CALENDAR FOR THE BOARD OF SUPERVISORS

CONTRA COSTA COUNTY

AND FOR SPECIAL DISTRICTS, AGENCIES, AND AUTHORITIES GOVERNED BY THE BOARD

BOARD CHAMBERS ROOM 107, ADMINISTRATION BUILDING, 651 PINE STREET
MARTINEZ, CALIFORNIA 94553-1229

GAYLE B. UILKEMA, *CHAIR*, 2nd DISTRICT
JOHN GIOIA, 1st DISTRICT
MARY N. PIEPHO, 3rd DISTRICT
KAREN MITCHOFF, 4th DISTRICT
FEDERAL D. GLOVER, 5th DISTRICT

DAVID J. TWA, CLERK OF THE BOARD AND COUNTY ADMINISTRATOR, (925) 335-1900

The Board of Supervisors respects your time, and every attempt is made to accurately estimate when an item may be heard by the Board. All times specified for items on the Board of Supervisors agenda are approximate. Items may be heard later than indicated depending on the business of the day. Your patience is appreciated.

AGENDA
October 11, 2011

9:00 A.M. Convene and adjourn to Closed Session in Room 101.

Closed Session Agenda :

A. CONFERENCE WITH LABOR NEGOTIATORS

1. Agency Negotiators: David Twa and Ted Cwiek.

Employee Organizations: Contra Costa County Employees' Assn., Local No. 1; Am. Fed., State, County, & Mun. Empl., Locals 512 and 2700; Calif. Nurses Assn.; Service Empl. Int'l Union, Local1021; District Attorney's Investigators Assn.; Deputy Sheriffs Assn.; United Prof. Firefighters, Local 1230; Physicians' & Dentists' Org. of Contra Costa; Western Council of Engineers; United Chief Officers Assn.; Service Empl. Int'l Union United Health Care Workers West; East County Firefighters' Assn.; Contra Costa County Defenders Assn.; Probation Peace Officers Assn. of Contra Costa County; Contra Costa County Deputy District Attorneys' Assn.; and Prof. & Tech. Engineers, Local 21, AFL-CIO.

2. Agency Negotiators: David Twa and Ted Cwiek.

Unrepresented Employees: All unrepresented employees.

B. CONFERENCE WITH LEGAL COUNSEL--EXISTING LITIGATION (Gov. Code, § 54956.9(a))

9:30 A.M. Call to order and opening ceremonies.

Inspirational Thought - *"Autumn is a second spring when every leaf is a flower."* ~ Albert Camus

CONSIDER CONSENT ITEMS (Items listed as C.1 through C.37 on the following agenda) – Items are subject to removal from Consent Calendar by request of any Supervisor or on request for discussion by a member of the public. Items removed from this section will be considered with the Short Discussion Item.

PRESENTATIONS

PR.1 PRESENTATION to honor Velma Bagby on her dedicated 38-year career with the State of California, retiring in 2011 as Deputy Division Chief in the Employment Development Department. (Supervisor Gioia) (See with C.10)

PR. 2 PRESENTATION proclaiming October 24-31, 2011 as Red Ribbon Week in Contra Costa County. (Dr. William Walker, Health Services Director) (See with C.11)

SHORT DISCUSSION ITEMS

SD. 1 PUBLIC COMMENT (3 Minutes/Speaker)

SD. 2 CONSIDER Consent Items previously removed.

DELIBERATION ITEMS

D. 1 CONSIDER accepting a report from Health Management Associates on the sustainability of the Contra Costa County Regional Medical Center and Health Centers; and PROVIDE direction to staff on further actions. (Theresa Speiker, Chief Assistant County Administrator)

D.2 CONSIDER reports of Board members.

Closed Session

CONSENT ITEMS

Special Districts & County Airports

C. 1 APPROVE and AUTHORIZE the Public Works Director, or designee, to terminate a 1994 service agreement with Diablo Water District for operations and maintenance of County Service Area M-28, Willow Mobile Home Park, Bethel Island. (No fiscal impact)

Claims, Collections & Litigation

C. 2 RECEIVE report concerning the final settlement of Gary Sly vs. County of Contra Costa; and AUTHORIZE payment from the Workers' Compensation Internal Service Fund in an amount not to exceed $75,000. (100% Workers' Compensation Internal Service Fund)

C. 3 RECEIVE report concerning the final settlement of Brenda Pozzesi vs. Contra Costa County; and AUTHORIZE payment from the Workers' Compensation Internal Service Fund in an amount not to exceed $25,000. (100% Workers' Compensation Internal Service Fund)

Statutory Actions

C. 4 ACCEPT Board member meeting reports for September 2011.

Honors & Proclamations

C. 5 ADOPT Resolution No. 2011/422 honoring Jim and Janet Frazier, Recipients of the 2011 Labor-to-Labor Community Service and Special Recognition Award, as recommended by Supervisor Gioia.

C. 6 ADOPT Resolution No. 2011/423 honoring Wilmer D. Ellis for being named the 2011 Labor-to-Labor Activist of the Year, as recommended by Supervisor Gioia.

C. 7 ADOPT Resolution No. 2011/424 honoring Ronald J. Lind, 2011 Labor-to-Labor Labor Leader of the Year, as recommended by Supervisor Gioia.

C. 8 ADOPT Resolution No. 2011/425 honoring Radback Energy, 2011 Labor-to-Labor Corporate Leader of the Year, as recommended by Supervisor Gioia.

C. 9 ADOPT Resolution No. 2011/432 recognizing the 40th anniversary of La Clinica de la Raza for providing low-cost health care services to the residents of Contra Costa County, as recommended by Supervisor Glover.

C.10 ADOPT Resolution No. 2011/433 honoring Velma Bagby on her dedicated 38-year career with the State of California, retiring in 2011 as Deputy Division Chief in the Employment Development Department, as recommended by Supervisor Gioia. (See PR.1)

C.11 Proclaiming Annual Red Ribbon Week in Contra Costa County Oct. 24-31, 2011. In recognition to the on-going prevention efforts of families, schools and community organizations in education and outreach programs that clearly communicate to children and youth the dangers inherent in alcohol and drug abuse, including prescription drug misuse.
(See with PR. 2)

Appointments & Resignations

C.12 DECLARE vacant At Large seat 4 on the Contra Costa Commission for Women previously held by Sara Mendoza due to resignation; and DIRECT the Clerk of the Board to post the vacancy, as recommended by the County Administrator.

C.13 REMOVE Joan Means from District IV Seat on First 5 Contra Costa Children and Families Commission; DECLARE the District IV seat vacant, and DIRECT clerk to post the vacancy, as recommended by Supervisor Mitchoff.

Intergovernmental Relations

C.14 ACCEPT report from the Transportation, Water and Infrastructure Committee on recent reprogramming of surplus Federal dredging funds by the U.S. Army Corps of Engineers.

Personnel Actions

C.15 ADOPT Position Adjustment Resolution No. 21001 to add two 20/40 Board of Supervisors Assistant-General Office and cancel one 40/40 Board of Supervisors Assistant-General Secretary in the District V Board of Supervisors Office. (Cost Neutral)

Grants & Contracts

APPROVE and AUTHORIZE execution of agreements between the County and the following agencies for receipt of fund and/or services:

C.16 APPROVE and AUTHORIZE the Librarian, or designee, to apply for and accept a California State Library, Library Services and Technology Act Pitch an Idea Fiscal Year 2011/12 program grant in the amount of $50,000 for the development and implementation of market analysis tools for library programs and services for the period September 1, 2011 through August 30, 2012. (No Library fund match)

C.17 APPROVE and AUTHORIZE the Animal Services Director, or designee, to execute a contract with the State of California, Food and Agriculture Department, to pay the County an amount not to exceed $15,000 for a Spay and Neuter Program for the period of January 1, 2011 through December 31, 2011. (100% State funds)

C.18 APPROVE and AUTHORIZE the District Attorney, or designee, to submit an application and execute a grant award agreement, and any extensions or amendments thereof, pursuant to State guidelines, with the California Emergency Management Agency, Victim Services Branch, for funding of the Underserved Victim Advocacy and Outreach Program for the period October 1, 2011 through September 30, 2012 in the amount of $125,000. (25% In-kind match provided by

Cities of Richmond and Pittsburg)

APPROVE and AUTHORIZE execution of agreement between the County and the following parties as noted for the purchase of equipment and/or services:

C.19 APPROVE and AUTHORIZE the Health Services Director, or designee, to execute a contract with The Center for Common Concerns, Inc., (dba HomeBase), in an amount not to exceed $190,000, to provide consultation and technical assistance to the Department with regard to Continuum of Care planning and resource development for the period October 1, 2011 through September 30, 2012. (58% Federal Medi-Cal Administrative Activities, 42% budgeted County General funds)

C.20 APPROVE and AUTHORIZE the Health Services Director, or designee, to execute a contract with Greater Richmond Inter-Faith Program, in an amount not to exceed $1,252,919, to provide emergency shelter program services for youth for the period October 1, 2011 through September 30, 2012. (45% Federal funding, 40% State Mental Health Services Act, and 15% Contra Costa Employment and Human Services Department)

C.21 APPROVE and AUTHORIZE the Health Services Director, or designee, to execute a contract with La Cheim School, Inc., in an amount not to exceed $600,000, to provide a school-based day treatment program and mental health services for the period from July 1, 2011 through June 30, 2012, including a six-month automatic extension through December 31, 2012, in an amount not to exceed $300,000. (37% Federal FFP Medi-Cal, 37% State Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), 26% School District Funds)

C.22 APPROVE and AUTHORIZE the Health Services Director, or designee, to execute a contract with Pittsburg Antioch Medical Group, APC (dba Springhill Medical Group), in an amount not to exceed $150,000, to provide professional primary care, cardiology, neurology, pulmonary, and endocrinology services for Contra Costa Health Plan members for the period October 1, 2011 through September 30, 2013. (100% CCHP Members Premiums)

C.23 APPROVE and AUTHORIZE the Conservation and Development Director, or designee, to execute a contract amendment with Wallace, Roberts and Todd, LLC, to extend the term of the contract to June 30, 2012 and to increase the contract limit by $41,020, to a new total payment limit of $997,377 to provide additional services related to the preparation of the Specific Plan and Environmental Impact Report for a portion of the North Richmond Redevelopment Area.

C.24 APPROVE and AUTHORIZE the General Services Deputy Director, or designee, to execute a contract with HDR, for as-needed architectural services for various health facilities projects, in an amount not to exceed $300,000, for the period October 18, 2011 through October 18, 2013. (100% Health Services Department funding)

C.25 APPROVE the new medical staff members, residents, staff affiliations, renewal and additional privileges, provisional extensions, advancement to permanent staff, biennial reappointments and resignations, as recommended by the Medical Executive Committee at their September 19, 2011 Meeting, and by the Health Services Director.

C.26 APPROVE and AUTHORIZE the Purchasing Agent, on behalf of the Health Services Department, to execute a purchase order with Data Systems Group in the amount not to exceed $150,000 for license support and software upgrades of the electronic claims and remittance system software, for the period from September 1, 2011 through August 31, 2012. (100% Enterprise Fund I)

C.27 APPROVE and AUTHORIZE the Health Services Director, or designee, to execute a contract with John Muir Behavioral Health Center in an amount not to exceed $1,000,000, to provide inpatient psychiatric hospital services for the period July 1, 2011 through June 30, 2012. (100% Mental Health Realignment funds)

C.28 APPROVE and AUTHORIZE the Health Services Director, or designee, to execute a contract with ZiaPartners, Inc., in an amount not to exceed $154,280, for consultation, training and technical assistance with regard to integration of the Health Services Department's Behavioral Health Division for the period October 1, 2011 through September 30, 2012. (100% Mental Health Realignment)

C.29 APPROVE and AUTHORIZE the Health Services Director, or designee, to execute a contract with Annie Thomas, M.D., in an amount not to exceed $174,720 to provide professional outpatient psychiatric services for the period October 1, 2011 through September 30, 2012. (100% Mental Health Realignment)

C.30 APPROVE and AUTHORIZE the Health Services Director, or designee, to execute amendments to specified contracts, effective October 1, 2011, to modify the service plan to include provisions allowing for assignment of fees and insurances benefits for electronic health records to the County, with no change in the payment limits and no change in the terms. (No fiscal impact)

Other Actions

C.31 APPROVE the Fiscal Year 2011/12 Keller Canyon Mitigation Fund (KCMF) allocation plan, as recommended by the KCMF Review Committee; and AUTHORIZE the Department of Conservation and Development Director, or designee, to enter in contracts with the agencies for the period July 1, 2011 to June 30, 2012.

C.32 AWARD a contract in the amount of $1,295,000 to W.A. Thomas Company, Inc., the lowest responsive and responsible bidder for the Residential Facility for the Homeless Project at 4639 Pacheco Blvd., Martinez, for the Health Services Department. AUTHORIZE the Deputy General Services Director, or designee, to execute the contract. (61% State Emergency Housing Assistance Program - Capital Development Grant, 39% Community Development Block Grant)

C.33 ADOPT Resolution No. 2011/428 amending appointments for Board Member Committee Assignments to reflect the addition of the TRAFFIX Board of Directors appointment and alternate and including these appointments in the Master List of appointments of Board members and other individuals to serve on Board committees, special county committees, and regional boards/ committees/commissions for 2011, as recommended by Supervisor Uilkema.

C.34 ADOPT Resolution No. 2011/431 authorizing the sale of specified tax-defaulted property at public auction, pursuant to the California Revenue and Taxation Code §3698, as recommended by the Treasurer-Tax Collector.

C.35 CONTINUE the emergency action originally taken by the Board of Supervisors on November 16, 1999 regarding the issue of homelessness in Contra Costa County, as recommended by the Health Services Director.

C.36 ACCEPT status report regarding update to the County's "Garaging of County Vehicles at and Employee's Home" policy, as recommended by the County Administrator.

C.37 AUTHORIZE the Department of Conservation and Development to study the feasibility of establishing a San Francisco-to-Stockton Maintenance Assessment District for channel dredging purposes in the Pinole Shoal Channel, Suisun Bay Channel, New York Sough, and Concord Naval Weapons Station shoreline areas, as recommended by the Transportation, Water and Infrastructure Committee.

GENERAL INFORMATION

The Board meets in all its capacities pursuant to Ordinance Code Section 24-2.402, including as the Housing Authority and the Redevelopment Agency. Persons who wish to address the Board should complete the form provided for that purpose and furnish a copy of any written statement to the Clerk.

Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the Clerk of the Board to a majority of the members of the Board of Supervisors less than 72 hours prior to that meeting are available for public inspection at 651 Pine Street, First Floor, Room 106, Martinez, CA 94553, during normal business hours.

All matters listed under CONSENT ITEMS are considered by the Board to be routine and will be enacted by one motion. There will be no separate discussion of these items unless requested by a member of the Board or a member of the public prior to the time the Board votes on the motion to adopt.

Persons who wish to speak on matters set for PUBLIC HEARINGS will be heard when the Chair calls for comments from those persons who are in support thereof or in opposition thereto. After persons have spoken, the hearing is closed and the matter is subject to discussion and action by the Board. Comments on matters listed on the agenda or otherwise within the purview of the Board of Supervisors can be submitted to the office of the Clerk of the Board via mail: Board of Supervisors, 651 Pine Street Room 106, Martinez, CA 94553; by fax: 925-335-1913.

The County will provide reasonable accommodations for persons with disabilities planning to attend Board meetings who contact the Clerk of the Board at least 24 hours before the meeting, at (925) 335-1900; TDD (925) 335-1915. An assistive listening device is available from the Clerk, Room 106.

Copies of taped recordings of all or portions of a Board meeting may be purchased from the Clerk of the Board. Please telephone the Office of the Clerk of the Board, (925) 335-1900, to make the necessary arrangements.

Forms are available to anyone desiring to submit an inspirational thought nomination for inclusion on the Board Agenda. Forms may be obtained at the Office of the County Administrator or Office of the Clerk of the Board, 651 Pine Street, Martinez, California.

Applications for personal subscriptions to the weekly Board Agenda may be obtained by calling the Office of the Clerk of the Board, (925) 335-1900. The weekly agenda may also be viewed on the County's Internet Web Page:

www.co.contra-costa.ca.us

STANDING COMMITTEES

The **Airport Committee** (Supervisors Karen Mitchoff and Mary N. Piepho) meets on the fourth Thursday of the month at 10:00 a.m. at Director of Airports Office, 550 Sally Ride Drive, Concord.

The **Family and Human Services Committee** (Supervisors Gayle B. Uilkema and Federal D. Glover) meets on the second Monday of the month at 11:00 a.m. in Room 101, County Administration Building, 651 Pine Street, Martinez.

The **Finance Committee** (Supervisors John Gioia and Federal D. Glover) meets on the first Monday of the month at 1:30 p.m. in Room 101, County Administration Building, 651 Pine Street, Martinez.

The **Internal Operations Committee** (Supervisors Mary N. Piepho and John Gioia) meets on the third Monday of the month at 9:30 a.m. in Room 101, County Administration Building, 651 Pine Street, Martinez.

The **Legislation Committee** (Supervisors Karen Mitchoff and John Gioia) meets on the third Monday of the month at 11:00 a.m. in Room 101, County Administration Building, 651 Pine

Street, Martinez.

The **Public Protection Committee** (Supervisors Federal D. Glover and Gayle B. Uilkema) meets on the first Monday of the month at 11:00 a.m. in Room 101, County Administration Building, 651 Pine Street, Martinez.

The **Transportation, Water & Infrastructure Committee** (Supervisors Mary N. Piepho and Karen Mitchoff) meets on the second Wednesday of the month at 9:30 a.m. in Room 101, County Administration Building, 651 Pine Street, Martinez.

Airports Committee	Oct 27, 2011	10:00 A.M.	See above
Family & Human Services Committee	Nov 14, 2011	11:00 A.M.	See above
Finance Committee	Nov 7, 2011	1:30 P.M.	See above
Internal Operations Committee	Oct 25, 2011	2:00 P.M.	See above
Legislation Committee	Oct 24, 2011	10:00 A.M.	See above
Public Protection Committee	Nov 7, 2011	11:00 A.M.	See above
Transportation, Water & Infrastructure Committee	Oct 24, 2011	2:00 P.M.	See above

PERSONS WHO WISH TO ADDRESS THE BOARD MAY BE LIMITED TO THREE (3) MINUTES

AGENDA DEADLINE: Thursday, 12 noon, 12 days before the Tuesday Board meetings.

Glossary of Acronyms, Abbreviations, and other Terms (in alphabetical order):

Contra Costa County has a policy of making limited use of acronyms, abbreviations, and industry-specific language in its Board of Supervisors meetings and written materials. Following is a list of commonly used language that may appear in oral presentations and written materials associated with Board meetings:

AB Assembly Bill
ABAG Association of Bay Area Governments
ACA Assembly Constitutional Amendment
ADA Americans with Disabilities Act of 1990
AFSCME American Federation of State County and Municipal Employees
AICP American Institute of Certified Planners
AIDS Acquired Immunodeficiency Syndrome
ALUC Airport Land Use Commission
AOD Alcohol and Other Drugs
ARRA American Recovery & Reinvestment Act of 2009
BAAQMD Bay Area Air Quality Management District
BART Bay Area Rapid Transit District
BayRICS Bay Area Regional Interoperable Communications System
BCDC Bay Conservation & Development Commission
BGO Better Government Ordinance
BOS Board of Supervisors
CALTRANS California Department of Transportation
CalWIN California Works Information Network
CalWORKS California Work Opportunity and Responsibility to Kids
CAER Community Awareness Emergency Response
CAO County Administrative Officer or Office
CCCPFD (ConFire) Contra Costa County Fire Protection District
CCHP Contra Costa Health Plan
CCTA Contra Costa Transportation Authority
CCRMC Contra Costa Regional Medical Center
CCWD Contra Costa Water District
CDBG Community Development Block Grant
CFDA Catalog of Federal Domestic Assistance
CEQA California Environmental Quality Act
CIO Chief Information Officer

COLA Cost of living adjustment
ConFire (CCCFPD) Contra Costa County Fire Protection District
CPA Certified Public Accountant
CPI Consumer Price Index
CSA County Service Area
CSAC California State Association of Counties
CTC California Transportation Commission
dba doing business as
EBMUD East Bay Municipal Utility District
ECCFPD East Contra Costa Fire Protection District
EIR Environmental Impact Report
EIS Environmental Impact Statement
EMCC Emergency Medical Care Committee
EMS Emergency Medical Services
EPSDT Early State Periodic Screening, Diagnosis and Treatment Program (Mental Health)
et al. et alii (and others)
FAA Federal Aviation Administration
FEMA Federal Emergency Management Agency
F&HS Family and Human Services Committee
First 5 First Five Children and Families Commission (Proposition 10)
FTE Full Time Equivalent
FY Fiscal Year
GHAD Geologic Hazard Abatement District
GIS Geographic Information System
HCD (State Dept of) Housing & Community Development
HHS (State Dept of) Health and Human Services
HIPAA Health Insurance Portability and Accountability Act
HIV Human Immunodeficiency Syndrome
HOV High Occupancy Vehicle
HR Human Resources
HUD United States Department of Housing and Urban Development
IHSS In-Home Supportive Services
Inc. Incorporated
IOC Internal Operations Committee
ISO Industrial Safety Ordinance
JPA Joint (exercise of) Powers Authority or Agreement
Lamorinda Lafayette-Moraga-Orinda Area
LAFCo Local Agency Formation Commission
LLC Limited Liability Company
LLP Limited Liability Partnership
Local 1 Public Employees Union Local 1
LVN Licensed Vocational Nurse
MAC Municipal Advisory Council
MBE Minority Business Enterprise
M.D. Medical Doctor
M.F.T. Marriage and Family Therapist
MIS Management Information System
MOE Maintenance of Effort
MOU Memorandum of Understanding
MTC Metropolitan Transportation Commission
NACo National Association of Counties
NEPA National Environmental Policy Act
OB-GYN Obstetrics and Gynecology
O.D. Doctor of Optometry
OES-EOC Office of Emergency Services-Emergency Operations Center
OPEB Other Post Employment Benefits
OSHA Occupational Safety and Health Administration
PARS Public Agencies Retirement Services
Psy.D. Doctor of Psychology
RDA Redevelopment Agency
RFI Request For Information
RFP Request For Proposal
RFQ Request For Qualifications
RN Registered Nurse
SB Senate Bill
SBE Small Business Enterprise
SEIU Service Employees International Union
SUASI Super Urban Area Security Initiative
SWAT Southwest Area Transportation Committee
TRANSPAC Transportation Partnership & Cooperation (Central)
TRANSPLAN Transportation Planning Committee (East County)
TRE or **TTE** Trustee
TWIC Transportation, Water and Infrastructure Committee
UASI Urban Area Security Initiative
VA Department of Veterans Affairs
vs. versus (against)
WAN Wide Area Network
WBE Women Business Enterprise
WCCTAC West Contra Costa Transportation Advisory Committee

To: **Board of Supervisors**

From: **David Twa, County Administrator**

Date: **October 11, 2011**

Contra Costa County

Subject: Report from Health Management Associates on Hospital Sustainability

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RECOMMENDATION(S):

CONSIDER accepting a report from Health Management Associates on the sustainability of the Contra Costa County Regional Medical Center and Health Centers and PROVIDE direction to staff on further actions.

FISCAL IMPACT:

No fiscal impact - report only. Implementation of options in the report may have an undetermined fiscal impact.

BACKGROUND:

On January 18, 2011, the Board of Supervisors approved a contract with Health Management Associates, Inc . (HMA) to conduct a sustainability review of the County's hospital, clinic and health plan system. Since that time, HMA has been working with staff from the County Administrator's Office, Health Services Department, other County departments, local hospitals, and a host of others to conduct their audit.

The goal of the audit was to develop policy options that can increase the financial and programmatic sustainability of the Contra Costa Regional Medical Center and the health center and clinic system in the County.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☑ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ☐ NOES ☐

ABSENT ☐ ABSTAIN ☐

RECUSE ☐

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Dorothy Sansoe, 925-335-1009

cc:

BACKGROUND: (CONT'D)

On September 28, 2011, Health Management Associates presented the report to the Medical Services Joint Conference Committee (JCC) as requested by the Board of Supervisors. This presentation was conducted in an open meeting attended by hospital staff, the public, staff from other County departments, and the press. An opportunity was provided to the audience to ask questions and make comments. The JCC then provided direction to staff including bringing this presentation to the Board of Supervisors on October 11, 2011 for discussion and direction.

Attached to this Board Order as part of this Background section is a complete copy of the Sustainability Audit, including a transmittal letter from the County Administrator; Frequently Asked Questions; Highlights; Stage I, II, and III reports including executive summaries; and the original Request for Proposals.

The entire audit is also available for download on at County internet site at: www.co.contra-costa.ca.us.

CONSEQUENCE OF NEGATIVE ACTION:

Opportunities to improve the on-going sustainability of the Contra Costa Regional Medical Center and Health Centers may be lost.

CHILDREN'S IMPACT STATEMENT:

Not applicable.

CONTRA COSTA COUNTY

HEALTH CARE SUSTAINABILITY 2011

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Sustainability Audit of the Contra Costa County Regional Medical Center and Health Centers

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County of Contra Costa
OFFICE OF THE COUNTY ADMINISTRATOR
MEMORANDUM

DATE: September 15, 2011

TO: Board of Supervisors

FROM: David J. Twa
County Administrator

SUBJECT: **SUSTAINABILITY AUDIT OF THE CONTRA COSTA COUNTY REGIONAL MEDICAL CENTER AND HEALTH CENTERS**

BACKGROUND INFORMATION

In 2009, shortly before the enactment of federal health care reform legislation known as the Affordable Care Act (ACA), the Board of Supervisors authorized the County Administrator to conduct a sustainability review (referred to as a "sustainability audit"), of facilities operated by Contra Costa Health Services Department. This work was part of ongoing Board deliberations, undertaken to consider various possibilities for provision of health care services to County residents.

The review was authorized to develop policy options to support the sustainability of the County's health care system and to present information that could assist Supervisors in ensuring the most efficient and effective delivery of health care services to Contra Costa County residents. The work was to take into account any federal and/or state health care reform measures that might be enacted and that would affect County programs and services. Since 2009 the national and state health care scene has been in an almost constant state of flux.

Significant work, undertaken at both the federal and the state levels of government, had and continues to have the potential to markedly affect the design and financing of health care. Passage of federal health care reform legislation in March 2010, followed shortly thereafter by State legislation to create the Health Benefit Exchange to implement national health care reform in California, has been part of this work. In November 2010, Federal and State action authorized the renewal of California's 1115 Medicaid Waiver. This Waiver, called the "Bridge to Reform", is a plan to slow the rate of growth in health care costs in the Medi-Cal program, and to enable federal reforms to take effect as planned in 2014. State budget deliberations in California, the debt ceiling debate and subsequent plan for deficit reduction in Washington, carry the possibility over the next several years to alter the financing, terms and conditions in current health care reform legislation, rules and regulations.

Because of the evolving health care climate, the County Administrator's Office adjusted the time frame for conducting the study to ensure that materials within the report would accurately reflect the most current status of health care issues.

By January 2011, both the federal and California State government had taken action on health care legislation, and the environment had stabilized enough to engage a consulting firm with knowledge of public health care and the requirements on county government and specializing in the field of health care finance and delivery. The County Administrator's Office asked Health Management Associates (HMA), to conduct the sustainability study and to reflect current laws, regulations and financial information from all levels of government in the final document.

TRANSMITTAL MATERIALS

This memo, the HMA sustainability audit and all accompanying materials together represent the accumulated work of the study. The transmittal memo, "Frequently Asked Questions" about the study and its contents, and report hightlights were prepared by the County Administrator's Office to accompany the materials submitted by HMA.

These documents are being transmitted to the Board of Supervisors to assist with ongoing policy deliberations about the role of Contra Costa County government in ensuring the availability of health care to residents of the County.

The HMA study contains an extensive amount of background information and data specific to Contra Costa County's health care system and medical facilities. Much of this information was provided through the work of departmental leadership, the management team and staff within the Health Services Department. This report could not have been possible without their involvement in the project and diligence in providing the materials requested. Their input and engagement has been appreciated by both the County Administrator's Office and the members of the HMA consultant team.

COUNTIES' RESPONSIBILITIES TO PROVIDE HEALTH CARE

County governments and Boards of Supervisors in California's counties are required by State law to ensure that health care to their residents who are medically indigent is available within their community. In addition to making sure that this care is available, counties are also required to participate, with the State and Federal government, in helping to cover the costs.

County Boards do have some options, within guidelines set by the federal and California State government, to choose how and what types and levels of indigent medical care will be available, and how persons living in their counties can access it.

Both the State and Federal government provide California counties with financial assistance to help pay for the costs of providing medical care to their indigent residents. However, these funds never cover the costs in full, and county governments are required by State and Federal law to provide local funds to fill in these gaps.

The Contra Costa Board of Supervisors has been regularly discussing available options to deliver and pay for the Federal and State requirements for provision of health care to County residents who are medically indigent. Within the past few years, the County's budget challenges and financial difficulties have added a new level of urgency to these discussions. The HMA report

was developed to assist the Board of Supervisors and County Administrator to consider the most desirable options for ensuring the provision of health care services, within the context of the County's financial picture, community expectations and State and Federal laws, guidelines, requirements and the funding assistance that is available.

NATIONAL HEALTH CARE REFORM AND COUNTY GOVERNMENT

The mandate for California county government to ensure and/or provide health care to their medically indigent residents is similar to the requirements in state laws throughout much of the country. Consequently, county governments followed the 2010 enactment and beginning steps towards implementation of the ACA with great interest. Because counties play such a pivotal role in the funding and provision of health care to their medically indigent residents, county Boards are finding it necessary to pay careful attention to the opportunities and challenges afforded in this complicated legislation and retool their systems accordingly.

As the HMA report indicates, the initial steps of implementation of the ACA have begun to relieve counties, including Contra Costa County, of some costs associated with the provision of medical care to their residents who are not insured or who are under-insured. Continued implementation of this law, as it's currently written, holds the promise for further significant financial assistance with these costs, and the report identifies opportunities that the Board of Supervisors might want to pursue or have researched further.

However, it's important to reiterate that the HMA report has been developed with the assumption that health care reform will continue to be implemented in the time frame and the fashion contained within current laws and the rules and regulations that have been and are being made. Options and calculations within the report have been developed in that context and should be viewed accordingly. If laws, rules or regulations are changed substantially, repealed or held unconstitutional (the Supreme Court is likely to take up the issue of mandated insurance and taxation in relation to the law during the 2011/12 term) there would be significant impact on the options and calculations within this report. Also, if the funding that's been assumed to be available in already-enacted legislation does not occur, calculations contained in the report will be affected as well.

PREVIOUS REPORTS AND THE HMA MATERIALS

Over the past few years there have been a number of studies considered by the Board of Supervisors at their regular Board meetings that have looked at various aspects of Contra Costa County's health care delivery system and related issues. These studies have reviewed such topics as options for changes in governance or structure of the medical center and clinic system, provision of and financing for medical care for persons who are incarcerated, human resource issues, total compensation data for staff and the eligibility levels and types of heath care benefits available to users of the system. The information and findings from these studies are referenced throughout the HMA report. Some of the findings are woven into the options that are presented for consideration by the Board of Supervisors. The work from these previous studies was not duplicated by HMA but was incorporated into this report wherever it was appropriate.

Within the HMA report there are several references to the changing situation at Doctor's Medical Center in San Pablo. In addition, information about the health care needs and available resources for County residents who use the services available through Doctor's Medical Center can be found in the report. This study does not explicitly cover options regarding the hospital and it was not part of the consultant's work for the sustainability review. However, Doctor Walker, Director of the Health Services Department, will provide information about the current situation regarding this facility as the Board of Supervisors considers their policy options.

PUBLIC ACCESS TO THE HMA REPORT AND RELATED MATERIALS

This report will be presented to the Joint Conference Committee of the Board of Supervisors at a special meeting of the Committee on Wednesday, September 28, 2011, at 12:30 p.m. in the Building One Conference Room, 2500 Alhambra Avenue, Martinez, California, and to the Board of Supervisors on Tuesday, October 4, 2011, from 10:30-12:00 noon, in the Board Chambers, County Administration Building, 651 Pine Street, Martinez, California. These and any subsequent public meetings on the topic will be publicized, noticed and posted in accordance with California State law and County Board policies.

Written materials, including the report and attachments and the Request for Proposals (RFP) announcing the study can be found on the county's website at http://www.co.contra-costa.ca.us/index.aspx?nid=94 . For questions or additional assistance to access the HMA report, please contact Terry Speiker in the Office of the County Administrator at 925-335-1096.

Sustainability Audit of the Contra Costa County Regional Medical Center and Health Centers
Frequently Asked Questions

What is the purpose of this report?

The goals of the audit are to develop policy options for Supervisorial consideration that will support the financial and programmatic sustainability of Contra Costa County's health care system, including the County's hospital and medical centers, and to ensure we have an effective and efficient delivery of medical services for County residents in conjunction with the implementation of health care reform. The report assumes that health care reform legislation continues to be implemented and all policy options, data and projections are based on that assumption.

Who authorized the report?

The Contra Costa Board of Supervisors, approving a recommendation from the County Administrator, authorized the audit in October of 2009, awarding the contract in January of 2011.

How much did it cost?

The contract amount is $390,000.

Who performed the audit?

The highly respected firm of Health Management Associates (HMA) was contracted to do the research, interviews, analysis and development of options to be considered by the Board of Supervisors. Staff in the County Administrator's Office and the Health Services Department worked with HMA to provide data and information for the final report. HMA was selected through a competitive bidding process.

When will the details be released?

All of the materials from the audit will be accessible from a link on the home page of the County's website Friday, September 16, 2011, at www.contracosta.ca.gov.

With budget cuts causing many Contra Costa County departments to reduce staffing and services, why didn't the study look at the possibility of allowing hospital and medical services to be absorbed by the private sector?

The audit did pose that question, but found that a significant lack of primary care service and hospital bed space outside the County system makes abandoning the current public hospital and clinic model impossible. In addition, counties remain legally responsible to provide care. For many services counties deliver, they are acting as agents of the state, providing services mandated by law from the State of California. This scenario is true for medical care; counties are required to provide health services to

their most vulnerable residents. We do have options regarding how those services are delivered and made available to county residents, and this audit will help guide the Supervisors' policy decisions about future service delivery and the design of the system.

What are some of the major findings of the audit?

With federal health care reform on the horizon via the Affordable Care Act, the consultants find Contra Costa County is positioned well to take advantage of the opportunities the Act will provide to enhance health care for county residents who are uninsured or under-insured.

Programmatic and policy options identified throughout the report can add to the system's sustainability. Crucial next steps, including such things as implementation of electronic medical records and the Patient-centered Medical Home, are highlighted in the audit.

The Health Services Department has done an excellent job of identifying and maximizing federal funding opportunities, consistently looking for ways to make the system as sustainable as possible and diminishing dependence on General Fund revenue. Consequently, the study found few new ideas for sources of revenue that had not already been utilized.

The General Fund Budget for the Hospital, Health Centers and Health Plan has been reduced by approximately $21.4 million over the past four years. These reductions are the result of cost controls and work improvements in the Department, excellent utilization of all available outside revenue sources and actions by the Board of Supervisors and County Administration in setting the Departmental budget.

In 2009, there were 154,000 uninsured residents in Contra Costa County. This number is projected to be reduced to as few as 41,000 residents in 2014. More information on this impact of the Affordable Care Act in the County can be found in the Report on pages 45-49.

It is doubtful that our public health care system alone will be able to meet future medical needs of vulnerable populations in Contra Costa County without assistance from the private sector. Public/private partnerships will continue to need exploration and development when health care reform provides access to care for people who will be newly or more adequately insured and those who remain without insurance coverage.

What happens next?

The Sustainability Audit will be presented to the Medical Services Joint Conference Committee of the Board of Supervisors on Wednesday, September 28, 2011, at 12:30 p.m., at the Contra Costa Regional Medical Center Campus in the Martinez Health Center/Building 1 North Conference Room, at 2500 Alhambra Avenue, Martinez. On Tuesday, October 4, 2011, the report will be presented to the full Board of Supervisors at 10:30 a.m. That presentation will take place during the Board's regular business meeting at 651 Pine Street in Martinez.

Many policy and program options in the design of the County's system are presented for Board consideration. Meetings regarding these options will continue to be publicly noticed in advance.

Background Information about the Contra Costa County Regional Medical Center and Health Centers

Contra Costa Regional Medical Center is a general acute care teaching facility. The 166 licensed bed center provides a full range of diagnostic and therapeutic services, including medical/surgical, intensive care, emergency, prenatal/obstetrical, and psychiatric services. Ancillary services include pharmacy, rehabilitation, medical social work, laboratory, diagnostic imaging, cardiopulmonary therapy and ambulatory care surgery service. The licensed basic emergency room provides medical and psychiatric evaluation/treatment of urgent cases.

The ten ambulatory care Health Centers provide a wide variety of services. Strategically located in parts of east, west and central Contra Costa County, they provide family practice-oriented primary care, geriatrics, dental, rehabilitation, prenatal and adult medical services, as well as specialty clinic services. Specialty clinics include: podiatry, infectious disease, pediatrics, eye, dermatology, orthopedics, urology, ENT, gynecology, Hansen's disease, and others.

A wide range of physician services are offered at the hospital and clinics by more than 100 family practice physicians, as well as family nurse practitioners, dentists, psychiatrists, psychologists and more than 306 specialty physicians. A Family Practice Residency Program affiliated with the University of California, Davis, provides clinical experience for over 39 residents who rotate through all inpatient acute services and provide staff for the emergency room and ambulatory care centers.

The Regional Medical Center does require some financial support from the County, as it provides care to individuals with a variety of insurance coverage. Examples of these include Medicare, Medi-Cal and private insurance. The cost of care provided to these individuals is offset by the fees collected. The Medical Center also provides services to indigent people who cannot pay for them. This unreimbursed amount is reflected in the budget as a contribution from the General Fund.

Contra Costa County, as do all California counties, has a legal obligation to provide medical services to our residents. The Medical Center provides services to individuals who cannot pay because the County has a general duty to provide care for indigent, as specified by the State of California in the Welfare and Institutions Code section 17000. The County Board of Supervisors is authorized to adopt standards of aid and care for the indigent and has done so. The County's indigent health care program is named the Basic Health Care (BHC) program. Under the BHC program, legal residents of Contra Costa County with incomes of less than 300 percent of the Federal Poverty Level are eligible for medical services at Contra Costa Regional Medical Center. Like all hospitals, however, the Contra Costa Regional Medical Center must offer services to anyone entering through the emergency department, regardless of ability to pay or citizenship.

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Sustainability Audit of the Contra Costa County Regional Medical Center and Health Centers

Report Highlights

Background:

- The goal of the audit, as authorized by the Board of Supervisors, was to develop policy options that can increase the financial and programmatic sustainability of Contra Costa County's Regional Medical Center (CCRMC) and the health centers and clinics; to research and present ideas that would support the operation of a highly effective and efficient health care delivery system and to develop all options in the context of health care reform. In addition, the audit was to take into account the mandates in State law for California counties to provide health care services to medically indigent residents as well as Contra Costa County's current and projected financial situation.

- The definition of "sustainability" that is used, for the purposes of the audit, is a system that has "appropriate capacity and effective and efficient use of that capacity to meet the needs of the population of persons being served." Options presented within the report are designed to support or create effective and efficient use of system capacity, in the context of the implementation of health care reform.

- Materials in the audit are presented in three parts (Stage 1 Report, Stage 2 Report and Stage 3 Report) and focus on the population of county residents who have health care benefits through publicly financed programs as well as those who are currently without health care coverage.

- The information is presented so that the three documents (Stages 1, 2 and 3) should be considered together and are a complete reporting of what was requested of the consultants. The reports include demographic data about the county's population and use of health care services, identification and discussion of the pros and cons of possible policy options the Board might want to consider and background data or research. There isn't a listing of recommendations within the documents. The Board of Supervisors directed the County Administrator and the consultants to research and present policy options to improve or maximize sustainability rather than make recommendations for Board action.

- Each document begins with a summary listing of findings and the options that have been included within that section of the materials and this Report Highlights document also lists some of the significant findings, options and ideas from the three reports.

- The consultants and county staff working on the project have made every effort to present accurate and factual materials for Board consideration. However, there may be corrections needed as the reports are reviewed and discussed by the Board of Supervisors and a larger audience.

Assumptions:

- The report materials assume that the Affordable Care Act (federal health care reform legislation that is known as the ACA), along with companion State legislation, will be implemented and financed in the manner and time frame laid out in current law, rules and regulations.

- If laws or funding changes substantially before 2014, when health care reform is set to be fully implemented, or portions of the federal law are ruled unconstitutional, the report's findings and the options available to the Board of Supervisors will need to be adjusted accordingly.

Factors to Consider:

- Throughout the materials, Contra Costa County is compared and contrasted with other counties in California, but the other Bay Area Counties of Alameda, San Mateo and Santa Clara are often used as the most comparable.

- CCRMC, one of 10 hospitals in the County, generates the third highest number of discharges per year and provides triple the number of hospital services to Medi-Cal residents than the next busiest hospital in the County.

- Currently, the East Bay has a very small number of hospital beds for the numbers of residents and age of the county's population. Emergency beds throughout the county can be at a premium and are often at capacity. As health care reform is fully implemented and newly insured citizens begin to use the health care system significant extra demand is projected to be experienced by a county-wide health care community that has limited unused capacity.

- Quality indicators for health care received at Contra Costa Regional Medical Center for most health conditions are satisfactorily comparable to others around the state and in the surrounding counties.

- Current revenue in the hospital and clinics is heavily weighted towards Medi-Cal patients, with 75% of each revenue dollar of net patient revenue being received from Medi-Cal. These revenues are consistent with the mission statement of the department and they reflect skillful maximization of federal and state reimbursement in the current environment.

- The consultants state that the County's health system is "vertically integrated within itself in a fashion that is comparable to what national health reform is hoping to foster. The pieces are in place to have a seamless system of care for vulnerable populations that can provide the right care, at the right place and at the right time."

- However, in the future, it is doubtful that any public health care system will be able to meet all the needs of vulnerable residents without assistance from and increased integration with the private sector of health care.

- HMA identifies a possible opportunity to utilize the existing network of care providers in a dialogue about how the entire health care community might accommodate, change and grow to meet what is projected to be the greatly increased demand for medical services as the ACA is implemented.

- The consultants identify some changes that would make the County's system more "nimble" (meaning better able to compete for necessary staff with private health care systems) and consequently more sustainable, including implementation of an expanded role for departmental management in human resource functions, procurement and union negotiations. These options are found in Section IV of the Stage 3 Report.

Fiscal Sustainability Issues:

- One of the most encouraging projections for fiscal sustainability for the County's hospital, health centers and health clinics is the projected decrease in the number of uninsured county residents if national and State health care reform plans continue being implemented as envisioned.

- By 2014, once health care reform is fully implemented, the majority of County residents can have health care coverage. Overall the number of uninsured residents is projected to decrease significantly, from an estimate of 15% of the County's population in 2009 to about 4% in 2014. More data about these statistics and related information can be found in the Stage 1 Report, on pages 45-49.

- The report identifies examples and specifics about the great success the financial management of the department has had in locating and acquiring outside revenue to finance the County's current health care system and to begin implementing the requirements associated with ACA. Because of their success, the consultants found very few ideas for generating additional revenue.

- However, the consultants did identify several opportunities that could be considered to gain additional revenue. Included are options regarding changes to the current business model, (such as greatly expanded clinic hours, days of service or locations of clinics), or the addition of new business lines (such as creation of transitional care beds). The consultants identify that these options would likely come with start-up costs which could be fleshed out by county staff if the Board would choose to consider them further. Specific ideas are found throughout the Stage 3 Report.

Patient Centered Medical Home Concept (PCMH):

- The Patient Centered Medical Home (PCMH) is a concept envisioned in health care reform legislation. Implementation information on this concept in relation to Contra Costa County is described in more detail in the Stage 2 and Stage 3 reports. PCMH is a "model for ambulatory care transformation" designed to improve the delivery of patient care and patient outcomes. Implementation is a major undertaking requiring significant investment and the health department has several elements already in place which could provide an important starting place for continued transformation. Successful full-scale implementation will require the County's health care system to make changes related to overall service capacity and these changes are identified in the consultant's report.

- HMA identifies the need to shift health care services from an inpatient focus to outpatient and ambulatory; fewer inpatient admittances per person served will be needed; systems will be paid for decreasing hospital admissions and avoiding preventable re-admissions; medical case management and care coordination for patients will be required. The ACA is predicated on funding that is based on proving that the most appropriate and least costly care is used for individual patients and Contra Costa will need to re-engineer its health care, billing and reporting systems accordingly.

- Because the department is already on the path to creating the PCMH model the suggestion is made for having the department report to the Supervisors on their most critical needs at this time, as well as the timeframe and costs associated with full implementation of the PCMH model design that the department has chosen.

- The report identifies the department's commitment to continuously improving the quality and safety of the care it delivers. The ongoing efforts at workflow streamlining and process improvements are viewed as vital to successfully continuing the implementation of the Patient Centered Medical Home model.

- Also vital to successful implementation of the model is timely and accurate completion of the transition to an electronic method of record keeping and streamlining the patient appointments process, both of which the department is now engaged.

Staffing and Workforce Capacity Considerations:

- The consultants stressed the importance of succession planning for key leadership positions, in light of the heavy work load and the short time frame associated with full implementation of health care reform. The Stage Three Report, Section V, contains this information and options for the Board of Supervisors to consider.

- To continue the implementation of health care reform in an effective and efficient fashion the consultants identified current and future service capacity needs. This information is presented in pages 50-71 of the Stage 1 Report and throughout the Stage 3 Report.

- Some of the issues identified include the need for the department to quickly secure the necessary technical staff to complete the conversion to an electronic medical records system; an emergency department where volume often can exceed the physical space; specialty clinics that appear to be at or near capacity with wait times greater than 30 days to secure an appointment; and panel sizes for primary care physicians that appear to be at 25% over capacity while visit productivity appears to be at 25% below capacity because of problems in scheduling appointments.

- HMA reviewed the January 2010 total Compensation Report prepared by the HayGroup in conjunction with their own review. Some wages and benefits for certain classifications are identified as greater than the median in this market for comparable jobs in the private sector. Others are much lower. Overall, the consultants state that the current wage and benefit package is "more conducive to retention than recruitment." Given these findings, another option for sustainability over time deals with several mechanisms identified in the reports for moving closer to the median on wages and benefits for all county staff within the hospital and clinic system.

- The consultants identify possible roles for the Supervisors and County Administrator in monitoring and tracking the departments work on implementing health care reform changes. These ideas can be found in the Stage 3 Report.

Options for Governance:

- The Board of Supervisors asked for information about governance options, the pros and cons of different types of governance and some examples of successful hospital systems using alternative governance models. The report points out that there are no easy or quick paths to implementing a different governance model. Any governance change would require input and/or agreement from multiple entities, including unions and employees, community stakeholders, members of the health care community in the county and other elected officials.

- The information and discussion of alternative governance options are described in more detail on pages 18 and 19 of Stage 2 and pages 20-28 of Stage 3.

Conclusions from the Report:

- The final section of the Stage 3 Report provides multiple options for the Board of Supervisors to consider in continuing its progress toward a more cost-effective, efficient, and sustainable health care system that best meets the needs of the expanding Medi-Cal population, uninsured, and other medically vulnerable residents of the county.

- Based upon HMA's assessment, the County has made tremendous strides in improving its delivery system. The county has put into place many of the pieces required to ensure the right care is at the right place at the right time. The next step for the Board of Supervisors to consider is movement towards becoming a full-scale PCMH system of care and the possibilities, challenges (and policy implications) of becoming an Accountable Care Organization.

- The County has also been a leader among other counties in California in maximizing revenue to the greatest extent possible. The structural, management, and measurement options presented throughout the materials would enable the county to better respond to the current and emerging environment, including the impact of health reform and workforce and financial issues. It will also allow the county to continually push towards excellence and excellent service to the residents of Contra Costa County in whatever governance model is chosen.

Next Steps:

- Once the Board of Supervisors has considered the documents and decided which options they wish to pursue further, county staff can flesh out the specifics, including financial assessments, for subsequent Board action.

- The Sustainability Audit will be presented to the Medical Services Joint Conference Committee of the Board of Supervisors on Wednesday, September 28, 2011, at 12:30 p.m., at the Contra Costa Regional Medical Center Campus in the Martinez Health Center/Building 1 North Conference Room, at 2500 Alhambra Avenue, Martinez. On Tuesday, October 4, 2011, the report will be presented to the full Board of Supervisors at 10:30 a.m. That presentation will take place during the Board's regular business meeting at 651 Pine Street in Martinez.

HMA

HEALTH MANAGEMENT ASSOCIATES

Sustainability Audit of the Contra Costa County Regional Medical Center and Health Centers: Stage 1 Information Memorandum Final Report

PRESENTED TO THE
CONTRA COSTA COUNTY ADMINISTRATOR

SEPTEMBER 2011

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Executive Summary

In January 2011, the County of Contra Costa engaged Health Management Associates (HMA) to conduct a sustainability audit of the Contra Costa Health Services-operated facilities: the Contra Costa Regional Medical Center (CCRMC) and health centers. The goals of the audit are to develop options to support the fiscal sustainability of the County's health care system and to ensure the most efficient and effective delivery of medical services to County residents that are consistent with the implementation of health care reform.

The work of this project is divided into three stages. This Information Memorandum completes the first stage and provides the following information to guide decisions and lay the groundwork for the subsequent two stages of work:

- Current and emerging demographics and health care utilization data for the County's Medi-Cal and uninsured populations.
- Discussion of the current capacity of the County's programs, services, and facilities and new service capacity needs that may arise from the section 1115 waiver and federal health reform.
- Discussion of the Basic Health Care (BHC) program.
- Description of the expected impact of the section 1115 waiver, including a Medi-Cal reimbursement analysis.
- Financial, utilization, and quality performance indicators for CCRMC and County health centers.

HMA staff conducted site visits in January, February, and March and interviewed key informants, including staff and leadership from the Board of Supervisors, Health Services Department, CCRMC, the Contra Costa Health Plan (CCHP), County health centers, and the County Administrator's office. The HMA team also reviewed policy and financial documents related to County programs and services, analyzed data on Contra Costa's overall and target population and financial, utilization, and quality performance, and, where possible, compared the data to Alameda, Santa Clara, and San Mateo Counties.

Summary of Findings

Section I: Contra Costa County's Medi-Cal and Uninsured Population

- Contra Costa's population is growing more rapidly compared to the State of California and to the comparable counties. In the next 20 years, Contra Costa will add approximately 350,000 people.
- Seniors 65 years and older make up a growing portion of the population and that is expected to continue through 2050 when nearly one in five residents will be aged 65 years or older.
- The current population is approximately 50 percent white, one quarter Hispanic, and slightly more than 10 percent Asian. By 2050, the population will look very different. Hispanics will become the majority ethnicity at 45 percent, and the Asian population will grow to about 17 percent. Currently, 60 percent of the County's Medi-Cal population speaks English, but this may change as the population changes.

- The County had a higher median and per capita income than the rest of the State or the country but had a growing portion of individuals living in poverty.
- Medi-Cal enrollees made up 12 percent of the County's total population, which was lower than the State and all but 10 other counties, including San Mateo. However, the Medi-Cal population in Contra Costa grew by more than 30 percent between 2003 and 2009. This is more than three times the State's growth rate than that of all but five counties during the same period.
- Only three hospitals, CCRMC, Alta Bates Summit Medical Center, and Sutter Delta Medical Center provided 65 percent of Medi-Cal fee-for-service discharges in the County.
- One in three Contra County residents with incomes under 133% of the FPL was uninsured in 2009. In addition, 20 percent of the population with income 133 to 300 percent FPL and five percent of the population with income over 300 percent FPL were also uninsured.
- As compared to the nine other counties with Health Care Coverage Initiative (HCCI) programs, Contra Costa County had more single, white, young, and English-speaking enrollees.
- Most of the County's health indicators were consistent with the State and other counties, except for lower rates of mammograms and the highest rate for six causes of death: all cancers, colorectal cancer, female breast cancer, stroke, chronic lower respiratory disease, and firearm-related deaths.
- There were racial and ethnic health disparities as well as disparities for the uninsured on a number of measures.
- Of the 154,000 currently uninsured individuals in the County, 73 percent are expected to obtain Medi-Cal or Health Benefits Exchange coverage in 2014 when federal Affordable Care Act provisions go into effect. Nearly 63,000 are projected to go into private insurance coverage through the Health Benefits Exchange and another 50,000 into Medi-Cal coverage. This would reduce the uninsured rate from 15 percent in 2009 to 4 percent in 2014.

Section II: Current and Future Service Capacity and Needs

- Based on current primary care staffing, there is limited opportunity (perhaps only 2%) to expand patients in Contra Costa Health Services (CCHS). However, with the planned construction and expansion of its outpatient facilities and the expansion of evening and weekend sessions, CCHS has the physical capacity to expand primary care. In some facilities this expansion of hours/sessions may necessitate the hiring of additional support staff.
- CCHS specialty clinics see a substantial number of visits annually. Based on the waiting times to obtain a specialty appointment, which may even be longer than reported, and the significant number of days that referrals are backlogged on the waiting list, many of the specialty clinics are at or near capacity.
- Based on the current occupancy rates and existing practices, there is little if any overall capacity in the CCRMC inpatient units. There are waits to admit patients to an inpatient bed. This is

particularly true on the Medicine-Surgery units. The Psychiatric Unit is very close to full capacity on many days. The Emergency Department is crowded and close to maximum capacity without additional space.

- Obstetrics can effectively increase capacity with its current space and staff by an additional 15 to 20 percent, which would mean 30 to 40 additional deliveries per month or 360 to 480 more per year.
- There is a lack of access to lower levels of care, especially for the underinsured and uninsured patient populations.
- There are significant recruitment and retention issues due to a reported difficult hiring process under County Human Resources rules and merit system. This will become increasingly important as the Health Services Department (HSD) works to maintain its competitive position with Kaiser, Sutter, and others.
- The increase in demand for primary care services has resulted in a mismatch of the supply of appointments available and the demand for these appointments. This results in few appointments available to give to patients who request them and excessively long phone queues.
- While CCHS has implemented many of the initial elements of a patient-centered medical home and continues to incorporate additional components into its outpatient centers, none of the ambulatory centers in CCHS are yet full-scope or advanced patient-centered medical homes. This is not an unusual situation, as many centers across the country are working towards full implementation of the patient-centered medical home model but there is far from universal achievement of this goal.
- The CCHS Family Medicine Residency Program is one of the more respected Family Medicine training programs in the U.S. and is extremely helpful for recruiting and retaining competent, quality providers.

Section III: Basic Health Care Program

- Contra Costa's BHC program eligibility to 300 percent FPL is more generous than all but Santa Clara County.
- The BHC program may only be serving a fraction of those who could be eligible for the program, although the County may decide to focus on enrolling people into the Health Care Coverage Initiative (HCCI) or other programs that have matching Federal funds

Section IV: Low Income Health Program

- *This section is now in the Stage 2 Preliminary Report.*

Section V: Data/Quality and Performance Indicators

- CCRMC's payer mix reflects extensive service to the medically indigent and Medi-Cal populations. This is consistent with the mission of the organization and reflects maximizing

reimbursement in the current environment. As health care reform moves forward, the organization will need to continually monitor the environment for changes in approach by the Federal and State government.

- CCRMCs benefits appear to be higher than other county hospitals.
- CCRMC's Emergency Department visits per treatment station indicated they may be operating at or beyond capacity and were higher than any of the three comparable hospitals.
- CCRMC's quality indicators for most but not all conditions were comparable to the State and comparable counties. However, Contra Costa does not have the lowest rate for any one measure and has the highest rate for 5 of the 14 measures.

Stage 2 and 3

The remaining two stages of the project will be a Preliminary Report that will be presented in April 2011 and a Final Report that will be presented in mid-June 2011. Each stage will build on the previous work and the Final Report will include a work plan for the establishment of a medical home system of care; a management review of Health Services Department programs; an evaluation of alternative governance structures; options for changes in the County's current procedures for data collection and analysis; and options for changes and/or enhancements to the County's organizational capacity for ongoing strategic planning, evaluation, and oversight.

Health Management Associates (HMA)

HMA is a consulting firm specializing in the fields of health system restructuring, with a particular focus on the safety net; health care program development; health economics and finance; program evaluation; data analysis; and health information technology and exchange. HMA is widely regarded as a leader in providing technical and analytical services to health care providers, purchasers and payers, particularly those who serve medically indigent and underserved populations. Founded in 1985, Health Management Associates has offices in Lansing, Michigan; Chicago, Illinois; Indianapolis, Indiana; Columbus, Ohio; Washington, DC; Tallahassee, Florida; Austin, Texas; Sacramento, California; New York, New York; Atlanta, Georgia; and Boston, Massachusetts.

Introduction

In January 2011, the County of Contra Costa engaged Health Management Associates (HMA) to conduct a sustainability audit of the Contra Costa Health Services-operated facilities: the Contra Costa Regional Medical Center (CCRMC) and health centers. The goals of the audit are to:

- Review the policies, operations, and structures of the CCRMC, health centers, and the Contra Costa Health Plan (CCHP);
- Develop options designed to support the fiscal sustainability of the County's health care system; and
- Develop options to ensure the most efficient and effective delivery of medical services to County residents that are consistent with the implementation of health care reform.

In order to ensure effective oversight and consultation with County staff, the work of this project is divided into three stages. The first stage, presented herein, is an Information Memorandum consisting of the following elements to guide decision-making and lay the groundwork for the subsequent reports:

- Demographic and health care utilization data for the County's Medi-Cal and uninsured populations;
- Discussion of the current capacity of the County's programs, services, and facilities and new service capacity needs that may arise from the section 1115 waiver and federal health reform;
- Discussion of the Basic Health Care program;
- Description of the expected impact of the section 1115 waiver, including a Medi-Cal reimbursement analysis; and
- Financial and service utilization data and quality indicators for CCRMC and health centers.

In order to conduct the analysis, HMA staff conducted site visits in January, February, and March and interviewed key informants. Key informants included staff and leadership from the Board of Supervisors, Health Services Department, CCRMC, CCHP, County health centers, and the County Administrator's office.

The HMA team also reviewed policy and financial documents related to County programs and services, analyzed data on Contra Costa's overall and target population, and analyzed performance data from the California Office of Statewide Health Planning and Development (OSHPD), the Agency for Healthcare Research and Quality (AHRQ) Quality Indicators, the U.S. Department of Health and Human Services Hospital Compare website, Contra Costa Health Plan's 2010 Annual HEDIS report, the CCRMC's Whole Systems Measures report, and other County documents. Data sources are listed in Appendix B.

The remaining two stages of the project will be a Preliminary Report that will be presented in April 2011 and a Final Report that will be presented in mid-June 2011. Each stage will build on the previous work and the Final Report will include the following elements:

- Work plan for the establishment of a medical home system of care.

- Management review of Health Services Department programs.
- Evaluation of alternative governance structure.
- Options for changes in the County's current procedures for data collection and analysis.
- Options for changes and/or enhancements to the County's organizational capacity for ongoing strategic planning, evaluation, and oversight.

I. Medi-Cal and Uninsured Populations

Introduction

In order to guide decisions about the existing Contra Costa County health care delivery system and what will be needed in the future, the County requires a clear picture of who the current and emerging target population is and what their demands and needs are now and will be overtime. To that end, this section provides detailed data on 1) the current demographics of Contra Costa County, 2) projected changes in the population demographics overtime, 3) the Medi-Cal and uninsured populations who are served by the Contra Costa County Regional Medical Center (CCRMC) and County health centers and the providers who serve them, and 4) the health status of the County population. These data on Contra Costa County are compared to California overall and Alameda, Santa Clara, and San Mateo Counties. The Contra Costa County Board of Supervisors and HMA identified these three counties for comparisons because they are all located in the Bay Area, have large and diverse populations, and participate in the Section 1115 waiver coverage initiatives. These counties are referred to as "comparable counties" throughout this report.

This section also presents detailed information on the impact of the federal Affordable Care Act (also known as Health Reform) and how it will change the coverage patterns of Contra Costa County residents.

Note: the Contra Costa Health Plan (CCHP) has several lines of business that serve groups in addition to populations (i.e., Medi-Cal, Healthy Families, Health Care Coverage Initiative, and Basic Health Coverage enrollees) discussed in this section. These groups, including County employees, private employer groups, etc. are not a part of this project's scope.

Contra Costa County

Contra Costa County, one of nine counties in the Bay Area, covers an area of 806 square miles northeast of San Francisco and southwest of Sacramento. Its county seat is the City of Martinez. The County is home to major corporate headquarters, including Chevron, The PMI Group Inc., Bio-Rad and AAA's Northern California, Nevada, and Utah headquarters. Other major corporate residents include AT&T, ConocoPhillips, Wells Fargo, Shell Refinery, Safeway, Tesoro, Bank of America, Dow Chemical, and PG&E. The County enjoys a diverse employment base with no single sector dominating the job market.[1]

Demographics

An analysis of the demographics of Contra Costa County compared to the similar surrounding counties of Alameda, San Mateo, and Santa Clara, (referred to in this report as "comparable counties") as well as to other California counties and the United States provides a profile of key characteristics. The analysis shows that Contra Costa County is:

[1] Contra Costa County Board of Supervisors; 2011 Key Issues; Board of Supervisors Retreat; January 31, 2011. http://www.co.contra-costa.ca.us/DocumentView.aspx?DID=5416.

- Growing more rapidly compared to the state of California and to adjacent counties. In the next 20 years, Contra Costa will add approximately 350,000 people. The growth appears to be more concentrated in urban areas within East Contra Costa County.
- Graying with seniors aged 65 years and older making up a growing portion of the population. This trend is expected to continue through 2050 when nearly one in five residents will be 65 years and older.
- Undergoing significant change in the population's racial and ethnic mix. The current population is approximately 50 percent white, one quarter Hispanic, and slightly more than 10 percent Asian. By 2050, the population will look very different. Hispanics will surpass whites as the majority ethnicity at 45 percent, and the Asian population will grow to about 17 percent.
- Enjoying a higher median and per capita income than the rest of the State or the country.
- Having a growing portion of individuals living in poverty. Poverty is especially prevalent for children living in households headed by single women.
- Comparing favorably to other California counties, the State, and the Country in the number of young people that graduate from high school. However, a smaller portion of the County's graduates goes on to get a college degree. *See page 17 for more information on this topic.*
- Having a relatively high unemployment rate compared to the nation but a lower rate than the State. The County's unemployment rate appears to be slowly declining. *See page 17 for more information on this topic.*

Total Population

The total population of Contra Costa County was estimated at 1,041,274 in 2009. This represents a 9.2 percent increase from the 2000 census compared to California's overall census growth of 8.5 percent and a U.S increase of 8.7 percent (Table I.1). In the past decade, Contra Costa had a much higher rate of population growth than the comparable counties. Contra Costa had the ninth highest population of California counties as of July 1, 2009.[2]

Table I.1: Total Population Growth, 2000 to 2009

	Contra Costa	Alameda	San Mateo	Santa Clara	California	United States
2009	1,041,274	1,491,482	718,989	1,784,642	36,887,615	306,656,290
2000	953,192	1,450,220	708,272	1,685,842	33,994,571	282,165,844
% change	9.2%	2.8%	1.5%	5.9%	8.5%	8.7%

Source: U.S. Census Bureau. County data is the estimate for July 1, 2009 accessed February 21, 2011. California and U.S. data is an updated estimate released February 2011.

The population growth in Contra Costa is not uniform throughout the County. Between 2000 and 2008, growth in six cities significantly exceeded the County's overall growth rate (Table I.2). Four of the six cities, Brentwood, Antioch, Oakley and Pittsburg, are located in East Contra Costa County. The

[2] U.S. Census Bureau; GCT-T1-R. Population Estimates (geographies ranked by estimates) 2009 California-County

population growth in these four cities alone accounted for 61 percent of the County's overall population growth between 2000 and 2008.

Table I.2: Population Growth in Select Contra Costa Cities, 2000-2008

	2000	2008	Population Change	% Increase
Contra Costa	953,304	1,029,703	76,399	8.0%
Brentwood	24,741	49,480	24,739	100%
Hercules	19,493	24,484	4,991	25.6%
Oakley	25,849	32,035	6,186	23.9%
Pittsburg	57,081	64,148	7,067	12.4%
Antioch	91,564	100,219	8,655	9.5%
San Ramon	44,922	49,161	4,239	9.4%

Source: Contra Costa Health Services; Community Health Indicators in Contra Costa County 2010 Report. http://cchealth.org/health_data/hospital_council/. Demographics accessed February 23, 2011.

Age Demographics

In 2009, the median age in Contra Costa was 38 years, which was slightly higher than all of the comparable counties except San Mateo (Table I.3). It was also higher than the median age of the State as a whole (34.6) and the U.S. (36.5).

Table I.3: Median Age and Age Distribution, 2009

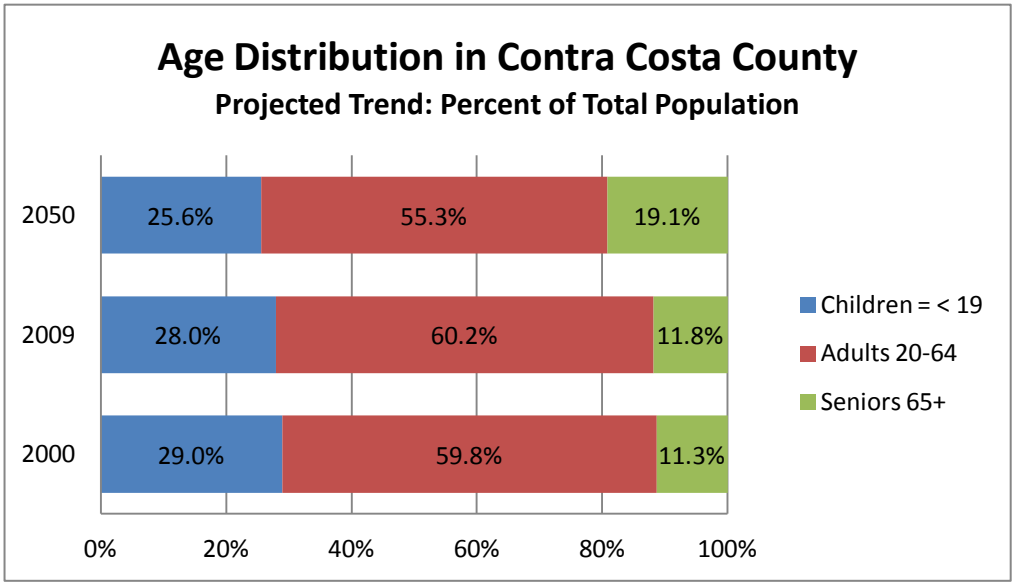
	Contra Costa	% of Total	Alameda	% of Total	San Mateo	% of Total	Santa Clara	% of Total	CA % of Total	US % of Total
Median Age	38.0 yrs		36.1 yrs		38.8 yrs		35.5 yrs		34.6 yrs	36.5 yrs
19 years and younger	284,098	28.0%	376,203	25.8%	172,729	24.6%	467,326	27.0%	28.9%	27.5%
20 to 24 years	60,543	6.0%	91,284	6.3%	40,445	5.8%	108,810	6.3%	7.2%	7.0%
25 to 44 years	274,902	27.1%	466,264	32.0%	208,577	29.7%	557,418	32.2%	29.3%	27.6%
45 to 59 years	224,694	22.1%	304,083	20.9%	153,704	21.9%	340,832	19.7%	19.5%	20.5%
60 to 64 years	51,242	5.0%	63,630	4.4%	35,107	5.0%	71,109	4.1%	4.3%	4.8%
65 to 74 years	61,860	6.1%	78,749	5.4%	44,972	6.4%	95,427	5.5%	5.7%	6.5%
75 years +	58,232	5.7%	76,882	5.3%	46,352	6.6%	88,456	5.1%	5.3%	6.1%

Source: ACS Demographic and Housing Estimates: 2005-2009; Data Set: 2005-2009 American Community Survey 5-Year Estimates Survey: American Community Survey

Contra Costa's higher median age was in spite of the fact that the percentage of Contra Costa's population that are children 19 years and younger (28%) was higher than the comparable counties, which had a range of 24.6 percent to 27 percent, and was comparable to the State (28.9%) and the U.S. (27.5%). A higher percentage of Contra Costa's population was 65 years and older compared to the State as a whole and to the comparable counties. Only San Mateo had a higher portion of seniors.

Population projections indicate that the aging of the County population is a trend that will continue. In 2050, nearly 20 percent of Contra Costa residents are expected to be 65 years and older (Figure I.1).

Figure I.1:



Source: State of California, Department of Finance; Population Projections for California and Its Counties 2000-2050, Sacramento, California, July 2007.

Race and Ethnicity[3]

White, Hispanic, and Asian populations comprised the three major racial/ethnic groups in Contra Costa County. This mirrors the comparable counties and the State as a whole, although the population distribution among these groups differed somewhat. The California Department of Finance's projections of the racial make-up of Contra Costa for 2010 indicate approximately 563,000 of residents were white, 255,000 were Hispanic, and 137,000 were Asian. Blacks represented a much smaller group with approximately 88,000 residents. Remaining groups were Pacific Islanders, American Indian, and multiracial.

Compared to the comparable counties and the State as a whole, a higher portion—just over half—of Contra Costa's residents were white. Only 30.9 percent of Alameda residents were white while Santa Clara (40.5%) and San Mateo (42.6%) portions were similar to California (42%). Hispanics comprised approximately 24 percent of Contra Costa's population, which was roughly similar to the comparable counties, all of which had a significantly lower Hispanic portion of the population (20% to 26%) than did the State (37.1%). Contra Costa's Asian population (12.8%) was similar to the State's (12%) but significantly smaller than the comparable counties. Blacks made up 8.2 percent of the population, which was a higher percentage than all the other comparable counties except Alameda (10.4%) and higher than the State's average (5.8%). (Table I.4 and Figure I.2).

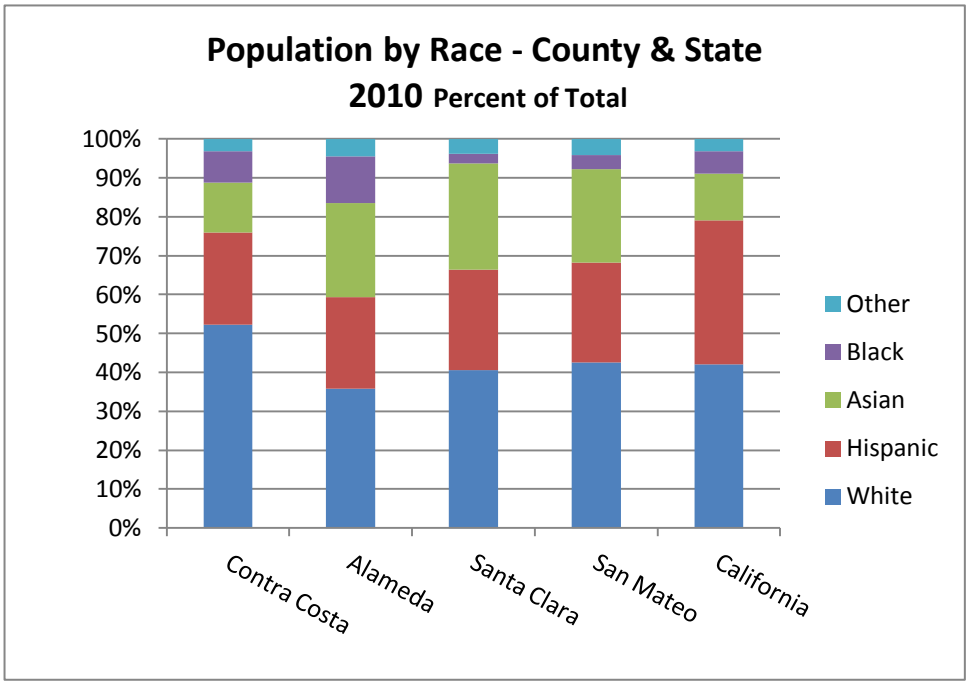
[3] Data in this section come from the State of California, Department of Finance; Population Projections for California and Its Counties 2000-2050, Sacramento, California, July 2007. This report contains the most recent county population projections on the Department of Finance website.

Table I.4: Race and Ethnicity Distribution

	Percent of Total Population, 2010				
	Contra Costa	Alameda	Santa Clara	San Mateo	California
White	52.3%	30.9%	40.5%	42.6%	42.0%
Hispanic	23.7%	20.3%	25.9%	25.6%	37.1%
Asian	12.8%	21.0%	27.3%	24.0%	12.0%
Black	8.2%	10.4%	2.6%	3.6%	5.8%
Other	3.1%	3.9%	3.8%	4.1%	3.1%

Source: State of California, Department of Finance; Population Projections for California and Its Counties 2000-2050, Sacramento, California, July 2007

Figure I.2:



Source: State of California, Department of Finance; Population Projections for California and Its Counties 2000-2050, Sacramento, California, July 2007.

Foreign Birth

One in five residents in Contra Costa was not born in the U.S., which was less than California's rate (26.8%), almost double that of the U.S. (12.4%), and lower than the comparable counties, which had approximately one in three residents born outside of the U.S. Similar to the comparable counties and the State, about half of foreign-born residents were not U.S. citizens. However, a higher portion of the County's foreign-born residents used English in the home. Only a third of the County's foreign-born residents speak a language other than English in the home.

Table I.5: Foreign Birth, U.S. Citizenship, and Language Spoken at Home

	Contra Costa	Alameda	San Mateo	Santa Clara	California	United States
Foreign Born	234,983	439,130	234,049	623,435	9,739,226	37,597,000
% of Total Population	23.1%	30.1%	33.3%	36.0%	26.8%	12.4%
Not a U.S. Citizen (of foreign born pop.)	49.1%	49.4%	45.6%	50.5%	55.9%	57.4%
Language other than English spoken at home	31.5%	41.1%	44.0%	49.6%	42.2%	

Source: U.S. Census Bureau. State and County data from the American Community Survey (ACS) 2005-2009 5-year Estimates, accessed February 26, 2011. U.S. data: Income, Poverty and Health Insurance Coverage in the United States: 2009, Current Population Reports, September 2010.

Income and Poverty

The federal Department of Health and Human Services releases poverty guidelines each year. These guidelines, referred to as "federal poverty levels" (FPL), are annually adjusted based on changes in the Consumer Price Index and vary based on the number of persons in a family (with pregnant women counting as two people). Medi-Cal, Healthy Families, HCCI, and BHC use an FPL percentage for determining income eligibility. FPL percentages by family size are summarized in the following table.

2011 Federal Poverty Level - Annual Income				
Family Size	100%	133%	200%	300%
1	$ 10,890	$ 14,484	$ 21,780	$ 32,670
2	$ 14,710	$ 19,564	$ 29,420	$ 44,130
3	$ 18,530	$ 24,645	$ 37,060	$ 55,590
4	$ 22,350	$ 29,726	$ 44,700	$ 67,050
5	$ 26,170	$ 34,806	$ 52,340	$ 78,510
6	$ 29,990	$ 39,887	$ 59,980	$ 89,970

Source: Federal Register, Vol. 76, No. 13, January 20, 2011, pp. 3637-3638

Contra Costa County enjoyed a higher median and per capita income compared to the State and the U.S. (Table I.6). A lower percentage of Contra Costa families (6.2%) also had income less than the FPL compared to the State (9.8%) and the U.S. (12.5%). Compared to comparable counties, Contra Costa residents appear to be financially better off than Alameda County residents but not as well off as those living in San Mateo and Santa Clara Counties.

Table I.6: Income and Families in Poverty

	Contra Costa	Alameda	San Mateo	Santa Clara	California	United States
Median Household Income	$77,838	$68,863	$84,426	$85,569	$60,392	$49,777
Per Capita Income	$37,742	$33,831	$43,286	$39,201	$29,020	$26,530
% of Families < 100% FPL	6.2%	7.8%	4.7%	6.0%	9.8%	12.5%

Source: U.S. Census Bureau; County and State: 2005-2009 American Community Survey 5-Year Estimates; accessed February 26, 2011. U.S. data: U.S. Census Bureau, Current Population Survey, 2009 and 2010 Annual Social and Economic Supplements.

It is no surprise that poverty is more prevalent among families with children and especially among single women with young children. In Contra Costa County, nearly one in three households of single women

with children under the age of five were living below the poverty level. This compares with 8.6 percent of all families with young children in the County and 3.7 percent of married couples with children under the age of five (Table I.7).

Table I.7: Percentage of Families and Individuals with Income Below the Federal Poverty Level

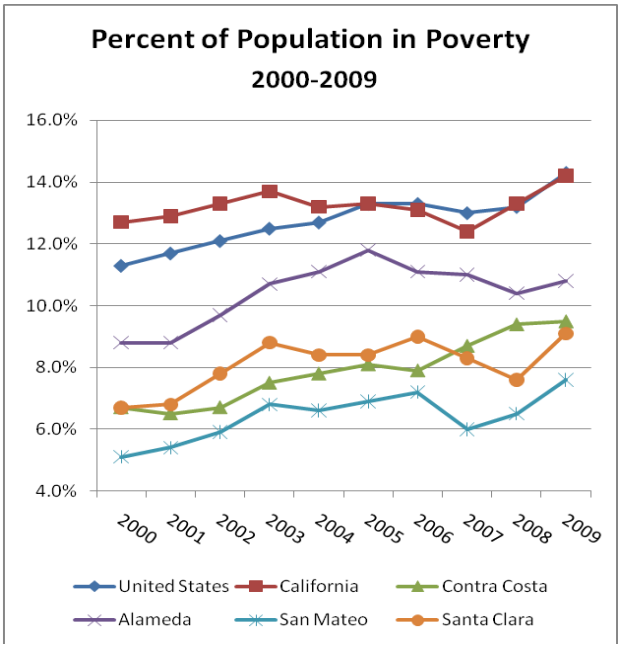
	Contra Costa	Alameda	San Mateo	Santa Clara	California	United States
All Families	**6.2%**	**7.8%**	**4.7%**	**6.0%**	**9.8%**	**12.3%**
With related children under 18 years	9.2%	11.2%	7.0%	8.3%	14.5%	17.1%
With related children under 5 years	8.6%	9.0%	5.9%	6.6%	13.2%	21.8%*
Married Couple Families	**3.2%**	**4.0%**	**2.8%**	**3.6%**	**5.9%**	**6.3%**
With related children under 18	4.2%	5.4%	3.9%	4.5%	8.3%	8.3%
With related children under 5	3.7%	3.0%	2.3%	3.2%	6.2%	11.5%*
Female householder no husband present	**19.3%**	**21.0%**	**13.6%**	**17.5%**	**24.2%**	**32.4%**
With related children under 18 years	26.8%	28.0%	20.6%	24.3%	32.2%	38.5%
With related children under 5 years	31.5%	31.4%	25.1%	27.3%	36.9%	51.3%*
Total Population	**8.6%**	**10.9%**	**7.2%**	**8.6%**	**13.2%**	**14.3%**
Under 18 years	11.2%	13.7%	9.6%	10.5%	18.3%	20.7%
18-64 years	8.2%	10.4%	6.5%	8.2%	11.9%	11.2%
65 years +	5.6%	8.2%	6.9%	6.6%	8.4%	8.9%

* Data is for families with related children under 6 years.

Source: U.S. Census Bureau; state and counties: 2005-2009 American Community Survey, US: Current Population Survey, Annual Social and Economic Supplement, 2009.

Contra Costa and the comparable counties are faring better than the State and the U.S. with respect to the portion of families and individuals with income below the poverty level. However, poverty rates for children were still high, particularly in single parent households.

Figure I.3:[4]



While the County's percent of individuals living in poverty was lower than that found in the U.S. and the State, the portion of Contra Costa's population in poverty has been on the rise. The rate did flatten out after an increase from the 2001 recession, but, unlike the State and the comparable counties, there has been no significant dip in the poverty rate over this period. Prior to 2009, when all counties, the State and the U.S. experienced an upswing, the percent of the population in poverty peaked for the State in 2003, for the U.S. and Alameda County in 2005, and for San Mateo and Santa Clara in 2006. Contra Costa's highest rate prior to 2009 was in 2008, continuing a steadily rising trend (Figure I.3).

[4] Source: U.S. Bureau of the Census, Current Population Survey, Annual Social and Economic Supplements.

Education Level

A larger portion of Contra Costa County students graduated from high school, compared to the State or the U.S. as a whole (Table I.8). The County fared as well as or better than comparable counties with 88.1 percent of the population having achieved high school graduation, which is similar to rates in surrounding counties (85.7% to 88.4%). A lower portion, however, went on to get a college education compared to surrounding counties. Nearly 38 percent of individuals 26 years and older had a Bachelor's or higher degree, compared to range of nearly 40 to 44 percent in the comparable counties. All of the comparable counties had a higher rate of educational achievement than did the State and the U.S. While nearly 20 percent of California's population 26 years and older did not have a high school diploma, less than 12 percent of Contra Costa's population had not completed a high school education. It appears that Contra Costa had a higher percentage of individuals who had some college education but did not get a degree (22.1% of the population 25 years and older) compared to the other counties (range of 17.2% to 18%). Contra Costa residents also had a slightly higher percentage with Associates degrees, 8.1 percent versus a range of 7.2 percent (Alameda) to 7.7 percent (San Mateo).[5]

Table I.8: Educational Achievement

	Contra Costa	Alameda	San Mateo	Santa Clara	California	United States
Population 26 years and older	277,720	989,608	488,712	1,153,242	23,219,217	199,928,000*
Percent with < 9th grade education	5.7%	7.6%	6.4%	7.6%	10.4%	N/A
Percent with no high school diploma	11.9%	14.3%	11.9%	14.2%	19.5%	12.9%
Percent high school graduate or higher	88.1%	85.7%	88.4%	85.8%	80.5%	87.1%
Percent bachelor's degree or higher	37.7%	39.9%	43.6%	43.9%	29.7%	29.9%

*Data for the United States is for the population that is 25 years and older.

Source: U.S. Census Bureau, County and state data are from the 2005-2009 ACS 5-year estimates, US data: Current Population Survey, 2010 Annual Social and Economic Supplement.

Unemployment

Contra Costa's unemployment rate in December 2010 (10.9%) and the unemployment rates in comparable counties were lower than the rate for the State (12.3%). Contra Costa's rate was slightly higher than the comparable counties and higher than the U.S. unemployment rate for the same period (Table I.9). It is interesting to note that Contra Costa had a higher percentage of its employed workforce in construction and trade-related occupations (9.8%[5]) than did the comparable counties (range of 7.1% to 7.8%). It also had a lower percentage in management and professional occupations (40.5% compared with 42.7% to 48% in comparable counties.) This might factor into the county-level differences seen in both unemployment figures and in education attainment characteristics.

[5] *Source: U.S. Census Bureau, County and state data are from the 2005-2009 ACS 5-year estimates, U.S. data: Current Population Survey, 2010 Annual Social and Economic Supplement.*

Table I.9: Unemployment Rate (Seasonally Unadjusted)[6]

	Contra Costa	Alameda	San Mateo	Santa Clara	California (unadjusted)	United States (unadjusted)
Unemployment Rate Dec 2010	10.90%	10.80%	8.30%	10.40%	12.30%	9.10%
Unemployment Rate Dec 2009	11.10%	11.00%	8.90%	11.30%	12.00%	9.70%

Source: Bureau of Labor Statistics, accessed February 26, 2011.

California's seasonally adjusted unemployment rate hit its peak in September 2010 (12.5%) and had remained at that level through December 2010.[7] While it appears that Contra Costa and the comparable counties saw some easing in unemployment, the rates remained in double digits with the exception of San Mateo.

Housing

Contra Costa County residents renting their homes paid more on average ($1,239) than Alameda County ($1,166) but less than San Mateo ($1,415) and Santa Clara Counties ($1,364). Contra Costa (70.7%) also had a much higher percentage of owner-occupied housing than the other counties (Alameda: 56%; San Mateo: 61.7%; and Santa Clara: 59.9%).

Table I.10: Housing Data for Comparable Counties, 2005-2009

	Contra Costa	Alameda	San Mateo	Santa Clara
Median Value of Owner-occupied Units	$574,700	$606,700	$786,500	**$704,200**
Median Gross Rent of Occupied Units Paying Rent	$1,239	$1,166	$1,415	**$1,364**
Owner-occupied Percent	70.7%	56.0%	61.7%	**59.9%**
Renter-occupied Percent	29.3%	44.0%	38.3%	**40.1%**
Occupied Housing Units Percent	93.1%	92.4%	94.8%	**95.4%**

Source: U.S. Census Bureau. Selected Data from the 2005-2009 American Community Survey for California, all counties, and all places. Accessed http://www.dof.ca.gov/research/demographic/documents/ACS2009-05_STCOPL_Extract.xls. Retrieved February 15, 2011.

The housing crises affected Contra Costa County similar to the comparable counties. The most recent data from realtytrac.com shows Contra Costa's rate of housing foreclosures remained significantly higher than the comparable counties.[8] This data seemed to indicate a bigger impact on County general fund revenues in Contra Costa as compared to similar counties.

Table I.11: Foreclosure Filings in December 2010 and January 2011

	Contra Costa	Alameda	San Mateo	Santa Clara
Total Households	395,625	566,621	267,041	617,697
Foreclosures Dec 2010	1 in 162	1 in 237	1 in 459	1 in 365
Foreclosure %	0.617%	0.421%	0.218%	0.274%
Foreclosures Jan 2011	1 in 142	1 in 240	1 in 421	1 in 305
Foreclosure %	0.704%	0.417%	0.237%	0.328%

Source: Realtytrac.com foreclosure rates for California counties; accessed February 18, 2011 and March 9, 2011

[6] California rates not seasonally adjusted are used for comparison purposes in the table because seasonally adjusted county-level data are not reported.
[7] *ibid*
[8] Realtytrac.com foreclosure rates for California counties; accessed February 18, 2011 and March 9, 2011

Population Projections

Contra Costa's population is growing rapidly relative to the comparable counties, the State, and the U.S. (Table I.12). From 2000 to 2050, the projected average annual growth rate (1.79%) exceeds the State's rate by 20 percent, the U.S. by 83 percent, and the surrounding counties by a range of 63 percent (Santa Clara) to nearly 500 percent (San Mateo).

