Task Force on the Future of the Health Care Safety Net in San Luis Obispo County

Final Report and Recommendations

July, 2003

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Executive Summary

BACKGROUND

On October 15, 2002 the San Luis Obispo County Board of Supervisors took the historic step of voting to close the inpatient services at General Hospital. After nearly two decades of debate over General Hospital and ensuring access to care, the Board directed County staff to develop a plan for eliminating the hospital inpatient services and contracting with local private hospitals for inpatient care. The Board endorsed concentrating county services in its outpatient clinics, and reiterated its funding support for safety net services.

The Economic Opportunity Commission of San Luis Obispo County, Inc. (EOC) in collaboration with the County Administrative Office, Public Health Department, County Medical Society, and the Community Health Foundation, obtained a grant from The California Endowment to fund a facilitated public planning process to involve local residents in a series of meetings and forums to develop recommendations on:

- The future configuration of safety net health services, and
- Ensuring and monitoring continued access to care for the uninsured and underserved.

A task force was established with a priority on seeking a balanced membership – geographic, gender, ethnic, and income. The role of the task force was to study the issues, interview key public and private officials, solicit input from community members in bilingual forums, and formulate a series of recommendations to the Board of Supervisors.

Task force meetings involved presentations by local, regional and statewide experts. Task force members had opportunity to question and dialogue with presenters, and were then guided by the facilitator to generate solutions for the County’s unique safety net issues using a series of questions to assist in framing input. In addition, four community forums were held throughout the county during April and May 2003, one each in Paso Robles, San Luis Obispo, Morro Bay, and Oceano.

Over the course of the eight task force meetings from January to June 2003, Future Vision examined the current configuration of the safety net and discussed recommendations for the future of the system. The topics discussed included:

- Outpatient Care
- Inpatient Care
- Behavioral Health Care
- Dental Care
- Needs of Limited English Proficient Patients

- Financing
- Monitoring

FINDINGS

Provider and Services issues

Outpatient care

Discussion on outpatient care dominated the task force sessions due to its importance in appropriate management of health care. There are two main safety net issues with outpatient care: location of clinics and scope of services. There are few or no services in some of the more remote population centers. Along the coast, the North Coast and Estero Bay areas have no clinics, except for limited services in Morro Bay. Nor do the rural areas of San Miguel, Shandon and Creston have any clinical services. With the general lack of public transportation in the remote parts of the county, much of the population in these areas has difficulty in accessing the available services.

A recent report by the County Administrative Office to the Board of Supervisors demonstrates that a full range of primary care services are not available at all clinics throughout the week. Community comment at each meeting stressed that extended and weekend hours are necessary to ensure access to services for those who work long daytime hours, particularly during harvest season, and cannot come to the clinics during the week. Walk-in clinics without appointment are viewed by the community as a minimum need for access for non-routine health problems and for those who could not make appointments.

Urgent/emergent care

The Task Force considered the urgent and emergent needs for the safety net. With the closing of General Hospital's emergency room, there are four remaining emergency departments in the county. For true emergencies, this appears to be adequate. There is, however, a serious issue of availability of on-call specialists, and access to primary care physicians for follow-up and referrals. Currently, many specialists, particularly neurology and plastic surgery, are on call simultaneously for several hospitals. Also, not all emergency rooms have all specialties covered at all times, although there is at least one specialist on call in the county.

Inpatient care

The issues with hospital access for the safety net appear to be much more related to financing rather than services. The County has long-standing contracts through CMSP with the four remaining hospitals for care of CMSP eligible patients. These contracts will continue. All the hospitals also take Medi-Cal.

However, for patients with no payer source such as CMSP or Medi-Cal, there are questions related to full access, particularly for surgeries for non-life threatening conditions. For these "elective" procedures, hospitals can require deposits or other form of advance financial payments

"Self-pay" patients are not generally aware of their ability to individually negotiate reduced rates similar to what health plans or other programs pay. And patients who are potentially eligible for CMSP or Medi-Cal do not always have adequate information or resources to apply for these programs within the prescribed time limits.

Mental Health and Substance Abuse

The Task Force devoted a full session to the discussion of issues in the delivery of mental health care. The magnitude of the issues and the limited time available meant that there would only be cursory review of mental health issues. Further in depth study limited to mental health is advisable.

The closure of SLOGH required the transfer of the County's license for the inpatient mental health unit, the only inpatient unit in the county. The County was successful in obtaining a license as a "psychiatric health facility." Medical coverage for those mental health patients requiring outpatient medical care will be provided by FCC, and inpatient medical needs will now be provided through a transfer agreement with French Hospital. In addition, the inpatient facility will increase its bed capacity from 14 to 16.

For substance abuse issues, one of the most frequent comments in community meetings was the lack of a residential detox unit in the county. Outpatient detox is available on a limited basis, but those who require more intensive interventions must be sent out of the county. Those with a medical condition, e.g. severe withdrawal syndrome, are treated at local hospitals.

Dental care

Access to dental services for low income persons is limited in the county, as it is elsewhere in the State. For children, numerous programs attempt to link children to services and pay for their care. Young children with severe dental conditions and disabled children have particular needs that are difficult to meet. Seniors citizens also face access barriers in obtaining dental care, since Medicare does not pay for dental services. Few private providers accept Denti-Cal (Medi-Cal) or Healthy Families on a regular basis. Referrals from public health programs or other providers are often necessary to obtain care. Low reimbursement rates are the most often cited reason for not accepting Denti-Cal and Healthy Families.

Pharmaceuticals

Access to pharmaceuticals is a problem well known to young and old alike. Medicare does not have prescription drug coverage and low-income seniors without supplemental coverage must pay out of pocket for drugs. The uninsured also face barriers in paying for prescriptions.

Provider shortages and participation

Medical provider shortages exist for both family practice and specialists throughout San Luis Obispo County**.** Although these problems exist for both the "haves" and "have-nots," the shortages exacerbate an already fragile safety net. Due to low reimbursement rates and the high cost of living, particularly housing, many physicians have given up their private practices for institutional employment or have left the county altogether. As physicians retire, new physicians are not moving to the area to fill the void. The remaining physicians are already overloaded with privately insured patient, and are less likely to take lower paying publicly insured patients, or uninsured patients. They have less time to volunteer, and are reluctant to take on additional burdens.

Patient issues

As discussed above, access to safety net services is not available in all areas of the county. The rural and remote areas, such as Shandon and Creston, lack services, as does the north coast and Estero Bay. Even where there are clinics, services are limited at many sites. Residents in the far south of the county reported that they often go to Santa Maria for care. Not only are they closer to Santa Maria, but there are more providers who speak Spanish and accept Medi-Cal. With very limited public transportation, families face additional barriers in accessing the available services.

