	0	
			Subtotal	14540	
			Grossing Factor (Percentage)	0	
			Total Estimate	14540	(Linked to "HSA Clinical")

STANISLAUS COUNTY CAPITAL PROJECTS

CHANGE ORDER NO. 02

PROJECT: HEALTH SERVICES AGENCY
COMPREHENSIVE STRATEGIC VISIONING PROJECT

CONSULTANT: PACIFIC HEALTH CONSULTING GROUP

DESCRIPTION OF WORK REQUESTED:

Request for Proposal processes including, but not limited to, evaluation, meetings, public hearings and interviews. Not to exceed 342 hours at the contractual rate. **Approved by the Board of Supervisors on July 17, 2018 in Item 7.3.**

CROSS-REFERENCE INFORMATION:

RFC No. N/A SI No. N/A
COR No. N/A RFQ No. N/A
CP No. N/A CD No. N/A

CONSULTANT AGREES: TO FURNISH ALL LABOR, MATERIALS AND EQUIPMENT AND PERFORM ALL WORK REQUIRED TO COMPLETE THE ABOVE-DESCRIBED WORK CHANGE IN ACCORDANCE WITH THE REQUIREMENTS FOR WORK COVERED BY THE CONTRACT FOR THE STATED CONSIDERATION. CONSULTANT AGREES TO PERFORM THE ABOVE-DESCRIBED CHANGES FOR THE AMOUNT AND WITHIN THE TIME INDICATED. NO WORK WILL BE STARTED UNTIL THIS CHANGE ORDER IS PROCESSED UNLESS OTHERWISE DIRECTED THROUGH CHANGE DIRECTIVE.

CONSULTANT: BJ Wunsch **DATE:** 4-17-19	**THIS CHANGE: ADD** X **DEDUCT** ___ $85,500.00
COUNTY: [signature] **DATE:** 4/18/19	**REVISED DATE OF COMPLETION:** Upon Completion of all Work
PAGE 1 **OF** 1	

Stanislaus County Board of Supervisors
July 17, 2018

Approval of the Health Services Agency (HSA) Strategic Visioning Business and Facility Plan as Recommended by Pacific Health Consulting Group and Related Actions to Implement the Plan Regarding Future Scope of HSA Programs and Future Facility Plans

Patricia Hill Thomas
Stanislaus County
Chief Operations Officer

There are risks and costs to a program of action. But they are far less than the long range risks and costs of comfortable inaction.

John F. Kennedy

1940

A - B. Unit - Stanislaus County Hospital

Previous Board Actions

- March 22, 2016: Approved the Issuance of a Request for Qualifications and Proposals for a Comprehensive Health Services Strategic Business and Facility Plan
- February 28, 2017: Approval to Select Pacific Health Consulting Group for the Work
- Today: July 17, 2018:Apporval of the HSA Strategic Visioning Business and Facility Plan as Recommended by Pacific Health Consulting Group