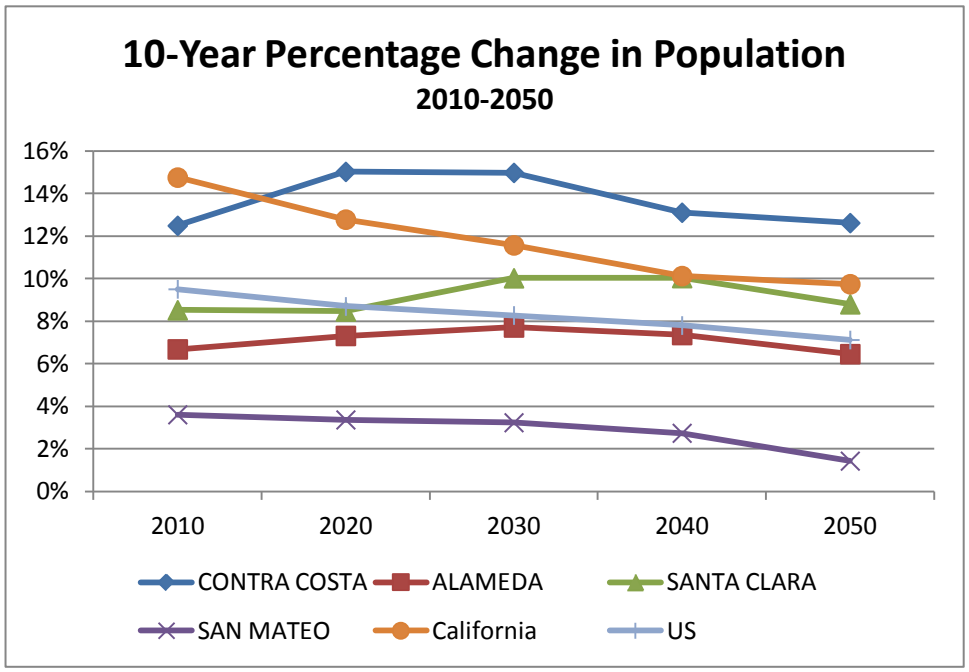
Table I.12: Population Growth, 2000-2050

	2000	2010	2020	2030	2040	2050	Ave Ann. Rate of Growth
Contra Costa	956,497	1,075,931	1,237,544	1,422,840	1,609,257	1,812,242	1.79%
Alameda	1,453,078	1,550,133	1,663,481	1,791,721	1,923,505	2,047,658	0.82%
Santa Clara	1,693,128	1,837,361	1,992,805	2,192,501	2,412,411	2,624,670	1.10%
San Mateo	711,031	736,667	761,455	786,069	807,587	819,125	0.30%
California	34,105,000	39,136,000	44,136,000	49,241,000	54,226,000	59,508,000	1.49%
US (in 000s)	282,125	308,936	335,805	363,584	391,946	419,854	0.98%

Source: Realtytrac.com foreclosure rates for California counties; accessed February 18, 2011 and March 9, 2011

Most of the growth in Contra Costa County is projected to occur in the next 20 years with the population increasing approximately 15 percent between 2010 and 2020 and another 15 percent between 2020 and 2030. While the rate of increase is projected to slow beyond 2030, it is still higher than the comparable counties, the State, and the U.S. (Figure I.4).

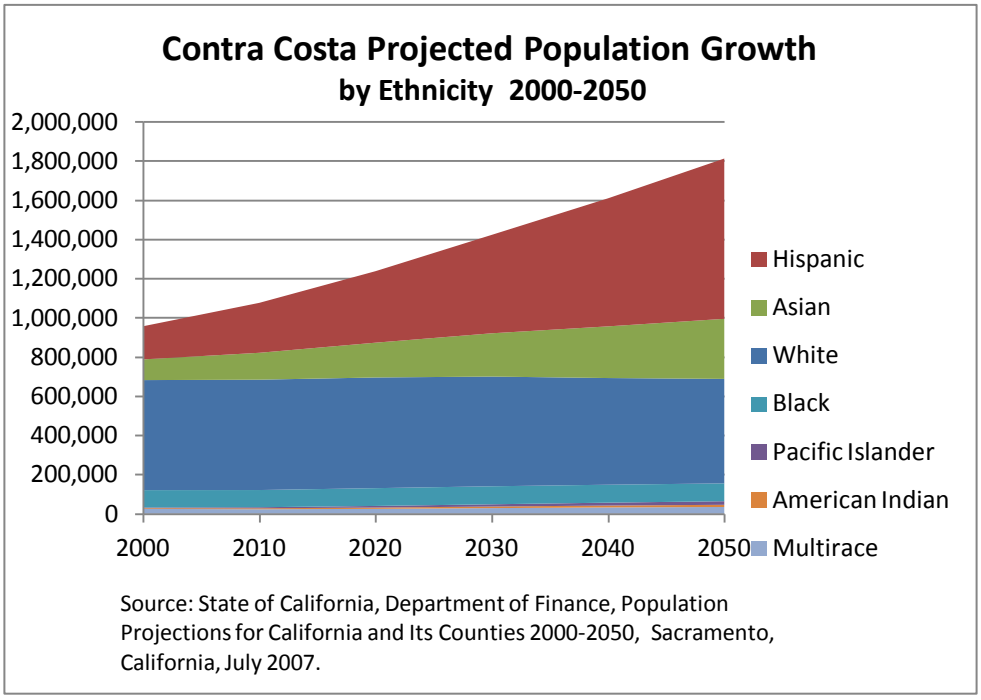
Figure I.4



Source: State of California Department of Finance, Population Projections for California and its Counties: 2000-2050, Sacramento, California, July 2007.

The projected population growth for Contra Costa varies considerably by race and ethnicity. As shown in the graph in Figure I.5, the projected Hispanic population rises sharply with more modest growth in the Asian population. The growth in the number of white residents is expected to be flat as is that for Black residents.

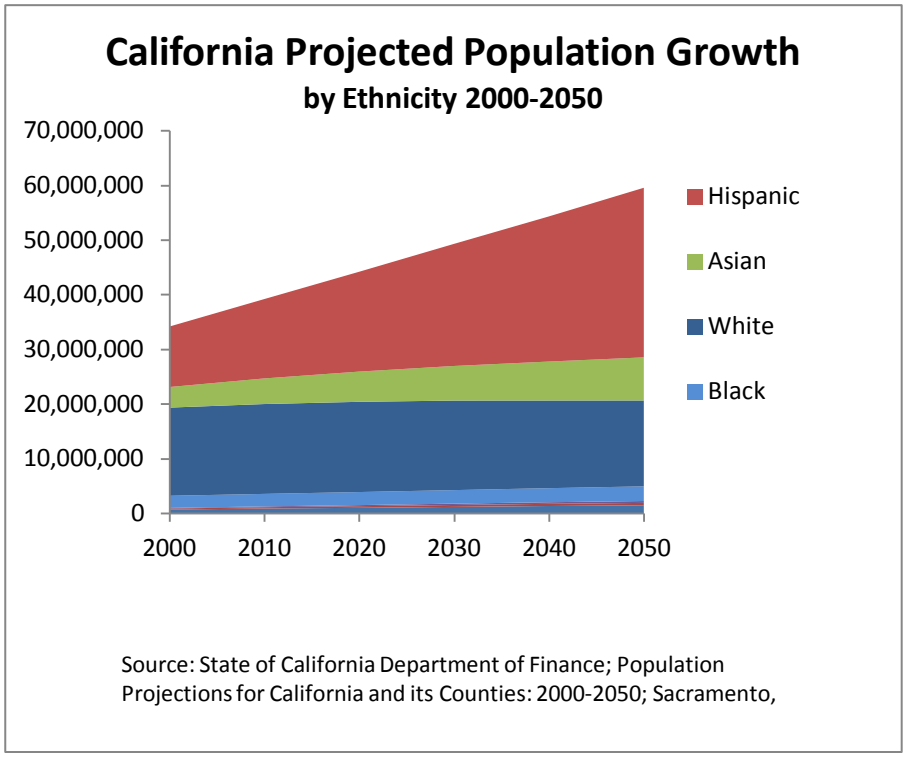
Figure I.5:



Source: State of California Department of Finance, Population Projections for California and its Counties: 2000-2050, Sacramento, California, July 2007.

The Contra Costa projected growth is a pattern similar to that projected for the State (Figure I.6).

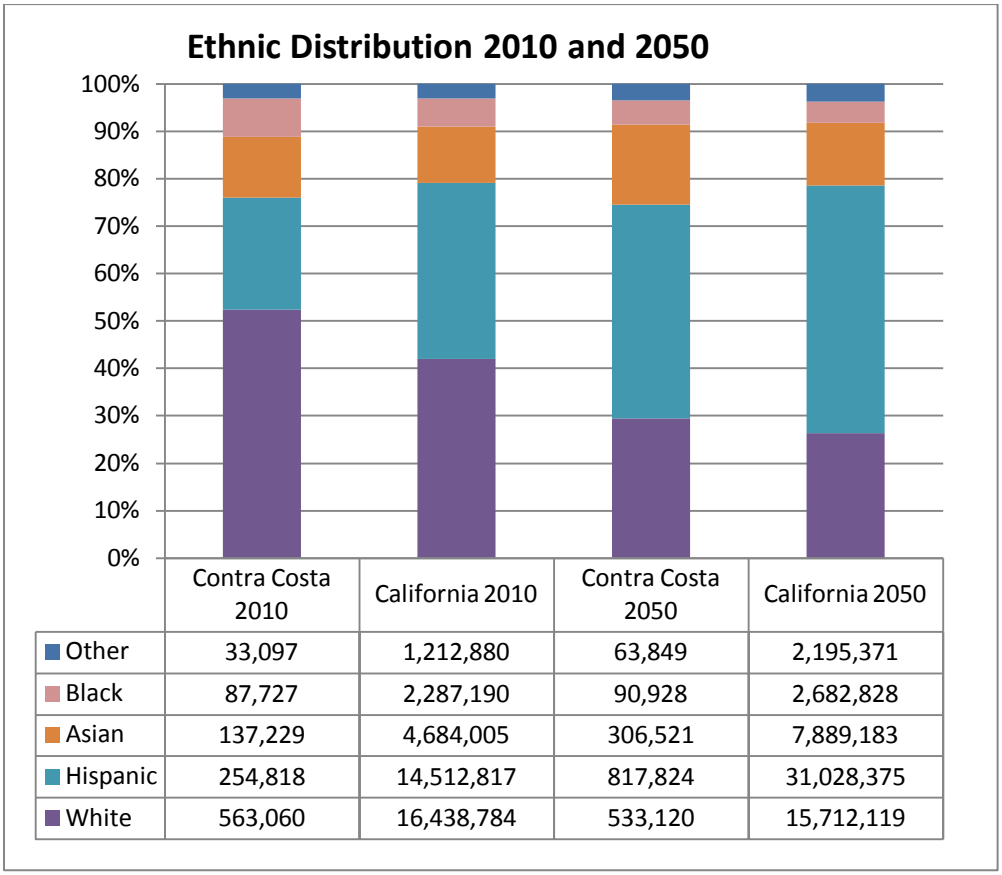
Figure I.6:



Source: State of California Department of Finance; Population Projections for California and its Counties: 2000-2050; Sacramento,

The number of Hispanic residents in Contra Costa is expected to more than triple over this timeframe from approximately 255,000 to 818,000. The number of Asians is expected to more than double from 137,000 to 307,000 (Figure I.7). In contrast, the white population will experience a slight decline from 563,000 to 533,000 and the Black population stays nearly flat.

Figure I.7



	Contra Costa 2010	California 2010	Contra Costa 2050	California 2050
Other	33,097	1,212,880	63,849	2,195,371
Black	87,727	2,287,190	90,928	2,682,828
Asian	137,229	4,684,005	306,521	7,889,183
Hispanic	254,818	14,512,817	817,824	31,028,375
White	563,060	16,438,784	533,120	15,712,119

Source: State of California Department of Finance, Population Projections for California and its Counties: 2000-2050, Sacramento, California, July 2007.

As shown in Table I.13, Contra Costa's racial and ethnic distribution will look very similar to the State as a whole in 2050 but with slightly higher portions of white and Asian residents and a slightly lower portion of Hispanic residents.

Table I.13: Racial Distribution 2010 and 2050

	Contra Costa 2010	California 2010	Contra Costa 2050	California 2050
White	52.3%	42.0%	29.4%	26.4%
Hispanic	23.7%	37.1%	45.1%	52.1%
Asian	12.8%	12.0%	16.9%	13.3%
Black	8.2%	5.8%	5.0%	4.5%
Other	3.1%	3.1%	3.5%	3.7%

Source: State of California Department of Finance, Population Projections for California and its Counties: 2000-2050, Sacramento, California, July 2007.

The Target Population

This report focuses on a target population of Contra Costa residents who are served by the Contra Costa County Regional Medical Center (CCRMC) and County health centers—i.e., those County residents who have benefits through public programs and those without health coverage. The target population is

estimated at just under 300,000. Half of the target population (154,378) are covered by public programs (i.e., Medi-Cal, Healthy Families, HCCI, and BHC) and half (154,160) are uninsured.

Table I.14: Contra Costa Target Population

Coverage Type	Number	Source, Point in Time
Medi-Cal	129,235	California DHCS as of July 2009*
Healthy Families	12,987	MRMIB as of January 2011
Health Coverage Initiative	10,600	CCHP as of December, 2010
Basic Health Care	**1,556**	CCHP as of December, 2010
Total Public Programs	154,378	
Uninsured	**142,000**	MCIC, 2009 (minus HCCI, BHC)
Total Target Population	296,378	
% of County Population	28%	

* Medi-Cal enrollment includes 21,184 enrollees who are dually eligible for Medicaid and Medicare and 15,725 Seniors and Persons with Disabilities who are not eligible for Medicare.

Note: the Contra Costa Health Plan (CCHP) has multiple lines of business that include groups beyond those included in the target population analyzed in this report. This includes County employees, County retirees, and other private employee groups.

The following subsection describes the target population in more detail and discusses which hospitals and health centers serve the target population, largely through comparing Contra Costa data to data for the State, Alameda County, San Mateo County, and Santa Clara County. A few Contra Costa characteristics are noteworthy.

- Nearly half of the Contra Costa Medi-Cal population (47%) was under age 19 years, which is slightly lower than for the State but higher than the comparable counties.
- The larger portion of the County's Medi-Cal population (60%) speaks English. This is higher than the State and comparable counties.
- The Medi-Cal population in Contra Costa grew by more than 30 percent between 2003 and 2009. This is more than three times the State's growth rate during the same period. Only 5 of the State's 58 counties—Placer, Riverside, Marin, San Benito and Nevada—grew faster.
- Medi-Cal enrollees made up 12 percent of the County's total population. This was lower than the State and all but 10 other California counties, including San Mateo.
- As with the State and comparable counties, Medi-Cal enrollees in Contra Costa accounted for a larger portion of hospital discharges (17%) than the portion of the total population that they comprised.
- Only three hospitals, CCRMC, Alta Bates Summit Medical Center, and Sutter Delta Medical Center provided 65 percent of Medi-Cal discharges in the County.
- CCHS health centers provided 77 percent Medi-Cal clinic visits.

- As would be expected, one in three Contra County residents with incomes under 133% of the FPL were uninsured in 2009. In addition, 20 percent of the population with income 133 to 300 percent FPL and five percent of the population with income over 300 percent FPL were also uninsured.
- During the first eight months of fiscal year 2011, CCRMC hospital discharges for the uninsured, totaled 1,072 which annualizes to 1,608 discharges a year, many more than the number of self-pay discharges for any other hospital.
- County health centers provide the majority of primary care clinic visits for the uninsured, including BHC and HCCI enrollees. The County health centers provide 56,000 clinic visits a year, which is more than twice as many clinic visits for the uninsured as provided by all other clinics in the County.
- As compared to the nine other counties with HCCI programs, Contra Costa County had more single, white, young, and English-speaking enrollees.

Medi-Cal Enrollees

The Medicaid program in California, called Medi-Cal, is jointly administered by the California Department of Health Care Services and the federal Centers for Medicare and Medicaid Services. Medi-Cal provides health benefits coverage to low-income state residents who meet eligibility requirements. Medi-Cal is only available to children, parents, adults 65 years and older, and adults who are blind or disabled.[9] As of July 2009, there were 129,235 Contra Costa residents enrolled in Medi-Cal. Nearly half (47%) of Contra Costa Medi-Cal enrollees were children under 19 years. The next largest age group (28%) was 19-44 years. Only 25 percent of Medi-Cal enrollees were 45 years and older.

Table I.15: Contra Costa Medi-Cal Enrollees by Age and Gender, As of July 2009[10]

	Female	Male	Total	
0 to 18	30,178	31,111	61,289	47%
19 to 44	24,431	11,646	36,077	28%
45 to 54	5,228	3,778	9,006	7%
55 to 64	3,717	2,706	6,423	5%
65 and over	11,093	5,347	16,440	13%
Total	74,647	54,588	129,235	

Source: State of California, Department of Health Care Services. Beneficiaries by Age and Gender by County, July 2009. Report Date: July 2010.

[9] Although the current Health Care Coverage for the Indigent program in Contra Costa County and nine other counties is financed in part with federal Medicaid funds, Health Care Coverage Initiative enrollees are not considered to be Medi-Cal enrollees.

[10] Because Medicaid enrollment can begin retroactively, the California Department of Health Care Services recommends that Medi-Cal enrollment data be considered incomplete for 12 months. July 2009 is the most recent complete Medi-Cal enrollment data by county available from the DHCS website.

The County's distribution of Medi-Cal enrollees by age was consistent with the State's distribution. When compared to the comparable counties, Contra Costa's Medi-Cal population was slightly younger. Contra Costa had a lower portion of enrollees 65 years and over and a higher portion in the 0-18 years age group.

Table I.16: Contra Costa Medi-Cal Enrollees by Age, As of July 2009

	California	Contra Costa	Alameda	San Mateo	Santa Clara
0 to 18	50%	47%	44%	45%	44%
19 to 44	26%	28%	26%	25%	27%
45 to 54	7%	7%	8%	6%	6%
55 to 64	5%	5%	6%	5%	4%
65 and over	13%	13%	17%	20%	19%

Source: State of California, Department of Health Care Services. Beneficiaries by Age and Gender by County, July 2009. Report Date: July 2010.

As with the County's total population, Medi-Cal enrollees from Contra Costa were more likely to speak English than were Medi-Cal enrollees in the State and comparable counties. While 60 percent of Contra Costa's Medi-Cal enrollees spoke English, 51 percent of State Medi-Cal enrollees did. The proportions of English-speaking enrollees in the comparable counties were lower than Contra Costa with 55 percent in Alameda, 47 percent in San Mateo, and 39 percent in Santa Clara. Contra Costa's portion of Spanish-speaking enrollees (29%) was lower than San Mateo (42%) and Santa Clara (35%) and higher than Alameda (23%).

Table I.17: Contra Costa Medi-Cal Enrollees by Language, As of July 2009

	California	Contra Costa		Alameda	San Mateo	Santa Clara
English	51%	77,074	60%	55%	47%	39%
Spanish	37%	38,000	29%	23%	42%	35%
Asian	5%	3,299	3%	11%	2%	17%
Other	7%	10,862	8%	11%	9%	9%
Total		129,235				

Source: State of California, Department of Health Care Services. Language by County, July 2009. Report Date: July 2010.

Medi-Cal enrollees receive Medi-Cal services either on a Fee-for-Service basis or through a managed care arrangement. In Contra Costa County, enrollees were evenly split between the two, consistent with State and comparable county data except for San Mateo County. In San Mateo County, only 21% of the Medi-Cal population is Fee-For-Service.

Table I.18: Contra Costa Medi-Cal Enrollees by Managed Care Status, As of July 2009

	Total	%
Fee-For-Service	64,752	50%
Managed Care	64,483	50%
Total	129,235	

Source: State of California, Department of Health Care Services, Managed Care Status by County. July 2009. Report Date: July 2010

Table I.19: Medicaid Enrollees by Managed Care Status

	California	Contra Costa	Alameda	San Mateo	Santa Clara
Fee-For-Service	3,431,291	64,752	115,651	14,858	125,203
Managed Care	**3,663,586**	**64,483**	**116,160**	**55,020**	**124,385**
Total	7,094,877	129,235	231,811	69,878	249,588
Fee-For-Service % of Total	48%	50%	50%	21%	50%

Source: State of California, Department of Health Care Services, Managed Care Status by County. July 2009. Report Date: July 2010.

As reported by the CCHP in their 2010 Annual Report of HEDIS[11] data, 80 percent of Medi-Call enrollees in managed care plans chose CCHP over the other available plan, Anthem Blue Cross. In addition, those that do not choose a health plan are enrolled by default in one of the two plans based on each plan's HEDIS scores and other data. CCHP has been performing better than Anthem Blue Cross in these measures. As a result, in 2011, all Contra Costa Medi-Cal enrollees who do not choose a plan on their own will be default enrolled into CCHP. Of the 12 Two-Plan counties, Contra Costa is the only one that will have all enrollees default enrolled into one plan in 2011.

Similar to the total County population, Contra Costa's Medi-Cal enrollment grew substantially between 2003 and 2009. Over this six-year period, Contra Costa's Medi-Cal enrollment grew 30 percent, from 98,994 in 2003 to 129,235 in 2009. This growth is more than three times the statewide Medi-Cal enrollment growth rate (10%). Contra Costa's Medi-Cal enrollment growth ranked as sixth highest of the 58 counties in the State. Only Placer, Riverside, Marin, San Benito, and Nevada Counties had higher growth rates during this period.

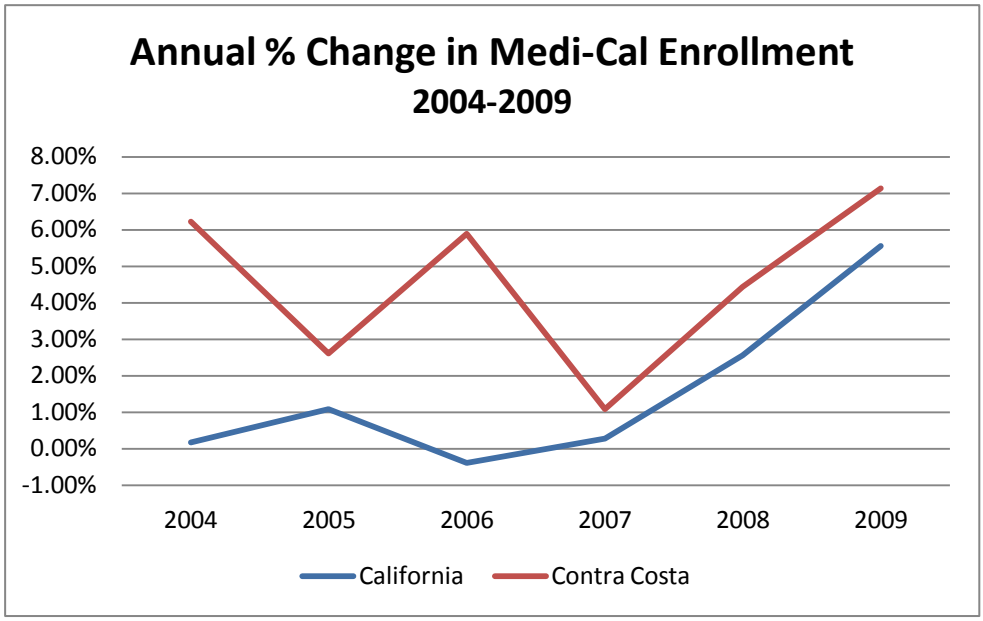
Table I.20: Medi-Cal Beneficiaries, 2003 through 2009, 10 Counties with Highest Growth Rate

	2003	2004	2005	2006	2007	2008	2009	Change 03-09
California	6,478,038	6,489,769	6,560,340	6,534,981	6,553,257	6,721,002	7,094,877	9.52%
Placer	19,813	22,185	23,295	22,770	23,703	25,387	27,770	40.16%
Riverside	264,576	275,347	287,298	287,047	303,425	325,321	360,365	36.20%
Marin	15,292	16,001	16,661	17,470	17,947	18,869	20,543	34.34%
San Benito	6,897	7,669	7,805	8,033	8,024	8,396	9,170	32.96%
Nevada	7,815	7,989	8,225	8,346	8,454	9,087	10,279	31.53%
Contra Costa	**98,994**	**105,151**	**107,905**	**114,259**	**115,503**	**120,622**	**129,235**	**30.55%**
Mono	993	1,148	1,152	1,111	1,124	1,146	1,286	29.51%
Santa Cruz	31,671	33,523	35,785	36,655	37,804	39,380	40,790	28.79%
Sutter	16,949	17,615	18,236	19,172	19,113	20,347	21,697	28.01%
Amador	3,103	3,067	3,140	3,315	3,348	3,519	3,969	27.91%

Note: Certified Medi-Cal Beneficiaries as of July of each year. Does not include unmet spend down, maternity PE, or FPACT Family Planning.
Source: http://www.dhcs.ca.gov/dataandstats/statistics/Pages/RASS_County_Enrollment.aspx

[11] HEDIS (Healthcare Effectiveness Data and Information Set) is a tool used by more than 90 percent of America's health plans to measure performance on a number of dimensions of care and service.

Figure I.8



Source: http://www.dhcs.ca.gov/dataandstats/statistics/Pages/RASS_County_Enrollment.aspx

Contra Costa had the ninth highest total county population in the State and the thirteenth highest Medi-Cal enrollment. As a result, Contra Costa's percentage of the total population that is Medi-Cal enrolled (12.1%) was relatively low compared to all 58 California counties. Only Sonoma, San Louis Obispo, Napa, Amador, Nevada, Mono, El Dorado, San Mateo, Placer, and Marin Counties had smaller portions of total population enrolled in Medi-Cal. This may not indicate that Contra Costa has low program participation by the eligible population but rather may indicate that the county's eligible population is smaller than in comparable counties.

Table I.21: Proportion of Population Enrolled in Medi-Cal, As of July 2009

County	Population	Beneficiary Count	Percent of Population
Tulare	445,251	158,659	35.6
Fresno	948,928	296,972	31.3
Merced	257,373	78,106	30.3
Imperial	181,772	54,725	30.1
Del Norte	29,500	8,139	27.6
Kern	834,041	225,349	27.0
Yuba	73,025	19,455	26.6
Madera	152,924	40,726	26.6
Lake	64,155	16,583	25.8
Tehama	62,941	16,168	25.7
Stanislaus	527,004	126,139	23.9
Mendocino	90,039	21,446	23.8
Glenn	29,273	6,914	23.6
San Joaquin	692,202	162,714	23.5
Siskiyou	45,983	10,439	22.7
Los Angeles	10,409,035	2,334,910	22.4
Modoc	9,699	2,174	22.4
Sutter	97,263	21,697	22.3
Butte	221,331	48,780	22.0
Kings	154,681	33,715	21.8
Sacramento	1,439,985	304,905	21.2
Shasta	183,928	38,859	21.1
San Bernardino	2,064,375	429,994	20.8
Colusa	22,092	4,597	20.8
Trinity	13,924	2,823	20.3
Humboldt	133,269	26,353	19.8
Monterey	433,887	84,260	19.4
Inyo	18,125	3,166	17.5
Santa Barbara	432,981	74,556	17.2
Riverside	2,127,612	360,365	16.9
San Benito	58,240	9,170	15.7
Alpine	1,180	183	15.5
Solano	426,431	64,512	15.1
Santa Cruz	270,882	40,790	15.1
San Francisco	851,485	126,876	14.9
Alameda	1,568,903	231,811	14.8
Yolo	202,220	29,700	14.7
Tuolumne	55,753	8,013	14.4
Lassen	35,482	5,075	14.3
Sierra	3,312	473	14.3
Ventura	841,001	119,821	14.2
Mariposa	18,252	2,544	13.9
Plumas	20,492	2,851	13.9
Santa Clara	1,872,049	249,590	13.3
Calaveras	45,959	6,072	13.2
Orange	3,155,393	408,461	12.9
San Diego	3,208,466	393,794	12.3
Contra Costa	**1,068,759**	**129,235**	**12.1**
Sonoma	490,231	55,798	11.4
San Luis Obispo	271,821	30,624	11.3
Napa	138,451	14,871	10.7
Amador	37,964	3,969	10.5
Nevada	98,721	10,279	10.4
Mono	13,558	1,286	9.5

County	Population	Beneficiary Count	Percent of Population
El Dorado	181,513	17,192	9.5
San Mateo	750,436	69,886	9.3
Placer	344,565	27,770	8.1
Marin	259,772	20,543	7.9
California	38,487,889	7,094,877	18.4

Source: State of California, Department of Health Care Services (DHCS), Proportion of Population Enrolled by County, July 2009. Report Date: July 2010. DHCS uses State of California, Department of Finance total county population estimates.

Providers Serving the Medi-Cal Population

While 12 percent of the Contra Costa population was enrolled in Medi-Cal, 17 percent of hospital discharges for Contra Costa residents were paid by Medi-Cal. The State and comparable counties had a similar differential, with Medi-Cal hospital discharges representing a larger portion of total discharges than the portion of the total county population that Medi-Cal enrollees comprised.

Table I.22: Federal Fiscal Year 2009 Hospital Discharges by Payer Source for Contra Costa Residents

	California		Contra Costa		Alameda		San Mateo		Santa Clara	
Medi-Cal	1,029,382	26%	17,662	17%	33,194	22%	9,515	15%	32,094	21%
Medicare	1,247,464	31%	34,739	33%	46,471	31%	23,278	36%	42,738	27%
Private	1,363,850	34%	44,139	43%	62,209	41%	28,693	44%	70,249	45%
Self-Pay	136,827	3%	2,890	3%	4,109	3%	1,589	2%	2,349	2%
Other	202,405	5%	4,359	4%	6,220	4%	1,956	3%	8,363	5%
Total	3,979,928		103,789		152,203		65,031		155,793	
Medi-Cal enrollees as % Total Pop.		18%		12%		15%		9%		13%

Source: Office of Statewide Health Planning and Development (OSHPD) Market Share Report

As the following table shows, about 65 percent of all Medi-Cal hospital discharges came from just three hospitals: CCRMC (41%), Alta Bates Summit Medical Center (12%), and Sutter Delta Medical Center (12%). After these three hospitals, a group of 27 other facilities provided 33 percent of Medi-Cal discharges and another group of 90 facilities provided 2 percent.

Table I.23: Medi-Cal Hospital Discharges, Contra Costa, Federal Fiscal Year 2009 for Contra Costa Residents

Facility Name	Medi-Cal	%
CONTRA COSTA REGIONAL MEDICAL CENTER	**7,278**	**41.21%**
ALTA BATES SUMMIT MED CTR-ALTA BATES CAMPUS	2,201	12.46%
SUTTER DELTA MEDICAL CENTER	2,197	12.44%
DOCTORS MEDICAL CENTER - SAN PABLO	1,012	5.73%
CHILDRENS HOSPITAL AND RESEARCH CTR AT OAKLAND	927	5.25%
JOHN MUIR MEDICAL CENTER-CONCORD CAMPUS	787	4.46%
JOHN MUIR MEDICAL CENTER-WALNUT CREEK CAMPUS	563	3.19%
KAISER FOUND HSP-ANTIOCH	390	2.21%
KAISER FND HOSP - OAKLAND CAMPUS	351	1.99%
UCSF MEDICAL CENTER	348	1.97%
KAISER FND HOSP - WALNUT CREEK	248	1.40%
JOHN MUIR BEHAVIORAL HEALTH CENTER	180	1.02%
ALTA BATES SUMMIT MED CTR-HERRICK CAMPUS	120	0.68%

Facility Name	Medi-Cal	%
ALAMEDA CO MED CTR - HIGHLAND CAMPUS	95	0.54%
ALTA BATES SUMMIT MED CTR-SUMMIT CAMPUS-HAWTHORNE	85	0.48%
SAN RAMON REGIONAL MEDICAL CENTER	78	0.44%
VALLEYCARE MEDICAL CENTER	53	0.30%
CALIFORNIA PACIFIC MED CTR-PACIFIC CAMPUS	50	0.28%
UNIVERSITY OF CALIFORNIA DAVIS MEDICAL CENTER	47	0.27%
SAN FRANCISCO GENERAL HOSPITAL	45	0.25%
KAISER FND HOSP - REHABILITATION CENTER VALLEJO	40	0.23%
KAISER FND HOSP - RICHMOND CAMPUS	36	0.20%
LUCILE SALTER PACKARD CHILDREN'S HOSP. AT STANFORD	30	0.17%
ST. ROSE HOSPITAL	28	0.16%
NORTH VALLEY-SOLANO COUNTY PSYCHIATRIC HEALTH FACILITY	27	0.15%
ST. HELENA HOSPITAL CENTER FOR BEHAVIORAL HEALTH	27	0.15%
STANFORD HOSPITAL	27	0.15%
SUTTER SOLANO MEDICAL CENTER	23	0.13%
ST. HELENA HOSPITAL	21	0.12%
CALIFORNIA PACIFIC MEDICAL CENTER - ST. LUKE'S CAMPUS	20	0.11%
90 Other Facilities	328	1.86%
Total	17,662	

Source: OSHPD Patient Origin Data

The distribution of Medi-Cal discharges by hospital was very different from the distribution of discharges by hospital for all payers. The three hospitals with the most total discharges for all payers comprised only 40% of total discharges: John Muir Medical Center Walnut Creek Campus (16%), Kaiser Foundation Hospital Walnut Creek (12%), and CCRMC (11%). A group of 27 other hospitals provided 58 percent of all discharges and another group of 257 hospitals provided 2 percent.

Table I.24: Total Hospital Discharges by Facility, Federal Fiscal Year 2009 for Contra Costa Residents

Facility Name	All Payers	%
JOHN MUIR MEDICAL CENTER-WALNUT CREEK CAMPUS	16,941	16.32%
KAISER FND HOSP - WALNUT CREEK	12,793	12.33%
CONTRA COSTA REGIONAL MEDICAL CENTER	**11,576**	**11.15%**
SUTTER DELTA MEDICAL CENTER	7,880	7.59%
KAISER FOUND HSP-ANTIOCH	7,865	7.58%
JOHN MUIR MEDICAL CENTER-CONCORD CAMPUS	7,799	7.51%
ALTA BATES SUMMIT MED CTR-ALTA BATES CAMPUS	5,796	5.58%
DOCTORS MEDICAL CENTER - SAN PABLO	5,555	5.35%
KAISER FND HOSP - OAKLAND CAMPUS	4,963	4.78%
SAN RAMON REGIONAL MEDICAL CENTER	3,690	3.56%
CHILDRENS HOSPITAL AND RESEARCH CTR AT OAKLAND	2,779	2.68%
UCSF MEDICAL CENTER	1,908	1.84%
ALTA BATES SUMMIT MED CTR-SUMMIT CAMPUS-HAWTHORNE	1,728	1.66%
JOHN MUIR BEHAVIORAL HEALTH CENTER	1,635	1.58%
CALIFORNIA PACIFIC MED CTR-PACIFIC CAMPUS	891	0.86%
KAISER FND HOSP - REHABILITATION CENTER VALLEJO	889	0.86%
VALLEYCARE MEDICAL CENTER	709	0.68%
ALTA BATES SUMMIT MED CTR-HERRICK CAMPUS	667	0.64%
STANFORD HOSPITAL	579	0.56%
KAISER FND HOSP - SAN FRANCISCO	540	0.52%
KAISER FND HOSP - RICHMOND CAMPUS	533	0.51%
KAISER FND HOSP - HAYWARD	335	0.32%
EDEN MEDICAL CENTER	334	0.32%

Facility Name	All Payers	%
TELECARE HERITAGE PSYCHIATRIC HEALTH FACILITY	327	0.32%
KAISER FND HOSP - REDWOOD CITY	273	0.26%
FREMONT HOSPITAL	267	0.26%
KAISER FND HOSP - SANTA CLARA	263	0.25%
ALAMEDA CO MED CTR - HIGHLAND CAMPUS	247	0.24%
ST. HELENA HOSPITAL CENTER FOR BEHAVIORAL HEALTH	220	0.21%
WASHINGTON HOSPITAL - FREMONT	169	0.16%
KAISER FND HOSP - SACRAMENTO/ROSEVILLE-MORSE	159	0.15%
LUCILE SALTER PACKARD CHILDREN'S HOSP. AT STANFORD	159	0.15%
ST. FRANCIS MEMORIAL HOSPITAL	155	0.15%
UNIVERSITY OF CALIFORNIA DAVIS MEDICAL CENTER	141	0.14%
MARIN GENERAL HOSPITAL	126	0.12%
SAN FRANCISCO GENERAL HOSPITAL	119	0.11%
PENINSULA MEDICAL CENTER	112	0.11%
MPI CHEMICAL DEPENDENCY RECOVERY HOSPITAL	111	0.11%
KAISER FND HOSP - SAN RAFAEL	101	0.10%
ST. MARY'S MEDICAL CENTER, SAN FRANCISCO	100	0.10%
257 Other Facilities	2,355	2.27%
Total	103,789	

Source: OSHPD Patient Origin Data

Medi-Cal enrollees in Contra Costa County, depending on whether they have Fee-For-Service or managed care coverage, can go to health centers or private doctors for primary care services. For those that choose to go to a health center, they have the choice of HSD Health Centers or other non-County administered federally qualified health centers (FQHCs). The following two tables show data for visits to CCHSD clinics and for non-County clinics.

Table I.25: CCHSD Health Centers, Medi-Cal Outpatient Primary Care Visits, Fiscal Year 2011 Year To Date through December 2010, Annualized For a Full Year

	Medi-Cal FFS	Medi-Cal HMO	Total
Pittsburg Clinic/Home	24,210	27,306	51,516
Richmond Clinic	21,564	14,616	36,180
Martinez Family Practice CL	11,336	12,012	23,348
Concord Clinic	9,874	11,096	20,970
Antioch Clinic	4,686	7,016	11,702
Brentwood Clinic/Home	4,562	6,704	11,266
OB Outpatient Clinic	4,374	1,736	6,110
N Richmond Ctr for Health	1,672	2,092	3,764
Pittsburg Healthy Start	2,694	658	3,352
Martinez Healthy Start	2,490	494	2,984
Richmond Healthy Start	2,248	494	2,742
Bay Point FHC	1,032	1,616	2,648
Concord Adult Med CL/Home	654	340	994
Antioch Adult Medicine CL	314	130	444
Brentwood Healthy Start	72	18	90
Total	91,782	86,328	178,110

Source: January 14, 2011 report from Contra Costa County Health Services Department

Table I.26: Other (Non-County) Primary Care Clinics in Contra Costa County, 2008 Medi-Cal Encounters

	Medi-Cal FFS	Medi-Cal HMO[12]	Total
Brookside CHC - San Pablo	14,077	7,959	22,036
La Clinica Monument	4,275	2,201	6,476
Brookside CHC - Richmond	2,793	2,018	4,811
La Clinica Pittsburg Medical	1,317	3,113	4,430
La Clinica Pittsburg Dental	3,401	426	3,827
Planned Parenthood Concord	2,715	979	3,694
Planned Parenthood Richmond	1,999	1,396	3,395
Planned Parenthood Antioch	1,245	1,560	2,805
Planned Parenthood Shasta Diablo	426	986	1,412
Planned Parenthood Walnut Creek	717	237	954
BAART Richmond Clinic	302	29	331
BAART Antioch	74	63	137
Planned Parenthood San Ramon	113	20	133
Options for Women of CA	n/a	n/a	n/a
Sutter Delta Community Clinic	n/a	n/a	n/a
Total	33,454	20,987	54,441

Source: OSHPD 2008 Annual Utilization Report of Primary Care Clinics

Healthy Families

Healthy Families, the Children's Health Insurance Program (CHIP) in California, is a state-administered health benefits program. Healthy Families provides health benefits coverage to uninsured children under 19 years who are citizens or qualified immigrants, do not qualify for Medi-Cal, and have family income at or below 250 percent FPL. Healthy Families benefits are delivered through managed care plans. As of January 2011, close to 13,000 Contra Costa children were enrolled in Healthy Families. As shown in Table I.27, Kaiser Permanente had the most enrollees (7,731) while CCHP also had a large portion of enrollees (5,243).

Table I.27: Contra Costa Healthy Families Enrollment by Health Plan, January 2011

	Enrollees
Anthem Blue Cross	8
Contra Costa Health Plan	5,243
Health Net	4
Health Plan of San Joaquin	1
Kaiser Permanente	7,731
Total	12,987

Source: www.mrmib.ca.gov/MRMIB/HFP/Jan_11/HFP Rpt15A.pdf

Healthy Families enrollment as a percentage of Contra Costa's total population is similar to the comparable counties. However, one aspect of Healthy Families enrollment in Contra Costa varies from the comparable counties: the portion of enrollees covered by the County plan. In Contra Costa, the County plan, Contra Costa Health Plan (CCHP), had 40% of the County's Healthy Families population.

[12] With Healthy Families encounters

This was lower than the portion enrolled in county plans in the comparable counties (Alameda 53%, Santa Mateo 58%, and Santa Clara 55%).

Table I.28: Healthy Families Enrollment by County and Type of Health Plan, January 2011

	California	Contra Costa	Alameda	San Mateo	Santa Clara
Contra Costa County Plan		**5,243**	**10,927**	**6,016**	**17,656**
Other Plans		7,744	9,804	4,407	14,516
Total	865,062	12,987	20,731	10,423	32,172
% enrollees w/County Plan		40%	53%	58%	55%

Source: http://www.mrmib.ca.gov/MRMIB/HFP/Jan_11/HFPRpt15A.pdf

The Uninsured

A UCLA Center for Health Policy Research estimate of insurance coverage by California county indicated that 17 percent of Contra Costa residents under the age of 65 were uninsured for all or part of 2009. While this was lower than the estimate for the State (24%) and Santa Clara (20%), it was higher than the estimates for Alameda (15%) and San Mateo (14%).

Table I.29: Insurance Status and Type during 12-Month Period, Ages 0-64

	California	Contra Costa	Alameda	San Mateo	Santa Clara
Job-Based Coverage All Year	50%	62%	61%	66%	61%
Medi-Cal, Health Families All Year	16%	11%	15%	6%	11%
Other Coverage All Year	9%	9%	10%	14%	9%
Uninsured All or Part of Year	24%	17%	15%	14%	20%

Source: UCLA Center for Health Policy Research Health Policy Fact Sheet: California's Uninsured by Count, August 2010. Rates are predicted estimates from a simulation model based on 2007 CHIS and 2007/2009 California Employment Development Department data.

An analysis by the Metropolitan Chicago Information Center (MCIC) of recent Census data indicated a similar Contra Costa population distribution by insurance status for 2009 with a slightly lower uninsured portion (15%).[13] MCIC data by age and insurance status (Table I.30) indicated that 10 percent of children 0-17 years, 19 percent of adults 18-64 years, and only 2 percent of adults 65 years and older were uninsured. By comparison, Medi-Cal enrollees included 23 percent of children 0-17 years, 8 percent of adults 18-64 years, and 9 percent of adults 65 years and older. Although the vast majority of the target population (i.e., Medi-Cal enrollees and the uninsured) was made up of adults 18-64 years, a higher percentage of all Contra Costa County children (33%) were in the target population.

[13] County and zip code estimates provided by the Metropolitan Chicago Information Center (www.MCIC.org). MCIC provides geographic allocations to counties and zip codes based on state-level 2008-2009 US Census Current Population Survey (CPS) Annual Social and Economic Supplements data adjusted by the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured to more accurately reflect poverty level calculations. Estimates reflect state Medicaid enrollment totals as reported by state Medicaid agencies. Estimates also reflect data from the Department of Homeland Security to correct for the undercount associated with citizenship status and to accurately represent the undocumented resident population who are ineligible for Medicaid or coverage through Health Benefit Exchanges.

Table I.30: 2009 Contra Costa Population by Coverage Category and Age

	0-17	%	18-64	%	65+	%	Total	%
Private Insurance	165,584	62%	414,664	64%	4,600	3%	584,848	56%
Individual Private Ins.	13,061	5%	42,995	7%	562	0%	56,618	5%
Medi-Cal & Healthy Families	62,835	23%	49,443	8%	12,453	9%	124,731	12%
Medicare	884	0%	11,967	2%	115,104	85%	127,955	12%
Uninsured	25,889	10%	125,006	19%	3,265	2%	154,160	15%
Total	268,253		644,075		135,984		1,048,312	

Source: MCIC analysis March 2011

MCIC 2009 data by insurance status and FPL ranges indicated that there were more uninsured persons with income under 133% FPL than in any other income range, but that substantial portions of the middle income ranges (21% and 19%) and even some high income individuals (5%) were also uninsured. The same was true for the target population, of which over two-thirds had income at or below 133 percent FPL.

Table I.31: 2009 Contra Costa Population by Coverage Category and Federal Poverty Level (Without Undocumented Individuals*)

	0-133%	%	134-199%	%	200-299%	%	300%+	%	Total	%
Family of 4 Annual Income	$29,726		$44,700		$67,050		$67,050+			
Private Insurance	23,049	12%	36,894	42%	58,046	47%	466,859	75%	584,848	57%
Individual Private Ins.	12,243	6%	4,916	6%	8,080	6%	31,379	5%	56,618	6%
Medi-Cal/Healthy Families	75,649	40%	14,710	17%	16,861	14%	17,511	3%	124,731	12%
Medicare	19,118	10%	12,870	15%	18,077	15%	77,890	12%	127,955	12%
Uninsured	59,147	31%	18,600	21%	23,412	19%	31,614	5%	132,773	13%
Total	189,206		87,990		124,476		625,253		1,026,925	
Target Population	134,796	71%	33,310	38%	40,273	32%	49,125	8%	257,504	25%

*Income distribution data for undocumented immigrants is not reliable.
Source: MCIC analysis March 2011

Providers Serving the Uninsured

As with Medi-Cal enrollees, only a few hospitals provide most of the care for those uninsured patients (referred to as "self-pay" patients). However, according to State of California Office of Statewide Health Planning and Development (OSHPD) data, it was a different group of hospitals that provided the majority (61%) of self-pay discharges: John Muir Medical Center Walnut Creek Campus (19%), Sutter Delta Medical Center (18%), Doctors Medical Center San Pablo (13%), and John Muir Medical Center Concord Campus (10%). CCRMC discharges comprised less than five percent of all self-pay discharges in the County.

Table I.32: Self-Pay Hospital Discharges by Facility, Federal Fiscal Year 2009 for Contra Costa Residents

Facility Name	Self-Pay	%
JOHN MUIR MEDICAL CENTER-WALNUT CREEK CAMPUS	551	19.07%
SUTTER DELTA MEDICAL CENTER	527	18.24%
DOCTORS MEDICAL CENTER - SAN PABLO	382	13.22%
JOHN MUIR MEDICAL CENTER-CONCORD CAMPUS	301	10.42%
KAISER FND HOSP - WALNUT CREEK	180	6.23%
KAISER FND HOSP - OAKLAND CAMPUS	139	4.81%
CONTRA COSTA REGIONAL MEDICAL CENTER	**137**	**4.74%**
KAISER FOUND HSP-ANTIOCH	111	3.84%
ALTA BATES SUMMIT MED CTR-ALTA BATES CAMPUS	104	3.60%
JOHN MUIR BEHAVIORAL HEALTH CENTER	51	1.76%
ALAMEDA CO MED CTR - HIGHLAND CAMPUS	30	1.04%
CALIFORNIA PACIFIC MED CTR-PACIFIC CAMPUS	28	0.97%
CHILDRENS HOSPITAL AND RESEARCH CTR AT OAKLAND	28	0.97%
ST. FRANCIS MEMORIAL HOSPITAL	26	0.90%
91 Other Facilities	295	10.21%
Total	2,890	

Source: OSHPD Patient Origin Data

Because of the way OSHPD data categorizes payer sources, discharges for uninsured persons who are covered by the county's HCCI and BHC programs are not included as self-pay discharges. As a result, the table above substantially underreports CCRMC discharges for the uninsured. According to a CCRMC Inpatient Discharges report dated March 18, 2011, BHC discharges for the first eight months of fiscal year 2011 totaled 1,072 which annualizes to 1,608 discharges a year, many more than the number of self-pay discharges for any other hospital.

County health centers provide the majority of primary care clinic visits for the uninsured, including BHC and HCCI enrollees. The County health centers provide 56,000 clinic visits a year, which is more than twice as many clinic visits for the uninsured as provided by all other clinics in the County.

Table I.33: CCRMC and CCHSD Health Centers - Primary Care Outpatient Visits for the Uninsured Fiscal Year 2011 YTD through December 2010, Annualized For a Full Year

	Self-Pay	BHC	HCCI	Total
Antioch Adult Medicine CL	10	42	280	332
Antioch Clinic	298	528	2,452	3,278
Bay Point FHC	66	154	422	642
Brentwood Clinic/Home	316	494	2,408	3,218
Brentwood Healthy Start	4	-	2	6
Concord Adult Med CL/Home	42	96	530	668
Concord Clinic	578	712	2,574	3,864
Martinez Family Practice CL	1,060	1,582	8,162	10,804
Martinez Healthy Start	52	8	10	70
N Richmond Center for Health	224	210	1,638	2,072
OB Outpatient Clinic	140	2	-	142
Pittsburg Clinic/Home	1,424	2,292	11,262	14,978
Pittsburg Healthy Start	44	-	12	56
Richmond Clinic	1,408	2,366	11,852	15,626
Richmond Healthy Start	12	-	4	16
Total	5,678	8,486	41,608	55,772

Source: January 14, 2011 report from Contra Costa County Health Services Department

Table I.34: Other Non-County Primary Care Health Centers in Contra Costa County, 2008 Self-Pay Encounters

	Self-Pay	%
La Clinica Monument	7,066	30%
Sutter Delta Community Clinic	6,126	26%
La Clinica Pittsburg Medical	3,960	17%
Planned Parenthood Walnut Creek	2,035	9%
Planned Parenthood Concord	1,509	6%
Planned Parenthood Richmond	803	3%
Planned Parenthood Antioch	735	3%
Planned Parenthood San Ramon	631	3%
Brookside CHC - San Pablo	427	2%
Planned Parenthood Shasta Diablo	265	1%
BAART Richmond Clinic	92	0%
Options for Women of CA	73	0%
Brookside CHC - Richmond	53	0%
BAART Antioch	29	0%
Total	23,804	

Source: OSHPD 2008 Annual Utilization Report of Primary Care Clinics

Duals

A subset of Medicaid enrollees is simultaneously enrolled in Medi-Cal and Medicare. These enrollees, referred to as duals, are low income, Medicaid-eligible, 65 years and older, blind, or disabled, and Medicare eligible by means of their own or a family member's work history. Contra Costa had 21,184 duals, which was 16 percent of all Medi-Cal enrollees. This percentage was the same as that of the State and lower than Alameda (20%), San Mateo (22%), and Santa Clara (20%). Similar to Contra Costa's total population, the County's duals were younger than duals in the State and comparable counties.

Table I.35: Contra Costa Enrollees Dually Eligible for Medi-Cal and Medicare by Age as of July 2009

	Contra Costa		California		Alameda		San Mateo		Santa Clara	
0 to 21	65	0%	2,347	0%	92	0%	19	0%	71	0%
22 to 64	7,728	36%	330,063	30%	13,266	29%	3,894	25%	10,025	21%
65 and over	13,391	63%	779,369	70%	32,028	71%	11,619	75%	38,779	79%
Total	21,184		1,111,779		45,386		15,532		48,875	
Total Medi-Cal	129,235		7,094,877		231,811		69,886		249,590	
Duals %	16%		16%		20%		22%		20%	

Source: State of California, Department of Health Care Services. Medi-Cal/Medicare Dual Eligibility by Age, by County, July 2009. Report Date: July 2010

Seniors and Persons with Disabilities

In addition to the duals, another Medi-Cal enrollee subset, referred to as Seniors and Persons with Disabilities (SPDs), comprises aged, blind, and disabled persons who are Medi-Cal enrolled but not eligible for Medicare. These individuals may be waiting for a disability determination to be made, may have had a disability determination made but are in the two-year waiting period before Medicare eligibility begins, or may be ineligible for Medicare because they do not have the work history required for Medicare eligibility. According to a Mercer study for the California HealthCare Foundation, Contra

Costa County has 15,725 SPDs, which was 12 percent of the county's Medi-Cal population. This was higher than in Alameda and Santa Clara Counties.

Table I.36: County Seniors and Persons with Disabilities by Age and Managed Care Status,[14] 2008

	Contra Costa				Alameda		Santa Clara	
	Managed Care	FFS	Total	%		%		%
Under 1	10	18	28	0%	43	0%	60	0%
1 to 4	183	120	303	2%	247	2%	611	3%
5 to 14	859	689	1,548	10%	1,039	8%	2,052	9%
15 to 24	774	1,553	2,327	15%	2,185	12%	2,235	10%
25 to 44	864	2,256	3,120	20%	4,157	18%	3,562	15%
45 to 64	1,299	4,615	5,914	38%	10,140	42%	7,946	34%
65 and over	370	2,115	2,485	16%	4,545	18%	6,779	29%
Total	4,359	11,366	15,725		22,356		23,245	
Medi-Cal Total			129,235		231,811		249,590	
SPDs %			12%		10%		9%	

Note: San Mateo is not a two-plan model and therefore was not included in this report.
Source: Medi-Cal Acuity Study - Seniors and Persons with Disabilities, Mercer for the California HealthCare Foundation, September 28, 2010

Health Care Coverage Initiative

The Contra Costa Health Care Coverage Initiative (HCCI) is one of the 10 original county HCCI programs in the State. HCCI provides health coverage to adults who:

- Are 19-64 years of age;
- Are ineligible for other public health coverage programs;
- Have been uninsured for three months or more;
- Are U.S. citizens or legal permanent residents in the U.S. for five years or more; and
- Have incomes at or below 200 percent FPL.

All HCCI enrollees receive coverage through the Contra Costa Health Plan (CCHP). As of December 2010, 10,600 Contra Costa residents were enrolled with HCCI with all but 120 enrollees receiving care through County health centers and CCRMC.[15] The 120 received care from the CCHP community provider network.

A UCLA Center for Health Policy Research report from March 2010 reported the following characteristics of HCCI enrollees in each county.

Table I.37: Characteristics of HCCI Enrollees, 2007 to 2009

	Ala-meda	Contra Costa	Kern	LA	Orange	San Diego	San Fran	San Mateo	Santa Clara	Ven-tura
Age										
18 to 40	12%	38%	34%	12%	32%	9%	36%	32%	27%	38%
41 to 50	23%	26%	28%	24%	20%	19%	21%	22%	21%	25%
51 to 60	44%	26%	29%	49%	32%	47%	29%	31%	34%	27%
61 +	21%	10%	9%	14%	15%	26%	14%	15%	18%	10%
Gender										

[14] Includes those without Medicare coverage who have been enrolled in Medi-Cal for six months or more.
[15] CCHP Enrollment Trend Report for December 2010 provided by CCHP leadership February 2, 2011.

	Ala-meda	Contra Costa	Kern	LA	Orange	San Diego	San Fran	San Mateo	Santa Clara	Ven-tura
Female	55%	48%	46%	66%	51%	60%	47%	51%	55%	52%
Male	45%	52%	54%	34%	49%	40%	53%	49%	45%	48%
Marital Status										
Married	33%	16%	16%	8%			25%	29%	28%	
Divorced, Separated, or Widowed	23%	21%	30%	4%			14%	19%	22%	
Single	43%	63%	53%	13%			60%	52%	48%	
N/A				75%	100%	100%				100%
Race/Ethnicity										
Asian/Pacific Islander	30%	8%	1%	8%	24%	6%	29%	16%	31%	
Black	29%	19%	10%	10%	2%	7%	1%	6%	5%	
Hispanic	20%	20%	41%	63%	23%	33%	10%	30%	29%	
White	15%	43%	46%	12%	23%	15%	3%	21%	25%	
Other	5%	11%	2%	3%	3%	2%	2%	6%	4%	
N/A				4%	24%	36%	56%	22%	7%	100%
Language										
Asian	22%	2%		5%	17%		24%	3%	20%	
English	65%	88%	82%	40%	68%		68%	76%	72%	70%
Spanish	12%	9%	12%	46%	14%		8%	20%	8%	30%
Other	2%	1%	0%	9%	1%		1%	1%		
N/A			6%			100%				
% FPL										
0-100%	88%	73%	80%	66%	64%	58%	71%	61%	71%	58%
101-200%	12%	27%	20%	4%	36%	34%	29%	39%	29%	42%
N/A				30%		8%				
Immigration										
Legal Permanent Resident	15%	12%	11%		19%			21%		
US Citizen	80%	88%	87%		81%			79%	100%	
N/A	5%		2%	100%		100%	100%			100%

Source: UCLA Center for Health Policy Research; March 2010 from www.dhcs.ca.gov/provgovpart/documents/hcci_Enrollee_Demo_Mar2010.pdf

A review of this HCCI demographic data by county shows a few Contra Costa characteristics that are notable, including:

- Contra Costa's HCCI population was younger than the other counties. The proportion of HCCI members 50 and younger (64%) was higher than the other HCCI counties.
- Contra Costa was one of only three counties that had more male (52%) than female (48%) HCCI members.
- Of those HCCI counties reporting data by marital status, Contra Costa had the highest percentage of single HCCI members (63%).
- Contra Costa had the second highest percentage of white HCCI members (43%).
- Nearly 9 out of 10 (88%) of Contra Costa HCCI enrollees spoke English, the highest percentage among HCCI counties.

Basic Health Care

Contra Costa's Basic Health Care (BHC) program provides health benefits coverage to those who have income above the HCCI threshold of 200 percent FPL and less than 300 percent FPL. Since May 2009, adults over 19 years who are not citizens or legal permanent residents are ineligible for BHC. As with HCCI, BHC enrollees receive care through the Contra Costa Health Plan at the County health centers and CCRMC. As of December 2010, 1,556 County residents were enrolled in BHC.[16] See Section III for more about the BHC program.

Health Status

This subsection takes a look at the health status of Contra Costa residents as compared to the State and the comparable counties.

- Although self-reported data for Contra Costa's general population indicated a smaller portion of residents with fair or poor health, the County's portion of Medi-Cal enrollees with fair or poor health was consistent with other counties and higher than State and all but one comparable county for the uninsured.
- The County's rate of early prenatal care for the total population was better than the State rate. County residents who are Hispanic or Black had the lowest rates of early prenatal care.
- In Contra Costa, only 27 percent of Medi-Cal enrollees and 19 percent of the uninsured received a mammogram in the last two years, according to self-reported data. This rate was much lower than in the State and the comparable counties.
- Rates for Pap smears were low for the County's total population and consistent with the comparable counties, the State for Medicaid, and uninsured populations.
- Rates for colorectal cancer tests were consistent with the State and the comparable counties for the total population and Medicaid enrollees but very low for the uninsured.
- Contra Costa death rates by 18 causes were generally consistent with the State and comparable counties. Although the County did not have the lowest rate of death in any of the categories, it had the highest rate for six causes of death: all cancers, colorectal cancer, female breast cancer, stroke, chronic lower respiratory disease, and firearm-related deaths.
- While Contra Costa's mortality rates were not lower than the State or the comparable counties for any causes, they were lower than the Healthy People 2010 goals for four causes: lung cancer, prostate cancer, stroke, and motor vehicle traffic crashes.

Self-Reported Health Status

A smaller portion of Contra Costa residents reported being in fair or poor health than the portion of residents in the state and those in comparable counties. Results of the 2009 California Health Interview Survey (CHIS), a telephone survey of California residents, indicated that 12.9 percent of Contra Costa

[16] CCHP Enrollment Trend Report for December 2010 provided by CCHP leadership February 2, 2011.

residents had fair or poor health. This was lower than CHIS estimates for the entire state (15.2%), Alameda (13.5%), San Mateo (13.5%) and Santa Clara (15.4%).

Table I.38: Health Status of County Population, Percentage of Population, 2009

	California	Contra Costa	Alameda	San Mateo	Santa Clara
Excellent	24.9%	24.4%	29.4%	26.3%	27.2%
Very good	31.8%	35.8%	33.8%	41.2%	33.2%
Good	28.0%	26.9%	23.4%	19.0%	24.1%
Fair	12.2%	9.7%	11.2%	11.0%	12.0%
Poor	3.0%	3.2%*	2.3%	2.5%	3.4%*
TOTAL	100%	100%	100%	100%	100%

* = statistically unstable

Source: California Health Interview Survey, 2009

The same data for uninsured residents revealed a slightly different picture. A much larger percentage (32%) of the uninsured population in the County reported fair or poor health. But instead of being lower, this was higher than the State (23.6%) and Alameda (25.9%) and Santa Clara (18.4%). Only San Mateo was higher (43.6%).

Table I.39: Health Status of the Uninsured, Percentage of Population, 2009

	California	Contra Costa	Alameda	San Mateo	Santa Clara
Excellent	15.9%	9.4%*	32.5%*	2.2%*	21.5%*
Very good	24.8%	12.4%*	25.3%*	33.5%*	25.8%*
Good	35.7%	46.1%	16.4%*	20.7%*	34.4%
Fair	19.2%	23.4%*	23.6%*	41.4%*	11.1%*
Poor	4.4%	8.6%*	2.3%*	2.2%*	7.3%*
TOTAL	100%	100%	100%	100%	100%

* = statistically unstable

Source: California Health Interview Survey, 2009

Medicaid enrollees in Contra Costa County who reported fair or poor health comprised 24 percent of all Medicaid enrollees in the State. The State (20%) and Santa Clara (19%) had lower comparable data while Alameda was nearly the same (25%) and San Mateo (36%) was much higher.

Table I.40: Health Status of Medi-Cal Enrollees, Percentage of Population, 2009

	California	Contra Costa	Alameda	San Mateo	Santa Clara
Excellent	23.2%	25.6%*	23.8%*	3.5%*	15.0%
Very good	24.4%	29.3%	23.0%	33.3%*	25.9%
Good	33.0%	21.4%	28.6%	27.1%*	40.4%
Fair	16.0%	15.4%*	21.1%	35.5%*	15.7%
Poor	3.5%	8.3%*	3.5%*	-	3.1%*
TOTAL	100%	100%	100%	100%	100%

* = statistically unstable

Source: California Health Interview Survey, 2009

Preventive Health

Data on the use of preventive services such as prenatal care, mammograms, Pap smears, and sigmoid/colonoscopy tests can indicate the relative health of a community and whether residents have access to the care they need. As reported by the Contra Costa County Health Services Department, 86 percent of pregnant County residents began prenatal care in the first trimester. This was better than the State as a whole but below the Healthy People 2010 objective.

Table I.41: Women in Early Prenatal Care[17] Per 100 Live Births, 2010

	California	Contra Costa	Healthy People
	2005-2007	2005-2007	2010 Objective
All Women	84.0	86.1	90.0
African American	N/A	81.4	N/A
Asian/Pacific Islander	N/A	89.0	N/A
Hispanic	N/A	80.3	N/A
White	N/A	91.7	N/A

Source: Community Health Indicators for Contra Costa County report, December 2010

2009 CHIS data indicated that 66 percent of Contra Costa women received a mammogram sometime during a two-year span. This is similar to comparable counties and the State.

Table I.42: Mammogram Screening History, Percentage of Females 30 or Older, Total Population, 2009

	California	Contra Costa	Alameda	San Mateo	Santa Clara
2 years or less	65.6%	66.3%	69.4%	64.7%	65.3%
More than 2 years ago	11.5%	9.0%	7.1%	9.8%	12.0%
Never had a mammogram	22.9%	24.7%	23.5%	25.4%	22.7%
TOTAL	100%	100%	100%	100%	100%

* = statistically unstable

Source: California Health Interview Survey, 2009

In 2009, Contra Costa's mammogram rate for Medicaid enrollees (27%) was substantially lower than the State (45%) and the comparable counties (Alameda 57%, San Mateo 80%, and Santa Clara 31%).

Table I.43: Mammogram Screening History, Percentage of Females 30 or Older, Medicaid Population, 2009

	California	Contra Costa	Alameda	San Mateo	Santa Clara
2 years or less	45.3%	27.4%*	57.0%	80.4%*	31.0%*
More than 2 years ago	12.3%	-	3.5%*	-	41.7%*
Never had a mammogram	42.5%	72.6%	39.4%*	-	27.4%*
TOTAL	100%	100%	100%	100%	100%

* = statistically unstable

Source: California Health Interview Survey, 2009

For the uninsured, Contra Costa's mammogram rate (19%) in 2009 was lower than for the State (43%) and Alameda (25%), similar to Santa Clara (19%), and higher than San Mateo (17%).

[17] Began prenatal care in first trimester.

Table I.44: Mammogram Screening History, Percentage of Females 30 or Older, Uninsured Population, 2009

	California	Contra Costa	Alameda	San Mateo	Santa Clara
2 years or less	43.0%	18.7%*	25.3%*	16.9%*	18.5%*
More than 2 years ago	20.9%	12.1%*	23.6%*	2.9%*	7.2%*
Never had a mammogram	36.1%	69.2%	51.1%	80.2%	74.3%
TOTAL	100%	100%	100%	100%	100%

* = statistically unstable

Source: California Health Interview Survey, 2009

2007 CHIS data indicated that 79 percent of Contra Costa women had a Pap smear test over a three-year period. This is lower than for the State (84%), Alameda (82%), San Mateo (87%), and Santa Clara (84%).

Table I.45: Pap Test History, Percentage of Total Population - 2007

	California	Contra Costa	Alameda	San Mateo	Santa Clara
3 years or less	84%	79%	82%	87%	84%
> 3 years ago	7%	8%	7%	8%	7%
Never	9%	13%	11%	5%	9%
TOTAL	100%	100%	100%	100%	100%

* = statistically unstable

Source: California Health Interview Survey, 2007

For the Medi-Cal population, the County's three-year Pap smear test rate (85%) was the same as California, higher than Alameda, and lower than San Mateo and Santa Clara.

Table I.46: Pap Test History, Percentage of Medi-Cal Population, 2007

	California	Contra Costa	Alameda	San Mateo	Santa Clara
3 years or less	85%	85%	71%	100%	89%
More than 3 years ago	5%	9%*	6%*		6.1%*
Never had a mammogram	10%	5.6%*	23%*		4.9%*
TOTAL	100%	100%	100%	100%	100%

* = statistically unstable

Source: California Health Interview Survey, 2007

Contra Costa's Pap smear test rate for the uninsured (76%) was higher than the State, Alameda, and San Mateo and the same as Santa Clara.

Table I.47: Pap Test History, Percentage of Uninsured Population, 2007

	California	Contra Costa	Alameda	San Mateo	Santa Clara
3 years or less	74%	76%	69%	55%*	76%
More than 3 years ago	9%	10%*	7%*	28%*	9.5%*
Never had a mammogram	17%	15%*	24%*	17%*	14.9%*
TOTAL	100%	100%	100%	100%	100%

* = statistically unstable

Source: California Health Interview Survey, 2007

2009 CHIS data indicated that 76 percent of Contra Costa residents 50 years or older received colorectal cancer early detection tests such as colonoscopies, sigmoidoscopies, and fecal occult blood tests. This rate was lower than for the State (78%, Alameda (82%), San Mateo (85%), and Santa Clara (82%).

Table I.48: Colonoscopies, Sigmoidoscopies or Fecal Occult Blood Test, Total Population, 2009

	California	Contra Costa	Alameda	San Mateo	Santa Clara
Never Had One of the Tests	22%	24%	18%	15%	18%
Had Test At Least Once	78%	76%	82%	85%	82%
Total	100%	100%	100%	100%	100%

Source: California Health Interview Survey, 2009

Contra Costa data for colorectal cancer tests for Medicaid enrollees was similar to data for the State and the comparable counties. The County's 55 percent rate was within one percent of the State and the comparable counties other than Santa Clara, which had a higher rate.

Table I.49: Colonoscopies, Sigmoidoscopies or Fecal Occult Blood Test, Medicaid Population, 2009

	California	Contra Costa	Alameda	San Mateo	Santa Clara
Never Had One of the Tests	44%	45%*	44%*	46%*	17%*
Had Test At Least Once	56%	55%*	56%	54%*	83%
TOTAL	100%	100%	100%	100%	100%

* = statistically unstable

Source: California Health Interview Survey, 2009

The colorectal test rate for the uninsured in Contra Costa (30%) was much lower than the State and the comparable counties other than San Mateo.

Table I.50: Colonoscopies, Sigmoidoscopies or Fecal Occult Blood Test, Uninsured Population, 2009

	California	Contra Costa	Alameda	San Mateo	Santa Clara
Never Had One of the Tests	54%	70%	34%*	76%	36%*
Had Test At Least Once	46%	30%*	66%	24%*	64%
TOTAL	100%	100%	100%	100%	100%

* = statistically unstable

Source: California Health Interview Survey, 2009

2009 CHIS data also showed that Contra Costa residents in total had a lower rate of psychological distress than residents in the State and comparable counties.

Table I.51: Had Psychological Distress during Past Year, Percentage Total Population, 2007

	California	Contra Costa	Alameda	San Mateo	Santa Clara
Likely	9%	5%	9%	9%	7%
Not Likely	92%	95%	91%	91%	93%
Total	100%	100%	100%	100%	100%

Source: California Health Interview Survey, 2007

The Medicaid population in Contra Costa, however, reported a higher rate of psychological distress than the State and the comparable counties.

Table I.52: Had Psychological Distress during Past Year, Percentage Medicaid Population, 2007

	California	Contra Costa	Alameda	San Mateo	Santa Clara
Likely	17%	27%*	17%*		0%
Not Likely	83%	73%*	83%*	100%	100%
TOTAL	100%	100%	100%	100%	100%

* = statistically unstable

Source: California Health Interview Survey, 2007

The uninsured reported a lower level of psychological distress.

Table I.53: Had Psychological Distress during Past Year, Percentage Uninsured Population, 2007

	California	Contra Costa	Alameda	San Mateo	Santa Clara
Likely	10%	3%*	7%*	5%*	16%*
Not Likely	90%	97%*	93%*	95%	84%
TOTAL	100%	100%	100%	100%	100%

* = statistically unstable

Source: California Health Interview Survey, 2007

Health Behaviors

Another gauge of a community's health is the incidence of health-related issues such as obesity, physical inactivity, smoking, drinking, and illegal drugs. With the exception of obesity and physical inactivity data, Contra Costa County health behavior data was similar to data for the State and comparable counties. As Table I.54 shows, Contra Costa's estimated age-adjusted rate of adult obesity for the total county (24%) was higher than rates for the three comparable counties while the other behavior data—rates of leisure-time physical inactivity, smoking and binge drinking—were similar to the State and the comparable counties. Notably, binge drinking among adults with Medicaid was much lower than the State and comparable counties.

Table I.54: Rates of Selected Health Behaviors, Total Population

	California	Contra Costa	Alameda	San Mateo	Santa Clara
Adult Obesity, Age Adjusted (2008)	N/A	24%	19%	19%	20%
Leisure Physical Inactivity (2008)	N/A	18%	17%	17%	17%
Adult and Teen Smoking (2007)	13%	10%	12%	15%	10%
Medicaid Adult and Teen Smoking (2007)	18%	21%*	14%*	5%*	18%*
Uninsured Adult and Teen Smoking (2007)	22%	24%*	18%	53%*	22%*
Adult Binge Drinking Past Year (2007)	30%	29%	28%	30%	26%
Medicaid Adult Binge Drinking Past Year (2007)	22%	6%*	23%*	16%*	18%*
Uninsured Adult Binge Drinking Past Year (2007)	35%	27%*	25%	30%*	32%

Source of Obesity and Inactivity data: Centers for Disease Control and Prevention: National Diabetes Surveillance System: http://apps.nccd.cdc.gov/DDTSTRS/default.aspx Retrieved February 19, 2011.
Source of Smoking and Drinking data: 2007 California Health Interview Survey

Health Outcomes

Public health data for the County as a whole showed that Contra Costa had health outcomes that were similar to the State and the comparable counties for the following outcomes

Table I.55: Estimated County Health Outcomes Data

	California	Contra Costa	Alameda	San Mateo	Santa Clara
Asthma Admits 2007 Age-adjusted rate of hospitalization for asthma per 10,000 population	9.0	10.1	15.0	6.8	6.6
Heart Attack Admits 2007 Age-adjusted rate of hospitalization for heart attack among persons 35 and over per 10,000 population	30.5	36.2	36.8	23.7	27.4
Infant Mortality 2002-2006 Average annual infant (less than 1 year of age) mortality rate per 1000 live births over five year period	5.2	4.0	4.5	4.4	4.1
Very Low Birth Weight 2002-2006 Average annual percent of very low birth weight (less than 1500 grams) live singleton births over five year period	0.90	0.79	0.88	0.78	0.73
Low Birth Weight 2006 Percent low birth weight (less than 2500 grams) live term singleton births	2.3	2.2	2.7	1.9	2.3
Preterm Births 2006 Percent of preterm (less than 37 weeks gestation) live singleton births	9.2	8.5	7.9	8.2	8.2

Source: US Center for Disease Control and Prevention National Environmental Public Health Tracking Network ephtracking.cdc.gov/showQueryScreen.action. Retrieved February 19, 2011.

Disease

Data on the incidence of disease in Contra Costa indicated that the County did not have significantly higher or lower incidences for diabetes, AIDS, sexually transmitted diseases, and tuberculosis than the State or the comparable counties.

In the case of diabetes, Contra Costa's age adjusted rate (6.6%) was lower than Alameda (7.5%) and Santa Clara (7.4%) and slightly higher than San Mateo (6.2%).

Table I.56: 2008 Estimated Rate of Diagnosed Diabetes, Percentage of Adults Over Age 20

	Contra Costa	Alameda	San Mateo	Santa Clara
Age Adjusted %	6.6%	7.5%	6.2%	7.4%

Source: Centers for Disease Control and Prevention: National Diabetes Surveillance System http://apps.nccd.cdc.gov/DDTSTRS/default.aspx. Retrieved February 19, 2011.

While Contra Costa's incidence data for AIDS, sexually transmitted diseases, and tuberculosis were above Healthy People 2010 levels, they were lower than data for the State for all diseases other than gonorrhea and lower than at least one comparable county. In the case of tuberculosis, Contra Costa's incidence was much lower than the comparable counties and lower than the State.

Table I.57: Incidence Per 100,000 of AIDS, Sexually Transmitted Diseases, and Tuberculosis, 2006-2008

	California	Contra Costa	Alameda	San Mateo	Santa Clara	HP 2010
AIDS Incidence*	11.6	7.8	17.8	4.5	8.4	1.0
Chlamydia Incidence	377.7	330.6	440.3	250.3	318.2	**
Gonorrhea Incidence	79.7	82.0	144.1	37.6	48.6	19.0
TB Incidence	7.2	5.8	9.6	10.4	12.4	1.0

*In population over age 13 years

**Healthy People 2010 objectives are not consistent with the data reported here.

Source: California Department of Public Health, Center for Health Statistics. Health Status Profiles for 2010.

Mortality

Contra Costa's age adjusted mortality rate per 100,000 for all causes of death (657.8) was higher than the rate for the comparable counties but just under the State rate. For most individual causes of death, Contra Costa's rate was neither the highest nor lowest when compared to the State and the comparable counties. The Contra Costa rate for influenza/pneumonia was lower than the State and comparable counties, and County rates were the highest for six causes of death: all cancers, colorectal cancer, female breast cancer, stroke, chronic lower respiratory disease, and firearm-related deaths. County rates were lower than the Healthy People 2010 goals for four causes: lung cancer, prostate cancer, stroke, and motor vehicle traffic crashes.

Table I.58: Age Adjusted Death Rates per 100,000, Based on 2006-2008

	California	Contra Costa	Alameda	San Mateo	Santa Clara	HP 2010
All Causes	666.4	657.8	641.7	560.8	531.9	*
All Cancers	155.9	**162.8**	150.9	149.4	134.9	158.6
Colorectal Cancer	14.7	**16.9**	15.9	15.7	12.4	13.7
Lung Cancer	38.1	37.8	35.7	35.5	31	43.3
Female Breast Cancer	21.2	**23.8**	21	21.1	18.3	21.3
Prostate Cancer	21.8	22.8	21.7	20.9	16	28.2
Diabetes	21.1	18.5	21.5	12.1	21	*
Alzheimer's Disease	25.7	31.7	19	24.2	32.6	*
Coronary Heart Disease	137.1	103.3	118	98.2	104.4	162.0
Stroke	40.8	**45.9**	41.9	36.4	31.2	50.0
Influenza/Pneumonia	19.6	16.4	16.5	24	18.4	*
Chronic Lower Respiratory Disease	37.8	**38.3**	30.8	28.3	25.7	*
Chronic Liver Disease and Cirrhosis	10.7	8.6	8.8	9.2	8.2	3.2
Accidents	29.7	25.5	27.5	21.6	22.6	17.1
Motor Vehicle Traffic Crashes	10.3	7.7	6.9	5.6	6.6	8.0
Suicide	9.4	9.3	7.7	8.2	7.6	4.8
Homicide	6.3	9.7	10.8	3.6	2.8	2.8
Firearm-Related Deaths	8.5	**12**	12	5.8	3.8	3.6
Drug-Induced Deaths	10.6	9.3	11.1	7.1	6.6	1.2

* Healthy People 2010 objectives are not consistent with the data reported here.

Source: California Department of Public Health, Center for Health Statistics. Health Status Profiles for 2010.

Impact of the Affordable Care Act

Several aspects of the Affordable Care Act (ACA or Health Reform) will change the coverage patterns of Contra Costa County residents. One provision, effective January 2014, will make anyone with income at or below 133 percent FPL eligible for Medi-Cal if they are either U.S. citizens or are legal permanent residents who have been in the U.S. for five years or more. This change will end the current categorical nature of Medicaid eligibility by which low-income individuals qualify if they are in at least one of the following categories: children, parents living with children under 18 years, seniors 65 years and older, and blind persons and disabled persons. With this change, non-disabled childless adults, including non-custodial parents, can qualify for Medi-Cal if they have income at or below 133 percent FPL.

A second change, also effective January 2014, establishes Health Benefit Exchanges (or Insurance Exchanges) through which the uninsured can access private health insurance coverage. Exchange coverage costs for low-income individuals, including premiums and cost-sharing expenses, will be subsidized by the Federal government. With these subsidies, costs will be minimal for those that have income at or below 200 percent FPL ($44,700 annually for a family of four) with premiums no more than 6.3 percent of income and cost-sharing at 87 percent of Exchange plan levels. Additional ACA provisions such as mandates for individuals to have health benefits coverage and for certain employers to offer health coverage to employees will also change health insurance coverage patterns.

MCIC estimates that 73 percent of the 154,000 currently uninsured individuals in Contra Costa County will obtain Medi-Cal or Exchange coverage in 2014 when ACA coverage provisions go into effect. An estimated 63,000 previously uninsured individuals will be covered through private coverage, while 50,000 are expected to move from no health coverage to Medi-Cal coverage. An estimated 41,000 will remain uninsured in 2014. In developing these estimates, MCIC assumed that 15 percent of the currently uninsured who are eligible for Medi-Cal or Exchange coverage will decide not to enroll in the newly available coverage, perhaps even paying fines for failing to enroll. As a result of these changes, the portion of the population that is uninsured is expected to drop from 15 percent in 2009 to 4 percent in 2014 with ACA implementation.

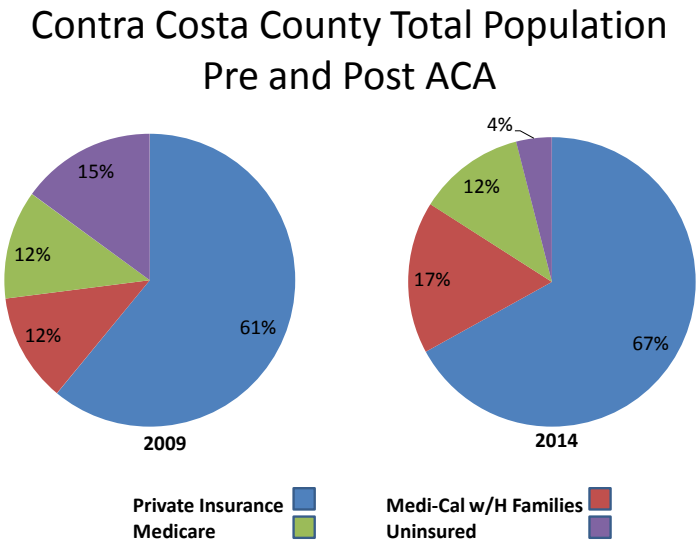
Table I.59: Contra Costa Population by Coverage Status, 2009 & Projected 2014 with ACA Implementation

	2009		%	2014 Movement		2014	%
Private Insurance	**641,500**		61%	63,000	**	704,500	67%
Medi-Cal w/H Families	**125,000**		12%	50,000	***	175,000	17%
Medicare	**128,000**		12%			128,000	12%
Uninsured	**154,000**	*	15%	(113,000)		41,000	4%
Total	1,048,500			-		1,048,500	

*The uninsured in 2009 (154,000) includes those (approximately 10,000) that are currently covered by HCCI.
**The uninsured that move to private insurance coverage in 2014 (63,000) include current HCCI enrollees with income over 133% FPL and those currently in the Basic Health Care program.
*** The uninsured who move to Medi-Cal coverage in 2014 (50,000) include current HCCI enrollees with income under 133 percent FPL.
Source: MCIC analysis March 2011

In 2014, with implementation of ACA coverage provisions, the 10,600 individuals who are currently covered by the HCCI program will become eligible for Medi-Cal or subsidized Health Benefits Exchange coverage. Those who have income at or below 133 percent FPL will be covered by Medi-Cal rather than HCCI, and those who have income above 133 percent and at or below 200 percent FPL will be covered by subsidized Health Benefits Exchange coverage instead of HCCI. The 1,556 currently covered by the BHC program that have income above 200 percent and at or below 300 percent FPL will be eligible for subsidized Health Benefits Exchange coverage at subsidy levels lower than for those with income under 200 percent FPL. In addition to the current HCCI individuals who will have Medi-Cal coverage in 2014, there is another group of individuals who are currently HCCI or Medi-Cal eligible but not enrolled. With the individual mandate and the national discussion of health benefits coverage that will occur as 2014 approaches, many who are currently eligible but not enrolled are expected to enroll in Medi-Cal.

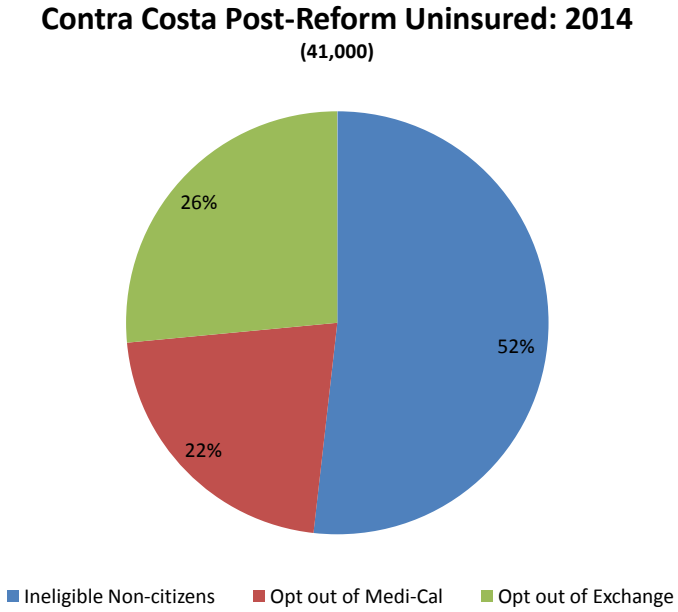
Figure I.9: Contra Costa Population by Insurance Coverage, 2009 and Projected 2014



Source: MCIC analysis March 2011

The 41,000 that will remain uninsured in 2014 are in three groups: undocumented immigrants (21,000), people who do not apply for or renew Medi-Cal coverage (9,000), and people who choose not to enroll in Health Benefits Exchange coverage (11,000).

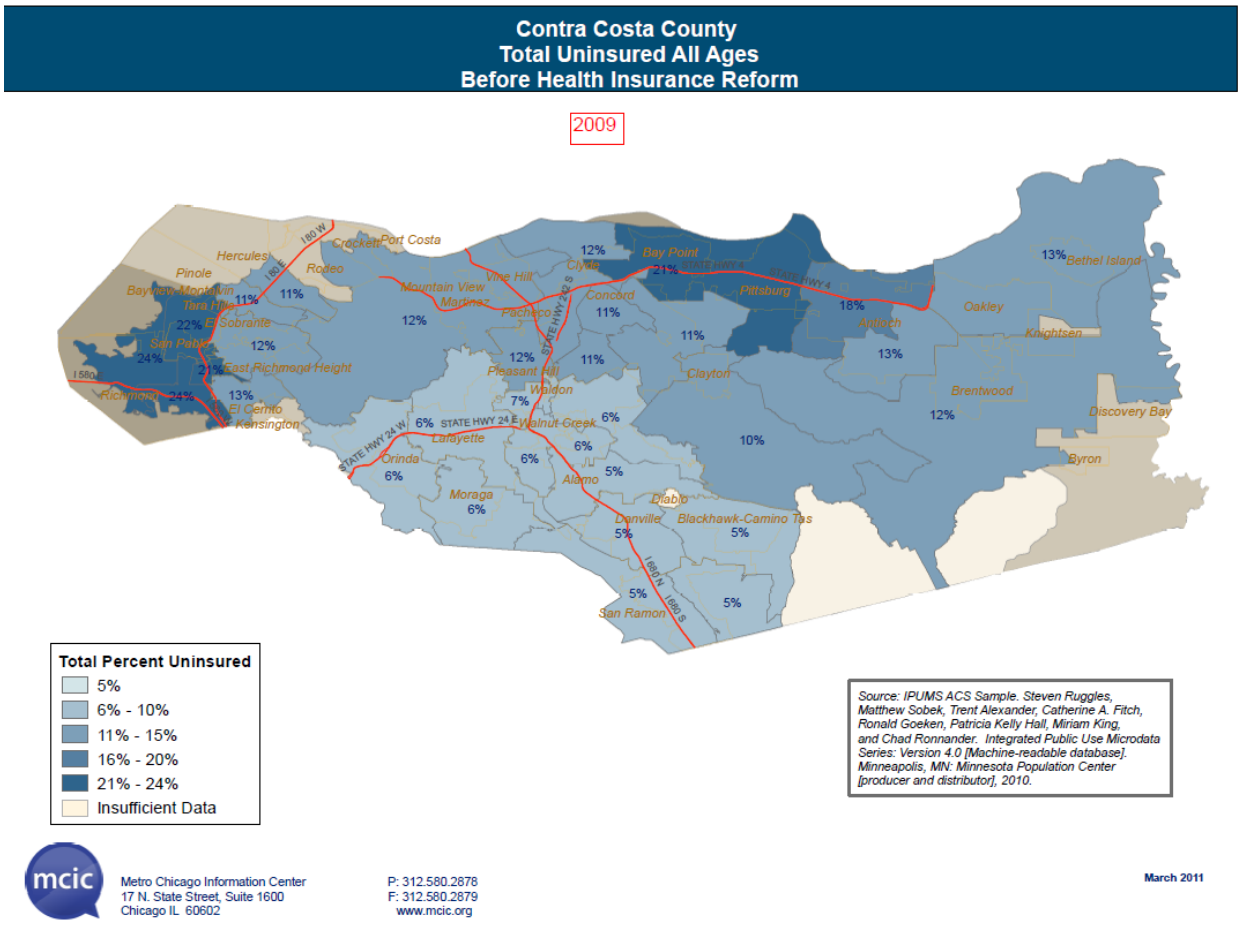
Figure I.10: Contra Costa Projected Uninsured Population, 2014



Source: MCIC analysis March 2011

The following two maps show uninsurance rates for each Contra Costa County zip code. The first map shows this for those who are currently uninsured based on 2009 data. The second map shows the estimated uninsured population after implementation of ACA provisions in 2014.