Patients and providers alike reported frustration regarding communications with persons of limited English proficiency (LEP). Although federal law requires minimal standards for interpretation (oral communication) and translations (written communication), such as the ATT Language Line, confidential provider-patient communication is impeded. Reliance on young family members, nonmedical staff, or providers with minimal proficiency in Spanish, does not substitute for communication with trained medical interpreters.

Over the years, General Hospital has been considered the safety net institution where uninsured, Medi-Cal, and CMSP patients could go to obtain a range of services. With the closure of SLOGH, and the full privatization of indigent inpatient care, community members want to ensure that full access will be maintained. The Task Force and community members discussed the possible structures of an independent program that could monitor access and advocate on behalf of consumers having difficulty accessing the system. The program could also assist patients in qualifying for public coverage programs (e.g. Healthy Families and Medi-Cal), or negotiating medical bills.

Uninsured patients also were unaware that they could negotiate their bills at the hospitals. The "charges" invoiced to uninsured patients are the full "retail" charge, which is rarely, if ever, paid by health plans, insurance companies, or government payers. The hospital is also willing to accept a reduced fee, since they have little chance of collecting the entire bill. Uninsured patients are also willing to pay their bills, but it has to be within their means without sacrificing other necessities of life.

Financing issues

The current County General Fund annual contribution towards health care is estimated to be $10.3 million. Should the Board of Supervisors maintain that level of funding, with the closure of General Hospital there is approximately $1 million available for system enhancements, increases in costs, particularly pharmacy, and cost of living adjustments. Even with the County's continued generous funding of indigent health care, there is insufficient funding in the system for the safety net. The Task Force discussed maximizing existing sources of revenues and reimbursements as well as developing new sources.

Certain health clinics, known as Federally Qualified Health Centers (FQHC), receive payments based on their actual costs, rather than a schedule of reimbursement rates. This makes Medi-Cal a highly favored source of income to a non-profit clinic. Community Health Centers of the Central Coast is the FQHC in the County, although FCC is examining the risks and benefits in applying to the federal government for FQHC "Look Alike" status.[1] FQHC status is key to the financial stability of the FCC.

Existing revenue sources may also be maximized by ensuring that all eligible persons are enrolled in available programs. Institutions and patients alike benefit from a third party payer, such as Medi-Cal or Healthy Families.

One local effort of note is to provide health coverage to all children in the County. Spearheaded by the First 5 Commission, the program will maximize enrollment in Healthy Families and Medi-Cal, and create a new local coverage program for those low -income children who are not eligible for Healthy Families or Medi-Cal.

An additional source of funding for the safety net is tobacco litigation Master Settlement Agreement which provides approximately $2.5 million annually to San Luis Obispo County. Measure A, passed by the voters in March 2002, sets specific allocations for the funds.

The Task Force noted that regardless of maximizing the current sources of revenue, there is still additional funding needed for the safety net. With one in

[1] FQHC "Look Alike" is very similar to the FQHC status, except that the "Look Alike" clinics do not get federal grants, but do get the enhanced reimbursement.

seven persons uninsured, inadequate reimbursement from Medi-Cal, and double digit increases in private insurance premiums, the gap needs to be closed with new revenues earmarked for the safety net.

A new ½ cent sales tax would yield approximately $13.5 million annually. Santa Maria is already ½ cent higher than San Luis Obispo County. The Task Force discussed the possibility of an “A to Z” tax for multiple community purposes, such as health, homeless, library, and recreation.

Governance and administration issues

The task force noted that the safety net in San Luis Obispo is a patchwork of providers, programs, and financing mechanisms in the public and private sectors. There is no body or organization overseeing the safety net to coordinate services, ensure that there is adequate access to providers in all areas of the county, or monitor the system. The various governance structures of county departments, nonprofit organizations and private businesses make it impossible to have one overall governing body. However, the Task Force did see a need for a coordinating body that ensures the viability of the safety net.

RECOMMENDATIONS

The following are the recommendations of the Task Force. The recommendations are divided into three sections. The first are those recommendations that the Task Force considers the basic minimum for a safety net in San Luis Obispo County. The second includes enhancements to the safety net that the Task Force considers highly desirable should funding be available. The third set of recommendations are those that would provide for an optimal system. As additional funding sources become available – FQHC, grants, or new taxes – the system can be enhanced.

Basic level of services	Enhanced Services	Optimal services
1. Clinics Two in North County Two in South County One in San Luis Obispo One on North Coast	Mobile unit for rural and remote communities	Satellite clinics in rural, remote areas
2. Services Primary care physician services for adults and pediatrics Obstetrical services Primary care services on	Referrals to specialists in *regions* X-ray available regionally Space for community providers (e.g. WIC, ASN)	Model regional health and human services center on the North Coast (possibly in vacant San Luis Coastal Unified School District facility). Transportation

Basic level of services	Enhanced Services	Optimal services
appointment basis, with a walk-in capability Integration of Public health and preventive services Referrals to specialists *centrally* orthopedics, gastrointestinal, cardiology, surgery, infectious disease, HIV/Hepatitis C, psychiatric liaison, emergency mental health Mental health treatment for non-severe cases Extended and weekend hours available regionally Pharmacy (some local, some centralized Emergency dental available regionally Operating room capacity for complicated dental cases Laboratory draw stations in clinics, central lab Vision and hearing screening and referral	Specialists in neurology (consults) and dermatology Integration of application processes for public programs, e.g. Medi-Cal, Healthy Families, CMSP Regional substance abuse detox programs – social and outpatient and crisis evaluation Central residential substance abuse detox Regional laboratory Pharmacies in all clinics or regions Dental services (preventive and restorative) available regionally	assistance (vouchers, vans, etc.) Vision services Community meeting rooms at clinics Universal and on-line applications for public programs (One-E-App) Inpatient substance abuse facility
3. Patient Services Eligibility and billing assistance at all sites Outstationed eligibility workers in clinics and hospitals		Acceptance of all coverages by all providers

Basic level of services	Enhanced Services	Optimal services
Social services information and referral Linkages to community services, e.g. IHSS, Home Care, SAFE System of Care Accept all coverages Advertised sliding fee scales Acceptance of "Medi-Cal pending" patients at all safety net providers.		
4. Provider shortages Support the Medical Society application for designation as a Health Professional Shortage Area Support increased reimbursement rates for Medi-Cal and Medicare Support use of "physician extenders" Support recruitment and retention efforts for all health care providers Encourage private provider participation through community clinics	Examine the possibility of incentives for new physicians, e.g. loan forgiveness or housing subsidies Expand coverage for the uninsured starting with children (through the First 5 Health Insurance Initiative)	Universal health care coverage Physician residency program
5. Services for limited English proficient (LEP)	Development of local community resources to assist with interpretation	