Mary Ann Lee

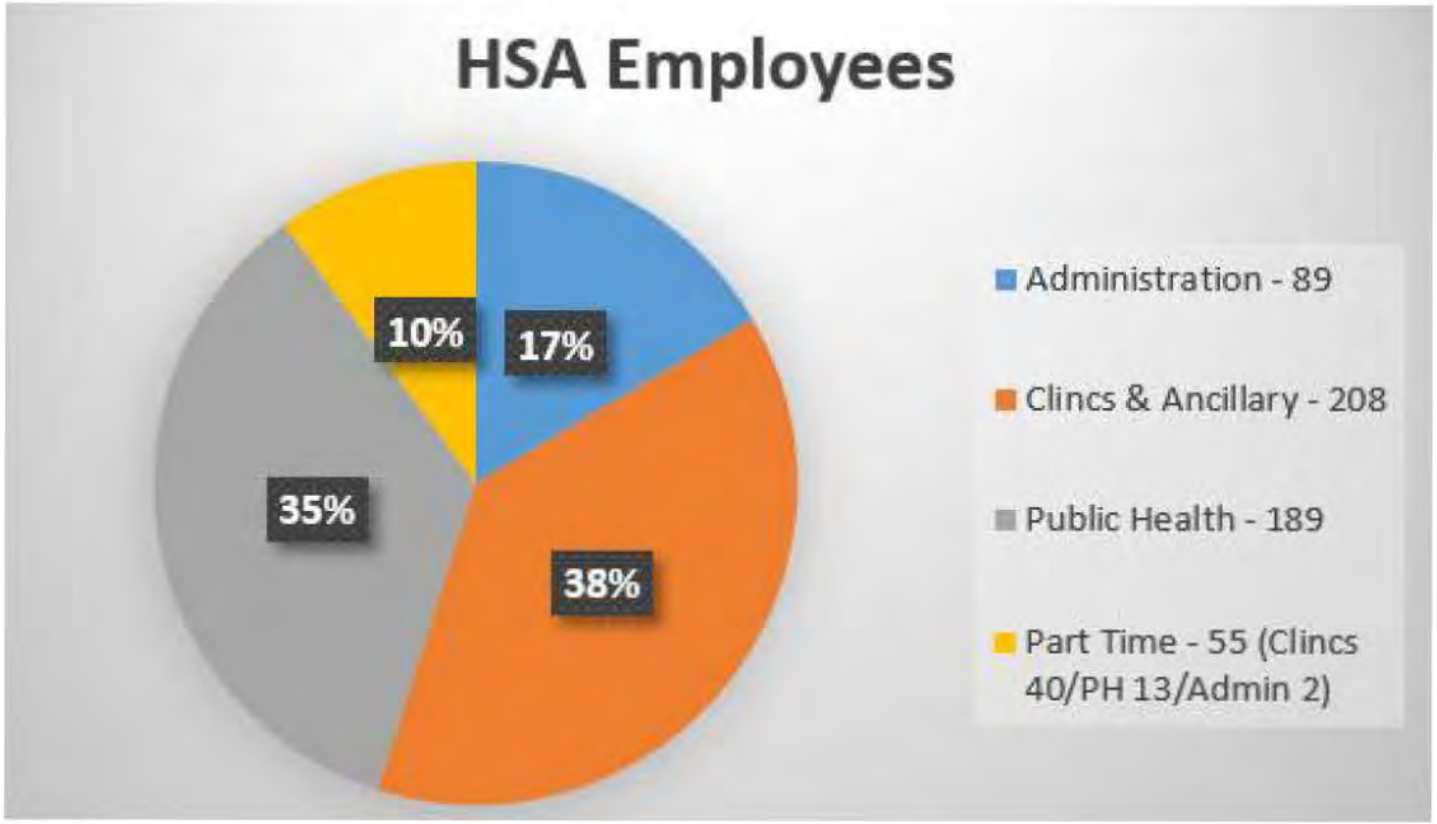
Health Services Agency

Managing Director

Stanislaus County

Striving to be the Best

Background


HSA Employees
10%
17%
35%
38%
Administration - 89
Clincs & Ancillary - 208
Public Health - 189
Part Time - 55 (Clincs 40/PH 13/Admin 2)

HSA Public Health

- 820 Scenic Drive
  - Public Health – Clinical Services (PH)
  - Community Assessment Planning & Evaluation (CAPE)
- 830 Scenic Drive (HSA Main Campus)
  - Community Health Services (CHS)
- 917 Oakdale Road (County Center III)
  - Children's Medical Services (CMS/CCS/CHDP)
  - Emergency Preparedness (EP)
- 1325 Sonoma Avenue (Sonoma School)
  - Medical Therapy Unit (MTU)
- Health Promotions/WIC (HP)
  - Modesto – 251 East Hackett Road
  - Ceres – 1424 Mitchell Road
  - Oakdale – 1405 W. F Street
  - Patterson – 101 W. Las Palmas Ave
  - Turlock – 1125 N. Golden State Blvd Suite # A & B
  - Waterford – 325 D Street #2

HSA Clinics & Ancillary

- Ceres Medical Office (CMO)
- Family & Pediatric Health Center (FPHC)
- Hughson Medical Office (HMO)
- McHenry Medical Office (MMO)
- Specialty Clinics (SPEC)/Physical Therapy (PT)
- Paradise Medical Office (PMO)
- Turlock Medical Office (TMO)