Exhibit I.1


Contra Costa County
Total Uninsured All Ages
Before Health Insurance Reform
2009
Hercules
Pinole
Crockett
Port Costa
Rodeo
Bay Point
Pittsburg
Bethel Island
Oakley
Knightsen
Antioch
Concord
Pacheco
Mountain View
Martinez
Vine Hill
Clyde
Pleasant Hill
Walnut Creek
Lafayette
Orinda
Moraga
Alamo
Diablo
Danville
Blackhawk-Camino Tas
San Ramon
Clayton
Brentwood
Discovery Bay
Byron
El Cerrito
Kensington
San Pablo
East Richmond Height
Total Percent Uninsured
5%
6% - 10%
11% - 15%
16% - 20%
21% - 24%
Insufficient Data
Source: IPUMS ACS Sample. Steven Ruggles, Matthew Sobek, Trent Alexander, Catherine A. Fitch, Ronald Goeken, Patricia Kelly Hall, Miriam King, and Chad Ronnander. Integrated Public Use Microdata Series: Version 4.0 [Machine-readable database]. Minneapolis, MN: Minnesota Population Center [producer and distributor], 2010.
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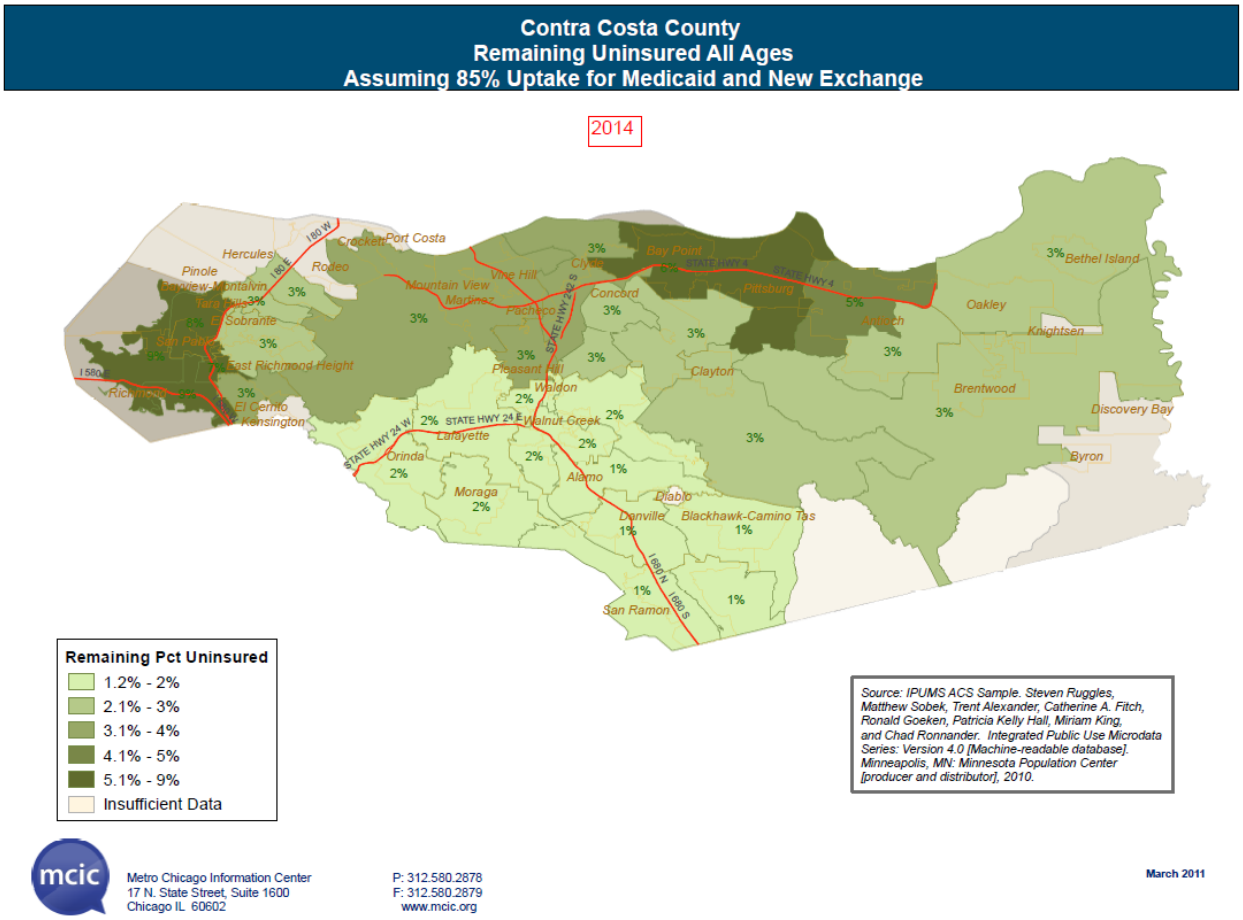
March 2011

Exhibit I.2


Contra Costa County
Remaining Uninsured All Ages
Assuming 85% Uptake for Medicaid and New Exchange
2014
Remaining Pct Uninsured
1.2% - 2%
2.1% - 3%
3.1% - 4%
4.1% - 5%
5.1% - 9%
Insufficient Data
Source: IPUMS ACS Sample. Steven Ruggles, Matthew Sobek, Trent Alexander, Catherine A. Fitch, Ronald Goeken, Patricia Kelly Hall, Miriam King, and Chad Ronnander. Integrated Public Use Microdata Series: Version 4.0 [Machine-readable database]. Minneapolis, MN: Minnesota Population Center [producer and distributor], 2010.
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II. Current and Future Service Capacity and Needs

Introduction

The financial sustainability of any health care system relies on having the appropriate capacity—and an efficient and effective use of that capacity—to meet the needs of the population it serves. This section includes an in-depth analysis of the current capacity of Contra Costa Health Services (CCHS) facilities, programs, and services and identifies areas of strength and challenges. The section also considers future direction for the County facilities and identifies positive innovations, gaps in service capacity and quality, and opportunities for improvement that HMA will further develop in subsequent reports.

Current Capacity

Primary Care

Contra Costa Health Services (CCHS) has developed an extensive primary care network to address the underinsured and uninsured patient populations in Contra Costa and patients with coverage who select CCHS as their health provider. Patients enrolled in Contra Costa Health Plan (CCHP) can choose to receive care from providers in CCHS or from participating private providers. Patients in the Basic Health Care (BHC) program and the Health Care Coverage Initiative (HCCI) are assigned to CCHS providers. Full-time County employees with benefits have two plan options from which to choose: Plan A offers a choice of County physicians and facilities, and Plan B allows members to choose physicians from the health centers or contracted community physicians. Enrollment in Medi-Cal managed care is determined by Health Care Options, a branch of the California Department of Health Care Services (DHCS). Medi-Cal Fee-For-Service (FFS) and Medicare patients also see providers at CCHS facilities. Undocumented immigrant patients are referred to three or four Federally Qualified Health Centers (FQHCs) with health centers in Contra Costa. CCHS has developed a fiscal relationship with these centers to support the care of the undocumented immigrant adults.

The backbone of the primary care delivery system in CCHS is Family Medicine, which provides Pediatric, Adolescent, Adult, and Obstetrical services. The majority of primary care visits in CCHS are provided by Family Medicine providers, many of whom are graduates of the Contra Costa Regional Medical Center Family Medicine Residency Program. Although pediatricians and Internal Medicine providers do provide primary care, they are more readily viewed and used as specialists supporting the Family Medicine providers. Complex pediatric and medical patients may also be entirely assigned to pediatricians and internists for their primary care needs.

In FY 2009-2010, CCHS provided a total of 198,189 primary care visits. Table II.1 shows the breakdown of visits by type of visit.

Table II.1: Primary Care by Visit Type, Fiscal Year 2009-2010

Primary Care Visit Type	Visits
Family Medicine	152,567
Family Medicine Perinatal	1,675
Family Medicine Short Notice/Respiratory, Cold, Flu	8,456
School based	8,486
Homeless	540
Internal Medicine	4,190
Integrative Care	440
Pediatrics	21,835
Total Primary Care	**198,189**

In addition, CCHS provided 34,606 Registered Nurse visits, 7,386 Healthy Start visits, and 16,332 Dental visits.

CCHS provides primary care services at eight separate health centers. These centers vary significantly in size and the scope of services provided. In the three large comprehensive health centers—Richmond, Martinez, Pittsburg—primary care is co-located with multiple specialty clinics, mental health care, public health programs, dental clinics, and diagnostic services. Each of these three large centers has from 40 to 68 exam rooms. The five other health centers—North Richmond, Bay Point, Concord, Antioch, and Brentwood—are smaller centers that predominantly deliver only primary care services. The five smaller health centers have from 2 to 15 exam rooms.

CCHS' health centers are widely distributed across Contra Costa County with the Richmond and North Richmond centers in the west region; Martinez, Bay Point, and Concord centers in the central region; and Pittsburg, Antioch, and Brentwood centers in the eastern region. This has enhanced the geographical accessibility of the primary care to the patients served by CCHS. There are no centers located in the southeast sector of Contra Costa. In the south part of the County, there are more than sufficient medical resources for that population in the private sector, and few of the patients who live there use County health services. The very southeast of the County is extremely rural, mostly parkland, farmland, and open space with very few people.

CCHS has devoted a significant amount of resources to upgrade its physical plants throughout the health care delivery system. New ambulatory health centers at Martinez, Brentwood, and North Richmond have been constructed and the Pittsburg comprehensive health center has been extensively renovated. The health centers in Concord, Bay Point, and Antioch are outdated, crowded, and functionally inefficient. The Richmond comprehensive center is very outdated, but there are active plans to relocate this facility to a newly constructed facility in San Pablo with approximately 25 percent additional space. Although CCHS has added some evening and Saturday hours at its larger centers, most of the clinical hours in the ambulatory care centers are 8:00 am to 5:00 pm. With the planned

With the planned construction and expansion of its outpatient facilities and the expansion of evening and weekend sessions, CCHS has the physical capacity to expand primary care.

Group visits may be an effective way for CCHS to increase visit capacity utilizing existing staff and space.

construction and expansion of its outpatient facilities and the expansion of evening and weekend sessions, CCHS has the physical capacity to expand primary care. In some facilities this expansion of hours/sessions may necessitate the hiring of additional support staff.

Several CCHS ambulatory centers have been actively piloting the use of group visits in a number of their sites. There currently are group visits for diabetes, prenatal care, well babies, childhood obesity, Laotian patients, and chronic pain. A primary care provider participates in all the groups and individually sees each patient. These billable group visits provided over 4,200 visits in 2009 and have high patient satisfaction. Group visits are continuing to increase in both volume of annual visits and clinical foci. Group visits may be an effective way for CCHS to increase visit capacity utilizing existing staff and space.

The ambulatory leadership of CCHS has established panel sizes for all primary providers in CCHS. Full-time Family Medicine physicians have target panel sizes of 2,000 patients, Pediatric physicians: 1,600 patients, Family and Pediatric Nurse Practitioners: 1,600 patients, Internal Medicine physicians: 700 patients, and Family Medicine residents: varying based on year of training (Year 1: 100, Year 2: 150, and Year 3: 250 patients). Based on Uniform Data System (UDS) data, the average medical panel size for primary care providers in FQHCs is approximately 1,100 to 1,200 patients per primary care providers of all categories, including physicians and mid-level providers. These assigned CCHS patients are all active patients with at least one visit in the previous 12 months. CCHS currently has 120 individual Family Medicine providers (72 Family Medicine physicians, 9 Family Nurse Practitioners, and 39 residents), 20 Pediatric providers (15 Pediatric physicians and 5 Pediatric Nurse Practitioners), and 4 Adult Medicine providers. An additional 10 Internal Medicine providers have panel size designations pending. There is a discussion in CCHS to decrease the panel size from 2,000 to 1,500 patients due to increasing patient severity index. Many primary care patients in CCHS have multiple co-morbidities and require more annual visits and more provider time at each visit. If the panel is decreased, CCHS will eventually need to have a larger primary care base to manage the same number of patients.

Table II.2: Contra Costa Health System: Primary Care Providers Paneled Patients by Health Center, Currently Assigned Patients, February 2011

Site	Family Medicine	Pediatrics	Internal Medicine (AMC)	Total
Antioch	8281	829	-	9110
Bay Point	2813	-	-	2813
Brentwood	9661	759	-	10,420
Concord	9663	3138	-	12,801
Martinez	17,914	794	59	18,767
North Richmond	2437	-		2437
Pittsburg	19,719	1609	27	21,355
Richmond	17,699	1537	-	19,236
More than One Service Site	-	1329	554	1883
Total	88,187	9895	640	98,822
Grand Total of Currently Paneled Patients				**98,822**

Source: Provider Panel Status Report, February 2011

Based on February 2011 data, 49 (34%) of the 144 primary care providers with assigned panels in CCHS are “open” to receiving new patients. However, 26 of the 49 providers with open panels already have

panels (adjusted to their percent time of employment) that exceed the targeted panel size. Eighty-three percent of all primary care providers exceed their expected panel size, some by well over 1000 patients. The CCHS primary care provider staff currently is assigned 98,822 individual patients. (Table II.2) This is nearly 10 percent of the entire Contra Costa population. The ambulatory leadership estimates that, at a maximum, the total patient panel census could be expanded by approximately 6000 new patients. This suggests that there exists a potential additional 5.9 percent primary care capacity in the system. Given that most of these new patients would have to be assigned to providers whose panels already exceed both internal and national FQHC guidelines, it is more realistic that only 2,000 new patients could be assigned (a 2% growth capacity). (Table II.3) Based on current primary care staffing, there is relatively limited opportunity for the expansion of patients in CCHS.

Based on current primary care staffing, there is limited opportunity to expand patients in CCHS.

Table II.3: Open Panels, February 2011

Provider	Number of Open Panels	Number of Additional Patients
Family Medicine < 2000 Panel Size	17	1388
Family Medicine > 2000 Panel Size	18	4436
Pediatrician	10	
Internal Medicine (AMC)	4*	200
Total Additional Patient Capacity		**6024**

*10 Internal Medicine providers are not yet assigned panels.

Source: Provider Panel Status Report, February 2011

Specialty Care

The CCHS provides a wide range of specialty care consultative services predominantly at its three large comprehensive care centers in Richmond, Martinez, and Pittsburg. Thirty-nine different specialty services are provided at CCHS facilities, including Allergy, Breast Health, Cardiology, Cardiology Pacemaker, Chest, Continuous Positive Airway Pressure (CPAP) Clinic, Dermatology, Dysplasia, Electromyography (EMG), Ear Nose Throat (ENT), Gastroenterology, Gastrointestinal (GI) Procedure, Gynecology, Hansen's Disease, Hematology, High Risk Prenatal, Infectious Disease, Joint Injection, Medical Pain, Minor Procedure, Musculoskeletal, Neurology, Ophthalmology, Orthopedics, Pediatric Chest, Psychiatry, Psychiatry Liaison, Plastic Surgery, Podiatry, Pulmonary, Renal, Rheumatology, Sexually Transmitted Diseases, Surgery, Urology, Vein Care, Women's Health, and Wound Care. These specialty clinical services provided 100,171 visits in 2010 (Table II.4). The kept appointment rate is excellent, approaching or exceeding 80 percent in almost all the specialty clinics. CCHS also has agreements with private providers in Contra Costa and with UCSF and UC Davis to provide specialty consultation that is not available within CCHS.

Table II.4: Contra Costa Health System: Specialty Clinic Visits, 2010

Specialty	Martinez	Pittsburg	Richmond	Bay Point	Brentwood	Concord	North Richmond	Total
Allergy	404	272						676
Breast Health	375		142					517
Cardiology	310		161					471
Cardiology Pacemaker	248							248
Chest	157	209	168					534
Dermatology	2579	1190	1617			104		5490
Dysplasia	632	774	556					1962
EMG	478							478
ENT	2741	1156	1082					4979
GI	2648	917	1020					4585
GI Procedure	1969							1969
Gynecology	3492	2147	1073					6712
Hansen's Disease	332							332
Hematology	4742	173						4915
High Risk OB	65	96	246					407
Infectious Disease	1025	695	564				151	2435
Joint Injection	105							105
Medical Pain	585		191					776
Minor Procedure	351		44					395
Musculoskeletal	446							446
Neurology	1308	860	723					2891
Ophthalmology	7878	3198	3725					14,801
Ophthalmology Tech	970							970
Orthopedics	6830	2438	1360					10,628
Pain and Wellness	376	804	261					1441
Pre-op	242							242
Psych Liaison	105	220	579					904
Plastic Surgery	1949	185	597					2731
Podiatry	2260	3196	1180					6636
Pulmonary/Bronch.	680							680
Renal	205	101						306
Rheumatology	712	367	284					1363
STD		393	398			350		1141
Surgery	3275	1973	910					6158
Urology	1661	826	769					3256
Vein	8							8
Women's Health		4100	1010	290	486	1554		7440
Wound Care	179							179
Total								**100,171**
			Specialty Support					
Audiology	1000		520					1520
Optometry	2719	1215	833					4767
Occupational Therapy	2375	1973	1037					5385
Physical Therapy	9131	7087	3788					20,006
Speech Therapy	388							388
Total								**32,006**
Infusion Center	4219							4219

Source: 2.8 Kept Appointment Rate, by Provider, December 2010

CCHS tracks waiting times for 23 of the 39 specialty clinics noted above and reports the waits per specialty and per each site where the specialty has sessions. The waiting times to obtain new and return appointments for 23 of the 39 specialty clinics noted above vary significantly from specialty to specialty and, even within a specialty, from site to site. Some of the site variability is so striking as to raise questions about the validity of the data and may require additional evaluation of the data and possibly the service delivery at some of the specialty clinic-sites.

Of the specialty clinic sites tracked, 17 of the 69 different sites had wait times greater than 30 days. Twelve had waits greater than 30 but less than 60 days. These clinic sites were Allergy-Martinez and Pittsburg, Dermatology-Pittsburg, Ophthalmology-Martinez and Richmond, Pediatric Chest-Richmond, Plastic Surgery-Martinez and Richmond, Podiatry-Pittsburg and Richmond, Pulmonary/Bronch-Martinez, and Urology-Richmond. Five specialty sites had waits greater than 60 days and were Cardiology-Richmond, Dermatology-Concord, Gastroenterology-Richmond, Neurology-Richmond, and Rheumatology-Pittsburg. Although listed as specialties with lengthy waits, Cardiology, Dermatology, Gastroenterology, Neurology, Ophthalmology, Podiatry, Urology, and Women's Health all had at least one additional site with waiting times less than 30 days somewhere in CCHS. Only Allergy, Pulmonary/Bronch, Plastics, and Pediatric Chest clinics had excessive waits without a more accessible alternative CCHS site.[18]

A number of specialty clinics have a backlog of referrals that have been placed on a waiting list (Table II.5). Dermatology, Gastroenterology, Neurology, Ophthalmology, Podiatry, Orthopedics, Gynecology, Urology, and ENT routinely have over 100 patients and some commonly have over 300-400 patient referrals in waiting for an appointment. HMA was not able to identify how long referrals stay in this pending appointment category. If this time is lengthy, the actual waiting time for appointments tracked by CCHS is longer than stated and reported.

Table II.5: Number of Patients on Wait List for Specialty Appointment, September 2010, February 2011

Department	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011
Peds. Consult	11	3	2	1	1	4
Psych. Liaison	25	20	53	12	15	29
Rheumatology	33	9	21	8	5	18
Gen. Surgery	47	76	48	32	39	71
Plastic Surgery	52	43	37	55	57	76
ENT	52	60	67	53	159	170
Internal Med.	56	51	50	56	55	44
Allergy	72	52	57	51	46	45
Pulmonary	99	114	88	86	81	83
Ophthalmology	176	245	318	304	342	318
Orthopedics	220	169	81	62	68	104
Podiatry	238	287	295	318	291	314
Gynecology	269	171	181	81	122	154

[18] During interviews, it was related that, on occasion, when the wait for an appointment within the system is deemed excessively long, CCHS refers a patient to contracted private specialists in the community. The volume of referrals sent to private specialists was not identified.

Department	September 2010	October 2010	November 2010	December 2010	January 2011	February 2011
Urology	301	254	185	112	47	50
Neurology	318	322	372	407	362	355
Gastroenterology	337	411	448	369	304	197
Dermatology	599	573	558	503	378	322
Totals	**2,905**	**2,860**	**2,861**	**2,510**	**2,372**	**2,354**

Source: Specialty Referral Unit HSD, Number of Patients Waiting Bar Graph, Report September 2010-February 2011

The CCHS has a central appointment center that schedules all new and return specialty appointments. Patients must be financially reviewed prior to being given an appointment. Some of the specialty clinics also screen referrals for approval, rejection, or to request additional pre-visit testing prior to an appointment being slated. The appointment center's policies also dictate how far into the future that an appointment date can be arranged. In addition to the demand for specialty consultation and the number of specialty provider-sessions, the pre-appointment screening process may contribute to the backlog in a number of key specialty clinics.

CCHS's Ambulatory Care Department tracks individual and specialty service provider productivity per health center. Almost all specialties have patient per hour standards and goals that are compared to their actual productivity. The 2010 Patients Seen per Clinic Hour, by Provider reported on the productivity of 86 specialty clinic-sites. Twenty-two specialty services with 58 clinic sites had written productivity goals.[19] However, only 23 of the 58 specialty clinic sites met their established productivity goals (Table II.6).

Table II.6: Contra Costa Health System: Specialty Clinic Productivity Per Hour, 2010

Specialty	Goal/Hour	Martinez	Pittsburg	Richmond	Bay Point	Brentwood	Concord	North Richmond
Allergy	1.5	2.03	2.39					
Breast health	1.75	2.19		1.61				
Cardiology	4.0	3.65		3.35				
Card pacemaker		2.79						
Chest	2.5	2.28	1.54	1.68				
Dermatology	2.25	2.48	2.14	2.44			1.30	
Dysplasia		1.62	1.82	1.99				
EMG		0.98						
ENT	3.0	2.26	1.98	2.50				
GI	2.5	1.82	1.33	1.70				
GI Procedure		0.87						
GYNE	2.25	2.41	2.50	2.40				
Hansen's Disease	1.30	1.52						
Hematology	2.25	1.62	1.34					
High risk OB		1.47	1.25	2.17				
Infectious Disease		1.84	1.55	1.74				1.52
Joint Injection		0.90						
Medical Pain	3.0	3.33		1.24				
Minor Procedure		0.77						
Musculoskeletal	2.5	2.64						

[19] HMA reviewed the chosen productivity goals for each specialty. The goals selected by CCHS were reasonable and attainable, and a few specialty goals were even somewhat low.

Specialty	Goal/Hour	Martinez	Pittsburg	Richmond	Bay Point	Brentwood	Concord	North Richmond
Neurology	1.5	1.57	1.61	1.82				
Ophthalmology	2.5	2.84	3.16	3.14				
Ophthalmology Tech		1.03						
Orthopedics	3.0	2.95	2.76	2.94				
Pain & Wellness	3.5	3.00	6.18	2.20				
Pre-Op		1.06						
Psych Liaison		0.56	0.68	0.74				
Plastic surgery	3.0	2.86	0.72	3.85				
Podiatry	3.8	3.44	3.99	3.93	1.52(PHC)			
Pulmonary/Bronch		1.91						
Renal		1.97	2.10					
Rheumatology		1.83	1.79	1.82				
STD			1.09	1.15				
Surgery	2.3	2.69	2.76	1.62				
Urology	3.0	2.91	2.50	2.60				
Vein		1.00						
Women's Health	2.0		1.82	1.57	1.8	2.11	1.69	
Wound Care		3.0						
Specialty Support								
Audiology	2.0	1.57		1.53				
Optometry	1.5	1.73	1.42	1.52				
Occupational therapy	1.15	1.24	1.16	1.15				
Physical therapy	1.15	0.90	1.12	1.06				
Speech Therapy	0.69							
Infusion Center								

Source: 3.2 Patients Seen per Clinic Hour, by Provider, December 2010

Current Specialty Capacity

CCHS' specialty clinics see a substantial number of visits annually. Based on the waiting times to obtain a specialty appointment, which may be longer than reported, and the significant number of days that referrals are backlogged on the waiting list, many of the specialty clinics are at or near capacity.

Emergency Services

The Contra Costa Regional Medical Center has a busy 17-bay/bed and 2 fast-track bay/bed Emergency Department (ED) that annually treats nearly 60,000 patient visits. The ED visit volume has doubled in the past six to seven years. To accommodate the unanticipated increased volume of patients, seven additional patient stations/gurneys have been formally "jerry-rigged" in the open hallways and corridors. Many of these "temporary overflow" stations lack optimal audio and visual privacy. The ED waiting room is routinely packed and overcrowded. In spite of the ED congestion, the Left-Without-Being-Seen (LWBS) is only 3 to 4 percent, which is comparable with U.S. rates.

The ED has a well-functioning agreement with John Muir Medical Center to transfer patients from CCRMC's ED with trauma, neurosurgical problems, and ST Elevation Myocardial Infarction (STEMI) patients. The STEMI transfer times are carefully monitored and have consistently met national standards for time from door to balloon (Cath Lab).

Two ED beds nearest to the ED entrance have been converted to fast-track bays in an attempt to more efficiently process the 30 percent of the ED patients who have the lowest level of acuity (Level 4-5). These patients do not need to be seen in an ED and could be more appropriately and cost effectively managed in a non-urgent care setting. A not insignificant number of fast-track patients simply need medication refills, but they could not get a timely appointment to their primary care provider. The ED Medical Director conservatively estimates that greater than 5 percent of all ED visits could be safely seen in a primary care office.

The ED does not have a standardized practice to notify primary care providers when their patients are in the ED. This notification is done only occasionally and sporadically. The ED does not have access to expedited, dedicated post-ED discharge appointments to a patient's primary care provider. At times patients are even sent to a specialty clinic for a problem that could have been managed in a primary care setting when a timely primary care appointment could not be arranged.

Process improvements to decrease the inpatient bed turnaround time would help with the congestion in the ED.

Many patients have prolonged stays in the ED while waiting for an inpatient bed to become available. Process improvements to decrease the inpatient bed turnaround time would help with the congestion in the ED. CCRMC does not have an observation unit, which could also potentially assist to decrease length of stays in the ED and prevent unnecessary inpatient admissions.

The ED collaborated with the Crisis Center (i.e., Psychiatric Emergency Services - PES) to minimize the number of mentally ill patients who need to be evaluated in the ED for medical clearance prior to entering the Crisis Center. By using an effective and creative pre-screening by ambulance medics, more than 400 additional ED visits per month are now being avoided.

Physical Space in Emergency Department

The CCRMC ED volume currently exceeds the physical space capacity of the ED. A combination of new policies and practices in CCHS and at CCRMC would assist to decrease the ED volume and LOS. Within or without these process changes, the ED needs additional space to effectively manage the current or even a somewhat smaller volume of patient visits.

Prenatal Care, Obstetrical, and Labor and Delivery

The Contra Costa Health Center has maintained a robust Obstetrical (OB) program. This sets CCHS apart from most public health care delivery systems in the U.S. who have experienced a decreasing number of deliveries over the past decade. CCRMC has the third largest OB service in Contra Costa, delivering approximately 190 to 210 babies a month. The 2200 to 2400 deliveries per year at CCRMC are 16.3 percent of the all the deliveries of pregnant women who are residents of Contra Costa and 21 percent of all the deliveries that occur in Contra Costa hospitals. Employees and even medical staff choose to deliver their children at CCRMC. It is

Contra Costa Health Center's has a robust Obstetrical program that sets CCHS apart from most public health care delivery systems in the country.

estimated that two-thirds of all the deliveries are by Hispanic women, 50 percent of whom are predominantly monolingual Spanish-speaking.

Prenatal Care is initiated by an aggressive Healthy Start Program that is located on the three large comprehensive health care center campuses in Martinez, Richmond, and Pittsburg. All pregnant women who call CCHS for a prenatal appointment are seen within one to two weeks in Healthy Start. Once they have been processed, have completed the initial prenatal labs, and been provided prenatal education, the mothers are given appointments at a CCHS center. In 2010, Healthy Start provided 7,386 visits to pregnant women. Prenatal Centering classes are offered at a number of CCHS sites. Nearly 12,300 prenatal visits were performed by CCHS providers in 2010 at seven different health centers. Prenatal care is also provided at Planned Parenthood clinics and at non-County FQHCs in Contra Costa. Very few women present late in their pregnancy for prenatal care.

The average length of stay of 2.4 day could be shortened with some process improvements and service enhancements at CCRMC and in CCHS.

The inpatient OB Unit is located on the fifth floor of the CCRMC. The OB Labor and Delivery (L&D) Suite has 10 beds, 4 triage beds, and 3 clinic beds. There are 20 post-partum beds and 1 isolation bed. Overflow beds are occasionally needed on the adjacent Medicine-Surgery unit. The C-section rate of 24 percent is comparable with U.S. rates. The average length of stay is 2.4 day and could be shortened with some process improvements and service enhancements at CCRMC and in CCHS. Primary providers are notified when the mother is admitted for delivery. Mothers and babies are given scheduled follow-up appointments with their primary care provider at the time of hospital discharge. The triage, L&D, and inpatient notes are viewable in all CCHS facilities and paper copies are faxed to non-County FQHCs and Planned Parenthood providers.

Physical and Staff Capacity

Although the OB unit is quite busy, OB and hospital leadership estimate that there is physical and staff capacity to manage an additional 15 to 20 percent more deliveries.

Hospital Care - OB/GYN, Medicine-Surgical, and Inpatient Psychiatry

Contra Costa Regional Medical Center (CCRMC), constructed in 1997, is the only public hospital in Contra Costa. There are also nine private or non-profit hospitals in the County. Doctor's Hospital is the only remaining district hospital in the County. Los Medronos Hospital was converted to the Pittsburg Comprehensive Health Care Center, and the Mt. Diablo District Hospital was sold and is now John Muir Medical Center – Concord. CCRMC has 166 licensed beds and 140 available beds as noted on HSD CCRMC Statistical Comparison chart. In 2006, CCRMC closed one of its two inpatient Psychiatric Units, which has 20 beds, and, in 2008, closed the inpatient Pediatric Unit, which had eight beds. CCRMC is a community hospital and has service and transfer agreements with the other nine hospitals in Contra Costa and the University of California, San Francisco (UCSF) and University of California, Davis (UC Davis) medical centers to provide services and procedures not available at CCRMC or as part of the coverage package for patients in some of their health plans.

The hospital has a full-service ED that provides nearly 60,000 visits per year. The ED transfers all trauma cases to John Muir Medical Center (JMMC), the only designated Trauma Center in Contra Costa. CCRMC also has formal transfer agreements with JMMC for patients requiring Joint Replacement, Cardiac and Neurosurgery, Cardiac Catheterization, Invasive Cardiac procedures, and patients with STEMI.

CCRMC is the only 5150 mental health crisis center in Contra Costa. The Crisis Center is situated just across the corridor from the ED. It has 22 beds or cots: a 11-bed male dorm, a 7-bed female dorm, and 4 individual rooms. The Crisis Center performs approximately 7,000 intake evaluations per year. The mean length of stay on the Crisis Center is 10 hours, but the more difficult-to place patients with drug intoxication or withdrawal have stays of 16 to 24 hours. The Crisis Center generates nearly 1,500 to 2,000 annual admissions. Half of patients (i.e., those with Medi-Cal, uninsured, and complicated patients) are admitted to the CCRMC Psychiatric Unit and half (i.e., those with private insurance and Medicare) are transferred to private psychiatric units or Institutions for Mental Diseases (IMDs) outside Contra Costa County. The Crisis Center has adequate space to manage the patients presenting for care 85 to 90 percent of the time. However, there are times when the Crisis Center is crowded and cramped.

The two dorm-like observation rooms are more readily described as tiny "barracks." The cots (recliner/chair beds) virtually touch each other. A significant number of Crisis Center admissions are preventable due to issues such as a problem with medication refill or compliance, substance abuse, loss of private insurance with cumbersome transition of care to the public mental health setting, and the lack of adequate intensive care coordination in the community for high-risk patients. The Crisis Center provides a valuable service for the ED. Contra Costa does have a successful, cost effective Criminal Mental Health Court that aggressively and intensively tracks and supports high-risk and high-utilizing mental health service users.

The CCRMC had an average daily census (ADC) of 107 in FY 2009-2010. This ADC has been stable since FY 2007-2008. The average daily bed distribution was 88 Med-Surgery patients and 19 Psychiatric patients. This computes to a daily occupancy rate of 76.4 percent, which is a high average occupancy rate. There are many days when emergent or urgent ED and ambulatory center patients and elective admissions must wait for an inpatient bed to become available. This delay contributes to the congestion and already crowded physical space in the Emergency Department.

In FY 2009-2010, CCRMC averaged 707 Medical discharges per month, 71 Psychiatric discharges per month, and 205 newborn discharges per month totaling 11,796 annual discharges. The Medicine-Surgery average length of stay (ALOS) was 3.79 days, Psychiatric Unit's ALOS 8.19 days, and the Nursery's ALOS was 2.39 days. The payer mix for FY2009-2010 for CCRMC hospital discharges was Medi-Cal at 47.1 percent, Medicare at 12.9 percent, Basic Health Care at 13.7 percent, HMO at 17.5 percent, and Other at 8.9 percent.

Given that over 1,600 medicine-surgery admissions are treated and leave CCRMC within 24 hours, there is opportunity to create additional inpatient Medicine-Surgery capacity by evaluating these admissions and identifying alternative treatment strategies.

The perinatal L&D unit delivered over 2,400 babies in FY 2009-2010. CCRMC has the third busiest OB service in Contra Costa

delivering over 20 percent of all mothers who chose to give birth in the County. As noted in the OB services section, although quite busy, the CCRMC has the space to increase its delivery capacity by 15 to 20 percent. Additional support staff and services such as social work and lactation specialists may be needed to decrease the ALOS on the OB unit and to manage any increase in deliveries.

Internal Medicine admissions have increased by 14 percent since 2005 and by 49 percent since 2000. Surgery admissions have remained stable during the same five-year period at approximately 1,310 annual surgical admissions. The Internal Medicine and Surgery units admitted 5,918 patients in 2009. A review of CCRMC length of stay data shows that 28 percent of all Internal Medicine admissions and 27% of all Surgery admissions are discharged within 24 hours, and 51 percent of Medicine admissions and 42 percent of Surgery admissions are discharged within 48 hours. Given that over 1,600 Medicine-Surgery admissions are treated and leave CCRMC within 24 hours. This points to an opportunity to create additional inpatient Medicine-Surgery capacity by evaluating these short-stay admissions and identifying alternative treatment strategies that would avoid costly and bed consuming admissions. The Medicine-Surgery unit occasionally houses stable patients for excessively long periods. These are patients who are difficult to place, including felons, people with behavior disorders, young adults, people who are homeless, people who are substance abusers, who are not readily welcome in nursing homes or skilled nursing facilities.

CCRMC is the only Medi-Cal FFS and uninsured surgical provider in Contra Costa. The surgical services provided include ENT, General Surgery, Gynecology, Ophthalmology, Orthopedics, Plastic Surgery, Podiatry, and Urology. For the most part, only common, general, and less complicated surgical procedures are performed at CCRMC. Patients requiring more extensive and specialized surgery including joint replacement, neurosurgical, trauma, cardio-vascular surgeries are transferred to outside medical centers.

CCRMC has four operating rooms (OR), but only three are being utilized. The fourth OR was closed pending the outcomes of an aggressive process improvement effort to maximize the OR efficiency and turnaround times. A potential fifth OR is currently used as a storage space.

In 2009 to 2010, CRMC performed an average of 135 inpatient and 190 outpatient surgeries per month. The total annual OR case volume of 3,900 surgeries (1,300 cases per OR suite; the goal for utilization should be 70% for each OR occupied during hours OR department is open) included 1,620 inpatient and 2,280 ambulatory same-day surgeries and procedures including incision and drainages (I&Ds), cystocopies, arthroscopies, and some endoscopies. Approximately 600 (37%) of the 1,620 inpatient surgeries were C-sections. Each OR does between five to six cases per day. Access to the CCRMC OR for truly emergent cases was perceived to be reasonable but urgent cases can wait for 18 to 72 hours for an OR or a surgical provider/team to be available.

The CCRMC Department of Surgery reported that the OR utilization was approximately 90%. This exceeds the USA goal for OR utilization of 70% for each OR occupied during hours OR department. This high utilization rate is achieved even though there is a 33% cancellation rate for scheduled OR cases. The cancelled cases are readily filled in by add-ons of urgent or emergent inpatient surgeries. When there are no cancellations, add-on cases bump scheduled, elective surgeries. There is only one OR team

scheduled on the weekends and holidays when only emergent and some urgent cases are allowed to be performed. Less urgent inpatient cases that can be delayed are postponed until the next workday. This contributes to a number of cancellations of scheduled surgeries on subsequent workdays. The pre-op clearance process is not centralized at CCRMC. Patients may need as many as three separate visits to complete all pre-requisite OR preparations, testing, education, and medical clearance. This multiple step pre-op process is also considered to a contributing factor to the 33% OR cancellation rate.

CCRMC's surgeons have indicated that a number of procedures, including I&Ds, localized biopsies, cataract extractions, cystoscopies, hysteroscopies, hysteroscopic tubal ligations, D&Cs, incision or excision of labial and vaginal abscesses and cysts, hernia repairs and other surgeries that are currently performed in the inpatient ORs could be readily and safely performed in more efficient and less rigorously regulated ambulatory surgery or outpatient procedure/treatment rooms.

There has been a steady decrease in the Psychiatric Unit's ALOS from 11.5 days to 8.14 days through more efficiently stabilizing and transferring patients not requiring the intensity of the inpatient Psychiatric Unit.

CCRMC has a 23-bed inpatient Psychiatric Unit. The census was 22 (96% occupancy) on the day of HMA's tour. The 2009-2010 average daily census was 19 (83%) and is running at 20 (87%) so far in 2010 to 2011. The unit discharged 71 patients per month with 852 annual discharges in 2009 to 2010. A second inpatient Psychiatric Unit with 20 beds was closed in 2006 due to low census and remains vacant. CCRMC has contracted with private with IMDs to transfer stabilized psychiatric patients expeditiously. A positive outcome of this closure was a steady decrease in the Psychiatric Unit's ALOS from 11.5 days to 8.14 days due to the pressure to be more efficient and to stabilize and transfer patients not requiring the intensity of the inpatient Psychiatric Unit.

CCRMC Hospital Capacity

Based on the current occupancy rates and existing practices, there is little overall capacity in the CCRMC inpatient units. There are waits to admit patients to an inpatient bed. This is particularly true on the Medicine-Surgery units, and the Psychiatric Unit is very close to full capacity on many days. The ED is crowded and is at near maximum capacity without additional space. The Crisis Center has to place mentally unstable patients into cramped barrack-like rooms lined with cots. At the same time, as stated, the OB can effectively increase capacity with its current space and staff by an additional 15 to 20 percent, which would mean 30 to 40 additional deliveries per month or 360 to 480 more per year. There is, however, significant unused OR physical capacity at CCRMC with only three of the four ORs in use. Shifting a number of the less complicated OR cases to an ambulatory or outpatient procedure suite could also create additional OR capacity.

Access to Lower Levels of Care

CCHS patients with Medicare, private insurance, and Medi-Cal under CCHP have reasonable access to skilled nursing facilities, nursing homes, long-term acute care hospitals (LTACs), and home health nursing. Medi-Cal patients with CCHP coverage are allowed skilled nursing facility/intermediate care facility services for the month of admission and the following month only.

Self-pay/uninsured patients and those covered by the BHC program and HCCI have difficulty or are not at all able to have appropriate lower level of medical care, including home health, mental health services, substance abuse services, prescription drugs for non-covered services, and services in a skilled nursing facility or an intermediate care facility. Providers related that CCHS/CCRMC has difficulty providing underinsured and uninsured patients with home wound care or home IV antibiotic services that would expedite discharges from the hospital and decrease the need for some ED and ambulatory clinic visits. CRRMC has contracts with IMDs to transfer mentally ill patients who have been stabilized from the inpatient Psychiatric Unit to their facilities. An undefined number of difficult-to-place medical and mental health patients have longer than clinically necessary length of stays, particularly on the Medicine-Surgery and Psychiatric Unit, due to CCRMC's inability to transfer these socially and behaviorally complex patients to skilled nursing facilities or IMDs. The Contra Costa Custody Services houses approximately 1,200 men and women in its detention centers on a daily basis. Yet there is not a medical infirmary in the Contra Costa detention system that could accept patient-detainees who could be discharged from the CCRMC if a lower level of care unit was available in a local detention facility. There is a notable shortage of inpatient and residential substance abuse beds in Contra Costa, which contributes in some part to increased hospital admissions, hospital lengths of stay, and ED and Crisis Center visits for this patient population.

Contra Costa Health Services does not have contracts with any facilities for lower levels of care or for such services as home health, substance abuse, etc. The social workers at CCRMC have referral lists of skilled nursing facilities in Contra Costa and surrounding counties and access to a list of 12 IMD placement facilities.

The exact fiscal and clinical burden to CCHS due to the lack of ready access to needed lower levels of care is uncertain. However, there clearly is a lack of access to these services by the underinsured and uninsured patient populations in Contra Costa.

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After-Hours, Non-Urgent, and Urgent Care

All CCHS patients are given a 24/7 Advice Nurse phone number to call when their primary care clinic is closed. These calls are initially screened by clerical personnel who can access an Advice Nurse for clinical questions and concerns. If determined by the Advice Nurse that a patient in the CCHP needs to be physically seen by a provider, the patient is sent to a contracted private urgent care center. Uncovered patients are advised to go to the CCRMC ED. The Advice Nurse has access to CCHS' scheduling system and can give next-day and same-day appointments to a patient's primary care provider.

CCHS patients also are provided with the phone number of the 24/7 Mental Health Crisis line where they can be advised and directed to urgent or less-immediate mental health services in Contra Costa and CCHS.

A limited number of walk-in patients are accepted during regular day hours at most CCHS ambulatory centers if the patient has first called and been screened about the urgency of their clinical concern. The three large CCHS comprehensive health centers have initiated some evening and Saturday hours to expand primary care and provide same-day appointments and walk-in care. The five smaller CCHS health centers are generally only open from 8:00 am to 5:00 pm from Monday through Friday. However, the Antioch Health Center is open until 9:00 pm Tuesday through Thursday. Evening clinics start at 5:30 pm and are staffed by three physicians. The Concord Health Center is open to walk-ins Monday through Thursday from 5:00 pm to 9:00 pm for all patients except pre-natal patients.

CCRMC treats over 16,000 Level 4-5 patients per year in its busy ED. Most of these patients could have been treated in primary care or immediate care settings. Data were not available to determine how many of these Level 4-5 ED patients had primary care providers in CCHS and what percentage of these patients would not have sought care in the ED if they had increased access to immediate, non-urgent care in the primary care centers or if they were allowed or directed to use one of the contracted urgent care centers. The CCHP contracts with three urgent care centers in the County to provide after-hours care for their members who cannot get to one of the health centers that offers after-hours care. Uninsured patients must go to the ED for after-hours care.

After-Hours Care Capacity

CCHS offers good access to nurse phone consultation in the off hours. However, it currently provides limited walk-in capacity during its health centers daytime hours. After-hours hands-on provider care capacity does not exist for underinsured or uninsured patients. These patients must be directed to the CCRMC ED when their primary care center is closed or not able to see them in a timely manner.

Patient-Centered Medical Home in CCHS

CCHS's outpatient centers have started the process to establish patient-centered medical homes throughout the ambulatory system. Each primary care patient is assigned to the panel of an individual primary care provider in one of the system eight ambulatory health centers. Although not all centers have a chronic disease registry, there is a home-grown Diabetes Registry that allows the tracking of provider/center-specific diabetes care in a number of CCHS health centers. Primary care providers are notified when a patient is admitted and discharged from the Medicine-Surgery and OB units at CCRMC but not by the ED. CCHS utilizes a 24/7 Advice Nurse phone line that all primary care patients can access. The Advice Nurse can contact a physician on-call for the CCHP patients but not for other categories of patients. Health plan patients who require hands-on assessment after hours are sent to a contracted urgent care center. Uninsured and Fee-For-Service (FFS) patients are directed to the CCRMC ED. CCHS currently has clerical "care coordinators" in most of its ambulatory settings. Although helpful in arranging group visits, accepting patient phone calls, forwarding clinical questions to a Registered Nurse, and facilitating the refill of prescriptions, these care coordinators do not provide the

While CCHS has implemented many of the elements of a primary care medical home and continues to incorporate additional components into its outpatient centers, none of the ambulatory centers are yet full-scope or advanced primary care medical homes.

full-scope care coordination that is essential to a functioning patient-centered medical home. CCHP does have case managers who seek out some high-risk patients, but no other high-risk/high-utilizing patient population in CCHS is proactively contacted, monitored, and managed. The Richmond Health Center has just started a care coordination pilot staffed by a Licensed Vocational Nurse (LVNs). The entire CCHS health care delivery system has electronic access to dictated CCRMC and ED notes, laboratory, radiology, and diagnostic reports, medication profiles, and electronic medication order entry data. However, CCHS does not yet have an electronic medical record (EMR). Rather nearly all of the outpatient provider notes are handwritten and maintained in a paper medical record. This will change in 2012 when an EPIC EMR is fully installed.

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Contra Costa Health System Family Medicine Residency Program at CCRMC

The CCHS Family Medicine Residency Program is the only residency program of any type at CCRMC and the only residency program in all of Contra Costa County. The CCHS program is one of the more respected Family Medicine training programs in the USA. There are 39 residents (13 per year) at any one time in the training program. There are over 600 applications for the 13 slots available in the program each year. The residents do their primary care continuity sessions in six of the eight CCHS ambulatory care centers. The residents cumulatively provide over 22,000 annual primary care visits to CCHS patients.

The CCHS Family Medicine Residency Program is one of the most respected Family Medicine training programs in the U.S. It is extremely helpful for recruiting and retaining competent, quality providers.

Staff Recruitment and Retention

The presence of the Family Medicine Residency is a boon to recruitment of primary care physicians as it provides an influx of new providers into the CCHS system but also to all other practices and systems in Contra Costa County. CCHS hires 33 percent of each year's graduates. Sixty-eight percent (45 physicians) of all the Family Medicine graduates from 2006 to 2010 stayed in Contra Costa County. This is consistent with U.S. physician recruitment data that has identified that a high number of graduating residents remain in or near the community where they were trained.

The CCHS Family Medicine Residency Program is an invaluable asset to CCHS and all of Contra Costa County. The presence of the training program has a significant positive impact on the primary care capacity in CCHS and in the entire County. It is extremely helpful to the recruitment and retention of competent, quality providers, especially primary care Family Medicine attending physicians to teach and practice at CCRMC and in CCHS. CCHS Ambulatory System recruits heavily from CCHS's Family Medicine program. The opportunity to teach, work with residents, pay back medical loans, and have an academic affiliation with UC Davis/UCSF significantly helps with recruitment and retention. Northern California Kaiser Permanente has started to recruit for more primary care physicians and will likely target the CCRMC Family Medicine residents and other physicians. However, there is currently a compensation

gap. New graduates at CCRMC start at $120,000 and that may increase to only $170,000 over 15 years. It was stated that Kaiser is starting new graduates at $180,000 with a benefit package that is similar to the County's and includes a sign-on bonus for primary care, loan repayment, and profit sharing. As indicated, 33 percent of each year's graduates are hired by CCHS and 68 percent (45 physicians) of all the Family Medicine graduates from 2006 to 2010 stayed in Contra Costa County. The physician recruiter, a retired CCHS physician, is currently looking for a replacement Pathologist, an Orthopedic Surgeon, and a Podiatrist, the latter two of which are new positions. There does not seem to be a recruiting budget in the HSD budget, although that could not be confirmed.

Recruitment for Registered Nurses (RNs) is being done by a recently retired former CCRMC Director of Nursing, which was a position she held for two years and had been with the HSD for 28 years prior to retirement. She is the "subject matter expert" who analyzes all applications from the County Human Resources Department (HR) and scores them for years of experience, education, specialty, and veteran status. She then places positions on a "cert list" as either beginner, experienced, or advanced based on score. Only 10 people at a time can be placed on the list. Employees who have not passed their probation period or who have been let go can go back on the list. HR will only send 10 candidates at a time. Although there is a surplus of nurses available locally, it can take three to four months to hire a vacant nurse position due to the county merit system, and they lose candidates every month. Therefore, CCHS is forced to utilize a Per Diem Pool. The RNs gain experience but do not get benefits or leave after a few years. Some stay because they have another non-CCHS job with benefits. CCHS has a very difficult time competing with Kaiser's higher salaries. CCHS' salary range for RNs is $36.40 to $48.00 per hour and per diems are $66 per hour. In contrast, Kaiser pays $52.00 per hour with just two years experience.

The retention of RNs seems to be working well. It was voiced that, even though salaries are lower compared to Kaiser and other hospitals, CCRMC is a good place to work with good benefits. CCRMC and the CCHS health centers currently have very few vacancies. The outpatient clinics use a combination of RNs, LVNs, and Certified Medical Assistants. However, the California Nurse Association just settled the Kaiser contract with a 5% increase per year for three years.

There are a number of CCRMC staff eligible to retire at the end of March and who are planning to retire to prevent their salary being reduced by the 6 percent rollback that has been proposed by the Chief Administrative Officer. CCRMC could possibly lose 18 people out of the Information Technology Department and at a critical time. The department is already short 30 FTEs for implementation of EPIC EMR.

The hiring process for ancillary and support staff is also slow and cumbersome and makes it difficult to attract good candidates.

The recruitment and retention of professional classifications will become increasingly difficult as the Health Service Department (HSD) works to maintain its competitive position with Kaiser, Sutter, and others while complying with the hiring rules of HR and the merit system.

Diagnostic Services

All the radiological diagnostic services in the CCHS are under the supervision of the CCRMC Department of Diagnostic Imaging. Weekday physician staffing is provided by eight (two full-time and six part-time) radiologists. A private offsite vendor reads films in the evening and weekends. Diagnostic imaging is provided at CCRMC and in the Richmond and Pittsburg comprehensive centers. Nuclear medicine studies, MRI-breast, CT-guided liver biopsies, and vascular interventions are referred to outside medical facilities. With the exception of mammography, all of the imaging studies are digitalized and bids are currently being solicited to digitalize mammography. Turnaround times (TAT) for radiology reports is 24-36 hours for routine studies. TATs are currently slowed by a paper order process that requires the order and medical history to be physically moved to the Radiologist. This will be improved to almost "real-time" reporting once EPIC is fully implemented. It was reported that RUVs for the Radiology Department doubled from 2001 to 2008, which mirrors the timeline of the rapid growth in visits to CCRMC's ED.

CT, MRI, Ultrasound (US), fluoroscopy, plain film studies, and select imaging- guided biopsies are provided onsite at CCRMC. CCRMC has one CT Scan (64 slice – two years old), one MRI (six years old), four ultrasonography units, and one special procedure suite (aging). All requests for MRI and CT studies are screened by a radiologist for appropriateness and urgency. Inpatient waits for CT and MRI are generally less than 24 hours, and the wait for inpatient US is approximately 48 hours or less. Lack of timely access to some diagnostic tests in the hospital, especially on weekends/holidays, at times when the sole CT and MRI units are in use, and the inability to obtain certain interventional (e.g. imaging-guided lung/liver biopsies) at CCRMC prolongs some patient stays. The specialized diagnostic studies (CT, MRI, special procedures) are at near capacity and, at times, have become a bottleneck to certain aspects of both the inpatient and outpatient health care delivery.

Plain films, mammography, GI fluoroscopy and abdominal/prenatal ultrasonography are provided at the three large comprehensive health centers: Pittsburg, Martinez, and Richmond. These outpatient studies/reports are readily available with relatively short waits. There are increasing waits (three to four weeks) for outpatient CT and MRI studies, waits that could be much longer without the meticulous screening of all requests for both inpatient and outpatient CT and MRI studies. As noted above, there is only one CT/MRI in the system (CCRMC) and, when waits are excessive, a number of requests for outpatient CTs and MRIs are contracted out to private radiology groups. However, it is difficult to arrange outpatient imaging studies at outside facilities for patients who are not in a health plan, do not have private insurance, or do not have Medicare.

Patients from the smaller CCHS health centers are referred to the comprehensive center in their cluster for most outpatient diagnostic testing. Patients in the health plans and Medi-Cal FFS are, at times, referred to a private contracted radiology center. The FQHCs in the Community Clinic Consortium also send patients to CCHS multi-specialty sites for diagnostic testing, including ultrasound, plain film, and mammography.

In some cases, outpatient diagnostic imaging appointments in the comprehensive health centers are available the same day, but, on average, there is only a one-week wait for mammograms. Ultrasound studies are available in approximately three to four weeks with obstetric ultrasound appointments

available in less than one week. The comprehensive health center radiology service accepts referrals from CCHS sites in its cluster, FQHCs, providers in CCHS' health plan network in its region, and its Homeless Care program. Reports/actual studies are viewable electronically. The services are digitalized and read at CCRMC with a 24 to 72 hour turnaround time. The center can refer some urgent studies that cannot be done quickly enough to outside contracted radiology services.

Diagnostic Services staff in the comprehensive health centers acknowledged they have capacity to see more patients. In some cases, additional support staff may be needed to increase capacity.

Diagnostic Services staff acknowledged that there is capacity to perform more outpatient mammograms, ultrasounds, and plain film studies. In some cases additional support staff may be needed to increase access to these studies. Having only one CT unit and one MRI unit for a 140 bed hospital, 60,000 ED visits, 100,000 unique primary care patients, and 450,000 ambulatory care patient contacts creates a bottleneck in access to imaging studies especially for uninsured and underinsured. The need for a second CT unit requires careful evaluation of the existing clinical demand and cost implications. The MRI and special procedure suite are reaching the end of their expected functional lives.

Pharmaceutical Services

Contra Costa Health Services does not run an outpatient pharmacy. However, they provide pharmacy services using a preferred drug list and contract with Perform Rx to provide 340B pricing at participating pharmacies. Medi-Cal patients can use any Walgreens or Rite Aid pharmacies as well as most independent pharmacies. BHC and HCCI recipients are limited to seven Walgreens pharmacies across Contra Costa County: Antioch, Brentwood, Concord, El Cerrito, Martinez, Pittsburg, and Richmond. Providers in each of the eight CCHCs enter prescriptions in the Meditech clinical information system available in each CCHS center, and these prescription orders are sent electronically to the patient's pharmacy.

Access to pharmacy services is adequate. However, patients often have a difficult time scheduling an appointment with their physician in order to have their medications renewed or changed. This means that they not infrequently end up in the ER or Crisis Center because they cannot access care for refills.

Scheduling/Appointment System

CCHS uses a centralized call system with 37 positions budgeted—down 13 staff—to schedule primary care visits. The centralized scheduling system was created to support open access (also known an Advanced Access) scheduling. Open access scheduling functioned effectively for several years and helped improve show rates from 70 to 85 percent. The scheduling for primary care and specialty appointments and the call center are physically located at one site but the Advice Nurse line is 24/7 and is administratively separate. Scheduling begins at 7:00 am and goes until 7:00 pm. Four staff start at 6:30 am and 21 staff start at 7:00 am. The Specialty Referral Unit is staffed with five FTEs (two RNS, one Lead Clerk, and two Clerks) and 1 FTE "borrowed" from the Appointment Unit. These staff work 8:00 am to 5:00 pm Monday through Friday.

In spite of having 12 phone lines coming into the scheduling unit, there can be as many as 150 patient calls on hold early in the morning. The phone wait time is frustrating for patients and lack of access to sufficient clinic appointments is frustrating for the staff. There have been days when six primary care clinics (half-days) are cancelled in one day, and there is no ability to backfill for cancelled clinics. At a minimum, one clinic is cancelled every day. Last minute cancellations by providers are very problematic for the call center. The patients need to be rescheduled, which increases work for call center staff and decreases access for patients. There are no protocols and/or guidelines for the staff to use to determine what patients need to return for an appointment. If there is no appointment available, patients can be referred to the Advice Nurse who can authorize appointments at one of the contracted urgent care centers if there is an urgent issue. Patients can also call their provider's care coordinator and get a message to their provider.

There are at least seven Family Medicine appointment types and complex steps to make appointments. The schedulers do a good job filling the provider's clinics with their own patients. However, there are numerous rules that require Medical Assistants (MAs) to call the appointment unit for access to appointment slots. Work is being done to streamline existing processes. Allowing MAs to make an appointment directly in the system would increase access to direct scheduling.

CCHS reserves a limited number of appointments for patients who call for short-notice visits. Providers are using slots and pre-booking appointments. There is a very small window for sick patients to access short-notice appointments. There may be 30 open slots in the system and, by 7:15 am, there can be 150 patients on hold trying to access these appointments.

Improved access and more specialists' provider slots are needed for patients needing a specialty appointment. There are four specialty clinic appointment types. There are no criteria/protocols for the RNs to follow regarding pre-testing needed for specific specialty appointments. A number of specialty visits are wasted when prerequisite tests or reports are not performed or available. Patients can wait months to get into see a specialist, and there are currently 2,000 to 3,000 patients waiting for specialty appointments. Some specialty providers have started reviewing the wait list, which is helpful to the triage process. The longest waits are for Neurology, Dermatology, and Gynecology. Uninsured patients must be financially screened for qualification for one of the health plans before they can be scheduled for a specialty appointment.

The procedure to process specialty referrals is complex. The CHC site sends a referral electronically with information about reason for the consult and any other relevant information. The consult is reviewed and the patient is scheduled based on priority. Testing may or may not be ordered prior to the consult. The patient is notified by mail of the appointment with instructions to call the call center to confirm the appointment within 14 days. If the patient does not return the call, the appointment is cancelled and given to a different patient. The specialty referral unit receives many returned letters.

The increase in demand for primary care services has resulted in a mismatch of the supply of appointments available and the demand for these appointments. This results in few appointments available to give to patients requesting appointments and excessively long phone queues. Open access scheduling is only effective when supply and demand are essentially met.

In a more pure open access-scheduling model, very few appointments would be pre-booked. This would increase the availability of same-day appointments. This would also decrease the number of patients who need to be rescheduled by the centralized call center for last-minute provider cancellations. However, this would increase the volume of calls and negatively impact continuity. Continuity is key for provider and patient satisfaction and patient-centered medical home development. So while there are issues to address with the present scheduling system, it has maintained low no-show rates and continuity.

Centralized scheduling is not meeting the needs of the system. A centralized approach could be effective if the supply of appointments matched the demand for appointments. Practices and the centralized scheduling staff both express great frustration with the lack of available appointments to give to patients. If the centralized system is continued, some simplification of the scheduling process and rules would help improve the process.[20]

The current centralized scheduling process is not meeting the needs of the system because the supply of appointments does not match the demand for appointments.

Today the only way to get an appointment in any of the practices is through the centralized scheduling system. As stated, patients, who call, frequently have very long waits on hold and most often, no appointment is available to give them. Primary care sites must also call the scheduling system to schedule patients for follow-up appointments. There are too many appointment types with complex rules for who and when these appointments can scheduled. Each of these scheduling rules increases the complexity of the scheduling process without any true benefit to the system. In addition, patients scheduled for specialty clinics are sent letters. The letter asks that they call the scheduling system within 14 days to confirm their appointment. This generates calls into an already over-burdened call system. If the patient does not confirm his/her appointment, the appointment is cancelled and given to another patient.

Improved communication between clinics and providers is needed. Currently there are no meetings held and no designated liaison with the call center and ambulatory sites/providers. The managers and staff in the call center seem competent and are able to list barriers to success and possible ways to overcome these barriers to improve access for patients.

Future Planning

As CCRMC's ability to provide inpatient care to the patient population of Contra Costa, especially those newly covered by the 1115 waiver and HCCI, is evaluated, it is important to understand that there will be a number of critical changes related to service capacity needs. This will include:

- A continuous shifting of services currently provided in the inpatient setting into outpatient and ambulatory service sites;
- Fewer hospital admissions per capita;

[20] In 2007, Deloitte did a review of the centralized scheduling system. This report was not available for HMA to review.

- Fiscal rewards to health systems for decreasing admissions and avoiding preventable admissions and readmissions; and
- Care coordinating patients at the lowest, most appropriate, and least costly level of care.

There will be numerous opportunities to expand and build off of some of the successful innovations and programs such as CCHS' Family Medicine Residency Program and more efficient process of stabilizing and transferring patients who do not require the intensity of the inpatient Psychiatric Unit.

There also will be opportunities to pursue more expansive delivery system improvements such as the patient-centered medical home. Although CCHS has put into place several initial elements of medical homes, full transformation will require a dedicated, intensive effort. Implementing an initiative to transform practices into patient-centered medical homes is a complex and challenging endeavor. Evaluations of early efforts have shown that, unlike other quality improvement efforts, practices cannot rely on making isolated, incremental improvements. Rather becoming a medical home requires a total transformation of practice organization, operations, orientation, and culture and a series of interdependent improvements. For CCHS, it will require, among other things, solving the problems with its appointment scheduling system, developing an approach to team-based care, developing systems for care transitions, and integrating mental health into primary care. Although it will not happen quickly, easily, or incrementally, improvements in health outcomes; cost savings; and provider, staff, and patient satisfaction through implementing medical homes can be achieved. And with implementing medical homes comes the opportunity to explore creating a high-performing medical "neighborhood" through developing a Safety Net Accountable Care Organization (ACO).

In the second report, HMA will discuss in more detail opportunities to build off of current positive innovations, including the following:

- Commitment from Senior Executive Leadership to Quality Improvement (Hospital Kaizens, HEDIS).
- CCHS Family Medicine Residency Program is a valuable asset to CCRMC and all of Contra Costa County.
- Moved Medical Clearance of Mentally Ill Patients to Psychiatric Emergency Services that has resulted in EMS screening being done and consequently 400 fewer ED visits.
- Psychiatric Liaison Services (20 hours a week focused on providing consultations to primary care) available in two of the comprehensive health centers.
- Provider Specific Data on productivity.
- Diabetes Registry in place.
- Closure of a second inpatient mental health unit in 2006 with significant decrease in ALOS.
- Planned construction and expansion of outpatient facilities with expansion of evening and weekend hours to improve physical capacity to expand primary care.

- Care coordinators in place in each of the eight health centers are clerical staff rather than clinical, but it is a step in the right direction toward true care coordination and an important step toward implementation of patient-centered medical homes.
- 24/7 Advice Nurse with the ability to give next day appointments (if they are available) and lab results.
- Planning to do a pilot integrating mental and medical health at Concord Mental Health Center.
- Health center-based order entry pharmacy services with electronic prescribing to Walgreens/Rite Aid in multiple locations throughout Contra Costa.
- Implementing EPIC electronic medical record by July 2012.
- Inpatient psychiatric unit in Contra Costa at CCRMC.
- Contra Costa is the 5150 Crisis Center is at CCRMC.
- Significant portion of outpatient care services is primary care.
- Contracts for after-hour Urgent Care for CCHP patients (not Medi-Cal FFS/uninsured).
- Contracts for Home IV and Home nursing for Medicare patients (not Medi-Cal/uninsured).

HMA will address gaps in service capacity and quality and identify opportunities to make improvements, including the following:

- Lack of true care coordination in outpatient centers.
- Lack of transition care consistency in ED.
- Long waiting lists for many specialty clinics and complex process for specialty referrals.
- Lack of medical teams in health centers.
- Lack of SNF/NH contracts.
- Lack of Assertive Community Treatment (ACT) teams to address high-risk and high-utilizing mental health users.
- Overcrowded ED with bed stations in hallways that create HIPAA issues.
- Apparent gaps in the provision of substance abuse treatment in the County (need to be verified by meeting with Drug and Alcohol Department) that will be merging with Mental Health this summer.
- Lack of after-hours urgent/non-urgent care with patients being sent to CCRMC ED (exception CCHP patients and maybe Medi-Cal.)
- Slow, frustrating HR process for non-physician positions with good candidates being lost to other systems. Hiring process is lengthy and is disruptive to attracting good candidates.
- Opportunity to move some inpatient surgeries and procedures to the ambulatory setting.

- The surgery pre-op process requires multiple patient visits, contributes to OR cancellations, and needs to be streamlined.
- Opportunities to decrease ALOS on the Psychiatric Unit, Medicine-Surgery, and OB by improved processes.
- MRI unit and special procedure unit are at the end of their anticipated functional lives.
- Having only one CT unit and one MRI unit in the CCHS is creating barriers to access to the care.
- Complicated, cumbersome appointment system. Complex steps to make appointments with very limited open appointment slots.
- Opportunity to offer appointments for medication refills. (Missed medications are a significant reason for readmission to inpatient psych unit, revisit to the PES, and Level 4-5 ED visits).
- Opportunity for improvement in the interactions, collaborations, and transfers between CCRMC Psychiatric Unit/ED and Mental Health.
- Opportunity for management involvement in budget preparation and accountability for monitoring and managing costs and expenses within their cost centers, departments, and health centers.
- Opportunity to be a leader in the implementation of a Safety Net ACO.

III. Basic Health Care Program

Introduction

The County requested an examination of areas where its current level of services for medically indigent and uninsured residents either exceeds or is insufficient to meet legally mandated minimum service levels as compared to other similar counties. This is important because State law requires that counties provide health care to low-income medically indigent adults.[21] In the case of Contra Costa, the question of whether the County has been more or less generous than other Counties, and whether there would be a legal basis to change benefits or eligibility, has been raised in past years.[22]

The current context in which these questions are being examined is quite different than that of 2006. Since the County's request for proposals for a sustainability audit was first issued last fall, the section 1115 waiver for the State of California was approved by CMS. Under this waiver, all counties in California, to the extent they have available matching funds, will be able to expand eligibility for the uninsured to individuals with incomes up to 200% of poverty. Moreover, there is a required minimum benefit package in order to participate, and there are requirements to work toward standardizing eligibility levels. As discussed in Section I of this report, in 2014, there will be a nationwide Medicaid eligibility expansion and coverage through the Insurance Exchanges with subsidies for individuals with low incomes. Therefore, some increased number of individuals whose only previously-available coverage option was through the BHC using 100% county funds, will now qualify for these coverage programs that draw federal matching funds. However, a comparison of Contra Costa's indigent health programs to those of other comparable counties still provides useful information to guide decisions about the target population going forward. This section provides an overview of BHC program eligibility, coverage, benefits, and services and compares them to the county indigent health programs of two of the comparable counties: Alameda and Santa Clara.

Counties must provide health care services to low-income residents who are not eligible for coverage under the Medi-Cal program, are not eligible for other publicly-funded health care programs, and do not have private insurance coverage. While the uninsured who are not eligible for Medi-Cal are most often childless (including non-custodial adults) or undocumented immigrant, eligibility for undocumented residents in county programs is limited.

Contra Costa County is one of 24 California counties operating under the Medially-Indigent Services Program (MISP). As such, Costa County manages its own programs; establishes criteria for eligibility and services; and provides health care services through the Contra Costa Regional Medical Center (CCRMC), a network of community and county-operated health center, and contracted providers.

Contra Costa administers the Health Care Coverage for the Indigent (HCCI) program, which provides care to indigent residents with income at or below 200 percent of the Federal Poverty. In addition, the BHC program provides health care coverage to eligible County residents who do not quality for coverage

[21] California Welfare and Institutions Code §17000.

[22] Although not the focus on this study, in 2006, the County Counsel offered an opinion that if the County were to make changes to its program without conducting an exhaustive study of the cost of living and subsistence needs in the County, there would be risk of a lawsuit challenging the decision.

under HCCI, have any other source of payment for health care services, and have income above 200 percent and at or below 300 percent of the Federal Poverty Level. Similar county indigent service programs in the comparable counties are:

- Alameda County Medically Indigent Services Program (CMSP);
- San Mateo County's Access and Care for Everyone Program (ACE), which is also the County's HCCI program; and
- Santa Clara County's Ability to Pay Determination Program (ADP).

County Indigent Health Program Comparison

In accordance with State law, Contra Costa, Alameda, Santa Clara, and San Mateo Counties have county indigent health programs. While the indigent health programs in Contra Costa, Alameda and Santa Clara Counties are separate from the coverage initiative programs, San Mateo County's, indigent care program has been integrated with their HCCI.

San Mateo County reports that residents enrolled under the HCCI are tracked separately so that federal matching funds will not be claimed for services provided to residents enrolled in the County indigent program. While San Mateo's County indigent program appears to have the same eligibility, benefits, and service package, there are provisions for residents who have more income than is the maximum for HCCI enrollees (200% FPL) to receive health care services at a discounted price. The following comparison does not include information on San Mateo's eligibility, benefit, and service package.

Eligibility and Coverage Comparison

There are three major differences in the county indigent programs for Contra Costa, Alameda, and Santa Clara counties: income eligibility limits, requirements for co-pays or share of cost, and process for eligibility determinations.

Contra Costa County's income eligibility limit is 300 percent FPL, while Alameda County's limit is 200 percent FPL and Santa Clara County's limit is 350 percent FPL. Both Alameda and Santa Clara Counties require a co-payment that is due at the time of service. The co-pay amount varies by income level in Alameda County and by income levels and service types in Santa Clara County. Contra Costa County does not require a co-payment but does have a share-of-cost quarterly payment that is based on an individual's age. Alameda and Santa Clara Counties do not have a share-of-cost requirement for their programs.

Table III.1 provides a summary of the eligibility, benefits, and services comparison.

Table III.1. County Medically Indigent Program Coverage Comparison for Contra Costa, Alameda, and Santa Clara Counties

Criteria	Contra Costa	Alameda	Santa Clara
Name of Health Plan	**Basic Health Care (BHC)**	**County Medically Indigent Services Program (CMSP)**	**Ability to Pay Determination Program (ADP)**
Eligible Poverty Level	300% FPL	200% FPL[23]	350% FPL
Co-Pay	No	Yes Due at time of service $5-$100 depending on income and service	Yes Due at time of service $10-$150 depending on income and service
Share of Cost	Yes Quarterly Fee: $0 to $225 for Adults $0 to $15 for children	No	No
Serve Undocumented	No	Yes	Yes
Eligible Ages	All	All	All
Coverage Duration	6 months Must re-apply Coverage not retroactively applied	12 months Must renew eligibility Coverage not be retroactively applied	6 months Must re-apply Coverage not retroactively applied
Out-of-County Use	Patients not reimburse for out-of-county care	Patients not reimbursed for out-of-county care	Patients not reimbursed for out-of-county care
Provider Payment	Contracted Rates	Contracted Rates	Contracted Rates
Authorization Prior to Care	No	No	May have to get authorization prior to care
Utilization Management	Yes	Yes	Yes
Disease Management	Yes	Yes	Yes

Source: California County Indigent Care Program Profiles, 2009, retrieved from http://www.chcf.org/~/media/Files/PDF/P/PDF%20ProfilesIndigent2009.pdf http://www.chcf.org/~/media/Files/PDF/P/PDF%20ProfilesIndigent2009.pdf. Accessed on January 11, 2011.

Benefits and Services Comparison

Under the mandated county indigent program, counties are able to design the benefits and services covered by the county program therefore variability between county program is not surprising. Based on information provided in 2009, Contra Costa and Santa Clara counties placed limitations on different services. In addition, both Contra Costa and Santa Clara counties cover podiatric services, while Alameda County does not. Contra Costa and Santa Clara counties do not cover Alcohol and Drug Treatment programs, but Alameda County does include these services under their program. In addition, only Alameda County provides some coverage for adult day health care and skilled nursing facility services.

Table III.2 provides a summary of county indigent care program benefits and services.

[23] The Alameda County's indigent health care plan covers those individuals who are not covered by the HCCI or any other type of coverage and undocumented immigrants and covers all age groups.

Table III.2 County Medically Indigent Program Services Comparison for Contra Costa, Alameda, and Santa Clara Counties

Service	Contra Costa	Alameda	Santa Clara
Inpatient Hospital Services	X	X	X
Outpatient Hospital & Clinical Serv.	X	X	X
Emergency Room Care	X	X	X
Lab and X-ray Services	X	X	X
Physician Services	X	X	X
Podiatry Services	X	No	X
Drug and Alcohol Treatment Services	No	X	No
Family Planning Services	X	X	Limited
Skilled Nursing Services	No	X	No
Home Health Agency Services	No	X	Limited
Dental Services	Limited	No	X
Audiology Services	Limited	No	X
Psychological Services	No	No	Limited
Chiropractic Services	No	No	Limited
Adult Day Health Services	No	X	No
Therapy Services (OT, PT, Speech)	Limited	No	X
Prescription Drugs	X	X	X
Optometry Services	Limited	No	X
Eye Appliances	No	No	No
Medical Transportation	Limited	X	No
Durable Medical Equipment	Limited	X	X
Hearing Aids	No	No	No
Orthotics and Prosthetics	Limited	X	X
Same Services as Medi-Cal?	No	Yes	No
Other Included Services	Allergy testing and injections, some Immunizations	No other services disclosed by County	Services outside Santa Clara Valley Medical Center (SCVMC) require prior authorization from medical director
Other Excluded Services	Pregnancy and fertility, abortions, cosmetic surgery, travel inoculations or medication, organ transplants, TMJ	No other services disclosed by County	Non-SCVMC acute mental health and outpatient mental health services

Source: California HealthCare Foundation, California County Indigent Program Profiles 2009, retrieved from http://www.chcf.org/~/media/Files/PDF/P/PDF%20ProfilesIndigent2009.pdf. Accessed on January 11, 2011.

Eligible But Unenrolled Residents

Metropolitan Chicago Information Center (MCIC) data indicates that 23,413 county residents have income between 200 and 300 percent FPL and are uninsured. The vast majority of these residents (19,426) are adults 18-64 years. The remainder are children under 18 years (3,580) and adults 65 years and older (406).

Because poverty level data for the undocumented is not reliable, MCIC data does not indicate what portion of the 200 to 300 percent FPL population is undocumented. Since MCIC estimates that there are only 21,387 uninsured undocumented residents of all income levels, the portion in the slim income slice of 200 to 300 percent is likely less to be less than 10,000. This would seem to indicate that of the 23,413

uninsured County residents in the BHC income range, perhaps as many as 8,000 are ineligible due to being undocumented immigrants, meaning that roughly 15,000 could be eligible for the BHC program. As mentioned in Section I, in December 2010, there were 1,556 Contra Costa residents in the BHC program. While data reliability issues make it is difficult to provide more precise estimate, this would indicate that all but 10 percent of the uninsured with income between 200 and 300 percent FPL could qualify for the BHC program but are not enrolled.

As indicated, Contra Costa's BHC program eligibility to 300 percent FPL is more generous than all but Santa Clara County. The BHC program may only be serving a fraction of those who could be eligible for the program.

V. Data/Quality and Performance Indicators

California hospitals operate in a difficult environment. In today's dynamic regulatory, reimbursement, and competitive health care arena, there are many factors that determine—and measure—the success of health care providers. While the characteristics of the populations that they serve contribute to a health care system's ability to survive and thrive, there are a number of performance indicators that also contribute greatly to a system's success and are amenable to improvement.

In this section, HMA examined three categories of performance indicators for CCRMC hospital: 1) financial, 2) utilization, and 3) quality. Where data were available or where appropriate, HMA also benchmarked the indicators against county hospitals in three other counties, identified as comparable to Contra Costa, to examine and compare performance and reveal opportunities for improvements. The county hospitals are: the Alameda County Medical Center (ACMC), the San Mateo Medical Center (SMMC), and the Santa Clara Valley Medical Center (SCVMC).

Financial Performance

Financial success in the public environment is based on meeting expectations measured as the amount of general fund dollars consumed compared to budget and prior periods. The recent four-year trend has been positive based on the percent of County support (Table V.1).[24] The percent of operating expense funded by the County General Fund has declined, and the percent of operating expense funded by third-party payers has increased.[25] Over the four fiscal years of data provided to HMA by the client, FY08-09 through FY11-12, there is a compound annual growth rate in the operating expenses of 12.3 percent with a 17 percent increase projected between FY10/11 and FY11/12.

Table V.1 County Hospital Operating Expense and General Fund Support ($000): FY08-09-FY2011-2012

	2008/09 *	2009/10 *	2010/11	2011/12
Operating Expense	$356,287	$369,707	$432,002	$505,269
County General Fund	$57,856	$41,794	$41,319	$36,249
Percent County Support	16.2%	11.3%	9.6%	7.2%

Source: Contra Costa Annual Financial Reports, 2009 and 20010 and data supplied by the County.

As Table V.2 indicates, CCRMC's November 2010 financial data, which includes both CCRMC and the County health centers, shows a positive outlook. CCRMC's net income is $0 while the projected 2010/2011 net income is nearly $400,000. Projected total operating revenues for the full year were 1.16% higher than budgeted, and total operating expenses were 1.02% higher than budgeted.

Table V.2: CCRMC and County Clinics Financial Performance Summary, YTD November 2010

Category	2010/11 Budget	2010/11 Full Year Projected
Total Operating Revenue	$344,473,213	$348,461,332

[24] Table V.1 in the first draft was based on CCRMC data submitted to OSHPD. However, based on feedback from the client we replaced that table with another table supplied by the client included here.
[25] While HMA does not know the assumptions underlying the 2010/2011 and 2011 /2012 numbers, data for the first two years can be verified by the Annual Reports.

Total Operating Expenses	$432,002,356	$436,406,365
Net from Non-Operating Revenue	$87,529,143	$88,339,280
Net Income	($0)	$394,247

Source: Data supplied by the County received March 31, 2011.

CCRMC Financial Performance Compared to Alameda, Santa Clara, and San Mateo County Hospitals

In order to evaluate CCRMC's financial performance, comparisons were made using 2009 hospital data relying heavily on the OSHPD Hospital Annual Financial Data (HAFD) reports and OSHPD Annual Utilization Report of Hospitals (AURH) reports for county hospitals in Alameda, Santa Clara, and San Mateo counties. The OSHPD 2009 data were used because 2010 audited comparative data from other county hospitals was not yet publicly available at the time this report was drafted. It should be noted that some numbers from San Mateo are not comparable as their system has a significant number of skilled beds, which have very different cost, FTE, and revenue characteristics.

Expenses

Operating Expenses

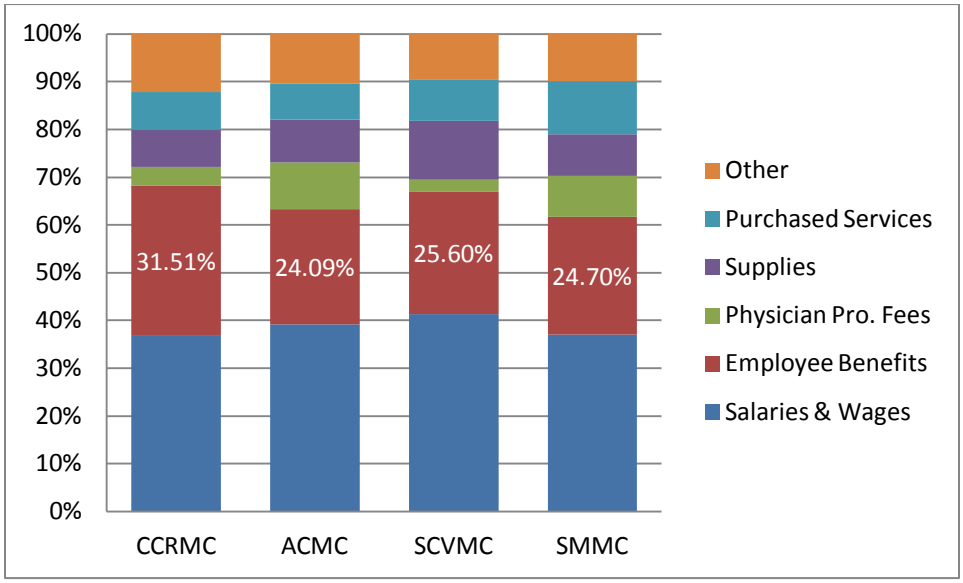
In 2009, total operating expenses for CCRMC were approximately $363.8 million as reported to OSHPD.[26] This reflects the expenses incurred by various cost center groups for providing patient care by the hospital. Direct expenses include salaries and wages, employee benefits, professional fees, supplies, purchased services, and other expenses.

The largest component of these expenses was salaries and benefits. Combined salaries and benefits comprised 68 percent of the total operating expenses, with salaries at 37 percent and benefits at 31 percent of the total operating expenses. By comparison, CCRMC's combined salaries and benefits were just slightly higher than that of the comparable hospitals, which ranged from 62 to 67 percent. It is worth noting that the two hospitals with the highest margins, SMMC and ACMC, had the lowest proportion of combined salaries and benefits, 62 percent and 63 percent. As Figure V.4 illustrates, benefits accounted for the largest difference between CCRMC's proportion of expenses attributable to salaries and benefits and the comparable hospitals. CCRMC benefits were nearly 32 percent of expenses compared to the other hospitals, which ranged between 24 percent and 26 percent.

If the benefits were restructured to align with the comparable hospitals, operating expenses could be reduced by an estimated $27 million.

[26] Please note that total operating expenses provided by the client were $356,287,000. This was within 2 percent of the value provided in the OSHPD report. Subsequently, we used the OSHPD data given that this provided more detail on the components of these expenses and also allowed for comparisons to other county hospitals.

Figure V.3: Expenses by Classification for CCRMC and Comparable Hospitals, HAFD 2009



Source: OSHPD HAFD 2009

If the benefits were restructured to align with the comparable hospitals, operating expenses could be reduced by an estimated $27 million.

Revenue

Reimbursement: Overall and by Payer Type

In 2009, CCRMC's payer mix[27] was heavily weighted toward Medi-Cal. Even relative to the comparable hospitals, CCRMC 's proportion of Medi-Cal was high with 75 cents of each dollar of net patient revenue from Medi-Cal compared to 51 to 57 cents of each dollar for the other county hospitals. By contrast, ACMC, which had positive margins, had just 57 percent of its net patient revenue from Medi-Cal and had the largest percentage of Fee-For-Service (FFS) Medicare net patient revenue and the largest percentage of commercially insured FFS net patient revenue of all the four hospitals we examined.

County hospitals sometimes have an incentive to offset their Medi-Cal revenue with revenue from other payers. A 2010 report by the California Association of Public Hospitals and Health Systems (CAPH)[28] analyzed the effect of California's current Section 1115 Medicaid waiver on public hospitals financing. The waiver covers approximately half of the costs of providing care to their Medi-Cal and uninsured patients. It results in public hospitals incurring costs for which they receive just a portion in federal reimbursement. This financing structure does not cover the cost of care and leaves public hospitals with a significant amount of unreimbursed Medi-Cal costs. Statewide, of the $10.5 billion in unreimbursed costs over the five-year life of the waiver, more than $7 billion is due to the waiver's CPE reimbursement structure. Thus, the two county hospitals that appeared to be more financially viable relied more heavily on payers other than Medi-Cal, e.g. Medicare and commercial insurance.

[27] According to County data, the payer mix remained similar from 2009 to 2010.
[28] Source: http://www.caph.org/content/upload/AssetMgmt/PDFs/Publications/CurrentWaiverBriefFeb2010.pdf

Payment Shortfalls

In FY08-09 CCRMC, based on data recently provided to HMA by the County, CCRMC had no payment shortfalls per their budgeting process. Based on the data reported to OSHPD and the OSHPD calculated shortfall, CCRMC experienced a total payment shortfall of $102,627,490 in FY08-09.[29] However, correspondence from the County indicated that these data do not accurately reflect payment shortfalls since some revenue designated for operating activities (patient care) such as Medi-Cal related CPEs, is booked as non-operating revenue for internal reporting purposes. Subsequently, the County's internal data indicate no payment shortfall for FY08-09.

The OSHPD report indicated a large shortfall of $86,732,836 was for patient care booked under the county indigent program. However, according to correspondence from the County, these expenses were covered by combination revenue from other sources, including surpluses from other sources (i.e. non-indigent, patient care activities, non-operating revenue, the county general fund, and the budgeted excess fund balance). (See Table V.6).[30]

Subsequently CCRMC reports a net income of $0 on patient care after taking into account the non-operating revenue associated with operating activities as shown in the table below.

Table V.4 Net Patient Revenue and Expense, FY08-09

Revenue Non Indigent Care:	
Managed Care Medicare	$5,989,721
FFS Medicare	29,636,814
Managed Care Medi-Cal	25,809,725
FFS Medi-Cal	158,181,632
FFS Other Third Parties	9,045,789
Managed Care Other Third Parties	18,611,819
All Other Payors	1,068,447
Sub-total Net Patient Revenue	$248,343,947
Medi-Cal Match Recorded as Non-Operating	$31,225,000
Total Patient Care Revenue (Non Indigent)	$279,568,947
Patient Care Expense (Non Indigent)	$264,238,601
Net Patient Care Surplus (Non Indigent)	$15,330,346
Revenue Indigent Care:	
Payment Surplus from Non Indigent Product Line	$15,330,346
Non-Operating Revenue Misc.	12,841,966
County General Fund	57,830,866
Operating Loss (Budgeted Excess Fund Balance)	729,658
Total Revenue Assigned to Indigent Care	$86,732,836
Indigent Care Expense	$86,732,836
Total Expense	$350,971,437
Total Revenue	$350,971,437
Net Income	$0

[29] Payment shortfalls, calculated by OSHPD are available from the OSHPD reports that can be downloaded here: http://www.oshpd.ca.gov/HID/Products/Hospitals/AnnFinanData/PivotProfles/default.asp. The report cited was prepared October 2010. These payment shortfalls are available overall and by payer.

[30] Tables for payment shortfalls for CCRMC and other county hospitals based on OSHPD Hospital Annual Financial Reports 2009, updated October 2010, the most recent audited OSHPD data, were provided in an earlier draft. However, based on comments from the client that the shortfalls did not accurately reflect CCRMC's accounting practices, these tables were omitted in this version.

In the first version of this document, financial ratios were presented based on comparable OSHPD data. However, based on feedback from the County that the financial ratios have limited applicability to CCRMC, and it is not clear whether other California county hospitals have adopted accounting practices that allow comparison to CCRMC. Therefore, no ratios have been included in this draft for CCRMC or other county hospitals.

How Hospitals In the Comparable Counties Improved Their Performance

A closer look at the county hospitals in comparable counties reveals some insights into the reasons for differences between CCRMC and the other county hospitals we examined.

Santa Clara Valley Medical Center, for example, appears to be struggling significantly as indicated by negative margins for both patient and non-patient activities. A report in the spring of 2010 found that the inefficiencies at Santa Clara County's Valley Medical Center (SCVMC) were adding to the county's $250 million deficit and making it more difficult for patients to access care. The analysis found that SCVMC's staffing levels were unsustainable and that salary and benefits for non-physicians were well above other California hospitals. Shortly after this report, the county Board of Supervisors began consideration of recommendations for operational changes.[1]

Conversely, Alameda County Medical Center (ACMC) in Oakland has demonstrated more success under duress and, in 2009, showed positive operating and total margins. This is in contrast to most county hospitals across the state, which as a group had negative margins. This has not always been the case for ACMC, which struggled for many years and had eight different Chief Executive Officers between 1991 and 2004. Beginning in 2003 there were changes in ACMC's governance structure, local revenue contribution, and organizational leadership that may explain the positive margins. This included:

- The establishment of a hospital district and an independent board of trustees to govern the medical center.
- A successful ballot measure that increased the county sales tax with a large portion of the proceeds going to ACMC.
- A new CEO who established a new leadership team.
- A financial improvement project that involved a collaboration of managers who identified expense reduction and revenue producing ideas (e.g., contract re-negotiations, expansion of and increased referrals to financially viable programs such as rehabilitation services and outpatient surgery, an expanded trauma program, and increasing Medicare and commercially insured patients the promotion of ACMC service lines to community clinics leading).
- Implementation of data systems that enabled them to monitor daily performance goals against define performance benchmarks and to communicate performance to leadership and staff.

The result of these changes is that ACMC's margins increased substantially in 2003. Their 2003 total margin of -13 percent increased in 2009 to a total margin of 3.6 percent.

San Mateo, like ACMC, has managed to turn itself around. The 2009 OSHPD report indicates a total net income margin of 6.2 percent. As outlined in a recent California Healthline article, six years ago SMMC, like many county hospitals, was in serious financial distress. The CEO was quoted as saying "There have been cuts and we've become more efficient…but we've also become a different kind of provider." They emphasized creating leaner operations and improving patient care by identifying a implementing a more streamlined, more efficient, and less costly care process. This was achieved through its Innovative Care Center (ICC). The ICC officially launched in 2009, but the hospital started a comprehensive clinic redesign two years earlier. The redesign and the ICC were meant to improve the quality of care, lower costs, and improve satisfaction for both patients and staff. Hospital officials did it by shifting to team-based care, adding an electronic health record system, instituting an outcomes measurement system, and emphasizing better care for patients with chronic care conditions. The clinic initiatives have resulted in fewer hospital readmissions, ER visits, and missed appointments as well as higher patient satisfaction.

The 2010 1115 Medicaid waiver agreement announced in November 2010 offers money for public hospitals to implement the kind of initiative SMMC is doing with its ICC, including financial incentivizes that reward hospitals for lowering cost and achieving better patient outcomes.