Basic level of services	Enhanced Services	Optimal services
and hearing impaired patients Bilingual written material for prescriptions, discharge instructions, billing, and education Trained medical interpreters for Spanish at all sites for both phone calls and providers Preference for bilingual personnel in hiring Sign interpreters at all sites by appointment Language line interpreters for non-Spanish LEPs		
6. Consumer assistance program Bilingual staff Monitor access at safety net facilities (e.g. waiting times, services, twenty-four hour access). Act on patient complaints on cost, quality and access Quarterly reporting to County and community at large on safety net issues Advisory committee of providers, patients and community representatives	Assistance with sliding scale fees and in negotiating medical bills with providers On-site assistance at clinics in understanding and applying for all public programs (Medi-Cal, Healthy Families, CMSP, CHDP, etc.) Education of staff and patients on appropriate processes	Assistance with patient compliance and prevention education
7. Financing	Grant funding be pursued	Local, dedicated funding

Basic level of services	Enhanced Services	Optimal services
County “Maintenance of Effort” to reflect its current general fund contribution with annual cost of living adjustments County apply for FQHC status Efforts be made to maximize other funding such as reimbursement for Medi-Cal Admin. Activities, etc. Polling of potential voters in San Luis Obispo to determine the likelihood of success and the scope of a ballot measure to enhance revenues	in a public-private partnership from federal and state sources as well as private foundations	streams for safety net
8. Governance The current provider independent governing boards remain intact. Governing boards be established or expanded according to needs (e.g. FQHC Look-Alike consumer board). Establish a health care council consisting of providers, and public and private representatives similar to the Task Force, to promote collaborative efforts for system, monitor access and make recommendations		

CONCLUSION

The notion of convening community residents about the safety net arose at the time that the Board of Supervisors voted to close General Hospital in Fall 2002. Since that time a number of changes have taken place in the health care environment in the county. General Hospital has closed. French and Arroyo Grande Hospitals have filed for bankruptcy and a sale is pending. A new dental clinic for low-income children opened in Paso Robles.

Relationships have developed, in part due to the Future Vision process that will provide further opportunities for partnership between the various sectors in the County. There is increased dialogue between the public and private sectors on ensuring a healthy safety net. The County Family Care Center has entered into a contract with the non-profit Community Health Centers of the Central Coast for physician services – the framework of a potential long-term partnership.

Universal health coverage and adequate reimbursement for providers for safety net patients will ultimately require federal or state solutions to the access problem. Providing universal health insurance locally for children through collaboration with potential partners such as the First Five Commission and other funders would provide significant progress in health access and is under evaluation at this time.

The recommendations of the Future Vision Task Force echo similar recommendations made by past committees. The current debate is no longer about “saving General Hospital” but rather how to have the best system possible in our County. Also, there is a realization that the generous commitment from the Board of Supervisors for supporting the safety net will not be sufficient for maintaining a strong system. New and secure revenue streams are essential. With the current economic and State budget climate, it will be a challenge to increase support for the system. But the Task Force believes that if the residents of San Luis Obispo County put their collective resources together, a solution is possible.

INTRODUCTION

Background

On October 15, 2002 the San Luis Obispo County Board of Supervisors took the historic step of voting to close the inpatient services at General Hospital. After nearly two decades of debate over General Hospital and ensuring access to care, the Board directed County staff to develop a plan for eliminating the hospital inpatient services and contracting with local private hospitals for inpatient care. The Board endorsed concentrating county services in its outpatient clinics, and reiterated its funding support for safety net services.

The Economic Opportunity Commission of San Luis Obispo County, Inc. (EOC), on behalf of a coalition of community and public organizations, including the County Administrative Office, Public Health Department, County Medical Society, and the Community Health Foundation, obtained a grant from The California Endowment to fund a facilitated public planning process to involve local residents in a series of meetings and forums to develop recommendations on:

- The future configuration of safety net health services, and
- Ensuring and monitoring continued access to care for the uninsured and underserved.

Steering Committee

A steering committee was convened to facilitate the public planning process. The committee was comprised of a representative of the Economic Opportunity Commission, the Public Health Director, a representative of the County Medical Society, and a member of the County administrative staff. The role of the steering committee was to plan and implement task force meetings and community forums, and to direct a contract facilitator in guiding the overall process. The steering committee commenced its work in January, 2003, by developing membership of the task force, setting the topic agendas for each task force meeting, recommending expert guests to provide information to the task force, and ensuring that all meetings were accurately recorded and reported to the task force. The steering committee’s tenure is completed with the provision of this report to the County Board of Supervisors.

Future Vision Task Force

Solicitation of task force members was by public announcement. Selection was made by the steering committee with a priority on seeking a balanced membership – geographic, gender, ethnic, and income. The role of the task force was to study the issues, interview key public and private officials, solicit input from community members in bilingual forums, and formulate a series of recommendations to the Board of Supervisors. A facilitator familiar with county health, indigent and health access issues was recruited to provide support to the task force, facilitate its meetings, and draft the final reports for the task force.

Members of the Task Force included representatives from:

Adult Services Policy Council

Children's Services Network

Community Health Centers of the Central Coast

Economic Opportunities Commission

Consumer advocates

County Administrative Office

County Board of Supervisors

County Health Commission

County Health Department

Tri-Counties Regional Center

Family Care Center

AIDS Support Network

Hospital Council of Northern and Central California

Hotline of SLO

Mental Health Board

SLO Community Health Foundation

SLO County Medical Society

Task force meetings involved presentations by local, regional and statewide experts in topic areas recommended by the steering committee. Task force members had opportunity to question and dialogue with presenters, and were then guided by the facilitator to generate solutions for the County's unique safety net issues using a series of questions to assist in framing input:

The input from the task force was recorded in the form of minutes that were subsequently provided to each task force member.

Community Forums

Four community forums were held throughout the county during April and May 2003, one each in Paso Robles, San Luis Obispo, Morro Bay, and Oceano. Following a brief introduction by the facilitator, community members were engaged in a dialogue and contributed ideas, stories and solutions for pressing community safety net issues. All responses were recorded on flip charts and transcribed into notes for review by the steering committee. Childcare, bilingual translation and refreshments were provided for each meeting, which were held from 6:30 - 8:30 pm. Approximately 100 persons attended the forums, including task force members, community service providers, and local residents. Approximately 20 monolingual Spanish speaking persons participated in the forums.