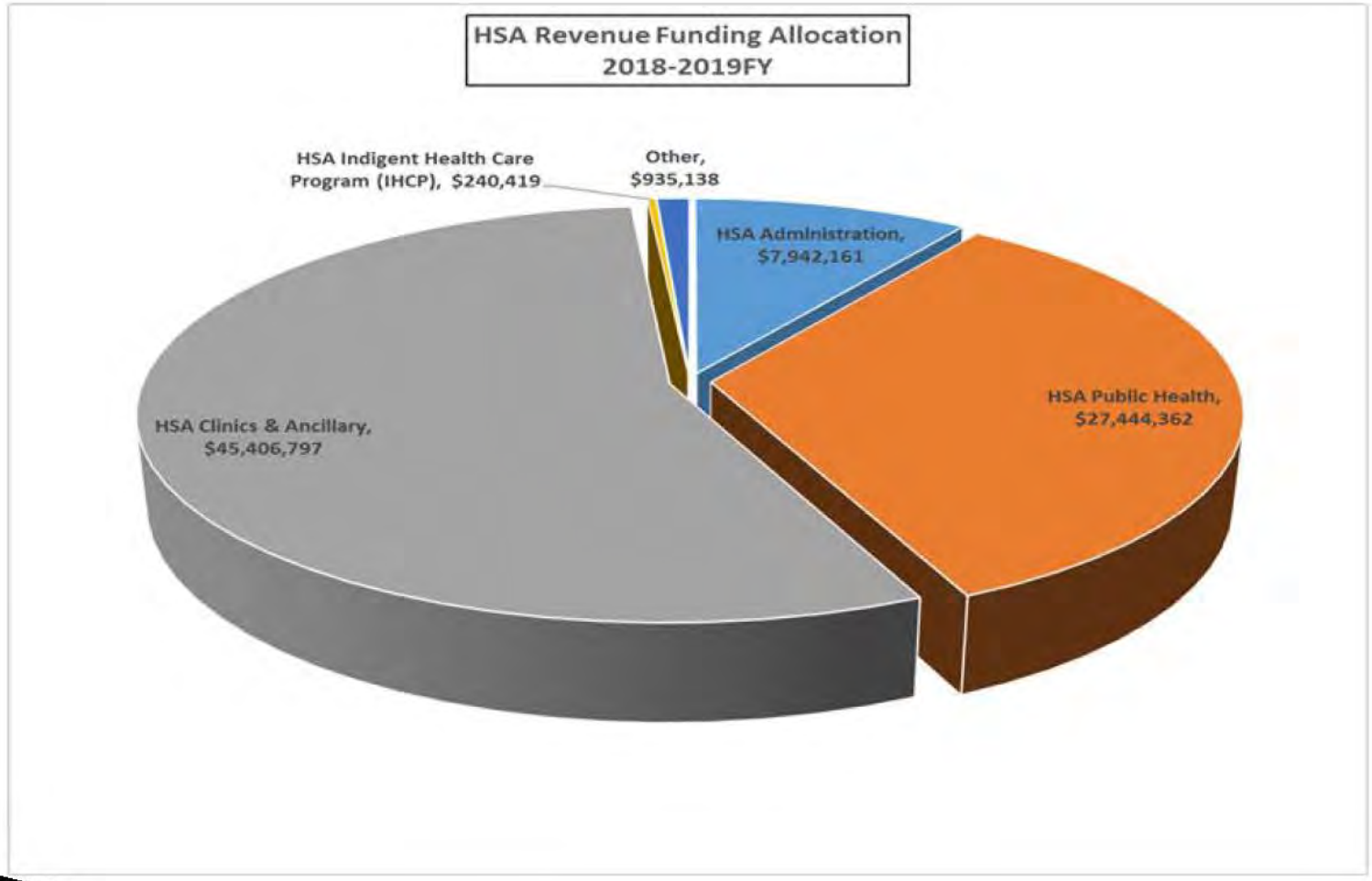
HSA Administration

★ 830 Scenic Drive (HSA Main Campus):
- Administration (Admin)
- Environmental Services (ES)
- Planning and Quality Services
- Human Resources/Safety (HR)
- Materials Management (MM)

★ 1533 Lakewood Avenue
- Central Business Office (CBO)/
- Central Scheduling Unit (CSU)
- Finance
- Information Technology (IT)

Fiscal Impact

HSA FY 18/19 Budget is approx. $82 million



Why do a Visioning Process?

1. Strong organizations periodically reassess and retool
2. Facilities are failing and poorly meeting service needs

Why do a Visioning Process?

- Deteriorating and Inefficient Buildings – an increasing resource distraction
  - Health Services Agency main campus 820-1030 Scenic Drive, Modesto: former county hospital site
  - Buildings constructed between 1940's and 1970's (Scenic only)
  - Not designed for today's functions, workarounds inefficient in many cases
  - Security more challenging due to design
  - Repairs often require abatement, more expensive and cause longer business interruptions. Failures caused urgent and temporary relocations of some functions off the Scenic campus, fragmenting the operation.

Why do a Visioning Process?

- Changing healthcare environment and County responsibilities prompted by Affordable Care Act
  - Limited/Zero Medically Indigent Adults due to State Medi-Cal Expansion
    - Pre-recession Approx. 6,000 annual enrollees
    - Recession Approx. 9,000 annual enrollees
    - Since Jan 2014 Medi-Cal expansion: < 15 enrollees
  - Doctors Medical Center 20 year agreement Dec 1997 – Nov 2017 *

Why do a Visioning Process?

- Increasing workforce recruitment/retention challenges
- County clinic volumes continually trending down, costs rising
- Community/Population Health statistics concerning – Public Health mandated role

Strategic Vision, Business and Facility Plan Needed

- Purpose was not a typical “3-Year Strategic Plan”, rather a broad look at opportunities, scope, and priorities, for Board of Supervisor consideration and policy decisions including a facility plan.