Utilization

Licensed Beds, Occupancy, and Average Length of Stay

CCRMC is a relatively small county hospital with 166 beds. The average number of licensed and staffed beds for California county general acute care hospitals was 354 and 327, respectively. CCRMC's occupancy rate based on licensed beds was 67 percent, which was similar to the comparable hospitals, which, on average, had 66 percent occupancy rate. However, general acute care bed occupancy rate was 75 percent, which was higher than any of the individual comparable hospitals and higher than the comparable hospitals' average of 51 percent.

There were a handful of beds dedicated to perinatal care: 10 perinatal beds (including labor, delivery, recovery, and postpartum but excluding nursery) with a 100 percent occupancy rate and six intensive care newborn nursery beds with a 76 percent occupancy rate.

CCRMC had no beds dedicated to skilled nursing services. In contrast, both ACMC and SMMC had beds dedicated to long-term care. It remains to be explored whether these types of services offer a revenue potential for CCRMC.

Emergency Room Activity

CCRMC is not designated as a trauma center.[31] However, the hospital had 70,850 Emergency Department (ED) visits with 8 percent of those resulting in an admission to the hospital in CY 2009 as reported in the OSHPD Annual Utilization Report of Hospitals (AURH). Given the relative size of the hospital, CCRMC, with less than 200 beds, has considerable ED activity relative to the comparable hospitals, all of which had more than 450 licensed beds. The ED visits per treatment station were higher than any of the three comparable hospitals and more than twice as high as ACMC. (See Table V.7)

Table V.5: Emergency Department Activity (OSHPD AURH 2009)[32]

Activity	CCRMC	ACMC	SMMC	SCVMC
ED Visits	70,850	83,611	35,149	72,126
ED Stations	20	52	15	24
ED Visits per Treatment Station	3,543	1,608	2,343	3,005
ED Admissions	8%	8%	9%	15%

The CY OSHPD AURH audited data offers the advantage of including more detailed data on EDs such as the number of treatment stations, which allows for the calculation of ED visits per treatment station. However, per the County's request, HMA has also included ED activity in Table V.8 that is based on the FY OSHPD HAFD unaudited data to provide additional detail from the report on ED visits by payer to illustrate the high proportion of county indigent visits. This table indicates that approximately 40 percent of ED visits are classified as county indigent (traditional) whereas the percentage of ED visits in this classification for the other hospitals is much lower, ranging from 0 percent to 29 percent.

Table V.6 Outpatient Emergency Services Visits, Including Psychiatric Visits, by Payer, FY09-10

Category	Contra Costa Regional Medical Center	Alameda County Medical Center	Santa Clara Valley Medical Center	San Mateo Medical Center
Medicare Traditional (Non managed care)	3,744	4,716	6,764	2,276
Medicare Managed Care	516	244	739	1,441
Medi-Cal Traditional (Non managed care)	15,093	14,359	13,995	3,269
Medi-Cal Managed Care	8,123	4,713	8,055	4,938
Co. Indigent Traditional(Non managed care)	24,522	18,253	14,094	0
Co. Indigent Managed Care	0	0	6,228	12,536
Third Party Traditional (Non managed care)	5,883	3,931	2,375	2,898
Third Party Managed Care	2,998	0	5,374	0
Other Indigent	0	1,542	14,963	2,121
Other Payers	455	15,945	0	6,524
Total	**61,334**	**63,703**	**72,587**	**36,003**

[31] Hospitals designated as trauma centers are licensed hospitals designated as such by a local Emergency Medical Services Agency and includes personnel, services and equipment necessary for the care of trauma patients. EMSA has established four trauma center designations, with Level 1 being the highest.

[32] The OSHPD Annual Utilization Report (AURH) reflects calendar year 2009. Note that this is different from the reporting period in the Hospital Annual Financial Disclosure Reports (HAFD). However, the AURH provided more detailed data on emergency care than the HAFD reports.

Source: 2010 OSHPD HAFD Unaudited Reports

Quality

Although there are limited publicly available data, there are a number of indicators that HMA examined to assess the quality of care and health outcomes achieved by CCRMC and the comparable hospitals. Overall, based on the limited indicators available, CCRMC shows a strong performance on some measures while a poorer performance on others indicating opportunities for quality improvement.

Inpatient Risk-Adjusted Mortality Rates

One important indicator of quality health care is inpatient risk-adjusted mortality rates. As Table V.9 illustrates, 2009 inpatient risk-adjusted mortality rates for CCRMC and the comparable hospitals reveal wide variation in mortality rates for specific conditions.[33] CCRMC performed better than at least one of the comparable hospitals on all but one measure: Acute Myocardial Infarction, which was significantly higher at 30 percent. At the same time, ACMC, which is stronger financially than both CCRMC and SCVMC, had higher mortality rates among all comparable hospitals for all conditions except Pneumonia, where SMMC had the highest mortality rate. ACMC's rates, however, were still higher than both CCRMC and SCVMC.

Table V.7: California Inpatient Risk-Adjusted Mortality Rates (Per 100 Cases) for Contra Costa, Alameda County, San Mateo Medical Center, and Santa Clara County Hospitals, 2009

CONDITION	Contra Costa Regional Medical Center	Alameda County Medical Center – *Highland Campus*	San Mateo Medical Center	Santa Clara Valley Medical Center
Craniotomy	0	13.6	0	10.6
Acute Myocardial Infarction	**30**	18.5	13.2	9
Congestive Heart Failure	2.1	4.5	2.6	3.1
Acute Stroke	12.1	14.8	11.1	8.2
GI Hemorrhage	1.2	2.4	0	2.2
Hip Fracture	0	6.5	0	0
Pneumonia	2.4	4.2	11.1	3.3

Source: Agency for Healthcare Research and Quality (AHRQ) Quality Indicators and SAS, Version 4.1, and OSHPD hospital patient discharge data, 2009.

Centers for Medicare & Medicaid Services' Hospital Compare Process of Care Measures

As part of its Hospital Compare initiative, the Centers for Medicare & Medicaid Services (CMS) have developed a set of measures that assess the quality of a hospital's "process of care." These measures are based on evidence-based guidelines for clinically appropriate care. As Table V.10 indicates, CCRMC scored slightly below the average for all California hospitals who reported 2009 and 2010 data on all measures and slightly below at least one comparable hospital on all measures. There were no major differences in scores except for one measure: Surgery patients who were given the right kind of antibiotic to help prevent infection. CCRMC's score of 90% was 8 percent below all comparable hospitals and 7 percent below the average for all reporting hospitals in California.

[33] Quality indicators were selected where there was data for CCRMC and all comparable hospitals.

Table V.8 CMS Hospital Compare Process of Care Measures[34]

Process of Care Measure	Average for All Reporting Hospitals in California	CCRMC (n)[35]	ACMC (n)	SMMC (n)	SCVMC (n)
Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection	96%	95% (106)	98% (127)	93% (108)	96% (423)
Surgery patients who were given the right kind of antibiotic to help prevent infection	97%	90% (107)	98% (130)	98% (105)	98% (427)
Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery)	92%	89% (104)	100% (124)	92% (104)	88% (389)
Surgery patients whose doctors ordered treatments to prevent blood clots after certain types of surgeries	91%	89% (131)	93% (108)	89% (131)	86% (199)

Source: http://www.hospitalcompare.hhs.gov. Retrieved February 18, 2011.

Contra Costa Health Plan HEDIS Measures

HEDIS is a tool used by the majority of U.S. health plans to measure performance based on 75 measures across 8 domains of care. Table V.11 below reports on HEDIS measures for the Medi-Cal population in the Contra Costa Health Plan (CCHP) where 71 percent of the members were served by the CCRMC system, 19 percent were served by the Community Provider Network (CPN), and 10 percent by Kaiser Permanente.

As Table V.11 illustrates, among the 16 measures,[36] Kaiser scored highest on most measures compared to CPN and CCRMC. Relative to CCRMC specifically, Kaiser was higher on 14 measures. However, CCRMC was within 5 percent of Kaiser on six measures and scored higher on the following two measures: 1) yearly well-child visit for children aged three to six years and 2) first trimester prenatal visit within first trimester. The four largest discrepancies between the Kaiser and CCRMC HEDIS results were for breast and cancer screening, physical activity counseling for children, and Diabetes-LDL Cholesterol less than 100.[37]

Table V.9: HEDIS Measures, Contra Costa Health Plan, 2010

CCHP Medi-Cal Population	2010 CCHP Final	2010 CCRMC Final	2010 CPN Final	2010 Kaiser Final
Nutrition counseling given for children	49.15%	52.70%	40.00%	60.00%
Physical activity counseling for children	38.44%	39.42%	32.59%	54.29%
Yearly well child visit, 3-6 years	74.70%	76.61%	75.83%	60.47%
Yearly adolescent well visits	38.69%	36.40%	37.86%	46.25%

[34] Data were collected during 2009 and 2010 and were based on a sample of cases. HMA included data that where the number of cases was high enough to determine how well a hospital performed and where there was data for CCRMC and all comparable hospitals.
[35] n = the total number of patient cases sampled
[36] Measures below include those where the data were not footnoted as having "data problems."
[37] This HEDIS measure is the percentage of members aged 18 to 75 years with diabetes (type 1 and type 2) who received lipid level control (LDL Cholesterol < 100 mg/dL) testing.

CCHP Medi-Cal Population	2010 CCHP Final	2010 CCRMC Final	2010 CPN Final	2010 Kaiser Final
No antibiotics for Acute Upper Respiratory, children	92.76%	94.98%	88.01%	97.70%
First trimester prenatal	84.67%	86.89%	80.28%	80.56%
No imaging for lower back pain	87.14%	86.71%	87.04%	91.67%
Breast cancer screening	56.19%	52.24%	47.06%	76.07%
Cervical cancer screening	69.34%	67.19%	61.64%	82.35%
Diabetes- LDL Cholesterol screening	78.65%	77.42%	74.75%	86.11%
Diabetes- LDL Cholesterol < 100 mg/dL	40.69%	39.30%	26.26%	58.33%
Diabetes-Hemoglobin A1c testing	85.40%	84.75%	84.85%	87.96%
Diabetes-Hemoglobin A1c < 8%	52.55%	52.20%	44.44%	60.19%
Diabetes-Nephropathy screen or treatment	86.50%	85.92%	85.86%	88.89%
Diabetes-Blood Pressure < 140/90 mmHg	53.10%	49.56%	58.69%	58.33%
Avoidance of antibiotics in adults with acute bronchitis	31.87%	32.32%	30.67%	37.50%

Source: Contra Costa Health Plan's 2010 Annual HEDIS Report

Joint Commission Hospital Quality Core Measures

The Joint Commission, a national accrediting agency, has developed a standardized set of core measures to assess hospital quality. Table V.12 below reports on four identified core measure sets for CCRMC, which are measured by the Joint Commission and CMS in accredited hospitals across the country: Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PN), and Surgical Care Improvement Project (SCIP). A hospital's performance is measured by its adherence to the core measure guidelines, which include evidence-based treatments, diagnostic tests, and other standards of care.

CCRMC has demonstrated sustained improvement over the baseline year of 2008. The AMI measure set is within the top 10 percent of the comparison source, Thomson Reuters, while HF, PN and SCIP are within the average range. Note that improvements in AMI care as essential given that, in 2009, CCRMC's inpatient age-adjusted mortality rate for AMI was 30 percent, which was significantly higher than comparable hospitals. Improved performance indicates CCRMC is working to provide care that is consistent with evidence-based practices that are linked to better patient outcomes.

Table V.10. Comparison of Composite Core Measure Sets with all Hospitals Reporting to Thomson Reuters

Core Measures	Number of Reporting Hospitals	CCRMC 2008 Baseline	CCRM Quarter 3 2010	Average	Top 10% of Reporting Hospitals
Acute Myocardial Infarction	448	90.00%	100.00%	86.48%	100.00%
Heart Failure	500	59.83%	89.13%	87.40%	100.00%
Pneumonia	502	60.62%	85.37%	86.48%	98.28%
Surgical Care Improvement Project	499	69.38%	86.36%	84.93%	98.57%

Source: Whole Systems Measures Report, Shelly Whalon, RN, CCRMC Director of Safety and Performance Improvement, Professional Affairs Committee, February 24, 2011

Although all of these measures are only a few measures among many possible quality indicators, these findings suggest that quality may not be directly correlated to a hospital's financial strength.

Ambulatory Care Sensitive Conditions (ACSCs) Ambulatory Care Sensitive Conditions (ACSCs) are conditions where appropriate outpatient care prevents or reduces the need for admission to hospital. A

hospitalization for an ACSC suggests that the patient may not have access to or receiving appropriate primary care. Table V.13 shows the frequency of hospital inpatient admissions for ACSCs in Contra Costa, the State, and comparable counties. In general, Contra Costa is similar to the State and the comparable counties. However, while Contra Costa does not have the lowest rate for any one measure, it has the highest rate for 5 of the 14 measures: Urinary Tract Infections, Hypertension, Pediatric Gastroenteritis, Chronic Obstructive Pulmonary Disease (COPD), and Diabetes short-term complications with uncontrolled Diabetes. These high rates may be due to a number of factors, including providers not delivering the right care at the right time, providers not actively supporting patient self-management, and patients not accessing or having access to primary care. As indicated in the first section of this report, however, it is not likely due to population differences. Regardless of the cause, all of these conditions can be improved to prevent avoidable and costly hospitalizations.

Table V.11: 2008 Rates of Preventable Hospitalizations

	California	Contra Costa	Alameda	San Mateo	Santa Clara
Lower-Extremity Amputation among Patients with Diabetes - Discharges per 100,00 Adults	27.6	31.1	32.3	23.9	31.7
Adult Asthma - Discharges per 100,000 Adults	82.5	125.9	142.1	91.3	91.9
Angina without Procedure - Discharges per 100,000 Adults	26.0	25.6	19.8	21.4	18.1
Urinary Tract Infection - Discharges per 100,000 Adults	147.1	**173.9**	156.7	124.5	165.7
Bacterial Pneumonia - Discharges per 100,000 Adults	249.6	249.1	249.1	245.4	235.1
Dehydration - Discharges per 100,000 Adults	66.7	60.2	61.5	35.1	61.2
Congestive Heart Failure - Discharges per 100,000 Adults	293.5	338.7	363.5	268.4	331.2
Hypertension - Discharges per 100,000 Adults	32.7	**36.1**	31.9	22.5	32.7
Pediatric Gastroenteritis - Hospitalizations per 100,000 Persons ages 3 Months to 17 Years	75.3	**91.5**	68.4	37.1	85.4
Chronic Obstructive Pulmonary Disease - Discharges per 100,000 Adults	127.7	**143.9**	128.2	81.1	115.2
Pediatric Asthma - Hospitalizations per 100,000 Persons Ages 2 to 17 Years	77.6	142.0	188.8	46.1	85.8
Long-Term Complications of Diabetes - Discharges per 100,000 Adults	105.2	107.7	120.4	77.6	99.9
Perforated Appendix - Discharges per 100 Non-Maternal Discharges Age 18+ with Appendicitis	26.4	25.4	21.9	29.9	21.9
Diabetes Short-Term Complications & Uncontrolled - Discharges per 100,000 Adults	55.2	**68.4**	64.6	37.7	51.4

Source: California Office of Statewide Health Planning and Development, Patient Discharge Data, 1999-2008 Agency for Healthcare Research and Quality, Prevention Quality Indicators, Version 3.1

Conclusion

The information presented in this Information Memorandum provides the initial information on Contra Costa County's current and projected overall and target population and an overview of the status and projected issues and opportunities related to service capacity; Basic Health Care; the Low Income Health Program; Health Reform; and financial, utilization, and quality performance. This information will guide decisions and lay the groundwork for the subsequent analysis and the development of options.

The Stage 1 analysis highlighted several areas where Contra Costa County is excelling and areas where the County can make improvements to support the fiscal sustainability of the County's health care system and to ensure the most efficient and effective delivery of care. These areas will be analyzed and discussed in more detail in the work of the next two stages.

The remaining two stages of the project will be a Preliminary Report that will be presented in April 2011 and a Final Report that will be presented in mid-June 2011. Each stage will build on the previous work and the Final Report will include the following elements:

- Work plan for the establishment of a medical home system of care.
- Management review of Health Services Department programs.
- Evaluation of alternative governance structures.
- Options for changes in the County's current procedures for data collection and analysis.
- Options for changes and/or enhancements to the County's organizational capacity for ongoing strategic planning, evaluation, and oversight.

Appendix A: Acknowledgements

HMA wishes to acknowledge the support and participation of numerous individuals in the preparation of this report. Persons interviewed included representatives of the Health Services Division, County government, health care providers from all parts of the county, and labor. The time spent, information provided, and ideas generated were invaluable in assisting HMA.

Appendix B: Data Sources

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HMA

HEALTH MANAGEMENT ASSOCIATES

Sustainability Audit of the Contra Costa County Regional Medical Center and Health Centers: Stage 2 Final Report

PRESENTED TO THE
CONTRA COSTA COUNTY ADMINISTRATOR

SEPTEMBER 2011

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

Table of Contents

Executive Summary

In January 2011, the County of Contra Costa engaged Health Management Associates (HMA) to conduct a sustainability audit of the Contra Costa Health Services-operated facilities: the Contra Costa Regional Medical Center (CCRMC) and County health centers. The goals of the audit are to develop options to support the fiscal sustainability of the County's health care system and to ensure the most efficient and effective delivery of health care services to County residents that align with the implementation of health care reform.

The work of this project is divided into three stages. In Stage 1, HMA submitted an Information Memorandum with demographics and health care utilization data demographics and health care utilization data; an analysis of the current and future capacity of the County's programs, services, and facilities; a discussion of the of the Basic Health Care program; and Financial, utilization, and quality performance indicators for CCRMC and County health center. The information in the Memorandum laid the groundwork for this report.

As part of this process, HMA staff conducted site visits in January, February, and March and interviewed key informants, including staff and leadership from the Board of Supervisors, Health Services Department, CCRMC, the Contra Costa Health Plan (CCHP), County health centers, and the County Administrator's office. The HMA team also reviewed policy and financial documents related to County programs and services, analyzed data on Contra Costa's overall and target population and financial, utilization, and quality performance, and, where possible, compared the data to similar counties.

For Stage 2, HMA conducted additional interviews; reviewed additional data, including data provided by the County; conducted analysis on possible options for delivery system changes; and prepared this Preliminary Report.

Summary of Findings

Section I: Preliminary Strategic Analysis

Delivery System Opportunities

The CCHS has in place a geographically distributed primary care network that annually provides over 275,000 primary care and ancillary care visits. Primary care is primarily provided by Family Medicine physicians with a sizable number of additional visits generated by Internal Medicine and Pediatric providers. The CCHS primary care system is currently at near capacity. Provider panels are felt to be excessive and are being reevaluated for thoughtful downsizing. Patients complain of difficulty obtaining unscheduled visits to their primary care centers. Options to maximize and expand access to primary care service capacity include:

- Developing Patient-Centered Medical Homes (PCMHs) system-wide, including incorporating medical teams, care coordination for high-risk patients, and pre-visit preparation.
- Carefully scrutinizing existing primary care provider panels.
- Closely tracking primary care provider productivity until PCMHs are fully developed.
- Managing provider resources, which is integral to the provision of primary care in CCHS.

- Further expanding of evening/weekend primary care sessions.
- Proceeding with the construction of additional ambulatory care space.
- Expanding current partnerships with private and public health care providers in the County.

At 1.1 beds per 1,000 population, the County's general acute licensed inpatient hospital bed ratio is well below the national and California norms. The average length of stay (ALOS) at CCRMC for Medicine-Surgery patients is less than national and the West region length, the OB ALOS are consistent with U.S. stays, and the inpatient psychiatric stays at CCRMC are somewhat longer than the national ALOS. Providers at CCRMC indicated that, although the ALOS are quite reasonable, there are opportunities to further improve these numbers on select patients on each of the inpatient services.

Delays and capacity issues can create bottlenecks to the timely delivery of inpatient as well as outpatient care. Lack of access to specialized inpatient diagnostic procedures can contribute additional days to a patient's hospital stay, particularly on weekends and holidays. The following options can further decrease the average lengths of stay on inpatient units at CCRMC and address the reasons for one-day admissions:

- Addressing operational barriers to the timely discharge of inpatients.
- Purchasing an additional CT unit, which could expand capacity/utilization.
- Providing availability of certain invasive diagnostic procedures on weekends so as to avoid prolongation of patient hospitalizations.
- Developing formal relationships and possibly contracts with Skilled Nursing Facilities (SNF), Long Term Acute Care centers (LTAC), Institutions for Mental Disease (IMDs) and nursing homes to expedite the discharge of difficult-to-place patients who require transitional residential care.
- Developing formal relationships or contracts with home visit and home IV nurse services to expedite the discharge of inpatients from the hospital to their homes.
- Evaluating the current policy of its Mental Health Department not to readily accept the referral of patients with behavioral disorders and mental illness complicated by substance abuse.
- Thoroughly studying reasons for one-day hospitalizations and considering alternatives to hospitalization.

The Emergency Department (ED) at CCRMC is extremely busy providing nearly 60,000 annual patient visits, with the visit volume doubling since the hospital and ED were constructed in 1997. The ED and the Psychiatric Emergency Services (PES) have exceeded their physical capacities. Options for more effectively utilizing ED and PES services include:

- Identifying and renovating additional physical space adjacent to the ED.
- Providing after-hours immediate and non-urgent care available to all patients cared for by CCHS.
- Creating an Observation Unit to help decrease congestion in the ED.

- Developing procedures to notify primary care providers and centers when a patient is in the ED or is being discharged so that all required transitional care can be provided.
- Studying the barriers that keep patients from consistently obtaining medication refills and using the ED simply to obtain prescriptions.

Thirty-nine specialty services provide over 100,000 annual visits primarily at CCHS's three comprehensive care centers. There are lengthy waiting times for 25% of the specialty services that are being monitored. The actual waiting times are longer than reported because many referrals are backlogged on a waiting list before an appointment is assigned. Options to reduce waiting times include:

- Implementing an automated, rule-based specialty referral screening system that would successfully approve or deny the majority of all specialty requests.
- Evaluating the reasons and initiate process improvements actions to improve the productivity of those specialty clinics that are unable to meet established productivity standards.
- Increasing in-house specialty capacity by hiring more specialists in backlogged services and/or contracting with community specialists to provide consultations when waits become prolonged.
- Initiating an e-consult initially for backlogged specialty services.

CCHS and CCRMC have committed resources and time to the development of an extensive, ongoing quality improvement effort involving all aspects of the delivery of health services across the continuum of care.

- Efforts of CCHS and CCRMS have been nationally recognized and need to be supported at all levels of the health and County administration.

Today, the increase in demand for primary care services has resulted in a mismatch of the supply of appointments available and the demand for these appointments. This results in few appointments available to give to patients requesting appointments and long phone queues. Open access scheduling is only effective when supply and demand are essentially matched.

- If the centralized system is continued, some simplification of the scheduling process and rules is encouraged.

CCRMC and CCHS are predominantly staffed by Family Medicine providers. Many are graduates of the Family Medicine Residency program at CCRMC. CCRMC has a long standing practice of assigning Family Medicine providers to spend a portion of their work week as "registrars" on inpatient and outpatient specialty services, inpatient teaching rotations, and in the ED. They also have a significant amount of their time dedicated to busy outpatient primary care practices in CCHS health centers.

- Monitor the time commitment of the registrars to assure that these primary care providers are mainly focused on the pivotal provision of primary care.

CCRMC's Family Medicine training program is the only residency program in Contra Costa County. It is a nationally recognized and respected program and a key source of primary care providers both in CCHS

and in the entire county of Contra Costa. The presence of a training program at CCRMC and CCHS contributes to the successful recruitment and retention of the interested, quality physicians to work in CCHS.

- The Family Medicine training program should be maintained and supported.

Most non-County providers view exploring potential partnerships with CCHSD positively. There is a perception that CCHS is a unique integrated system consisting of CCRMC, the health centers, and the Contra Costa Health Plan (CCHP). However, they are integrated to each other but not to the rest of the private system. As access to care to the vulnerable population in Contra Costa County expands, a countywide, integrated approach will be increasingly critical. Options to address a countywide integrated delivery system for the vulnerable population in the County include:

- Taking the lead in exploring the concept of a Safety Net Accountable Care Organization (ACO) with key stakeholders.
- Leveraging the Access To Care Stakeholders Group to begin the discussion.

Section II: Potential Alternative Models

There are a minimum of six alternative governance structures that could address the operational and financial issues related to the financial sustainability of the CCRMC, County health centers, and the CCHP and could help improve the efficiency and cost effectiveness of delivering health care services in Contra Costa County. They are:

- Public Ownership/Private Management of Hospital
- Separate Governmental Entity
- Separate Non-Profit Entity
- Privatization
- Hospital Authority
- Health District

Section III: Human Resources and Staffing Analysis

County Medical Staff Needs

Given that the population of Contra Costa County is projected to grow by more than 350,000 people over the next 20 years and the implementation of health reform, the capacity of the CCHS primary care delivery system will need to expand to meet the growing demand.

There are critical investments in technology, tools, and human resources that will strengthen Contra Costa Health Services' (CCHS) ability to serve its population and continuously improve its services.

The data suggest that panel sizes may need to be reduced while simultaneously implementing operational efficiencies to care for those patients.

Recruitment of new providers is key to CCHS attaining its goal of increasing primary care capacity; this may become a challenge as the salaries of nearby health systems are significantly higher than that offered at CCHS with similar benefits and work hours.

CCHS is well positioned to successfully implement Patient-Centered Medical Homes (PCMH) with many of the components being piloted or existing. The transition to an electronic health record (EHR) and a more robust IT strategy will assist in this effort.

CCHS is committed to continuously improving the quality and safety of the care it delivers and there are opportunities with selected conditions in the hospital to decrease morbidity and mortality among hospitalized patients.

Health systems can expect that state and Federal programs will increasingly reward systems that measure and can demonstrate better outcomes.

Human Resource Policies and Procedures

Several organizational entities and environmental factors limit the ability of the Contra Costa County Health Services Department's (HSD) ability to recruit and retain staff as quickly as needed.

Total compensation needs to be reviewed.

The recruitment of nurses needs to be linked with physician recruitment so that newly hired physicians have the staff support when hired.

According to the Hay Report, when salaries were added to overall benefit costs, Contra Costa County had the highest Employee Total Cost of all the counties in the survey.

Benefit costs may be higher than what was presented in the Hay Report and will require additional analysis to clarify the current benefit cost.

The current wage and benefit package is more conducive to the retention of staff than to the recruitment of new staff.

Section IV: Maximizing Federal Reimbursements

The Medicaid program, in terms of funding, is a Federal-state partnership. The extent to which each party contributes varies by state and is determined by a complex formula outlined in the Federal statute. In general, the lower the average income of a state, the more the Federal government contributes compared to what the state is required to pay.

Federal maximization is generally a state strategy. In California, however, a significant funding burden falls on counties and public hospitals because of the way services have historically been structured. Contra Costa is no exception. It can be argued that the County has had more success in Federal maximization compared to other counties.

Section V: Impact of the LIHP

The extension of California's Section 1115 waiver includes provisions for the Low Income Health Program with two components: a Medicaid Coverage Expansion (MCE) for individuals under 133

percent FPL and a Health Care Coverage Initiative (HCCI) for adults with between 133 and 200 percent FPL.

Because Contra Costa County currently covers adults 18-64 with income at or below 200 percent FPL in their Low Income Health Program (LIHP) without an enrollment cap, LIHP does not create a new eligibility group. However, an increase in enrollment is anticipated.

MCIC data indicates that the County has an estimated 30,000 uninsured U.S. citizens and eligible immigrants 18-64 with income under 200 percent FPL. This indicates that the 11,000 MCE and HCCI enrollees represent a third of the potentially eligible population.

If the State approves LIHP federal match in the amount requested, the County would see an increase in federal revenues greater than the increase in county costs. The County would cover more people for a lower net cost to their base year budget.

The new waiver also changes the method by which Medi-Cal services are delivered to Seniors and Persons with Disabilities (SPD) who do not have Medicare coverage. There will be a major shift from the majority of care provided fee-for-service to SPD enrollees mandatorily enrolled with organized delivery systems such as CCHP beginning mid-2011.

Section VI: Preliminary Steps in Creating Patient-Centered Medical Home

Patient-Centered Medical Home (PCMH) systems of care assure that patients have a source of primary care which functions as the central point for coordinating care around the patient's needs and preferences. The medical home team, consisting of the primary care provider and supporting staff, coordinates information between all of the various caregivers, which include: the patient, family members, other non-professional caregivers, specialists, and other healthcare service providers.

Each PCMH within the system of care is patient-centered and accessible, provides a continuous healing relationship with a primary care provider, comprehensively meets patients' health care needs, coordinates the delivery of care and accomplishes all of these features with teams of individuals functioning at the top level of their license and qualifications. Quality and safety are hallmarks of a well-functioning PCMH.

Contra Costa will need to choose a particular model in order to conduct a gap analysis between the current delivery system and the goals.

Introduction

In January 2011, the Contra Costa County engaged Health Management Associates (HMA) to conduct a sustainability audit of the Contra Costa Health Services-operated facilities: the Contra Costa Regional Medical Center (CCRMC) and County health centers. The goals of the audit are to develop options to support the fiscal sustainability of the County's health care system and to ensure the most efficient and effective delivery of health care services to County residents that align with the implementation of health care reform.

The work of this project is divided into three stages. In Stage 1, HMA submitted an Information Memorandum with demographics and health care utilization data demographics and health care utilization data; an analysis of the current and future capacity of the County's programs, services, and facilities; a discussion of the of the Basic Health Care program; and Financial, utilization, and quality performance indicators for CCRMC and County health center. The information in the Memorandum laid the groundwork for this report.

In order to conduct the analysis required for the second stage of this project, HMA conducted interviews, reviewed data provided by Contra Costa Health Services (CCHS), and assessed data from external sources. The Stage 2 Report is a Preliminary Report that focuses on: 1) opportunities for improving the performance of the County's health care delivery system, including inpatient, outpatient, and the Contra Costa Health Plan (CCHP); 2) alternative governance structures that could address the operational and financial issues related to the financial sustainability of the County's health care delivery system and that could help improve the efficiency and cost effectiveness of delivering health care services to low-income and uninsured populations in the County; 3) increasing primary care capacity to care for the expected increase in the number of vulnerable patients who will be impacted by health reform; 4) the human resource functions and processes related to recruiting and retaining professional staff while in compliance with the County hiring policies; 5) an overview of strategies and programs designed to maximize Federal reimbursements to the County for health care services for Medi-Cal recipients and uninsured residents; 6) the Low Income Health Program (LIHP), a significant element from the point of view of financing the County's health care system; and finally, 7) initial options for the establishment of a "medical home system of care" that would best serve the expanding Medi-Cal population, uninsured, and other medically vulnerable residents of the County.

Stage 3

The final Stage 3 report of the sustainability audit will be presented in mid-June 2011 and will include options for the County to consider in determining the most cost-effective and efficient way to provide care for the expanding Medi-Cal population, uninsured, and other medically vulnerable residents of the County. The options will focus on governance, financing, operations, integrated care delivery, and human resources as noted below.

- Alternative governance models – Options and implications of options
- Human Resource functions – Recruitment and retention strategies related to wage and benefit package

- Labor Relations – Planning and coordinating
- Integrated care delivery – Work plan for the establishment of a Patient-Centered Medical Home "system of care"
- Health Services Department management review
- County oversight and management of health care programs
- Maximizing Federal Reimbursement – Eligibility requirements for any potential new revenue sources and an evaluation of Contra Costa County's ability to obtain such funding
- Cost structure, which becomes more critical post-health health reform

Health Management Associates (HMA)

HMA is a consulting firm specializing in the fields of health system restructuring, with a particular focus on the safety net; health care program development; health economics and finance; program evaluation; data analysis; and health information technology and exchange. HMA is widely regarded as a leader in providing technical and analytical services to health care providers, purchasers and payers, particularly those who serve medically indigent and underserved populations. Founded in 1985, Health Management Associates has offices in Lansing, Michigan; Chicago, Illinois; Indianapolis, Indiana; Columbus, Ohio; Washington, DC; Tallahassee, Florida; Austin, Texas; Sacramento, California; New York, New York; Atlanta, Georgia; and Boston, Massachusetts.

I. Preliminary Strategic Analysis

This section presents a discussion of preliminary opportunities for improving the performance of the County's health care delivery system. It includes considerations for the County Health Services Department, CCRMC, County health centers, CCHP, and affiliated health care organizations and institutions within the County to provide a comprehensive and high-performance health care network for the County's low-income, uninsured, and medically vulnerable populations.

Introduction

As CCRMC's ability to provide inpatient care to the patient population of Contra Costa, especially those newly covered by the 1115 waiver and HCCI, is evaluated it is important to understand that there will be a number of critical changes related to service capacity needs. This will include:

- A continuous shifting of services currently provided in the inpatient setting into outpatient and ambulatory service sites
- Fewer hospital admissions per capita
- Fiscal rewards to health systems for decreasing admissions and avoiding preventable admissions and readmissions
- Care coordinating patients at the lowest, most appropriate, and least costly level of care.

To a significant degree, these changes will be driven by changes in the delivery of primary care. The PCMH is a model for this ambulatory care transformation. Although CCHS has put into place several initial elements of PCMHs, full transformation will require a dedicated, intensive effort. Implementing an initiative to transform practices into PCMHs is a complex and challenging endeavor. Evaluations of early efforts have shown that, unlike other quality improvement efforts, practices cannot rely on making isolated, incremental improvements. Rather becoming a PCMH requires a total transformation of practice organization, operations, orientation, and culture and a series of interdependent improvements. For CCHS, it will require, among other things, solving the problems with its appointment scheduling system, developing an approach to team-based care, developing systems for care transitions, and integrating mental health into primary care. Although it will not happen quickly or easily, improvements in health outcomes; cost savings; and provider, staff, and patient satisfaction through implementing PCMHs can be achieved. Implementing PCMHs brings the opportunity to explore creating a high-performing medical "neighborhood" through developing a Safety Net Accountable Care Organization (ACO).

Primary Care Capacity Expansion

The CCHS has in place a geographically distributed primary care network that annually provides over 275,000 primary care and ancillary care visits. Primary care is primarily provided by Family Medicine physicians with a sizable number of additional visits generated by Internal Medicine and Pediatric providers. Based on the active patient panels of these providers, the CCHS primary care network is responsible for at least some of the health care needs of nearly 100,000 individual patients. The CCHS

primary care system appears to be currently near or over capacity. Provider panels are felt to be excessive and are being reevaluated for thoughtful downsizing. Patients complain of difficulty obtaining unscheduled visits to their primary care centers. It is estimated that Federal health reform will enable approximately 115,000 Contra Costa residents to become eligible for either Medi-Cal or subsidized private insurance; 8,480 of these individuals are already covered by Contra Costa's HCCI and Basic Health Care (BHC) programs. CCHS needs to be prepared to expand its access to primary care if it expects to maintain its current HCCI/BHC patient population and to be positioned to provide care to a portion of the large number of Contra Costa residents who will be covered in and after 2014. The current capacity of the ambulatory system cannot be calculated without more data on the population (e.g., age, gender, chronic disease burden). Using panel sizes, the system is likely 25% or more over capacity. Using visit productivity, the system is 25% or more below capacity. The contrast of these two measures reinforces the need for delivery system redesign; the current system is bound to be unsatisfying for many patients, providers, and payers.

The following options can maximize and expand access to primary care service capacity:

- **Develop system-wide PCMHs, incorporating medical teams, care coordination for high-risk patients, and pre-visit preparation.** This will allow more effective use of CCHS's existing primary care providers. The goal of future health care delivery is not providing more visits but maximizing care and patients' health so that fewer visits may actually be needed.
- **Carefully scrutinize existing primary care provider panels.** The current methodology used to determine active panel size (i.e., 1 visit in previous 12 months) may need to be modified with a weighted severity index being used to more accurately assess panel size. This could result in the development of more realistic, right-sized panels. There could be additional capacity identified by this process, though the process is more likely to reveal a need to decrease panel sizes. On the other hand, the “right-sizing” process would endeavor to get the “right patients” (e.g., those with ambulatory sensitivity conditions) on the panels and, thereby, affect cost and quality.
- **Closely track primary care provider productivity until PCMHs are fully developed.** CCHS Ambulatory leadership already monitors provider productivity and patient show rates and uses this data to define and modify provider panels. The measure of productivity, however, needs to change from volume to value. For instance, having a patient return for an in-person visit for the refill of a stable chronic disease medicine is counted as increased productivity. Yet this medically unnecessary visit consumes resources (i.e., provider and staff time) and will too often have the negative result of an important medicine not being taken. With the development of functioning medical teams, provider productivity—in terms of delivering value—will steadily increase, but the productivity will need to be measured in a way that reveals this progress towards greater value. Controlled costs, improved quality, and a positive patient experience will need to be delivered for a prospectively defined patient panel. The capacity will be defined by the number of patients for whom this triple aim can be delivered.

- **Manage provider resources to maximize primary care sessions and patient access to their primary care provider team.** CCHS has a unique system of Family Medicine registrars, wherein primary care providers attain "champion" expertise in some aspects of specialty care with resultant decrease in the use of costly specialty consultations and an increase in the appropriateness of expensive and limited diagnostic resources. This unique system may have significant service and cost benefits. However, leadership must assure that primary care providers are mainly focused on the actual delivery of primary care. CCHS administration must also assure that unplanned provider absences are cross-covered by back-up providers
- **Further expand evening/weekend primary care sessions.** CCHS has initiated evening and weekend sessions in a number of its health centers. With the appropriate provision of support staff, further expansion of evening/weekend primary care sessions can increase patients' access to vital primary care.
- **Proceed with the construction of additional ambulatory care space in San Pablo and Concord and consider offer of expanded space for Bay Point.** This space will allow for the increased provision of primary care in the system.
- **Expand current partnerships with private and public health care providers in Contra Costa to assure that all residents of the county have optimal access to primary care.** It is impossible for CCHS by itself to provide all the needed primary care capacity, especially with the impact of health reform and the increased movement of patients into managed care. CCHS's relationship with the non-County FQHCs to enhance the care of the uninsured must be solidified, particularly in light of the fact that 41,000 Contra Costa residents will remain uninsured after health reform is fully implemented.

Inpatient Services at CCRMC

Contra Costa County currently has 1,146 general acute licensed[1] inpatient hospital beds equaling approximately 1.1 beds per 1,000 population. This is well below the national norm of 3.2 per 1,000 population and 1.9 beds per 1,000 in California.[2] CCRMC currently has 166 licensed and 146 available inpatient beds. Contra Costa has 10 hospitals and CCRMC generates the third highest number of annual hospital discharges (11,576 in Federal FY 2009) accounting for greater than 11% of all annual hospital discharges in the County. CCRMC is the leading provider (41%) of inpatient care to Medi-Cal covered County residents, triple the number of the next busiest hospital. CCRMC is also the main provider of inpatient care to the uninsured patient population and those covered under the Basic Health Care program and HCCI. CCRMC has an average daily occupancy rate of approximately 75%. Many days, patients wait in the Emergency Department (ED) for a Medicine-Surgery or a psychiatric bed to become available. There are times in the year when all the hospitals in Contra Costa are at full- or near-full occupancy.

[1] OSHPD HAFD 2009 Audited Report
[2] www.aha.org/aha/trendwatch/2006/cb2006toc.PPT

Length of Inpatient Stays at CCRMC

The average length of stay (ALOS) at CCRMC for Medicine-Surgery patients is 3.76 days, 2.4 days for OB patients, and 8.14 days for Psychiatric Unit patients. The national Medicine-Surgery ALOS is 4.6 days and the West region of the U.S. is 4.3 days.[3] The OB ALOS are consistent with U.S. stays, and the inpatient psychiatric stays at CCRMC are somewhat longer than the national ALOS of 7.1 days.[4] (It should be noted that the unit at CCRMC is a locked unit, which may account for a higher length of stay based on a different patient mix.)Providers at CCRMC communicated that, although the ALOS are quite reasonable, there are opportunities to further improve these numbers on select patients on each of the inpatient services. 27 to 28% of all Medicine-Surgery admissions are discharged within 24 hours while 51% of Medicine and 42% of Surgery patients are discharged within 48 hours. Occasionally, stable patients on Medicine-Surgery and Psychiatric Units have excessively long lengths of stay due to delays in identifying suitable post-discharge placement facilities or services. CCRMC has only one CT scan and one MRI Unit, both of which are at near-full capacity utilization. This creates bottlenecks to the timely delivery of inpatient as well as outpatient care. Lack of access to specialized inpatient diagnostic procedures can contribute additional days to a patient's hospital stay. This is particularly a concern on weekends and holidays.

The following options can further decrease the average lengths of stay on inpatient units at CCRMC and address the reasons for one day admissions:

- **Address operational barriers to the timely discharge of inpatients.** This is an ideal project for the high-level quality improvement program at CCRMC. On some inpatient units this issue is already being studied and reviewed.
- **Purchase an additional CT unit,** which could expand capacity/utilization.
- **Provide availability of certain invasive diagnostic procedures on weekends** so as to avoid prolongation of patient hospitalizations.
- **Develop formal relationships and possibly contracts with Skilled Nursing Facilities (SNF), Long Term Acute Care centers (LTAC), Institutions for Mental Disease (IMDs) and nursing homes to expedite the discharge of difficult-to-place patients who require transitional residential care** (e.g., patients with behavior disorders, mental illnesses, substance abuse issue, homelessness, criminal records, etc.). This is particularly an issue for patients without any or without adequate health coverage. Health reform funding mechanisms will require CCRMC to develop transfer agreements to move stable patients to less expensive, more appropriate lower levels of care.
- **Develop formal relationships or contracts with home visit and home IV nurse services to expedite the discharge of inpatients from the hospital to their homes.** This is particularly a barrier to discharge for uninsured or underinsured patients.

[3] www.hcup-us.ahrq.gov/reports/.../2007/hcup_partnersV2.jsp
[4] http://www.cdc.gov/nchs.fastats/mental.htm

- **Evaluate the current policy of its Mental Health Department not to readily accept the referral of patients with behavioral disorders and mental illness complicated by substance abuse.** This is an occasional barrier to discharging patients from the inpatient psychiatric unit. The upcoming merger of Mental Health with Alcohol and Other Drug Services Division may prompt further discussions and actions on this issue.
- **Thoroughly study reasons for one-day hospitalizations and consider alternatives to hospitalization,** including the development of an observation unit at CCRMC.

Operating Room Services at CCRMC

CCRMC currently utilizes three hospital operating rooms (OR) for nearly all of the inpatient and ambulatory surgery provided in CCHS. A fourth OR is temporarily unused pending the completion of a utilization study of the efficiency of OR procedures. It was reported the OR utilization rate is 90%; the national goal for OR utilization is 70%. The ORs have a case cancellation or patient no-show rate of 30%. These cancellations are filled in by urgent cases that would otherwise have bumped scheduled elective or less urgent surgeries. Some of the OR cancellations are due to the existing preoperative clearance process that can result in patients having to return for up to three separate appointments to complete all pre-operative exams, education, and testing. A sizable number of the surgeries and procedures performed in the hospital ORs could be safely, more efficiently, and more cost effectively done in an outpatient surgery center or even in a clinic procedure room.

The following options can more effectively utilize the hospital operating rooms.

- **Establish a centralized, one stop pre-operative preparation and clearance clinic** at the Martinez Health Center.
- **Consider opening the fourth OR to handle all urgent and emergent surgeries.** This may require the availability of an additional OR team. This could reduce or eliminate cancelling or bumping scheduled elective cases, which is disruptive to patient care and a significant cause of patient dissatisfaction with a health care system.
- **Shift lower risk, uncomplicated surgeries and procedures to an ambulatory surgery center or a clinic procedure room.** Hospital ORs are costly units of service with extensive regulatory guidelines and oversight. Surgeries that can be safely performed in a less-intense setting should not be performed in a hospital OR.

Emergency Department Services at CCRMC

The Emergency Department (ED) at CCRMC is extremely busy providing nearly 60,000 annual patient visits. The ED visit volume has doubled since the hospital and ED were constructed in 1997. The physical space in the ED is fully utilized with designated temporary, audio-visually compromised stations in the hallways and a congested waiting room. When inpatient units are at capacity, patients awaiting admission occupy beds in the already crowded ED. Of ED visits, 30% are classified as Level 4-5 (low acuity, non-urgent). Therefore, many of these patients could be safely treated in an urgent or immediate care center, an ambulatory clinic, or a physician's office. A number of the Level 5 patients simply require

a medication refill, but they have had difficulty contacting their primary care center. Except for the ED, there is limited opportunity for uninsured or underinsured patients to access urgent care when their primary care center is closed. The ED does not routinely notify primary providers when their patients are in the ED or are being discharged from the ED. The ED also does not have access to expedited post-ED appointments to primary care providers. The Psychiatric Emergency Service (PES) houses mentally ill men and women in two very crowded spaces. One of the main reasons for a repeat visit to the PES is the failure of patients to take their medication or difficulty in obtaining medication refills.

The following options can more effectively utilize ED and PES services.

- **Identify and renovate additional physical space adjacent to the ED** to assure that care provided in these two units is maximally efficient and audio-visual privacy maintained. This is critical because the ED and the PES have exceeded their physical capacities.
- **Provide after-hours immediate and non-urgent care available to all patients cared for by CCHS.** The ED should be used only by patients with emergent or urgent conditions. This would be cost-effective and decrease the demand on the ED and can be created internally or developed through formal agreements.
- **Create an Observation Unit to help decrease congestion in the ED.** Patients waiting for admission or patients requiring short-term treatment could effectively utilize this unit, which will free up beds in the ED.
- **Develop procedures to notify primary care providers and centers when a patient is in the ED or is being discharged so that all required transitional care can be provided.** This could decrease costly re-visits to the ED for high-risk patients.
- **The CCHS quality improvement program should study the barriers that keep patients from consistently obtaining medication refills and using the ED simply to obtain prescriptions.**

Specialty Care

Thirty-nine specialty services provide over 100,000 annual visits primarily at CCHS's three comprehensive care centers. The waiting times for appointments to 23 of the 39 specialty services is monitored and reported. There are lengthy waiting times for 25% of the specialty services that are being monitored. The actual waiting times are longer than reported because many referrals are backlogged on a waiting list before an appointment is assigned. In February 2011, eight specialties had 100 to greater than 300 consultation requests parked on waiting lists. In order to minimize the waiting times and the sizes of the waiting lists, some specialty services have begun to manually screen requests for appropriateness and completion of indicated pre-visit tests. The long waits and the backlogged waiting lists indicate that a number of specialty services are at or full capacity. In 2010, only 60% of the specialty clinics attained the productivity goals established by CCHS.

The following can enhance access to specialty consultation.

- **Implement an automated, rule-based specialty referral screening system that would successfully approve or deny the majority of all specialty requests.** This auto-screening would

free clinical staff from manually reviewing requests and could diminish waits for appointments and time on waiting lists.

- **Evaluate the reasons and initiate process improvement actions to improve the productivity of those specialty clinics that are unable to meet established productivity standards.**
- **Increase in-house specialty capacity** by hiring more specialists in backlogged services and/or contracting with community specialists to provide consultations when waits become prolonged.
- **Initiate an e-consult initially for backlogged specialty services.** The implementation of the new EHR should help facilitate this process. Many specialty referrals are essentially soliciting advice on patient management that does not require a hands-on visit and can be effectively handled electronically. Specialists with high volumes of e-consult requests will need to have time reserved to provide these e-consults.

Quality Improvement Programs at CCHS and CCRMC

CCHS and CCRMC have committed resources and time to the development of an extensive, ongoing quality improvement effort involving all aspects of the delivery of health services across the continuum of care. Its leadership has attended intensive national training in quality improvement processes and programs. Staff have been selected and given fellowships in becoming "change agents" for the system. Numerous quality improvement projects have been initiated focusing on complicated areas of service.

- **Efforts of CCHS and CCRMS need to be supported at all levels of the health and County administration.** This quality program has been nationally recognized and adds value to the health care delivery system at CCRMC and CCHS and is worth the resource and time commitment of the County.

Appointment Scheduling

The centralized scheduling system was created to support open access (i.e., advanced access) scheduling. Open access scheduling functioned effectively for several years and helped improve show rates from 70% to 85%.

Today, the increase in demand for primary care services has resulted in a mismatch of the supply of appointments available and the demand for these appointments. This results in few appointments available to give to patients requesting appointments and long phone queues. Open access scheduling is only effective when supply and demand are essentially matched.

- **If the centralized system is continued, some simplification of the scheduling process and rules is encouraged.** The CCRMC CEO noted that there is a plan in place to begin a Value Stream Mapping process for this department as part of a Kaizen project, which will include participation by physicians and staff.

Family Medicine Provider Base

CCRMC and CCHS are predominantly staffed by Family Medicine providers. Many are graduates of the Family Medicine Residency program at CCRMC. CCRMC has a long standing practice of assigning Family

Medicine providers to spend a portion of their work week as "registrars" on inpatient and outpatient specialty services, on inpatient teaching rotations, and in the Emergency Department. They also have a significant amount of their time dedicated to busy outpatient primary care practices in County health centers.

Family Medicine physicians who assist specialists on inpatient units and outpatient specialty clinics acquire a significant amount of knowledge about their assigned specialty service. They become "champions" in this specialty. They provide an accessible conduit for the communication of updates to their primary care colleagues in the outpatient care centers about the care of patients with specialty conditions. They commonly assist their colleagues to determine which patients would benefit from a specialty consultation. They screen out inappropriate or unnecessary referrals freeing valuable specialty appointments for the most appropriate patients. These Family Medicine registrars provide unique clinical and cost benefits to the patients of CCHS and the health delivery system.

Ambulatory clinical and administrative leadership must consistently evaluate the primary care needs of the CCHS patient. The existence of the Family Medicine registrar system at CCRMC has notable cost implications. Family Medicine physicians are paid at significantly lower rates than specialists. If specialists (e.g., cardiologists, orthopedists, general and specialty surgeons, etc.) were hired to provide the inpatient and outpatient duties of the registrars, there would be an increase in the CCHS's salary and contract commitments.

The following change in use of Family Medicine physicians as registrars should be considered.

- **Monitor the time commitment of the registrars to assure that these primary care providers are mainly focused on the pivotal provision of primary care.**

Family Medicine Training Program

CCRMC's Family Medicine training program is the only residency program in Contra Costa County. The program has 13 residents in each of the three years of the residency. The program matches 100% of its positions with U.S. medical school graduates. Each year CCRMC and CCHS hires 33% of the training programs graduates; 68% of all the graduates since 2006 have chosen to stay in Contra Costa and serve the residents of the county.

The CCRMC Family Medicine Residency is a nationally recognized and respected program. Family Medicine programs are not formally ranked but its enviable match rate, the quality of its residents, and its status as the only residency program not only at CCRMC but in the country, has led national Family Medicine leaders to place this program in the upper echelon of Family Medicine residencies in the country. The CCRMC Family Medicine Training Program is a key source of primary care providers both in CCHS and in the entire county of Contra Costa. The loss of this training program would have an immediate and negative impact on the provision of primary care for all residents of Contra Costa County. The presence of a training program at CCRMC and CCHS contributes to the successful recruitment and retention of the interested, quality physicians to work in CCHS.

- **The Family Medicine training program should be maintained and supported.**

Partnerships/Integration with Other County Providers

Health reform will change the coverage of low-income residents in the County, and California's Section 1115 Medicaid waiver renewal provides expanded access for this population. The economic climate is making the pressure at the local level immediate and the need to design new systems essential. Health reform requires models for effectively delivering care and improving health status, not simply providing insurance coverage. Local models, built on an integrated approach, will be extremely helpful as the Country looks to assure real access to quality, efficiently-delivered health care.

Most non-County providers view exploring potential partnerships with CCHSD positively. There is a perception that CCHS is a unique integrated system consisting of CCRMC, the health centers, and the CCHP. However they are integrated to each other but not to the rest of the private system. Capacity is becoming an issue for providers across the County. As access to care to the vulnerable population in Contra Costa County expands, a countywide, integrated approach to assuring patients actually have access to the right care in the right setting at the right time will be increasingly critical.

The following options can address a countywide integrated delivery system for the vulnerable population in the County.

- **Take the lead in exploring the concept of a Safety Net Accountable Care Organization (ACO) with key stakeholders.**
- **Leverage the Access To Care Stakeholders Group to begin the discussion.** This will include private hospital and health plan CEOs and other decision makers, the leadership of the non-county FQHCs, and local private physicians that are part of the group.

II. Potential Alternative Models

This section identifies six alternative governance structures that could address the operational and financial issues related to the financial sustainability of the CCRMC, County health centers, and the CCHP and could help improve the efficiency and cost effectiveness of delivering health care services in Contra Costa County.

While this phase of the sustainability audit calls for a preliminary discussion of alternative models, the Stage 3 report will include a more robust discussion of the options and implications of options for Contra Costa County. This will include an analysis of which challenges are and are not addressed by a particular option, funding impacts (if any), and key barriers or success factors.

Model 1: Public Ownership/Private Management of Hospital

This structure would involve contracting with a private organization to manage and staff the CCRMC, while the clinics and health department remain with the County. CCRMC would continue to be owned by the County and would remain a public hospital, but the private entity would have the responsibility of operating the facility under a contract with the County. This would allow CCRMC to be outside the purchasing and employment issues with which they are currently concerned but would give them the advantage of the skills of an organization where hospitals are their primary business. However, separating the CCRMC and County health centers could weaken the health system coordination overall since the County health centers are closer to traditional County operations, essential to public health, and the backbone of a well-integrated health system for vulnerable populations.

As an example, the Travis County Health and Human Services Department in Austin, Texas has used this model successfully.

Model 2: Separate Governmental Entity

CCRMC, CCHS health centers, CCHP, and the public health department could be spun off into a separate governmental entity with a Board appointed by elected officials. This would allow for a Board to concentrate on health issues alone and have a structure focused solely on the needs of the health care organization. This agency could have its own tax rate or receive a set subsidy from the County for the services provided. This keeps the advantage of integrating all the health efforts in the County and creates infrastructure attune to the needs of a health care organization.

Health and Hospital Corporation of Marion County, Indiana has established this model and Cambridge, Massachusetts had a similar structure for a time.

Model 3: Separate Non-Profit Entity

CCRMC, CCHS health centers, and CCHP could be spun off into a single 501(c) 3 with a subsidy from the County. This would preserve an intact hospital. Under such a structure, it is possible to be recognized as a public hospital for certain purposes while for all intents and purposes operating as a private hospital. It could have a subsidy that comes from a specific levy or from the general fund. Regardless of the source,

the County could give all of the money to the one entity or give some amount to others based on specific contributions they make.

Kansas City, Missouri and Truman Medical Center have successfully established these types of entities.

Model 4: Privatization

CCRMC, CCHS health centers, and CCHP could be spun off to a private entity. The money that might have been used to support the public system instead could be used to subsidize private entities for certain services or to pay for Section 17000 requirements until 2014. This would make the demands on the County budget known and predictable. This model would also envision some measurable requirement on the 501(c) 3 hospitals in the community to provide a certain amount of care to the indigent.

Milwaukee, Wisconsin and a number of counties in California follow this model. The state of Indiana did something similar with their University Hospitals by moving the ownership and operation to a private entity, Methodist Hospital (now called Indiana University Health) but is continuing to provide Intergovernmental Transfers (IGTs) for the new entity.

Model 5: Health Authority

All or any portion of the current division could be moved to a Health Authority. This is similar to some of the other structures presented and has been used in many other locations.

As an example, the Alameda County Medical Center is a Public Hospital Authority governed by a Board of Trustees appointed by the County Board of Supervisors. The Denver Health and Hospital Authority also uses this model.

Model 6: Health District

The County could form a countywide health district with a Board of Directors and CCRMC, the County health centers, and CCHP could be made part of that structure.

As an example, the Maricopa County Special Health Care District in Phoenix, Arizona, which was established in 2004.

All of these models present potentially viable alternatives for the County and have advantages and disadvantages, which will be presented in more detail in the final report. The report also will include an analysis of what the requirements of each option will be under California law.

III. Human Resources and Staffing Analysis

Subsection 1: County Medical Staff Needs

The population of Contra Costa County is projected to grow by more than 350,000 people over the next 20 years. The number of Medi-Cal enrollees and the number of individuals over 65 years old in the County are increasing. This increase will be critical for the County because both of these populations use more health care services than other groups. The table below shows significant growth in the number of Contra Costa residents covered by Medi-Cal in 2014 with implementation of the Affordable Care Act (ACA) Medicaid expansion provision. However, not all of the Medi-Cal enrollment growth will be new patients to CCRMC and the County health centers. Of the 10,600 individuals currently enrolled in the County's Health Care Coverage Initiative (HCCI) program, those with income at or below 133 percent Federal poverty level (FPL) will move to Medi-Cal coverage in 2014. At least 80% of HCCI enrollees (8,480) are estimated to have income under 133% percent FPL.[5] Since this group of HCCI enrollees are already in CCHP, they will not be new to the system in 2014. As a result, the estimated number of new ("2014 Movement" in Table III.1) CCHP Medi-Call enrollees (line 2 in Table III. 1) will be 8,480 less than 50,000 resulting in just over 41,500.

Table: III.1 Contra Costa Population by Coverage Status, 2009 and Projected 2014 with ACA Implementation

	2009		%	2014 Movement		2014	%
Private Insurance	**641,500**		61%	63,000	**	704,500	67%
Medi-Cal w/H Families	**125,000**		12%	50,000	***	175,000	17%
Medicare	**128,000**		12%			128,000	12%
Uninsured	**154,000**	*	15%	(113,000)		41,000	4%
Total	1,048,500			-		1,048,500	

*The uninsured in 2009 (154,000) includes those (approximately 10,000) that are currently covered by HCCI.
**The uninsured that move to private insurance coverage in 2014 (63,000) include current HCCI enrollees with income over 133% FPL and those currently in the Basic Health Care program.
*** The uninsured who move to Medi-Cal coverage in 2014 (50,000) include current HCCI enrollees with income under 133 percent FPL.
Source: MCIC analysis March 2011.

Today, CCHS provides primary care to 98,822 individual patients in eight separate health centers. Age, medical complexity, and utilization per patient are not available for current analysis. However, based on information in the CCHS Strategic Plan, CCHS patients do have lower literacy, are more likely to be non-English speaking and have poorer health status than those at other hospitals.

The CCHS strategic plan identified four major categories of delivery system changes needed to prepare for health reform, strengthen the delivery system, enhance care, and improve outcomes. They are:

- Infrastructure development
- Innovation and redesign

[5] A June 1, 2010 UCLA Center for Health Policy Research report titled "Interim Evaluation Report on California's Health Care Coverage Initiative" indicates that 72% of Contra Costa HCCI enrollees have income at or below 100% FPL. The remaining 28% have incomes greater than 100% and at or below 200% FPL.

- Population focused improvement
- Urgent improvement in care

Infrastructure Development

The CCHS strategic plan identifies the following investments in technology, tools, and human resources that are necessary to strengthen the organization's ability to serve its population and continuously improve its services.

Buildings

The CCHS strategic plan includes constructing two new buildings and expanding one additional site. This is an important step in improving health center functioning. HMA's analysis showed that Bay Point, Concord, and Antioch Health Centers are outdated, crowded, and functionally very inefficient. Bay Point only has two medical exam rooms. Concord is divided into two separate two-story buildings. Antioch clinics are divided by a public corridor. The physical limitations of these sites interfere with maximal clinical efficiency. Even if the physical limitations are addressed, there are other important measures that could improve access to and delivery of services. In particular, offering extended hours will allow the existing sites to serve more patients. However, this will require hiring the appropriate numbers of additional support staff and physicians and/or nurse practitioners.

Information Technology

Plans are in place to upgrade and expand technology across CCHS with the goal of supporting and enhancing all operations of the system.

Human Resources

Panel Size

The CCHS strategic plan acknowledges that it is critical to expand primary care capacity to meet the growing demand. The present panel sizes and visits per FTE reflect little unused physician capacity in the system. In CCHS, the average panel size among primary care providers is 2,050 patients /FTE and range from 1,500 to 3,300 patients /FTE. Although it is important to note that these panels are mostly historically based rather than prospectively assigned, most national benchmarks, particularly for vulnerable populations, use panel sizes of 1200-1800. The Veteran's Administration uses a panel size target of 1,200 unique patients/FTE provider.

That said, the optimal panel size for any provider is determined by the medical complexity of the patients, age, and appropriate utilization. For example, a panel which includes a large number of women of child-bearing age may need to be smaller than 1,500 since the usual-risk woman will need 10 visits over the course of an uncomplicated pregnancy though some women may require 15 to 18 visits and some women will show up for fewer.[6]

[6] Traditionally, low-risk pregnant women in the United States who participate in prenatal care have been scheduled for approximately 14 to 16 prenatal visits, which is the schedule recommended by the American College of Obstetricians and Gynecologists. In 1989, an expert panel convened by the United States Department of Health and Human Services proposed a reduced frequency prenatal visit schedule for low-risk, healthy women based on the timing of specific tests or events that occur

Similar to using the weighted severity index indicated in the previous section, CCHS could determine panel size using a weighting system that uses the concept of "patient-equivalents." Under this model, every panel would contain a certain number of patient equivalents. The number of patient equivalents is an arbitrary but meaningful number based on the following question: If every patient was an average patient, for how many patients could one FTE primary care physician be accountable? For example, if for Contra Costa this were 1,500 patient equivalents that would translate into approximately three visits per year for that average patient if the following assumptions are made: 3 visits per hour, 32 hours per week, 46 weeks per year.[7] This is very close to the number that was widely used to determine allowable costs for FQHC's rate determination (i.e., 4,200 patient visits per year). Each patient would need to be weighted in terms of patient-equivalents. This can be done in a variety of ways but one option is with age and gender tables with additional weight added for specific chronic diseases.

When the patient panel is thus weighted, incentives for "churning" patients are minimized. The provider would have five minutes per month for a patient with a member equivalent weight of "1" (e.g., an elderly person without chronic disease or a 45 year old with diabetes) or 15 minutes per month for a patient weighted a "3" (e.g., an elderly person with multiple chronic diseases). Some of the provider's time would be expected to be spent communicating with the patient through mechanisms other than a visit, such as telephone calls. Time would also be spent enabling other care team members to take actions for the patient (e.g. standing orders). Since this "medical home team" would be judged on the outcomes for the panel of patients rather than on the number of visits, the incentive would be to find efficient ways to deliver care.

Overly large panel sizes do not serve the patients/system well. Today, the scheduling system is dysfunctional mostly due to inadequate numbers of appointments available to meet the patient demand for care. When the most cost-effective venue is not available, patients will go without care, delay care, or are treated in more expensive and less-appropriate settings.

Provider Recruitment and Retention

Recruiting new providers is key to CCHS's attaining its goal of increasing primary care capacity. Historically, the recruitment of qualified primary care providers to work in the CCHS has not been a significant challenge. However, salaries of nearby health systems are significantly higher than that offered at CCHS with similar benefits and work hours. This growing disparity will adversely affect both recruitment and retention of qualified providers. Signing bonuses, adjustments in base salaries and financial incentives for meeting and/or exceeding organizational goals such as quality, productivity and

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in pregnancy. Available evidence shows no adverse effect on maternal or neonatal outcomes for low-risk pregnant women who follow a reduced visit schedule, making it a highly important consideration for pregnant women and their health care providers.

In the Centering Pregnancy model of care, groups of pregnant women with similar due dates attend two-hour prenatal visits in which they are able to network with other pregnant women, receive an assessment of their pregnancy status and education specific to their needs, as well as postnatal education including breastfeeding and contraception. Approximately 8 to 12 women attend each visit, which begin around the 12th to 16th week of pregnancy, for 10 visits. This is significantly less than the 14 to 16 recommended by ACOG. In a study done by Yale University, it was shown that participants of Centering programs reduced their risk of preterm birth by 33% and were more likely to report feeling empowered to choose health-promoting behaviors.

[7] Per Ambulatory leadership physicians at CCHS work an average of 45 weeks per year.

patient satisfaction are all potential recruitment and retention strategies. Enabling physicians to have meaningful input into the practices is also key to retention. Additionally, improvements in operational processes will lessen provider burnout and help with retention.

Innovation and Redesign

CCHS is well positioned for a successful implementation of a Patient-Centered Medical Home. Many of the components already are being piloted or exist. The transition to EPIC and a more robust information technology (IT) strategy also will assist in this effort.

Group visits are one innovative approach being used successfully in CCHS primary care practices and are one potential way for the system to build capacity. Additional opportunities exist for expanding this approach. Although group visits do not always increase capacity, they have been shown to improve outcomes, patient self-management skills, and patient satisfaction.

Nationally, there are successful models of pharmacist-run clinics for conditions such as diabetes, hypertension, and lipid management. CCHS might consider this model to expand access, improve care, and decrease costs.

Population-Focused Improvement

CCHS's strategic plan includes substantial enhancement of the IT system. This will facilitate the identification and management of all patients, not just those who present for care. Case management, care coordination and the use of registries are all central to a highly functional patient centered medical home.

Urgent improvements in Quality and Safety

CCHS is committed to continuously improving the quality and safety of the care it delivers. The strategic plan acknowledges that there are opportunities with selected conditions to decrease morbidity and mortality among patients hospitalized at CCRMC. Efforts to address hospitalizations for Ambulatory Care Sensitive conditions such as increasing the use of asthma controllers, improving prenatal care, and medical management of congestive heart failure can lead to better outcomes, decreases in hospital care, and substantial cost savings.

While implementing an EHR is a critical first step, it does not automatically result in improvements in quality and cost. There will have to be additional and deliberate efforts made to ensure that the system is fully used and/or enhanced to improve quality and costs.

CCHS could establish a dedicated quality team, which would include physicians and actively involve senior leadership, as a strategy to increase its focus on data-driven processes and improvements in care. This could yield important benefits as State and Federal programs will increasingly reward systems that measure and demonstrate positive patient health outcomes, decrease admissions, avoid preventable admissions and readmissions, and have fewer medical errors.

Subsection 2: Recruitment and Retention Policies and Procedures

Several organizational entities and environmental factors impact the ability of the Contra Costa County Health Services Department's (HSD) ability to recruit and retain staff. As noted in the Stage 1 Report the key factors include: the human resource function, labor relations/unions, and the County hiring process.

Human Resource Function

HSD Human Resources (HR) is responsible for approximately 3,200 employees. HR is responsible for coordinating the employment processes, providing consultation to managers, and administering time sheets for payroll. Payroll is a paper-based manual process that is time consuming and challenging to administer. No electronic time and attendance system is in place at this time, but the County has engaged ADP to implement one in the future. Given the lack of an integrated time collection and management system, detailed staffing reports are neither readily available nor used by managers at HSD or by HSD HR. The County provided a list of budgeted FTEs in the system but not actual FTEs.

A Professional Services Unit (PSU) study[8] was recently completed by an external consulting group for the overall County HR function and process. The purpose of the PSU study is to assess HR practices and policies for the PSU. Originally, HSD HR was to be excluded from the study, but it was subsequently agreed to include it, since HSD paid the additional cost to be part of it and were very interested in the outcome of the study. The study was completed in January 2011. HSD leadership considers the conclusions and recommendations in the PSU study critical implementation steps and would improve HSD HR's ability to do its job. A major part of the study was the analysis of the current processes for classification, compensation of positions, and recruitment of staff into the County. The study includes recommendations to streamline several processes in order to improve recruitment. There is a current backlog of 35 pending exams that were submitted to County HR for approval. HSD believes that the current approval process is time consuming and is keeping HSD HR from replacing vacancies in a timely fashion. It is believed that County HR replicates much of the work already done by HSD HR. Overtime and agency usage is used to meet staffing requirements resulting from vacancies and hiring delays.

HSD issues were identified beginning on page 36 of the PSU study. The following are relevant to the current process for recruiting or replacing staff at HSD:

> *"One of the major concerns expressed by the departments is that delays in responding to HR issues, recruitments, and list requisitions can have a significant impact on funding. If a position isn't filled, these departments can lose funding. In most cases, the jobs involved are unique to the department which is a strong argument for having the department take responsibility for HR activities within the department."*
>
> *"Departments would like the authority to maintain and produce their own eligibility lists for those positions that are unique to the department. There is a strong feeling that the departments and PSU share a mutual desire to comply with County policies and regulations and*

[8] Contra Costa County – PSU Audit Review. Audit Review of Practices and Functions. Renne Sloan Holtzman Sakai LLP. Prepared by: Geoffrey Rothman, Principal Consultant, Doug Johnson, Consultant.

that added NEOGOV access would improve department access without any significant risk in complying with the same requirements the PSU works under."

"Some departments conduct salary comparability studies for compliance with Federal regulations; however, PSU will redo the survey, which ignores the fact that both PSU and the department have a mutual objective in providing accurate and pertinent information."

As a result of the Audit and issues raised, the following are some of the recommendations made by the consultants beginning on page 38:

Document and process tracking

- Establish consistent standards and practices.
- Utilize uniform methods and timelines for communicating with departments.
- Transparency of process and status.
- Shift more of the analytical P300 burden to the operating departments for jobs that do not have significant cross-department equity issues.

Deep class reassignments

- Utilize a streamlined review process primarily requiring approval within the operating department and limited analysis/review by PSU.

PeopleSoft access for employee data and ad-hoc reporting

- Open up access to PeopleSoft data and eliminate the need for PSU staff to be involved in ad-hoc reporting.

Classification and compensation systems and issue analysis

- Establish guidelines and standards for conducting market surveys with an effort to limit the need and use of market data for most ad-hoc analyses.
- Shift the burden of data collection to the operating departments with PSU staff serving in an advisory and review role.
- Establish updated classification plan standards, concepts, and guidelines (possibly requiring a countywide study).
- Identify compensable factors and job characteristics for consistent use in evaluating internal equity (does not require a quantified point driven system)
- Establish limits/thresholds for creating new job classifications.
- Make sure PSU staff is in the "bargaining loop" to assess impacts and issues.

Duplication of effort in classification and compensation analyses

- Shift a greater burden of effort to the operating departments and adopt an advisory consultant role with PSU staff.

List certifications

- Increase the use of NEOGOV in operating departments and shift the burden of list management for job classes that have little cross-departmental impact.

Based on HSD staff interviews and the review of the PSU Audit, HMA's assessment is that HSD cannot recruit nor replace staff as quickly as needed. There appears to be redundancy in staff effort and processes that result in delays that create additional staff costs and the loss of qualified candidates. There appears to be no ability to adjust to changing market conditions in order to compete for qualified staff. Generally speaking, at this point there is a surplus of available nurses and other health professionals; however, the need for more primary care physicians will be critical. It is important to become more nimble in order to compete for staff when shortages occur again or when the need becomes imminent.

Labor Relations/Unions

There are a total of 10 bargaining units at HSD who negotiate contracts directly with the County. HSD wages and benefits are part of these negotiations. Once negotiations are completed, the contracts go to the County Board of Supervisors for approval. Historically, the unions bargained as a coalition. The County contracts with the Industrial Distributors Employee Association (IDEA) to serve as the lead negotiator. Currently, the County has an RFP out for performing the negotiation process. There are 85 union leaders and members and five staff members representing the County in the same room at the same time. The California Nurses Association (CNA), who represents the nurses working at the HSD, and the Physicians and Dentists of Contra Costa (PDOCC), who represent physicians and dentists, no longer bargain as part of the coalition. CNA's contract is due to be renegotiated in August of this year. PDOCC has not had a signed contract for two years, and there does not appear to be a formal negotiation planned for the near term.

Very few individuals working at the HSD are not represented by Union Contracts. Only the top executives are exempt at this time. A new union representing the HSD middle management staff was formed and is ready to join the Coalition for bargaining. Projected wage reductions and projected changes to the health plan, a lower cost plan, will be matched up with lower wages and appears to have the unions and staff concerned about the upcoming negotiations.

According to the County HR Director, the HSD HR Director has a seat at the bargaining table and represents HSD's needs in the bargaining process. This position reports to the CEO of the HSD and is the primary point of contact between HSD and County HR. It was noted that while the HSD HR Director is part of the negotiating team, the position has little or no influence over what is negotiated during the process.

HSD leadership stated that the HSD needs are an afterthought when union negotiations take place. No strategic vision or alignment with HSD's business needs is planned for and represented in the negotiating process. As an example, COLAs are granted to all classifications when pay changes need to be targeted at "hard-to-recruit" classifications. There is no collective preparation or impact analysis for negotiations. The outcome is no ownership for the results; County decisions regarding benefits and compensation are made to maintain labor serenity and to create a positive public sentiment. This is not good for HSD and does not allow any flexibility for change to improve HSDs operations.

The Business Agent for Local 1 appears to be the most visible union leader of all the unions that represent staff at HSD. It was said that he has a strong local presence and that other union leadership look to him for insights when dealing with the County. The Business Agent stated that communication with HSD needs to improve. He believes that day-to-day labor relations would improve with more proactive communication with the union regarding changes that affect union membership.

HSD leadership and the County staff think that the labor relations and process is not problematic and is not adversarial.

Recruitment and Retention of Nurses and Physicians

The nurse recruiting function is performed by the former Hospital DON. She has held this position for two years but has been with the system 28 years. She is the "subject matter expert" who analyzes all applications she receives from HR and scores them for years of experience, education, by specialty, and veteran status. She then places positions on a "cert list," either beginner, experienced, or advanced based on the score assigned. Only 10 candidates at a time can be placed on the cert list. Newly hired employees who do not pass the probation period or whose employment has been terminated go back on the list for reconsideration for up to six months. County HR only sends 10 candidates for consideration at a time. It typically takes between three to four months to hire a registered nurse (RN) due to the County rules and merit system, even though the County allows "continuous recruitment" of RNs. This means that HSD is authorized to post RN positions at all times and are not required to create vacancies for specific jobs. The biggest challenge and problem they face is when they need to justify hiring an RN with special skills for positions that are not "general" patient care-related skills.

As a result of not being able to respond to candidates quickly, they lose candidates every month. In response, HSD has created a Per Diem Pool of 250 RNs. The nurses in the Pool get experience, but don't get jobs that provide benefits and leave after a few years. Some Pool RNs do stay because they have another job with benefits. CCHS Nursing believes that they cannot compete with Kaiser Permanente's starting salaries. That being said, Nursing Leadership stated that RNs see CCHS as a good place to work with great benefits even though salaries are lower compared to Kaiser and other hospitals. The range for RNs is $36.40 to $48.00 per hour. Per Diems are $66 per hour. Kaiser pays $52 per hour with two years experience. The pension plan is good. There is a high level of teamwork with physicians and RNs are empowered and have a high level of autonomy. CNA just settled the Kaiser contract with a 5% increase per year for three years.

Physician panel sizes have increased even more so with the economy. Northern California Kaiser has started to recruit for more primary care physicians, and they are recruiting CCRMC Family Medicine residents and other physicians. Concern was expressed regarding CCHS ability to deliver on the mission in the current HR environment in the County. There is also concern about a compensation gap. New graduates start at $120,000 at CCRMC and can get to $170,000 over 15 years. Kaiser is starting new graduates at $180,000 with a benefit package that is not that dissimilar to the County's. But it also includes a sign-on bonus for primary care, loan repayment, and profit sharing. All CCRMC OB staff are employed. Primary care physicians are represented by PDOCC. HSD is currently recruiting for a

replacement Pathologist and has had 50 responses. HSD is also recruiting for an orthopedic physician and a podiatrist, both new positions.

Some physicians prefer to be independent contractors because they can work like employees and get more upfront money. However, they have no health care benefits, which is a problem for some. The current physician recruiter believes that the County ignores Independent Contractor designation rules and guidelines.

At this time there is no designated recruiting budget. There is one budget for HSD, and it is managed and controlled by the COO/CFO.

HSD Physician Leadership said that HSD's mission is to serve a population in the County who is in need. A self-selected group of Family Medicine physicians stay because of the mission. CCRMC is viewed as a secure place to be, isolated from financial restrictions. The average age of the medical staff is under 40 years old. The Residency program attracts very good residents. It is believed that there is a need to get salary, pension, and benefits outside of County bureaucracy. In addition, the following changes are necessary to attract and retain physicians into the future:

- Strengthen the Residency program since it is well regarded and affiliated with UC Davis. It has 600 applications for 13 spots.
- Do not furlough physicians.
- Incentivize Family Medicine clinic physicians. Possibly create a stipend within the contract.

The real competition for physicians and staff are Kaiser, John Muir, and Sutter, not other counties who the County compares benefits and pay. It is important for CCRMC compensation and benefits to match up with the true competition.

It was noted that other counties face the same competitive staffing challenges to a greater or lesser degree than what CCRMC faces. It is believed that the Pension and Retiree health plan are primarily "golden hand cuffs" and not an incentive for hiring graduating physicians. From a budget standpoint, labor costs make us "prisoners of our system" and linked to these are expensive benefits. Total compensation needs to be reviewed.
It is also important to link RN and other nursing staff recruitment with physician recruitment so that newly hired physicians have the appropriate staff support when hired.

Total Compensation

The Hay Group completed a Compensation and Benefits survey in March of 2010[9] that utilized 2009 compensation data. The study compared compensation related programs with nine Bay Area comparison counties. The following observations regarding the Health Plan and Pension plan the County provides its employee were included in the report:

[9] Hay Group. Contra Costa County Final Report. Custom Salary Survey & Benefits Costs Analysis. March 2010.

Contra Costa – Health Care[10]

- In the health care area, Contra Costa currently offers one of the most competitive health and dental plans compared to other Bay Area counties with regards to employer funding and the health and dental employee costs are among the lowest.
- Compared to the typical Bay Area county, Contra Costa funds a higher than average amount for family health care coverage ($14,744). This high amount is a function of Contra Costa's generous cost-sharing arrangement (98% employer/2% employee).
- Contra Costa's employee cost-sharing percentage of 2% is well below the average of 12.9% for the other counties.
- Six of the nine counties surveyed charge the employees nothing for dental insurance while Contra Costa charges 2% of full premium.

Contra Costa – Retirement

- Contra Costa currently provides a competitive retirement program when compared to the other Bay Area counties.
    - The County offers an employer contribution of 27% of annual salary (including POB rates), which is the highest in the Bay Area.
    - The annual employee share is 3.0%, which is in the lower quartile.
- The Contra Costa plan employer cost ranks the highest in the market and provides the second highest funding level of the counties surveyed.
- Contra Costa charges employees the third lowest level of contribution.

When salaries were added to overall benefit costs, the Hay Study indicated that Contra Costa County had the highest Employee Total Cost of all the counties in the survey. Overall benefit costs were the drivers behind this.

County HR reviews of hospital classification conclude that HSD compensation is comparable with private hospitals. Analysis of HSD department payroll data indicate that benefit costs may be higher than what was presented in the Hay Report and will require additional analysis to clarify the current benefit cost. Additional stage 3 analysis will also include the following: determine cost of overtime and registry, productivity standards, and benefits costs.

It is HMA's assessment that the current wage and benefit package is more conducive to the retention of staff than to the recruitment of new staff. The longer term, strategic implication of this approach needs to be analyzed further. An older workforce brings some stability but also some additional cost such as increased FMLA usage and higher average wages that drive up benefit costs and overall labor costs. This will be explored further in the Stage 3 Report.

[10] Contra Costa County has negotiated major changes to health care cost-sharing since this survey data was collected.

IV. Maximizing Federal Reimbursements

This section provides an overview of strategies and programs designed to maximize Federal reimbursements to the County for health care services for Medi-Cal recipients and uninsured residents and Contra Costa County's existing maximization strategies. In the Stage 3 Report, HMA will provide a description of eligibility requirements for any potential new revenue sources and an evaluation of Contra Costa County's ability to obtain such funding.

The Medicaid program, in terms of funding, is a Federal-state partnership. Within limits, the Medicaid program allows for the non-Federal share of Medicaid expenditures to be made by local government entities. The extent to which each party contributes varies by state and is determined by a complex formula outlined in the Federal statute. In general, the lower the average income of a state, the more the Federal government contributes compared to what the state is required to pay.

As a general rule, states seek to adopt strategies to maximize Federal revenues. These strategies take multiple forms, including the following:

- Putting state or local services that could otherwise be funded by Medicaid under the Medicaid umbrella in order to claim Federal funds. This is a maximization strategy because the state is replacing state/local dollars with Federal dollars.
- Raising rates to providers (thus increasing the total size of payments) while funding the increase with a tax on the same providers or by using local funds to pay for these higher rates. This is a maximization strategy because more Federal funds are coming into the system without the state having to contribute more from the general fund.
- Expanding eligibility or payments through a waiver in order to draw down Federal matching funds. This is a maximization strategy because the new costs are matched by the Federal government, and states tend to do this only when there is an identifiable source of non-Federal share such as intergovernmental transfers, a new tax, or earmarked funds (e.g., funds from the various tobacco settlements).

It can be argued that the County has had more success in Federal maximization compared to other counties.

As is clear in the above explanation, Federal maximization is generally a state strategy. However, a number of states, including California, have joined forces with local entities in implementing these strategies. In California, a significant funding burden falls on counties and public hospitals because of the way services have historically been structured and the counties' responsibility for covering the indigent. Contra Costa is no exception, and it can be argued that the County has had more success in Federal maximization compared to other counties.

One reason for this is the fact that the County has a public hospital, the CCRMC. As a public hospital, CCRMC can participate in intergovernmental transfers (IGTs) and certification of public expenditures (CPEs), both of which enable the County to leverage Federal funds as a participant in funding the

Medicaid program. In addition, as a public entity, the CCRMC can be reimbursed at cost. For uncompensated care the maximization potential is even greater because in California, unlike other states, this care is funded at 175% of cost in the Disproportionate Share Hospital (DSH) program up to the state's total DSH allotment.

Contra County has established a Federally Qualified Health Center (FQHC) for its outpatient services, providing it with the highest rate structure allowable in the Medi-Cal program, with built-in Federally required cost of living increases. Further, Contra Costa County is one of six grandfathered provider-based FQHCs, which provides an even higher rate by allowing the costs of the hospital to be allocated to the FQHC.

In addition, the County operates its own health plan, which has the majority of Medicaid enrollments in Contra Costa. While Contra Costa is at risk for the cost of services, the State is required to pay the County an actuarially-based rate that is above the cost of providing care. The health plan enrolls its members in three different networks, but the predominant one is the CCRMC and the system of County health centers. These health centers are FQHCs with a relatively high reimbursement rate. With the FQHC, the health plan is required by State and Federal law to pay its FQHC at the State rate it would pay a private physician, and the County FQHC then bills the State the difference between the plan rate and the FQHC's prospective payment rate. This means the County has leveraged its market share with its public health center status to maximize Medicaid reimbursement.

Another important strategy to maximize Federal funds, as provided under the 2005 hospital-financing waiver, was the Health Care Coverage Initiative (HCCI). This program allowed 10 counties to draw down Federal funds to support programs they would otherwise be paying for with local dollars in order to satisfy their Section 17000 obligation. As one of the 10 original counties, Contra Costa has been successful in pursuing this strategy. The Bridge to Reform waiver approved in 2010 expands this opportunity and counties can cover additional individuals under the new Federal budget neutrality construct. The County has already submitted its application. The HSD has asked for a significant expansion, as explained in the Low Income Health Program (LIHP) section. This program replaces local funds with Federal funds, thus representing a significant maximization strategy.

Other maximization strategies undertaken by the County include placing a variety of health functions under the CCRMC hospital license, including public health nursing, in order to draw down the maximum possible reimbursement. The integration of health functions under the HSD umbrella allows for such strategies to be successful.

In short, the County has done a good job of maximizing Medicaid reimbursement for health services. The County should continue to take advantage of new opportunities as they arise.

V. Impact of the LIHP

On November 2, 2010, the Centers for Medicare and Medicaid Services (CMS) approved an extension to California's Section 1115 waiver. The new waiver continues the 2005 hospital waiver and is called the "Bridge to Reform." The waiver provides about $10 billion in Federal funds for Medi-Cal, including $3.3 billion for the State's public hospital safety net, $2.9 billion for coverage expansions for low-income uninsured individuals, and $3.9 billion for uncompensated care costs. CMS is making funds available to California through a combination of mechanisms:

- Giving budget neutrality "credit" for expanding to new populations covered under the Patient Protection and Affordable Care Act (ACA), even if these expansions are not statewide and enrollees are not given a full benefit package;
- Counting savings from existing managed care waivers that are being folded into the 1115; and
- Carrying forward special pools from prior waivers, including the Selective Provider Contracting Program (SPCP), which had been folded into the 1115 waiver that was approved in 2005.

While several aspects of the waiver will benefit Contra Costa County, this section focuses on the Low Income Health Program (LIHP), a significant element from the point of view of financing the County's health care system.

Low Income Health Program

In the previous waiver, there was a capped Coverage Initiative (CI) component funded as part of the Safety Net Care Pool. Funds were constrained by Federal budget neutrality rules, with the result being that only 10 counties, including Contra Costa, could participate. The State chose these counties on a competitive basis.

The main financial benefit, from the point of view of expansion capacity and maximizing revenue, is that CMS will treat County-level expansions covering adults 19-64 who have income at or below 133 percent of the FPL as if they were part of the State plan. Because the ACA created a state plan option for expanding coverage to this population, CMS can approve this expansion without requiring budget neutrality, resulting in no cap on available Federal funding for this group. This means the amount of Federal funds flowing to the County will increase.

The CI component of the new waiver is described as two separate options: a Medicaid Coverage Expansion (MCE) and a Health Care Coverage Initiative (HCCI). Requirements for the two options are summarized in the following table.

Table V.1: Medicaid Coverage Expansion (MCE) Summary

	Medicaid Coverage Expansion
Description	Adults age 19-64, not otherwise eligible for Medicaid or CHIP, not otherwise precluded because of immigration status
Upper Income Limit	133% of the FPL, or lower at County option
Enrollment Cap Allowed?	Yes, but HCCI must be capped before MCE
Benefit Package	Core Benefits (if included in California State Plan) • Medical equipment and supplies • Emergency care (including transportation) • Acute inpatient hospital • Laboratory • Mental health* • Prior-authorized non-emergency medical transportation • Outpatient hospital services • Physical therapy • Physician services (including specialty care) • Podiatry • Prescription and limited non-prescription medications • Prosthetic and orthotic appliances and devices • Radiology
Additional Benefits Allowable?	Yes, with CMS approval, except excluded benefits listed below
Excluded Benefits	• Organ transplants • Bariatric surgery • Infertility related services

* In cases where the enrollee is diagnosed by an MCE participating provider, within their scope of practice, with a diagnosis specified in the most recent version of the Diagnostic and Statistical Manual, the enrollee must have a significant impairment in an important area of life functioning or a probability of significant deterioration in an important area of life functioning and the intervention must be reasonably calculated to significant diminish the impairment or prevent significant deterioration.

Table V.2: Health Care Coverage Initiative (HCCI) Summary

	Health Care Coverage Initiative
Description	Adults age 19-64, not otherwise eligible for Medicaid or CHIP, not otherwise precluded because of immigration status
Lower/Upper Income Limit	Between MCE (if offered) and 200% of the FPL, or lower at County option
Enrollment Cap Allowed?	Yes
Benefit Package	Core Benefits (if included in California State Plan) • Medical equipment and supplies • Emergency care (not including transportation) • Acute inpatient hospital • Laboratory • Outpatient hospital services • Physical therapy • Physician services (not including specialty care) • Prescription and limited non-prescription medications • Prosthetic and orthotic appliances and devices • Radiology
Additional Benefits Allowable?	Yes, with CMS approval, except excluded benefits listed below
Excluded Benefits	• Organ transplants • Bariatric surgery • Infertility related services

Impact on Contra Costa

Contra Costa submitted its LIHP application to the State on February 14, 2011. In this application, the County describes plans for implementing MCE and HCCI. Because the County currently covers adults 18-64 years with income at or below 200 percent FPL in their LIHP without an enrollment cap, this waiver provision does not create a new eligibility group. However, an increase in enrollment is anticipated. The County's LIHP application to the State indicates an expected HCCI enrollment increase of 18% during the first program year, 10% growth in program year 2, and 5% growth each in year 3 and 4.