WORKING DEFINITION OF "SAFETY NET"

In order the frame the work of the task force, the members developed a working definition of the health care safety net. The definition was derived from "The Status of Local Health Care Safety Nets," written by Raymond J. Baxter, and published in Health Affairs, July/August 1997, and then augmented with local concerns.

Who the safety net serves:

- the uninsured
- the difficult to serve
- those who might be discriminated against, and
- those who cannot get care elsewhere.
- Examples include the uninsured, Medi-Cal recipients, those who are eligible for County Medical Services Program (CMSP), people with HIV/AIDS, substance abusers, frail elderly, low income children and pregnant women, homeless, mentally ill, developmentally disabled, disabled, limited English proficient, Hepatitis C, and the underinsured.

Who provides the care:

- Institutions, programs, professionals devoting substantial resources to serving uninsured and socially disadvantaged
- Public hospitals and clinics; private and not-for-profit hospitals
- Emergency/urgent care centers
- Community health centers
- Local health department
- Private providers – as "pro bono" or as contracting providers, and providers of community and technical support
- Other "ancillary" services – transportation, referrals for housing and food, translation, advocacy in gaining entitlements; social services; health and human services systems; pharmacy

What finances the system:

- Medi-Cal, Healthy Families, County Medical Services Program (CMSP), Children Health and Disability Prevention Program (CHDP)
- Federal and state funding for clinics- Expanded Access to Primary Care (EAPC)
- Local funds –County General Fund, First 5 Prop. 10 funds
- Tobacco litigation master settlement agreement
- Charity care and billing adjustments by private providers and institutions;
- Grants and donations

WHAT WE LEARNED

Over the course of the eight task force meetings, Future Vision examined the current configuration of the safety net and discussed recommendations for the future of the system. The topics discussed included:

- Outpatient Care
- Inpatient Care
- Behavioral Health Care
- Dental Care
- Needs of Limited English Proficient Patients
- Financing
- Monitoring

This section presents the findings of the Future Vision task force. The following section presents the recommendations. The findings are presented under four main headings:

- Provider and services issues
- Patient Issues
- Financing Issues
- Governance and administration issues

Provider and services issues

a) Outpatient

Location of clinics
There are clinics operated by the Family Care Centers (FCC), Community Health Centers of the Central Coast (CHC), and the Public Health Department (PHD) in the major population centers of the county. The County Health Commission recently completed a review of these services, and the County Administrative Office has charted and mapped the clinics to identify the locations and the services provided. (See Attached)

The major issue with the location of the clinics is that there are few or no services in some of the more remote population centers. Along the coast, the North Coast and Estero Bay areas have no clinics, except for limited services in Morro Bay. Nor do the rural areas of San Miguel, Shandon and Creston have any clinical services. With the general lack of public transportation in the remote parts of the county, much of the population in these areas has difficulty in accessing the available services.

While it may be unreasonable to expect full on-site clinical services in these locations, the Task Force discussed the possibilities of mobile clinics to serve these areas on a regular basis. Apparently, CHC may have mobile services

available to provide some of these services in the near future. The costs and suitability of mobile clinics needs to be examined more fully.

In addition, enhancement to health related public transportation should be considered since even with primary care services, specialty services will require access to centralized locations.

Range of services at clinics
The Health Commission and County Administrative Office report demonstrate that a full range of primary care services are not available at all clinics throughout the week. Public comments at all the community meetings reiterated this point. For instance, FCC is only in Paso Robles two days per week, and adult care is not provided in Grover Beach. It is confusing to patients as to which clinics provide which services and on what days. While, co-location of FCC and PHD clinics is seen as a good idea, integration of their services would be less confusing to patients and possibly less costly to the County.

In addition, clinic hours need to reflect the needs of the working population. Community comment at each meeting stressed that extended and weekend hours are necessary to ensure access to services for those who work long daytime hours, particularly during harvest season, and cannot come to the clinics during the week. Walk-in clinics without appointment are viewed as a minimum need for access for non-routine health problems and for those who could not make appointments.

b) Urgent/emergent care

The Task Force considered the urgent and emergent needs for the safety net. With the closing of General Hospital's emergency room, there are four remaining emergency departments in the county. For true emergencies, this appears to be adequate. In accordance with the federal Emergency Medical Treatment and Active Labor Act, all emergency departments in the county provide screening and necessary treatment of all patients, prior to inquiring about financial ability to pay.

The "urgent care" centers throughout the county are basically private physician offices providing an enhanced level of care. They do not generally accept Medi-Cal, and for the uninsured they operate on a cash basis. As such, they do not act as a major component of the safety net for low-income patients, although they are an important source of care for those that can afford the services.

There is a perception that the closing of the General Hospital walk-in clinic may adversely impact the other emergency departments. However, recent

data from the County show that only an average of fourteen patients a day used the walk-in clinic. Nevertheless, community members at every meeting were concerned about the lack of walk-in services for those without appointments. The primary concern with emergency care among the community was one of cost.

Regardless of the closing of General's ER, there are other issues concerning emergent care throughout the County. Clinical issues include availability of on-call specialists, and access to primary care physicians for follow-up and referrals. Currently, many specialists, particularly neurology and plastic surgery, are on call simultaneously for several hospitals. Also, not all emergency rooms have all specialties covered at all times, although there has been to date one of each needed specialist on call in the County. This fact may not continue without considerable effort.

c) Inpatient care

With the closure of General Hospital's inpatient unit, the County will be left with four acute care hospitals. The Community Health Status Report prepared by the County Public Health Department in January 2003 shows hospital licensed bed capacity and occupancy in 2001. However, similar data were not available for "available beds" or "staffed beds" which would be more accurate in determining capacity. Also, since the data were obtained from the Office of Statewide Health Planning and Development (OSHPD) General Hospital has closed.

Hospital	Number of Licensed Beds	Licensed Bed Occupancy Rate
Sierra Vista	207	44.4%
French	112	39.7%
Twin Cities	84	67.4%
Arroyo Grande	65	62.8%
General Hospital	92	21.7%
Total	560	45.3%

The closure of General Hospital would result in the loss of 92 licensed beds; however the average daily census was fewer than 12 per day.

The two hospitals owned by Vista Health Systems, French and Arroyo Grande Community Hospitals are currently in bankruptcy proceedings and being sold to another hospital investor. Reports have indicated that local physicians are attempting to purchase the hospitals from the buyer which would give local control to their management. The sales are not expected to change the current services in the short term.

Questions were raised as to whether there is sufficient capacity for labor and delivery in the other hospitals with the closure of SLOGH. Since many of the Medi-Cal labor and delivery patients are County patients (through PHD and FCC), regional hospital issues, such as physician and midwife coverage, need to be determined. The three remaining private hospitals that provide labor and delivery have indicated that there are no capacity issues. Many south county residents are reported to deliver at Marian Hospital in Santa Maria. There are also discussions of a newly formed private, nonprofit group operating a labor and delivery service at the vacated SLOGH site.