Six Chosen Topic Areas – Why and What

Considered all the programs, services, and systems

- Is it mandated or discretionary
- Is it working well
- Do we anticipate changes in the future
- Is there a weakness to be addressed
- Is there an opportunity for improvement

Used this process to narrow down areas we should focus on

If it's not on the list it DOESN'T mean that its not important!

The Six Topics of Focus

1. Public Health: Health Data Analytics and Culture of Quality Improvement
2. Public Health: Community Clinical Services and Other Programming Integration
3. Public Health Laboratory
4. Public Health: Emergency Medical Services Agency
5. Primary Care, Specialty and Physical Rehabilitation Clinics
6. Valley Family Medicine Residency Program

1. Health Data Analytics and Culture of Quality Improvement

Situation: Area for organizational improvement. Lack capacity and supported system for consistent, timely and accessible community health data. Data needs for effective organizational outcomes management.

2. Community Clinical Services and other programming integration

Situation: Opportunities for more collaboration on planning and health improvement interventions with the medical offices/clinics and with Behavioral Health and Recovery Services

3. Public Health Laboratory

Situation: Statewide shortage of Public Health Lab Directors – counties sharing Directors under differing models. Ours is of limited size for efficiency, volume variability and funding for equipment as technology advances. Currently dependent on another county for some volume of testing while determining future model.

4. Emergency Medical Services Agency

Situation: Currently in a 5-county Joint Powers Agency, with 4 small mountain counties. Project was to analyze whether this was the best model to serve the County needs, given opportunities and changes in the medical first response environment.

5. Primary Care, Specialty and Physical Rehabilitation Clinics

Situation: Currently operate 6 primary care clinics which are Federally Qualified Health Center Look-Alike designated, a Specialty clinic and a Physical Rehabilitation clinic. Not a required county service, but a long tradition of direct care delivery. Visit volumes are down largely due to the physician shortage. An increasing amount of County General Fund is required to balance this budget. Primary Care clinics under shared governance with Community Health Center Board (required for FQHC-LA).

6. Valley Family Medicine Residency Program

Situation: Decades-long history of training. Invested in new/replacement program in 2010 to meet a federal requirement, including establishment of non-profit Valley Consortium for Medical Education. The program boasts approximately 30% after-graduation retention rate for the community. Faculty physician retention attributed to desire to teach.

Bobbie Wunsch
Founder and Partner
Pacific Health Consulting Group

Stanislaus County
Striving to be the Best

Strategic Visioning Process (March 2017 – June 2018)

DELIVERABLES

- Health Environmental Scan evaluating community health outcomes and needs
- Strengths, Weaknesses, Opportunities and Constraints (SWOC) analysis of the Health Services Agency
- Strategic Visioning Report outlining 10-Year Strategic Vision and Topical Memos on 6 Strategic Issues
- Facility Plan Report

Strategic Visioning Process

ACTIVITIES

- 10+ Planning Sessions with Health Services Agency "Visioning Team" to complete SWOC analysis and develop Strategic Vision
- 15 Key Informant Interviews
- HSA management focus group (23 participants)
- HSA FQHC Look-Alike Board of Directors Focus Group
- Community Data Profile and Needs Assessment
- Intensive analysis of 6 strategic issues/topics within HSA to assess current performance and characteristics, potential future options and evaluation of each option against key criteria
- Review and evaluation of HSA facilities

Health Environmental Scan Key Findings

- **Substance use and mental health**
- **Access to timely health care services**
- **High community prevalence and impact of chronic disease**
- **Community factors like poverty, education, community safety and the physical/built environment** significantly impact community health

Stakeholder Feedback

- Well-regarded for its historically strong role in fulfilling core public health department responsibilities
- Lack of awareness about HSA's community health priorities
- Interest in a bigger HSA leadership role and focus on prevention/early intervention, population health and the social determinants of health
- Importance of building the primary care workforce/capacity in the community but some question the role of HSA as a direct clinical services provider

Key Findings

- There is a lack of integration both within HSA (e.g. between clinical services and public health) and between HSA services and other county agencies (e.g. Behavioral Health and Recovery Services);
- Limitations on data systems and staffing have impacted the ability of HSA to promote integration, quality and efficiency across the organization;
- Challenges recruiting and retaining staff and medical providers is a persistent and significant challenge impacting the ability of HSA to provide direct clinical services and advance its public health strategic initiatives.

HSA Strategic Visioning
10-Year Vision Statement

"Over the next ten years, the Health Services Agency (HSA) will invest in transformative change into a system that explicitly focuses on **prevention and population health**. While maintaining mandated and essential individual services and programs, HSA will prioritize efforts that address the socio-economic factors and individual behaviors that shape the health of community residents and can lead to meaningful improvement in the health of the community. This will require transformative change in the organizational mindset, practices, infrastructure, skill sets and resources of the agency."