Table V.3: Estimated LIHP Enrollees by Program Year (PY)

Average Monthly Enrollment	MCE 0-133% FPL	HCCI 133-200% FPL	Total	% Growth
11/1/10	8,200	3,000	11,200	
PY 1 11/10 to 10/11	9,714	3,500	13,214	18.0%
PY 2 11/11 to 10/12	10,685	3,850	14,535	10.0%
PY 3 11/12 to 10/13	11,220	4,042	15,262	5.0%
PY 4 11/13 to 10/14	11,781	4,245	16,026	5.0%

Source: Contra Costa County Low Income Health Program Application dated January 25, 2011.

While the County's projected enrollment growth during the first three years appears aggressive without a major outreach effort, MCIC[11] data indicates that the County has an estimated 30,000 uninsured U.S. citizens and eligible immigrants 18-64 years with income under 200% FPL. This indicates that the 11,000 MCE and HCCI enrollees (as of November 2010) represent a third of the potentially eligible population. By the end of the third program year, in late 2013, Health Benefit Exchange outreach and information to the general population about the individual mandate will likely encourage many unenrolled persons in this population to choose to enroll in Medicaid or the Exchange.

The County Application shows total expenditures by program year of $103 million for the first year (ending October 31, 2011), $113.4 million, for the second year (ending 10 October 31, 2012), $119 million for the third year (ending October 31, 2013) and $125 million for the fourth year (ending October 31, 2014). The County estimates an average per member per month cost of $650 for the four program years. The applications' enrollment and cost estimates are summarized in the following tables.

[11] Metropolitan Chicago Information Center (www.MCIC.org). In the first report, MCIC provided geographic allocations to counties and zip codes based on state-level 2008-2009 US Census Current Population Survey (CPS) Annual Social and Economic Supplements data adjusted by the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured to more accurately reflect poverty level calculations. Estimates reflected state Medicaid enrollment totals as reported by state Medicaid agencies. Estimates also reflected data from the Department of Homeland Security to correct for the undercount associated with citizenship status and to accurately represent the undocumented resident population who are ineligible for Medicaid or coverage through Health Benefit Exchanges.

Table V.4: Program Year 1 Enrollment and Cost Estimates

Month	MCE	HCCI	Combined	PMPM	Capitation
Nov-10	9,714	3,500	13,214	$ 650.00	$8,589,100
Dec-10	9,714	3,500	13,214	$ 650.00	$8,589,100
Jan-11	9,714	3,500	13,214	$ 650.00	$8,589,100
Feb-11	9,714	3,500	13,214	$ 650.00	$8,589,100
Mar-11	9,714	3,500	13,214	$ 650.00	$8,589,100
Apr-11	9,714	3,500	13,214	$ 650.00	$8,589,100
May-11	9,714	3,500	13,214	$ 650.00	$8,589,100
Jun-11	9,714	3,500	13,214	$ 650.00	$8,589,100
Jul-11	9,714	3,500	13,214	$ 650.00	$8,589,100
Aug-11	9,714	3,500	13,214	$ 650.00	$8,589,100
Sep-11	9,714	3,500	13,214	$ 650.00	$8,589,100
Oct-11	9,714	3,500	13,214	$ 650.00	$8,589,100
Year 1	**9,714**	**3,500**	**13,214**		**$103,069,200**

Table V.5: Program Year 2 Enrollment and Cost Estimates

Month	MCE	HCCI	Combined	PMPM	Capitation
Nov-11	10,685	3,850	14,535	$ 650.00	$9,447,750
Dec-11	10,685	3,850	14,535	$ 650.00	$9,447,750
Jan-12	10,685	3,850	14,535	$ 650.00	$9,447,750
Feb-12	10,685	3,850	14,535	$ 650.00	$9,447,750
Mar-12	10,685	3,850	14,535	$ 650.00	$9,447,750
Apr-12	10,685	3,850	14,535	$ 650.00	$9,447,750
May-12	10,685	3,850	14,535	$ 650.00	$9,447,750
Jun-12	10,685	3,850	14,535	$ 650.00	$9,447,750
Jul-12	10,685	3,850	14,535	$ 650.00	$9,447,750
Aug-12	10,685	3,850	14,535	$ 650.00	$9,447,750
Sep-12	10,685	3,850	14,535	$ 650.00	$9,447,750
Oct-12	10,685	3,850	14,535	$ 650.00	$9,447,750
Year 2	**10,685**	**3,850**	**14,535**		**$113,373,000**

Table V.6: Program Year 3 Enrollment and Cost Estimates

Month	MCE	HCCI	Combined	PMPM	Capitation
Nov-12	11,220	4,042	15,262	$ 650.00	$9,920,300
Dec-12	11,220	4,042	15,262	$ 650.00	$9,920,300
Jan-13	11,220	4,042	15,262	$ 650.00	$9,920,300
Feb-13	11,220	4,042	15,262	$ 650.00	$9,920,300
Mar-13	11,220	4,042	15,262	$ 650.00	$9,920,300
Apr-13	11,220	4,042	15,262	$ 650.00	$9,920,300
May-13	11,220	4,042	15,262	$ 650.00	$9,920,300
Jun-13	11,220	4,042	15,262	$ 650.00	$9,920,300
Jul-13	11,220	4,042	15,262	$ 650.00	$9,920,300
Aug-13	11,220	4,042	15,262	$ 650.00	$9,920,300
Sep-13	11,220	4,042	15,262	$ 650.00	$9,920,300
Oct-13	11,220	4,042	15,262	$ 650.00	$9,920,300
Year 2	**11,220**	**4,042**	**15,262**		**$119,043,600**

Table V.7: Program Year 4 Enrollment and Cost Estimates

Month	MCE	HCCI	Combined	PMPM	Capitation
Nov-13	11,781	4,245	16,026	$ 650.00	$10,416,900
Dec-13	11,781	4,245	16,026	$ 650.00	$10,416,900
Jan-14	11,781	4,245	16,026	$ 650.00	$10,416,900
Feb-14	11,781	4,245	16,026	$ 650.00	$10,416,900
Mar-14	11,781	4,245	16,026	$ 650.00	$10,416,900
Apr-14	11,781	4,245	16,026	$ 650.00	$10,416,900
May-14	11,781	4,245	16,026	$ 650.00	$10,416,900
Jun-14	11,781	4,245	16,026	$ 650.00	$10,416,900
Jul-14	11,781	4,245	16,026	$ 650.00	$10,416,900
Aug-14	11,781	4,245	16,026	$ 650.00	$10,416,900
Sep-14	11,781	4,245	16,026	$ 650.00	$10,416,900
Oct-14	11,781	4,245	16,026	$ 650.00	$10,416,900
Year 2	**11,781**	**4,245**	**16,026**		**$125,002,800**

Currently, the County receives $15.25 million per year in Federal match on the HCCI program. With a 50% Federal match rate, this results in match on the first $30.5 million of County HCCI spending under the old waiver. County funds support all spending over this amount. The new waiver allows for uncapped match on MCE expenditures. In addition, the County requested Federal funds for HCCI spending that assumes 50% Federal match for all spending. The state has not yet awarded funds to Contra Costa for the HCCI portion of the new waiver program. If Federal match on HCCI spending is approved as the County requested, the County would receive 50% Federal match on all LIHP spending. The County Fiscal Year 2011-2012 budget's $40 million increase in Federal LIHP funds appears to assume

match on all LIHP spending. As shown in the next table, the County would be able to cover more people for less cost to their budget compared to the base year. This positive variance ranges from $20.6 million in year one to $9.7 million in year four.

Table V.8: LIHP Spending and Federal Match Estimates, Dollars in Millions

	Ave. Mo Enrollment	PMPM	Annual Spending	Chg From Base	Federal Funds	Chg From Base	Net Change
LIHP Base	11,200	$ 650.00	$ 87.4		$ 15.3		
LIHP PY 1	13,214	$ 650.00	$ 103.1	$ 15.7	$ 51.5	$ 36.3	$ 20.6
LIHP PY 2	14,535	$ 650.00	$ 113.4	$ 26.0	$ 56.7	$ 41.4	$ 15.4
LIHP PY 3	15,262	$ 650.00	$ 119.0	$ 31.6	$ 59.5	$ 44.3	$ 12.7
LIHP PY 4	16,026	$ 650.00	$ 125.0	$ 37.6	$ 62.5	$ 47.3	$ 9.7

One significant change in the new waiver program is the requirement that county LIHPs reimburse out of network providers for emergency services at 30% of the Medi-Cal rate for those services. Although a significant policy change, this may not be a significant cost increase, since 30% of Medi-Cal is probably less than the cost CCRMC would incur to provide this care.

From a clinical perspective, the County's plans to implement LIHP waiver provisions will require additional primary care provider capacity to serve the enrollment growth of 18%.

The County's LIHP application requests a retroactive effective date of November 1, 2010. Additional program aspects contained in the County's application include:

- A closed MCO provider network with mental health services through CCHP.
- MCE income eligibility of 133% of the FPL.
- HCCI income eligibility of 133-200% of the FPL.
- Expected enrollment caps triggered when HCCI spending hits $33 million and, after that, when MCE spending reaches $92 million.
- No retroactive eligibility.
- In addition to minimum core benefits, dental emergency services will be provided to MCE and HCCI enrollees in year one.
- Beginning in year two, add-on mental health services will be included for HCCI enrollees.
- A primary care provider to enrollee ratio of 1:1900 for both programs with a network of 131 primary care providers and 3,017 specialty care providers.
- Cost-based MCE and HCCI payments funded with Certified Public Expenditures (CPEs) for the first year. Actuarially sound rates funded with IGTs will be used for FY 2012 and beyond.

Seniors and Persons with Disabilities

The new waiver also changes the method by which Medi-Cal services are delivered to Seniors and Persons with Disabilities (SPD) who do not have Medicare coverage. SPD care is currently provided fee-for-service (FFS) to the majority of enrollees in Contra Costa. In Calendar Year 2008, 11,366 of the

County's 15,725 SPD enrollees had FFS coverage with the remaining 4,359 in managed care.[12] Beginning mid-2011, FFS SPD enrollees will be mandatorily enrolled with organized delivery systems such as CCHP.

The Contra Costa Health Plan (CCHP) is preparing to enroll the county's SPD population. Of the 15,725[13] that were enrolled in calendar year 2008, the County's budget provides for 7,830 to choose CCHP. SPDs without Medicare coverage will have a choice between CCHP and Anthem Blue Cross. Those that do not choose a plan will be auto-enrolled into one of the plans.

Prospective Role of CCHP

The Contra Costa Health Plan (CCHP) will grow in importance as provisions of the new section 1115 waiver are implemented over the following months. As explained above, enrollment is expected to increase both for the LIHP and also because enrollment of the SPD population in managed care will now be mandatory. In addition, the changes to Medicaid in 2014 will bring even more Medicaid eligibles into the picture as well as more individuals who will be purchasing insurance through the Exchange. This means that the CCHP has to be prepared both for an increase in covered lives as well as a change in the type of population served.

In many respects, the most significant short-term challenge is the enrollment of the SPD population. As stated, this population is predominantly served in the FFS program, although some SPDs are already enrolled in CCHP. Looking ahead to the mandatory enrollment requirement, CCHP expects 80 percent of those who choose a plan to choose CCHP, and they expect to get all default enrollments based on quality scores. Of the SPDs who will be mandatory under the waiver, 64% of them already have established relationships with providers in the CCHP networks, including both County physicians and contracted physicians. The CCHP is endeavoring to include other providers into the network in order to better serve the potential SPD population.

While the LIHP will represent an enrollment increase for the LIHP population, there really are no issues related to comparison or competition with other health plans and/or networks. This is because the only plan available to LIHP enrollees will be the CCHP. However, HMA considers it imperative that the CCHP think of itself as competing with other plans for future enrollees after 2014. When the Federal Medicaid expansion takes place, the County will no longer be able to restrict enrollment to the CCHP. If California keeps Medi-Cal enrollees in a two-plan model, CCHP will be competing with Blue Cross for individuals who would have otherwise been in the MCE. Individuals in the HCCI would be receiving subsidies to purchase coverage on the exchange, so there will be multiple plans to choose from. If MCE and HCCI enrollees' experiences with CCHP are less than ideal, this may lead to a migration away from CCHP in the future.

[12] Medi-Cal Acuity Study – Seniors and Persons with Disabilities, Mercer for the California HealthCare Foundation, September 28, 2010.
[13] Medi-Cal Acuity Study - Seniors and Persons with Disabilities, Mercer for the California HealthCare Foundation, September 28, 2010.

VI. Preliminary Steps in Creating Patient-Centered Medical Homes

This section presents initial options for the establishment of a "medical home system of care" that would best serve the expanding Medi-Cal population, uninsured, and other medically vulnerable residents of the County.

Introduction

Patient-Centered Medical Home (PCMH) systems of care assure that patients have a source of primary care which functions as the central point for coordinating care around the patient's needs and preferences. The medical home team, consisting of the primary care provider and supporting staff, coordinates information among all of the various caregivers, including the patient, family members, other non-professional caregivers, specialists, and other health care service providers. Each PCMH within the system of care is patient-centered and accessible, provides a continuous healing relationship with a primary care provider, comprehensively meets patients' total health care needs, coordinates the delivery of care, and accomplishes all of these features with teams of individuals functioning at the top level of their license and qualifications. Quality and safety are hallmarks of a well-functioning PCMH.

The PCMH is a key building block of an Accountable Care Organization (ACO), which is intended to deliver on the Triple Aim[14] of improved outcomes across a population, lower overall cost, and a better patient experience. An ACO ought to deliver care more efficiently. Efficiency, however, is not an attribute per se of the PCMH but rather is an intended outcome. Although improved quality and outcomes have been demonstrated when implementing PCMH, at least for underserved populations,[15] cost savings are not a proven outcome.

PCMH Models

There are various PCMH constructs, each intended to make these core attributes more granular and these specific constructs often add extra components to the medical home. Examples for CCHS to consider include:

Joint Principles of the PCMH

The Joint Principles of the PCMH have been endorsed by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association.[16] These seven principles are:

- A Personal physician
- Physician directed medical practice
- Whole person orientation
- Care that is coordinated and/or integrated

[14] The Triple Aim: Care, Health, And Cost. Donald M. Berwick, Thomas W. Nolan and John Whittington, Health Affairs, 27, no. 3 (2008): 759-769.

[15] Stuart Guterman, Stephen C. Schoenbaum, M.D., M.P.H., Karen Davis, Ph.D., Cathy Schoen, M.S., Anne-Marie J. Audet, M.D., M.Sc., Kristof Stremikis, M.P.P., and Mark A. Zezza, Ph.D. High Performance Accountable Care: Building on Success and Learning from Experience. April 14, 2011. The Commonwealth Fund sxg@cmwf.org.

[16] http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home

- Quality and safety
- Enhanced access
- Payment that appropriately recognizes the added value provided to patients who have a PCMH

National Committee for Quality Assurance PCMH Recognition Program

National Committee for Quality Assurance (NCQA) has a PCMH recognition program[17] that assesses health centers and practices against three levels of PCMH standards. In 2011, NCQA revised the PCMH standards for 2011 to elevate the level of accountability and emphasize the patient-centered and team-based care aspects of care. The revised standards for accreditation as a PCMH include the following:

- Access and Continuity
- Identify and Manage Patient Populations
- Plan and Manage Care
- Self-Management Support
- Track and Coordinate Care
- Performance Measurement and Quality Improvement

Joint Commission's Primary Care Home Option

The Joint Commission is developing a Primary Care Home option for accreditation.[18] Standards are being developed which will complement their existing Ambulatory Care Accreditation Program.

Safety Net Medical Home Initiative

Beginning in April 2009, the Commonwealth Fund, Qualis Health, and MacColl Institute for Healthcare Innovation at the Group Health Research Institute are in the process of implementing a Safety Net Medical Home Initiative[19] for safety net primary care health centers to become PCMHs. The pilot continues through April 2013. While this initiative did not develop a mechanism to certify PCMHs, it does serve as a model for transforming safety net health care delivery. The Initiative calls for partnerships between safety net providers and community stakeholders to work together towards a new model of primary care delivery that is recognized and rewarded for its holistic approach to patient care. Policy activation is critical in this transformation, and all partners in this Initiative are expected to participate in Medicaid and other policy reform efforts in their respective regions. Thus far the Initiative's efforts have made a difference in quality outcomes for safety net populations.

PCMH Payment

Various states have defined the features of a PCMH for payment mechanisms under Medicaid. This is generally done through a per member per month payment for primary care case management

[17] The Primary Care Development Corporation has developed a how-to manual for safety net providers to apply for and obtain NCQA's PCMH recognition. http://www.pcdcny.org/index.cfm?organization_id=128&section_id=2047&page_id=8777

[18] www.jointcommission.org/accreditation/pchi

[19] Safety Net Medical Home Initiative. Transforming Safety Net Clinics into Patient Centered Medical Homes. www.qhmedicalhome.org/safety-net

Next Steps

Contra Costa will need to choose a particular model and then conduct a gap analysis between the current delivery system and the goals of the model.

Contra Costa will also need to decide if capacity exists to provide all populations with the PCMH model of care. Although the benefits of this model of care are clear and nearly self-evident, it is also true that higher risk populations will benefit to a greater degree. Contra Costa may decide that for certain lower-risk populations, episodic care will be delivered without a continuous relationship with a medical home team. The episodic model may make sense for young, healthy patients who are likely to be seen less than once a year. Alternatively, CCHS may decide to provide a PCMH to all patients who use or are assigned to the CCHS but "weight" the patients so that the young, healthy patients cause less "crowd out" on the panels. These choices will be discussed in more detail in the next phase of the report.

Contra Costa's outpatient practices have begun the process of establishing PCMH practices. Examples of attaining features of a PCMH include:

- Patients are seen by the same provider over time, creating an environment for continuous healing relationships and defining a historical panel.
- Providers are notified when their patients are admitted and discharged from CCRMC.
- Electronic access is available across the system to radiology and laboratory results and medication profiles.
- EHR implementation across the system is in the planning stage.
- Dictated CCRMC and ED notes are available across the system.
- A nurse advice line with the capability of scheduling appointments and providing lab results is available 24/7.
- The ambulatory setting has a home grown registry for patients with diabetes.
- Traditional primary care is being integrated with mental health services in a pilot project at Concord.

The table below summarizes the further transitions CCHS will need to make to realize the benefit of PCMH system of care.

Table VI.1: Critical Transitions from Current Care to PCMH Care

Current Care	PCMH Care
My patients are those who have made appointments to see me.	Our patients are those who are in a panel, assigned to our PCMH.
Patients' chief complaints or the reasons for visit determine care.	We systematically assess all our patients' health needs to plan care.
Care is determined by today's problem and time available today.	Care is determined by a proactive plan to meet patient needs, often without visits.
Care varies by scheduled time and the memory or skill of the doctor.	Care is standardized according to evidence-base guidelines.
Patients are responsible for coordinating their own care.	A prepared team of professionals coordinates all patients' care.
I know I deliver high quality care because I am well trained.	We measure our quality and make rapid changes to improve it.
Acute care is delivered in the next available appointment or through walk-in procedures with long waits.	Acute care is delivered through open access mechanisms and non-visit contacts.
It's up to the patient to tell us what happened to them.	We track tests and consultations and follow-up after ED and hospital.
Clinic operations center on meeting the physician's needs.	A multidisciplinary team works at the top of our licenses to serve patients.

Building on the present strengths and the organizational goals of CCHS, potential high yield areas to address might include:

- Assure all stakeholders have a thorough understanding of the capabilities and weaknesses of the EPIC EHR.
    - EPIC has a module for FQHCs. Does CCHS intend to use this module?
    - Can EPIC deliver reliable electronic population health management functions (patient registry functions)?
    - How difficult will it be to capture patient specific measures? Can it track patients' quality measures throughout the health system?
    - Does it have built-in Clinical Decision Support tools or automated alerts for needed care?
- Ensure that panel assignment to a medical home team is connected to operations throughout the system (e.g. third party assignment of patients such as managed care assignments, scheduling, quality measure reporting, business rules for outreach, etc.)
- Develop robust population health management capabilities (typically accomplished through the use of a patient registry) that are interfaced with EPIC (minimal data entry and minimal need for provider to access two electronic systems).

- Create passive (i.e., automatic) notification to medical home teams of ED visits and hospital discharges.
- Develop system wide quality measures and goals for case management such as coronary artery disease, diabetes, ADHD, well-child care, and prenatal care.
- Develop care management roles and technology-supported activities for case management that will drive the attainment of the quality goals (e.g. software that will pull in lab data and create a list of patients with diabetes for outreach who have not had an lipid panel in over a year).
- Strengthen the medical home team to include additional case management and care coordination.
- Provide after-hours access in non-ED settings for all patients.
- Further integrate primary care and mental health integration.

Conclusion

Based on HMA's review, the County has been very creative in terms of identifying and maximizing funding related to its CCRMC, the County health centers, and other providers. In fact, there are few if any counties in California that have been more creative within the rules and leveraged county investment to the greatest extent possible. There are a number of initiatives still moving forward in response to the latest waiver, and it is evident from HMA's interviews of key informants that the County is knowledgeable of the opportunities and taking the appropriate steps to take full advantage of those opportunities.

Over time, the County has achieved a vertically integrated system that is very comparable to what the latest national health reform is hoping to foster. The pieces are in place to have a seamless system of care for vulnerable populations that provides the right care at the right place at the right time. The system relies heavily on Family Medicine and on expanding their scope of service based on additional training and experience. This would be expected to yield a cost-effective medical system. The addition of integrating the more traditional health department areas into the CCRMC and the County health centers has yielded good results in terms of funding and collaboration. HMA will continue to look at mental health for opportunities to support better integration with physical health, while acknowledging that such integration is made challenging by the how services are funded in California.

In the future, it is doubtful that a public system will be able to meet all the needs of the vulnerable populations without at least some assistance from the private sector. As an example, San Francisco has developed a collaborative approach that is beneficial for all parties involved. We will continue to review the collaborations—both those already in existence and those that are planned—in order to understand opportunities for Contra Costa County.

A fully integrated system must have the ability to continually push towards excellence. The tension involved in private physicians, hospitals, health plans, and advocates working together, while at times creating some inefficiency, can promote excellence through the process of partners challenging each other. We need to continue to explore with Contra Costa how they maintain the drive for excellence and transparency in a somewhat closed system.

Finally, the system is reviewing opportunities related to their planned installation of EPIC, electronic health record (EHR) system, in an expedited manner; the use of a closed unit for psychiatric care or expanded obstetrical service; and some unused surgical rooms. HMA will further examine these areas to understand the potential revenue impact.

With the expansion of Medi-Cal and the launch of Health Insurance Benefit Exchanges in 2014, a majority of residents will have coverage, and the Contra Costa system is generally well positioned with FQHCs, a health plan, etc. to deliver cost-effective, high-quality health care. As we move toward the completion of Stage 3, HMA will further explore the cost structure as this will become more critical post-health reform when most people will have coverage.

In mid-June, HMA will submit the third and final report to Contra Costa County. The Stage 3 Report will include:

- A final work plan for implementing a "medical home system of care."
- A management review of Health Services Department programs that identifies options for structural, organizational, and program changes to contain costs and maximize return on County investments
- An evaluation of alternative governance structures that could enhance the County's ability to provide appropriate, accessible, and effective health care services to its customers
- An evaluation of local labor market conditions, medical staff recruitment and retention strategies, labor agreements, and the use of contracted vendors and options to ensure access to appropriate and effective medical services at the least cost to the County
- Options for changes in the County's current procedures for data collection and analysis and in the use of performance indicators, program outcomes, and customer satisfaction reports that will enhance the County's oversight and management of its health care programs and support sustainability.
- Recommendations for changes and/or enhancements to the County's organizational capacity and policies that would enhance the County's oversight and management of its health care programs and support sustainability.

Appendix A: Acknowledgements

HMA wishes to acknowledge the support and participation of numerous individuals in the preparation of this report. Persons interviewed included representatives of the Health Services Division, County government, health care providers from all parts of the county, and labor. The time spent, information provided, and ideas generated were invaluable in assisting HMA.

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HMA

HEALTH MANAGEMENT ASSOCIATES

Sustainability Audit of the Contra Costa County Regional Medical Center and Health Centers: Stage 3 Final Report

PRESENTED TO THE
CONTRA COSTA COUNTY ADMINISTRATOR

SEPTEMBER 2011

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Table of Contents

Executive Summary

In January 2011, the Contra Costa County Administrator's Office was authorized by the Board of Supervisors to engage Health Management Associates (HMA) to conduct a sustainability audit of the Contra Costa Health Services-operated facilities: the Contra Costa Regional Medical Center (CCRMC) and County health centers. The overall goal of the audit has been to develop options for the Board of Supervisors to consider that can sustain the County's health care system, taking into account the implementation of health care reform. HMA has produced this final report that details options for the County to improve the effectiveness, efficiency, and sustainability of its health care system. The options in this document are presented in the context of health care reform as it has been enacted, both in the federal and state levels. Although in many instances the options are presented as recommendations for consideration by the Board of Supervisors, HMA acknowledges that final recommendations will move forward for implementation through resolutions enacted by the Board of Supervisors. The sections in this document cover the following topics:

- Transforming into a Patient-Centered Medical Home (PCMH) system of care;
- A management review and options to contain costs, improve financial sustainability, and continue to improve care and patient outcomes;
- An evaluation of alternative governance models and discussion of those options;
- Local labor market strategies;
- Organizational changes that are desirable and/or needed for the County to continue to implement health care reform; and
- Performance measurement and monitoring options.

A summary of the sections is presented below. Additional details are provided in the sections themselves.

Section I: Final Work Plan

Although a major undertaking, transformation to a patient-centered medical home (PCMH) model of care has been shown to improve health outcomes across populations, control cost, and improve patient experience. The County's Health Services Department has several elements of the medical home already in place, and these can provide an important starting place for continued transformation. However, there many additional elements that would need to be put into place to become a full-scope PCMH system of care. This section outlines the work needed to prioritize and implement the elements of a PCMH.

Section II: Management Review

In this section, HMA presents various options for the Board to consider that would maximize the return on its investment, including structural, organizational, and/or program changes that are needed to contain costs, increase revenues, and improve care and outcomes. This includes a number of options and opportunities for cost containment and/or service enhancement such as creating an Observation

Unit at the Contra Costa Regional Medical Center (CCRMC), decreasing the in-patient length of stay at CCRMC, maximizing Operating Room (OR) utilization and access to surgery and decrease OR cancellation rates, optimizing Emergency Department (ED) utilization and physical capacity, enhancing specialty care access, sustaining and/or increasing the volume of obstetrical deliveries, and simplifying and improving the appointment scheduling process at the health centers.

Section III: Alternative Governance Structures

In this section, HMA presents alternative governance structures for the Board to consider that could enhance the County's ability to provide appropriate, accessible, and effective health care services to its residents. While the Stage 2 report presented a preliminary discussion of alternative models, this report outlines the various arrangements and discusses the implications for cost, revenues, degree of County control, and impact on labor/management issues. Models include 1) retaining the current governance structure; 2) retaining ownership of hospital and clinics but having the hospital privately managed by an outside entity; and 3) spinning CCRMC off into a separate 501(c)(3), a private entity, or as a separate government entity such as a health district or health authority. As noted in this section, any discussions about a possible governance change should take into consideration the situation of Doctors Medical Center in San Pablo.

Section IV: Local Labor Market Conditions

In this section, HMA presents options for the Board of Supervisors' consideration regarding medical staff recruitment and retention strategies, negotiation of labor agreements, and the use of contracted vendors. The labor strategies include those related to contract negotiations, compensation, the Professional Services Unit findings, and transparency.

Section V: Organizational Changes

In this section, HMA provides options for the Board of Supervisors' consideration for changes and/or enhancements to the County's organizational capacity that would enhance the oversight and management of County health care programs and support sustainability. HMA presents options that are designed to increase transparency, accountability, and continuity and position the County to continue to draw down maximum state and federal funding as health care reform is implemented.

Section VI: Performance Measurement and Monitoring Options

Contra Costa County has already made great strides in its goal of becoming a high-performing and sustainable health care system, including investments in several quality initiatives such as Kaizen projects and supporting a fellowship for the CEO of CCRMC. In this section, HMA presents options for Board consideration that better measure performance and use its measurement process to target and monitor improvements and report on outcomes. The section includes overall principles and options for performance measurement and monitoring and specific options related to a PCMH system of care, operations, labor, and fiscal management. These options support the type of transparent and clearly

communicated performance measurement process that will be required as health care reform is fully implemented.

Introduction

In January 2011, the Contra Costa County Administrator's Office was authorized by the Board of Supervisors to engage Health Management Associates (HMA) to conduct a sustainability audit of the Contra Costa Health Services-operated facilities: the Contra Costa Regional Medical Center (CCRMC) and County health centers. The goals of the audit are to develop options for supporting both the delivery of services and fiscal sustainability of the County's health care system and to align with the implementation of health care reform.

The work of this project was divided into three stages. In Stage 1, HMA submitted an Information Memorandum with demographics and health care utilization data; an analysis of the current and future capacity of the County's programs, services, and facilities; a discussion of the Basic Health Care program; and Financial, utilization, and quality performance indicators for CCRMC and County health centers. This information laid the groundwork for the Stage 2 report.

In Stage 2, HMA produced a Preliminary Report that focused on: 1) opportunities for improving the performance of the County's health care delivery system, including inpatient, outpatient, and the Contra Costa Health Plan; 2) alternative governance structures; 3) increasing primary care capacity to care for the expected increase in the number of vulnerable patients who will be impacted by health reform; 4) the human resource functions and processes related to recruiting and retaining professional staff; 5) an overview of strategies and programs designed to maximize Federal reimbursements to the County for health care services for Medi-Cal recipients and uninsured residents; and 6) initial options for the establishment of a Patient-Centered Medical Home (PCMH) system of care.

For Stage 3, HMA has produced this report, which includes options for the Board of Supervisors to consider in determining the most cost-effective and efficient way for the County to provide care for the expanding Medi-Cal population, uninsured, and other medically vulnerable residents of the County. The report includes:

- A detailed work plan and description for how the County could transform its health care system into a full service PCMH system of care;
- Structural, organizational, and/or program options that can contain costs, improve the County's General Fund revenue picture, and improve care;
- An evaluation of alternative governance models and discussion of those options;
- Local labor market conditions and strategies for improving the County's ability to manage its workforce supply and expenditures;
- Options for changes and/or enhancements to the County's organizational structure that would enhance the Board of Supervisors' oversight and management of its health care system and will be required as health care reform is implemented; and

- Options that are aligned with the requirements of health care reform for collecting, analyzing, and using data.

Health Management Associates (HMA)

HMA is a consulting firm specializing in the fields of health system restructuring, with a particular focus on the safety net; health care program development; health economics and finance; program evaluation; data analysis; and health information technology and exchange. HMA is widely regarded as a leader in providing technical and analytical services to health care providers, purchasers and payers, particularly those who serve medically indigent and underserved populations. Founded in 1985, Health Management Associates has offices in Lansing, Michigan; Chicago, Illinois; Indianapolis, Indiana; Columbus, Ohio; Washington, DC; Tallahassee, Florida; Austin, Texas; Sacramento, California; New York, New York; Atlanta, Georgia; Boston, Massachusetts; and Harrisburg, Pennsylvania.

I. Final Work Plan

Background

Transformation to a patient-centered medical home (PCMH) model of care is a major undertaking that requires a significant investment. Emerging evidence shows that PCMH transformation can improve health outcomes across populations, control cost, and improve patient experience. Because of this, PCMH is a primary focus of health reform's plans for improving the delivery of care and patient health outcomes. Additionally, the PCMH is one of the basic building blocks of an Accountable Care Organization (ACO) and, should the Board of Supervisors make a policy decision to pursue funding to operate as an ACO in the future, total transformation to the PCMH model of care will create a strong foundation. At this time, the health department has several elements of the medical home already in place, which could provide an important starting place for continued transformation.

Patient-Center Medical Home Elements

The central principle of the PCMH is that the way that care is delivered is organized around the needs of patients. A true PCMH system of care has to have systems in place to ensure that:

- Patients have a primary care provider who they see over time;
- Patients have timely access to all the types of care they need;
- Providers work with a team of other health care professionals and take responsibility for managing and coordinating the care of patients across all care settings;
- Patients get support for taking care of their health and managing their conditions;
- Providers have the information on patients and populations they need to proactively coordinate and manage their care; and
- The performance of care and health outcomes of individuals and populations and patient experience is measured and, when needed, improved.

Contra Costa County has already begun the process of establishing PCMH systems of care. Examples include:

- Patients are seen by the same provider over time.
- Providers are notified when their patients are admitted and discharged from CCRMC.
- Electronic access across the system is available to radiology and laboratory results and medication profiles.
- Electronic Health Record (EHR) implementation across the system is in the planning stage.
- Dictated CCRMC and Emergency Department (ED) notes are available across the system.

- A nurse advice line is in place that has the capability of scheduling appointments and providing lab results is available 24/7.
- The ambulatory setting has a homegrown registry for patients with diabetes.
- Traditional primary care is being integrated with mental health services in a pilot project at Concord.

There are further transitions the County will need to make to become a PCMH system of care. These transitions are summarized in the table below.

Critical Transitions from Current Care to PCMH Care

Current Care	PCMH Care
My patients are those who have made appointments to see me.	Our patients are those who are in a panel, assigned to our PCMH.
Patients' chief complaints or the reasons for visit determine care.	We systematically assess all our patients' health needs to plan care.
Care is determined by today's problem and time available today.	Care is determined by a proactive plan to meet patient needs, often without visits.
Care varies by scheduled time and the memory or skill of the doctor.	Care is standardized according to evidence-base guidelines.
Patients are responsible for coordinating their own care.	A prepared team of professionals coordinates all patients' care.
I know I deliver high quality care because I am well trained.	We measure our quality and make rapid changes to improve it.
Acute care is delivered in the next available appointment or through walk-in procedures with long waits.	Acute care is delivered through open access mechanisms and outside of traditional office visits (e.g., email).
It's up to the patient to tell us what happened to them.	We track tests and consultations and follow-up after ED and hospital.
Clinic operations center on meeting the physician's needs.	A multidisciplinary team works at the top of our licenses to serve patients.

Discussed below are a number of other options that will help the County transform its system into a PCMH system of care.

A Primary Care Provider Who Sees the Patient Over Time

The PCMH model requires that patients have a relationship with a primary care provider who cares for them over time. This creates continuity of care, which is critical to managing and improving patients' health. The County already ensures that every patient has a primary care provider. However, continuity of care only works if patients have timely access to their provider and the care they need, as discussed below.

Timely Access to All the Types of Care

Timely access to care is at the core of the PCMH model. This includes access to primary care, specialty care, and inpatient care. It also includes access to behavioral health/mental health and substance abuse services. As discussed in the previous reports, the County is experiencing several access issues that must be addressed in order for it to transform into and operate as a PCMH system of care. This points to several critical first steps for the County, including:

Rightsizing Primary Care Provider Panels: As discussed in detail in the Stage 2 report, the County's primary care system is currently at near capacity and provider panels are felt to be excessive. Patients complain of difficulty obtaining unscheduled visits to their primary care centers. This will require carefully assessing current panel sizes and reducing panel size as needed. HMA has proposed the option of using a different methodology to determine panel size. A weighted severity index, rather than 1 visit in previous 12 months, can more accurately assess panel size and help the County develop realistic, right-sized panels. Coupled with this step is the need to manage provider resources, including closely tracking and addressing primary care provider productivity.

Creating Additional Primary Care Access: There are several options for increasing primary care capacity, including further expanding evening and weekend primary care hours, proceeding with the construction of additional ambulatory care space, increasing the use of group visits and expanding current partnerships with private and public health care providers in the County.

Balancing the Supply of and Demand for Primary Care Appointments: Additional steps need to be taken to improve the centralized scheduling system.[1] This includes simplifying the scheduling process and rules.[2]

Addressing Inpatient Delays and Capacity Issues: Several options are detailed in the Stage 2 report. Among them are addressing physical capacity issues of the Emergency Department (ED) and Psychiatric Emergency Services (PES), assessing reasons for one-day hospitalizations and developing alternatives to hospitalization, and studying and addressing why patients are using the ED to obtain medication refills.

Integrating Mental Health and Substance Abuse Services with Physical Health: Although full integration will take substantial effort and is made challenging by the how services are funded in

[1] Open access scheduling functioned effectively for several years and helped improve show rates from 70% to 85%.

[2] The CCRMC CEO noted that there is a plan in place to begin a Value Stream Mapping process for this department as part of a Kaizen project, which will include participation by physicians and staff.

California, the County can pursue several immediate options to reduce barriers and improve access. These include addressing the current policy of its Mental Health Department not to readily accept the referral of patients with behavioral disorders and mental illness complicated by substance abuse. The County can also develop formal relationships and possibly contracts with Institutions for Mental Disease and other institutions to expedite the discharge of difficult-to-place patients who require transitional residential care (e.g., patients with behavior disorders, mental illnesses, substance abuse issue, homelessness, criminal records, etc.). A pilot project in Concord that is integrating traditional primary care with mental health services may reveal other opportunities that can be spread across the system as well.

Decreasing Waiting Times for Specialty Services: Lengthy waiting times for specialty services can be reduced a number of ways, including implementing an automated, rule-based specialty referral screening system, improving the productivity of specialty clinics that don't meet established productivity standards, increasing in-house specialty capacity through hiring more specialists and/or contracting with community specialists to provide consultations when waits become prolonged, and initiating an e-consult for backlogged specialty services.

Managing and Coordinating the Care of Patients Across All Care Settings

The central responsibility of a patient's primary care provider is to manage and coordinate the total health care needs of their patients across all care settings. This is a very different model of care than the traditional model, which places that responsibility with the patient. There are several elements of a PCMH system of care that will facilitate that transition, including:

Patient Care Teams: At the heart of most PCMH models of care is a provider who works with a team of trained health care professionals. These "patient care teams" are responsible for all aspects of care, including but not limited to:

- Identifying and documenting patients' health care conditions and needs, including complex care needs, risk factors, health behaviors, and mental health and/or substance abuse issues;
- Developing a care plan with patients and, as appropriate, their families;
- Tracking, following up on, and coordinating tests, referrals, and care across all care settings;
- Assessing mental health needs and providing or arranging for mental health and substance abuse treatment;
- Assessing patients' progress toward treatment and health goals and addressing barriers;
- Tracking referrals to other care settings and conducting follow-up;
- Reconciling patient medications at visits and after hospitalizations; and
- Following up on patients after they are discharged for the hospital.

The teams should be organized so that each member of the care team is functioning at the top level of their license and qualifications. That means that non-clinical tasks should be completed by clerks or nursing assistant staff. This enables physicians and registered nurses (RNs) to focus on performing clinical functions. For example, RNs should not be doing vital signs and rooming patients, although they should be cross-trained to do this. Trained clerical staff can function as care coordinators who make reminder calls to patients about upcoming appointments at the direct request of the providers or other team members.

The County health centers have taken steps to provide team-based care. For example, some clerical staff have taken on the role and title of care coordinator. The County may consider creating and organizing more patient care teams at the County health centers. This could be done as a pilot at one site and then spread to other centers as appropriate.

Health Information Technology: The use of health information technology will greatly enhance the patient care teams' ability to manage and coordinate care for individual patients and populations. The HSD strategic plan includes substantial enhancement of the information technology system, including transition to EPIC, an EHR system. This will facilitate the identification and management of all patients, not just those who present for care. While implementing an EHR is a critical first step, it does not automatically result in improvements in quality and cost. There will have to be additional and deliberate efforts made to ensure that the system is fully used and/or enhanced to improve quality and costs.

Consistent Communication: Consistent communication across care settings and care teams is vital to improve the coordination of care and there are several opportunities to strengthen work already begun. As examples, currently, notification of an inpatient admission to the primary care provider is encouraged and occurs through email, but it would function better if it were automated. Other staff members such as nurses or care coordinators should be notified of these clinical events because, under a PCMH team-based model, they may be responsible for follow up. The ED notification also should be automated so that it is consistently completed. Phone outreach to patients does occur in certain but not all circumstances. This should be built into the function of care teams, including assigning the task to a specific team member and developing clear protocols and workflows for conducting outreach.

Support for Taking Care of their Health and Managing their Conditions

In the PCMH model, patients are at the center of the care team. Patients need assistance and support with their self-care and self-management. For example, home monitoring and behavior changes (self care and self management) have been shown to decrease ED and hospital use and improve outcomes in patients with illness such as diabetes, asthma and congestive heart failure. Care teams must assess and address patients' abilities to manage their conditions and engage in appropriate self-care. The care plan should be developed collaboratively with patients and, as appropriately, their families and include ways to reduce barriers. Members of the team should be trained to counsel and support patients' healthy behaviors. The team should provide tools and resources, including community-based resources that support the patients in meeting their health goals.

Access to Patient and Population Information to Proactively Coordinate and Manage Patient Care

A PCMH requires that the health care system as well as providers and patient care teams have the right information at their fingertips in order to proactively manage care for their patients and populations. This information includes demographic data, clinical data, and patient preferences. As examples, on the individual patient level, the patient care teams would use the data to develop a plan for a visit *before* a patient comes in. The visit plan would address the reason the patient is coming in for the visit and other needs that have been identified previously. On a population level, the health care system would use the data to create lists of patients who need tests or some other type of follow up (e.g., a list of patients with diabetes who need to be contacted because they have not had a lipid panel in over a year). As stated, the EHR system will help facilitate much of this if it is fully used. In the meantime, there are other options for the County to consider.

Expanded Registry: As it begins the EHR implementation, the County could consider expanding its diabetes registry to include other conditions and measures. A registry is an important tool for managing the health of individuals and populations. It is an electronic tool that brings together and organizes clinical data. It is used for individual patient care (e.g., support for clinical decisions, planning for a visit), population management (e.g., outreach to patients with diabetes – who need additional care), and provider management (e.g., which providers are having trouble getting patients to a goal blood pressure level). The HSD currently has a registry to track diabetes. This could be expanded to other conditions. Many EHR systems, including EPIC, include registry functions while other registries, including the diabetes registry, are stand-alone systems. If HSD implemented a more robust integrated registry, they could use it as a tool to help the health care system and patient care teams:

- Proactively contact, educate, and track patients by disease status, risk status, self-management status, and community and family need;
- Clarify what patients need and distribute tasks among care team members ;
- Monitor metrics to evaluate improvement efforts and outcomes;
- Provide care management services for high-risk patients and/or patients with complex conditions (e.g., multiple chronic conditions);
- Track and support patients when they obtain services across care settings;
- Follow-up with patients within a few days of an ED visit or hospital discharge;
- Communicate test results and care plans to patients and, as appropriate, their families;
- Plan care according to specific patient needs; and
- Use of point-of-care reminders based on clinical guidelines.

Performance Measurement and Improvement of Patient and Population Care, Health Outcomes, and Experience

Measuring performance and making continuous improvements in quality of care is central to a PCMH system of care. Section VI details performance measurement options, including those for measuring PCMH aspects of care.

Next Steps for Contra Costa County

As stated, the road to becoming a PCMH system of care is long and requires significant effort. The HSD has already taken several important steps toward transformation. Other than those already indicated, HMA proposes the following for continuing that transformation.

Assess the System's Current PCMH Status

The best first step in becoming a PCMH system of care is to assess how close the County system is to being a PCMH system of care now. An assessment will also reveal where gaps in PCMH attainment exist and can be used to create a PCMH transformation roadmap. There are a number of national assessment tools that can be used. The two primary assessment tools are:

- The Safety Net Institute's PCMH assessment tool, which is a free tool that can be customized by the County (see Appendix D).
- The National Committee on Quality Assurance's (NCQA) 2011 Patient-Centered Medical Home Recognition Program, which includes consensus-based standards for PCMHs.[3] These standards can be used to assess the level of the County's PCMH attainment.

Develop a PCMH Plan

PCMHs can be developed for entire populations or specific subpopulations. Based on the assessment and its strategic plan, the County will need to select the population for which it wants to develop PCMHs. There are a number of options to consider. The County will also need to decide if it wants to provide all populations currently served with the PCMH model of care. Or the County may decide to focus on higher-risk populations who would better benefit from the PCMH model of care. For certain lower-risk populations (e.g., young, healthy patients who are likely to be seen less than once a year), the current model of care might be adequate. Alternatively, the County may decide to provide a PCMH to all patients who use or are assigned to the County's system but "weight" the patients so that those with higher-risk get more intensive PCMH care.

The County should then select the areas for redesign and improvements, develop success measures, and designate a PCMH transformation team. Given the magnitude of the undertaking, the County may chose to start with a pilot site at one of its County health centers and then spread the model after the pilot is complete.

The specific work plan is presented in its entirety in Appendix C. It is presented as a supplemental reference for this section.

[3] Details about the program and standards can be found here: http://www.ncqa.org/tabid/631/Default.aspx

II. Management Review

Introduction

While Section I and Appendix C speak to HMA's approach to building a PCMH system of care, Section II is intended to present options for the Board of Supervisors to consider to maximize the return on its investment and either reduce costs, raise revenues or both. This encompasses structural, organizational, and/or program changes that are needed to contain costs, improve the revenue picture, and improve care and outcomes. The work is built upon the picture painted in Stage 1 with regard to the health care needs of the County residents and the current state of the health care system in providing for these needs as well as the preliminary findings presented in Stage 2 about what is and is not working in the system. Although these options have a different focus, they should be considered in concert with the recommendations discussed in Section V on organizational changes relating to County oversight of its health care operations and in Section VI on data collection and analysis. The recommendations are as follows:

Create an Observation Unit at Contra Costa Medical Center (CCRMC) to address short-stay inpatient admissions, Emergency Department congestion, and re-admissions.

The relatively high percentage of inpatients at CCRMC who ultimately end up with short-stay status (i.e., stays less than 24 hours) is a potential red flag for unnecessary admissions and places the facility at risk for disallowances under recovery audits.[4] With the full implementation of federal health reform, payment models will encourage providers to institute practices and services that will prevent the unnecessary consumption of resources and costly hospital admissions, thus increasing the importance of this issue. Approximately 28 percent of the Medicine-Surgery admissions to CCRMC are discharged in less than 24 hours, and an estimated 45 to 50 percent are discharged within 48 hours. Medicare recovery audit contractors (RACs) are now carefully scrutinizing short-stay admissions to recover inpatient diagnosis-related group (DRG) payments for those admissions deemed inappropriate.[5] Currently medical necessity is a top issue in CA Region D (includes CCC). According to the National Recovery Audit Program 3rd quarter FY2011 Quarterly Newsletter, when beneficiaries with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for less than 24 hours, they are considered outpatient for coverage purposes regardless of the hour they presented to the hospital, whether a bed was used, and whether they remained in the hospital after midnight.[6] Medicaid RAC audits have not yet started in CA. it is expected that procurement for a contractor will be out this fall.

[4] Section 6411 of the Affordable Care Act of 2010 required States and territories to establish Medicaid Recovery Audit Contractor (RAC) programs. Medicaid RACs are tasked with identifying and recovering Medicaid overpayments and identifying underpayments. http//www.cms.gov/medicaidracs.

[5] http://journals.lww.com/hcmrjournal/Fulltext/2011/01000/Emergency_department_observation_units__A_clinical.6.aspx

[6] http://www.cms.gov/Recovery-Audit-Program/Downloads/FFSUpdate/pdf

One way to address issues related to the short-stay admissions and ED volume would be to establish an Observation Unit (OU). Over 60 percent of the hospitals in California have established OUs as part of their ED or ambulatory services. These units focus on a relatively limited, although expanding, number of diagnoses and conditions that are amenable to protocol-driven testing and treatment for patients with a high probability of being ready for discharge within 24 hours or less. OUs have been demonstrated to improve patient outcomes, avoid unnecessary admissions and diagnostic testing, decrease lengths of stay for the small percentage of OU patients who ultimately require admission, generate cost savings, increase profitability for a number of diagnostic conditions, and increase adherence to Centers for Medicare and Medicaid Services (CMS) and the Joint Commission's (JC) clinical measures.[7] The County should consider:

- Evaluating the need and the clinical, financial, and administrative impact of an observation unit and
- Determining the optimal location for an OU.

Further decrease the inpatient length of stay at CCRMC.

The average length of stay (LOS) for inpatients on the Medicine-Surgery and Obstetrical Units are generally consistent with national averages, and the Psychiatric Unit's LOS slightly exceeds the national average for inpatient mental health units. Although CCRMC is generally in line with established norms for LOS, HMA identified opportunities for further reduction. Going forward, the County should establish ongoing metrics to track and carefully study the reasons for unnecessary additional days of hospitalization. HMA identified potential changes that could decrease the LOS on select patients on each of the inpatient services. CCRMC should evaluate the options that are identified by the study. Four options identified by HMA are:

- Purchase or contract for an additional CT scan to increase both inpatient and outpatient access to this diagnostic modality and to minimize avoidable additional hospital days;
- Provide access on weekends to those select specialty procedures that contribute to delayed discharges of inpatients;
- Consider formalizing contracts and agreements with Skilled Nursing Facilities, Nursing Homes, Long Term Acute Care hospitals, Home Nursing and Home Intravenous Treatment services, and Institutions for Mental Diseases (IMDs) to provide options for patients and providers; minimize short stay hospital admissions; and further decrease length of stays for all CCHS patients without regard to coverage status; and
- Re-evaluate the existing policy and practice of the Mental Health Department to deny referrals of certain categories of mentally ill patients who are substance users. (The upcoming integration

[7] http://www.hospitalmedicine.org/AM/Template.cfm?Section=White_Papers&Template=/CM/ContentDisplay.cfm&ContentID=21890; p. 6.

of the Mental Health Department and Alcohol and Other Drug Services Division present a significant opportunity to objectively revisit this issue.)

Maximize Operating Room (OR) utilization and access to surgery and decrease OR cancellation rates

CCRMC currently utilizes only three of the hospital's four operating rooms (ORs). Hospital ORs are costly to maintain and staff. Therefore, if three ORs can efficiently address the needs of the County's patient population then the unoccupied OR should not be reopened. It was reported that there is a 30 percent cancellation rate of OR cases at CCRMC. (Over 20 percent is considered a poor performing OR.) OR case cancellations nationally result in significant patient dissatisfaction. CCRMC should consider the following to address OR issues:

- Creating a "one-stop" multidisciplinary pre-operative assessment and clearance clinic where patients would receive the required pre-operative testing, education, and consultation to improve patient compliance and minimize OR cancellations;
- Relocate limited complexity ambulatory surgeries and procedures from the CCRMC operating rooms into non-hospital ambulatory surgery suites or office/clinic treatment and procedure rooms to increase access to these procedures, decrease costly utilization of inpatient OR suites, and minimize OR cancellations. Relocation to existing space that meets OSHPD standards, requiring minimal renovation, would be the most cost effective however this should be evaluated for cost versus increased revenue from the number of IP surgeries that could be performed if there was access to OR time and space ;
- Evaluate the need to re-open the fourth OR and to open access to non-emergent surgeries on Saturdays. The evaluation should include the cost to staff (anesthesia and nursing) the fourth OR versus revenue anticipated by providing access for more surgeries.

Optimize Emergency Department (ED) utilization and physical capacity

The CCRMC's Level II Emergency Department is extremely busy and operates at near-full capacity. Many days, patients wait in the Emergency Department (ED) for a Medicine-Surgery or a psychiatric bed to become available. The physical space in the ED is fully utilized with a congested waiting room and designated temporary stations in the hallway that are visually compromised. The number of patient visits to the ED has doubled since 1997 when the unit was completed, now exceeding 60,000 annual visits. In spite of the ED congestion, the Left-Without-Being-Seen (LWBS) rate is only 3 to 4 percent, which is comparable with U.S. rates. As more people have coverage with the health reform expansion, the ED will be challenged further to provide alternatives for expanding physical capacity. CCRMC should consider the following options to better serve their patients:

- Expand or contract for after-hours, immediate care capacity in areas of Contra Costa with high ED use by Level 4-5 patients without regard to their coverage. It is quite foreseeable that the

County would create an immediate/urgent care center on the CCRMC campus where patients can self-direct or be redirected from CCRMC's ED;

- Expand (if focused efforts to decompress the ED are not successful) the physical capacity and emergency and fast-track stations in the CCRMC ED to allow more effective management of the high volume of patients;
- Provide the ED with access to expedited primary and specialty care appointments for select discharged patients who require immediate (i.e., one to five days) ambulatory care evaluation; and
- Proceed with planning for the Martinez Clinic Replacement Project to expand and improve the physical capacity of the Psychiatric Emergency Service (PES), which will include a walk-in service for patients and thus decrease the number of patients presenting to the ED and PES for prescription refills. The project includes consolidation of the health and mental health clinics in one new building. The medical portion of the new clinic will include 18 exam rooms, 2 large group treatment rooms, and support functions. The focus of the medical clinic will be primary care. The mental health clinic will include interview rooms, exam room, and other space appropriate for the delivery of urgent and crisis mental health services. There will be separation of space in the waiting room for youth and adults and designation of separate interview and consultation areas for the different age groups.[8]

Enhance specialty care access

Contra Costa Health Services (CCHS's) three comprehensive care centers are the primary sites for the provision of over 100,000 outpatient specialty care consultations in 39 medical and surgical specialties and subspecialties. This access to specialty consultations is invaluable to the quality of care in the system and is absolutely necessary for the support of its large primary care network. Although there are existing timeliness regulations regarding access to specialty appointments, these standards are anticipated to be more vigilantly tracked and monitored as the 1115 waiver and health reform moves more patients into truly managed care. Inability to meet these standards and report on outcomes will result in penalties with potentially negative impact on revenue generation. CCHS should consider the following options to improve access to specialty care for the patient population it serves in the FQHCs:

- Implement an automated rule-based electronic referral screening system that would successfully approve or deny the vast majority of referrals to the County's specialty and diagnostic services to allow the most appropriate use of valuable resources;
- Perform a pilot review of backlogged priority specialty clinics to assure that stable patients are expeditiously discharged from the specialty clinics and referred back to primary care providers;

[8] Per Dorothy Sansoe, County Administrator's Office, June 16, 2011.

- Initiate an e-consult system initially focused on specialty services with prolonged waits for appointments; and
- Continue to track and monitor the productivity of specialty providers.

Sustain and/or increase the volume of obstetrical deliveries

CCRMC has the third highest number of deliveries in Contra Costa County. Employees and medical staff choose to deliver at CCRMC. They are the main delivery site for Medi-Cal patients in the County. Although busy, OB/Labor and Delivery (L&D) has some capacity—15 to 20 percent—to deliver more patients, but would need to free up post-partum beds to do this efficiently and safely. The length of stay in post partum could be decreased if CCRMC considers the following options:

- Implement a more efficient discharge process for AM and PM discharges and revise the current prescription procurement process at discharge;
- Facilitate early education for new mothers on newborn care and feeding;
- Increase lactation support by providing access to lactation consultants for a minimum of 16 hours per day in the hospital;
- Establish an outpatient lactation program; and
- Utilize the former psych unit, which is currently closed, to expand OB services as a longer-term option. If the psych beds are still on the license but in suspense CCRMC would only be required to submit a letter to the local California Department of Public Health (CDPH) Licensing and Certification Division (L&C) district office to request that the beds be put back into active status. However, capital may be required for a security system and/or renovation of the space for post-partum use.

Simplify and improve the appointment scheduling process

This is a recommendation that will enhance patient, provider, and scheduling staff satisfaction and was discussed in both the Stage 1 and 2 reports. The increase in demand for primary care services has resulted in a mismatch of the supply of appointments available and the demand for these appointments. This results in few appointments available to give to patients requesting appointments and long phone queues. Open access scheduling is only effective when supply and demand are matched. We understand a plan has been put in place to begin to address this situation in early June 2011.

III. Alternative Governance Structures

Introduction

As part of the sustainability audit, HMA was asked to present information to the Board of Supervisors about alternative governance structures that could enhance the County's ability to provide appropriate, accessible, and effective health care services to its residents.

The Stage 2 report presented a preliminary discussion of alternative models. This report includes a more robust discussion of the options and implications of options for Contra Costa County, with an emphasis on which challenges to the system are and are not addressed by a particular option, funding impacts (if any), and key barriers or success factors.

Contra Costa County owns and operates its hospital, clinics, and health plan. This structure presents unique opportunities in terms of financing and integration but also carries certain challenges associated with the hospital's status as a public entity. Health Services Division leadership repeatedly mentioned hiring delays, purchasing complications, and the high cost of County benefits—coupled with lack of flexibility in the union negotiation process—as barriers to sustainability. In general, public ownership of hospitals is on the decline, at least in part because of the desire of public entities to get out from under these types of challenges. It is for this reason that the Board of Supervisors asked to learn more about alternative governance models.

An important environmental factor to consider when weighing whether to pursue a possible governance change is the current status of Doctors Medical Center in San Pablo. As of the drafting of this paper, news reports have indicated the hospital is at risk of another bankruptcy. This has two major implications with regard to governance of CCRMC. The first one is that the public at large may be skeptical of any proposed change in governance that would be perceived as placing the CCRMC at similar risk. These concerns would need to be addressed in any public discourse around this issue. Secondly, it may make sense for the County to consider options that allow for Doctors Medical Center and CCRMC to operate under some sort of umbrella structure, assuming concerns about financing could be addressed. The late-breaking nature of this situation does not allow for an exhaustive review of combined governance options, but this is a factor that should be kept at the forefront as any possible governance discussions take place.

Alternative Structures

In general, the alternative structures can be grouped into three major categories.

- Model type 1 is to retain the current structure. Under this model, the County would retain ownership and continue to operate the hospital, clinics and health plan. Policy and administrative changes would continue to proceed in preparation for health reform and to address any issues or problems noted as part of the sustainability study.
- Model type 2 can be described as an "arm's length" relationship, whereby the County would retain ownership of hospital, clinics and health plan, but the hospital could be privately managed under contract with an outside entity.
- Model type 3 is a divestiture arrangement and could take one of three separate forms. The CCRMC could be spun off to a separate 501(c)(3), a private entity, or as a separate government entity such as a health district or health authority. Assets could be sold or leased on a long-term basis.

The following table outlines the various arrangements and discusses the implications for cost, revenues, degree of County control, and impact on labor/management issues. The table also discusses barriers associated with implementation of each option as well as the keys to a successful implementation should the Board of Supervisors decide to explore any of these possible arrangements further.

MODEL TYPE 1: RETAIN CURRENT STRUCTURE			
Explanation	**Implications**	**Barriers**	**Keys to Success**
No Governance Change Under this model, the County would retain ownership and operation of the hospital, clinics, and health plan with no significant changes. Policy decision and administrative changes would proceed to continue implementing health reform and to address any issues or problems noted as part of the sustainability study or during the implementation of health care reform.	*Cost* – No automatic impact on cost to the General Fund; any cost savings would be dependent on County action regarding recommendations outlined in other sections of this report. *Revenue* – No automatic impact on revenue. To the extent certain revenues (e.g., federal match for intergovernmental transfers) depend upon public status, these would be protected under this arrangement. *County Control* – Board of Supervisors control over the health system would be maintained. However, HMA has outlined options regarding transparency and accountability that would improve oversight of the health care system and system outcomes. *Labor/Management Issues* – No automatic impact on labor/management issues. However, HMA has provided options regarding union negotiation, hiring, and purchasing that should be implemented with or without any governance change.	N/A	In order to continue to be successful and sustainable, the County will need to consider implementing the recommendations outlined elsewhere in the report, even if no governance change is contemplated at this time.

MODEL TYPE 2: "ARMS LENGTH" ARRANGEMENT			
Explanation	**Implications**	**Barriers**	**Keys to Success**
Public Ownership/Private Management This structure would involve contracting with a private organization to manage and staff the CCRMC, while the health plan, clinics and health department remain within the County government structure. CCRMC would continue to be owned by the County and would remain a public hospital, but the private entity would manage the facility under a contract with the County.	*Cost* – Assuming the arrangement results in a more streamlined process for hiring and purchasing than is now the case, certain costs could potentially be reduced. *Revenue* – Revenues that depend upon public status would be preserved. If private management results in changes that streamline operations (e.g., reducing the cancellation rate in the OR), revenues could potentially increase. *County Control* – The County would retain control over the system. The extent of day-to-day control (and conversely the degree to which the private management entity would be able to act nimbly when needed) would depend upon the exact structure of the contract under which the system would operate. *Labor/Management Issues* – Simply switching to private management would not necessarily simplify negotiations with the unions. The vast majority of employees at the hospital would continue to be County employees and would continue to be represented by the various bargaining units. If anything, there could be tension associated with the fact that they are being managed by a group of individuals who are not County employees.	The chief barrier would be fear on the part of the County workforce and community advocates that the nature of the hospital and related services would change under private management.	In order for such a plan to succeed, the private management company would have to be a trusted entity that is able to build community support in advance of taking over hospital operations. It will be important to secure buy-in from the Board of Supervisors, unions, and the public at large.

MODEL TYPE 3: DIVESTITURE			
Explanation	**Implications**	**Barriers**	**Keys to Success**
Separate Non-Profit Entity The hospital and clinics could be spun off into a 501(c)(3) with an agreed-upon subsidy from the County. Under such a structure, it is possible to be recognized as a public hospital for certain purposes while for all intents and purposes operating as a private hospital with an independent board of governors.	*Cost* –The County could continue to contribute towards the cost of uncompensated care but its contribution could be capped, thus making costs to the County more predictable. Actual cost containment within the hospital would depend upon management actions. *Revenue* – Revenues that depend upon public status are protected only if the state is successful in persuading the Centers for Medicare and Medicaid Services (CMS) that the hospital should continue to be considered as a public entity. This has been done in other instances, including Truman Hospital in Kansas City. A private non-profit can also access other sources of funding not otherwise available to a government institution, such as community foundation funds. *County Control* – Under this option, the hospital would no longer be under the direct control of the Board. There would be an independent governing board, though the articles of incorporation could be set forth in such a way that the Board of Supervisors retains the ability to appoint a portion of the board. *Labor/Management Issues* – The employees would no longer be County employees, though given the labor environment in California, they would likely still be represented by bargaining units. These units would no longer bargain as part of a coalition with other unions representing County employees, however.	As with any other substantive change in governance, the main barriers would be the need to secure whatever legislation or Board resolution may be required to effect this change. In comparison with other options, this one may be more palatable to the community, as a community-based non-profit would have a different "feel" than turning the management of the hospital over to a private company.	It will be important to secure buy-in from the Board of Supervisors, unions, and the public at large. Another key to success will be setting up the new non-profit structure appropriately so that decisions can be made and the process does not become overly political. In addition, it would be important to consider the addition of individuals to the governing board who can be helpful in fund development, given that a private non-profit can tap into additional sources of revenue and capital fund not otherwise available to a governmental entity.

MODEL TYPE 3: DIVESTITURE			
Explanation	**Implications**	**Barriers**	**Keys to Success**
Privatization The clinics and/or the hospital could be spun off to a private entity. The money that would have otherwise been used to support the public system could be used to subsidize private entities for certain services or to pay for Section 17000 requirements until 2014, when the Section 17000 population is covered under health care reform (either through Medi-Cal or the exchanges). The assets (e.g., buildings) could either be sold or leased.	*Cost* – The immediate and ongoing cost to the County would be determined via a negotiation process with the private entity. In terms of cost control within hospital operations, presumably a private entity would have an increased ability compared to a governmental entity to expeditiously implement cost containment strategies should they become necessary. *Revenue* – Revenues that are based on public status would be lost. This would be significant in Contra Costa, given that the County has been very successful in maximizing federal revenues through intergovernmental transfers and other strategies. In addition, in light of the large Medi-Cal expansion contemplated under health care reform, public financing strategies could become even more important. *County Control* – This option would result in the least degree of control by the Board of Supervisors. *Labor/Management Issues* – Under this option, the employees would become private sector employees. Usually over time, County costs would diminish as employees no longer enter leave the County-funded retirement program.	As with any other substantive change in governance, the main barriers would be the need to secure whatever legislation or Board resolution may be required to effect this change. This may be the most difficult option to implement because of the need to locate and negotiate with a private partner that is acceptable to the community and the unions.	In HMA's judgment a change of this nature is not possible unless there is a strong Board of Supervisors and community consensus that the hospital as a public entity is in serious immediate jeopardy.
Health Authority/District All or any portion of the current Health Services Department could be moved to a health authority. A similar arrangement would be to form	*Cost* – Presumably, a separate entity such as a health authority or health district would have more leverage to implement cost-containment measures. It is important to point out, however, that public meeting rules would still apply and to the extent that the nature of the public	As with any other substantive change in governance, the main barriers would be the need to secure legislation to effect this change.	As with other options, it will be important to secure buy-in from the Board of Supervisors, unions, and the public at large.

MODEL TYPE 3: DIVESTITURE			
Explanation	**Implications**	**Barriers**	**Keys to Success**
a health district, which would be a countywide entity with taxing authority that could encompass the hospital and clinics.	process makes it difficult for the County to make changes, these same issues could exist under a new structure. The County could continue to make a contribution and this contribution could be capped for predictability. *Revenue* – Since these arrangements would preserve the public status of the institutions, the revenues that derive from this status would be protected. In addition, under a health district arrangement, there would be independent taxation authority. *County Control* – Any continuing County control of operations would derive from conditions associated with the ongoing contribution (if any) and from any Board of Supervisors appointments to the government board and the enabling legislation. *Labor/Management Issues* – It is reasonable to expect that the new entity would be negotiating with at least some of the same unions that currently represent health care system employees. However, as with other structures that disengage the health care entities from the County at large, coalition bargaining with other County employees cease. Pension costs incurred prior to the changeover would still need to be financed.	An added complication associated with this option is potential community push back associated with the creation of a new entity that has the power to impose its own taxes.	

Summary

A number of key points can be implied from this analysis. They are:

- Any substantive governance change is a lengthy process requiring buy-in from multiple stakeholders including the County Board of Supervisors, unions, advocates, and the public at large.
- There are no "magic bullet" solutions that will quickly and automatically address the issues about which the Health Services Division is most concerned, especially the issues associated with the costs of doing business as part of the County's operations.
- Irrespective of any future change in governance that is contemplated, the County should proceed with the options presented in other sections of this report. A change in governance can take years, and the County can make an impact on operations sooner by proceeding with the other improvements.
- If the hospital is ultimately spun off to a separate entity, careful consideration should be given to the membership, structure, and other details of the governing board so that the County does not end up creating a structure that is too political and unwieldy in terms of being able to respond to the many challenges and fast-moving changes on today's health care landscape.
- Some potential governance changes (e.g., privatization, spinning off into a non-profit) have the potential to increase the ability of the hospital to raise capital for construction and other projects. With respect to privatization, this benefit would need to be carefully weighed against the risk of losing access to certain revenues that are derived from the hospital's status as a public institution.
- It appears unlikely for the Board of Supervisors to get buy-in for the most extreme governance options unless there is a clear public consensus that the hospital is in immediate jeopardy as a public institution.
- Any discussions about possible governance changes should take into consideration the status of and plans for Doctors Medical Center in San Pablo, the geography and demographics of the County, the location of hospitals and clinics, and the small number of hospital beds in the East Bay compared to population.

IV. Local Labor Market Conditions

Introduction

HMA recognizes the challenging labor environment in which the Health Services Department (HSD) operates. Labor laws, union contracts, merit rules, and competition with non-government hospitals create complexities that most hospitals do not face when attracting and retaining qualified staff to provide patient care. The environment will only become more complex—and the stakes higher—with

the implementation of health reform provisions in the coming months and years. Part of HMA's charge in this project was to present options for the County's consideration that would ensure access to appropriate and effective medical services at CCRMC and County health centers, taking into consideration local labor market conditions, medical staff recruitment and retention strategies, labor agreements, and the use of contracted vendors. The following labor strategies are options for HSD to improve its ability to meet its strategic staffing obligations to prosper into the future.

Labor Strategy 1: Contract Negotiation

HSD should take a much greater role in negotiating and managing the contracts with Physicians and Dentists of Contra Costa (PDOCC) and the California Nurses Association (CNA). Physicians and nurses are the key drivers for providing revenue to HSD and clinical services to its patients. As such, it makes sense for the HSD to have greater participation as regards these contracts. HSD's strategic sustainability depends primarily on its ability to attract, retain, and motivate physicians and nurses. HSD needs to be in a position to bargain strategically with physicians and nurses in order to be able to compete for these staff resources into the future. The current surplus of available nurses in the existing market will diminish over time, and competition for physicians will continue to be a challenge HSD will face in the future. Currently, total compensation for physicians working at HSD accounts for approximately 14 percent of the total labor costs of the HSD. Nurses total compensation accounts for 28 percent of HSD's total compensation, and professional/certified staff accounts for 31 percent. All other classifications represent 27 percent of HSDs total compensation. The role HSD takes in negotiations with the other bargaining units needs strengthening by including key HSD leadership in the preparation, issue resolution, and negotiation processes. It appears that the HSD Human Resource (HR) Director is the only HSD leadership person actively engaged in those processes, which limits the breadth of knowledge and insights needed to represent HSD interests and needs.[9]

Some outcomes that could be derived from an expanded role for HSD include:

- The ability to target and negotiate compensation and benefit changes to ensure a competitive position with non-government hospitals
- More direct alignment of hospital strategies with labor efforts
- A stronger voice in the labor negotiations process
- The ability to place health care needs in a primary position compared to government needs
- Potential to improve work rules that negatively impact working conditions for physicians and nurses
- Ability to negotiate improvements to work rules[10]

HMA is aware that HSD has generated a proposal for expanded involvement. The proposal is included as an Appendix to this report.

[9] In the event the County is required to be part of the process HSD should remain in the lead of the negotiations.

[10] The feasibility of implementing this change needs to be considered in concert with relevant State and Federal laws.

Labor Strategy 2: Compensation

A key to sustainability for the County's health care system, no matter what governance decisions the Board of Supervisors might choose to pursue, will be to slow the rise in staffing costs, and a reasonable goal is to move the County to a "middle market" position for total compensation. Therefore, the second item for the Board of Supervisors to consider is a strategy designed is to hold the line on benefit costs and continue to shift and share cost with employees.

The 2010 Society for Human Resources report on benefits indicates that "Organizations spend an average of 19 percent of employees' annual salary on mandatory benefits, 18 percent on voluntary benefits, and 11 percent on pay for time-not-worked benefits."[11] This totals to 50 percent of annual pay for benefits nationally for employers with more than 500 employees. The comparable benefit cost for Contra Costa County (CCC) is 62 percent, which is greater than the national average. In addition CCC was deemed by the Hay report to be the leader in providing benefits when compared to other counties in the area.

The County could reduce expenses significantly by lowering the value of the package to the area median (Option 1), or reduce them even more by lowering the value to the national average (Option 2). These two options can be illustrated as follows. Option 1: If CCC were at the 50th percentile (median) for the region, rather than at the top, total benefit costs would be reduced by $22,824,000 for an average annual base salary of $90,000. Option 2: If CCC gave benefits worth 50% of the package, which is the national average, costs could be reduced even more – by $28,314,000.

The Hay study indicated the retirement contributions by the County were 27 percent of annual salary. Analysis of the proposed staffing budget effective July 1, 2011 indicates that retirement contributions are now 38.4 percent.[12] Recent County benefit changes and current negotiations appear to be designed to increase employee cost sharing for pension and benefits and are appropriate steps to begin to control benefit costs and increases. The challenge of complying with State laws is significant, and the existing public labor environment is challenging. However, the County should begin to move to the market median with respect to the provision of benefits in order to reduce labor costs and to be better positioned to respond to market shifts and staff shortages as they occur in the future.

Flexibility in design of benefits plans when negotiating with physicians and nurses needs to be granted as well. In order to move to the market median, HSD may want to adopt a total compensation philosophy for providing compensation and benefits to physicians and nurses. This will require the practice of convening and using annual, formal market surveys to determine HSD's competitive position with hospitals and other organizations it competes with for physicians and nurses. This will provide consistent and timely information for negotiations and will serve as a basis for communicating compensation related information with recruits and staff.

[11] Source: 2010 Employee Benefits (SHRM, 2010) 2010 Society for Human Resources.

[12] Lisa Driscoll, County Finance Director, indicated that the Hay data was outdated and that retirement costs have gone up since that survey was conducted.

Labor Strategy 3: Implement Professional Services Unit (PSU) Report Findings

As outlined in the Stage 2 report, CCC should implement all recommendations found in the Professional Services Unit (PSU) study.[13] Streamlining the recruitment and selection process for physicians and nurses will result in staff savings, better care, and reduced administrative expenses. HMA's assessment of the current situation is that HSD can neither recruit nor replace staff as quickly as needed. This results in delays that create additional staff costs (e.g., overtime and agency use) and the loss of qualified candidates. A discussion of HMA' analysis of the PSU recommendations is found in the Stage 2 report previously submitted to the County Administrator's Office. HSD should assume primary responsibility for recruitment and hiring of the staff it employs.

Labor Strategy 4: Increase Transparency

HMA recommends that in order to increase transparency and empower managers to participate in decision-making, management staff should be provided with productivity and labor staffing reports and information. This would have the effect of creating accountability for labor cost optimizations throughout the chain of command. In addition, the County should prioritize the implementation of an electronic time and attendance system to automate the payroll process and provide real-time labor cost data. It is expected electronic time and attendance systems will provide consistent time management, labor cost oversight and precise payment of overtime hours worked.

A final recommendation is to create and utilize staff metrics for productivity and measuring staff effectiveness. Without detailed work analysis, there is no way to oversee staff output and effort. The generation of management reports and feedback can be shared with all who have a vested interest in the efficient operations of HSD.

[13] Contra Costa County – PSU Audit Review. Audit Review of Practices and Functions. Renne Sloan Holtzman Sakai LLP. Prepared by: Geoffrey Rothman, Principal Consultant, Doug Johnson, Consultant.

V. Organizational Changes

Introduction

As part of the sustainability audit, HMA was asked to provide options for changes and/or enhancements to Contra Costa County's organizational capacity that would enhance the Board of Supervisors' oversight and the County's management and sustainability of its health care program. While HMA has a number of suggestions for the Board and the County Administrator's Office to consider going forward, it is important to note that the current arrangement and structure has produced excellent results. Nonetheless, the time has come to consider some improvements, particularly in light of the future expansion of public programs.

The Contra Costa County health care system will face unprecedented challenges and opportunities in the coming months and years. Examples include mandatory managed care for Seniors and Persons with Disabilities (SPDs) due to the Section 1115 waiver and the creation of the waiver's Delivery System Reform Incentive program, the large Medi-Cal expansion under health care reform that could shift the costs of providing coverage for large parts of the medically indigent to the state, the development of PCMHs to better serve the patient population, and the planned implementation of electronic health records. This year's budget discussion renews the debate about how the County can meet all of its financial obligations, including health and public safety. However, there can be new opportunities for increased federal funding with the new federal waiver and with national health care reform.

In addition to the perennial challenge of identifying adequate funding, the level of external scrutiny will increase dramatically as Medicare, Medi Cal, and commercial plans establish a base for pay-for-performance programs and fully implement the Disproportionate Share Hospital (DSH) Audit requirements mandated in Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The audit requirements require patient level detail for the first time which includes costs. In response, the system must make a special effort to assure access to the system's financial performance data is readily available and reporting of performance is clear, complete, and fully documented. Health care reform will require the County system to change and many stakeholders to support these changes. In turn they will require information which clearly shows the need for that change.In the past, many systems have routinely used allocation methods that generated accurate results for managerial decisions. However, current and developing standards are such that precise, patient level detail is needed to support reported values for uninsured costs, community benefit, and indigent care. Therefore, unlike the present methodology where indigent care costs were imputed from overall estimates of costs not covered by other payers, a methodology will need to be implemented to meet the new requirements by identifying and accumulating costs for indigents and uninsured at the individual patient and claim level.

As stated, a fundamental component of a sustainable health care system is having the management tools to measure how the system is performing and to determine the best course of action should corrections be needed. The Board of Supervisors and the County Administrator's Office need to know whether programs are running as planned, whether the amount of funding is sufficient and will not

unexpectedly increase, and that services are being delivered in such a way that patient needs are being met. Section II presents a discussion of management changes that could be made in the hospital and clinics while Section VI presents a discussion of options regarding data collection and analysis. This section, by contrast, speaks to building an overall management structure at the County level that supports the health care system's ability to be sustainable. The best data collection and analysis capabilities are wasted if the governance and policy setting today and/or the management structure does not provide for meaningful and real-time capacity to determine and implement policy and operational changes in response to the analysis. In addition, the Board of Supervisors, as the governing body, will want to discuss and fully understand the policy decisions that are needed to implement health care reform.

The recommendations in this section should be considered in the context of reporting authorities and accountability established by the Board of Supervisors in 2009. While pre-existing County ordinances stipulated that the HSD director was accountable to both the Board of Supervisors and the County Administrator's Office (CAO), in 2009 the Board strengthened the role of the CAO.

The Board had historically appointed the leadership of the HSD, while day-to-day supervision and accountability for the leadership rested with the CAO. However, this arrangement was updated and the CAO's role strengthened in 2009 when the Board passed a resolution (2009/486) that gives the CAO responsibility for recruiting and interviewing candidates for this position, in addition to ongoing supervision and evaluation of performance. The CAO is required to keep the Board informed and respond to questions or concerns.

The options for Board members to consider in this section are based on several key observations made by HMA staff throughout the course of this project that relate to the underlying concepts of transparency, accountability, and continuity. They are:

- Top-level leadership and knowledge has been held over the years by very few people. Currently, executive leadership is provided by a retired CEO and a CFO/COO who is not an employee of the County but rather is a long-time contractor.
- There appears to be no obvious succession plan for top leadership. This could create a very disruptive situation if unforeseen circumstances necessitated a change during the heavy pace and demanding time frame needed to implement health care reform in the manner that is currently envisioned by the Health Services Department.
- Key managers in charge of important components of the system (e.g., health plan, hospital, clinics) appear to have less involvement in making overall budget decisions and less financial knowledge of the part of the organization they are running than will be required to keep pace with change under health care reform.. As health care reform is implemented, this will put the organization at risk for making timely adjustments to changing conditions and requirements. The current structure and communication practices leads to questions and concerns where often none should exist.HMA realizes that the Board of Supervisors will need to make crucial decisions about governance for the hospital, clinics, and health plan in response to the rapidly

changing health care environment brought on by the recent waiver and health care reform. While the exact oversight procedures that will be needed will to some degree depend upon the governance structure that is chosen (as discussed in Section III), HMA recommends that the Board of Supervisors considers certain fundamental changes in the management structure irrespective of the final governance model that is chosen by the Board. These are discussed in the following pages and grouped under the headings of transparency, accountability, and continuity. Each recommendation relates back to one or more of the observations outlined above.

Transparency

Adopting these actions would increase the degree to which the Board of Supervisors, County Administrator and other stakeholders have access to information about the financial status and general sustainability of the Contra Costa health care system:

- As the economic impact of HSD is material to the County's well being, health care reform brings new financial challenges. The leadership of the County (i.e., Board of Supervisors and County Administrator) should receive monthly financial reports that are in sufficient detail to monitor variances from the planned budget. These reports would also be used to monitor progress on corrections or adjustments that need to be made. High-level information from these reports should also be presented in a dashboard format each month.
- The waiver and health care reform bring new revenues and new requirements to HSD. While the General Fund impact of department operations is one crucial measure, the health services division has significant other revenue sources. The cost baseline for the sake of measurement of successes and challenges should relate to total expense. Deviations from this should be noted and explained. In difficult economic times, new revenues should be used to meet Board priorities including potentially reducing reliance on the General Fund.
- As health care reform may require sacrifice from a variety of stakeholders and at a minimum will require all to understand the new requirements and their impact, other stakeholders, including employees and bargaining unit representatives, should have enough financial information to understand how they can contribute to the overall sustainability and success of the organization.

Accountability

Choosing to implement these actions would increase the degree to which the department is accountable to the Board of Supervisors and County Administrator and, in turn, the degree to which the management structure of the various components of the health care system can be held accountable for their departments and divisions. Health care reform requires the ability to shift resources to improve the care of the population at a lower cost and a complete departure from more volume based approaches.

- Department managers should have sufficient information to manage their areas and if warranted make trade-offs to improve overall operations. They should have both actual financial data and productivity measures.

- To start the succession planning process and improve sustainability post retirement of key leadership, the CFO/COO position should be split, and the new COO should be a County employee. This action would have an obvious sustainability impact as the position would be an employee with an expectation of continuing employment after retirements of other key leaders. It would also begin to distribute authority and information more widely making the organization able to bring in new ideas.
- As discussed in the Local Labor Market section, HSD leadership should have a greatly expanded role in negotiations with unions representing employees of the health care facilities. This is discussed in more detail in Section IV.
- HSD staff should be responsible for hiring hospital and clinic positions within policies established and overseen by County administration. Purchasing should be handled in the same fashion.

Continuity

Implementing these actions would ensure that in the event of change in executive leadership, health care services and the operation of the HSD would not be negatively impacted. It becomes especially critical as health care reform moves forward and the rate of change increases significantly.

- Given the current management structure of the HSD there is a risk of a leadership vacuum if a sudden change occurs. Part of sustainability and succession is ensuring that the remaining managers can function in such a situation, and the options described that regard transparency and accountability would assist. In addition, splitting the CFO/COO position would widen the number of people equipped to lead the department financially. An additional recommendation would be to develop a succession plan that would specify the individuals/positions who would step up during an interim period of change. It would be expected that these individuals would be kept "in the loop" of key decisions and information to lessen the impact of any leadership change, either planned or unforeseen.

Summary

In HMA's estimation, the health care system in Contra Costa has received recognition for innovation and is striving to rise to the challenge and opportunity of health care reform. However, some options designed to increase transparency to the public as well as accountability up the chain of command to the Board of Supervisors and the County Administrator's Office are desirable going forward. In addition, there are critical steps that the Board of Supervisors can choose to put in place to increase continuity and mitigate against the potential negative impact of a planned or unplanned change in leadership at this critical period in the implantation of health care reform.

VI. Performance Measurement and Monitoring Options

Introduction

A hallmark of a high-performing and sustainable health care system is continually measuring its performance and using its measurement process to target and monitor improvements. This measurement should encompass all of the key domains and levels of the health systems operations and outcomes, including the effectiveness and efficiency of the care delivery system and operations, patient and population outcomes, and financial management.

In this section, HMA presents options for changes to the County's current process for establishing performance priorities and principles and collecting, analyzing, and using data to enhance the Board of Supervisors' and County administration's oversight and management of its health care programs and support its performance and sustainability. The options include indicators and process options for a PCMH system of care, operations, labor, and fiscal management. A regularly communicated and transparent performance measurement process with clear accountabilities at multiple levels of the system will enable the Board of Supervisors and the County Administrator's Office to ensure that the system is performing optimally.

Overall Principles and Options

Although HMA was not provided extensive detail about how the County measures and improves performance, there are important principles and options for the Board of Supervisors to consider. They are:

- There should be clear accountabilities established for measurement, reporting, and improvement, with ultimate responsibility and accountability lodged in the Board of Supervisors and the County Administrator's Office.
    - This practice or format should include an appropriate infrastructure and reporting lines to oversee and manage performance measurement, reporting, and improvement. An existing example is the Patient Safety and Performance Improvement Committee, which issues reports directly to Board's Professional Affairs Committee.
- The County should establish a public performance dashboard of key performance indicators, similar to the System Level Dashboard that was outlined in the Contra Costa Health Services' 2010-2015 Delivery System Reform Improvement Plan (DSRIP)/Strategic Plan submitted in response to the California 1115 waiver. These would *not* include all indicators being measured across the system but rather would be identified as critical success factors for the health care system. The indicators may include but should not be limited to the 13 measures included in the Whole System Measures framework promoted by the Institute for Healthcare Improvement (IHI) and indicated in the Strategic Plan. The dashboard and the response to the performance measurement should be regularly reviewed by the County Administrator's Office and presented to the Board of Supervisors for their oversight and input.

- Clinical, operational, financial, and management performance measurement should be transparent and communicated at all levels of the organization. This practice is particularly critical as health care reform is implemented and because creating a high-performing system can only be accomplished through the attention and efforts of multiple departments and people and using data as a shared tool for improvement. These principles were well articulated in the Health Service Department's Strategic Plan prepared for the Delivery System Reform Incentive Plan under the section 1115 waiver..

PCMH System of Care

In terms of quality measurement, Contra Costa County's 2010 Quality Assessment and Performance Improvement Plan/Patient Safety Plan for CCRMC and County health centers is a clear and robust plan as is the department's Strategic Plan. Additionally, the Health Department is doing well on many of its HEDIS measures. However, in order to fulfill the promise of quality envisioned in the PCMH model, the HSD will need to augment its performance plan and adopt indicators and develop mechanisms that enable real-time reporting of quality down to specific care teams. It will also have to include measures that are specific to the County's health centers and coordination across care sites.

HMA proposes that in selecting additional quality measures, measures are used that have been nationally vetted and endorsed by the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF), which has a portfolio of endorsed performance measures that can be used to measure and quantify health care processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the provision of high-quality care. Additionally, the County may consider using condition-specific recognition programs by NCQA [14] or Bridges to Excellence[15]—either just the assessments or through seeking recognition itself—to select measures and target improvements. Importantly, the measures included in the programs would enable the County to measure both achievement of performance goals and improvement towards those goals.

Regardless of the measures selected, the indicators should specify the period of measurement, the sample (e.g., all patients in a panel or some percentage), and the accountable department and lead. Again, the HSD can build off of the Quality Assessment and Performance Improvement Plan/Patient Safety Plan template.

Additionally, the HSD should measure if improved outcomes are sustained over time, not just achieved. This should involve developing sustainability plans prior to implementing an improvement and use a dashboard type device to monitor both achievement *and* sustainability.

There are a number of options the County could pursue to regularly collect and monitor performance. In addition to the measures indicated in the existing plan, HMA proposes the following:

- The HSD should assess its current PCMH level of attainment. As stated, the Safety Net Institute (SNI) PCMH assessment tool is a free tool that can—and should—be customized by the County

[14] NCQA's recognition programs are for Back Pain, Heart/Stroke, and Diabetes.

[15] Bridges to Excellence's recognition programs are for Asthma, Cardiac, Congestive Heart Failure, COPD, Coronary Artery Disease, Depression, Diabetes, Hypertension, and Spine.

to assess the "medical home-ness" of its County health centers (see Appendix C). The customized assessment and its measures can also help the County monitor its progress toward achieving a full-scale PCMH system of care. PCMH indicators should be measured while the HSD is implementing improvements and overtime to ensure the sustainability of the improved outcomes.

- The HSD should select and monitor quality measures that are specific to the County health centers[16] and implement a uniform set of measures and measurement procedures that are consistent across all centers and reported to the County Administrator's Office and the Board of Supervisors. A subset of those measures should be included in the County dashboard, particularly measures that point to improvement opportunities across care settings. The County may consider using the population-focused improvement measures outlined in the Strategic Plan as a starting place for selecting measures.
- The HSD should prioritize measuring—and implementing strategies to reduce—hospitalizations for Ambulatory Care Sensitive Conditions (ACSCs). As indicated in the Stage 1 report, CCRMC had the highest rate for 5 of the 14 ACSCs measures: Urinary Tract Infections, Hypertension, Pediatric Gastroenteritis, Chronic Obstructive Pulmonary Disease (COPD), and Diabetes short-term complications with uncontrolled Diabetes.[17] Note that NCQA and Bridges to Excellence both have recognition programs for both COPD and Diabetes and could be used as guides to assess performance, measure progress, and/or implement improvements.
- The HSD should measure the following utilization indicators:
    - 7 day, 30 day, and 90 day readmission rates[18]
    - Rate of ED utilization
    - Percent of ED visits that are low acuity and/or ACSCs

Quality, Access, and Operations

There are a number of access and operational measures that could assist the HSD in monitoring and improving the performance of its operations. As with PCMH measures, operational effectiveness and efficiency should be measured while the County is implementing improvements and overtime to ensure sustainability of outcomes. Measures should include but not be limited to:

- Number of pediatric, OB, adult outpatient visits;
- Readmission less than 30 days;[19]
- Patients with 24 hour admissions
- Frequent users, repeat, and high cost users of the ED
- Excess Length of Stay (LOS)

[16] Although the health centers indicated that they had initiatives that focused on measuring and improving hand washing and patient experience, they did not provide any additional information on other quality indicators.