One clinical issue with the inpatient safety net care is the inability to arrange follow-up care with a “medical home.” Safety net patients often do not have a primary care provider making it difficult for discharge planning and continued care after hospitalization.

The issues with hospital access for the safety net appear to be much more related to financing rather than services. The County has long-standing contracts through CMSP with the four remaining hospitals for care of CMSP eligible patients. These contracts will continue. All the hospitals also take Medi-Cal. However, for patients with no payer source such as CMSP or Medi-Cal, there are questions related to full access, particularly for surgeries for non-life threatening conditions. For these “elective” procedures, hospitals can require deposits or other form of advance financial payments.

“Self-pay” patients are not generally aware of their ability to individually negotiate reduced rates similar to what health plans or other programs pay. And patients who are potentially eligible for CMSP or Medi-Cal do not always have adequate information or resources to apply for these programs within the prescribed time limits. For instance, application for CMSP must be made within seven days of admission, while Medi-Cal can sometimes authorize payment for services provided within three months of application.

d) Access to specialists

Perhaps the most persistent difficulty in providing physician care for safety net patients is the inability to access specialists for referrals. This problem exists both for primary care doctors and emergency departments for patients not admitted who need outpatient follow-up specialty services. CHC has some specialists on contract, while FCC has had some success in contracting and using volunteer specialists. The two major issues cited by those familiar with the problem are the general lack of providers in the county and the poor reimbursement rates for Medi-Cal and other public programs. Physicians are also concerned about becoming the patient’s primary provider after they have

provided specialist services. The Task Force discussed the need to create incentives to take care of uninsured/underinsured patients

e) Mental health

The Task Force devoted a full session to the discussion of issues in the delivery of mental health care. The magnitude of the issues and the limited time available meant that there would only be cursory review of mental health issues. Further in depth study limited to mental health is advisable.

The closure of SLOGH required the transfer of the County's license for the inpatient mental health unit, the only inpatient unit in the county. The County was successful in obtaining a license as a "psychiatric health facility." Medical coverage for those mental health patients requiring outpatient medical care will be provided by FCC, and inpatient medical needs will now be provided through a transfer agreement with French Hospital. In addition, the inpatient facility will increase its bed capacity from 14 to 16.

Outpatient mental health services were also addressed at length. Since there are insufficient funds to cover all needs, the public programs have focused on "mandatory populations" that the county is required to serve by state law. Eligibility for programs offered by the Behavioral Health Department is limited by diagnosis and functional impairment. The populations served include primarily those on Medi-Cal, those in custody, or those who are referrals from schools for individualized educational programs.

There are a wide variety of innovative programs in the mental health system, but funding restraints limit their scope. The programs are seen as being "a mile wide and an inch thick." Only about 40% of those who need services can get treatment.

Services for those with private coverage are not necessarily any better that for those with public coverage. Services are limited countywide. Although there are many psychiatrists in the county, only nine psychiatrists are in private practice. The remainder work for public institutions such as Atascadero State Hospital, California Men's Colony and the County.

Youth services are available through school linked and community based services. The SAFE System of Care program in North County and South County works with families in need and provides services and referrals. Once again, services are "a mile wide and an inch thick," and state mandated clients receive priority. Transportation remains an issue for many families. There is a small adolescent day treatment program, but no inpatient youth services are available in the county except at the general inpatient mental health unit. .

Adult services are also limited. With the elderly population growing faster that the youth population, the gap in services will continue to grow. With categorical funding, it is difficult to place patients with multiple problems of mental illness, physical illness and substance abuse. Discharge and housing issues are particularly difficult for the homeless.

Emergency mental health was also discussed. Persons with serious mental health issues are brought to hospital emergency rooms for evaluation. Under section 5150 of the Welfare and Institutions Code, an involuntary 72 hour hold may be placed on a person who meets the criteria of being gravely disabled or a danger to self or others. In this county, only county mental health workers and peace officers are allowed to place a person in an involuntary hold. Physicians and private providers do not have that authority.

Emergency department physicians reported delays in the response time by the county crisis team. They stated that it often takes hours to respond while the patient remains in the emergency department, although it was reported that the crisis team is very good in it role. The Behavioral Health Department has recently received additional funding to enhance their crisis response contract.

Recruiting and retaining qualified bilingual staff remains very difficult in both the public and private sector in the mental health field.

f) Substance abuse

County Drug and Alcohol Services takes a non-medical model approach to providing services. It has a strong bilingual staff located in numerous programs throughout the county. However, once again, the programs are underfunded, and the state budget deficit is requiring additional cuts to the already limited services.

One of the most frequent comments in community meetings was the lack of a residential detox unit in the county. Outpatient detox is available on a limited basis, but those who require more intensive interventions must be sent out of the county. Those with a medical condition, e.g. severe withdrawal syndrome, are treated at local hospitals.

g) Dental

Access to dental services for low income persons is limited in the county, as it is elsewhere in the State.

For children, numerous programs in the Public Health Department attempt to link children to services and pay for their care. Head Start and Migrant Head Start report large expenditures for dental care for their children. Young

children with severe dental conditions and disabled children have particular needs that are difficult to meet.

Community Health Centers has offered dental services at its Nipomo site, including a walk-in service, for many years. CHC has also expanded recently to Templeton. Appointment waiting times for routine care can be up to three months. A new nonprofit community dental clinic, Clinica de Tolosa, opened in June in Paso Robles. This clinic is open to all children regardless of ability to pay, and adults on an emergency basis. Demand for appointments is reported to be high.

Few private providers accept Denti-Cal (Medi-Cal) or Healthy Families on a regular basis. Referrals from public health programs or other providers are often necessary to obtain care. Low reimbursement rates are the most often cited reason for not accepting Denti-Cal and Healthy Families.

The disabled population and young children with complex needs are more difficult to serve. They often require anesthesia in order to be treated. Several dentists from both in and out of the county agree to treat these patients, and have provided services through the SLOGH's operating rooms. With SLOGH closing the issue of operating room time in the other hospitals has become critical. It is unclear whether all these cases need to be done in a hospital setting, but the problem remains that willing providers cannot treat this population without adequate hospital OR availability.

Seniors citizens also face access barriers in obtaining dental care. Several people commented at the community meetings that they were unable to replace dentures or receive other necessary services for lack of money. Since Medicare does not pay for dental services, most have to pay out of pocket.

h) Pharmacy

Access to pharmaceuticals is a problem well known to young and old alike. Medicare does not have prescription drug coverage and low-income seniors without supplemental coverage must pay out of pocket for drugs. The uninsured also face barriers in paying for prescriptions.