Topical Memos on Strategic Issues

1. Public Health: Health Data Analytics and the Culture of Quality Improvement
2. Public Health: Community Clinical Services and Other Programming Integration
3. Public Health Laboratory
4. Public Health: Emergency Medical Services (EMS)
5. Primary Care, Specialty and Physical Rehabilitation Clinics
6. Valley Family Medicine Residency Program

Memo Components

- ✓ Current performance, including strengths/weaknesses and comparison to similar entities
- ✓ Trends in the field
- ✓ Potential future options/pathways
- ✓ Evaluation of options against key criteria
- ✓ Key findings to inform HSA 2-year recommendations to the Board of Supervisors

Public Health: Health Data Analytics and the Culture of Quality

Major Findings:

- Current data systems are fragmented and limited; Quality and Data staff are unable to move beyond executing basic responsibilities
- Current quality efforts are siloed; HSA has not yet developed a shared understanding of quality or forums to achieve an aligned agency-wide quality strategy
- Quality initiatives compete with other priorities for resources and attention

Public Health: Health Data Analytics and the Culture of Quality

Options Evaluated:

1. Build a foundation by establishing a quality and data platform for the future
2. Complete #1 and institute an agency-wide Population Health Initiative
3. Complete #1 and #2 and implement a community-wide Population Health Initiative

Public Health: Health Data Analytics and the Culture of Quality

Recommendations:

1. Implement a Community-Wide Population Health Initiative.

2. Expand Data and Quality Foundation. Strengthen HSA's health and organizational information gathering capabilities and systems

Public Health: Community Clinical Services and Other Programming Integration

Major Findings:

- Many communities are pursuing integrated clinical and public health strategies
- Community health priorities like cardiovascular morbidity/mortality, diabetes prevention, smoking cessation maternal child health and opioid overdose prevention are examples of community health priorities that can be effectively addressed
- Integration conversations have begun between HSA and BHRS

Public Health: Community Clinical Services and Other Programming Integration

Options Evaluated:

1. Support Community Health Objectives through coordination of existing HSA Programs in Public Health Services and Clinical Operations

2. Expand the focus of coordination of public health with behavioral health clinical interventions to improve community health objectives to a larger segment of the population

Public Health: Community Clinical Services and Other Programming I Integration

Recommendations:

1. **Coordinated Public Health and Clinical Service Interventions.**

2. **HSA-BHRS Collaboration**

Public Health Laboratory

Major Findings:

- Rapid changes in lab technologies, coverage and reimbursement
- Critical shortage of qualified lab directors
- Declining testing volumes and revenue are likely to continue; operations are vulnerable to staffing changes due to small size; acquiring new technologies would be challenging and expensive
- A regional model could offer important advantages including stability, greater access to advanced testing and potentially favorable economics and efficiencies of scale

Public Health Laboratory

Options Evaluated:

1. Retain Local Stanislaus County Public Health Lab Model
2. Retain Local Stanislaus County Public Health Lab Model with increased testing volumes and/or lowered costs
3. Join a Regional Public Health Lab Model

Public Health Laboratory

Recommendations:

1. **Regional Lab Partnership.** Explore a regional Public Health Laboratory model in FY18-19 with partner county(ies) while maintaining local intake.

Public Health: Emergency Medical Services

Major Findings:

- Stanislaus County needs to ensure adequate leadership and resources for effective EMS services
- Opportunities exist within current structure to address the above
- Shifting to a single-county, new 2-county or multi-county agency presents important operational challenges and could result in increased net county costs

Public Health: Emergency Medical Services

Options Evaluated:

1. Continue as Regional MVEMS Member and Address Current Concerns
2. Form a Single County EMS Agency
3. Form a New Stanislaus County-Operated Multi-County EMS Agency
4. Form a New 2-County EMS Agency

Public Health: Emergency Medical Services

Recommendations:

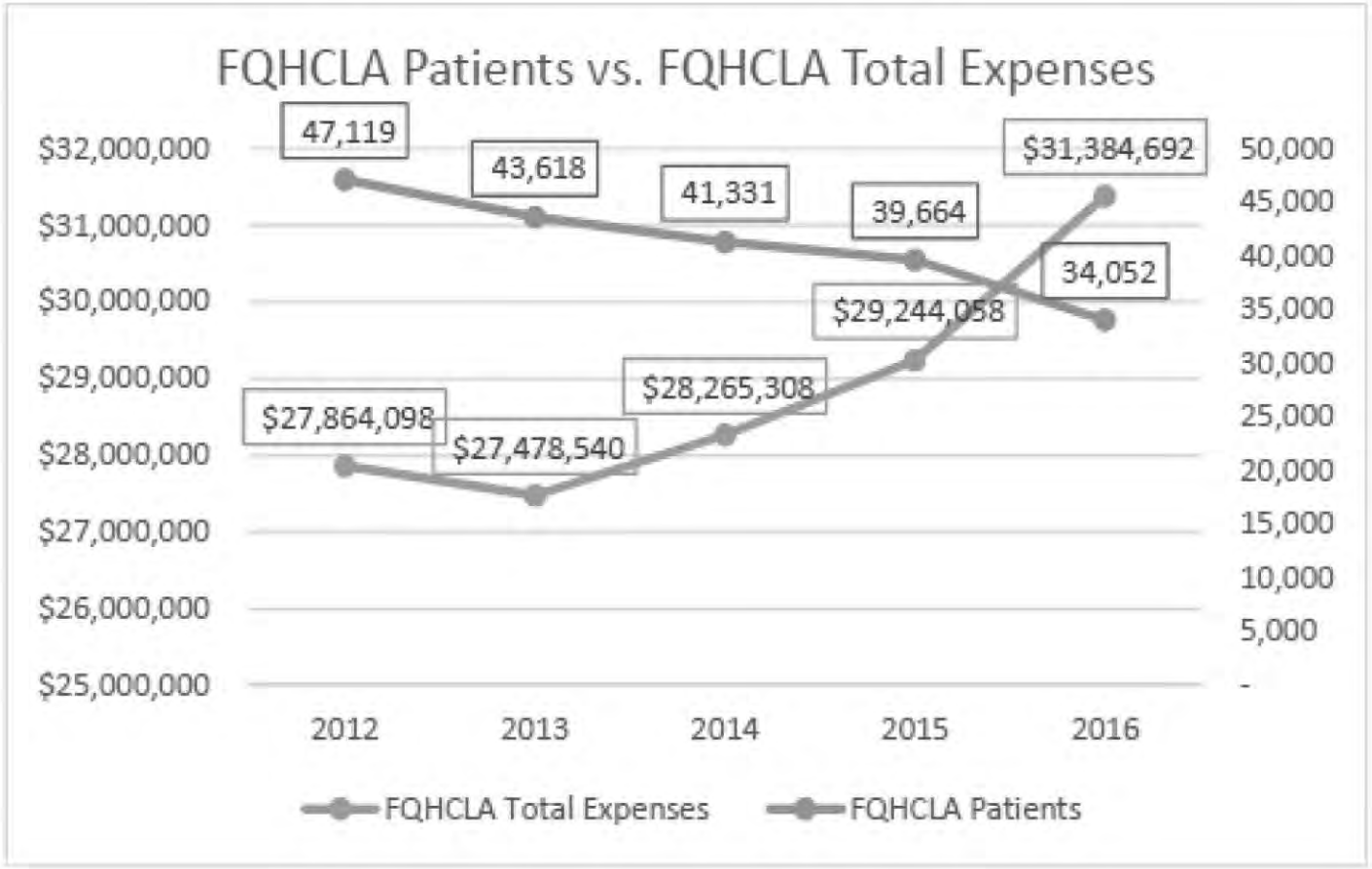
1. **Continue in Regional EMS Agency.**

2. Additional Support for EMS Service Delivery in Stanislaus County.

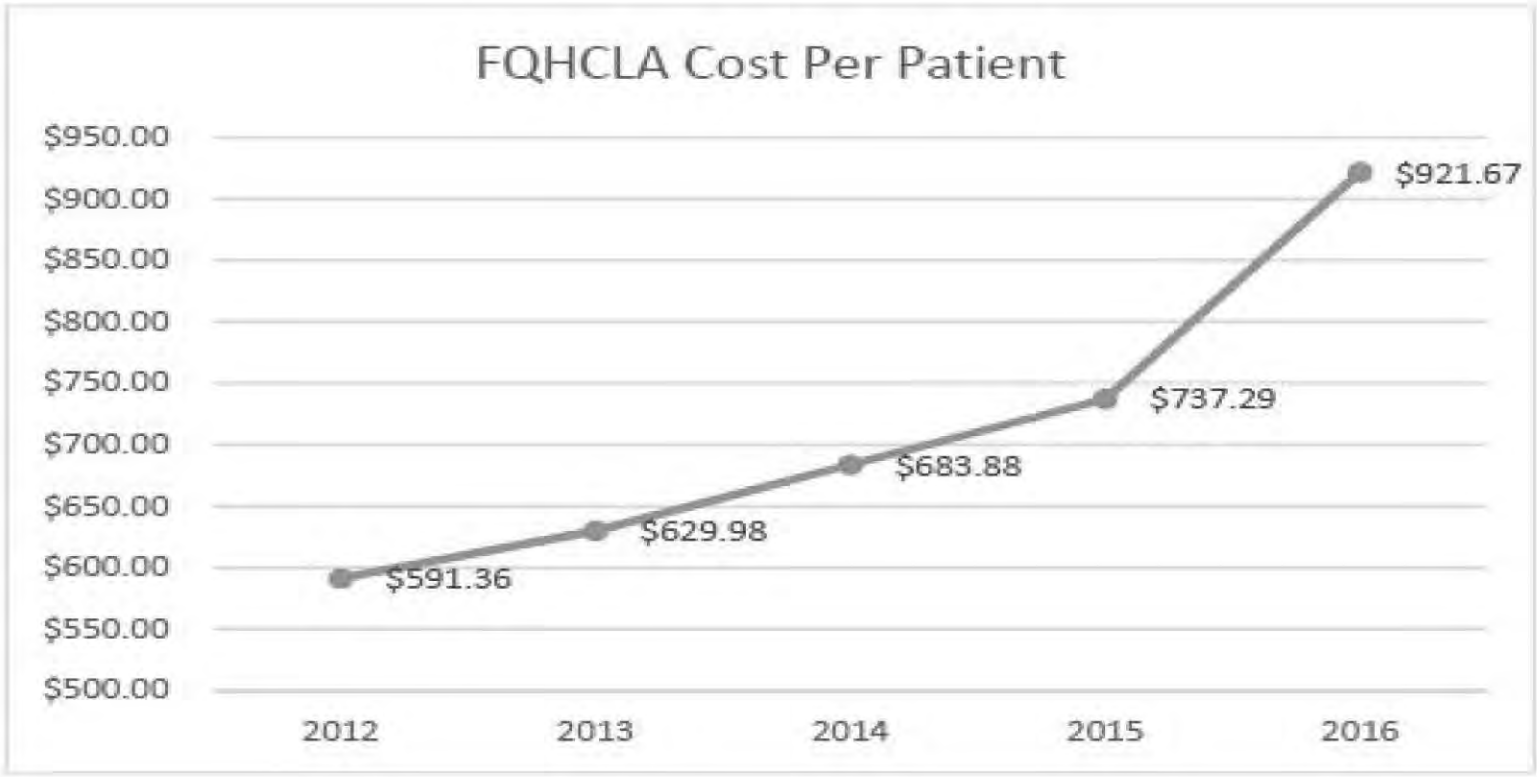
Primary Care, Specialty, and Physical Rehabilitation Clinics

- Stanislaus County FQHCLA clinics have experienced dramatic declines in number of patients served while expenses have continued to climb. This has contributed to a growing cost per patient served.

Primary Care, Specialty, and Physical Rehabilitation Clinics



Primary Care, Specialty, and Physical Rehabilitation Clinics



Primary Care, Specialty, and Physical Rehabilitation Clinics

Options Evaluated:

1. Retain Current FQHCLA/Other Clinics with system improvements
2. Strategically consolidate clinic sites with improvements and explore strategic partnerships/approaches to maintain access to care and optimize resources
3. Transition or limit County role from direct service clinic provider as other providers expand services with Stanislaus County

Primary Care, Specialty, and Physical Rehabilitation Clinics

Recommendations:

1. **Clinical Services Access**. With the goal of preserving and expanding clinical services for low-income residents, evaluate and pursue clinical care alternatives by other mission-driven safety net providers that may be better positioned than HSA in the future to provide sustainable, high-quality clinical services in multiple community locations.

Valley Family Medicine Residency Program

Major Findings:

- A real and persistent primary care provider shortage exists and is particularly difficult in San Joaquin Region - 22% less primary care providers than state average
- Stanislaus County plays a unique and essential role in maintaining and championing the residency program
- Challenges in administering, funding, growing and strengthening the impact of the residency highlight the importance of new strategic partnerships within the program

Valley Family Medicine Residency Program

Options Evaluated:

1. Retain current Valley Family Medicine Residency for Stanislaus County

2. Retain and expand Valley Family Medicine Residency for Stanislaus County with new partners

Valley Family Medicine Residency Program

Recommendations:

1. **Continued HSA Residency Leadership.**
2. **Expanded Residency Partnerships.**

Facility Planning

Activities:

1. Identified and categorized all facilities between Public Health, Clinical and Administrative Uses
2. Toured facilities in each category
3. Reviewed with HSA each department to determine projected space needs in 5 years and preferred co-location adjacencies
4. Determined HSA division size independent of existing spaces occupied by HSA and incorporated efficiencies associated with sharing resources for co-located divisions

Facility Planning

General Findings:

- Current conditions and relocations due to facility failures has created inefficiencies in the spaces being used.
- Relocation of uses from aging buildings presents an opportunity to co-locate uses for improved operations and communication.