[17] California Office of Statewide Health Planning and Development, Patient Discharge Data, 1999-2008 Agency for Healthcare Research and Quality, Prevention Quality Indicators, Version 3.1.

[18] Note that 30 day readmissions was included as an indicator in the Strategic Plan.

[19] Note that 30 day readmissions was included as an indicator in the Strategic Plan.

- ADC data against national norms
- Access to primary care, including telephone access, evening/weekend hours, e-contacts, and care coordination;
- Cancelled clinics;
- Missed appointments;
- Appointment supply and demand; and
- Primary care and specialty provider productivity.

Labor Force Issues

There are critical performance measures related to labor and productivity that can help the County and the Health Services Department to manage its workforce more effectively. HMA proposes the Board of Supervisors consider the following:

- As stated, as part of a total compensation philosophy for providing compensation and benefits to physicians and nurses, the County may want to conduct an annual, formal market survey to determine HSD's competitive position with hospitals and other organizations. The information from the surveys would provide consistent and timely information for negotiations and provide a basis for communicating compensation related information.
- Create access to real-time labor cost data by implementing an electronic time-keeping and attendance system.
- Develop and provide managers with productivity and labor staffing reports and information. Create accountability for labor cost optimizations throughout the chain of command and make reports transparent. Prioritize the implementation of an electronic time and attendance system to automate the payroll process and provide real-time labor cost data. It is expected electronic time and attendance systems will provide consistent time management, labor cost oversight, and precise payment of overtime hours worked.
- Create and utilize metrics for measuring clinical and non-clinical staff productivity and effectiveness. Create staffing benchmarks that can be compared with other health care organizations.

Fiscal Management

Section V outlines options the Board of Supervisors can consider for organizational changes that could strengthen the performance and sustainability of the health care system. While that section will provide more detail, there are important data collection and analysis procedures related to these options. They include:

- The County Administrator's Office and the Board of Supervisors should receive monthly financial reports that enable them to monitor variances from the planned budget and for all care settings. Indicators from these reports should be included in the any dashboard that is developed.

- Measures of financial performance should include all revenue sources and be delineated by care setting.
- The cost baseline for the HSD should relate to total expense and all deviations be noted and explained.
- Department managers should have sufficient information to manage their areas and if warranted make trade-offs to improve overall operations. They should have access to both "real-time" and actual financial data and productivity measures

Summary

Contra Costa County has made great strides towards becoming a high performing and sustainable health care system. The measures and methods used to monitor its progress and to target and monitor improvements will become increasingly critical as it moves toward a PCMH model of care and operates in an environment being changed by health reform. For over 4 years CCRMC has been a leader in performance improvement methods. The County, Board of Supervisors and executive leadership have spent valuable resources in time in supporting a Fellowship from the Institute of Healthcare Improvement for Anna Roth (CEO), numerous Kaizen continuous improvement teams, a Change Agent Fellowship (within CCRMC), and an Improvement Academy. Most recently CCRMC has joined HHS' Partnership for Patients (effort to decrease medical errors). However, the County can still benefit greatly from a more transparent and clearly communicated performance measurement process. The options presented in this section could support what is in place and enhance the County's ability to provide better oversight and management of its health care system, as health care reform implementation continues.

Conclusion

This final report provides multiple options for the Contra Costa County Board of Supervisors to consider in continuing its progress toward a more cost-effective, efficient, and sustainable health care system that best meets the needs of the expanding Medi-Cal population, uninsured, and other medically vulnerable residents of the County.

Based on HMA's assessment, the County has made tremendous strides in improving its delivery system. The County has put into place many of the pieces required to ensure the right care at the right place at the right time. The next step for the Board of Supervisors to consider is movement toward becoming a full-scale PCMH system of care and the possibilities, challenges (and policy implications) of becoming an Accountable Care Organization.

The County also has been a leader among other counties in California in maximizing revenue to the greatest extent possible. The structural, management, and measurement options presented in this report would enable the County to better respond to the current and emerging environment, including the impact of health reform and workforce and financial issues. It will also allow the County to continually push towards excellence and excellent service to the residents of Contra Costa County in whatever governance model is chosen.

Appendix A: Acknowledgements

HMA wishes to acknowledge the support and participation of numerous individuals in the preparation of this report. Persons interviewed included representatives of the Health Services Division, County government, health care providers from all parts of the county, and labor. The time spent, information provided, and ideas generated were invaluable in assisting HMA.

Appendix B: Data Sources

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Lisa Driscoll, County Finance Director, February 2011.

Appendix C: Medical Home Work Plan for Contra Cost County

This Appendix is provided as a supplement to Section I of this report and presents details about a work plan that could be implemented by Contra Costa County.

Assessment of "Medical Home-ness" of Contra Costa County Health Centers

Contra Costa County health centers have aspired to the PCMH model and have certainly moved down the path of providing care under that model. However, gaps are also apparent, although the specifics of these gaps need to be more formally assessed as an early step in the work plan. Dr. Chris Farnitano, Ambulatory Medical Director of Contra Costa Health Services, has outlined some of the strengths, gaps and future plans related to PCMHs in a presentation called "The Contra Costa Medical Home: Past, Present and Future."[20] The model and work plan outlined in this section meet the general needs and constructs outlined in the presentation.

Each PCMH model has self-assessment tools to gauge current status as well as to measure progress over time. For example, the SNI model offers a free assessment tool[21] (see Appendix D). The assessment tool is public domain and can be modified for specific institutional needs. An assessment will be needed in order to build on the current strengths and address the gaps. This can be preliminarily assessed at the level of basic principles of the PCMH as follows:

Patient centeredness

Contra Costa County health centers regularly assess the experience of patients and family through satisfaction surveys and have very good results. However, patient-centered care will require additional steps. For example, interpretive services are critical for patients with limited English proficiency; however, although interpretive services are available, in a 2010 pediatric obesity project, the providers signaled roadblocks in using interpretive services. Also not systematically in use are methods for patient self-management education and goal setting and motivational interviewing techniques that support patient behavior change. Patients' care preferences (and their families') will also need to be assessed, documented, and incorporated into care plans.

Continuous healing relationships with primary care provider

Patients are generally seen by the same provider over time, and patient panels are defined historically by the patients that a provider has seen in the past. A challenge for Contra Costa County health centers will be to *prospectively* define the patient panels. The panels need to be synchronized with the reality of their responsibilities. This means that at any given point in time a provider and the team would know the entire population for whom they are responsible. This can be accomplished in various ways, but a patient registry that interacts with health plan assignment data is one method that will likely make sense for Contra Costa County. Defining a panel allows a truer balancing of capacity and demand. Defining a prospective or synchronous panel also necessarily means limiting the introduction of new patients into the panel to a number that maintains this balance. This limitation is a major challenge for

[20] http://www.naph.org/Homepage-Sections/Collaborate/Fellows-Program/2010-Fellows-Information/Session-2-Information.aspx

[21] http://www.qhmedicalhome.org/safety-net/upload/PCMH-A_public.pdf

safety net providers. Typically in a safety net institution, the patients who are either the sickest or are the most tolerant, persistent, and/or insistent are the patients that will be seen (at least for populations such as non-pregnant adults for whom inadequate insurance is prevalent). Access is difficult because the number of patients needing care exceeds the capacity of the system. The PCMH model does not address this fundamental issue, but Contra Costa County will need to do so. An option is to offer this model of care only to those for whom Contra Costa is contractually obligated to care and to those that the comprehensive PCMH- approach to care is most likely to help. Patients in Contra Costa Health Plan (CCHP) or other plans would all be included. For County residents who are uninsured, criteria would need to be developed for enrollment in a PCMH. Care for others would be done in an episodic manner that would not conform to the principle of a continuous healing relationship.

Access

Access is an issue for Contra Costa County health centers. This is in part due to panel sizes that are too large (reported to be up to 3,000 patients for individual practices). A typical safety net, adult population panel size is in the range of 1,200 to 1,800. Contra Costa County reports panel sizes that far exceed this level. In order to reconcile this, Contra Costa County leadership needs to emphasize depth over breadth in terms of primary care delivery. If current panel sizes are double a reasonable size and yet per hour visit productivity is below goal, the system cannot be adequately serving the patients. A sign of this is the difficulty of obtaining a routine follow-up appointment. The appointments are released on a rolling 30-day basis. This makes a good deal of sense for most patients because the patients are more likely to make the appointments if they have made them more recently. However, in Contra Costa County health centers, there is a scramble each day for patients to call in early enough to get an appointment. All of the appointments are quickly filled. This is a sign that the panel sizes are too large and that productivity increases alone (these are definitely needed as well) will not solve the primary care access situation.

Contra Costa County does have a 24/7 nurse line funded by health plans. Detailed utilization and performance measures were not available for HMA's review. Key information including volume and time of call, the reason for the call, and the performance, i.e., dropped calls, hold times, etc, will need to be examined. This careful look will help determine how this service is presently serving the needs of the patients, and, if changes are needed, how it can best support the PCMH system.

Coordinated Care

Coordinated care includes care management for higher-risk patients, pro-active outreach to patients not meeting care goals, bi-directional communication with specialty and diagnostic services, and integration of information technology. These items fit within the functions outlined above and a patient registry should fulfill the functions. Contra Costa County health centers use a diabetes registry, and, although this is a good start and a foundation to build on, it is important to note the limitations of this registry. The registry is only for patients with diabetes and only for diabetes-related measures. The registry does not include blood pressure, which is arguably the most important objectively measurable parameter. The registry report does not appear to lend itself well to assisting with planned care (i.e., patient-specific day-of-care reports that identify and assist in completing needed care).

There are other opportunities to improve the coordination of care to enhance care and satisfaction. Currently, notification of an inpatient admission to the primary care provider occurs through email and is consistent, though not automated. The notification at discharge is encouraged but not consistently completed. Other staff members such as nurses or care coordinators are not notified of these clinical events. The ED notification is limited. Phone outreach to patients does occur in certain but not all circumstances.

Comprehensive care

Comprehensiveness is a strong point for the Contra Costa County, although some gaps exist. In most health centers, phlebotomy is only available once per week. The health centers have made up for this problem by offering point-of-care testing (POCT) for frequently used tests. Various centers offer limited evening hours and only some are open on Saturdays. Urgent care services are dependent on payer class. They are only available outside of clinic hours to health plan members.

Contra Costa County has developed programs/initiatives to focus on providing comprehensive are to specific high-need/high-risk populations and built programs for the care of these patients. This includes an anticoagulation clinic, behavioral health integration, Tuberculosis Prophylaxis Clinics, Treat-to-Target Insulin Program, and CHF program.

Part of comprehensive care is delivering quality care. In the SNI model, one of the change concepts is to choose and use a QI model. CCRMC uses a nationally-recognized model called Kaizen. The model includes process flow mapping, Plan/Do/Check/Act cycles, and continual and incremental improvement with "Lean" management principles. The QI model will lend itself well to some aspects of the PCMH transformation, although it should be recognized that a majority of changes will not require incremental adjustments "down in the weeds," but rather system-level decisions to provide the support, tools, and incentives to transform. In terms of quality measurement, Contra Costa County is doing well in terms of HEDIS measures. However, in order to fulfill the promise of quality envisioned in the PCMH model, a more robust, real-time reporting of quality down to specific care teams will be needed.

Team-based care

The PCMH team functions best with crossed trained individuals who consistently performtasks at the top of their license, skill, and credentialing. This means registered nursing (RN) staff, in general or routinely, should not be doing vital signs and rooming patients, though they should be cross-trained to do this. The County health centers have taken steps to provide team-based care. Some clerical staff have taken on the role and title of care coordinator. The primary activity of the care coordinators is making reminder calls to patients about upcoming appointments at the direct request of the providers. This role assignment provides the opportunity to have other tasks completed by these clerks (or nursing assistant staff) and, therefore, enable RNs to focus on performing clinical functions.

Summary

Pursuit of a true PCMH model affords Contra Costa County health centers great opportunity for transformation. Although there are other issues to consider, the scheduling processes and the history-based panel definitions currently respect the need and role of continuous relationships. Today, most

patients do see their defined primary care provider on return visits. However, the demand of open-ended panels creates poor access. Truly coordinated care ~~not only~~ requires both technological solutions for generating automated tasks (e.g., coordinate an outpatient visit within five days of hospital discharge) and staff well trained to take on new patient centered care coordination responsibilities. Contra Costa County health centers can use the SNI PCMH model to assess and meet these crosscutting challenges.

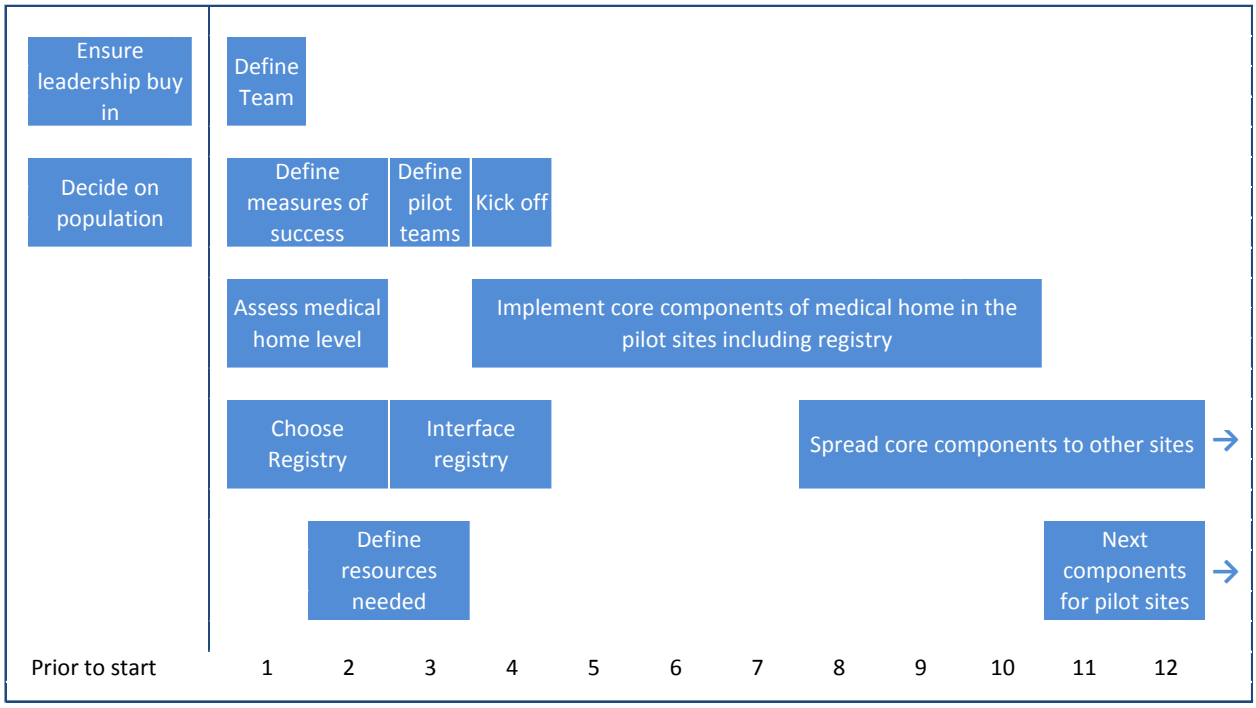
Selection of Initial Components for Contra Costa County PCMHs

Selecting components for initial work plan focus is critical. These components should provide the foundation for continued implementation as well as provide high yields in terms of measurable "wins." In this regard, Contra Costa County can build on current efforts. Note that some items are not included because the health centers already seem to do them well (e.g., assessing patient satisfaction) and, therefore, are not high yield areas of focus. The work plan outlines the attainment of the following components of the PCMH—although a more tightly defined set of initial changes may be needed:

- Create prospective patient panels for each primary care provider
    - Determine and understand which patients should be empanelled in the PCMH
        - Determine capacity above and beyond health plan members
        - Determine criteria for patients to be added and subtracted from patient panels
    - Actively manage practice patient load so that value, not volume, is delivered for the highest risk patients and for patients assigned to Contra Costa County
        - Integrate practice management software with robust registry and scheduling functions
- Continuous and Team-Based Healing Relationships
    - Assure that in most cases patients see their own provider or care team
    - Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members
    - Cross-train care team members to maximize flexibility and ensure that patients' needs are met
- Enhanced Access
    - Implement mechanisms to minimize cancelled clinics and missed appointments and measure progress in this process improvement
    - Provide scheduling options that are patient and family-centered and accessible to all empanelled patients
- Care Coordination
    - Provide care management services for high risk patients
    - Standardize the role of unlicensed clerical staff in care coordination
    - Follow-up with patients after each ED visit or hospital discharge
    - Communicate test results and care plans to patients/families
    - Use panel data and registries to proactively contact, educate, and track patients by disease status and risk status

- Organized, Evidence-Based Care
  - Use of planned care according to patient need
  - Use of point-of-care reminders based on clinical guidelines
  - Enable planned care interactions with patients by making up-to-date information available to providers and the care team at the time of the visit

Timeline/work plan:



The stages in the timeline above are detailed below:

Ensure engagement/buy-in of key leadership to the PCMH model

The physician leadership and perhaps key physician "influencers" will need to understand the PCMH model and agree to champion the transformation. Physicians are essential for success. Leadership in other areas will also need to be fully committed and engaged. Creating the right message and defining roles early will help cement this level of commitment and clarify the type and level of engagement needed. Part of ensuring engagement will be delivering a clear message concerning the underlying reasons for transforming care. Reasons may include: patient experience, quality of care, cost containment, and/or meeting future requirements for payment. Being clear about the reasons for making the full PCMH transformation and why this is the moment to make that transformation will help to create a more deep commitment to the change. Contra Costa County includes leadership with national experience in promoting and discussing the PCMH model, which will likely prove to be a key strength for successful transformation.

Decide on which populations will be prioritized for enrollment

Preliminary data suggest that Contra Costa County health centers cannot serve all of the unique patients currently seen each year with the current number of primary care providers in a fully developed PCMH model. This seems counterintuitive because the patients are already being seen. Yet the number in the historically defined panels is too high to get the access and level of service envisioned in the PCMH model. This would mean that a majority of patients would be seen only once a year. A typical safety net ambulatory system serves many middle-aged people with multiple chronic diseases and the average number of visits would be expected and needed to be much higher.

Given that the current number is too high and that there is presumably need for some patients to be added each month, decisions will need to be made about how to resolve this mismatch. Adding more primary care capacity is an option. Another option is to limit the model to certain categories. (These options are not mutually exclusive.) In fact, to an unknown extent, the County already does this through the arrangement to have undocumented patients seen at a non-public FQHC. The highest priority for the County is likely to be the patients in managed care plans since there is a contractual agreement to provide a number of these elements. The next priority may be the patients that are at highest risk for preventable utilization of the ED and hospital. The challenge, of course, is identifying these patients before the utilization occurs. There are a number of predictive models and systems that are available for this purpose.

Identify and formally constitute a PCMH transformation team

The first step will be to identify the team that reports directly to the CCHS Ambulatory Medical Director, Dr. Chris Farnitano and is responsible for attaining clearly defined outcomes. The team will need to have the authority to clear the way for the pilot sites to implement new processes. The team should include leaders with operational expertise and staff from clerical, nursing, provider, human resources, and pharmacy areas. Optimally, the team should have the right expertise but be sufficiently small to allow for efficient decision-making. Three to seven is a reasonable range.

Define resources needed to accomplish work plan

The team will need to define the resources needed to accomplish the plan. One concrete external resource that will be needed is a commercial patient registry. Although the various vendors have different pricing methods, a registry is likely to cost, (as a very gross estimate) $1,000 per year per primary care provider. Another way to think about this is less than $1.00 per patient served per year.

The County would also benefit from retaining outside expertise in transforming the primary care practices to the PCMH model. Although sufficient internal resources may be available in terms of time, prior experience in implementing PCMH in the safety net is needed to avoid pitfalls and navigate an often-obstructed path to transformation.

The largest commitment of resources will need to be internal. Aside from the time of the leadership team, which will likely be a total of 2.0 FTEs during pilot and spread, a clinical team will be needed to guide the process of defining measures of success and to provide input into process of implementation (e.g., the customization of the registry, defining of the care management program), and an information

technology team will need to guide the registry implementation. Through the Kaizen process, the County has a record of identifying and committing internal resources to initiatives.

The transformation process will begin with pilot teams. The pilot process will need 0.10 to 0.20 FTE from four to six PCMH team members (i.e., primary care provider, nurse, unlicensed clinical person, clerical person, and an administrator) for about six to nine months. When spreading to other teams, less time may be needed by the spread teams.

Define measures of success

This is a critical activity. The SNI PCMH assessment tool (see Appendix C) scores can be useful as a "soft" but critical measure of success. The tool is generic and will need to be customized for Contra Costa County. The PCMH team will need to identify process and outcome measures that will define success. Process measures will mostly derive from the assessment tool. Section V outlines potential outcome measures that could be used to define success.

Choose registry as foundational tool for implementing PCMH components

A registry, as explained above, is really a set of functions that could conceivably be performed by other systems such as an EHR. However, the software designed specifically for population health management is, at this time, much more functional than EHR software. The County should have the PCMH transformation team evaluate vendors against an internally defined set of criteria that should include technology platform, size of customer base, customer satisfaction, ease of use, ability to interface with other data sources, and ability to support the priority components of the PCMH model.

Create interfaces with scheduling, inpatient/ED ADT transactions, prescriptions, and potentially point-of-care testing (POCT)

The registry will function poorly as a tool if more than a very small amount of data entry is needed in order to gain meaningful reports and impact on patient care. The main way data needs to get into the registry is through interfaces. These will need to be custom built with cooperation between institutional IT staff and the vendor. The importance of various data elements will be apparent after the PCMH team defines the measures of success. For instance, an initial process measure might be that 95 percent of patients have a visit within five days of discharge from the hospital with their assigned PCMH provider. Getting an actionable daily report to affect this measure will take an interface with the hospital's ADT feed. Measuring progress in attaining the goal would additionally take a feed into the scheduling system or the outpatient ADT transactions.

Common chronic conditions will likely be chosen as initial areas of focus, including diabetes and these will have associated measurement outcomes. With many of the health centers having limited laboratory services, a process improvement to consider is point-of-care testing, although interfacing with laboratory information systems is generally not a problem for registry vendors. More challenging, at least before the implementation of an EHR, will be getting the crucial blood pressure data into the registry. This could be accomplished with interfaces to commercial automated blood pressure monitors, but a cost-benefit analysis would need to be done. The alternative is manual entry of the blood pressure data, but this takes significant staff time and effort.

Choose pilot teams

Certain criteria will define the best teams for the pilot stage. The provider should an "early adopter"/champion type of person. The nurse associated with the team is likely to see the biggest shift in his or her role. Teams with nurses that are familiar with care management activities, including goal setting and motivational interviewing, would allow for a more smooth transition from pilot to spread. The administration at the pilot site should also be early adopter types and allow for innovation in developing the model within the County system. Other factors in selecting pilot teams will include geographic distribution and the physical facilities. The opening of a new health center and new space presents a perfect opportunity to introduce a new model of care delivery.

Educate pilot teams on model, measures of success, and registry

The education and skill building can be accomplished in various ways. With four to six pilot teams, one high-yield method for providing education and skills training is through learning sessions where the pilot teams come together in a structured way outlined in Institute for Health care Improvement (IHI) publications and referred to as the Breakthrough Series Model. This model includes defining measures to determine whether a change leads to an improvement, team pre-work, three learning sessions with action periods in between, and a summary evaluation session. Using this model assumes that the best ways of achieving the outcomes and implementing the components of the model is best discovered collectively through implementing the Model of Improvement, which utilizes Plan, Do, Study, Act (PDSA) cycles[22] The agenda of each session includes didactic material on the component, planning for the next action period, and sharing work accomplished. Properly facilitated, these learning sessions allow pilot teams to learn from each other and incorporate what they learn into their PDSA cycles.

This model of having pre-work, learning sessions, action periods, and a method for testing changes at the care site is perfectly in tune with the Kaizen method as well. The Kaizen model also includes rapid cycle improvement through cycles of planning, doing, studying and incorporating practices that work. Since the County already has experience with the Kaizen process and a communication strategy has been built up around this model, this process should also be communicated within that structure.

Implement core components in pilot sites: use of panels and care coordination through the use of registry

Three foundational and high-yield components of a PCMH implementation are using panels, using a registry, and instituting a care management program. The PCMH team may decide that other components, such as team-based care or access, must be included in the initial pilot phase. However, a more concentrated focus is more likely to result in short-term success to then build on when incorporating to other components.

The implementation occurs during the action periods in between learning sessions. Significant assistance will be needed for the pilot teams to accomplish implementation. It also needs to be recognized from the start that the ability of the pilots to accomplish the implementation of these components is

[22] PDSAs are a structured method for rapidly testing changes in the real work setting championed by IHI and are already in use in the County's Patient Safety and Performance Improvement Program.

dependent on success at other levels. For instance, there needs to be a highly functional and integrated registry product in order for the pilot teams to incorporate the use of registry into their daily practice. Leadership must have successfully wrestled with decisions and subsequent process related to the population of focus and the criteria for patients to get on and remain in the panel in order for the pilot team to accomplish effective panel management. These types of foundational decisions and accomplishments must be made before the pilot teams are asked to transform their practices.

Define the PCMH staffing plan through pilot site experience

Although a preliminary staffing model will need to be chosen for the pilot teams, it is within the pilot process that the County will learn which staffing model is right for their system. A process for defining, testing, and refining the staffing model should be put in place so that at the time of spread this will be incorporated into the spread plan and communicated. For staff who will have new functions or a shift in roles based on the pilot site experience, Human Resources will need to alter job descriptions and other staffing processes, which may require the involvement of Labor. Yet this is a critical step to ensure the sustainability of the new ways of operating as a PCMH and the associated outcomes.

Spread core components to other sites

The spread of components can begin before the pilots have even finished their workshops or learning sessions. The experience of the pilot teams will inform this spread. An example might be specific uses of the registry. The pilot teams may find that a process in which the team clerk signs on to the registry each morning and calls the one or two patients who have been discharged from the hospital is highly successful. This may be the first process spread to non-pilot teams. The spread of the process, however, would include defining the panel for that next spread team, the staff model, and training the team on the use of the registry. This process would include all three of the initial components: empanelment, care management, and registry use. Initial spread will likely be the most intensive and using a specific best practice to accomplish this initial spread is an excellent way to get buy in for further spread.

Introduce next highest priority components to the pilot sites

The next components to be tackled will depend on the initial success and the barriers encountered. Access will be only partially addressed by defining reasonable patient panels. Teams will need to identify other changes to improve access, including but not limited to extended hours, point-of-care testing, same-day access, and making the 24-hour nurse line function well for the entire empanelled population. Planned care interactions may be a natural next step as most registries have day-of-care plans that conveniently display up-to-date clinical information and incorporate reminders about guidelines.

Summary

The work plan for achieving a highly functioning PCMH for the patients of Contra Costa County is formidable and will require significant commitment and work. The accomplishment of the PCMH model will be foundational and allow the County to pursue other strategic objectives such as retaining patients and identifying or responding to other payment models. The County continues to demonstrate a commitment to the best patient care. This work plan outlines a path to attaining a higher level of patient care for the patients that Contra Costa defines as within their sphere of responsibility.

Appendix D: Patient-Centered Medical Home Assessment

PUBLIC COPY

PATIENT-CENTERED MEDICAL HOME ASSESSMENT (PCMH-A)

DIRECTIONS FOR COMPLETING THE SURVEY

This survey is designed to help systems and provider practices move toward the "state-of-the-art" in delivering patient-centered care in the context of a medical home. The results can be used to help your team identify areas for improvement. Instructions are as follows:

1. **Answer each question** from the perspective of one physical site (e.g., a practice, clinic, hospital, health plan).

   Please provide name and type of site (e.g., Central Health Center/FQHC)

2. For each row, **circle the point value** that best describes the level of care that currently exists in the site. The rows in this form present key aspects of patient-centered care. Each aspect is divided into levels showing various stages in development toward a patient-centered medical home. The stages are represented by points that range from 1 to 12. The higher point values indicate that the actions described in that box are more fully implemented.

3. **Review your score on page 12. If taken on a computer,** this form will auto-calculate your score.
   If taken in hard copy (on paper) you will need to sum the points in each section (e.g., total part 1 score), calculate the average score (e.g., total part 1 score / # of questions), and enter these scores at the end of each section. Then sum all of the section scores and complete the average score for the program as a whole by dividing this by 8.

4. **Save a copy for yourself** by clicking here SAVE A COPY

4. **Print a copy for yourself** by clicking here PRINT A COPY

For more information about how to complete the survey, please email info@qhmedicalhome.org.

PART 1: EMPANELMENT

1a. Determine and understand which patients should be empanelled in the medical home, and which require temporary, supplemental, or additional services.
1b. Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self management status, community and family need.
1c. Understand patient supply and demand and balance patient load accordingly.
1d. Enable feedback to team and for external reporting on processes of care and population outcomes.

Components	Level D	Level C	Level B	Level A
1. Patients	...are not assigned to specific practice panels.	...are assigned to specific practice panels but panel assignments are not routinely used by the practice for administrative or other purposes.	...are assigned to specific practice panels and panel assignments are routinely used by the practice mainly for scheduling purposes.	...are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.
Score	1 2 3	4 5 6	7 8 9	10 11 12
2. Registry or panel-level data	...are not available to assess or manage care for practice populations.	...are available to assess and manage care for practice populations, but only on an ad hoc basis.	...are regularly available to assess and manage care for practice populations, but only for a limited number of diseases and risk states.	...are regularly available to assess and manage care for practice populations, across a comprehensive set of diseases and risk states.
Score	1 2 3	4 5 6	7 8 9	10 11 12
3. Registries on individual patients	...are not available to practice teams for pre-visit planning or patient outreach.	...are available to practice teams but are not routinely used for pre-visit planning or patient outreach.	...are available to practice teams and routinely used for pre-visit planning or patient outreach, but only for a limited number of diseases and risk states.	...are available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states.
Score	1 2 3	4 5 6	7 8 9	10 11 12
4. Reports on care processes or outcomes of care	...are not routinely available to practice teams.	...are routinely provided as feedback to practice teams but not reported externally.	...are routinely provided as feedback to practice teams, and reported externally (e.g. to patients, other teams or external agencies) but with team identities masked.	...are routinely provided as feedback to practice teams, and transparently reported externally to patients, other teams and external agencies.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Total Health Care Organization Score 0.0 **Average Score (Health Care Org. Score/4)** 0.0

PART 2: CONTINUOUS TEAM-BASED HEALING RELATIONSHIPS

2a. Clearly link patients to a provider and care team so both the patients and provider/care team recognize each other as partners in care.
2b. Assure that patients are able to see their provider or care team whenever possible.
2c. Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.
2d. Cross-train care team members to maximize flexibility and ensure that patients' needs are met.

Components	Level D	Level C	Level B	Level A
5. Patients are encouraged to see their paneled provider and practice team	...only at the patient's request.	...by the practice team, but is not a priority in appointment scheduling.	...by the practice team and is a priority in appointment scheduling, but patients commonly see other providers because of limited availability or other issues.	...by the practice team, is a priority in appointment scheduling, and patients usually see their own provider or practice team.
Score	1 2 3	4 5 6	7 8 9	10 11 12
6. Non-physician practice team members	...play a limited role in providing clinical care.	...are primarily tasked with managing patient flow and triage	...provide some clinical services such as assessment or self management support.	...perform key clinical service roles that match their abilities and credentials.
Score	1 2 3	4 5 6	7 8 9	10 11 12
7. The practice	...does not have an organized approach to identify or meet the training needs for providers and other staff.	...routinely assesses training needs and assures that staff are appropriately trained for their roles and responsibilities.	...routinely assesses training needs, assures that staff are appropriately trained for their roles and responsibilities, and provides some cross training to permit staffing flexibility.	...routinely assesses training needs, assures that staff are appropriately trained for their roles and responsibilities, and provides cross training to assure that patient needs are consistently met.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Total Health Care Organization Score 0.0 **Average Score (Health Care Org. Score/3)** 0.0

PART 3: PATIENT-CENTERED INTERACTIONS

3a. Assess and respect patient and family values and expressed needs.
3b. Encourage patients to expand their role in decision-making, health related behaviors, and self management.
3c. Assure communication with their patients in a culturally appropriate manner in a language and at a level that the patient understands.
3d. Provide self management support through collaborative goal setting and patient action planning.

Components	Level D	Level C	Level B	Level A
8. Assessing patient and family values and preferences	...is not done.	...is done, but not used in planning and organizing care.	...is done and providers incorporate it in planning and organizing care on an ad hoc basis.	...is systematically done and incorporated in planning and organizing care.
Score	1 2 3	4 5 6	7 8 9	10 11 12
9. Involving patients in decision-making and care	...is not a priority.	...is accomplished by provision of patient education materials or referrals to classes.	...is supported and documented by practice teams.	...is systematically supported by practice teams trained in decision making techniques.
Score	1 2 3	4 5 6	7 8 9	10 11 12
10. Patient comprehension of verbal and written materials	...is not assessed.	...is assessed and accomplished by assuring that materials are at a level and language that patients understand.	...is assessed and accomplished by hiring multi-lingual staff, and assuring that both materials and communications are at a level and language that patients understand.	...is supported at an organizational level by translation services, hiring multi-lingual staff, and training staff in health literacy and communication techniques (such as closing the loop) assuring that patients know what to do to manage conditions at home.
Score	1 2 3	4 5 6	7 8 9	10 11 12
11. Self-management support	...is limited to the distribution of information (pamphlets, booklets).	...is accomplished by referral to self-management classes or educators.	...is provided by goal setting and action planning with members of the practice team.	...is provided by members of the practice team trained in patient empowerment and problem-solving methodologies.
Score	1 2 3	4 5 6	7 8 9	10 11 12
12. The principles of patient-centered care	...are included in the organization's vision and mission statement.	...are a key organizational priority and included in training and orientation.	...are explicit in job descriptions and performance metrics for all staff.	...are consistently used to guide organizational changes and measure system performance as well as care interactions at the practice level.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Total Health Care Organization Score 0.0 **Average Score (Health Care Org. Score/5)** 0.0

PART 4: ENGAGED LEADERSHIP

4a. Provide visible and sustained leadership in overall culture change and specific strategies to improve quality and sustain and spread change.
4b. Establish a QI team that meets regularly and guides the effort.
4c. Build the practice's values on creating a medical home for patients into the staff hiring and training process.

Components	Level D	Level C	Level B	Level A
13. Executive leaders	...are focused on short-term business priorities.	...visibly support and create an infrastructure for quality improvement, but do not commit resources.	...allocate resources and actively reward quality improvement initiatives.	...support continuous learning throughout the organization, review and act upon quality data, and have a long-term strategy and funding commitment to explore, implement and spread quality improvement initiatives.
Score	1 2 3	4 5 6	7 8 9	10 11 12
14. Clinical leaders	...intermittently focus on improving quality.	...have developed a vision for quality improvement, but no consistent process for getting there.	...are committed to a quality improvement process, and sometimes engage teams in implementation and problem solving.	... consistently champion and engage clinical teams in improving patient experience of care and clinical outcomes.
Score	1 2 3	4 5 6	7 8 9	10 11 12
15. The organization's hiring and training processes	...focus only on the narrowly defined functions and requirements of each position.	...reflect how potential hires will affect the culture and participate in quality improvement activities.	...place a priority on the ability of new and existing staff to improve care and create a patient-centered culture.	...support and sustain improvements in care through training and incentives focused on rewarding patient-centered care.
Score	1 2 3	4 5 6	7 8 9	10 11 12
16. The responsibility for conducting quality improvement activities	...is not assigned by leadership to any specific group.	...is assigned to a group without committed resources.	...is assigned to an organized quality improvement group who receive dedicated resources.	...is shared by all staff, from leadership to team members, and is made explicit through protected time to meet and specific resources to engage in QI.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Total Health Care Organization Score 0.0 **Average Score (Health Care Org. Score/4)** 0.0

PART 5: QUALITY IMPROVEMENT (QI) STRATEGY

5a. Choose and use formal models for QI
5b. Establish and monitor metrics to evaluate improvement efforts and outcomes and provide feedback.
5c. Obtain feedback from patients/families about their healthcare experience and use information for quality improvement.
5d. Ensure that providers, staff and patients and families are involved in QI activities.

Components	Level D	Level C	Level B	Level A
17. Quality improvement activities	...are not organized or supported consistently.	...are conducted on an ad hoc basis in reaction to specific problems.	...are based on a proven improvement strategy in reaction to specific problems.	...are based on a proven improvement strategy and used continuously in meeting organizational goals.
Score	1 2 3	4 5 6	7 8 9	10 11 12
18. Performance measures	...are not available for the clinical site.	...are available for the clinical site, but are limited in scope.	...are comprehensive – including clinical, operational, and patient experience measures – and available for the practice, but not for individual providers.	...are comprehensive – including clinical, operational, and patient experience measures – and fed back to individual providers.
Score	1 2 3	4 5 6	7 8 9	10 11 12
19. Quality improvement activities are conducted by	...a centralized committee or department.	...topic specific QI committees.	...all practice teams supported by a QI infrastructure.	...practice teams supported by a QI infrastructure with meaningful involvement of patients and families.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Total Health Care Organization Score 0.0 **Average Score (Health Care Org. Score/3)** 0.0

PART 6: ENHANCED ACCESS

6a. Promote and expand access by ensuring that established patients have 24/7 continuous access to their care team via phone, email or in-person visits.
6b. Provide scheduling options that are patient- and family-centered and accessible to all patients.
6c. Help patients attain and understand health insurance coverage.

Components	Level D	Level C	Level B	Level A
20. Appointment systems	...are limited to a single office visit type.	...provide some flexibility in scheduling different visit lengths.	... provide flexibility and include capacity for same day visits.	...are flexible and can accommodate customized visit lengths, same day visits, scheduled follow-up and multiple provider visits.
Score	1 2 3	4 5 6	7 8 9	10 11 12
21. Contacting the practice team during regular business hours	...is difficult.	...relies on the practice's ability to respond to telephone messages.	...is accomplished by staff responding by telephone within the same day.	...is accomplished by providing a patient a choice between email and phone interaction, utilizing systems which are monitored for timeliness.
Score	1 2 3	4 5 6	7 8 9	10 11 12
22. After hours access	...is not available or limited to an answering machine.	...is available from a coverage arrangement without a standardized communication protocol back to the practice for urgent problems.	...is provided by coverage arrangement that shares necessary patient data and provides a summary to the practice.	...is available via the patient's choice of email, phone or in-person directly from the practice team or a provider closely in contact with the team and patient information.
Score	1 2 3	4 5 6	7 8 9	10 11 12
23. A patient's insurance coverage issues	...are the responsibility of the patient to resolve.	..are addressed by the practice's billing department.	...are discussed with the patient prior to or during the visit.	...are viewed as a shared responsibility for the patient and an assigned member of the practice to resolve together.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Total Health Care Organization Score 0.0 **Average Score (Health Care Org. Score/4)** 0.0

PART 7: CARE COORDINATION

7a. Link patients with community resources to facilitate referrals and respond to social service needs.
7b. Have referral protocols and agreements in place with an array of specialists to meet patients' needs.
7c. Proactively track and support patients as they go to and from specialty care, the hospitals and the emergency department.
7d. Follow-up with patients within a few days of an emergency room visit or hospital discharge.
7e. Test results and care plans are communicated to patients.

Components	Level D	Level C	Level B	Level A
24. Medical and surgical specialty services	...are difficult to obtain reliably.	...are available from community specialists but are neither timely nor convenient.	.... are available from community specialists and are generally timely and convenient.	...are readily available from specialists who are members of the care team or who work in an organization with which the practice has a referral protocol or agreement.
Score	1 2 3	4 5 6	7 8 9	10 11 12
25. Behavioral health services	...are difficult to obtain reliably.	...are available from mental health specialists but are neither timely nor convenient.	...are available from community specialists and are generally timely and convenient.	...are readily available from behavior health specialists who are onsite members of the care team or who work in a community organization with which the practice has a referral protocol or agreement.
Score	1 2 3	4 5 6	7 8 9	10 11 12
26. Patients in need of specialty care, hospital care, or supportive community-based resources	...cannot reliably obtain needed referrals to partners with whom the practice has a relationship.	...obtain needed referrals to partners with whom the practice has a relationship.	...obtain needed referrals to partners with whom the practice has a relationship and relevant information is communicated in advance.	...obtain needed referrals to partners with whom the practice has a relationship, relevant information is communicated in advance, and timely follow-up after the visit occurs.
Score	1 2 3	4 5 6	7 8 9	10 11 12

PART 7: CARE COORDINATION CONTINUED ON PAGE 9

PART 7: CARE COORDINATION CONTINUED

7a. Link patients with community resources to facilitate referrals and respond to social service needs.
7b. Have referral protocols and agreements in place with an array of specialists to meet patients' needs.
7c. Proactively track and support patients as they go to and from specialty care, the hospitals and the emergency department.
7d. Follow-up with patients within a few days of an emergency room visit or hospital discharge.
7e. Test results and care plans are communicated to patients.

Components	Level D	Level C	Level B	Level A
27. Follow-up by the primary care practice with patients seen in the Emergency Room or hospital	...generally does not occur because the information is not available to the primary care team.	...occurs only if the ER or hospital alerts the primary care practice.	...occurs because the primary care practice makes proactive efforts to identify patients.	...is done routinely because the primary care practice has arrangements in place with the ER and hospital to both track these patients and ensure that follow-up is completed within a few days.
Score	1 2 3	4 5 6	7 8 9	10 11 12
28. Linking patients to supportive community-based resources	...is not done systematically.	...is limited to providing patients a list of identified community resources in an accessible format.	...is accomplished through a designated staff person or resource responsible for connecting patients with community resources.	...is accomplished through active coordination between the health system, community service agencies and patients and accomplished by a designated staff person.
Score	1 2 3	4 5 6	7 8 9	10 11 12
29. Test results and care plans	...are not communicated to patients.	...are communicated to patients based on an ad hoc approach.	...are systematically communicated to patients in a way that is convenient to the practice.	...are systematically communicated to patients in a variety ways that are convenient to patients.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Total Health Care Organization Score 0.0 **Average Score (Health Care Org. Score/6)** 0.0

PART 8: ORGANIZED, EVIDENCE-BASED CARE

8a. Use Planned Care interactions according to a comprehensive set of patient needs.
8b. Assure access to care management resources to provide more intensive support to high risk patients.
8c. Use point of care reminders based on clinical guidelines.
8d. Enable planned interactions with patients by making up-to-date information available to providers and care team at the time of the visit.

Components	Level D	Level C	Level B	Level A
30. Comprehensive, guideline-based information on prevention or chronic illness treatment	...is not readily available in practice.	...is available but does not influence care.	...is available to the team and is integrated into care protocols and/or reminders.	...guides the creation of tailored, individual-level data that is available at the time of the visit.
Score	1 2 3	4 5 6	7 8 9	10 11 12
31. Visits	...largely focus on acute problems of patient.	...are organized around acute problems but with attention to ongoing illness and prevention needs if time permits.	...are organized around acute problems but with attention to ongoing illness and prevention needs if time permits. The practice also uses subpopulation reports to proactively call groups of patients in for planned care visits.	...are organized to address both acute and planned care needs. Tailored guideline-based information is used in team huddles to ensure all outstanding patient needs are met at each encounter.
Score	1 2 3	4 5 6	7 8 9	10 11 12
32. Care plans	...are not routinely developed or recorded.	...are developed and recorded but reflect providers' priorities only.	...are developed collaboratively with patients and families and include self-management and clinical goals, but they are not routinely recorded or used to guide subsequent care.	...are developed collaboratively, include self-management and clinical management goals, routinely recorded and guide care at every subsequent point of service.
Score	1 2 3	4 5 6	7 8 9	10 11 12
33. Clinical care management services for high risk patients	...are not available.	...are provided by external care managers with limited connection to practice.	...are provided by external care managers who regularly communicate with the care team.	...are systematically provided by the care manager functioning as a member of the practice team, regardless of location.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Total Health Care Organization Score 0.0 **Average Score (Health Care Org. Score/4)** 0.0

Briefly describe the process you used to fill out the form (e.g., each team member filled out a separate form and reached consensus in a face-to-face meeting; filled out by the team leader in consultation with other team members as needed).

SCORING SUMMARY

(Bring forward average score at end of each section to this page)

1. Empanelment	0.0
2. Continuous Team-Based Healing Relationships	0.0
3. Patient-Centered Interactions	0.0
4. Engaged Leadership	0.0
5. Quality Improvement (QI) Strategy	0.0
6. Enhanced Access	0.0
7. Care Coordination	0.0
8. Organized, Evidence-Based Care	0.0
Overall Total Program Score (Sum of all scores)	0.0
Average Program Score (Total program Score/8)	0.0

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WHAT DOES IT MEAN?

The PCMH-A is organized such that the highest "score" (a "12") on any individual item, subscale, or the overall score (an average of the eight PCMH-A subscale scores) indicates optimal support for patient-centered care. The lowest possible score on any given item or subscale is a "1", which corresponds to limited support for patient-centered care. The interpretation guidelines are as follows:

Between "1" and "3" = limited support for patient-centered care

Between "4" and "6" = basic support for patient-centered care

Between "7" and "9" = reasonably good support for patient-centered care

Between "10" and "12" = fully developed patient-centered care

It is fairly typical for teams to begin a collaborative with average scores below "5" on some (or all) areas of the PCMH-A. After all, if everyone was providing optimal patient-centered care, there would be no need for a patient-centered medical home collaborative or other quality improvement programs. It is also common for teams to initially believe they are providing more patient-centered care than they actually are. As you progress in your quality improvement efforts, you will become more familiar with what an effective system of care involves. You may even notice your PCMH-A scores "declining" even though you have made improvements; this is most likely the result of your better understanding of what optimal patient-centered care looks like. Over time, as your understanding of optimal care increases and you continue to implement effective practice changes, you should see overall improvement on your PCMH-A scores.

Safety Net Medical Home Initiative

This is a product of the Safety Net Medical Home Initiative, which is supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers, or staff. The Initiative also receives support from the Colorado Health Foundation, Jewish Healthcare Foundation, Northwest Health Foundation, The Boston Foundation, Blue Cross Blue Shield of Massachusetts Foundation, Partners Community Benefit Fund, Blue Cross of Idaho, and the Beth Israel Deaconess Medical Center. For more information about The Commonwealth Fund, refer to www.cmwf.org.

The objective of the Safety Net Medical Home Initiative is to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative is administered by Qualis Health and conducted in partnership with the MacColl Institute for Healthcare Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.qhmedicalhome.org/safety-net.

For more information about this survey, please contact:
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Appendix E: PSU Audit Implementation

PSU AUDIT IMPLEMENTATION

DELEGATION OF PERSONNEL FUNCTIONS TO HEALTH SERVICES DEPARTMENT

The following steps must be completed to process recruitment and exam functions to ensure compliance with the merit system rules and regulations (PMR's, Salary Regulations, Resolutions, etc...).

RECRUITMENT AND EXAM PROCESS

I. P-300 Process
   a. HSD determines need for new position within an existing classification.
   b. HSD determines that funding is available' within existing resources (new revenue, add/cancel /position hours increase/decrease and re-titling of classifications, etc.)
   c. HSD completes P-300 Personnel Adjustment Request form and submits it in the Agenda Quick system, including the Board Order.
   d. County Administrator's Office (CAO) reviews the request, need for position and available funding. If denied, the request is returned to Department. If approved, CAO's office finalizes Board of Supervisors (BOS) agenda item and approves recommendation to the BOS.
   e. BOS approves or denies request. If denied, request is returned to Department. If approved, Central Human Resources prints approved Board Order and P-300 from the agenda system.
   f. Central Human Resources assigns position number, etc., and notifies department of such
   g. HSD submits request to fill newly established position.
   h.

II. Obtain Freeze Exemption Approval from CAO's Office. (HSD)

III. Check w/Central HR to determine if an existing eligibility lists exist: 1) Layoff, 2) Re-employment, 3) Prior Lists (see PMR Section 7) If no other eligibility list exists, proceed to next steps. (HSD)

IV. Create requisition using the "HSD Only - (Open and Promotional)" department field

V. Research, Review & Preparation
   a. Job Analysis, Salary Survey (9 bay area counties), if applicable
   b. Review Previous Exams; test components; close-out worksheet
   c. Determine if open or promotional or open and promotional (both)
   d. Obtain Essential Functions (Risk Management)
   e. Prepare Physical Effort Worksheet
   f. Prepare Recruitment Summary Form & Job Categories — Affirmative Action Profile
   g. Prepare Applicant Flow Report for adverse impact
   h. Review Outreach and Recruitment Efforts
   i. Review Timetables and Goals
   j. Develop Job Announcement
   k. Review Jab Specification for proposed changes (five year review/update)
   l. Prepare Supplemental Questionnaire (if applicable)
   m. Represented/Unrepresented — union notification of open recruitment

n. Include draft copy of Beginning-to-End Exam Timeline and testing components for recruitment in compliance with PMR Section 504, 505, and 506.

Central HR will conduct Exempt/High Level Recruitments. Attachment #1 identifies those classifications delineated as "Exempt/High Level" classifications.

VI. Affirmative Action Review — Allow four (4) business days for Review
- a. Submit or e-mail: all documents prepared above to the AA Officer for review, approval and Consent Decree compliance;
  - i. If approved — move forward with exam;
  - ii. If disapproved — additional discussion and review.

VII. Forward Entire Packet to Central HR for Review and Approval
- a. Allow three business days for Central HR Review and Approval. Once approved, move to next step;
- b. Upon approval, Central HR returns packet to HSD.

VIII. Create Exam Plan in NeoGov
- a. Attach all documents for exam to the attachments section of the exam plan (recruitment summary form, job announcement, job specification, job categories sheet, app. flow report, union fax sheet, job analysis, essential functions, physical efforts, timetables and goals, supplemental questionnaire;
- b. Set up job posting in NeoGov (Announcement of Examination PMR Section 401);
- c. Advertising: mailing List (One Source for paper & Outlook mailing Outreach and Recruitment) (department does not currently have access); (OneSource requires access and training provided by General Services — Print and Mail Division, Email list require Outlook 2010 and permissions granted by Central Human Resources)
- d. Union notification of exam opening;
- e. All exams must be posted on the TET Website for five business days;
- f. Allow for three (3) business clays for postmarked application submission;
- g. Announce exam for a minimum of (5) business days;
- h. Provide verification of advertising to Central H.R. for AA review and Consent Decree compliance.

IX. Review, Evaluate and Screen Applications for MQs (PMR Section 404.1)
- a. Notify rejected candidates;
- b. Respond to appeals (make appropriate changes to candidates disposition); (See candidates profile request —how to be notified of County correspondence via USPS Mail or Email address) This process begins the five (5)-business day appeal process per PMR Section 404.3 Notification of Disqualified Applicant);

X. Finalize appropriate testing components (T&E, Written, Oral, Performance, Agility)
- a. If the number of candidates accepted is less than a full certification, prepare a waiver request memo and forward to Central HR for approval;
- b. If full certification, department determines whether to utilize an oral, written or both exam process;

c. If entry level classification, Consent Decree must be followed in accordance with Section D.2.C.;
d. Schedule interview dates, times, schedule board raters, and secure interview location PMR Section 509;
e. Mail notification to interview to candidates (allow 10 calendar days);
f. Ensure diverse panel of oral board raters for compliance with Consent Decree;
g. Administer/Monitor written, oral and performance exams (Record Oral Interview PMR Section 511);
h. Central HR will develop Pass point Analysis for all written exams, itemization report for Affirmative Action Time Tables and Goals, prior to certification; (allow three (3) business days for processing).
i. Verify scores and dispositions and input into NeoGov (written/orals) PMR Section 512; Section 603; apply Veterans, Seniority, or Promotional points per PMR Section 403, 606, and 607;
j. Develop list of eligible candidates

XI. Administer/Monitor written, orals and performance exams
a. Record oral interview in accordance with PMR Section 511;
b. Input candidates scores into the NeoGov;
c. Submit test result documents to HR for analysis (candidate scores, pre-upload file & ready to upload file); HR will review and provide results to the department (allow three (3) business days for HR review);
d. Oral interview (if applicable) — input oral scores into NeoGov & verify (PMR 512 & 603);
e. Ensure and verify scores and dispositions are changed in NeoGov (PMR Section 512 and 603); apply Veterans, Seniority or Promotional points per PMR Sections 403,606 & 607, Break ties;
f. Promulgate List/Determine certification (PMR, Section 7);
g. Notify candidates of departmental interview.

XII. Notify candidates of final results, ranking and expiration date of eligibility list

XIII. Certification - HSD will certify eligibility list (Refer to PMR. Section 7)

XIV. Close Out
a. Prepare data file (see attached Data/Application/Eligible File)
b. Complete Analyst Recruitment/Exam Form (attached)
c. Prepare Applicant file (rejected/paper applications)
d. Prepare Eligible File (eligible/paper applications)
e. Prepare Applicant Flow Reports — Submit to AA Officer
f. Prepare Eligible Report — Submit to AA Officer
g. Forward Close Out file to Central HR for storing.

XV. Price & Associates— The Consent Decree
a. Prepare and respond to all Price & Associates (P&A Inquiries);
b. All P & A responses must be forwarded to Central HR for review and compliance with Consent Decree.

XVI. Bilingual Testing

a. H5D to handle all Bi-lingual testing with Central HR oversight. Central HR will require written justification of flagging of bilingual positions prior to bilingual testing.

XVII. Personnel Transactions

a. Central HR will retain all personnel transaction functions. All personnel transactions will continue to be forwarded to Central HR for processing.

Comments/Issues/Questions

(Note: There is no definitive time frame, in which to determine the length of time it takes to process recruitments from beginning to end. However, PSU data reflects that a recruitment can take anywhere from 45 days to six months. Small, specialized recruitments, resulting in a waiver of competition may take up to 45 days. A small, specialized recruitment, with one selection step (oral/written) may take up to 60 days. Medium size recruitments (+/-200 recruitments) with one selection step may take 3 4 months. Large recruitments with multiple assessment steps can take as long as six (6) months to complete. These estimates are based on the assumptions that the Consultant has no recruitment backlog which would result in a delay in the recruitment process; and the job specification description is current and does not require revision and/or union review, which may require the department to meet and confer with the union).

1. Health Services currently have access to all eligibility & "continuous' lists for HSD.
2. Central HR will create a form for the department in order to verify the current eligibility list (HR will provide electronic request form)
3. What is the mechanism for monitoring HS certification lists? (TBD)
4. If candidate pool is less than a full certification (ten, 10) — Waiver of Examination (same process up to structured oral interview) PMR Section SOB.
5. Administration of all eligible lists will remain with Central HR, including removal of names of disqualified candidates and extension of eligible list.
6. HSD will not have access to countywide exam plans for any other department
7. Create a third departmental field — HS Only (Open & Promotional)

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CONTRA COSTA COUNTY

On October 20, 2009 the Contra Costa County Board of Supervisors authorized the County Administrator to undertake a "sustainability audit" of the Contra Costa County Regional Medical Center (Hospital) and Clinics.

The Board requested this work because of unrelenting financial pressures on the County's General Fund, caused by dwindling streams of revenues and growing demand on the Fund. Steadily rising costs associated with the state mandate for providing health care to county residents unable to pay for their medical needs is a significant component of the pressure on General Fund dollars.

The Board approved recruitment of independent qualified consultants and/or certified public accountancy firms to carry out the audit and to work with county staff to develop options for providing health care and control the growth in use of General Fund revenue to pay for the costs of this care.

This Request for Proposals (RFP) is the public bid process through which professional service contract(s) may be awarded to undertake the work authorized by the Board of Supervisors.

Description of Consultant Services Being Sought

The Board of Supervisors directed the County Administrator and county staff to seek out and work with a consultant(s) to develop options and recommendations, for Board of Supervisors consideration, that will provide sustainable models and methods of delivering health care to Contra Costa County residents, especially those who are unable to pay for the cost of their care.

Attachments 1 and 2 to this RFP contain background information. **Attachment 3 lists the components of the study/questions which consultants are being sought to research and answer.**

Because of the high degree of interconnectedness between the County's hospital, physicians, clinics and health plans the consultant(s) must factor these entities and their relationship with one another into the sustainability options/recommendations recommended to control growth in the use of the General Fund.

Options developed by the consultant must be structured for 21st century realities, including:

- health care reform,
- California's legal requirements for counties to finance the provision of medical and related health care services for persons who are unable to pay for their care,
- extension of the State's 1115 Medicaid Waiver,
- demographics, medical care needs and geography of the County, and
- competitiveness and/or duplication of efforts in the local/regional health care industry.

Options/recommendations developed by the consultant must include financial analysis, the policy pros and cons of the recommendations, a projected timeframe and the financial, legal and operational steps

needed for implementation. "Best practice" standards and models should be identified. Options must be fiscally sound and sustainable, for both the short and long term.

Background Information on the Health Services Department, the Hospital, Clinics and Health Plan

Contra Costa County's budget provides the following description of the Health Services Department: "offers the full spectrum of health-related services under one organizational structure….the system includes primary, specialty and inpatient medical care, mental health services, substance abuse treatment, public health programs, environmental health protection, hazardous materials response and inspection and emergency medical services, as well as a county-operated health maintenance organization."

"For low income and uninsured residents of Contra Costa provides a safety net of medical services not available to them elsewhere and a financial structure, the Contra Costa Health Plan, that promotes appropriate use of services and funds them efficiently with third-party revenues."

Contra Costa County's 164 bed hospital and ambulatory care clinics, managed as part of the Health Services Department, currently have a $341 million operating budget and employ more than 1,700 county staff. The County's Health Plans currently serve 65,000 members, comprised of enrollees from the County's own work force and residents of the community. Members use the County's hospital and clinics for care, as well as a network of private doctors and community hospitals located throughout Contra Costa County.

Specifics of the RFP

The RFP describes the process for bidders to submit proposals to provide all or part of the consultant services being sought. Bidders should carefully review the entire RFP, following all instructions and time deadlines.

Bidders must submit specific cost estimates for all components of their bid. Proposals that do not contain this information will not be considered.

Contra Costa County values the work of local, small, women owned, minority and disadvantaged businesses. The County encourages qualified individuals/firms from these categories to respond to this RFP or to partner with others to respond.

The County will review all proposals submitted in compliance with this RFP, resulting in the award of professional service contract(s) as outlined below:

REQUEST FOR PROPOSAL GUIDELINES AND INSTRUCTIONS

Timeline: (Dates subject to change)

Date	Time	Activity
October 20, 2009	n/a	Contra Costa County Board of Supervisors authorizes issuance of RFP.
September 22, 2010	n/a	Announcement of funding opportunity. Legal notice is published. Copies of RFP will be mailed to bidders beginning on this date.
October 1, 2010	1:30 p.m.	Informal informational meeting for potential bidders held at 651 Pine Street, Room 101, Martinez, CA .
October 28, 2010	3:00 p.m.	Submission deadline. Earlier submission is encouraged and

Date	Time	Activity
		appreciated. Either 1) one original and five (5) copies of the proposal or 2) an electronic PDF version of the proposal must be received by Dorothy Sansoe in Martinez. No proposals will be received after 3:00 p.m. There will be no exceptions to this deadline.
November 8, 2010	n/a	Review panel(s) meet(s) to evaluate proposals and develop funding recommendations for County Administrator.
November 10, 2010	n/a	Announcement of awards. Written notification of contract award will be sent to the Board of Supervisors and all bidders.
November 22, 2010	5:00 p.m.	Appeal period – deadline to submit appeal letters.
December 14, 2010	9:30 a.m.	Approval of contract by Board of Supervisors at Board meeting.
December 15, 2010	n/a	Performance period of contract (may change based on scope of work and negotiated time frames)

Questions should be directed to Theresa Speiker at tspei@cao.cccounty.us, telephone (925) 335-1096 or Dorothy Sansoe at dsans@cao.cccounty.us, telephone (925) 335-1009; 651 Pine Street, 10th Floor, Martinez, CA 94553.

I. QUALIFICATIONS, ELIGIBLITY AND FUNDING RESTRICTIONS

Eligibility is limited to responsible and responsive bidders with experience in performing the scope of work outlined in this RFP. Respondents need not be based in Contra Costa County to be eligible; however, agencies must demonstrate sufficient knowledge of health service provision within Contra Costa County and the State of California to meet the programmatic objectives. Individuals and firms may come together for the purpose of bidding on this RFP.

A bidder may not use a fiscal agent and must demonstrate that it is currently fiscally stable. A bidder or bidding agency with unresolved outstanding federal/state tax obligations is not eligible to apply for funding.

Bidders must comply with all of the time frames and requirements of the RFP or proposals will not be considered. The County may waive any requirement of the RFP if it determines that waiving a requirement is in the best interest of the County.

Bidders must address in their proposal how their agency meets qualifications and eligibility requirements and specify the costs/budget for each component.

Proposal costs for development and submittal are the entire responsibility of the bidder and shall not be reimbursed.

II. CONTRACTUAL OBLIGATIONS

Winning bidders will be required to enter into a contract with the County. The contract(s) will require the bidder to:

A. Indemnify the County for all claims arising out of the contractor's performance under the contract.
B. Agree to abide by the Health Insurance Portability and Accountability Act (HIPPA).
C. Maintain adequate insurance during the performance of the contract and for any follow-up period or work.
D. Track all related contract expenses in keeping with generally accepted accounting principles.
E. Submit timely payment demands as outlined in the contracts payment provisions.

F. Retain all documents pertaining to this contract for five years from the date of submission of contractor's final payment demand or fiscal cost report.
G. Attend all required meetings/mutually agreed upon meetings as a requirement of contract compliance.

III. PROPOSAL REQUIREMENTS

At a minimum, the following information must be included in the proposal:

A. Demonstration of the capabilities and experience necessary for examining the County's hospital, clinic and health plan. Include reference letters from past completed jobs that are similar in nature.

B. A statement outlining the qualifications, including: names, educational and experiential backgrounds of principal members; firm founding date; names of public entities for which similar studies have been performed, descriptions of and work samples from/copies of the studies performed.

C. Description of the title(s), experience and number of staff that would be assigned to the study. Resumes of key staff should be attached and lead staff contact person(s) identified.

D. A work plan and budget for each portion of the services requested and being addressed, time estimates for each significant segment of the work and the staff level to be assigned, including target date for completion and presentation of final recommendations and reports.

IV. RFP REQUIREMENTS AND INSTRUCTIONS FOR BIDDERS

The requirements in this section are mandatory. Contra Costa County reserves the right to waive any nonmaterial variation.

A. Bidders may request an electronic version of this RFP by either e-mailing their request to Dorothy Sansoe at dsans@cao.cccounty.us or by downloading a copy in PDF format from the Contra Costa County website at http://www.cccounty.us.

B. Proposals may be submitted in hard copy or email.

1. If a hard copy proposal is submitted, an original and five (5) copies, including supporting documentation, must be delivered to and received no later than 3:00 on October 28, 2010 by **Nancy Yee, Dorothy Sansoe or Theresa Speiker** at:

   Contra Costa County Administrators Office
   651 Pine Street
   10th Floor
   Martinez, CA 94553

2. If the proposal is submitted via email, it must be submitted to Dorothy Sansoe by **3:00 p.m. on October 28, 2010**. Electronic versions of the proposal will be accepted **only** if in Portable Document Format (PDF).

C. All formatting requirements listed in this RFP apply equally to electronic, mailed, or hand delivered proposals.

D. Proposals and required attachments shall be submitted as specified and must be signed by officials authorized to bind the bidder to the provisions of the RFP.

E. **Late proposals will not be accepted.** Facsimile copies are not acceptable. Proposals must be complete when submitted; changes and additions will not be accepted after submission.

F. A bidder's authorized representative may withdraw a proposal prior to 9:00 a.m. on November 5, 2010 by submitting a written request to Dorothy Sansoe.

G. Issuing an RFP does not obligate the County to award a contract to any provider. The County retains the right to award parts of the contract to several bidders, to not select any bidders, and/or to re-solicit proposals.

Questions about the requirements and components of the proposals may be directed to Theresa Speiker at tspei@cao.cccounty.us, telephone (925) 335-1096 or Dorothy Sansoe at dsans@cao.cccounty.us, telephone (925) 335-1009.

Note: Award of funds to qualifying entity(s) will result in a contract for services after final negotiations regarding work plan and budget. There are general conditions, including insurance and indemnity requirements, which are common to all County contracts. A copy of these conditions is available upon request.

V. PROPOSAL OUTLINE

All proposals become property of Contra Costa County and shall not be returned.

A. Responses must contain a complete proposal with all required supporting information and documents. Each bidder must submit their proposal as outlined in Section VI above.

B. Narrative materials should be single-spaced on 8 ½" by 11" paper with no less than one-inch margins on all sides, top and bottom.

C. Contents should be in the order outlined here with the pages numbered sequentially throughout the proposal including any attachments.

D. Pages in hard copy submissions must be stapled together or bound, whether hard copy or email each section must be clearly identified by the following proposal component name:

1. **Agency Overview (5 page maximum)**
   Describe in detail your primary services, licenses, staff expertise and years in operation.

   i. List agency location, contact information, and describe the availability of staff within Contra Costa County.
   ii. Provide at least five references, naming specific projects and studies completed with other governmental or large corporate bodies. Include contact names and telephone numbers. The County will perform detailed reference checks for the top qualifying respondents on information provided and other information available to the County.

iii. Attach the most recent agency audit available.

2. **Program Proposal (10 page maximum)**
   Explain your plan to meet the services requested, including a timeline for performance. Specifically detail plans, including anticipated staffing. Proposals may target one, several or all of the components identified in the "Description of Consultant Services Being Sought" on page 1 and attachment 3 of this RFP. Identify all component(s) that you will perform.
3. **Budget and Narrative (3 page maximum)**
   Supply a budget for the program, clearly stating applicable fee rates and all other anticipated costs. Costs will be weighed competitively in relation to services offered. Provide a detailed budget for each component, explaining anticipated staffing levels and related fees.

4. **Financial Statement (No maximum)**
   A copy of your most recent audited financial statement - including the auditor's management letter and all notes.

5. **Other Materials (5 page maximum)**
   Bidders may attach up to five additional pages in support of the proposal.

VI. REVIEW PROCESS - The review/selection process is comprised of the following steps:

Administrative Review County staff will review all submitted proposals to ensure proposals are complete according to instructions and in compliance with the requirements defined herein. Proposals not conforming to these basic standards will not be reviewed further and will be considered as not meeting the application deadline. Agencies that filed incomplete proposals will be notified in writing of their ineligibility no later than one week following receipt of their materials by the County Administrator's Office.

Review of Proposal A panel of individuals will independently evaluate each proposal. Individual panel members' preliminary scores will be combined to determine a preliminary ranking for all proposals. Recommendations for awards will be made to the County Administrator. The panel will meet to discuss merits and weaknesses of each proposal and finalize the rankings. Program elements will be rated as follows with a maximum score of 100:

*Applicant Overview – 30 points (*Includes staff qualifications, expertise, organizational reputation, experience and references)
Program Proposal – 50 points
Budget and Narrative – 20 points

Notification of Award The Board of Supervisors and each agency submitting a proposal will be notified in writing of the award decision.

Appeals Bidders may appeal the process, not funding outcomes. Appeals must be submitted in writing to the Contra Costa County Administrator's Office, attention Dorothy Sansoe, within seven (7) days of receiving written notification of the funding decision. Appeals must identify what part of

the RFP process is being appealed and the reasons for the appeal. The County Administrator will make decisions regarding appeals within five (5) working days of appeal receipt.

Contract Approval The contract will be approved at a regularly scheduled meeting of the Board of Supervisors, following completion of the appeal period.

SUSTAINABILITY AUDIT
HOSPITAL & CLINICS *
June 15, 2009

Contra Costa Regional Medical Center Sustainability Strategic Plan

Background

1. The County Administrator has advised the Board that the County's overall financial structure is not sustainable due to the decline in the property tax base, rising Health Insurance liability and rising pension costs.

2. The County Administrator has advised the Board that further reductions to County Departments are likely for the foreseeable future.

3. The Board recognizes that:

   (a) The County's Health Care delivery system is fragile and plays a critical role in providing needed medical services to the community

   (b) One out of every five Californians lack health insurance coverage.

   (c) Being uninsured is a significant barrier to accessing necessary health care services.

   (d) The rise and fall in employment based health care coverage generally runs parallel with the state's economy and unemployment rate.

   (e) The current recession has increased the County's unemployment rate from 5.4% to 9.7% as of April 2009. As a result the County is experiencing a significant decline in employer based coverage and a growth in the uninsured. *

   (f) The growth in the uninsured is placing an overwhelming demand for services on the County Health Services delivery system.

   (g) Federal health care reform is currently being debated. Its final form and timing is unknown. *

4. On September 23, 2008 the Board received a report from the Health Director and a presentation from the law firm of Ropes and Gray concerning Health Services finances and Governance Options.

5. The Board acknowledges that it has some legal obligations under Section 17000 of the Welfare and Institutions code to provide health care services to the indigent population of the County.

*** UPDATE NOTES AS OF MAY 1, 2010**

(e) Contra Costa County's unemployment rate has increased significantly and as of 3-1-2010 was 12%.

(g) Federal health care reform has passed and is anticipated as having a large impact on Contra Costa County's health care system as it is implemented.

County Administrator

County Administration Building
651 Pine Street, 11th Floor
Martinez, California 94553-4068
V-925-335-1080
F-925-335-1098

David Twa
County Administrator

Contra Costa County

April 9, 2010

Board of Supervisors
Contra Costa County
Martinez, CA 94553

Dear Board Members:

Contra Costa County has long focused on our Mission "to provide public services which improve the quality of life of our residents and the economic viability of our businesses." As we move towards fiscal years 2010-2011-2012 and beyond, it is not possible to understate how serious we are being challenged in our efforts to meet our public service mission.

Maintenance of current year's countywide service delivery levels impossible

While the Global and National economy are showing signs of a slow recovery, the same cannot be said for California or Contra Costa County. California State's budget deficits are estimated at $20 billion each year for 2010-11 and several years beyond. The impact of the housing market collapse on local property tax revenues and pension cost increases continue to negatively impact our Budget for 2010-11 as well as for the next several years. Additionally, we continue to see increased demand for services and no appetite on the part of the public to provide additional funding for services.

In this environment, it is not possible to sustain services at the current level. Since 2008-09 County Departments have reduced their budgets or increased revenue by over $190 million. Reserve use is likely to increase in the next budget cycle as revenues continue to decline and expenses increase. As was the case for the past two years, significant cuts will be necessary.

We are no longer able to provide the level of services the public demands, nor are we able to sustain our current level of wages and benefits without reductions in the number of employees.

Cuts to our General Government operations will impact our ability to: serve the agriculture community, complete appraisals timely, perform general accounting, respond to public concerns, issue records and reports, support county departments, provide public information, respond and resolve information technology problems, maintain our county properties, and complete personnel actions.

Cuts to our Law and Justice operations will impact our ability to: provide animal service responses, investigate and prepare cases for court, prosecute/defend/provide probation services for misdemeanors, serve at risk youth and domestic violence victims, track probationers, remove abandoned vehicles, provide crime prevention services, complete criminal investigations, respond to crime calls, supervise inmates, and recruit/train/deploy law enforcement officers.

Cuts to our Health and Human Services operations will impact our ability to: respond and serve children, adults and families in our protection programs, provide new-born home visiting, tutor foster youth, help families needing assistance with workforce services, support community organizations, offer therapy services for children and adults, provide access and timely mental health services for children, utilize therapeutic settings for children, perform public health outreach and education, and serve the homeless.

In developing our 2010-2011 budget recommendation, we have strived to adhere to the Board of Supervisor's policies requiring a balanced budget, reserves, and acceptable debt ratios. Most importantly the recommended budget continues to address the Board of Supervisor's fiscal and service delivery priorities including health care cost containment by allocating funds to our OPEB prefunding trust.

The County Administrator's Office has worked closely with our Department Heads to submit budget recommendations that adhere to these policies and to achieve our financial targets. All departments were provided direction to absorb their increased costs of doing business, plus their share of local revenue loss, and their OPEB prefunding requirement. Some departments will also need to make additional cuts once the State Budget is approved. No department is free from impact. This budget is offered as a balanced package including $3.3 million in general fund reserves; however, in order to keep reserve use as low as possible, we have relied on 'one time only funds' from a variety of sources, the most significant being ARRA (Federal Stimulus funds) and ATA (furloughs). This will result in significantly greater cuts to our 2011-12 budgets unless new stimulus funding occurs, or we are able to arrive at significant wage and benefit savings. Should the Board of Supervisors direct any reductions in the proposed cuts to our 2010-11 budget, this will require changes in other County priorities in order to maintain a balanced budget.

Normally the Baseline Budget identifies the projected funding gap by determining the level of resources required to provide in the budget year the same level of service provided in the prior year. Again due to the significant impacts of mid-year reductions, the Baseline Budget is based upon level of service as of January 1, 2010.

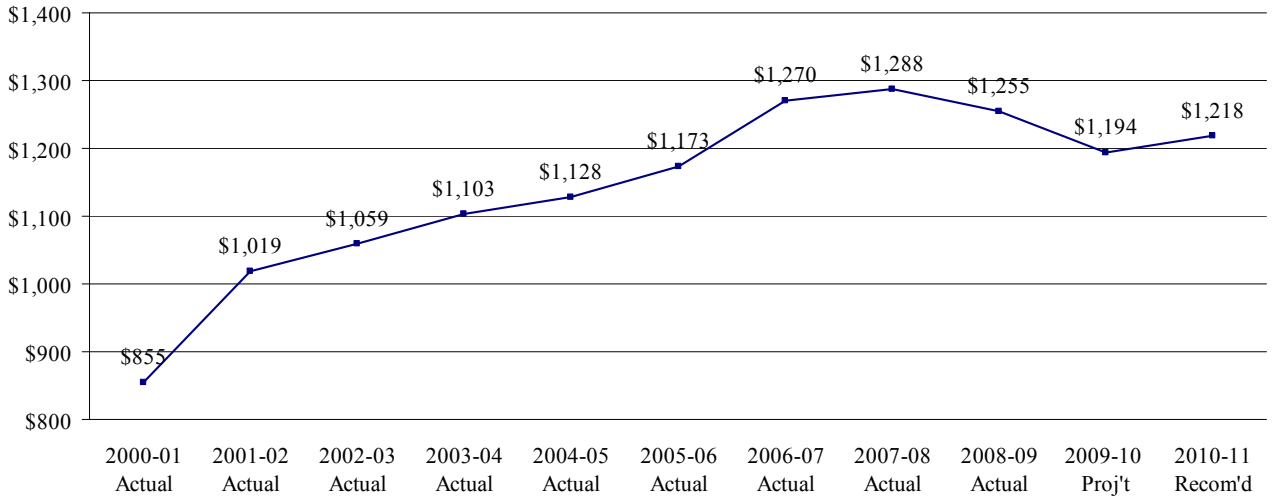
In summary, we are proposing a General Fund budget of $1.218 billion, which is 2% or $34.4 million lower than our Baseline Budget total expenditures. Of this amount, $3.0 million was reduced from health services (excluding Enterprise Funds). Our Hospital Enterprise Fund cut $3.2 million in maintenance level General Fund subsidy and the Contra Costa Community Health Plan Enterprise Fund cut $1.0 million for a combined $7.2 million in reductions from the General Fund to health services.

Revenues show a $10.9 million increase from Baseline, $8.8 million of which is in Employment and Human Services from state caseload growth allocations and federal stimulus. This budget requires the elimination of $23.5 million in programmatic expenditures in the General Fund including 78 funded full-time equivalent position reductions from the Baseline level identified by our departments. This level of required reduction is especially alarming when you consider the Board of Supervisors has already taken action to reduce the County and Special District Budgets by over $90 million in FY 2008-09 and $65 million in FY 2009-10.

Historical Perspective

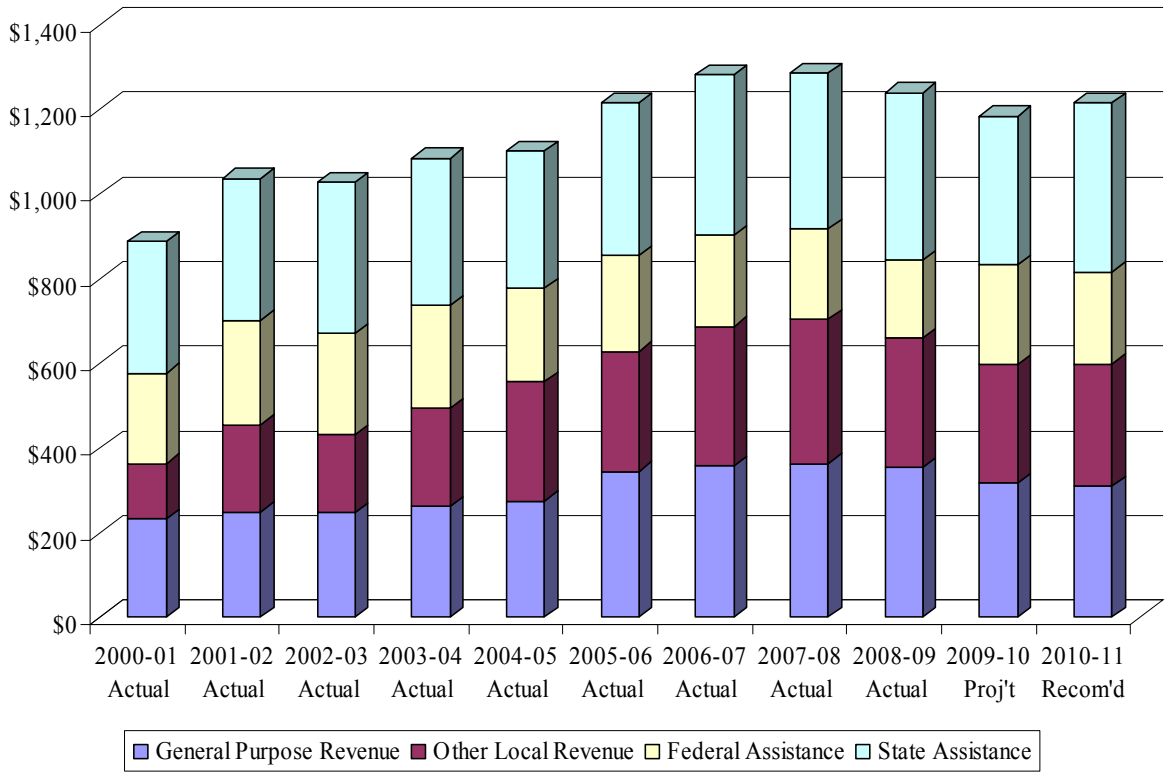
Between FY 2000-01 and FY 2007-08, total expenditures for the General Fund grew by an average of 6.6%. They decline by 2.6% in FY 2008-09 and another 4.9% in FY 2009-10. Although they are expected to grow by approximately 2% in FY 2010-11 due to one-time resources, a decline rather than growth is expected for the next several years.

10 Year Expenditure Growth (in millions)



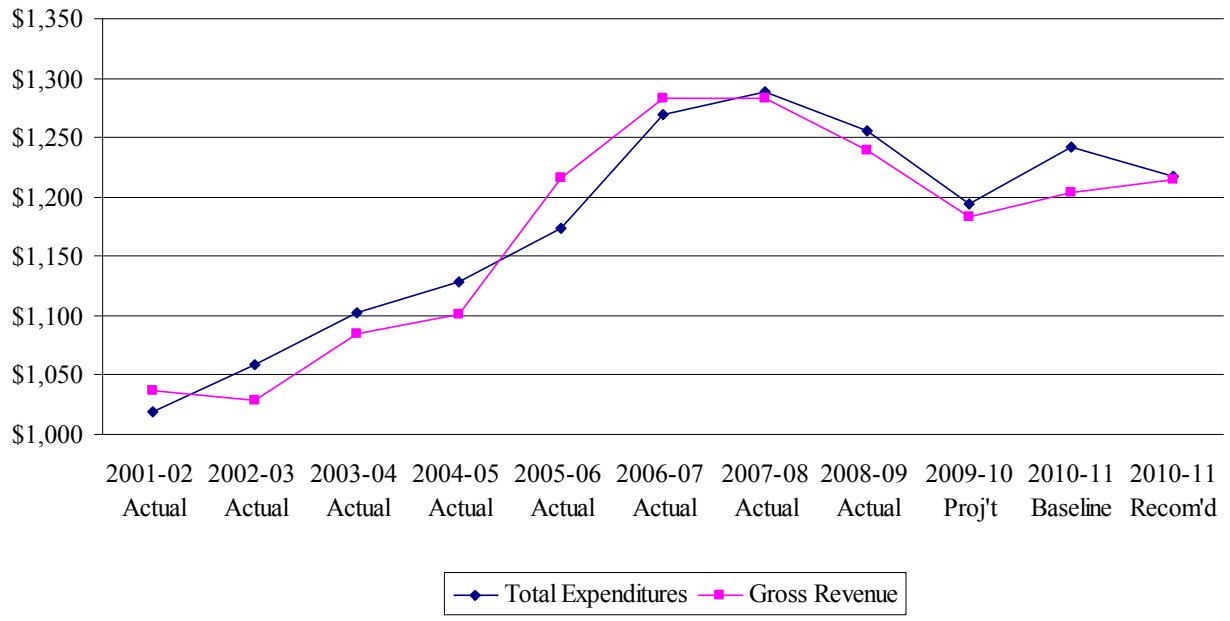
As depicted in the following chart, total revenues began to decline in FY 2008-09 but are expected to increase slightly next year due to one time sources. Although they are expected to grow by approximately 2.6% in FY 2010-11, a decline rather than growth is expected for the next several years.

10 Year Revenue Generation (in millions)



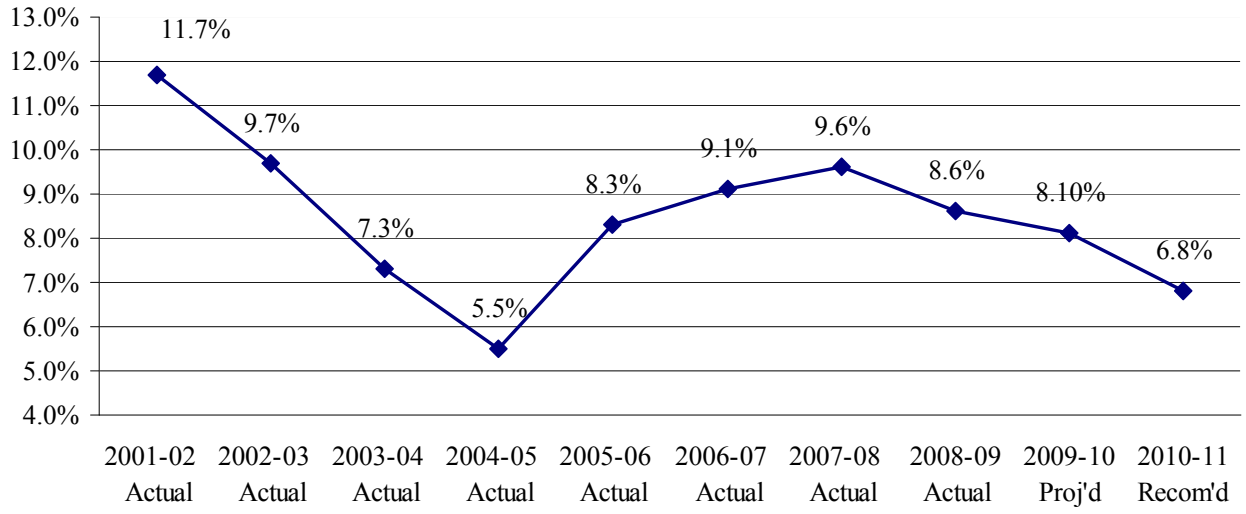
As shown below, the County has struggled with maintaining a structurally balanced budget over the years and is projecting to be unable to balance the current year budget with available annual revenues; the recommended reductions presented for FY 2010-11 use $3.3 million in General Fund Reserves.

Change in General Fund Actual Status (in millions)



Prior to the housing market collapse last year; the County had reversed the declining reserves trend experienced earlier this decade. It is anticipated that reserves will be expended in the current fiscal year, and the FY 2010-11 Recommended Budget already includes $3.3 million in planned reserve spending for on-going program expenses.

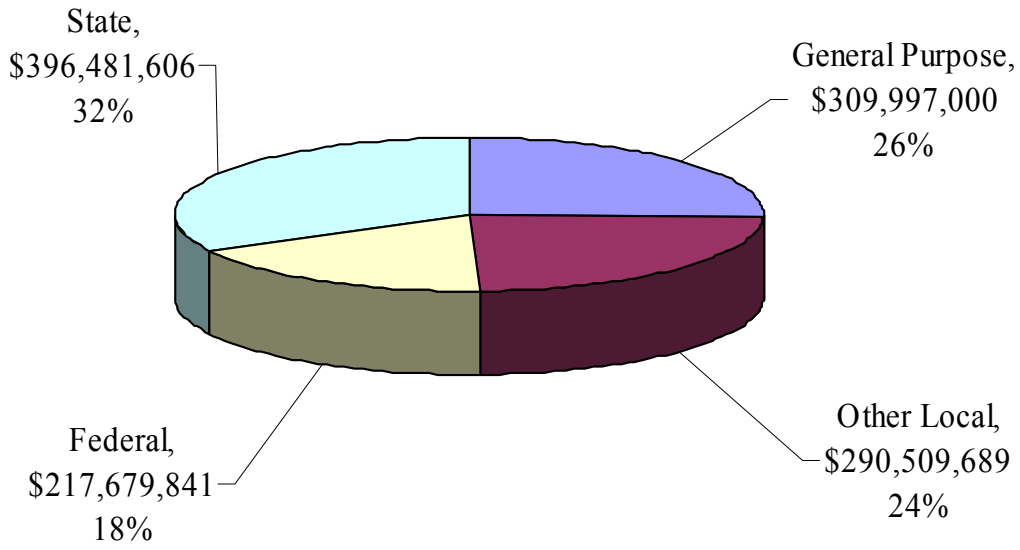
Unreserved Fund Balance (as of June 30)



General Fund Revenue and Appropriations/Recommended Budget

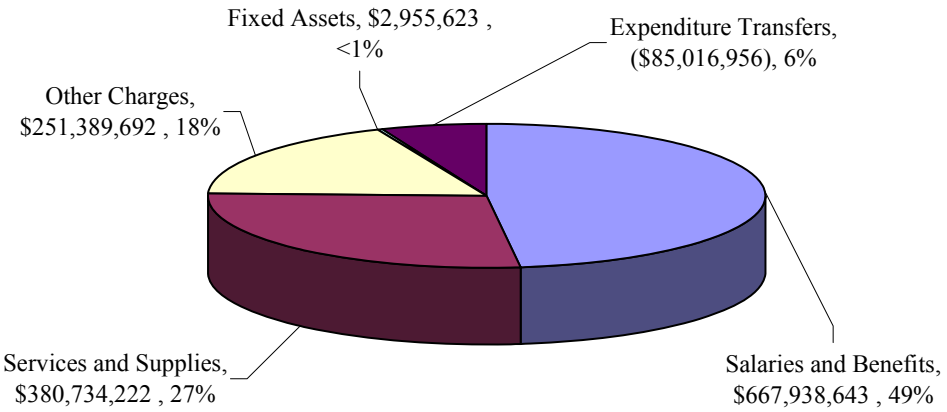
The recommended General Fund budget of $1.218 billion is supported by local, federal, and state resources. Over half of our revenue, $614.2 million (50.6%) is dependent on State and Federal allocations. Our general purpose revenue available from sources such as property tax and interest income is only $310.0 million. The remaining 'Other Local' revenue is generated primarily by fees, fines, and licenses. In the past, the assessed valuations of the County's tax rolls had increased in the double digits due to the strong housing market. The current economic downturn has eliminated growth in assessed valuation and has greatly reduced almost all revenue sources. In FY 2008-09, assessed valuation growth was flat (0.226%), in FY 2009-10 it declined by 7.19%, and it is projected to decline by another 5% in FY 2010-11. The following chart breaks out total revenue by source.