Providing pharmacy services has become a large and increasing cost to the county. The pharmacy based at SLOGH will continue with limited Atascadero coverage. The pharmacy provides prescription drugs for CMSP and other patients with and without coverage. Weekend prescription coverage has emerged as an issue for self-pay and Medi-Cal pending patients, and it is not clear how the indigent will be able to get prescriptions filled.

The community expressed a need for greater access to pharmacy services on a local basis, and suggested such things as mail order, or pick up in local

pharmacies. CHC provides pharmaceuticals as part of it services, with the use of on-site dispensaries and pick up at local pharmacies. FQHC status for FCC may allow for more joint purchasing or drugs and enhanced reimbursement.

Spanish-speaking community members also were concerned that prescriptions were sometimes not labeled in Spanish.

i) Provider shortages and participation

Medical provider shortages exist for both family practice and specialists throughout San Luis Obispo County**.** Although these problems exist for both the “haves” and “have-nots,” the shortages exacerbate an already fragile safety net. Due to low reimbursement rates and the high cost of living, particularly housing, many physicians have given up their private practices for institutional employment or have left the county altogether. As physicians retire, new physicians are not moving to the area to fill the void. The remaining physicians are already overloaded with privately insured patient, and are less likely to take lower paying publicly insured patients, or uninsured patients. They have less time to volunteer, and are reluctant to take on additional burdens.

To overcome the low Medicare reimbursement rates, the Medical Society has filed an application with the federal Health Resources and Services Administration to designate San Luis Obispo County a Health Professional Shortage Area (HPSA). A HPSA designation would increase the Medicare reimbursement rates for all providers in the county. The very low Medi-Cal rates would not be affected.

Private provider participation in Medi-Cal has always been low due to low reimbursement rates, the onerous paperwork, and a population that is often not educated with the private practice model. CMSP participation has been similar.

Community clinics have relied upon recruitment of full time physicians. In a new partnership, FCC is entering into short-term contract with CHC to provide physician services at FCC clinics. If successful, a renewal of the contract is possible and it may become a model for future service delivery at FCC.

Access to specialists for safety net patients has also historically been limited, particularly in orthopedics. Both FCC and CHC have contracted with physicians, and FCC has also relied upon volunteer physicians to staff certain clinics. Some out of town specialists have also come to provide clinical services for children.

Community members had a number of suggestions for recruiting and retaining physicians. They proposed loan forgiveness programs for new physicians coming into the area, housing subsidy programs for new physicians, and development of residency programs.

Patient issues

a) Geographic access

As discussed above, access to safety net services is not available in all areas of the county. The rural and remote areas, such as Shandon and Creston, lack services, as does the north coast community of Cambria. Even where there are clinics, services are limited at many sites.

Residents in the far south of the county reported that they often go to Santa Maria for care. Not only are they closer to Santa Maria, but there are more providers who speak Spanish and accept Medi-Cal.

With very limited public transportation, families face additional barriers in accessing the available services. Unless they can spend all day coordinating with infrequent bus schedules, they need to rely on private transportation. Dial-a-ride services are not always available and the costs are barriers. Often they don't have a working vehicle, or the wage earner in the family has the car. They often rely on informal private transportation and pay dearly for the health care services they subsequently receive.

b) Limited English Proficient access

Patients and providers alike reported frustration regarding communications with persons of limited English proficiency (LEP). Although federal law requires minimal standards for interpretation (oral communication) and translations (written communication), such as the ATT Language Line, confidential provider-patient communication is impeded. Reliance on young family members, nonmedical staff, or providers with minimal proficiency in Spanish, does not substitute for communication with trained medical interpreters.

It was reported that many of the clinics have bilingual administrative staff. Some providers speak Spanish, particularly in the community clinics, and others rely on available interpreters, whether they are family members or other staff. While many providers have Spanish speaking staff, they rely on the ATT Language Line for less common language and dialects.

c) Ombudsman and consumer assistance

Over the years, General Hospital has been considered the safety net institution where uninsured, Medi-Cal, and CMSP patients could go to obtain a range of services. While all the other hospitals in the county serve the uninsured and Medi-Cal, and CHC has long served this population, the common advice to those struggling to find care was “Go to General, and they will take care of you.”

With the closure of SLOGH, and the full privatization of indigent inpatient care, community members want to ensure that full access will be maintained. Without the safety valve of the General emergency room and walk-in clinic, there is a concern that the other hospital’s emergency rooms are ill-equipped to handle both the increased volume of patients and the diversity of patients that were seen at General. There is also apprehension that the high cost of care and billing practices for non-emergency care will act as a barrier to obtaining care.

The Task Force and community members discussed the possible structures of an independent program that could monitor access and advocate on behalf of consumers having difficulty accessing the system. The program could also assist patients in qualifying for public coverage programs (e.g. Healthy Families and Medi-Cal), or negotiating medical bills.

Suggestions for staffing an “ombudsman” program were made at community meetings including use of volunteers or AmeriCorps participants to supplement the professional staff.

d) Hospital and provider billing

It was reported that medical debt was the number one reason for bankruptcy filing in the country. The consequences of medical debt are obvious – choices between housing, food, education, gas etc, must be made. The health consequences are not always obvious, but were strongly voiced by community members. Several community participants stated that due to large bills incurred in prior visits to the hospital, they delayed care and did not pursue care even though they knew it was needed. This resulted in increased pain and suffering, increased severity of the condition, and ultimately more expensive care.

Uninsured patients also were unaware that they could negotiate their bills at the hospitals. The “charges” invoiced to uninsured patients are the full “retail” charge, which is rarely, if ever, paid by health plans, insurance companies, or Medi-Cal. The hospital is often willing to accept a reduced fee, since they have little chance of collecting the entire bill. Uninsured patients are also willing to pay their bills, but it has to be within their means without sacrificing other necessities of life.

Financing issues

The current County General Fund annual contribution towards health care is estimated to be $10.3 million. Should the Board of Supervisors maintains that level of funding, it could be structured as follows:

- Approximately $9 million needs to be allocated to the current FCC operations, additional hospital payments for CMSP patients, and changes in Behavioral Health revenues and expenses.
- An additional $200,000 is required to fully fund physician services and provide enhanced on-call services for county patients.
- $100,000 will be made available for a patient hotline and advocacy services
- $1 million is available for enhancements, increases in costs, particularly pharmacy, and cost of living adjustments.