Facility Planning

Scenic Campus Findings:

- Age and construction of existing buildings are an immediate risk for continued operations of the HSA uses occupying that campus.
- The existing buildings have been adapted for their current use from dissimilar uses and therefore are inefficient and oversized.
- Relocation could reduce square footage of space occupied, as well as risk.

Facility Plan

Recommendations:

1. Consolidate and Relocate Administration from the Scenic Campus.

2. Relocate Public Health from 820 Scenic.

Kathy Drummy
Partner
Davis Wright Tremaine LLP

Stanislaus County
Striving to be the Best

The County's Duty to Provide Medical Care to MIAs

- Welfare & Institutions Code 17000 has been interpreted to impose a mandatory duty on public entities like Stanislaus County to provide support to medically indigent adults ("MIAs") for medically necessary health care where no other means are available to provide that care.
  - California counties have used various models to fulfil this mandate, including the use of private providers.

The County's Current Outpatient Clinic Operations

- HSA provides primary care services through 6 primary care clinics which have been designated by the federal agency Health Resources & Services Administration ("HRSA") as a Federally Qualified Health Center Look Alike ("FQHCLA").
  - FQHCs and FQHCLAs provide access to primary care services to low income individuals.
  - Any alteration of a FQHCLA's scope of services includes HRSA's involvement and a review of alternative sources of similar primary care services, e.g., other FQHCs or clinic providers.

County Clinics' Relationship to VCME Medical Residencies

- The County is a member of the Valley Consortium for Medical Education ("VCME") which supports residencies in Family Medicine and Orthopedics, to encourage access to County residents to such services and to such Family Medicine and Orthopedic practitioners and is also a VCME teaching site under contractual arrangement.

Staff Recommendations

Stanislaus County
Striving to be the Best

Recommendations

1. Approve the Health Services Agency Strategic Visioning Business and Facility Plan as recommended by Pacific Health Consulting Group regarding the future scope of programs to be provided by the County's Health Services Agency as summarized below:

Recommendations

a. Implement a Community-Wide Population Health Initiative Focus for the Health Services Agency; and expand the Data and Quality Foundation for Public Health Services

b. Public Health: Pursue Community Clinical Services and Other Programming Integration Initiative including Coordinated Public Health and Clinical Service Interventions; and Pursue Health Services Agency/Behavioral Health and Recovery Services Coordination

c. Explore Regional Public Lab Partnership Opportunities to be returned to the Board of Supervisors for future recommended actions

Recommendations

d. Public Health: Emergency Medical Services (EMS) – Continue to participate in the Mountain Valley Emergency Medical Services Agency (MVEMSA) including seeking additional support for EMS Service Delivery in Stanislaus County

e. For Primary Care, Specialty and Physical Rehabilitation Clinics: Explore options for alternative service providers with the goal of preserving and potentially expanding access to clinical services for low-income residents

Recommendations

f. Physician Training: Continue the County's Commitment and partnership in the Physician Training Residency Program: Valley Consortium for Medical Education (VCME) in partnership with Doctors Medical Center and Memorial Medical Center

g. Approve the HSA Facility Plan and Direct the Finalization of an Implementation Plan to relocate future Health Services Agency Programs

Recommendations

2. Approve an Amendment to the Contract with Pacific Health Consulting Group to facilitate a Request for Qualifications/ Proposals process related to County Clinical Services to ensure access to and operations of primary care clinics and specialty care in an amount not to exceed $85,500

3. Authorize staff to return to the Board of Supervisors with a Request for Qualifications/ Proposals for the provision of continued access to primary and specialty clinical care for County residents

Recommendations

4. Direct the staff to finalize the facilities and funding plan needed to implement the Master Facilities Plan including a recommendation to relocate the Health Services Agency from County Center II (Scenic Drive) to New facilities at County Owned Property at County Center III (Scenic Drive and Oakdale Road, Modesto)

Recommendations

5. Authorize staff to prepare and return to the Board of Supervisors with a Request for Qualifications/Proposals for Professional Planning and Design Services for new facilities needed by the Health Services Agency for future Board of Supervisors' consideration.

Next Steps

- August/September: Return to Board of Supervisors with draft Request for Qualifications/Proposals (RFQ/P)
- August/September: Issue approved RFQ/P
- December/Winter 2019: Present RFQ/P recommendations to Board of Supervisors

“Wherever we are, it is but a stage on the way to somewhere else, and whatever we do; however, well we do it, it is only a preparation to do something else that shall be different.”

Robert Louis Stevenson

Thank You & Questions