Total Revenue: $1.215 Billion



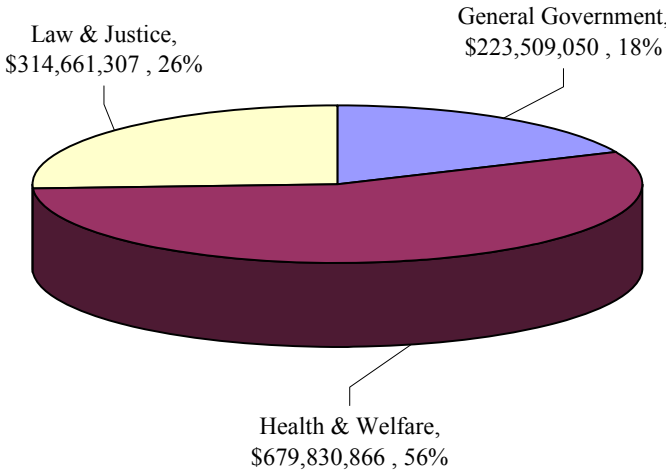
These revenue resources are used to fund programs throughout the County. All categories below are self explanatory, except 'Other Charges', which includes contributions to other funds such as the Enterprise Funds and interest expense on bonds and other debt. The following chart breaks out recommended expenditures between the major expense areas.

Total Expenditures: $1.218 Billion



Our General Fund resources fund three functional areas: General Government, Law and Justice, and Health and Human Services. Last year's Recommended Budget included General Government at 18%, Law and Justice at 26%, and Health and Human Services at 56%. The following chart shows the distribution of resources in these three areas in the FY 2010-11 Recommended Budget.

Distribution of Expenditures



Each department of the County is included in one of these functional areas and is described in detail in the Recommended Budget. The General Government Functional Group includes Agriculture (including Cooperative Extension functions), Assessor, Auditor-Controller, Board of Supervisors, Central Support Services, Clerk-Recorder, Conservation and Development (formally Building Inspection and Community Development), County Administrator, County Counsel, Crockett/Rodeo Revenues, Debt Service, Department of Information Technology, Employee/Retiree Benefits, General Services, Human Resources, Public Works, and Treasurer-Tax Collector. The Law and Justice Functional Group includes Animal Services, Conflict Defense, District Attorney, Justice Systems Development/Planning, Probation, Public Defender, Sheriff-Coroner, and Superior Court Related Functions. The Health and Human Services Functional Group includes Child Support Services, Employment and Human Services, Health Services Department, and Veterans Services.

As was described above, each of these departments were asked to submit budgets which balanced their requirement to provide services with the County's goals of adopting a FY 2010-11 General Fund budget that balances annual expenses and revenues, and that addresses revenue loss and includes an appropriation for partially pre-funding the County's OPEB liability. The following chart compares the Recommended Budget's share of general purpose revenue between Agencies to the current year.

Changes in Overall Department Share of General Purpose Revenue

	FY 2009/10 Budgeted Net County Cost	Share of Total	FY 2010/11 Recommended	Share of Total
Agriculture-Weights & Measures	1,765,976	0.5%	1,920,124	0.6%
Animal Services	3,250,294	1.0%	3,155,367	1.0%
Assessor	14,756,524	4.5%	14,885,580	4.8%
Auditor-Controller	2,992,166	0.9%	2,904,778	0.9%
Board of Supervisors	6,843,935	2.1%	4,567,880	1.5%
County Administrator	6,696,950	2.0%	4,735,929	1.5%
County Clerk-Recorder	4,231,940	1.3%	4,108,343	1.3%
County Counsel	1,652,072	0.5%	1,603,822	0.5%
District Attorney	11,988,718	3.7%	13,388,579	4.3%
Employment & Human Resources	20,213,944	6.2%	18,047,764	5.8%
General Services	12,023,828	3.7%	11,672,664	3.7%
Health Services	95,336,278	29.1%	89,654,532	28.6%
Human Resources	2,642,816	0.8%	1,888,211	0.6%
Justice System Planning	3,975,628	1.2%	3,847,398	1.2%
Miscellaneous Services	10,136,736	3.1%	8,057,351	2.6%
Plant Acquisition	293,394	0.1%	42,127	0.0%
Probation	34,745,647	10.6%	36,470,257	11.6%
Public Defender	17,225,208	5.3%	16,722,134	5.3%
Public Works	0	0.0%	0	0.0%
Sheriff-Coroner	64,054,640	19.6%	63,948,880	20.4%
Superior Court-Jury Commissioner	10,393,316	3.2%	9,846,320	3.1%
Treasurer-Tax Collector	1,481,790	0.5%	1,301,985	0.4%
Veterans Services	696,296	0.2%	560,061	0.2%
	327,398,096	100.0%	313,330,086	100.0%

The following chart compares the Recommended Budget's share of general purpose revenue between Agencies to the Baseline Budget Request.

Comparison of Share between Recommended Budget and Baseline Request

	FY 2010/11 Baseline Request	Share of Total	FY 2010/11 Recommended	Share of Total
Agriculture-Weights & Measures	1,725,440	0.5%	1,920,124	0.6%
Animal Services	3,561,954	1.0%	3,155,367	1.0%
Assessor	15,105,580	4.4%	14,885,580	4.8%
Auditor-Controller	2,911,546	0.8%	2,904,778	0.9%
Board of Supervisors	4,789,831	1.4%	4,567,880	1.5%
Conservation & Development	42,743	0.0%	0	0.0%
Cooperative Extension	252,094	0.1%	0	0.0%
County Administrator	4,921,911	1.4%	4,735,929	1.5%
County Clerk-Recorder	4,108,343	1.2%	4,108,343	1.3%
County Counsel	1,817,587	0.5%	1,603,822	0.5%
District Attorney	15,611,427	4.5%	13,388,579	4.3%
Employment & Human Services	26,868,867	7.8%	18,047,764	5.8%
General Services	12,388,820	3.6%	11,672,664	3.7%
Health Services	96,832,985	28.0%	89,654,532	28.6%
Human Resources	2,368,136	0.7%	1,888,211	0.6%
Justice System Planning	3,975,628	1.1%	3,847,398	1.2%
Miscellaneous Services	8,057,351	2.3%	8,057,351	2.6%
Plant Acquisition	43,394	0.0%	42,127	0.0%
Probation	37,078,943	10.7%	36,470,257	11.6%
Public Defender	17,204,840	5.0%	16,722,134	5.3%
Public Works	1,454,154	0.4%	0	0.0%
Sheriff-Coroner	72,166,363	20.9%	63,948,880	20.4%
Superior Court-Jury Commissioner	10,393,316	3.0%	9,846,320	3.1%
Treasurer-Tax Collector	1,536,585	0.4%	1,301,985	0.4%
Veterans Services	560,061	0.2%	560,061	0.2%
	345,777,899	100.0%	313,330,086	100.0%

It would appear from the Recommended Budget that the majority of program reductions are coming from a handful of County departments. It should be noted that 80.8% of our general purpose revenue is spent in just seven departments. The chart below shows the ranking of Agency share of general purpose revenue. If we were to attempt to close the budget gap by totally eliminating general purpose revenue funding from departments beginning with the bottom of this chart, we would need to eliminate 16.5 of our 26 departments.

Ranking of Department Share of General Purpose Revenue

	FY 2010/11 Baseline Request	FY 2010/11 Recommended	Share of Total	
Health Services	96,832,985	89,654,532	28.6%	
Sheriff-Coroner	72,166,363	63,948,880	20.4%	
Probation	37,078,943	36,470,257	11.6%	
Employment & Human Services	26,868,867	18,047,764	5.8%	80.8%
Public Defender	17,204,840	16,722,134	5.3%	
Assessor	15,105,580	14,885,580	4.8%	
District Attorney	15,611,427	13,388,579	4.3%	
General Services	12,388,820	11,672,664	3.7%	
Superior Court-Jury Commissioner	10,393,316	9,846,320	3.1%	
Miscellaneous Services	8,057,351	8,057,351	2.6%	
County Administrator	4,921,911	4,735,929	1.5%	
Board of Supervisors	4,789,831	4,567,880	1.5%	
County Clerk-Recorder	4,108,343	4,108,343	1.3%	
Justice System Planning	3,975,628	3,847,398	1.2%	
Animal Services	3,561,954	3,155,367	1.0%	19.2%
Auditor-Controller	2,911,546	2,904,778	0.9%	
Agriculture-Weights & Measures	1,725,440	1,920,124	0.6%	
Human Resources	2,368,136	1,888,211	0.6%	
County Counsel	1,817,587	1,603,822	0.5%	
Treasurer-Tax Collector	1,536,585	1,301,985	0.4%	
Veterans Services	560,061	560,061	0.2%	
Plant Acquisition	43,394	42,127	0.0%	
Conservation & Development	42,743	0	0.0%	
Public Works	1,454,154	0	0.0%	
Cooperative Extension	252,094	0	0.0%	
	345,777,899	313,330,086	100.0%	

The following chart shows total appropriations by agency regardless of the funding source. Please note that several agencies – such as the Library and Child Support – do not appear in the charts above because they do not receive any general purpose revenues.

County Departments	FY 2010-11 Baseline Request	FY 2010-11 Recommended	Difference
Agriculture-Weights & Measures	5,488,581	5,683,265	194,684
Animal Services	10,801,974	10,676,627	-125,347
Assessor	19,513,587	19,413,587	-100,000
Auditor-Controller	8,161,802	8,155,034	-6,768
Board of Supervisors	6,873,408	6,651,457	-221,951
Child Support Services	18,902,523	18,902,523	0
Conservation & Development	74,234,530	70,816,287	-3,418,243
Cooperative Extension	252,094	0	-252,094
County Administrator	17,596,021	16,402,910	-1,193,111
County Clerk-Recorder	22,947,574	22,947,574	0
County Counsel	5,706,740	5,492,975	-213,765
District Attorney	30,572,571	28,896,280	-1,676,291
Employment & Human Services	425,742,268	424,126,800	-1,615,468
General Services	63,275,864	62,559,708	-716,156
Health Services	979,819,471	968,462,565	-11,356,906
Human Resources	8,289,661	7,754,136	-535,525
Justice System Planning	11,248,566	11,267,869	19,303
Library	25,457,667	24,745,269	-712,398
Miscellaneous Services	76,719,445	76,719,445	0
Plant Acquisition	3,093,456	3,092,189	-1,267
Probation	64,243,961	61,088,281	-3,155,680
Public Defender	17,249,529	16,766,823	-482,706
Public Works	146,338,031	144,685,743	-1,652,288
Sheriff-Coroner	199,448,740	195,553,161	-3,895,579
Superior Court-Jury Commission	18,358,503	17,641,653	-716,850
Treasurer-Tax Collector	5,093,407	4,858,807	-234,600
Veterans Services	735,061	735,061	0
Special Districts			
CCC Fire Protection District	125,166,070	117,752,070	-7,414,000
Crockett/Carquinez Fire	869,806	485,581	-384,225
Special Districts (other than Fire)	123,893,660	123,893,660	0
Appropriation Grand Total	2,516,094,571	2,476,227,340	-39,867,231

Full-Time Equivalent Positions (FTEs)

The chart below reflects total estimated position elimination counts as of today for all departments (of the 119 listed, 78 are in the General Fund and were funded this year). Please note that these numbers represent rounded/funded FTEs and are not necessarily filled. The actual number of positions recommended for elimination on May 11 will be higher; this is due to the requirement that all vacant positions within a department in a specific classification with a lay-off be eliminated – funded or not. The actual number of lay-offs will be lower due to vacant positions and bumping.

	FY 2010-11 Baseline Request	FY 2010-11 Recommended	% of Whole	Reduction
County Departments				
Board of Supervisors	28	28	0.4%	0
Miscellaneous Services	32	32	0.4%	0
County Administrator	129	106	1.4%	-23
Human Resources	45	44	0.6%	-1
Auditor-Controller	54	54	0.7%	0
Treasurer-Tax Collector	30	28	0.4%	-2
Assessor	122	122	1.6%	0
County Counsel	50	49	0.6%	-1
Health Services	2,817	2,803	36.1%	-14
Employment & Human Resources	1,693	1,688	21.7%	-5
County Clerk-Recorder	80	80	1.0%	0
Sheriff-Coroner	990	990	12.7%	0
Probation	345	330	4.2%	-15
Agriculture-Weights & Measures	47	47	0.6%	0
Animal Services	76	76	1.0%	0
Conservation & Development	199	181	2.3%	-18
Child Support Services	170	170	2.2%	0
District Attorney	175	169	2.2%	-6
Public Defender	85	83	1.1%	-2
Public Works	279	262	3.4%	-17
General Services	252	248	3.2%	-4
Library	172	169	2.2%	-3
Veterans Services	6	6	0.1%	0
Total County FTE	7,876	7,765	100.0%	-111
Special Districts				
CCC Fire Protection District	373	365	n/a	-8
Special Districts (non-Fire)	12	12	n/a	0
All Funds FTE	8,261	8,142		-119

Other Post Employment Benefits (OPEB)

In addressing this top fiscal and service delivery challenge, the Recommended Budget again includes $20 million in partial pre-funding. The January 1, 2010 funding level was 2%. While we would prefer a greater level of pre-funding, the absence of any new resources makes this impossible without further service cuts. Nevertheless, $20 million will continue to have a significant impact on the County's OPEB liability. The recently released 2010 Actuarial Valuation indicated that over the last four years, the County has reduced its OPEB UAAL by 60%, Normal Cost by 78%, 30 year amortization of UAAL by 60%, and annually required contribution by 71% (from $216 million to $63 million). None of these reductions could have been achieved without the support and cooperation of our employees. Continued negotiations towards Countywide health care cost containment strategies and the redirection of designated future resources remain key to resolving the OPEB dilemma. The Board of Supervisors continues to make significant progress towards a solution for one of the biggest fiscal challenges the County has faced to date.

American Recovery and Reinvestment Act of 2009

Department and CAO staff has been very involved in tracking and pursuing opportunities available through the American Recovery and Reinvestment Act of 2009 (Federal Stimulus), which was signed into law on February 17, 2009. The $787 billion stimulus package provides for unprecedented levels of transparency and accountability and offers a unique opportunity to strengthen our local economy, create jobs, and fund a variety of local and regional projects. The Employment and Human Services Department alone is anticipating $21.1 million from the Federal Stimulus for a number of programs. Over $19 million in Federal Medical Assistance Percentages has been included in the 2010-11 Recommended Budget. In an effort to keep the residents of Contra Costa Country informed about the American Recovery and Reinvestment Act and our efforts in Contra Costa County, the County Administrator's Office has posted a report that tracks the County's efforts in securing stimulus funding for various projects that will improve the lives of our residents and stimulate the economy. The report, which is updated regularly, is available for review at www.cccounty.us.

Fleet/Internal Services Fund

The FY 2010-11 Recommended Budget includes fully funded vehicle depreciation. Requiring the annual budgeting of full vehicle depreciation will continue to facilitate regularly scheduled replacement of County vehicles, which began in FY 2008-09.

Capital Improvement Planning

FY 2008-09 began implementation of our Capital Facility Improvement Program. The facility maintenance analysis, which was completed in FY 2007-08, revealed the level of improvements that will be required to extend the useful life of County facilities, and promote the health and safety of employees and the public who utilize our County facilities.

The analysis included comprehensive building condition assessments of 93 facilities and a total of 2.9 million square feet of building space, and identified a total of $251.2 million in deferred facilities maintenance needs and capital renewal requirements organized into 4 categories based on level of priority. The distribution of costs by level of priority was as follows:

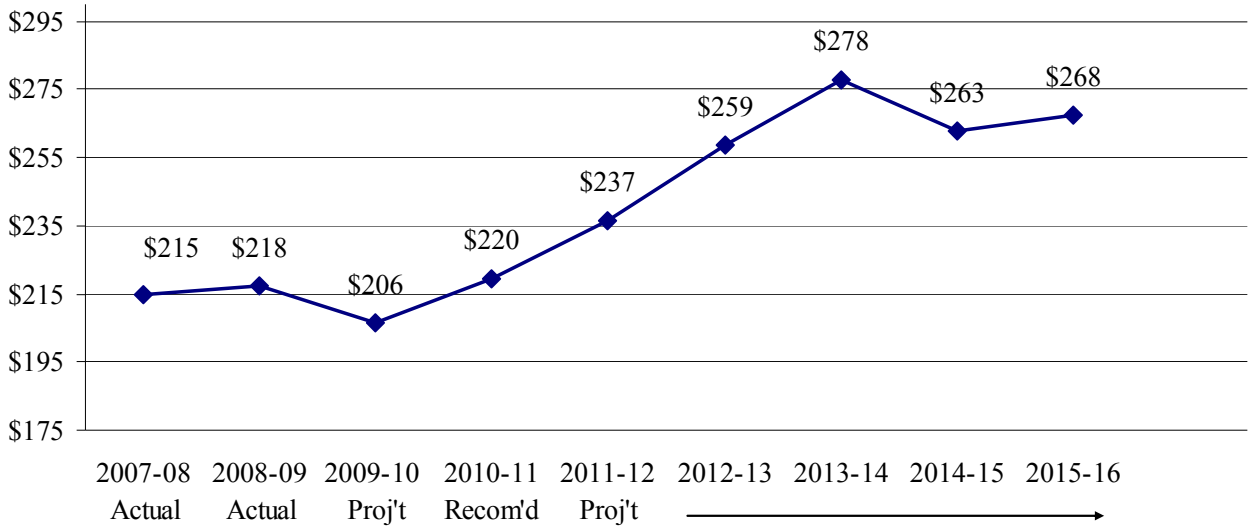
Priority 1 – Currently Critical	$ 2,059,913
Priority 2 – Potentially Critical	25,881,877
Priority 3 – Necessary, but not Critical	175,052,172
Priority 4 – Necessary, within 6-10 Years	48,180,568

Due to significant fiscal constraints, the FY 2009-10 budget did not include appropriations for capital improvements and neither does the FY 2010-11 Recommended Budget. However, staff will continue to work towards a plan to address our highest priority critical health and safety capital improvements and to develop a mechanism for periodic thorough review of all facilities and use. The County Administrator continues to work with the General Services Director to implement the Real Estate and Asset Management Program (RAMP), which was formalized in the last year. Savings has begun to be achieved through a thorough review of all facility use and the resulting elimination/consolidation of under used properties/leases.

Retirement/Pension Costs - Future Year Projections/Budgets

General Fund retirement expense in the current year is over $13.6 million less than FY 2008-09. Departments Countywide were able to reduce projected expenditures for FY 2009-10 by a like amount without reducing programs or services. However, beginning in FY 2010-11 calendar year 2008 market losses (26.5%) in combination with unachieved earning assumptions (7.8%) exceeded 34% and have begun to necessitate increased contributions to the Contra Costa County Employees Retirement Association (CCCERA). Positive market experience for calendar year 2009 of 21.9% has drastically changed the projection of pension increases since last year; however, pension costs are still expected to increase for the next five years. Actual FY 2007-08 retirement expenses and projected increased contributions, assuming 7.8% earnings annually for the next five years are depicted in the chart below:

Projected Retirement Expense



Recommendations

In conclusion, this proposal provides for a General Fund budget of $1.218 billion. It contains $23.5 million in reductions including our Enterprise Funds. All Departments are impacted—however, the impact is relatively slight compared to past years. These changes are the minimum necessary to respond to economic losses and to address our costs of providing public services. The worst is yet to come.

It is recommended that the Board of Supervisors:

1. Open and conduct a public hearing to receive input on the FY 2010-11 Recommended Budget;

2. Acknowledge that, due to significant market losses in the Contra Costa County Employees Retirement Association assets, retirement expenses have begun to and are expected to continue to increase significantly in the next five years.

3. Acknowledge that the Recommended Budget is not structurally balanced containing over $41.2 million in one-time or non-continuing monies including Federal Stimulus;

4. Acknowledge that action by the State regarding its budget may require subsequent adjustments to the Recommended Budget adopted by the Board;

5. Acknowledge that, although the Recommended Budget does not include a specific appropriation for contingency, the Board maintains its ability to manage General Fund contingencies during the fiscal year by use of reserve funds set aside for that purpose;

6. Direct the County Administrator to prepare for Board adoption on May 11, 2010, the FY 2010-11 County and Special District Budgets, as modified, to incorporate any changes directed by the Board during these public hearings; and

7. Direct the County Administrator to prepare for consideration by the Board of Supervisors on May 11, 2010, lay-off resolutions necessary to carryout Board action on the Recommended Budget.

Sincerely,

DAVID TWA
County Administrator

DT:LD

Attachment 3

Sustainability Goal: Position Contra Costa County for optimal performance under Health Care Reform, including: meet legal mandates for provision of health care to medically indigent county residents; control growth in the use of General Fund revenues to pay for indigent health care; and develop options, for Board of Supervisor's consideration, that support availability and access to care for county residents and achieve good health outcomes for the community.

A. Review and identify barriers, either in the County's organization or within the Health Services Department, that impede the efficient, cost effective and optimal delivery of health care services. Make recommendations to correct deficiencies, including structural or organizational changes, operational steps and projected costs needed to correct barriers.

B. Research the County's legal mandate for the provision of indigent medical care to its residents. Compare/contrast the County's scope of benefits, eligibility and the methods used to meet the mandate by other Bay area governments. Recommend changes which will result in a decrease in use of General Fund expenditures for cost of this care; lay out the steps and timeframe needed to implement.

C. Recommend changes to business lines or methods of program or service delivery of County financed health care that would address the sustainability goals of this study.

D. Determine if alternative governing models would enhance the ability of CCRMC (the County's hospital, including physicians and clinics) and/or Health Plan to compete in the rapidly changing health care environment. Describe the options and pros and cons of those recommended for consideration; cite examples of locations where the various governance models are successfully operating. If alternatives are recommended, determine the cost as well as projected cost savings, the legal and operational steps and time estimates needed for implementation.

E. Review the existing labor agreements with the California Nurses Association and the Physician Union. Contractor will determine if alternative labor models are needed (for example, a Faculty Practice Plan) to best position the County's hospital for recruitment, retention and incentive alignment under health care reform. If alternatives are recommended, determine the pros and cons of the options, the cost, time-frame, legal and operational steps needed for implementation.

F. Determine how to implement linking future compensation increases to available health care revenues. Describe specifics of the recommendations and lay out steps to implementation.

G. Determine what opportunities exist, within the current governance and legal model, to maximize the use of external vendors for the provision of specialty services. Describe the policy pros and cons of using external vendors; lay out legislative or rule changes needed to provide the County with the authority and flexibility to maximize use of these vendors without changes in the current governance or legal model.

H. Conduct a hospital peer comparison of (a) average length of stay by service line, (b) emergency room admission rate, (c) hospital readmission rates, (d) mortality rates, (e) emergency department and obstetric utilization, (f) cost drivers that are out of line with expected levels for similar operations and (g) core measure performance. Based on the comparison, Contractor will review those areas, if any, where CCRMC is outside of industry norms. The review will determine the reason for variations from the norm and if alternative methods of health care delivery would be more economical and/or feasible.

I. Recommend new or enhanced revenue opportunities that will address the sustainability goals listed and limit the use of General Fund revenues..

J. Recommend new or enhanced opportunities for the county to engage in community partnerships to ensure provision of health care to Contra Costa County residents.

To: **Board of Supervisors**

From: **Julia R. Bueren, Public Works Director/Chief Engineer**

Date: **October 11, 2011**

Contra Costa County

Subject: Termination of 1994 agreement with Diablo Water District for operations and maintenance of County Service Area M-28

RECOMMENDATION(S):

APPROVE and AUTHORIZE the Public Works Director, or designee, to terminate a 1994 service agreement (Attachment A) with Diablo Water District for operations and maintenance of County Service Area M-28, Willow Mobile Home Park, Bethel Island. (100% County Service Area M-28 funds)

FISCAL IMPACT:

No Fiscal Impact.

BACKGROUND:

On July 12, 1994 Contra Costa County entered into a Service Agreement with Diablo Water District (DWD) for the operation and maintenance of County Service Area (CSA) M-28. In December of 2008, DWD began subcontracting these services to Diversified Pump and Well (Diversified) with the intention of eventually relinquishing the responsibility for the operation and maintenance of CSA M-28 to Diversified. Since that time, Diversified has demonstrated that they are capable of operating the system.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ☐ NOES ☐

ABSENT ☐ ABSTAIN ☐

RECUSE ☐

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Susan Cohen, 925 313-2160

cc: B. Cambell, Auditor-Controller, W. Quever, Finance, W. Lai, Engineering Services, T. Ellsworth, Environmental Health, M. Yeraka, Diablo Water District

BACKGROUND: (CONT'D)

Effective September 1, 2011, the County has directly contracted for services with Diversified. The effective date of termination of the 1994 agreement with DWD was September 23, 2011, per written notice (Attachment B) received by Public Works. In that termination notice was an offer to continue to be available for consultation if so requested by the County; however, at this time, the County is not entering into a contract with DWD. All files and records, spare parts, instruments, tools and equipment paid for by the County Service area for operation and maintenance of the facility were returned to the County prior to September 23, 2011.

CONSEQUENCE OF NEGATIVE ACTION:

Without Board approval, the 1994 DWD agreement would not be fully terminated.

CHILDREN'S IMPACT STATEMENT:

Not applicable

1.25

TO: BOARD OF SUPERVISORS

FROM: J. MICHAEL WALFORD, PUBLIC WORKS DIRECTOR

DATE: July 12, 1994

SUBJECT: APPROVE SERVICE AGREEMENT AND AUTHORIZE THE CHAIR TO EXECUTE THE AGREEMENT WITH DIABLO WATER DISTRICT FOR OPERATION AND MAINTENANCE OF THE WATER SYSTEM IN THE KNIGHTSEN (CSA M-25), BEACON WEST (CSA M-26), WILLOW PARK MARINA (CSA M-27) AND WILLOW MOBILE HOME PARK (CSA M-28), IN THE KNIGHTSEN/BETHEL ISLAND AREAS. PROJECT NOs. 7498-6X9E99, 7471-6X9E50, 7472-6X9E60 AND 7473-6X9E70 RESPECTIVELY.

Specific Request(s) or Recommendation(s) & Background & Justification

I. **Recommended Action:**

APPROVE Service Agreement and AUTHORIZE chair to execute said agreement between Diablo Water District and Contra Costa County for the operation and maintenance of the water systems located in following areas; Knightsen, Beacon West, Willow Park Marina, and Willow Mobile Home Park, in the Knightsen/Bethel Island areas.

II. **Financial Impact:**

The cost of operating the system will be recovered from the customers of the water system through user charges.

III. **Reasons for Recommendations and Background:**

The California Department of Health Services requires that only a Certified Water Treatment Plant Operator can provide the maintenance and operations for water service facilities.

IV. **Consequences of Negative Action:**

Without the services of a Certified Water Treatment Plant Operator, as required by the California Department of Health Services, the County will not be able to operate the water system in this area.

Continued on attachment: ___ yes SIGNATURE: J. Michael Walford

_____ RECOMMENDATION OF COUNTY ADMINISTRATOR
_____ RECOMMENDATION OF BOARD COMMITTEE
_____ APPROVE _____ OTHER

SIGNATURE(S):

ACTION OF BOARD ON: JUL 12 1994 APPROVED AS RECOMMENDED ✓ OTHER ___

SERVICE AGREEMENT
CONTRA COSTA COUNTY
AND
DIABLO WATER DISTRICT

Effective Date and Parties: Effective on July 1, 1994, DIABLO WATER DISTRICT, a public entity (hereinafter called "DWD"), and CONTRA COSTA COUNTY, a political subdivision of The State of California (hereinafter called "County"), mutually agree and promise as herein set forth.

Purpose: The parties desire to provide for the performance by DWD of those services required to continue the operation and maintenance of four water systems in Contra Costa County known as Beacon West, Willow Mobile Home Park, Willow Park Marina and Knightsen, hereinafter called "the Water Systems", the costs thereof to be borne by County.

DWD Services: DWD shall provide the following services:

A. Scope of Services:

1. Operation and Maintenance of Facilities--Provide all personnel, supervision, services of consultants and contractors, machinery, equipment, tools, materials, and supplies necessary to operate and maintain the facilities of the Water Systems to industry standards. DWD shall be responsible for determining what services and supplies are necessary to carry out the terms of this agreement. However, DWD shall not unreasonably refuse to perform services or furnish supplies requested by the County.

2. Laboratory Testing--Provide all laboratory testing in accordance with requirements of the State Department of Health Services, and County Department of Health Services, and additional testing as agreed to by the parties.

3. Emergency Services--Provide personnel, vehicles, equipment, materials and spare parts to correct system malfunctions and/or other emergencies twenty-four (24) hours a day.

4. Spare Parts--Maintain an adequate spare parts inventory purchased for the sole use and benefit of the Water Systems which shall be stored separately from DWD parts. A copy of the inventory shall be made available to the County initially for approval and thereafter reconciled at least annually.

5. Capital Expenditures--Obtain the prior written approval of the County before incurring capital expenditures, which are defined as expenditures on new facilities, as opposed to repair or maintenance of existing facilities.

6. Records--Provide all personnel and facilities to preserve, maintain and update a complete set of separate files and records of the Water Systems.

B. Personnel:

1. Basic Crew--DWD shall provide the necessary personnel and equipment to accomplish the work described in Paragraph A above. All DWD's personnel shall be under the supervision of DWD's Superintendent of Operations, who will receive policy and priority direction from DWD's General Manager.

2. Qualified Persons--The personnel furnished shall perform work requiring the skills set forth in relevant DWD job classifications, and they shall meet the minimum requirements as described in the job specifications and as required by the State of California statutes, rules and regulations.

Limits of DWD Responsibility:

DWD shall not be responsible for the operation, maintenance or repair of any pipe, appliance, equipment or other property, nor shall it bear any risk of loss of water or damage to persons or property beyond the following points:

a. in the Beacon West and Knightsen systems at the discharge flange of each customer's meter;
b. in the Willow Mobile Home Park at the discharge from the hydropneumatic tank;
c. in the Willow Park Marina at the isolation valve at each service.

5. DWD Charges for Services, Billings and Payment:

County shall pay DWD, as compensation for the services performed hereunder, the actual cost of providing the services, subject to the following conditions:

A. Personnel--DWD charges for its personnel shall be based upon each individual's "hourly cost accounting rate" for each job classification. As used in this agreement, "hourly cost accounting rate" is defined as actual salary and benefit, and appropriate DWD overhead. Overhead rates used by DWD under this agreement shall be approved by the County for all services and billings by DWD.

B. Vehicles, Machinery and Equipment--All vehicles, machinery and equipment used in performing services hereunder shall be charged at an hourly rate which represents the actual cost of operating and maintaining the vehicles, machinery or equipment, together with appropriate DWD overhead.

C. Materials--Materials provided by DWD will be charged at DWD's actual cost.

D. Contractors' and Consultants' Charges--The actual amount of charges for necessary work and service provided by DWD's contractors and consultants shall be reimbursed by County.

E. Miscellaneous Expenses--Miscellaneous costs incurred by DWD hereunder, such as mileage payments, and authorized overtime meals, shall be charged at actual cost.

F. Revision of Rates--All rates for personnel, vehicles, machinery and equipment shall be subject to revision by DWD to reflect current costs, as those costs increase. The rates which shall apply initially to personnel, vehicles, consultants to be used on a routine basis, machinery and equipment are shown on Attachment "A". As these rates change, DWD shall within thirty (30) days send written notice to the County of such change.

G. Billings and Payments--DWD shall keep monthly itemized cost records on all services performed and forward a monthly statement to the County. Payments by County shall be made within thirty (30) days of receipt of the statement. Each DWD statement shall generally include, but need not be limited to, the following:

1. Personnel (staff) charges according to the applicable hourly cost accounting rate.

2. Hourly charges for vehicles, machinery and equipment.

3. Material charges.

4. Charges of contractors and consultants.

5. Miscellaneous expense.

6. Description of services provided.

H. Budget Formation and Fees--The County Public Works Department staff shall be responsible for establishing the annual budget and setting fees. County shall consider DWD recommendations relative to budgetary and/or fee formulation.

I. Audit--The annual audit of DWD shall be expanded to include the services provided to the County. The audit shall be performed within the time limits prescribed by State law. The incremental cost for the expended audit shall be borne by County. Copies of the completed audit shall be presented to the County as soon as it is available to DWD.

6. Status of Employees: All DWD employees performing work under the direction of DWD's Superintendent of Operations shall be employees of DWD and not of County, and no County employee as such shall be taken over by DWD because of this agreement. Nothing in this Section is intended to prevent DWD's engagement of contractors and consultants to perform necessary work hereunder.

7. Supervision of Employees: In performing services under this agreement, DWD personnel shall be subject to supervision and direction solely from DWD's management.

8. Hold Harmless: County shall fully defend, hold harmless and indemnify the DWD, its officers, agents, and employees against any and all claims, demands, damages, costs, expenses, or liability costs arising out of or in connection with (1) any work performed under this Agreement, except for liability arising from the sole negligence or willful misconduct of the DWD, its officers, agents, or employees, and (2) any damages due to pollution. DWD shall cause County, its officers, employees and agents to be added as additional insured on DWD's public liability insurance excluding coverage for losses due to pollution and damages to County facilities, and shall provide County with a certificate of insurance evidencing said addition prior to the effective date of this Agreement. The certificate shall require thirty (30) days' written notice to County of policy cancellation, lapse, or modification. The cost to DWD of said addition which exceeds the cost of insurance reflected in its overhead charge shall be paid by County. Nothing in this Agreement shall relieve DWD of its responsibility for any damage to the facilities of the Water Systems caused by the negligence or willful misconduct of DWD's, officers, agents, or employees.

9. Notice: Any and all notices or statements or reports to County required by the terms of this agreement shall be given in writing addressed to the Public Works Director, 255 Glacier Drive, Martinez, California 94553. Any and all notices, statements or reports to DWD required by the terms of this agreement shall be given in writing to its General Manager, Post Office Box 127, Oakley, California 94561.

10. Term;Termination: This agreement shall continue in full force and effect from year to year until terminated. This agreement may be terminated at any time by either party giving written notice to the other party at least six (6) months prior to the effective date of termination or at a date mutually agreed upon by both parties. Upon termination of this agreement, all files and records, and all spare parts, instruments, tools, and equipment paid for by the County shall be delivered to the County.

11. Successors: This agreement shall inure to the benefit of and be binding on the successors and assigns of each party.

npliance with Laws: In performing this Agreement DWD shall comply with all applicable laws, atutes, ordinances, rules and regulations, whether federal, state or local in origin, including all Workers' Compensation laws.

NTRA COSTA COUNTY

By: _____
Chair, Board of Supervisors

Attest: Phil Batchelor,
Clerk of the Board of Supervisors and
County Administrator

By: _____
Deputy

RECOMMENDED FOR APPROVAL:

J. MICHAEL WALFORD
Public Works Director

By: _____

APPROVED AS TO FORM:

Victor J. Westman
County Counsel

By: _____
Deputy

DIABLO WATER DISTRICT

By: _____
President, Board of Directors

Attest:

By: _____
Secretary

APPROVED AS TO FORM:

_____
FREDERICK BOLD, JR.
District Counsel

SE:fp
g:\FLDCTL\SRDISTC\2010\DWD.Agr
May 25, 1994

ATTACHMENT "A"

Description	Hourly Rate
General Manager	$59.48
Superintendent of Operations and Maintenance	$44.82
Administrative Aide	$24.80
Accounting Office Manager	$27.16
Leaderperson	$35.87
Clerk I	$18.80
Clerk II	$20.47
Vehicle (pick up truck/sedan)	~~$6.50/hour~~ NOW 8.00 PER CALTRANS HOURLY RATE
Overhead on District Labor	30%
Outside Consultant	at cost

DIABLO
WATER
DISTRICT

CERTIFIED MAIL
RETURN RECEIPT

March 18, 2011

2107 Main St.
P.O. Box 127
Oakley, CA 94561-0127
925 • 625 • 3798
Fax 925 • 625 • 0814
www.diablowater.org

Ms. Julie Bueren
Public Works Director
Contra Costa County
Public Works Department
255 Glacier Drive
Martinez, CA 94553

Subject: Termination of Service Agreement to Maintain water System at County Service Area M-28

Dear Ms. Bueren:

As I'm sure your staff has informed you, on February 14, 2008, Diablo Water District (DWD) sent the County a notice of termination of our July 1, 1994, agreement to operate and maintain the well system on Bethel Island known as M-28. Upon receiving the letter, County staff asked DWD not to terminate its services until another operator could be found to run the system. As DWD did not want to leave the County in a bind, we agreed to withdraw our termination notice and brought Diversified Pump & Well in to take over the operation of the facility, while DWD continued to provide the County with technical support.

Since that time, Diversified Pump & Well has demonstrated that they are capable of operating the system. That being the case, we recently forwarded the attached agreement to your staff terminating DWD's responsibilities to operate the facility, but still providing for DWD to be available for consultation if so requested by the County.

Since the County has the ability to contract with Diversified Pump & Well to operate the facility, please consider this letter as the six (6) month notice of termination required by Section 10 of our July 1, 1994, Agreement. The effective date of termination will be September 23, 2011, at which time the facility will be turned back over to the County for operation and

maintenance, and Diablo Water District will no longer be responsible for operation of the facility.

Sincerely,

Mike Yeraka, P.E.
General Manager

Enclosure

Cc: Brian Balbis, County Public Works Department, w/enclosure
Susan Cohen, County Public Works Department, w/enclosure
Tim Ellsworth, County Environmental Health
Mark Brading, Willow Mobile Home Park

To: **Board of Supervisors**

From: **Sharon Offord Hymes, Risk Manager**

Date: **October 11, 2011**

Contra Costa County

Subject: Final Settlement of Claim, Gary Sly vs. County of Contra Costa

---

RECOMMENDATION(S):

RECEIVE this report concerning the final settlement of Gary Sly and AUTHORIZE payment from the Workers' Compensation Internal Service Fund in an amount not to exceed $75,000.

FISCAL IMPACT:

Workers' Compensation Internal Service Fund payment of $75,000.

BACKGROUND:

Attorney Mark A. Cartier, defense counsel for the County has advised the County Administrator that within authorization, an agreement has been reached settling the workers' compensation claim of Gary Sly v. County of Contra Costa. The Board's September 20, 2011 closed session vote was Supervisors Gioia, Uilkema, Piepho, Mitchoff and Glover - Yes. This action is taken so that the terms of this final settlement and the earlier September 20, 2011 closed session vote of this Board authorizing its negotiated settlement are known publicly.

CONSEQUENCE OF NEGATIVE ACTION:

Case will not be settled.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ____ NOES ____

ABSENT ____ ABSTAIN ____

RECUSE ____

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Sharon Hymes-Offord, 925-335-1450

cc:

CHILDREN'S IMPACT STATEMENT:

None.

To: **Board of Supervisors**

From: **Sharon Offord Hymes, Risk Manager**

Date: **October 11, 2011**

Contra Costa County

Subject: Final Settlement of Claim, Brenda Pozzesi vs. Contra Costa County

---

RECOMMENDATION(S):

RECEIVE this report concerning the final settlement of Brenda Pozzesi and AUTHORIZE payment from the Workers' Compensation Internal Service Fund in an amount not to exceed $25,000.

FISCAL IMPACT:

Workers' Compensation Internal Service Fund payment of $25,000.

BACKGROUND:

Attorney Tom M. Hinton, defense counsel for the County has advised the County Administrator that within authorization, an agreement has been reached settling the workers' compensation claim of Brenda Pozzesi v. Contra Costa County. The Board's September 27, 2011 closed session vote was Supervisors Gioia, Uilkema, Piepho, Mitchoff and Glover - Yes. This action is taken so that the terms of this final settlement and the earlier September 27, 2011 closed session vote of this Board authorizing its negotiated settlement are known publicly.

CONSEQUENCE OF NEGATIVE ACTION:

Case will not be settled.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ☐ NOES ☐

ABSENT ☐ ABSTAIN ☐

RECUSE ☐

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Sharon Hymes-Offord, 925.335.1450

cc:

CHILDREN'S IMPACT STATEMENT:

None.

To: Board of Supervisors

From: Ruth Helot, Clerk of the Board

Date: October 11, 2011

Contra Costa County

Subject: BOARD MEMBER MEETING REPORTS FOR JULY AUG 2011

RECOMMENDATION(S):

ACCEPT Board member meeting reports for September 2011.

FISCAL IMPACT:

None.

BACKGROUND:

Government Code Section 53232.3(d) requires that members of legislative bodies report on meetings attended for which there has been expense reimbursement (mileage, meals, lodging, etc). The attached reports were submitted by Board of Supervisors members in satisfaction of this requirement.

CONSEQUENCE OF NEGATIVE ACTION:

The Supervisors will fail to meet the requirements of Government Code Section 53232.3(d) .

CHILDREN'S IMPACT STATEMENT:

None.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☑ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ☐ NOES ☐

ABSENT ☐ ABSTAIN ☐

RECUSE ☐

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: R. Helot, 925-335-1900

cc:

Supervisor Karen Mitchoff
September 1 to September 30, 2011

DATE	MEETING NAME	LOCATION	PURPOSE
9/7/2011	Pleasant Hill Ad Hoc Task Force	Pleasant Hill	Regional flood control issues
9/7/2011	Contra Costa Transportation Autho	Walnut Creek	Regional transportation issues
9/8/2011	TRANSPAC	Pleasant Hill	Regional transportation issues
9/9/2011	Health Plan Joint Conference Com	Martinez	Evaluate county health plan
9/9/2011	Senior Center Benefit	Concord	Community outreach
9/11/2011	9/11 Commemoration	Pleasant Hill	Community outreach
9/12/2011	EBRPD/BOS Liasion Committee	Martinez	Regional park issues
9/12/2011	First Five Commission	Concord	Regional children's issues
9/13/2011	Board of Supervisors	Martinez	Decisions on agenda items
9/13/2011	Pacheco Municipal Advisory Counc	Pacheco	Community outreach
9/14/2011	Transportation, Water & Infrastructu	Martinez	Evaluate county policy
9/16/2011	Hispanic Heritage Celebration	Concord	Community outreach
9/20/2011	Board of Supervisors	Martinez	Decisions on agenda items
9/21/2011	Contra Costa Transportation Autho	Pleasant Hill	Regional transportation issues
9/22/2011	Delta Protection Commission	Walnut Grove	Regional water issues
9/24/2011	Community Service Day	Pleasant Hill	Community outreach
9/24/2011	Fall Prevention Walk	Pleasant Hill	Community outreach
9/26/2011	Workforce Development Board	Pleasant Hill	Community outreach
9/27/2011	Board of Supervisors	Martinez	Decisions on agenda items
9/28/2011	Legislation Committee	Martinez	Evaluate county policy
9/29/2011	Finance Committee	Martinez	Evaluate county policy
9/29/2011	Pleasant Hill Ad Hoc Task Force	Pleasant Hill	Regional flood control issues

To: **Board of Supervisors**

From: **John Gioia, District I Supervisor**

Date: **October 11, 2011**

Contra Costa County

Subject: Resolution Honoring Jim and Janet Frazier, Recipients of the 2011 Labor-to-Labor Community Service and Special Recognition Award.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES _____ NOES _____

ABSENT _____ ABSTAIN _____

RECUSE _____

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of

Contact: Kate Rauch, 510-374-3231

of the Board of Supervisors

By: , Deputy

cc:

The Board of Supervisors of Contra Costa County, California

In the matter of: **Resolution No. 2011/422**

Congratulating Jim and Janet Frazier, President and Executive directors of The Network of Care, recipients of the 2011 Labor-to-Labor Community Service and Special Recognition Award.

Whereas, Jim and Janet Frazier grew up in Concord and have called Oakley home for 28 years; and
Whereas, Jim and Janet Frazier experienced a life-changing tragedy in 2006, from which their healing had led to the benefit of thousands; and
Whereas; in 2006, Jim and Janet Frazier's two daughters, Stephanie and Lindsey were in a horrible car accident. Stephanie didn't survive, and Lindsey sustained major injuries and a long recuperation; and
Whereas, during Lindsey's hospitalization, a nurse checking in on the grieving parents who were maintaining vigil at their daughter's bedside brought them a sandwich, encouraging them to maintain their strength; and
Whereas, looking back on that day, Jim and Janet Frazier realized how meaningful the nurse's care and concern for them was during a difficult time; and
Whereas, Jim and Janet Frazier established the Stephanie Marie Frazier Memorial Foundation, in memory of their daughter, and started The Network of Care, a volunteer organization donating nourishing food baskets to families with hospitalized children; and
Whereas, The Network of Care, a volunteer effort, has helped over 85,000 families since 2004 throughout California and in Colorado, donating food baskets to hospitals; and
Whereas, in recognition of their efforts for grieving families, the Contra Costa County Central Labor Council and Building & Construction Trades Council have selected Bill and Janet Frazier as the 2011 Community Service and Special Recognition award recipients.

Now, Therefore, Be It Resolved that the Board of Supervisors of Contra Costa County does hereby honor Jim and Janet Frazier for their inspirational work with The Network of Care and congratulate them for receiving the 2011 Labor-to-Labor Community Service and Special Recognition Award.

_____
GAYLE B. UILKEMA
Chair,
District II Supervisor

_____
JOHN GIOIA
District I Supervisor

_____
MARY N. PIEPHO
District III Supervisor

_____
KAREN MITCHOFF
District IV Supervisor

_____
FEDERAL D. GLOVER
District V Supervisor

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa,

By: _____, Deputy

C. 6

To: Board of Supervisors

From: John Gioia, District I Supervisor

Date: October 11, 2011

Contra Costa County

Subject: Resolution Honoring Wilmer D. Ellis, 2011 Labor-to-Labor Activist of the Year

---

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ____ NOES ____

ABSENT ____ ABSTAIN ____

RECUSE ____

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of

Contact: Kate Rauch 510-374-3231

Supervisors

By: , Deputy

cc:

The Board of Supervisors of
Contra Costa County, California

In the matter of: **Resolution No. 2011/423**

Honoring Wilmer D. Ellis, Business Representative of Boilermakers 549, as the 2011 Labor-to-Labor Activist of the year.

Wilmer D. Ellis, a resident of Martinez, California, and the Assistant Business Manger for Local 549 of the International Brotherhood of Boilermakers, has been a union boilermaker for 34 years; and
Whereas, Wilmer D. Ellis has jurisdiction for all International Brotherhood of Boilermaker's projects in Contra Costa County; and
Whereas, Wilmer D. Ellis, during the 2010 election cycle, ran his business office in the day, and opened his hall during the nights and on weekends for phone-banking, precinct-walking and other duties; and
Whereas, Wilmer D. Ellis recruited members for election volunteer work, helped them set-up and clean-up from their work, and even made sure they had dinner; and
Whereas, in recognition of his going-beyond-the-call-of-duty efforts for the Boilermakers Local 549, the Contra Costa County Central Labor Council and Building & Construction Trades Council selected Wilmer D. Ellis has the 2011 Activist of the year.

Now, Therefore, Be It Resolved that the Board of Supervisors of Contra Costa County hereby congratulate Wilmer D. Ellis as being chosen the 2011 Labor-to-Labor Activist of the Year.

_____
GAYLE B. UILKEMA
Chair,
District II Supervisor

_____
JOHN GIOIA
District I Supervisor

_____
MARY N. PIEPHO
District III Supervisor

_____
KAREN MITCHOFF
District IV Supervisor

_____
FEDERAL D. GLOVER
District V Supervisor

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa,

By: _____, Deputy

To: **Board of Supervisors**

From: **John Gioia, District I Supervisor**

Date: **October 11, 2011**

Contra Costa County

Subject: Resolution Honoring Ronald J. Lind, 2011 Labor-to-Labor Labor Leader of the Year

---

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ____ NOES ____

ABSENT ____ ABSTAIN ____

RECUSE ____

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of

Contact: Kate Rauch 510-374-3231

Supervisors

By: , Deputy

cc:

The Board of Supervisors of
Contra Costa County, California

In the matter of: **Resolution No. 2011/424**

Congratulating Ronald J. Lind as being named the 2011 Labor-to-Labor "Labor Leader of the Year."

Whereas, Ronald J. Lind is president of the United Food & Commercial Workers Local 5 in San Jose, the largest private sector union in the San Francisco Bay Area with 32,000 members; and
Whereas, Ronald J. Lind, during his 30 year career with the union has served as Communications Director, Organizing Director, and Education Director prior to being elected as president of Local 428, one of eight locals that merged to form Local 5; and
Whereas, Ron Lind is Vice-President of the UFCW International Union and is the President of the South Bay AFL-CIO Labor Council and serves as the chair of the Northern California UFCW Employers Pension Fund which has more than $3 billion in assets; and
Whereas, Ron Lind is a graduate of San Jose State University and a credentialed college professor, who has taught courses on media relations, labor history and collective bargaining and is serving his third four-year term as a governing board member of the San Jose/Evergreen Community College District; and
Whereas, Ron Lind is a fellow of the American Leadership Forum, and an active volunteer in his community focusing on education and services for low-income youth. He also serves on the board of Loaves and Fishes, a nonprofit that feeds the homeless, and the San Francisco Chapter of the Leukemia Lymphoma Society; and
Whereas, in recognition of his years of service to workers and to his community, Ronald Lind was selected as the 2011 Labor-to-Labor Labor Leader of the Year.

Now, Therefore, Be It Resolved that the Board of Supervisors of Contra Costa County does hereby congratulate Ronald J. Lind for being named the 2011 Labor Leader of the Year by Contra Costa County's Central Labor Council and Building & Construction Trades Council.

_____
GAYLE B. UILKEMA
Chair,
District II Supervisor

_____
JOHN GIOIA
District I Supervisor

_____
MARY N. PIEPHO
District III Supervisor

_____
KAREN MITCHOFF
District IV Supervisor

_____
FEDERAL D. GLOVER
District V Supervisor

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa,

By: _____, Deputy

To: **Board of Supervisors**

From: **John Gioia, District I Supervisor**

Date: **October 11, 2011**

Contra Costa County

Subject: Resolution Honoring Radback Energy, 2011 Labor-to-Labor Corporate Leader of the Year

---

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ____ NOES ____

ABSENT ____ ABSTAIN ____

RECUSE ____

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED:
October 11, 2011
David J. Twa, County Administrator and Clerk of the Board of

Contact: Kate Rauch 510-374-3231

Supervisors

By: , Deputy

cc:

The Board of Supervisors of
Contra Costa County, California

In the matter of: **Resolution No. 2011/425**

Honoring Radback Energy, 2011 Labor-to-Labor Corporate Leader of the Year.

Whereas, Radback Energy, Inc., based in Danville, California is dedicated to developing renewable sources of energy to help mitigate the effects of global warming; and
Whereas, Radback Energy, provides a bridge between communities and electric utilities; and
Whereas, Radback Energy supports renewable energy projects that are responsibly integrated with clean, efficient, natural gas fired energy projects, using natural gas to backstop intermittent renewable sources such as wind and solar; and
Whereas, Radback Energy is building a state-of-the-art natural gas-fired electrical generating facility called the Oakley Project; and
Whereas, the Oakley Project, started in June 2011, projects a $120million construction payroll; $4 million of supplies purchased locally; $5.8 million in local sales and use taxes; a 33-month construction cycle with an average workforce of 300 union workers and a peak of 730 union workers; mainly from Contra Costa County; the creation of more than 20 permanent "living wage" jobs, and the generation of approximately $10 million per year in property taxes; and
Whereas, Radback Energy's President and CEO is Bryan J. Bertacchi (PE, MBA); and Senior Vice Presidents are Greg Lamberg (PE) and Jim McLucas (PE), bringing a breadth and depth of experience in the construction and operation of renewable energy projects; and
Whereas, In recognition of its commitment to hiring a union workforce, Radback Energy was selected as the 2011 Corporate Leader of the Year by Contra Costa County's Central Labor Council and Building and Trades Council.

Now, Therefore, Be It Resolved that the Board of Supervisors of Contra Costa County does hereby congratulate Radback Energy for being selected the 2011 Labor-to-Labor Corporate Leader of the Year.

_____
GAYLE B. UILKEMA
Chair,
District II Supervisor

_____
JOHN GIOIA
District I Supervisor

_____
MARY N. PIEPHO
District III Supervisor

_____
KAREN MITCHOFF
District IV Supervisor

_____
FEDERAL D. GLOVER
District V Supervisor

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa,

By: _____, Deputy

To: **Board of Supervisors**

From: **Federal D. Glover, District V Supervisor**

Date: **October 11, 2011**

Contra Costa County

Subject: Proclamation for La Clinica de la Raza's 40th Anniversary

---

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ____ NOES ____

ABSENT ____ ABSTAIN ____

RECUSE ____

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of

Contact: Ed Diokno, 925-427-8138

Supervisors

By: , Deputy

cc:

The Board of Supervisors of
Contra Costa County, California

In the matter of: **Resolution No. 2011/432**

Recognizing the 40th anniversary of La Clinica de la Raza for serving the health care needs of residents of Contra Costa County and the East Bay.

WHEREAS, La Clínica de La Raza, Inc. was founded 40 years ago in 1971 by a group of volunteers including doctors, community members, and students from the University of California at Berkeley;
WHEREAS, La Clinica was founded to offer low-cost health care to residents who could not afford it;
WHEREAS, La Clinica has expanded from its first clinic in Oakland to serving about tens of thousands of patients at 26 sites in Alameda, Solano and Contra Costa counties including two medical clinics in Pittsburg and Concord; their dental clinic in Pittsburg and with a Dental Care Mobile unit and will soon be opening a clinic in Oakley; and
WHEREAS, according to the 2000 Census, Latino Americans make up the largest minority group in Contra Costa County of making up 21.1 percent of the total county population of 1,006,486; and
WHEREAS, on Oct. 4, 2011, the Contra Costa Board of Supervisors proclaimed Sept. 15 to Oct. 15 as National Hispanic Heritage Month thus placing the public's attention on the contributions and needs of the Latino American community; and
WHEREAS, the Latino American community continues to contribute to the social, economic and cultural richness the United States of America in general and of Contra Costa County specifically; and
WHEREAS, La Clinica's Pittsburg Clinic is holding its 7th Annual Health Fair on Oct. 22, 2011 at Pittsburg Adult Education School, 1001 Stoneman Avenue, Pittsburg.

NOW, THEREFORE, BE IT RESOLVED, that the Board of Supervisors of Contra Costa County, California does hereby proclaim October 22, 2011 as a day to reflect on the contributions of La Clinica and commend the organization for serving the health needs of residents of Contra Costa County and the East Bay for 40 years.

_____
GAYLE B. UILKEMA
Chair,
District II Supervisor

_____
JOHN GIOIA
District I Supervisor

_____
MARY N. PIEPHO
District III Supervisor

_____
KAREN MITCHOFF
District IV Supervisor

_____
FEDERAL D. GLOVER
District V Supervisor

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa,

By: _____, Deputy

C.10

To: Board of Supervisors

From: John Gioia, District I Supervisor

Date: October 11, 2011

Contra Costa County

Subject: Honoring Velma Bagby on her 38 Years of Public Service with the State of California

---

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ____ NOES ____

ABSENT ____ ABSTAIN ____

RECUSE ____

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of

Contact: Kate Rauch, 510-374-3231

Supervisors

By: , Deputy

cc:

The Board of Supervisors of
Contra Costa County, California

In the matter of: **Resolution No. 2011/433**

Honoring Velma Bagby for her 38 years of dedicated public service and leadership with the State of California.

Velma Bagby started her career with the state of California 38 years ago when she was 18 and hired as a "Youth Aide," working in a variety of positions for the state, progressing from stenographer to "Employment Program Representative," where she processed unemployment claims, work that she excelled at; and

Ms. Bagby continued working in employment services in various capacities, based for many years in Richmond. She specialized in connecting people with employment opportunities, career training, and jobs; and

In 2000, Velma Bagby was promoted to a managerial position in the state's Oakland Job Service Office, where she helped supervise roughly 70 employees and partners and completed college-level managerial classes to enhance her skills; and

Velma Bagby was promoted to manager of Workforce Service Contra Costa County in 2005, and was responsible for four county sites - San Pablo, Concord, Pittsburgh, and Brentwood, as well as two sites in Richmond; and

In 2007, Velma Bagby earned a double masters degree in Biblical Theology and Biblical Studies. In 2008 she was promoted again to Chief of Staff of Workforce Services Northern Workforce Services Division, based in Sacramento, overseeing Employment Development Department (EDD) offices from the Oregon border to Monterey County; and

In 2009, Ms. Bagby was again promoted to Deputy Division Chief overseeing offices in Contra Costa, San Joaquin, Stanislaus, and Merced counties; and

After 38 years of helping Californians find work and navigate unemployment, through recessions and booms, Velma Bagy retired from the state in August 2011.

Now, Therefore, Be It Resolved that the Board of Supervisors of Contra Costa County do hereby honor Velma Bagby for her dedicated career with the state of California and congratulate her on her retirement.

_____
GAYLE B. UILKEMA
Chair,
District II Supervisor

_____
JOHN GIOIA
District I Supervisor

_____
MARY N. PIEPHO
District III Supervisor

_____
KAREN MITCHOFF
District IV Supervisor

_____
FEDERAL D. GLOVER
District V Supervisor

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa,

By: _____, Deputy

C.11

To: **Board of Supervisors**

From: **William Walker, M.D., Health Services Director**

Date: **October 11, 2011**

Contra Costa County

Subject: OCTOBER 24th - 31ST, 2011 RED RIBBON WEEK

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ____ NOES ____

ABSENT ____ ABSTAIN ____

RECUSE ____

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of

Contact: Fatima Matal Sol, 335-3307

Supervisors

By: , Deputy

cc:

To: **Board of Supervisors**

From: **Dorothy Sansoe, County Administrator**

Date: **October 11, 2011**

Contra Costa County

Subject: Declare Vacancy on the Contra Costa Commission for Women

---

RECOMMENDATION(S):

DECLARE vacant At Large Seat 4 on the Contra Costa Commission for Women previously held by Sara Mendoza due to resignation, and DIRECT the Clerk of the Board to post the vacancy.

FISCAL IMPACT:

None.

BACKGROUND:

On September 27, 2011 Ms. Mendoza notified the Contra Costa Commission for Women of her resignation from her appointment to At Large Seat 4 on the Commission for personal reasons.

CONSEQUENCE OF NEGATIVE ACTION:

The Commission may be unable to meet due to lack of a quorum.

CHILDREN'S IMPACT STATEMENT:

Not applicable.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☑ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ☐ NOES ☐

ABSENT ☐ ABSTAIN ☐

RECUSE ☐

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Dorothy Sansoe, 925-335-1009

cc:

C.13

To: **Board of Supervisors**

From: **Karen Mitchoff, District IV Supervisor**

Date: **October 11, 2011**

Contra Costa County

Subject: Removal/Vacancy District IV Seat on the First 5 Contra Costa Children and Families Commission

---

RECOMMENDATION(S):

REMOVE Joan Means from District IV Seat on First 5 Contra Costa Children and Families Commission; DECLARE the District IV seat vacant, and DIRECT clerk to post the vacancy, as recommended by Supervisor Mitchoff.

FISCAL IMPACT:

None.

BACKGROUND:

The Contra Costa County Board of Supervisors established the First 5 Contra Costa Children and Families Commission on June 15, 1999 (Ordinance 99-15). The Board appointed nine Commission members and nine Alternate members on September 1, 1999.

Members include one Supervisor from the County Board of Supervisors, the directors of the County departments of Health Services and Employment and Human Services, and a representative from the County Administrator's Office of Children's Services. The other five members of the Commission are appointed by the Board of Supervisors and represent each Supervisorial District. The members serve at the pleasure of the Board and may be removed during their term of office. (Ordinance Section 26-14.010(a).

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ____ NOES ____

ABSENT ____ ABSTAIN ____

RECUSE ____

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Carolina Salazar, (925) 521-7115

cc:

BACKGROUND: (CONT'D)

Commissioners and Alternate Commission members represent various disciplines and backgrounds including pediatrics, early childhood education, child welfare, and schools. Alternate members, including second representatives from the Board of Supervisors, the county agencies mentioned above, and the five districts, hold all the powers of the appointed Commissioners except voting privileges.

In January 2011, the Clerk of the Board's Maddy List on the County website mistakenly listed the District IV First 5 appointee term as expiring August 16, 2011. Based on this information, Supervisor Mitchoff recruited a nominee to fill the new term.

Subsequently, the First 5 Executive Director alerted the Supervisor's office to the fact that under the Board Order appointing the commissioner for District IV the term did not expire until August 16, 2012. Once this information was brought to Supervisor Mitchoff's staff's attention, they researched past board orders relating to this position and found that the Maddy List information on the website was not correct. Because of this incorrect information, it is recommended that the Board of Supervisors take action to remove the current appointee to the position in order to create a vacancy which will be posted in accordance with the Maddy Act. In the meantime, a review of the termination dates for all seats on the Commission is being undertaken by the County Administrator's Office.

CONSEQUENCE OF NEGATIVE ACTION:

A new appointment to the District IV Seat would not be possible.

CHILDREN'S IMPACT STATEMENT:

Not applicable.

C.14

To: Board of Supervisors

From: Transportation, Water and Infrastructure Comm

Date: October 11, 2011

Contra Costa County

Subject: Reprogramming of Federal Funds for Dredging Navigation Channels

---

RECOMMENDATION(S):

ACCEPT report from the Transportation, Water and Infrastructure Committee on recent reprogramming of surplus Federal dredging funds by the U.S. Army Corps of Engineers.

FISCAL IMPACT:

NONE.

BACKGROUND:

The U.S. Army Corps of Engineers has reprogrammed $1,017,211 in surplus Federal funds from a County-sponsored dredging project to the Port of Oakland, where maintenance dredging was underfunded. The Corps made this decision with the County's concurrence, which is a new requirement for the Corps when it wants to move its funds from one dredging project to another.

☐ APPROVE ☐ OTHER

☐ RECOMMENDATION OF CNTY ADMINISTRATOR ☑ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ☐ NOES ☐

ABSENT ☐ ABSTAIN ☐

RECUSE ☐

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: John Greitzer, 335-1201

cc:

BACKGROUND: (CONT'D)

The funds were to be used for the annual maintenance dredging of the Suisun Bay Channel segment of the San Francisco-to-Stockton Ship Channel. The Suisun Bay Channel is the segment of waterway that extends from the Benicia-Martinez Bridge to Antioch. The County is the local sponsor of this annual project. Shoaling (depositing of sediment) this year was significantly lighter than usual, according to the Corps, so they were able to complete the dredging for this project more quickly than expected. This saved costs and led to a surplus of funds.

The Corps contacted County staff on August 10 seeking our concurrence in shifting the surplus funds to the Port of Oakland, where additional dredging was needed but underfunded. The Corps told County staff they needed an answer by August 12. At that time, the next Board of Supervisors meeting wasn't until September 13, and the Corps indicated they could not wait that long for a decision on concurrence. Typically, staff would seek Board review and action for this type of decision.

Staff investigated whether the surplus Federal funds could be used for the County's other dredging project (Pinole Shoals Channel), but the Corps responded that they had already completed that project. Staff also asked if the funds could be carried over to next year, but the Corps stated that uncommitted surplus funds are being diverted by Corps headquarters to the Midwest for flood relief there, and there was a risk that the surplus funds being proposed for re-programming would meet this same fate. The Corps further informed us that both of our local dredging projects are already funded for next year, so there is no need to carry the funds over.

Staff believed the best option was to keep the funds in the region, and concurred with the Corps decision to shift the surplus Federal funds to the Port of Oakland. The resulting dredging at the Port of Oakland is expected to provide some benefit to Contra Costa industries who use the Port.

In the past, the Corps did not seek local concurrence when it wanted to shift dredging funds from one project to another. Their new policy requires them to gain concurrence from the local project sponsor before shifting funds.

Staff provided this report to the Transportation, Water and Infrastructure Committee on September 14. The Committee directed staff to pass the report along to the Board for information.

Attached is the correspondence pertaining to this matter, including the Corps' original email request to County staff for concurrence, the letter by County staff offering concurrence, and a letter from the Port of Oakland thanking Contra Costa County for the surplus funds.

CONSEQUENCE OF NEGATIVE ACTION:

The Board can provide alternative direction to staff on the County's position regarding reprogramming of surplus Federal dredging funds by the U.S. Army Corp of Engineers in the future.

CHILDREN'S IMPACT STATEMENT:

Not applicable.

August 10, 2011

Email from Karen Rippey, U.S. Army Corps of Engineers, San Francisco District to John Greitzer, County Delta and Navigation staff

Classification: UNCLASSIFIED
Caveats: NONE

Good Morning John

As we discussed this morning, the Suisun and New York Slough Channels were dredged using the government dredge verses the normal commercial dredging contract due to maintenance delays of the government dredge. The maintenance delays allowed the government dredge to be in San Francisco Bay to coincide with the Suisun/NY Slough fish window. Therefore, the dredging of the Suisun and New York Slough Channels will be complete today. There are funds remaining in the Suisun account. The Port of Oakland did not receive adequate funds to complete the Oakland dredging. The Oakland project was broken into option tasks so that portions of the project could be constructed.

The remaining funds in Suisun would enable one of Oakland's option tasks to be completed. To transfer the funds from Suisun to Oakland, we notify our Non-Federal Sponsor for their awareness and support.

Per our conversation, would you please verify that Contract Costa County, Suisun Bay Channel Dredging Project Non-Federal Sponsor, approves reprogramming $1,017,211 from Suisun Channel Dredging Project to Port of Oakland Dredging Project?

Your response to this email is all the confirmation the District would need from Contract Costa County to reprogram the funds. Please let us know if you need additional information.

Thank you,

Karen Rippey
Project Management
(415) 503-6747
(415) 418-9419 (cel)
(415) 503-6687 (fax)

Classification: UNCLASSIFIED
Caveats: NONE

Department of
Conservation &
Development

County Administration Building
651 Pine Street
North Wing, Fourth Floor
Martinez, CA 94553-1229

Phone: (925) 335-1201

Contra
Costa
County

Catherine O. Kutsuris
Director

August 22, 2011

Jessica Burton Evans
SPN Navigation Program Manager
Army Corps of Engineers
San Francisco District
1455 Market Street
San Francisco, CA 94103-1398

Dear Ms. ~~Burton~~ Jessica Evans:

Contra Costa County has reviewed the Corps's desire to reprogram surplus Suisun Bay Channel dredging funds to areas at the Port of Oakland which are in need of dredging.

Based on our telephone conversation, I understand that dredging for the Suisun Channel was completed under-budget because of lighter-than-usual shoaling this year, and the Pinole Shoals Channel dredging also is complete. Both Suisun and Pinole are funded in the President's Budget for next fiscal year as well. I also understand the Corps will use the surplus funds only for dredging projects rather than a study such as our Delta Long-Term Management Strategy.

Further, I understand that if we choose to hold over the surplus Suisun funds to apply to next year, there is a chance the funds will be reprogrammed to other areas of the country.

Given these considerations, we agree with the Corps's recommendation to reprogram the available Suisun funds to the Port of Oakland dredging projects. We hope this will enable the Corps to complete the annual operations and maintenance dredging at the Port, which is a major source of jobs and an important component of the East Bay economy.

Thank you for seeking our concurrence as your non-federal sponsor in the Suisun dredging project.

Sincerely,

John Greitzer
Delta and Navigation Staff

G:\Conservation\Water Agency\Navigation\letter SF USACE reprogram Suisun funds.doc
C: Members, Board of Supervisors' Transportation, Water and Infrastructure Committee
M. Avalon, Public Works Deputy Director—Flood Control
L. DeLaney, County Administrator's Office
S. Goetz, Deputy Director—Conservation, Transportation Planning & Redevelopment Programs
P. Schlesinger, Alcalde & Fay
I. Isantowski, Port of Oakland

August 23, 2011

Email from Jessica Burton-Evans, Interim Navigation Program Manager, Army Corps of Engineers, to John Greitzer, County Delta and Navigation staff

John,

Thank you very much for the letter of concurrence with the reprogramming of funds from the Suisun Bay Channel O&M to Oakland Harbor O&M.

I look forward to sharing more about our Navigation Program and the Corps' budget process with you and others in the Contra Costa County Water Agency. Give me a call or email when you're ready to schedule and we can find a date and time that will work well for everyone.

Regards,
~Jessica

<><><><><><><><><><><><><><><><><><><><>
Jessica Burton Evans
Interim Navigation Program Manager

U.S. Army Corps of Engineers
San Francisco District
1455 Market Street
San Francisco, CA 94103-1398

PORT OF OAKLAND

OMAR R. BENJAMIN
Executive Director

August 26, 2011

Mr. John Greitzer
Delta and Navigation Staff
Contra Costa County Department of Conservation & Development
651 Pine Street, North Wing, Fourth Floor
Martinez, CA 94553

Dear Mr. Greitzer:

On behalf of the Port of Oakland, I would like to take this opportunity to thank you for your assistance in concurring with the U.S. Army Corps of Engineer's request to reprogram surplus Suisun Bay Channel dredging funds to the Port's ongoing operations and maintenance dredging program.

These reprogrammed funds will help to ensure that the Corps is able to initiate the FY11 O&M dredging program and maintain the Oakland Harbor channel at its authorized depth, which is a critical component in delivering jobs, economic growth, and international trade opportunities for the regional economy. Given the constraints of the Corps' needs nationwide, these funds could have been at risk of being reprogrammed to other projects around the country and the local impact of this work would have been lost.

Again, thank you for assistance and we look forward to continuing to deliver positive economic benefits for the region through the continuation of our annual dredging program.

Sincerely,

Omar R. Benjamin
Executive Director

CC: Jessica Burton Evans, SPN Navigation Program Manager, U.S. Army Corps of Engineers

Supervisor Mary Piepho, Chair, Transportation, Water & Infrastructure Committee

Supervisor Karen Mitchoff, Vice Chair, Transportation Water & Infrastructure Committee

Mitch Avalon, Deputy Director, Contra Costa County Public Works Department

Laura Delaney, Contra Costa County Office of the Administrator

Steve Goetz, Deputy Director, Conservation, Transportation Planning & Redevelopment Programs

Paul Schlesinger, Alcalde & Fay

530 Water Street ■ Jack London Square ■ P.O. Box 2064 ■ Oakland, California 94604-2064
Telephone: (510) 627-1100 ■ Facsimile: (510) 627-1826 ■ Web Page: www.portofoakland.com

8-6

C.15

To: **Board of Supervisors**

From: **Federal D. Glover, District V Supervisor**

Date: **October 11, 2011**

Contra Costa County

Subject: P300 #21001 Add and Cancel

RECOMMENDATION(S):

ADOPT Position Adjustment Resolution No. 21001 to add two (2) 20/40 Board of Supervisors Assistant-General Office (J992) positions at salary level B85 1011 ($2,907-$4,901) and cancel one (1) 40/40 Board of Supervisors Assistant - General Secretary (J993) position #2473 in the District V Board of Supervisors Office.

FISCAL IMPACT:

During the first year, this action will result in an annual cost savings of approximately $12,600, and at top step this action is cost neutral.

BACKGROUND:

On July 26, 2011, the Board of Supervisors approved Map Proposal 17D Amended on a 3-2 vote as the proposed new supervisorial district boundaries. On August 9, 2011, the Board of Supervisors approved Ordinance No. 2011-15, establishing the proposed boundaries and set the effective date at September 9, 2011.

These new supervisorial district boundaries have resulted in a dramatic geographic change for District V. As a result of the realignment, the Supervisor's staffing needs require adjustment.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ____ NOES ____

ABSENT ____ ABSTAIN ____

RECUSE ____

Contact: Lynn Reichard-Enea 925-427-8138

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

cc: Roxana Mendoza, Gladys Scott Reid

CONSEQUENCE OF NEGATIVE ACTION:

The District V Office will not have the staffing allocation necessary to meet the needs of their constituents.

CHILDREN'S IMPACT STATEMENT:

No Impact.

POSITION ADJUSTMENT REQUEST

NO. 21001
DATE 9/26/2011

Department No./
Department Board of Supervisors - District V Budget Unit No. 0001 Org No. 1105 Agency No. 01

Action Requested: CANCEL one 40/40 Board of Supervisors Assistant - General Secretary (J993) position #2473 and ADD two 20/40 Board of Supervisors Assistant - General Office (J992)

Proposed Effective Date: 10/12/2011

Classification Questionnaire attached: Yes ☐ No ☒ / Cost is within Department's budget: Yes ☒ No ☐

Total One-Time Costs (non-salary) associated with request: $0.00

Estimated total cost adjustment (salary / benefits / one time):

Total annual cost	($12,635.00)	Net County Cost	($12,635.00)
Total this FY	($9,476.00)	N.C.C. this FY	($9,476.00)

SOURCE OF FUNDING TO OFFSET ADJUSTMENT Cost Savings

Department must initiate necessary adjustment and submit to CAO.
Use additional sheet for further explanations or comments.

Supervisor Federal D. Glover
_____
(for) Department Head

REVIEWED BY CAO AND RELEASED TO HUMAN RESOURCES DEPARTMENT

_____ _____
Deputy County Administrator Date

HUMAN RESOURCES DEPARTMENT RECOMMENDATIONS DATE _____
Add two (2) 20/40 Board of Supervisors Assistant-General Office (J992) positions at salary level B85 1011 ($2,907-$4,901) and cancel one (1) 40/40 Board of Supervisors Assistant - General Secretary (J993) position #2473

Amend Resolution 71/17 establishing positions and resolutions allocating classes to the Basic / Exempt salary schedule.
Effective: ☒ Day following Board Action.
☐ _____(Date)

_____ _____
(for) Director of Human Resources Date

COUNTY ADMINISTRATOR RECOMMENDATION: DATE _____
☐ Approve Recommendation of Director of Human Resources
☐ Disapprove Recommendation of Director of Human Resources
☐ Other: _____

_____
(for) County Administrator

BOARD OF SUPERVISORS ACTION:
Adjustment is APPROVED ☐ DISAPPROVED ☐

David J. Twa, Clerk of the Board of Supervisors and County Administrator

DATE _____ BY _____

APPROVAL OF THIS ADJUSTMENT CONSTITUTES A PERSONNEL / SALARY RESOLUTION AMENDMENT

POSITION ADJUSTMENT ACTION TO BE COMPLETED BY HUMAN RESOURCES DEPARTMENT FOLLOWING BOARD ACTION
Adjust class(es) / position(s) as follows:

P300 (M347) Rev 3/15/01

REQUEST FOR PROJECT POSITIONS

Department _____ Date 10/6/2011 No. xxxxxx

1. Project Positions Requested:

2. Explain Specific Duties of Position(s)

3. Name / Purpose of Project and Funding Source (do not use acronyms i.e. SB40 Project or SDSS Funds)

4. Duration of the Project: Start Date _____ End Date _____
   Is funding for a specified period of time (i.e. 2 years) or on a year-to-year basis? Please explain.

5. Project Annual Cost

   a. Salary & Benefits Costs: _____ b. Support Costs: _____
   (services, supplies, equipment, etc.)

   c. Less revenue or expenditure: _____ d. Net cost to General or other fund: _____

6. Briefly explain the consequences of not filling the project position(s) in terms of:
   a. potential future costs
   b. legal implications
   c. financial implications
   d. political implications
   e. organizational implications

7. Briefly describe the alternative approaches to delivering the services which you have considered. Indicate why these alternatives were not chosen.

8. Departments requesting new project positions must submit an updated cost benefit analysis of each project position at the halfway point of the project duration. This report is to be submitted to the Human Resources Department, which will forward the report to the Board of Supervisors. Indicate the date that your cost / benefit analysis will be submitted

9. How will the project position(s) be filled?
   - ☐ a. Competitive examination(s)
   - ☐ b. Existing employment list(s) Which one(s)? _____
   - ☐ c. Direct appointment of:
     - ☐ 1. Merit System employee who will be placed on leave from current job
     - ☐ 2. Non-County employee

   Provide a justification if filling position(s) by C1 or C2

USE ADDITIONAL PAPER IF NECESSARY

C.16

To: **Board of Supervisors**

From: **Barbara Flynn, County Librarian**

Date: **October 11, 2011**

Contra Costa County

Subject: Apply for and Accept a Grant in the Amount of $50,000 from the California State Library

---

RECOMMENDATION(S):

APPROVE and AUTHORIZE the Librarian, or designee, to apply for and accept a California State Library, Library Services and Technology Act Pitch an Idea FY 2011-12 program grant in the amount of $50,000 for the development and implementation of market analysis tools for library programs and services for the period September 1, 2011 through August 30, 2012.

FISCAL IMPACT:

No library fund match.

BACKGROUND:

The "Predicting Success" grant will create decision-making tools and staff expertise to swiftly and reliably anticipate customer needs so that library programs and services can be developed in light of current trends. An effective business conducts ongoing market analysis whenever it is considering a new product or service. The goal of Predicting Success is to use concepts from the business sector to get ahead of trends – anticipating instead of reacting to community needs so that library resources are allocated efficiently.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ____ NOES ____

ABSENT ____ ABSTAIN ____

RECUSE ____

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Barbara Flynn, 925-927-3201

cc:

BACKGROUND: (CONT'D)

The Contra Costa County Library Strategic Plan (2006) identifies Information for Lifelong Learning as a strategic initiative; namely, that the library will, "marshal its information resources in ways that… encourage curiosity, provide the means of discovering information and answers to questions on a broad array of topics, and help learners of all ages achieve their goals."

The grant will provide library staff with training in the principles of market analysis. Market analysis tools will be created and tested in five disparate communities within the county. Data will be used to pilot library programming at the five libraries. The data will not be 'one size fits all' but will be specific to the community and will provide needed information so library staff can create relevant programs and services for children, youth, teens, and adults. A toolkit will be developed which will be available to all Contra Costa County staff and libraries throughout the state. Staff will gain knowledge and expertise in market analysis. Library customers will gain library services that are relevant to their lives.

CONSEQUENCE OF NEGATIVE ACTION:

The Library will not be able to work with experts in the principles of market analysis to develop programs and services.

CHILDREN'S IMPACT STATEMENT:

The grant meets all five community outcomes established in the Children's Report Card. By implementing principles of market analysis the library will use proven techniques to effectively design programs and services that directly benefit children, youth and families in advance of need.

To: **Board of Supervisors**

From: **Glenn E. Howell, Animal Services Director**

Date: **October 11, 2011**

Contra Costa County

Subject: State of California Food & Agriculture Agreement

RECOMMENDATION(S):

APPROVE and AUTHORIZE the Animal Services Department Director, his designee, to execute a contract with the State of California, Food and Agriculture Department, to reimburse the County an amount not to exceed $15,000 for a Spay and Neuter Program for the period of January 1, 2011 through December 31, 2011 (100% State funds).

FISCAL IMPACT:

N/A. Only State funds will be used to fund this program.

BACKGROUND:

On April 27, 2011 the Animal Services Department was notified that a competitive application submitted to the California Department of Food & Agriculture for it's 2010 Municipal Spay-Neuter Grant Fund Program was accepted and awarded a grant in the amount of $15,000 for the period of January 1, 2011 through December 31, 2011. Grant funds will be used by the Department to provide special spay and neuter programs for County residents for the balance of 2011. (No County match required).

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ☐ NOES ☐

ABSENT ☐ ABSTAIN ☐

RECUSE ☐

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Kathy O'Connell, Executive Secretary

cc:

CONSEQUENCE OF NEGATIVE ACTION:

The loss of grant funds will reduce the Department's ability to provide additional spay and neuter services to County residents.

CHILDREN'S IMPACT STATEMENT:

N/A.

To: **Board of Supervisors**

From: **Mark Peterson, District Attorney**

Date: **October 11, 2011**

Contra Costa County

Subject: Underserved Victim Advocacy and Outreach Program Grant

---

RECOMMENDATION(S):

APPROVE and AUTHORIZE the District Attorney, or designee, to submit an application and execute a grant award agreement, and any extensions or amendments thereof, pursuant to State guidelines, with the California Emergency Management Agency, Victim Services Branch, for funding of the Underserved Victim Advocacy and Outreach Program for the period October 1, 2011 through September 30, 2012 in the amount of $125,000.

FISCAL IMPACT:

The District Attorney will receive up to $125,000 to fund victim advocacy staff to provide better services to underserved populations in targeted areas. This funding requires a 25% in-kind match which will be met with services provided by the Richmond and Pittsburg Police Departments.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ____ NOES ____

ABSENT ____ ABSTAIN ____

RECUSE ____

Contact: Cherie Mathisen, (925) 957-2234

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

cc:

BACKGROUND:

The Underserved Victim Advocacy and Outreach Program is supported by Victims of Crime Act (VOCA) Assistance and is authorized by the Victims of Crime Act of 1984, as amended. The primary goal of the program is to enhance the safety of unserved/underserved victim populations in California by establishing victim advocacy positions solely dedicated to the unserved/underserved population, coordinate direct services in an enhanced response to victimization of specific crime populations among locally involved agencies and implement an outreach awareness program to the specific population determined as unserved/underserved.

This grant will fund .75 FTE Victim Witness Program Specialist and one Administrative Intern - Temporary to provide services to the designated unserved/underserved victim population.

CONSEQUENCE OF NEGATIVE ACTION:

CHILDREN'S IMPACT STATEMENT:

THE BOARD OF SUPERVISORS OF CONTRA COSTA COUNTY, CALIFORNIA

and for Special Districts, Agencies and Authorities Governed by the Board

Adopted this Resolution on 10/11/2011 by the following vote:

AYES:

NOES:

ABSENT:

ABSTAIN:

RECUSE:

Resolution No. 2011/427

Resolution of the Board of Supervisors of the County of Contra Costa authorizing the District Attorney to sign, on behalf of the Board of Supervisors, an agreement between the California Emergency Management Agency, Victim Services Branch and the County of Contra Costa.

Whereas the Board of Supervisors, Contra Costa County, desires to undertake a certain project designated as the Underserved Victim Advocacy and Outreach Program to be funded from funds made available under the authority of the California Emergency Management Agency, Victim Services Branch.

NOW, THEREFORE BE IT RESOLVED that the District Attorney of the County of Contra Costa is authorized to execute, on behalf of the Board of Supervisors, the Grant Award Agreement, including any extensions or amendments thereof.

BE IT FURTHER RESOLVED that the grant funds received hereunder shall not be used to supplant expenditures previously authorized or controlled by this body.

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

Contact: Cherie Mathisen, (925) 957-2234

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

cc:

To: Board of Supervisors

From: William Walker, M.D., Health Services Director

Date: October 11, 2011

Contra Costa County

Subject: Contract #25–012–22 with The Center for Common Concerns, Inc. (dba HomeBase)

RECOMMENDATION(S):

Approve and authorize the Health Services Director, or his designee, to execute, on behalf of the County, Contract #25–012–22 with The Center for Common Concerns, Inc. (dba HomeBase), a non-profit corporation, in an amount not to exceed $190,000, to provide consultation and technical assistance to the Department with regard to the Continuum of Care planning and resource development, for the period from October 1, 2011 through September 30, 2012.

FISCAL IMPACT:

This Contract is funded 58% by Federal Medi-Cal Administrative Activities (MAA) and 42% by budgeted County General funds. (No rate increase)

BACKGROUND:

On October 12, 2010, the Board of Supervisors approved Contract #25–012–21 with The Center for Common Concerns, Inc. (dba HomeBase), for the period from October 1, 2010 through September 30, 2011, for the provision of consultation and technical assistance to the Department with regard to the Continuum of Care planning and resource development, including grant-writing services for County's McKinney-Vento application.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ____ NOES ____

ABSENT ____ ABSTAIN ____

RECUSE ____

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Wendel Brunner, MD 313-6712

cc: D Morgan

BACKGROUND: (CONT'D)

Approval of Contract #25–012–22 will allow the Contractor to continue providing services through September 30, 2012.

CONSEQUENCE OF NEGATIVE ACTION:

If this contract is not approved, County will no longer have the expertise needed to meet all federal guidelines to secure maximum McKinney-Vento funding required to implement the 10-year plan to eliminate homelessness in Contra Costa County.

CHILDREN'S IMPACT STATEMENT:

Not Applicable

C.20

To: Board of Supervisors

From: William Walker, M.D., Health Services Director

Date: October 11, 2011

Contra Costa County

Subject: Contract #25–063–6 with Greater Richmond Inter-Faith Program

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RECOMMENDATION(S):

Approve and authorize the Health Services Director, or his designee, to execute, on behalf of the County, Contract #25–063–6 with Greater Richmond Inter-Faith Program, a non-profit corporation, in an amount not to exceed $1,252,919, to provide emergency shelter program services for youth, for the period from October 1, 2011 through September 30, 2012.

FISCAL IMPACT:

This Contract is funded 45% by Federal funding, including Department of Health and Human Services and Federal Emergency Management Administration, 40% by State Mental Health Services Act, and 15% by Contra Costa Employment and Human Services Department. (No rate increase)

BACKGROUND:

This Contract meets the social needs of County's population by providing homeless service programs for homeless youth at County's Emergency Shelter in Richmond and a Transitional Housing Program in El Sobrante. On October 12, 2010, the Board of Supervisors approved Contract #25–063–5 with Greater Richmond Inter-Faith Program, for the period from October 1, 2010 through September 30, 2011, for the provision of emergency shelter program services for youth.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ____ NOES ____

ABSENT ____ ABSTAIN ____

RECUSE ____

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Wendel Brunner, MD 313-6712

cc: D Morgan, D Gary

BACKGROUND: (CONT'D)

Approval of Contract #25–063–6 will allow the Contractor to continue providing services through September 30, 2012.

CONSEQUENCE OF NEGATIVE ACTION:

If this contract is not approved, Contractor will not operate County's Emergency Shelter in Richmond and Transitional Housing Program in El Sobrante.

CHILDREN'S IMPACT STATEMENT:

This Homeless Services Program supports the Board of Supervisor's "Communities that are Safe and Provide a High Quality of Life for Children and Families" community outcome by providing temporary shelter and services to homeless youth to stabilize their situation.

To: Board of Supervisors

From: William Walker, M.D., Health Services Director

Date: October 11, 2011

Contra Costa County

Subject: Contract #74–224–11 with La Cheim School, Inc.

RECOMMENDATION(S):

Approve and authorize the Health Services Director, or his designee, to execute, on behalf of the County, Contract #74-224-11 with La Cheim School, Inc., a non-profit corporation, in an amount not to exceed $600,000, to provide a school-based day treatment program and mental health services for the period from July 1, 2011 through June 30, 2012. This Contract includes a six-month automatic extension through December 31, 2012, in an amount not to exceed $300,000.