Even with the County's continued generous funding of indigent health care, there is insufficient funding in the system for the safety net. The Task Force discussed maximizing existing sources of revenues and reimbursements as well as developing new sources.

The dominant source of safety net funding in the United States is the federal/state Medicaid program, known as Medi-Cal in California. The federal government pays for approximately half of Medi-Cal expenditures, and the State pays the rest. Payments to primary care providers are generally accomplished in one of three methods: fee for service, managed care, and cost based reimbursement. We do not have Medi-Cal managed care in this county. Unless an entity qualifies for a special federal designation, they are paid on a fee for service basis which is often below the actual cost of providing the services. Hospital based clinics, such as FCC under General Hospital, received an additional per visit payment. That enhancement is unavailable with the closure of General Hospital.

Certain health clinics, known as Federally Qualified Health Centers (FQHC), receive payments based on their actual costs, rather than a schedule of reimbursement rates. This makes Medi-Cal a highly favored source of income to a non-profit clinic. Community Health Centers of the Central Coast is the FQHC in the County, although FCC is examining the risks and benefits in applying to the federal government for FQHC "Look Alike" status.[2] FQHC status is key to the financial stability of the FCC.

In addition to provider payments for seeing patients, certain safety net institutions, deemed "disproportionate share hospitals" (DSH) received grant funding from the federal government. General Hospital was the only DSH in

[2] FQHC "Look Alike" is very similar to the FQHC status, except that the "Look Alike" clinics do not get federal grants, but do get the enhanced reimbursement.

the county, and received approximately $1 million per year. Those payments are lost with the closure of the hospital.

Existing revenue sources may also be maximized by ensuring that all eligible persons are enrolled in available programs. Institutions and patients alike benefit from a third party payer, such as Medi-Cal or Healthy Families. It was noted that not all safety net facilities have “outstationed” Medi-Cal eligibility workers that could enroll eligible patients in the program. Similarly, CMSP enrollment takes place at the office on the SLOGH site, but there are plans to make applications available on line at all hospitals. Some providers are more diligent than others in trying to assist patients enroll in coverage programs.

Statewide there is an effort to allow on-line application for Medi-Cal and Healthy Families through Health-E-App. An extension of that pilot project, One-E-App would include local coverage programs such as CMSP.

One local effort of note is to provide health coverage to all children in the County. Spearheaded by the First 5 Commission, the program will maximize enrollment in Healthy Families and Medi-Cal, and create a new local coverage program for those low -income children who are not eligible for Healthy Families or Medi-Cal. The program, yet to be named, is in its planning stages with funding from First 5 and the County.

It was noted that bilingual and culturally competent staff were essential to maximizing enrollment in programs.

An additional source of funding for the safety net is tobacco litigation Master Settlement Agreement which provides approximately $2.5 million annually to San Luis Obispo County. Measure A, passed by the voters in March 2002, sets specific allocations for the funds. Included in the allocations are funds for community clinics (20%), and reimbursement of emergency room physicians (23%) and hospitals (6%) for non-paying patients.

New revenue streams. The Task Force noted that regardless of maximizing the current sources of revenue, there is still additional funding needed for the safety net. With one in seven persons uninsured, inadequate reimbursement from Medi-Cal, and double digit increases in private insurance premiums, the gap needs to be closed with new revenues earmarked for the safety net.

The Task Force explored various possibilities for new sources of revenue. The following table summarizes possible options for public funding:

Type of tax	**Necessary vote**	**Potential revenue**	**Comments**
Property tax	None if no	Variable	Need to form district through

	increase in tax		LAFCO, and negotiate with municipalities for a share of current revenues
Property tax	2/3 vote	Variable	For capital projects only
Parcel tax	2/3 vote	$500,000 per year if $7 on unimproved and $20 on improved parcels	Similar to Cambria Health Care District and recent LA County Trauma Care Center tax
Transient occupancy tax	2/3 Board vote for designated purpose; Maj. vote if not earmarked	1% increase yields approx. $500,000	Only available in unincorporated areas of county
Sales Tax	2/3 vote for designated purpose; Majority if not earmarked	½ cent yields $13.5 million; 80% from city areas; 20% from uninc. areas	Santa Maria is already ½ cent higher. Could do “A to Z” tax for multiple community purposes
Development fees	?		Can only be directly related to impact of development

Comments at the community meetings were supportive of increased taxes to support the safety net, but this support came from those who were interested in the safety net. They also had additional ideas such as “sin” taxes on alcohol and tobacco, bake sales and rental of advertising space on county vehicles and buildings.

Unlike other counties, San Luis Obispo County has for the most part not aggressively pursued grants to fund health programs and services. These potential sources of revenues from with public sources or private foundations often involve competitive processes with funds for demonstration projects, enhancements, start-ups, and innovations. Funds for ongoing services are generally limited.

Governance and administration

The task force noted that the safety net in San Luis Obispo is a patchwork of providers, programs, and financing mechanisms in the public and private sectors. There is no body or organization overseeing the safety net to coordinate services, ensure that there is adequate access to providers in all areas of the county, or monitor the system. The various governance structures of county departments, nonprofit organizations and private businesses make it impossible to have one overall governing body. However,

the Task Force did see a need for a coordinating body that ensures the viability of the safety net.

Services are provided by the public, nonprofit and private sectors. Although there did not appear to be much duplication of services, it was expressed that enhanced public-private partnerships are essential to an efficient system. There is an emerging relationship between the County and CHC. However, further involvement of the private physicians remains a challenge. With a limited supply of doctors due to the current physician shortage, it will take much effort to enlist more private providers into safety net services. Enhanced reimbursement rates would help, but there is an acknowledgment that safety net funding is limited and the State budget precludes any rate increases. Sharing on-call, easing referrals back to primary care providers, and making the payments system as painless as possible are potential ways to lure private providers back into the system.

The Medical Society has been working to bridge the gap between the private practitioners and the safety net clinic. The efforts are to be encouraged and should be expanded.

WHAT WE RECOMMEND

The following section contains the recommendations of the Task Force. The recommendations are divided into three sections. The first are those recommendations that the Task Force considers the basic minimum for a safety net in San Luis Obispo County. The second includes enhancements to the safety net that the Task Force considers highly desirable should funding be available. The third set of recommendations are those that would provide for an optimal system.

The recommendations are also presented in a chart in the Executive Summary.

Provider and services issues

1. Outpatient

Basic level of services

The Task Force recommends that there be a minimum of six primary care clinics located throughout the county as follows:

- Two in North County
- Two in South County
- One in San Luis Obispo and
- One on the North Coast

Services in *all* these locations should include:

Health Services

- Primary care physician services for adults and pediatrics
- Obstetrical services
- Primary care services on appointment basis with a walk-in capability
- Integration of public health and preventive services, e.g. immunizations, well baby
- Referrals to specialists in regions
- Mental health treatment for non-severe cases
- Pharmacy (some local, some centralized
- Laboratory draw stations
- Vision and hearing screening and referral

Patient Services

- Outstationed eligibility workers
- Billing and payment assistance
- Social services information and referral
- Linkages to community services such as in home supportive services (IHSS), SAFE System of Care, etc.
- Accept all coverages, and Medi-Cal- and CMSP-pending

- Advertised sliding fee scales

Regional services in north, central, and south should include:
- Extended and weekend hours
- Emergency dental care
- Substance abuse detox programs – social and outpatient and crisis evaluation
- Laboratory

Centralized services should include:
- Specialists in orthopedics, gastrointestinal, cardiology, surgery, infectious disease, HIV/Hepatitis C, psychiatric liaison, emergency mental health
- Pharmacy
- Operating room availability for complicated dental cases
- Residential detox program

Enhanced level of services

Health Services
- Vision services
- Inpatient detox program
- Regional dental services for restorative and preventive care
- Mobile clinics for basic services in rural, remote areas
- X-ray available regionally
- Referral to specialists in *regions*
- Specialists in neurology (consults) and dermatology
- Pharmacy in all regions

Patient Services
- Transportation assistance (vouchers, vans, etc.)
- Space for community providers at clinic sites (e.g. WIC, ASN)
- Integration of application processes for public programs, e.g. Medi-Cal, CMSP, Healthy Families

Optimal level of services

Health Services
- Model regional health and human services center on the North Coast (possibly in vacant San Luis Coastal Unified School District facility)
- Satellite clinics in rural, remote regions
- Vision services
- Inpatient substance abuse facility

Patient Services
- Acceptance of all coverages by all providers
- Community meeting room at clinics

- Universal and on line applications for public programs (One-E-App)

The exact services to be provided in each clinic should be subject to an inventory of available services in the community and patient needs. Determinations of specific services should be based upon ensuring that there is access to those services as noted above.

In addition, further study is needed on the issue of mental health services, and the County should develop a plan for further study and recommendations.

2. Provider shortage issues

The issue of provider shortages is being addressed on several levels. The Task Force recommendations include:

Basic level
- Support the Medical Society application for designation as a Health Professional Shortage Area
- Support increases in reimbursement rates for Medi-Cal and Medicare
- Support the use of physician extenders
- Support recruitment and retention efforts for all health care providers

Enhanced level
- Expand coverage for the uninsured starting with children (through the First 5 Health Insurance Initiative)
- Examine the possibility of incentives for new physicians, e.g. loan forgiveness or housing subsidies

Optimal level
- Universal health coverage
- Support the creation of a medical residency program

3. Public private partnership

- Encourage private provider participation through community efforts
- Encourage and expand partnerships between community and public agencies to increase coverage and avoid duplication. The CHC/FCC physician services agreement appears to be a good first step.

Patient Issues

1. Services for limited English proficient and hearing impaired patients

The Task force recommends:
Basic level

- Bilingual written material for prescriptions, discharge instructions, billing and education
- Trained medical interpreters for Spanish at all sites for both phone calls and providers
- Preference for bilingual personnel in hiring
- Sign interpreters at all sites by appointment
- Language line interpreters for non-Spanish LEPs

<u>Enhanced level</u>
- Development of local community resources to assist with interpretation

2. Consumer Assistance

The Task Force recommends the following for a consumer assistance program:

<u>Basic level</u>
- Bilingual staff
- Monitor access at safety net facilities (e.g. waiting times, services, twenty-four hour access).
- Act on patient complaints on cost, quality and access
- Quarterly reporting to County and community at large on safety net issues
- Program should be
    - Independent of providers and payers
    - Countywide
    - Community based
    - Have authority to act on complaints
    - Have an advisory committee of providers, patients and community representatives
    - Funded by public and private sources, including County, private providers and foundations
    - Selected through an RFP

<u>Enhanced level</u>
- Assistance with sliding scale fees and in negotiating medical bills with providers
- On-site assistance at clinics in understanding and applying for all public programs (Medi-Cal, Healthy Families, CMSP, CHDP, etc.)
- Education of staff and patients on appropriate processes

<u>Optimal level</u>
- Assistance with patient compliance and prevention education

Financing

The Task Force recommends:

Basic level

- County maintain its current $10.3 million general fund contribution with annual cost of living adjustments
- County apply for FQHC status should "due diligence" show it to be possible and advisable
- Efforts be made to maximize other funding such as reimbursement for Medi-Cal Administrative Activities and others
- New revenues be explored to supplement, not supplant, current sources including tax increases specifically designated for health services. As a first step, there should be polling of potential voters in San Luis Obispo to determine the likelihood of success and the scope of a ballot measure

Enhanced level

- Grant funding be pursued in a public-private partnership from federal and state sources as well as private foundations

Optimal level

- Local, dedicated funding stream for safety net

Governance

The Task Force recommends:

- The current provider independent governing boards remain intact
- Governing boards be established or expanded according to needs (e.g. FQHC Look-Alike consumer board).
- A health care council be created consisting of providers, and public and private representatives similar to the Task Force, to promote collaborative efforts, monitor access and make recommendations

CONCLUSION

The notion of convening community residents about the safety net arose at the time that the Board of Supervisors voted to close General Hospital. Since that time a number of changes have taken place in the health care environment in the county. General Hospital has closed; French and Arroyo Grande Hospitals have filed for bankruptcy and a sale is pending. A new dental clinic for low-income children opened in Paso Robles.

There is increased dialogue between the public and private sectors on ensuring a healthy safety net. The County Family Care Center has entered into a contract with the non-profit Community Health Centers of the Central Coast for physician services – the framework of a potential long-term partnership. Other relationships

have developed, in part due to the Future Vision process that will provide further opportunities for partnership between the various sectors in the County.

Universal health coverage and adequate reimbursement for providers for safety net patients will ultimately require federal or state solutions to the access problem. Providing universal health insurance locally for children through collaboration with potential partners such as the First Five Commission and other funders would provide significant progress in health access and is under evaluation at this time.

The recommendations of the Future Vision Task Force echo similar recommendations made by past committees. The debate is no there is longer about “saving General Hospital” but rather how to have the best system possible in our County. There is also a realization that the strong commitment from the Board of Supervisors for supporting the safety net will not be sufficient for maintaining a strong system. New and secure revenue streams are essential, and the community needs to support them. With the current economic and State budget climate, it will be a challenge to increase support for the system. The Task Force believes that if the residents of San Luis Obispo County put their collective resources together, a solution is possible.