FISCAL IMPACT:

This Contract is funded 37% by Federal FFP Medi-Cal, 37% by State Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), 26% by School District Educationally Related Mental Health Services Funds. (No rate increase)

BACKGROUND:

This Contract meets the social needs of County's population by providing an Intensive Day Treatment Program, mental health services and medication support in a school setting for Seriously Emotionally Disturbed (SED) youth, ages six through nineteen years. The program maintains an ongoing census of approximately 47 youth for the County and serves approximately 70 minors per year.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ☐ NOES ☐

ABSENT ☐ ABSTAIN ☐

RECUSE ☐

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Cynthia Belon, 957-5201

cc: D Morgan, D Gary

BACKGROUND: (CONT'D)

On September 21, 2010, the Board of Supervisors approved Novation Contract #74-224-10 with La Cheim School, Inc., for the period from July 1, 2010 through June 30, 2011, for the provision of a school-based day treatment program and mental health services. Approval of Contract #74-224-11 allows the Contractor to continue providing services through June 30, 2012.

CONSEQUENCE OF NEGATIVE ACTION:

If this contract is not approved, there will be fewer school-based services in Contra Costa County, which could result in higher levels of care for SED students.

CHILDREN'S IMPACT STATEMENT:

This program supports the following Board of Supervisors' community outcomes: "Children Ready For and Succeeding in School"; "Families that are Safe, Stable, and Nurturing"; and "Communities that are Safe and Provide a High Quality of Life for Children and Families". Expected program outcomes include an increase in positive social and emotional development as measured by the Child and Adolescent Functional Assessment Scale (CAFAS).

To: **Board of Supervisors**

From: **William Walker, M.D., Health Services Director**

Date: **October 11, 2011**

Contra Costa County

Subject: Contract #27-351-2 with Pittsburg Antioch Medical Group, APC (dba Springhill Medical Group)

RECOMMENDATION(S):

Approve and authorize the Health Services Director, or his designee (Patricia Tanquary) to execute on behalf of the County, Contract #27-351-2 with Pittsburg Antioch Medical Group, APC (dba Springhill Medical Group), a professional corporation, in an amount not to exceed $150,000, to provide professional primary care/cardiology/neurology/pulmonary/endocrinology services for the Contra Costa Health Plan for the period from October 1, 2011 through September 30, 2013.

FISCAL IMPACT:

This Contract is funded 100% by Contra Costa Health Plan (Health Plan) member premiums. Costs depend upon utilization. (No rate increase)

CONSEQUENCE OF NEGATIVE ACTION:

If this contract is not approved, certain specialized professional health care services for its members under the terms of their Individual and Group Health Plan membership contracts with the County will not be provided.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ☐ NOES ☐

ABSENT ☐ ABSTAIN ☐

RECUSE ☐

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Patricia Tanquary 313-6004

cc: Demetria Gary

BACKGROUND:

The Health Plan has an obligation to provide certain specialized professional health care services for its members under the terms of their Individual and Group Health Plan membership contracts with the County. In November 2009, the County Administrator approved and the Purchasing Services Manager executed Contract #27-351-1 with Pittsburg Antioch Medical Group, APC (dba Springhill Medical Group), for the period from October 1, 2009 through September 30, 2011, to provide primary care/cardiology/neurology/ pulmonary/endocrinology services. Approval of Contract #27-351-2 will allow the Contractor to continue to provide primary care/cardiology/neurology/pulmonary/endocrinology services through September 30, 2013.

CHILDREN'S IMPACT STATEMENT:

Not Applicable.

To: Board of Supervisors

From: Catherine Kutsuris

Date: October 11, 2011

Contra Costa County

Subject: Preparation of Specific Plan and EIR in the North Richmond Redevelopment Area

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RECOMMENDATION(S):

APPROVE and AUTHORIZE the Conservation and Development Director, or designee, to execute a contract amendment with Wallace, Roberts and Todd, LLC, to extend the term of the contract to June 30, 2012 and to increase the contract limit by $41,020 to a new total payment limit of $997,377 to provide additional services related to the preparation of the Specific Plan and Environmental Impact Report for a portion of the North Richmond Redevelopment Area.

FISCAL IMPACT:

None to the County General Fund. The cost of the proposed contract amendment will be covered by the Redevelopment Agency using North Richmond Redevelopment Area Capital Project Funds.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ____ NOES ____

ABSENT ____ ABSTAIN ____

RECUSE ____

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Pat Roche 335-1242

cc:

BACKGROUND:

On June 5, 2007, the Board of Supervisors authorized the preparation of a Specific Plan for the northern, industrial area of North Richmond, generally bounded by Wildcat Creek, San Pablo Creek, Richmond Parkway and the Union Pacific Railroad tracks. The purpose of the Specific Plan is to provide General Plan policy direction and guidance on how this area of North Richmond would develop as a new neighborhood with a mix of residential, commercial and public uses. The Specific Plan process was originally initiated at the request of Signature Properties. However, due to changed economic conditions, Signature Properties formally withdrew from the Specific Plan process in May, 2008, and work on the Specific Plan was suspended. Subsequent to Signature Properties withdrawal from the Specific Plan, in September, 2008, the Board reaffirmed its interest in preparing the Specific Plan, the Redevelopment Agency assumed responsibility for funding this effort and work on the Specific Plan and Environmental Impact Report (EIR) resumed.

Based on recent California Environmental Quality Act (CEQA) case law, resulting from *Sunnyvale West Neighborhood Association v. City of Sunnyvale (*190 Cal.App.4th 1351), the EIR needs to analyze an additional traffic scenario not previously included in the scope of work. The Sunnyvale case requires existing or baseline traffic conditions to be evaluated against the project and project alternatives. In addition, the scope of work needs to be expanded to address a new alternative for a proposed truck route through the Specific Plan and to evaluate additional intersections for compliance with General Plan growth management program requirements. The payment limit is being increased by $41,020 for a new total payment limit of $997,377 to allow for the expanded traffic analysis.

CONSEQUENCE OF NEGATIVE ACTION:

The contract amendment would not be approved and the proposed additional services would not be provided by the Contractor. The Department would need to reconsider how to proceed with environmental review of the proposed project.

CHILDREN'S IMPACT STATEMENT:

None.

Contra Costa County
Standard Form L-7
Revised 2008

CONTRACT AMENDMENT AGREEMENT
(Purchase of Services - Long Form)

Number 49786
Fund/Org# 7893
Account # 2310
Other #

1. **Identification of Contract to be Amended.**

   Number: 49786

   Effective Date: February 13, 2008

   Department: Conservation & Development

   Subject: Preparation of Specific Plan and EIR in the North Richmond Redevelopment Area

2. **Parties.** The County of Contra Costa, California (County), for its Department named above, and the following named Contractor mutually agree and promise as follows:

   Contractor: **Wallace, Roberts and Todd, LLC**
   Capacity: LLC
   Address: 444 Townsend Street Suite 4 San Francisco, California 94107

3. **Amendment Date.** The effective date of this Contract Amendment Agreement is October 11, 2011 .

4. **Amendment Specifications.** The Contract identified above is hereby amended as set forth in the "Amendment Specifications" attached hereto which are incorporated herein by reference.

5. **Signatures.** These signatures attest the parties' agreement hereto:

COUNTY OF CONTRA COSTA, CALIFORNIA

BOARD OF SUPERVISORS	ATTEST: Clerk of the Board of Supervisors
By _____ Chairman/Designee	By _____ Deputy

CONTRACTOR

Name of business entity: Wallace, Roberts and Todd, LLC	Name of business entity:
By _____ (Signature of individual or officer)	By _____ (Signature of individual or officer)
_____ (Print name and title A, if applicable)	_____ (Print name and title B, if applicable)

Note to Contractor: For Corporations (profit or nonprofit), the contract must be signed by two officers. Signature A must be that of the president or vice-president and Signature B must be that of the secretary or assistant secretary (Civil Code Section 1190 and Corporations Code Section 313). All signatures must be acknowledged as set forth on Form L-2.

Contra Costa County
Standard Form L-2
Revised 2008

ACKNOWLEDGMENT/APPROVALS
(Purchase of Services - Long Form)

Number

ACKNOWLEDGMENT

STATE OF CALIFORNIA)
)
COUNTY OF CONTRA COSTA)

On _____, before me,_____
(insert name and title of the officer), personally appeared _____
_____ who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS MY HAND AND OFFICIAL SEAL.

_____ (Seal)
Signature

ACKNOWLEDGMENT (by Corporation, Partnership, or Individual)
(Civil Code §1189)

APPROVALS

RECOMMENDED BY DEPARTMENT

By: _____
Designee

FORM APPROVED
COUNTY COUNSEL

By: Kathleen M. Andrus
Deputy County Counsel

APPROVED: COUNTY ADMINISTRATOR

By: _____
Designee

Wallace, Roberts & Todd, LLC
Preparation of Specific Plan and EIR for the North Richmond Redevelopment Area

Amendment Specifications
"Sunnyvale Coverage" and Additional Analysis at Intersections

Based on recent California Environmental Quality Act (CEQA) case law, resulting from *Sunnyvale West Neighborhood Association v. City of Sunnyvale 190 Cal.App.4th1351*, the Environmental Impact Report (EIR) needs to analyze an additional traffic scenario not previously included in the scope of work. Contra Costa County ("County") and Contractor agree that the Scope of Service is amended to (1) extend the term limit of the contract to June 30, 2012, and (2) provide for a new traffic analysis scenario in response to the Sunnyvale case (also referred to as "Sunnyvale Coverage") in which existing or baseline traffic conditions will be evaluated against the project and project alternatives, as follows:

Preferred Project: Assess the potential project impacts of this scenario on study intersections and freeway segments and identify mitigation measures to lessen the potential impacts. Analysis and findings will be summarized in the Draft EIR, including Final EIR/ Response to Comments on the Draft EIR. Analysis and findings will be summarized in the Draft EIR, including Final EIR/ Response to Comments on the Draft EIR.

Cost: $6,826

Reduced Density Alternative: Assess the potential project impacts of the Reduced Density Alternative on study intersection and freeway segments where significant impacts are identified under the Preferred Project scenario and identify mitigation measures to lessen the potential impacts. .

Cost: $2,374

7th Street Truck Route Alternative: Assess the potential project impacts of the 7th Street Truck Route Alternative on study intersections and freeway segments and identify mitigation measure to lessen the potential impacts. . It is assumed that only the portion of truck route along the project frontage would be constructed, thereby providing project access at Davilla Road, North Park Street, Brookside Drive and San Pablo Creek Drive. Analysis and findings will be summarized in the Draft EIR, including Final EIR/ Response to Comments on the Draft EIR. .

Cost: $5,196

Additional Analysis Intersections: In response to request from staff from both the Public Works Department and Department of Conservation & Development, expand the intersection level of service analysis to include four additional study intersections including the future truck route intersections at Parr Boulevard, North Park Drive and Market Street, as well as the intersection of San Pablo Avenue and North Richmond parkway as detailed below. Analysis and findings will be summarized in the Draft EIR, including Final EIR/ Response to Comments on the Draft EIR.

Preferred Project: Analysis required for the Preferred Project scenario is described as follows.

Existing: Existing traffic volumes for the San Pablo Avenue and Richmond Parkway intersection would be compiled from the Sugar Bowl Casino study (Abrams 2004). Intersection Level of Service (LOS) analysis for this location would be performed and documented.

Existing with Full Project Buildout: Traffix model network would be modified to include the four additional study intersections and allow for project traffic distribution to the San Pablo Avenue intersection. Background traffic volumes at the North Park Drive intersection would be derived from an adjacent study intersection where counts are available. However, since the truck route is not projected to extend beyond the project site's northern and southern boundaries, intersection LOS analysis would be performed for only the San Pablo Avenue/Richmond Parkway and North Park Drive/Soto Street Extension intersections and mitigation measures would be identified.

Year 2020 Interim**:** Future traffic volumes for the San Pablo Avenue/Richmond Parkway intersection would be derived from CCTA travel demand model output using the same process as was used for other study intersections. Intersection LOS analysis for this location would be performed and documented.

Year 2020 with Interim Project Phases: Traffix model network would be modified to include the San Pablo Avenue/Richmond Parkway intersection and allow for project traffic distribution to this location. Intersection LOS analysis would be performed for this location and mitigation measures would be identified. No analysis would be done for the three intersections on the truck route since the truck route is not assumed to be constructed until after Year 2020

Cumulative: The San Pablo Avenue and Richmond Parkway intersection is assumed to be grade separated by Year 2030. Therefore, this intersection would not be assessed under Cumulative conditions. Future traffic volumes for the Parr Boulevard and Market Street intersections along the truck route would be derived from projected volumes at adjacent intersection. Intersection LOS analysis for the two truck route locations would be performed and documented. The North Park Drive intersection is not included as it is a proposed project access.

Cumulative with Full Project Buildout: Traffix model network would be modified to include the three study intersections on the truck route. Background traffic volumes at the North Park Drive intersection would be derived from an adjacent study intersection. Intersection LOS analysis would be performed for the three intersections and mitigation measures would be identified.

Cost: $5,094

Reduced Density Alternative: For the Reduced Density Alternative, intersection LOS analysis would be performed only for those intersections identified to be significantly impacted under the Preferred Project scenario.

Cost: $754

7th Street Truck Route Alternative: Intersection LOS analysis would be performed for the four additional intersections in manners similar to the Preferred Project scenario.

Cost: $ 2,058

Peer Review: Review of additional scenario within the Proposed Project and the alternatives and update and review of the following EIR sections affected by the traffic analysis:

- Air Quality
- Greenhouse Gas Emissions
- Noise and Vibration
- Alternatives: Reduced Density, 7th Street Alternative Route and Integrated Resource Recovery Facility

Cost: $12,250

Project Management: Project coordination/management, conference calls, contact management, invoicing, sub-consultant coordination, work review, etc.

Cost: $6,468

PAYMENT PROVISIONS

The payment limit of the contract is increased by $41,020 for a new total payment limit of $997,377, to allow completion of the additional services.

To: Board of Supervisors

From: Steve Silveira, Deputy General Services Director

Date: October 11, 2011

Contra Costa County

Subject: Approve and Authorize a Consulting Services Agreement with HDR (Sacramento) for As-Needed Architectural Services for Health Facilities Projects

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RECOMMENDATION(S):

1. APPROVE a two-year Consulting Services Agreement with HDR, in the maximum amount of $300,000, to provide as-needed architectural services for various health facilities projects.

2. AUTHORIZE the General Services Deputy Director, or designee, to execute the agreement when the Consultant has returned the signed agreement together with required evidence of insurance and other documents, and the General Services Deputy Director, or designee, has reviewed and found them to be sufficient.

FISCAL IMPACT:

Projects will be assigned to the as-needed architect when there is an approved project and funding. The contract amount of $300,000 is a maximum payment limit (not actual appropriated dollars), and it is possible that the limit may not be reached. The contract limit of $300,000 is spread over a two-year contract term.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ☐ NOES ☐

ABSENT ☐ ABSTAIN ☐

RECUSE ☐

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Rob Lim, (925) 313-7200

cc: GSD Administration, GSD Accounting, GSD CPM Division Manager, GSD CPM Clerical, Auditor's Office, County Counsel's Office, County Administrator's Office, County Administrator's Office

BACKGROUND:

The purpose of the as-needed consulting services agreement is to provide architectural services for health facilities projects as they occur during the two-year contract period. When the General Services Department receives a project request that is approved by the County Administrator's Office, it will be determined whether or not to utilize an as-needed architect. The as-needed architect provides services such as programming, design, and construction administration. The types of projects will vary and may include remodels, tenant improvements, additions, modernization, and reconstruction. It is unknown at this time how many project assignments will be issued because the services are provided on an as-needed basis.

Having as-needed contracts in place will allow the design phase to commence sooner and provide for a shorter project completion schedule. There are currently four contracts of this type in place, and three of these contracts have reached their dollar limits. To provide flexibility and capacity for project delivery, it is recommended that the subject as-needed contract be approved at this time. Potential future projects may include remodels, tenant improvements, and infrastructure upgrades to facilities at the Contra Costa County Regional Medical Center and the various County health clinics.

A competitive qualifications-based selection process was conducted to determine the best qualified firms and a ranked list was established. HDR is the next firm on the list to be considered for an as-needed architectural services agreement for various health facilities projects.

CONSEQUENCE OF NEGATIVE ACTION:

If the as-needed contract is not approved, the County may not be able to expedite completion of design work and provide for a shorter project completion schedule for various health facilities projects.

CHILDREN'S IMPACT STATEMENT:

Not applicable.

To: **Board of Supervisors**

From: **William Walker, M.D., Health Services Director**

Date: **October 11, 2011**

Contra Costa County

Subject: Medical Staff Appointments and Reappointments – September 2011

RECOMMENDATION(S):

Approve the new medical staff members, residents, staff affiliations, renewal and additional privileges, provisional extensions, advancement to permanent staff, Biennial reappointments and resignations, as recommended by the Medical Executive Committee at their September 19, 2011 Meeting, and by the Health Services Director.

FISCAL IMPACT:

None.

BACKGROUND:

The Joint Commission on Accreditation of Healthcare Organizations has requested that evidence of Board of Supervisors approval for each Medical Staff member will be placed in his or her Credentials File. The above recommendations for appointment/reappointment were reviewed by the Credentials Committee and approved by the Medical Executive Committee.

CONSEQUENCE OF NEGATIVE ACTION:

If this action is not approved, Contra Costa Regional Medical and Contra Costa Health Centers' medical staff would not be appropriately credentialed and not be in compliance with the Joint Commission on Accreditation of Healthcare Organizations.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ____ NOES ____

ABSENT ____ ABSTAIN ____

RECUSE ____

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Anna Roth, 370-5101

cc: Tasha Scott, Demetria Gary

CHILDREN'S IMPACT STATEMENT:

Not applicable.

A. New Medical Staff Members

Semon Bader, MD	Surgery – Ortho
David Brody, MD	Internal Medicine
Valerie Curtis, MD	Ob/Gyn
Evan Hirsch, MD	Emergency Medicine
Roobal Sekhon, DO	Psychiatry/Psychology
Helen Steele, MD	Emergency Medicine
Louay Toma, MD	Surgery-Ortho

B. Application for Staff Affiliation

Flore Djang-Estill, NP	Ob/Gyn
Sandra Murguia-Gregory, NP	Family Medicine
Ellen Nurkse, CNM	Ob/Gyn

C. Family Medicine 2nd. Year Resident

Trang Lehman, MD	Family Medicine

D. David Grant Medical Center – Travis AFB Family Medicine Residents

Sarah Avila, MD
Lee Church, MD
Curtis Gapinski, DO
Joni Hodgson, DO
Adam Howes, MD
Kyle Jarnagin, MD
Debra Koenigsberger, MD
Elizabeth Landman, MD
Michael Odom, MD
Alexander Reynolds, DO

E. Request for Additional Privileges

Pringl Miller, MD	Surgery

F. 12-Month Provisional Status - Request to extend for an additional 3-12 Months

Kewang Li, MD	Pathology

G. Advance to Non-Provisional

Karl Harnish, DO	Emergency Medicine	C
Brian Hauck, MD	Internal Medicine	C
David Kline, MD	Anesthesia	A
Anita Wang, MD	Emergency Medicine	C

Definitions:	A=Active	C=Courtesy	Aff=Affiliate	P/A=provisional Active	P/C=Provisional Courtesy

H. Biennial Reappointments

Karl Adler, MD	Psychiatry/Psychology	C
Anna Budayr, MD	Psychiatry/Psychology	C
Sara Chan, DDS	Dental	A
Douglas Hanlin, MD	Psychiatry/Psychology	A
Steven Harrison, MD	Surgery	A
Patricia Hennigan, PhD	Psychiatry/Psychology	A
Gerald Lutovich, MD	Psychiatry/Psychology	C
Joshua Niclas, MD	Psychiatry/Psychology	A
Constantine Nicholas, MD	Surgery – Ortho	P/A
Rajiv Pramanik, MD	Emergency Medicine	A
David Solomon, MD	Family Medicine	A
Jeffrey Stern, MD	Ob/Gyn	C
Denise Tai, MD	Family Medicine	A
Brian Thomas, MD	Psychiatry/Psychology	A
Felicia Tornabene, MD	Internal Medicine	A

I. Biennial Renewal of Privileges

Heather Cedermaz, NP	Family Medicine	Aff
Kenneth Hanson, OD	Surgery	Aff
Catherine Kissinger, NP	Family Medicine	Aff
Bette Lucey, NP	Family Medicine	Aff
Deborah Nix, NP	Family Medicine	Aff
Anthony Pizzo, NP	Family Medicine	Aff
Cathy Steirn, NP	Family Medicine	Aff

J. Voluntary Resignations

Sloane Blair, MD	Surgery – Ortho
Gerald Dalgleish, MD	Pathology
Katarzyna Rapa, MD	Family Medicine

****

Definitions:	A=Active	C=Courtesy	Aff=Affiliate	P/A=provisional Active	P/C=Provisional Courtesy

To: **Board of Supervisors**

From: **William Walker, M.D., Health Services Director**

Date: **October 11, 2011**

Contra Costa County

Subject: Data Systems Group Software Maintenance

RECOMMENDATION(S):

Approve and Authorize the Purchasing Agent, on behalf of the Health Services Department, to execute a Purchase Order with Data Systems Group (DSG) in the amount not to exceed $150,000 for license support and software upgrades of the Electronic Claims and Remittance System Software, for the period from September 1, 2011 through August 31, 2012.

FISCAL IMPACT:

100% Enterprise Fund I.

CONSEQUENCE OF NEGATIVE ACTION:

If this purchase is not approved, Health Services will not receive critical software updates.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ____ NOES ____

ABSENT ____ ABSTAIN ____

RECUSE ____

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: David Runt, 313-6228

cc: Tasha Scott, Demetria Gary

BACKGROUND:

Since 2001, the department has used “The Data System Group (DSG) to license, install and support an automated Electronic Claims and Remittance System Software for the Health Services Patient Accounting Department. The Patient Accounting Unit of the Health Services Department uses DSG to simplify claims processing and revenue cycle. DSG sends claims to Keane (Health Services Patient Accounting System) nightly. CCHS uses the following DSG modules to increase revenue and improve affiances: 1. Electronic Claims Processing: Billing Forms are represented exactly and submitted directly for faster turnaround of payments. 2. Remittance and Payment Processing: This is used to enable quick and accurate posting of payments and adjustment to the Patient Accounting system. 3. Real-time Transactions Eligibility: This module is used to check for eligibility before a claim is submitted to ensure that it will be paid the first time and expedites payment. Claims Status: This module provides the ability to know if a claim is being processed and being paid without having staff 4. Financial Reporting: This module provides detailed reports, financial dashboard, and financial analysis tools.

CHILDREN'S IMPACT STATEMENT:

Not applicable.

To: **Board of Supervisors**

From: **William Walker, M.D., Health Services Director**

Date: **October 11, 2011**

Contra Costa County

Subject: Contract #24–794–8 (10) with John Muir Behavioral Health Center

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RECOMMENDATION(S):

Approve and authorize the Health Services Director, or his designee, to execute, on behalf of the County, Contract #24–794–8(10) with John Muir Behavioral Health Center, a non-profit corporation, in an amount not to exceed $1,000,000, to provide inpatient psychiatric hospital services for children and adolescents, for the period from July 1, 2011 through June 30, 2012.

FISCAL IMPACT:

This Contract is funded 100% by Mental Health Realignment funds and includes a rate increase in the Administrative Day of Psychiatric Services rate. No County match required.

BACKGROUND:

Assembly Bill (AB) 757, (Chapter 633, Statutes of 1994), authorized the transfer of state funding for Fee-For-Service/Medi-Cal (FFS/MC) acute psychiatric inpatient hospital services from the Department of Health Services to the Department of Mental Health (DMH). On January 1, 1995, the DMH transferred these funds and the responsibility for authorization and funding of Medi-Cal acute psychiatric inpatient hospital services to counties that chose to participate in this program.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ☐ NOES ☐

ABSENT ☐ ABSTAIN ☐

RECUSE ☐

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Cynthia Belon 957-5201

cc: J Pigg, D Gary

BACKGROUND: (CONT'D)

On October 12, 2010, the Board of Supervisors approved Contract #24–794–8 (9) with John Muir Behavioral Health Center, for the period from July 1, 2010 through June 30, 2011 for the provision of inpatient psychiatric hospital services to County-referred children and adolescents.

Due to lengthy negotiations, the Contractor continued to provide services in good faith. Approval of Contract #24–794–8 (10) will allow the Contractor to continue to provide services through June 30, 2012, including mutual indemnification to hold harmless both parties for any claims arising out of the performance of this Contract as part of their standard for approval of the Agreement with the County.

CONSEQUENCE OF NEGATIVE ACTION:

If this contract is not approved, County's mental health clients will not receive the inpatient psychiatric services that they need from Contractor's facility.

CHILDREN'S IMPACT STATEMENT:

This program supports the following Board of Supervisors' community outcome: "Communities that are Safe and Provide a High Quality of Life for Children and Families". Expected program outcomes include a decrease in the need for inpatient care and placement at a lower level of care.

To: Board of Supervisors

From: William Walker, M.D., Health Services Director

Date: October 11, 2011

Contra Costa County

Subject: Approval of Contract #74–430 with ZiaPartners, Inc.

RECOMMENDATION(S):

Approve and authorize the Health Services Director, or his designee, to execute, on behalf of the County, Contract #74–430 with ZiaPartners, Inc., a corporation, in an amount not to exceed $154,280 to provide consultation, training and technical assistance with regard to integration of the Health Services Department's Behavioral Health Division, for the period from October 1, 2011 through September 30, 2012.

FISCAL IMPACT:

This Contract is funded 100% by Mental Health Realignment.

BACKGROUND:

Under Contract #74-430, the Contractor will provide consultation, training and technical assistance with regard to the Health Services Department's Behavioral Health Division including but not limited to reviewing policies and procedures, on-site and off-site training and providing tools to assist with implementing an integrated system of care, through September 30, 2012.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ☐ NOES ☐

ABSENT ☐ ABSTAIN ☐

RECUSE ☐

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Cynthia Belon, 957-5201

cc: Tasha Scott, Demetria Gary

CONSEQUENCE OF NEGATIVE ACTION:

If this contract is not approved, Department's Behavioral Health Division will not be able to immediately develop a customer focused process for designing and implementation a welcoming, recovery oriented, trauma-informed and integrated system of care.

CHILDREN'S IMPACT STATEMENT:

Not applicable.

To: **Board of Supervisors**

From: **William Walker, M.D., Health Services Director**

Date: **October 11, 2011**

Contra Costa County

Subject: Contract #74–409-1 with Annie Thomas, M.D.

RECOMMENDATION(S):

Approve and authorize the Health Services Director, or his designee, to execute, on behalf of the County, Contract #74–409-1 with Annie Thomas, M.D., a self-employed individual, in an amount not to exceed $174,720, to provide professional outpatient psychiatric services for the period from October 1, 2011 through September 30, 2012.

FISCAL IMPACT:

This Contract is funded 100% by Mental Health Realignment, offset by third-party billing. (Rate increase)

BACKGROUND:

For a number of years the County has contracted with Medical, Dental and Mental Health Specialists to provide specialized professional services, which are not otherwise available. On October 19, 2010, the Board of Supervisors approved Contract #74-409 with Annie Thomas, M.D., for the period from October 1, 2010 through September 30, 2011 for the provision of professional outpatient psychiatric services.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ☐ NOES ☐

ABSENT ☐ ABSTAIN ☐

RECUSE ☐

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Cynthia Belon 957-5201

cc: D Morgan, D Gary

BACKGROUND: (CONT'D)

Approval of Contract #74-409-1 will allow the Contractor to continue providing services through September 30, 2012.

CONSEQUENCE OF NEGATIVE ACTION:

If this contract is not approved, County's clients will not have access to Contractor's professional outpatient psychiatric services.

CHILDREN'S IMPACT STATEMENT:

Not Applicable

To: Board of Supervisors

From: William Walker, M.D., Health Services Director

Date: October 11, 2011

Contra Costa County

Subject: EHR Amendments with various Contra Costa Regional Medical Center physicians

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RECOMMENDATION(S):

Approve and authorize the Health Services Director, or his designee, to execute, on behalf of the County, amendments to contracts specified on the attachment, effective October 1, 2011, to modify the Service Plan to include provisions for Electronic Health Records (EHR) assignment with no change in the original payment limits and no change in the original terms.

FISCAL IMPACT:

These Contracts are funded 100% by Enterprise Fund I. No rate increases.

BACKGROUND:

In accordance with Title 42, Part 495 of the Code of Federal Regulations, physicians are obligated to take steps necessary to allow the County to realize the benefits of the EHR Incentive Program. Approval of these Amendments will modify language in the Service Plans of each Contract allowing assignment of fees and insurances benefits due and payable for medical services rendered pursuant to the Contract.

Approval of these Amendments will allow the Contracts to be amended to include electronic health records assignment language therefore allowing Contractors to continue providing services.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ____ NOES ____

ABSENT ____ ABSTAIN ____

RECUSE ____

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: David Goldstein, MD, 370-5525

cc: Tasha Scott, Demetria Gary

CONSEQUENCE OF NEGATIVE ACTION:

If these amendments are not approved, the County would not be able to collect and retain EHR Incentive Program payments for services provided to County under these Contracts.

CHILDREN'S IMPACT STATEMENT:

Not applicable.

Attachment

Contractor	Contract Number
Liam Keating, M.D., a self-employed individual	26-508-4
Pringl Miller, M.D., a self-employed individual	26-596-8
Rauf Shaista, M.D., a self-employed individual	26-673-1
Siri Sunderi Cheng, M.D., a self-employed individual	26-672-1
Kevin Beadles, M.D., a self-employed individual	26-936-13
David H.C. Raphael, M.D., a self-employed individual	26-938-15
Thomas McDonald, M. D., a self-employed individual	26-967-13
Mark Van Handel, M.D., a self-employed individual	26-975-7
Ramon Berguer, M.D., a self-employed individual	26-971-15
Paul Reif, M.D., a self-employed individual	26-830-31
Gupta Etwaru, M.D., a self-employed individual	26-969-12

To: **Board of Supervisors**

From: **Catherine Kutsuris**

Date: **October 11, 2011**

Contra Costa County

Subject: FY 2011/12 Keller Canyon Mitigation Fund (KCMF) Proposed Allocation Plan

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RECOMMENDATION(S):

1. **APPROVE** the FY 2011/12 Keller Canyon Mitigation Fund (KCMF) allocation plan in the amount of $766,796 for specified projects as recommended by the KCMF Review Committee (see Exhibit 1); and

2. **AUTHORIZE** the Department of Conservation and Development Director, or designee, to enter into contracts with the agencies for the period July 1, 2011 to June 30, 2012.

FISCAL IMPACT:

The FY 2011/12 KCMF allocation plan is consistent with policies adopted by the Board on May 24, 2011. The projected revenue amount is based on the trend over the last several years; has been reduced by 20 percent; and prior year deficits have been deducted resulting in a total of $766,796 available to be allocated.

CONSEQUENCE OF NEGATIVE ACTION:

Not approving the recommended allocations will result in further delays in implementing important projects/programs benefiting residents of the KCMF target areas.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ☐ NOES ☐

ABSENT ☐ ABSTAIN ☐

RECUSE ☐

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Bob Calkins, (925) 335-7220

cc: Elizabeth Verigin

BACKGROUND:

FY 2011/12 Allocation Process: On May 24, 2011 the Board of Supervisors (Board) approved new policies regarding the administration of the Keller Canyon Mitigation Fund (Exhibit 2). Consequently, the FY 2011/12 KCMF funding allocation process is the first year that the new policies governed the process. Listed below are the applicable policies and a discussion on how they were incorporated into this year's allocation process:

1. **Policy IA:** The composition of the KCMF Review Committee shall include the following individuals: District V Supervisor, District V Chief of Staff (or other person assigned by the Supervisor), a representative of the Bay Point Municipal Advisory Committee (MAC) appointed by the Bay Point MAC, a Principal (or other senior school official) from a school located in the Bay Point area, and a representative from the Bay Point Chamber of Commerce. The representatives from the MAC, Bay Point area school, and Chamber of Commerce shall be appointed to minimum two year terms***Action:*** *The KCMF Review Committee comprised of District V Supervisor, Federal D. Glover; Chief of Staff, David E. Fraser; Bay Point Municipal Advisory Committee Member, Vicki Zumwalt (appointed by the Bay Point MAC); and Bay Point Chamber of Commerce Representative, Shah Khurram (appointment confirmed by the Board on June 28, 2011). At this point, recruitment of the school representative was unsuccessful but efforts are continuing.*
2. **Policy IB:** KCMF Review Committee members shall be subject to the Political Reform Act and Government Code section 1090. On a case by case basis, individual KCMF Review Committee members, depending on the individual circumstances, may be required to recuse themselves from participating in the discussion and consideration of a particular application for KCMF funding in compliance with the Political Reform Act and Government Code section 1090. Because each situation can be different, each KCMF Review Committee member shall be encouraged to consult with County Counsel to determine how the Political Reform Act and Government Code section 1090 may apply to them as they consider KCMF applications, and make funding recommendations to the Board of Supervisors. KCMF Review Committee members shall receive training on the Political Reform Act and Government Code section 1090 on a yearly basis***Action:*** *The KCMF Review Committee was provided training on the Political Reform Act and Government Code Section 1090. During the applicant interview process and deliberations, two Committee members recused themselves because they are members of the Board of Directors of an agency applying for funding.*
3. **Policy IC:** The KCMF Review Committee shall be responsible for reviewing and updating, if necessary, the KCMF application materials and rating/evaluation criteria to ensure they are consistent with the conditions of approval for the Keller Canyon Landfill, as amended. ***Action:*** *The FY 2011/12 KCMF application and rating/evaluation criteria were updated to better reflect the newly adopted policies (Exhibit 3).*
4. **Policy ID:** The KCMF Review Committee's funding recommendations shall be guided by the KCMF Target Area Map (Exhibit 1a) that establishes "Primary" and "Secondary" target areas for the use of KCMF funds. 100 percent of KCMF funds shall be used for programs/projects/services directly serving those within the "Primary" and Secondary" target areas. In addition, no less than 70 percent of the KCMF funds shall be used to fund programs/projects/services directly serving those in the "Primary" target area***Action:*** *The KCMF Review Committee's FY 2011/12 funding recommendations result in 86 percent of the funds being used for programs/projects that directly serve those in the "Primary" target area.*
5. **Policy IE:** Funding recommendations from the KCMF Review Committee shall be presented at a Board of Supervisors regularly scheduled meeting. The Board Order will list all of the applicants, the amount of funding requested, the amount recommended, and a short description of the proposed program/project and the proposed outputs and/or outcomes.***Action:*** *Beginning on May 31, 2011, the KCMF Review Committee met eight times to review the recently adopted KCMF policies, review and discuss the revised application and evaluation criteria, interview applicants, and to develop funding recommendations. Exhibit 1 presents the FY 2011/12 KCMF funding recommendations as adopted by the Committee on September 23, 2011. Exhibit 4 summarizes all of the requests received for the FY 2011/12 funding cycle.*
6. **Policy IIA:** To increase the public's knowledge on how, where, and when to apply for KCMF funding, the funding timeline, request for proposal (KCMF application), and other applicable materials shall be placed on the District V and County websites. The websites shall also allow organizations and interested persons to add their contact information to ensure notification on matters related to KCMF. ***Action:*** *The Supervisor's office and DCD staff engaged in a comprehensive outreach effort to notify the public of the availability of funds. Apart from posting the notice and application on the County's website, emails were sent to several updated email lists, including previous KCMF applicants. Notice was also sent to all local media outlets. The Contra Costa Times and others published articles/notices regarding the availability of KCMF funds. In addition, a voluntary bidder's conference was convened on May 31, 2011 to apprise potential applicants of the new policies. At that time, significant attention was paid to the funding protocol based on the primary and secondary target areas.*
7. **Policy IIB:** The current list of interested organizations wishing to be notified about the opportunity to apply for KCMF funding shall be reviewed and updated annually to ensure the broadest outreach as possible. ***Action:*** *See #6 above.*
8. **Policy IIC**: To ensure the tax exempt status of a nonprofit agency requesting funds is valid and in good standing, KCMF applicants shall submit their current non-profit status determination letter from the IRS, a copy of their most recent tax return, and the printout from the California Business Portal (http://kepler.sos.ca.gov/)***Action:*** *Any application that did not contain the required documents, including the printout from the California Business Portal, was deemed to be incomplete and therefore not accepted.*
9. **Policy IID:** KCMF Board Orders shall include detailed line items that identify the agencies who applied for funding, the amount of funds requested, the amount recommended, and a complete description of the proposed program/project to be

funded. An approved copy of all Board Orders shall be provided to the Auditor-Controller for their files. ***Action:*** *See #5 above. In addition, when approved by the Board, a copy of this Board Order will be provided to the Auditor-Controller.*

10. **Policy IIE:** By September 30 of each year, the KCMF Review Committee shall prepare a report to the Board of Supervisors on the use of KCMF funds in the previous fiscal year. At a minimum, this report shall describe the revenue received during the year, the amount allocated and spent by each grantee, and the outcomes(s) achieved for each funded activity. *Action: The above report was approved by the Board of Supervisors on September 27, 2011.*
11. **Policy IIF:** Any deficit in the KCMF fund after the end of each fiscal year shall be eliminated by allocating the necessary amount from next year's projected revenue.***Action:*** *At the end FY 2010/11, the total deficit in the KCMF account was $193,204 ($25,204 from FY 2010/11 and $168,000 from previous fiscal years). This deficit was taken into account when staff determined the estimate of funds available for FY 2011/12.*

Projected Revenue	$1,200,000
80 percent of Projected Revenue	$ 960,000
Less FY 2010/11 Deficit	($ 25,204)
Less Prior Years Deficit	($ 168,000)
FY 2011/12 Anticipated Revenue	**$ 766,796**

12. **Policy IIG:** When estimating the amount of KCMF funds to be made available for projects in future fiscal years, staff shall analyze the revenue trend lines from previous years and the KCMF Review Committee shall only allocate 80 percent of the anticipated revenue for the upcoming year. This protocol will reduce the likelihood that expenses will be greater than actual revenue received during the year. Any revenue over expenses in one year may be added to the amount made available in the following year. ***Action:*** *Based on revenue trends over the last several years, staff has projected that the KCMF account will receive $1,200,000 in revenue during FY 2011/12, and based on the KCMF policies a total of $766,796 is available to be allocated to projects/programs this year (see above table). With such a reduced funding base when compared to previous years, the KCMF Review Committee prioritized projects that met all geographical and other categorical requirements based on factors such as how essential the proposed project/program were deemed to the respective communities, availability or lack thereof of similar services, prospect of applicants securing other funding, etc. The KCMF Review Committee requested that staff return in January and April, 2012 to update them the income the KCMF has received to date. The Committee indicated its desire to restore some or all of the cuts, up to $100,000, it has recommended to the Sheriff's Office Bay Point School Resource Officer based on the updated income projections.*

CHILDREN'S IMPACT STATEMENT:

The recommended projects support at least one of the five community outcomes established in the Children's Report Card: 1) children ready for and succeeding in school; 2) children and youth healthy and preparing for productive adulthood; 3) families that are economically self-sufficient; 4) families that are safe, stable and nurturing; and 5) communities that are safe and provide a high quality of life for children and families.

The Keller Canyon Mitigation Fund Review Committee recommends the following FY 2011/12 allocations in the amount of $766,796 for specified projects.

1. AdvanceCamp Inc..... $1,000
Funding will support educational advancement opportunities for young men involved in scouting working towards the rank of Eagle Scout. The funds would be used for rental equipment and materials, food to feed the staff and the young men, supplies for classes, equipment for advancement requirements, medical supplies for First Aid Station, postage and stationary supplies, awards and recognition for the young men and commemorative event patch for this 24 - hour annual event.

2. Amador Institute, Inc..... $5,000
Funding will support the Youth Development Program that engages, challenges, nurtures, supports, and develops youth into becoming self confident, self-directed, independent young men and woman as they transition out of child weldfare, juvenile justice system or alternative school situations.

3. Ambrose Recreation & Park District – Bay Point Youth Sports Program..... $5,000
Funding will support programs focusing on soccer, basketball and baseball for basic level youth sports targeting age groups 6-8 years old and modeled after the Fist Five Program.

4. Ambrose Recreation & Park District – Sink and Counter Replacement..... $7,818
Funding will support the installation of three new basin sinks and counter top in the Center's dining room kitchen.

5. Bay Point Chamber of Commerce – Welcome to Bay Point Sign and Beautification.... $10,000
Funding will support a "Welcome to Bay Point" sign, including landscaping, at the western end of Bay Point to help promote a positive image for the community.

6. Bay Point Community Foundation – CARES Garden..... $2,000
Funding will support the after school program for instructional school gardens where sites will use produce from their gardens for cooking classes. The program will promote gardening, nutrition and physical activity.

7. Bay Point Garden Club – Ambrose Community Garden Construction Phase II..... $3,500
Funding will support the construction of a fence around the Ambrose Community Center Garden.

8. Bay Point Garden Club – Spring Derby Memorial, Parade and Festival..... $3,000
Funding will support the enhancement of the Festival portion of the Spring Derby by inviting more vendors and drawing participation from other neighboring communities to promote their mission – "We Grow More than Plants!"

9. Brighter Beginnings – Teen Family Success..... $4,500
Funding will support the Teen Family Success program, a child abuse/neglect prevention and early intervention program for pregnant and parenting teens including young fathers.

10. Center for Human Development – Four Corners..... $5,000
Funding will support the Four Corners Program which provides violence and gang prevention groups and indivdual support for high-risk junior high stedents attending Hillview Junior High in Pittsburg.

11. Center for Human Development – Unity in Community..... $5,000
Funding will support the Bay Point Partnership Ninth Annual Unity in Community event which cultivates resident leadership, fosters relationships between residents and service providers, offers community resources, celebrates diversity of people and cultures, and promotes civic pride.

12. City of Pittsburg – Every Day is a Special Day..... $6,000
Funding will support the collarboration between the City of Pittsburg, Kiwanis and Pittsburg Unified School District to provide special needs students with programs and recreational activities.

13. Contra Costa County, Bay Point Municipal Advisory Council (MAC)..... $5,000
Funding supports the advisory council's activities throughout the year. The MAC provides advice and recommendations to the Contra Costa County Board of Supervisors on planning issues and services provided in Bay Point.

14. Contra Costa County, County Counsel, Code Compliance Attorney..... $47,500
Funding will support the cost of a Code Compliance Attorney for the Bay Point area of District V. The County Counsel's Office will provide legal support to enforcement officials who are responsible for the effective and timely enforcement of existing zoning, building, housing, safety, and health ordinances as well as policy makers in the adoption, implementation and enforcement of new ordinances and regulations.

15. Contra Costa County, District V Code Enforcement..... $45,000
Funding will support the cost of a enforcement inspector for the Bay Point area of District V. The Code Enforcement Program addresses complaints of junkyard, abandoned, boarded-up, vacant properties, land-use and building issues, mobile homes and in residential neighborhoods being used for improper and illegal activities.

16. CCC EHSD - Service Intergration Program, Community Career Center..... $7,500
Funding will support a neighborhood-based program that strives to advance the economic well-being of unemployed, underemployed and "working poor" Bay Point residents, while providing them with meaningful opportunities to actively engage in the revitalization of their community.

17. Contra Costa County General Services – East County Beautification Program..... $30,000
Funding provides community beautification through roadside cleanup of litter, trash, appliances, tires, abandoned vehicles and other waste marterials as well as landscape maintenance in Bay Point.

18. Contra Costa County Health Services Department – Cali House Youth Shelter.....$10,000
Funding will support the Cali House which provides shelter and citical services to runaway and homeless youth ages 14-21 from Primary and Secondary Target areas.

19. Contra Costa County Office of the Sheriff – Bay Point Annual Holiday Dinner and toy give away. $6,000
Funding will support the annual free event open to all Bay Point residents and held at the Ambrose Recreation & Park District Center.

20. Contra Costa County Office of the Sheriff – Bay Point Resident Deputy.....$175,000
Funding provides enhancement of law enforcement services to the Bay Point community to improve the quality of life.

21. Contra Costa County Office of the Sheriff – Bay Point School Resource Officer..... $75,000
Funding provides a part-time uniformed officer within the Bay Point schools to establish a safe school environment and promote the positive development of Bay Point youth.

22. Contra Costa County, Public Works, Bay Point Crossing Guard..... $60,000
Funding will support provisions for State approved training, equipment, and compensation for crossing guards at 10 Bay Point intersections.

23. Contra Costa County, Supervisor Glover, District V Interns..... $5,000
Funding will provide a stipend for summer and winter internships at the District V office

24. Contra Costa County, Supervisor Glover, District V Staffing..... $132,604
Funding will support the growing needs of constituents in East County through the provision of 1 FTE staff positions focused on the primary mitigation area of Bay Point.

25. Contra Costa County, Supervisor Glover, District V – Annual Reception $2,000
Funding will support the annual reception for service providers who receive funding from the Keller Canyon Mitigation Fund. Participants share with attendees the scope and nature of the services they provide and collaborate on service expansion. The allocation includes the cost of food, rental and other charges related to the reception.

26. Contra Costa County, Supervisor Glover, Grant Writing Seminar..... $5,000
Funding will support a Grant Writing Seminar to enhance the ability of nonprofit agencies to secure funding through an in-depth education of the grant process, including the revenue building tools necessary to write, budget and implement grants in the most beneficial manner possible.

27. CCC, Sup Glover, Gang Summit/Youth Summit/Small Business Wkshop $45,000
Funding will support three events: Gang Summit, Small Business Workshop and the Annual Contra Costa County Youth Summit. These one day conferences offer opportunites to enhance and educate participants through the examination of possible solutions for the individual issues they are facing within their realm.

28. Contra Costa Library – Family & Children's Programming..... $5,000
Funding will support youth oriented programs and additional reading materials to encourage youth to develop a life-long love of reading and foster literacy in the Bay Point community.

29. Contra Costa Library – SAT Preparation..... $7,000
Funding will provide comprehensive SAT courses to junior and seniors from Pittsburg High School and Mt. Diablo High School including professional development sessions for faculty.

30. Contra Costa Regional Health Foundation – African American Health Expo..... $4,850
Funding will support a one day health event to encourage personal and community action to improve health and reduce disparities for Bay Point, Pittsburg and Antioch African Amercian residents.

31. Craft Community Care Center – Art Education, World Music and Art Program..... $5,000
Funding will support the program that provides and cultivates understanding, acceptance and appreciation of the various cultures making up District V's population though song, dance, history and art. The Arts Education Program brings music and art from around the world to all Pittsburg students and their families.

32. East County Kids in Motion..... $5,524
Funding will support multicultural dance classes to youth from the Bay Point area by offering a dedicated, healthy, positive and safe environment.

33. Habitat for Humanity East Bay – Neighborhood Revitilization Initiative..... $5,000
Funding will support direct efforts in the Bay Point community towards preserving affordable homeownership opportunities for families and eliminating blight through neighborhood beautification projects.

34. Hapgood Theatre – Young Audience Education Program..... $5,000
Funding will support free matinee performances of live, professional theatre for District V high school and community college students. The teachers are supplied with study materials to use in class prior to each production. Students also take part in post-show artist talkbacks and master classes provide opportunities for students to work alongside and get coaching from professional actors.

35. Positive Edge Experience – The Positive Edge..... $7,000
Funding will support providing professional clothing, accessories, image enhancement and career development to low-income women and men actively seeking employment.

36. The Williams Group – Street Engagement Team..... $5,000
Funding will support the collarboration of the Youth Intervention Network and the Antioch Police Department to provide intervention strategies for gang members and gang affiliates involved in criminal activity and gang conflicts residing in the Sycamore Corridor area of Antioch.

37. Turn the Youth Around – SOYFFL..... $4,000
Funding will support a fitness program to enhance physical activities and nutritional information through the SOYFFL Fitness Training Program. The purpose of the program is to decrease the rise of childhood obesity and encourage youth activities through physical fitness.

38. Pittsburg Arts and Community Foundation..... $5,000
Funding will support the FY 2010/11 Pittburg Twilight Criterium (Bicylce Race) and Famility Fitness Festival. This allocation was approved by the Board of Supervisors on May 3, 2011 but funds were not expended last year. The Festival included providing a variey of free health related screenings including blood pressure, body fat, Body Mass Index, glucose, and cholesterol.

CONTRA COSTA COUNTY
Department of Conservation and Development
Keller Canyon Mitigation Fund Policies

Adopted by the Board of Supervisors on May 24, 2011

I. KELLER CANYON MITIGATION FUND REVIEW COMMITTEE

A. The composition of the KCMF Review Committee shall include the following individuals: District V Supervisor, District V Chief of Staff (or other person assigned by the Supervisor), a representative of the Bay Point Municipal Advisory Committee (MAC) appointed by the Bay Point MAC, a Principal (or other senior school official) from a school located in the Bay Point area, and a representative from the Bay Point Chamber of Commerce. The representatives from the MAC, Bay Point area school, and Chamber of Commerce shall be appointed to minimum two year terms.

B. KCMF Review Committee members shall be subject to the Political Reform Act and Government Code section 1090. On a case by case basis, individual KCMF Review Committee members, depending on the individual circumstances, may be required to recuse themselves from participating in the discussion and consideration of a particular application for KCMF funding in compliance with the Political Reform Act and Government Code section 1090. Because each situation can be different, each KCMF Review Committee member shall be encouraged to consult with County Counsel to determine how the Political Reform Act and Government Code section 1090 may apply to them as they consider KCMF applications, and make funding recommendations to the Board of Supervisors. KCMF Review Committee members shall receive training on the Political Reform Act and Government Code section 1090 on a yearly basis. In addition, the KCMF Review Committee is subject to County Resolution 2011/55 making family members of the Board of Supervisors ineligible for appointment to the Committee.

C. The KCMF Review Committee shall be responsible for reviewing and updating, if necessary, the KCMF application materials and rating/evaluation criteria to ensure they are consistent with the conditions of approval for the Keller Canyon Landfill, as amended.

D. The KCMF Review Committee's funding recommendations shall be guided by the KCMF Target Area Map (Exhibit 1a) that establishes "Primary" and "Secondary" target areas for the use of KCMF funds. 100 percent of KCMF funds shall be used for programs/projects/services directly serving those within the "Primary" and Secondary" target areas. In addition, no less than 70 percent of the KCMF funds shall be used to fund programs/projects/services directly serving those in the "Primary" target area.

E. Funding recommendations from the KCMF Review Committee shall be presented at a Board of Supervisors regularly scheduled meeting. The Board Order (BO) will list all of the applicants, the amount of funding requested, the amount recommended, and a short description of the proposed program/project and the proposed outputs and/or outcomes.

II. KELLER CANYON MITIGATION FUND ALLOCATION PROCESS

A. To increase the public's knowledge on how, where, and when to apply for KCMF funding, the funding timeline, request for proposal (KCMF application), and other applicable materials shall be placed on the District V and County websites. The websites shall also allow organizations and interested persons to add their contact information to ensure notification on matters related to KCMF.

B. The current list of interested organizations wishing to be notified about the opportunity to apply for KCMF funding shall be reviewed and updated annually to ensure the broadest outreach as possible.

C. To ensure the tax exempt status of a nonprofit agency requesting funds is valid and in good standing, KCMF applicants shall submit their current non-profit status determination letter from the IRS, a copy of their most recent tax return, and the printout from the California Business Portal (http://kepler.sos.ca.gov/).

D. KCMF Board Orders shall include detailed line items that identify the agencies who applied for funding, the amount of funds requested, the amount recommended, and a complete description of the proposed program/project to be funded. An approved copy of all Board Orders shall be provided to the Auditor-Controller for their files.

E. By September 30 of each year, the KCMF Review Committee shall prepare a report to the Board of Supervisors on the use of KCMF funds in the previous fiscal year. At a minimum, this report shall describe the revenue received during the year, the amount allocated and spent by each grantee, and the outcome(s) achieved for each funded activity.

F. Any deficit in the KCMF fund after the end of each fiscal year shall be eliminated by allocating the necessary amount from next year's projected revenue.

G. When estimating the amount of KCMF funds to be made available for projects in future fiscal years, staff shall analyze the revenue trend lines from previous years and the KCMF Review Committee shall only allocate 80 percent of the anticipated revenue for the upcoming year. This protocol will reduce the likelihood that expenses will be greater than actual revenue received during the year. Any revenue over expenses in one year may be added to the amount made available in the following year.

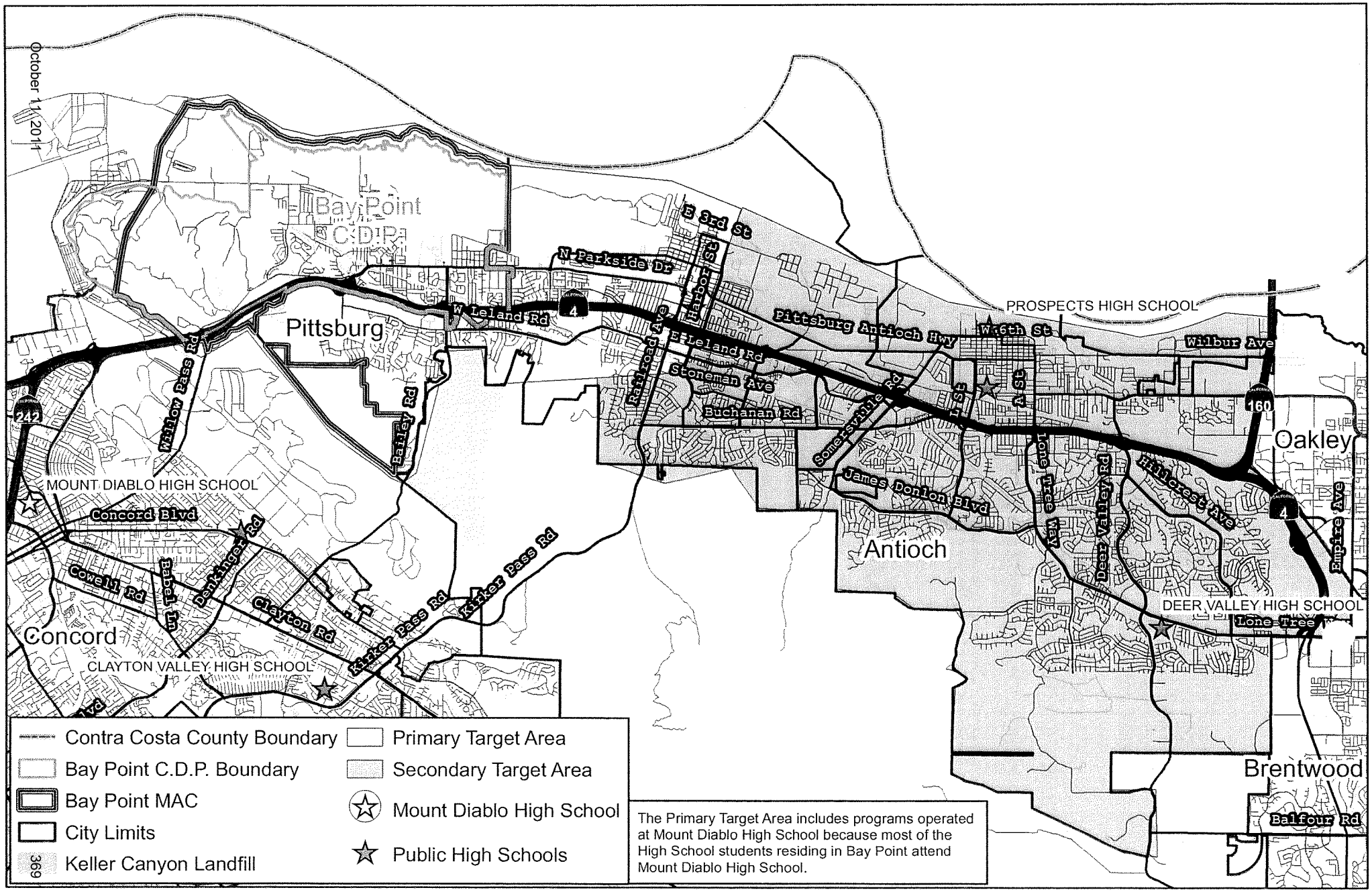
III. DISBURSEMENT OF KELLER CANYON MITIGATION FUNDS

A. KCMF funded agencies that receive other County/Sate/City funds and who are typically paid on a cost reimbursement basis for the programs they operate shall receive their KCMF allocation on a cost reimbursement basis.

B. Funded agencies that can demonstrate that providing KCMF funding on a cost reimbursement basis will create a financial hardship and be detrimental to the operation of the KCMF funded program shall be eligible to receive up to ½ of the grant amount after the KCMF contract is executed. The remaining amount of the grant will be disbursed after the agency has submitted information documenting how the initial disbursement was spent. At the conclusion of the program, the agency shall be required to submit information documenting how the second disbursement was spent, and provide information documenting program outputs and outcomes.

C. Each Demand for payment forwarded to the Auditor-Controller will include the name of the agency, the KCMF item agenda number, and the item number of the approved program/project. (For example: New Connections, C.49, Item #45).

Keller Canyon Mitigation Fund Target Area Map



Map created 3/11/2011
by Contra Costa County Department Conservation and Development
Community Development Division–GIS Group
651 Pine Street, 4th Floor North Wing, Martinez, CA 94553-0095
37:59:48.455N 122:06:35.384W

CONTRA COSTA COUNTY
KELLER CANYON MITIGATION TRUST FUND
2011-2012 APPLICATION

EXHIBIT 3

This proposal is for a (check one): ☐New ☐Previously Funded ☐One-time Project

Agency Type (check one): ☐Nonprofit ☐Public Agency ☐For Profit

Tax Identification Number: _____

NAME OF ORGANIZATION / AGENCY: _____

ADDRESS: _____

CITY, STATE ZIP: _____

CONTACT PERSON: _____

TITLE: _____

TELPHONE NUMBER: _____ CELL: _____

FAX NUMBER: _____

EMAIL ADDRESS: _____

WEB SITE: _____

NAME OF PROPOSED PROJECT: _____

PROJECT ADDRESS / LOCATION: _____

TOTAL PROJECT COST: $_____

AMOUNT OF FUNDING REQUESTED: $ _____

PROJECT SUMMARY (40 word max):

Application may be submitted via e-mail to: dist5@bos.cccounty.us

CONTRA COSTA COUNTY
KELLER CANYON MITIGATION TRUST FUND
2011-2012 APPLICATION

Please answer **all** the following questions completely. The narrative portion of the application, exclusive of the budget or relevant appendices, should not exceed seven typed pages, double-spaced, with twelve-point or larger font and one-inch margins.

BACKGROUND & PROJECT DESCRIPTION

1. Provide a description of the project.

2. Is your project a single event or a continuous service?

3. Who is the target population for the project?

4. Using the Keller Canyon Mitigation Fund Target Area Map (see Exhibit 1), of the total number of clients to be assisted by the project how many reside in the "Primary" target area and how many reside in the "Secondary" target area. Please note, Keller Canyon Mitigation Trust Fund polices require 100 percent of the Keller Canyon funds be used for programs/projects/services directly benefiting those within the Primary and Secondary Target areas. No less than 70 percent of the Keller Canyon funds, in aggregate, must be used to fund programs/projects/services directly serving those in the Primary target area.

5. What are the eligibility criteria for client receipt of services?

PROPOSAL NARRATIVE

6. Statement of Need: Describe the need for your project (use research data to quantify the need).

7. Outline the goal(s) for the project. Goals should be general in nature, but relevant to the purpose of the project.

8. Provide the objectives of the project that will assist your agency in meeting the goal(s).

9. Describe the outcome(s) and impact(s) of the project. Outcomes should be specific, measurable, attainable, realistic and time-bound. Impacts identify verifiable changes at the client-level as a result of the outcomes.

10. How will you evaluate the success of your project? How will success be measured? How will the outcomes of your project be demonstrated to the community?

11. What is the specific timeline for your project?

CONTRA COSTA COUNTY
KELLER CANYON MITIGATION TRUST FUND
2011-2012 APPLICATION

PROJECT FUNDING

12. Provide a detailed budget for your project showing ALL funding sources and uses, including the use of Keller Canyon Mitigation Funds. See example (Exhibit 2). The budget must reflect the entire operational cost of the project as well.

13. Is the project provided in other supervisorial districts beyond District V? If so, what is the base level of funding and source of funding for each district?

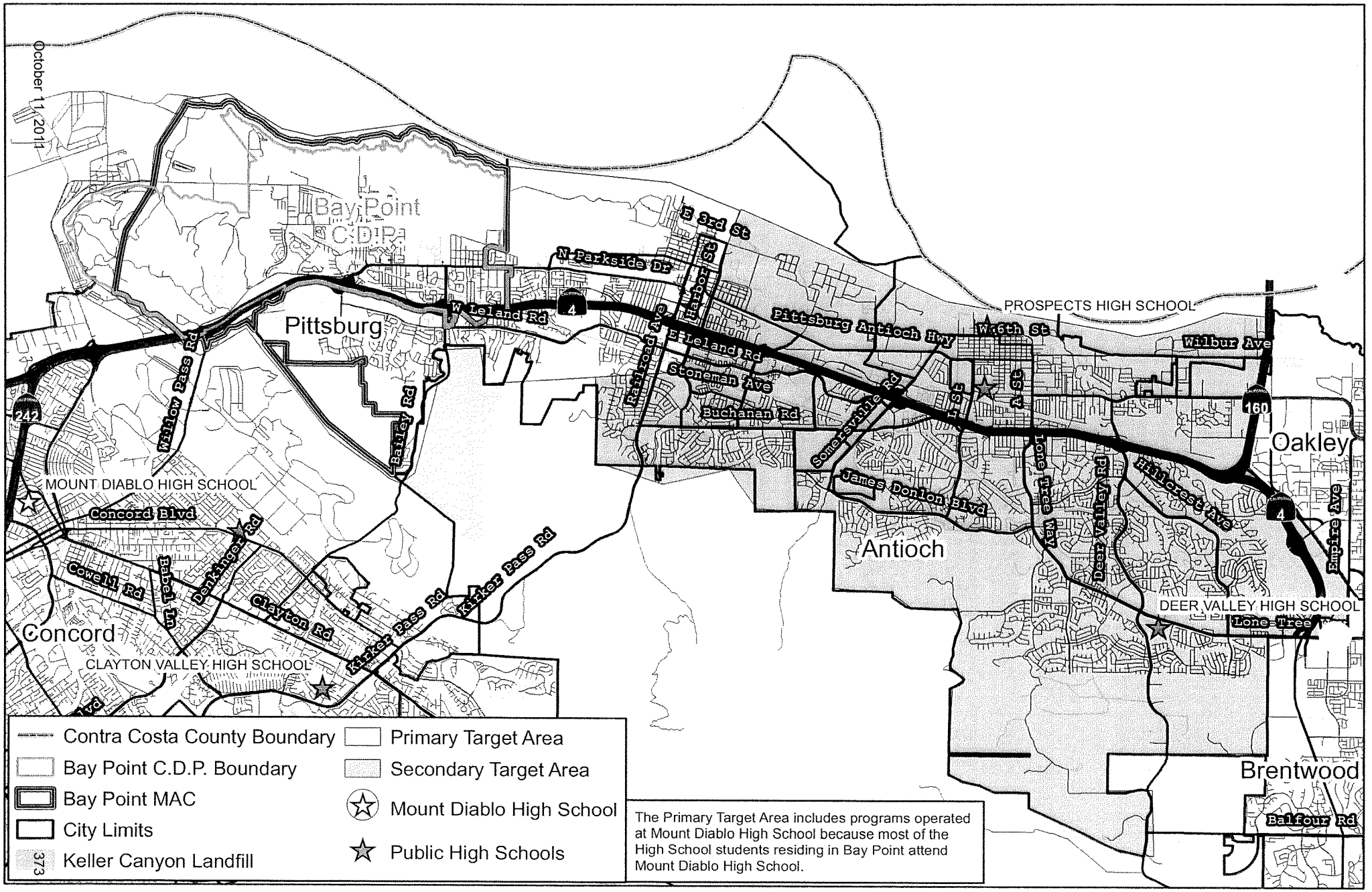
14. If your agency is not the fiscal agent for the Keller Canyon Mitigation Funds, who will be? Provide all organizational information specified on the first page of this application for the fiscal agent.

15. Nonprofit Organizations who are direct applicants or fiscal agents for other applicants, must include the following attachments with your application:

a. List of Board of Directors including name, title, and address of each member
b. Non-Profit Status Determination letter from the Internal Revenue Service
c. Most recent (current) Internal Revenue Service Form 990 filed
d. California Business Portal printout (proof that your agency is currently registered with the California Secretary of State). Go to: http://kepler.ss.ca.gov/list.html. Enter your agency's name, find it in the matrix and then print the page.
e. Commitment Letters for all approved funding sources needed to carry out the proposed project

Note: Public agencies are excluded from the requirements outlined in Item 15.

Keller Canyon Mitigation Fund Target Area Map



Map created 3/11/2011
by Contra Costa County Department Conservation and Development
Community Development Division--GIS Group
651 Pine Street, 4th Floor North Wing, Martinez, CA 94553-0095
37:59:48.455N 122:06:35.384W

Sources and Uses Budget

		DHHS, HRSA	EBCF	Lions	TOTAL
Personnel					
Community Health Worker	40,000	40,000			**40,000**
Nutritionist	30,000	15,000	15,000		**30,000**
Benefits @ 30%	21,000	16,500	4,500		**21,000**
Total Salary and Benefits	**91,000**	**71,500**	**19,500**	**0**	**91,000**
Operating Expenses					
Office lease	4,000	1,500	2,500		**4,000**
Equipment	1,200			1,200	**1,200**
Telephone	800		800		**800**
Total Direct Costs	**97,000**	73,000	22,800	1,200	**97,000**
Indirect Cost @ 10%	9,700	7,000	2,200	500	**9,700**
TOTAL	**106,700**	**80,000**	**25,000**	**1,700**	**106,700**

KELLER CANYON MITIGATION FUND - SUMMARY OF APPLICATIONS / FUNDING RECOMMENDATIONS

Agency	Program	Amount Requested	Amount Recommended
NON-PROFIT ORGANIZATIONS			
A Peace of Mind Service for Domestic Violence	Domestic Violence Community Awareness Fair	$ 10,000	$ -
AdvanceCamp, Inc.	Advance Camp 2011	$ 5,000	$ 1,000
Against All Odds, Inc.	Black Diamond Sports Awareness Workshop	$ 9,940	$ -
All Out Sports Leage	Youth Sports	$ 10,000	$ -
Amador Institute	Youth Development Program - Violence Prevention	$ 5,000	$ 5,000
Ambrose Rec & Park District	Ambrose Center Stove Replacment	$ 6,228	$ -
Ambrose Rec & Park District	Bay Point Youth Sports Program	$ 14,500	$ 5,000
Ambrose Rec & Park District	Sink and Counter Replacement at Ambrose Center	$ 21,028	$ 7,818
Ambrose Rec & Park District	Fun Starts at 60	$ 5,000	$ -
Antioch Little League	Antioch Little League	$ 10,000	$ -
Antioch Music Foundation	Concert for Kids	$ 6,000	$ -
Antioch Music Foundation	Eleven Days of Peace	$ 2,000	$ -
Antioch Rivertown Jamboree	The Harleem Ambassadors Basketball Show	$ 8,850	$ -
Arts & Cultural Foundation	Art4Schools	$ 10,000	$ -
Assistance League of Diablo Valley	Operation School Bell	$ 10,000	$ -
Bay Area Legal Aid	East County Domestic Violence Legal Services Project	$ 10,000	$ -
Bay Point Chamber	Bay Point Trade Show	$ 4,000	$ -
Bay Point Chamber	Welcome to BP Sign and Beautification	$ 11,500	$ 10,000
Bay Point Chamber	Shop Bay Point Saturdays	$ 14,500	$ -
Bay Point Chamber	Bay Point Yard Sale	$ 4,350	$ -
Bay Point Chamber	Bay Point Holiday Celebration	$ 5,700	$ -
Bay Point Community Foundation	CARES Garden	$ 2,000	$ 2,000
Bay Point Garden Club	BP Sping Derby Memorial, Parade and Festival	$ 3,000	$ 3,000
Bay Point Garden Club	Ambrose Community Garden Construction Phase 2	$ 10,000	$ 3,500
Brighter Beginnings	Teen Family Success	$ 4,500	$ 4,500
California Delta Water	CA Delta Water Education on the Water Project	$ 7,150	$ -
CC Child Care Council	Early Start to Success	$ 9,900	$ -
CC Reg Health Foundation	African American Health Empowerment Expo	$ 4,850	$ 4,850
City of Pittsburg	Promote Small World Park	$ 10,000	$ -
City of Pittsburg	Every Day is a Special Day	$ 6,000	$ 6,000
City of Pittsburg Recreation	Fun, Fellowship and Food	$ 10,000	$ -
City of Pittsburg Recreation	Community is Key	$ 10,000	$ -
Classy Crew, Inc	Classy Crew	$ 10,000	$ -
Community Housing Dev. Corp	Earn it Keep it Save it	$ 7,500	$ -
Community Violence Solutions	Sexual Assault Trauma Response Services	$ 10,000	$ -
CC Youth Council	Read to Live	$ 10,000	$ -
Craft Community Care Center	Art Education Program World Music and Arts Dev.	$ 10,000	$ 5,000
Craft Community Care Center	123 Tutoring Program	$ 10,000	$ -
Center for Human Dev.	Unity in Community	$ 5,000	$ 5,000
Center for Human Dev	Four Corners	$ 10,000	$ 5,000
Deer Valley High School Library	Wolverine Afterschool Library Program	$ 10,000	$ -
Delta 2000	Youth Job Internship Program	$ 10,000	$ -
Delta 2000	Sports & Fitness for Kids at Ambrose	$ 7,420	$ -
Delta 2000	Community Computer Access	$ 7,500	$ -
Delta Learning Center	Tutoring Scholarship Fund	$ 5,000	$ -
Delta Science Center	Sac-San Joaquin Educational Calendar	$ 10,000	$ -
East County Business Education Alliance	Work-Ready / Essential Skills Initiative	$ 10,000	$ -
East County Kids in Motion	East County Kids-N-Motion Program	$ 5,524	$ 5,524
East County Midnight Basketball League (CC Hc	Fall Season 2011	$ 10,000	$ -
El Campanil Theatre	Children's Cultural Programming	$ 10,000	$ -
First Baptist Head Start	Alumni Program	$ 20,000	$ -
Full Stride Track Club	Track Club East Bay	$ 1,800	$ -
Give Always to Others	Community Multicultural Program	$ 4,000	$ -
Give Always to Others (Multicultrual Program)	What's Happening in my Community	$ 2,930	$ -
Greater Faith Food Pantry	Food Pantry	$ 8,000	$ -
Habitat for Humanity East Bay	Neighborhood Revitilization Initiative	$ 10,000	$ 5,000
Hapgood Theatre	Yougn Audience Education Program	$ 6,000	$ 5,000
Homeless Animals Response Program	Spay/Neuter services	$ 10,000	$ -
Jewish Family & Children's Ser.	Mutlicutural Senior Project	$ 10,000	$ -
Junior Achievement of N. CA	ECCC Youth Empowerment Project	$ 5,000	$ -
Junior Statesmen Foundation	CCC Civic Engagement Program	$ 10,000	$ -
La Clinica De La Raza	(6th Annual Health Fair)	$ 7,500	$ -
Legacy Treatment Centers, Inc.	A Better You, Better Me Health Workshop	$ 6,000	$ -
Los Medanos College	LMC Respect Campaign	$ 10,000	$ -
Los Medanos College	Facility Usage	$ 10,000	$ -
Loaves & Fishes of CC	Feeding the Hungry in BP	$ 10,000	$ -
Meals on Wheels & Senior Outreach Services	Senior Fitness Circuit	$ 8,756	$ -
Meals on Wheels & Senior Outreach Services	Reducting Preventable Falls for Older Adults	$ 2,500	$ -
Meals on Wheels & Senior Outreach Services	Celebration of Holidays	$ 3,600	$ -
N The Classroom	Youth Services	$ 27,750	$ -

N The Classroom	Organizational Tool Kit	$	18,500	$	-
Opportunity Junction	Job Training & Placement Program	$	10,000	$	-
PCSI	PACO	$	10,000	$	-
PCSI	Foreclosure Mitigation Housing Counseling	$	10,000	$	-
PCSI / Pittsburg National Little League	Little League Baseball for Disabled	$	2,000	$	-
PCSI	Soroptimist International Pittsburg Kids on Target	$	5,000	$	-
PCSI (Soroptomist International)	Soroptimist International Pittsburg Reading Project	$	7,000	$	-
Parents Connected	College Preparation Project	$	10,000	$	-
People Who Care Children Assoc.	Hip Hop After School Youth Solar and Env. Training	$	8,500	$	-
PHS Band Boosters	2011 Instrument Purchase Project	$	10,000	$	-
PICES	Food Pantry	$	10,000	$	-
Pittsburg Historical Society	Passport to the Discovery of History	$	2,300	$	-
Pittsburg Adult Education Center	Cisco Systems Networking Academy	$	10,000	$	-
Pittsburg Arts and Community Foundation	Art Literacy & Education	$	10,000	$	-
Pittsburg Arts and Community Foundation	Family Fitness Festival	$	5,000	$	5,000 FY 2010/11 unspent allocation
Pittsburg Pony Baseball, Inc	Bring Youth Baseball Back to Bay Point	$	12,000	$	-
Positive Edge Experience	The Positive Edge	$	10,000	$	7,000
PUSD	College Application Bootcamp	$	10,000	$	-
PUSD	Academic Achievers Assoc.	$	10,000	$	-
PUSD	Accept No Boundaries	$	10,000	$	-
Rehab Services of N. CA	Bedford Scholarships for Low Income Seniors	$	10,000	$	-
Rotary Club of Pitts. Foundation	Encourage Love of Learning and CA High School Exit Exam	$	9,000	$	-
RUAH Community Outreach	Trinity Family Wellness Services	$	18,772	$	-
St. Vincent de Paul	Food Support programs and Free Medical Clinic	$	10,000	$	-
STAND	Proud Fathers Program	$	10,000	$	-
Stoneman Village	Dinner Meal Program	$	10,000	$	-
Team Select	College Placement Program	$	10,000	$	-
The Child Abuse Prevention Council	Nuturing Parenting Connection	$	10,000	$	-
The Vangabound Players	2011/12 Production Season	$	10,000	$	-
The Williams Group	Street Engagement Team	$	10,000	$	5,000
TODOS UNIDOS	Juntando Generaciones	$	15,000	$	-
Turn the Youth Around	SOYFFL	$	8,400	$	4,000
Twilight Basketball League	Basketball League	$	10,000	$	-
UrAtWork / YIN	YIN Sycamore Cooridor Focus	$	10,000	$	-
	SubTotal	**$**	**924,248**	**$**	**104,192**
COUNTY DEPARTMENTS					
CCC Department of Conservation and Developm	District V Code Enforcement	$	90,000	$	45,000
CCC Office of Education	Early Childhood Education	$	10,000	$	-
CCC General Services Dept.	East County Beautification Program	$	30,000	$	30,000
CCC County Counsel Office	Code Development & Compliance Attorney	$	141,688	$	47,500
CCC Health Services Dept.	Cali House Youth Shelter	$	10,000	$	10,000
CCC Library	Family & Childrens Programming	$	10,000	$	5,000
CCC Library	SAT Preparation	$	10,000	$	7,000
CCC EHSD - Service Integration Program	Bay Point Works Community Career Center	$	15,000	$	7,500
CCC Sheriff Office	Resident Deputy	$	211,573	$	175,000
CCC Sheriff Office	Bay Point SRO	$	211,573	$	75,000
CCC Sheriff Office	BP Annual Xmas Dinner and Toy Give Away	$	6,000	$	6,000
CCC Public Works Department	Bay Point Crossing Gurard Program	$	71,000	$	60,000
CCC Department of Conservation and Developm	KCMF Administration	$	36,000	$	-
District V Staff	KCMF Target Area Staff Services	$	150,000	$	132,604
	SubTotal	**$**	**1,002,834**	**$**	**600,604**
DISTRICT V INITIATIVES					
Bay Point MAC	Municipal Advisory Committee Operations		$10,000	$	5,000
Gang Summit/Youth Summit/Small Business Wc	Seminars/Summits		$45,000	$	45,000
Grant Writing Seminar	Seminar to improve nonprofits ability to compete for funding		$5,000	$	5,000
District V Interns	Internships providing assistance with KCMF funded activities		$5,000	$	5,000
Keller Reception	Networking event for KCMF funded agencies		$2,000	$	2,000
	SubTotal	**$**	**67,000**	**$**	**62,000**
	TOTALS	**$**	**1,994,082**	**$**	**766,796**

To: **Board of Supervisors**

From: **Steve Silveira, Deputy General Services Director**

Date: **October 11, 2011**

Contra Costa County

Subject: Award of Construction Contract for the Residential Facility for the Homeless at 4639 Pacheco Blvd., Martinez

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RECOMMENDATION(S):

1. APPROVE the plans, specifications, and design for the above project.

2. AWARD a contract in the amount of $1,295,000 to W.A. Thomas Company, Inc. ("W.A. Thomas"), the lowest responsive and responsible bidder for the subject project; and DIRECT the General Services Deputy Director, or designee, to prepare the contract.

3. DETERMINE that W.A. Thomas has documented an adequate good faith effort to comply with the specifications and the requirements of the County's Outreach Program in connection with the above project and WAIVE any irregularities in such compliance.

4. FURTHER DETERMINE that W.A. Thomas, as the lowest responsive and responsible bidder for the above project, has entered into a Project Labor Agreement with the Contra Costa Building and Construction Trades Council to comply with the requirements of the County's Project Labor Agreement policy.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ☐ NOES ☐

ABSENT ☐ ABSTAIN ☐

RECUSE ☐

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Rob Lim, (925) 313-7200

cc: GSD Administration, GSD Accounting, GSD CPM Division Manager, GSD CPM Project Manager, GSD CPM Clerical, Auditor's Office, County Counsel's Office, County Administrator's Office, County Administrator's Office

RECOMMENDATION(S): (CONT'D)

5. DIRECT that W.A. Thomas shall submit two good and sufficient security bonds (performance and payment bonds), each in the amount of $1,295,000, and that W.A. Thomas and its subcontractors shall sign a Project Labor Agreement for the project.

6. ORDER that, after W.A. Thomas has signed the contract and returned it, together with the bonds, the signed Project Labor Agreement, evidence of insurance, and other required documents, and the General Services Deputy Director has reviewed and found them to be sufficient, the General Services Deputy Director, or designee, is authorized to sign the contract for this Board.

7. AUTHORIZE the General Services Deputy Director, or designee, to exonerate any bid bonds posted by the bidders after execution of the above contract.

8. AUTHORIZE the General Services Deputy Director, or designee, to sign any escrow agreement prepared for this project to permit the direct payment of retentions into escrow or the substitution of securities for monies withheld by the County to ensure performance under the contract, pursuant to Public Contract Code Section 22300.

9. AUTHORIZE the General Services Deputy Director, or designee, to order changes or additions to the work pursuant to Public Contract Code Section 20142.

10. DELEGATE, pursuant to Public Contract Code Section 4114, the Board's function under Public Contract Code Sections 4107 and 4110, with regards to subletting and subcontracting, to the General Services Deputy Director, or designee.

11. DELEGATE, pursuant to Labor Code Section 6705, to the General Services Deputy Director or to any registered civil or structural engineer employed by the County the authority to accept detailed plans showing the design of shoring, bracing, sloping or other provisions to be made for worker protection during trench excavation covered by that section.

12. DECLARE that, should the award of a contract to W.A. Thomas be invalidated for any reason, the Board would not in any event have awarded the contract to any other bidder, but instead would have exercised its discretion to reject all of the bids received. Nothing herein shall prevent the Board from re-awarding a contract to another bidder in cases where the successful bidder establishes a mistake, refuses to sign the contract, or fails to furnish required bonds or insurance in accordance with Public Contract Code Sections 5100-5107.

FISCAL IMPACT:

No General Funds are involved for construction. 61% of funding is provided by a State Emergency Housing Assistance Program - Capital Development ("EHAPCD") grant, and 39% by a Community Development Block Grant ("CDBG").

BACKGROUND:

In 2010, the Health Services Department Homeless Program selected County-owned property at 4639 Pacheco Boulevard, Martinez ("Old Discovery House") adjacent to the existing New Discovery House, as the site for a residential facility for the homeless. The existing Old Discovery House is being demolished and a new homeless facility is to be constructed on the same site. The new Residential Facility for the Homeless will provide housing for up to twelve persons plus a resident manager. The new facility will operate in conjunction with other Health Services Department programs offered in the adjacent New Discovery House.

Plans and specifications for the project have been prepared for the General Services Department by P. Steven Perls, Architect, and filed with the Clerk of the Board by the General Services Deputy Director.

Two bids were received and opened by the General Services Department on September 15, 2011, and the bid results are as follows:

Bidder	Base Bid
W.A. Thomas Company, Inc., Martinez	$1,295,000
Vila Construction Co., Richmond	$1,588,626

Both bids were above the architect's estimate of $900,000. W.A. Thomas submitted the lowest responsive and responsible bid, which is $293,626 lower than the bid submitted by Vila Construction. Staff recommends that the contract be awarded to W.A. Thomas for a total award amount of $1,295,000. While the low bid exceeds the Architect's estimate, there are sufficient grant funds for construction. The Health Services Department has indicated it has sufficient funds for the other project-related costs.

W.A. Thomas has submitted its documentation of good faith efforts to comply with the specifications and requirements of the County's Outreach Program. Staff has determined that W.A. Thomas has documented an adequate good faith effort to comply with the requirements of the Outreach Program and recommends that the Board so determine and waive any irregularities relating to the Outreach documentation.

Pursuant to the County's Project Labor Agreement ("PLA") policy, a PLA is required for this project. W.A. Thomas has signed a PLA. As a condition of contract award, W.A. Thomas' subcontractors will also be required to sign the PLA.

The general prevailing wage rates, which shall be the minimum rates paid on this project, are on file with the Clerk of the Board, and copies are available to any party upon request.

CONSEQUENCE OF NEGATIVE ACTION:

If the contract is not awarded, the County's Homeless Program will have less capacity to address the needs of the homeless population. Unused grant funds would revert back to the grant agencies.

CHILDREN'S IMPACT STATEMENT:

Not applicable.

C.33

To: **Board of Supervisors**

From: **Supervisor Gayle B. Uilkema**

Date: **October 11, 2011**

Contra Costa County

Subject: AMENDMENT TO BOARD MEMBER ASSIGNMENTS TO 2011 BOARD COMMITTEES, SPECIAL COUNTY COMMITTEES, and REGIONAL ORGANIZATIONS

RECOMMENDATION(S):

ADOPT Resolution No. 2011/428 amending appointments for Board Member Committee Assignments to reflect the addition of the TRAFFIX agency as an Internal Appointment of the Board of Supervisors and including the appointment and an alternate to the TRAFFIX Board of Directors in the Master List of appointments of Board members and other individuals to serve on Board committees, special county committees, and regional boards/ committees/commissions for 2011. (Attachments I and II.)

FISCAL IMPACT:

No fiscal impact to the County from this action.

BACKGROUND:

On September 23, 2008 the Board of Supervisors authorized the "Joint Exercise of Powers Agreement for the Measure J Traffic Congestion Relief Agency, dba TRAFFIX," forming the entity that oversees implementation of the San Ramon Valley School Bus Program, funded by Measure J.

The Board of Directors of TRAFFIX is established in the JEPA as follows:

☑ APPROVE ☐ OTHER

☐ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ____ NOES ____

ABSENT ____ ABSTAIN ____

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED:
October 11, 2011
David J. Twa, County

RECUSE ☐

Contact: Lara DeLaney, 925-335-1097

Administrator and
Clerk of the Board of
Supervisors

By: , Deputy

cc:

BACKGROUND: (CONT'D)

Section 2.5. Governing Board. The Agency shall be administered by a Board of Directors consisting of seven (7) Directors, as follows: one (l) Director appointed by the Board of Supervisors of the County, two (2) Directors appointed by the Town Council of the Town of Danville,two (2) Directors appointed by the City Council of the City of San Ramon, and two (2) Directors appointed by the Board of Education of the San Ramon Valley Unified School District. The Board shall select the Program Manager and shall provide overall policy guidance for the Agency.

Section 2.5.4. Each Legislative Body shall appoint an alternate Director for that Member. The alternate Director may act as the Director in the absence of the Director appointed by that Legislative Body. The alternate Director for the City, Town, and School District shall also be a member of the Legislative Body that appointed the alternate Director, but the alternate Director for the County may be an employee of the County.

Section 2.5.5. All Directors and their alternates shall serve at the pleasure of the Member that appointed them.

The Supervisor for District III, Mary N. Piepho, has been serving on the Board of Directors, with her chief of staff acting as Alternate. Chair Gayle B. Uilkema recommends that she, Supervisor of District II, be appointed to the Alternate position for the remainder of the current year.

According to the policies and procedures adopted by the Board pertaining to Board member appointments, the Chair of the Board makes recommendations regarding appointments, and the Board of Supervisors must adopt a Master Resolution with a complete roster of all appointments whenever terms expire or new appointments are made.

CONSEQUENCE OF NEGATIVE ACTION:

The appointments for Board Member Committee Assignments will not be accurate.

CHILDREN'S IMPACT STATEMENT:

Not applicable.

THE BOARD OF SUPERVISORS OF CONTRA COSTA COUNTY, CALIFORNIA

and for Special Districts, Agencies and Authorities Governed by the Board

Adopted this Resolution on 10/11/2011 by the following vote:

AYES:

NOES:

ABSENT:

ABSTAIN:

RECUSE:

Resolution No. 2011/428

AMENDED BOARD MEMBER ASSIGNMENTS TO BOARD COMMITTEES, SPECIAL COUNTY COMMITTEES, AND REGIONAL ORGANIZATIONS for 2011

WHEREAS each year when the Board of Supervisors reorganizes, the incoming Chair reviews and makes recommendations to the Board on committee assignments. The annual review of committee assignments is governed by a policy adopted by the Board of Supervisors in March 2000; and

WHEREAS the establishment of the TRAFFIX agency and its Board of Directors in 2008, which includes a member of the Board of Supervisors and an alternate, required that these appointments be included in the Master List of all Board member assignments; and

WHEREAS these appointments seek to provide policy oversight for all major County functional areas, balance the workload of the Supervisors, as well as consider some of the time-intensive responsibilities and appointments of the Supervisors on regional bodies; and

WHEREAS these appointments attempt to maintain, to the extent possible, continuity on Board standing committees to facilitate recommendations on many very complex policy issues currently on referral to those committees; and

WHEREAS adoption of a new Master Resolution with a complete roster of all appointments is required by Board policy whenever terms expire or new appointments are made;

Now, Therefore, Be It Resolved:

1. As recommended by the Chair of the Board of Supervisors, the District III Supervisor, Mary N. Piepho, is appointed to the TRAFFIX Board of Directors, with a term expiring December 31, 2011.

2. The District II Supervisor, Gayle B. Uilkema, is appointed as the Board of Supervisors' alternate appointment to the TRAFFIX Board of Directors.

3. INDICATE that this RESOLUTION No. 2011/428 supersedes in its entirety Resolution No. 2011/404, which was adopted by the Board of Supervisors on September 20, 2011.

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

Contact: Lara DeLaney, 925-335-1097

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

cc:

BOARD COMMITTEE ASSIGNMENTS FOR 2011
RESOLUTION NO. 2011/428

Type*	Committee Name	New Appointee	Term Expiration
I	Family & Human Services Committee, Vice Chair	Federal D. Glover	12/31/2011
I	Family & Human Services Committee, Chair	Gayle B. Uilkema	12/31/2011
I	Finance Committee, Vice Chair	Federal D. Glover	12/31/2011
I	Finance Committee, Chair	John Gioia	12/31/2011
I	Internal Operations Committee, Vice Chair	John Gioia	12/31/2011
I	Internal Operations Committee, Chair	Mary N. Piepho	12/31/2011
I	Legislation Committee, Vice Chair	John Gioia	12/31/2011
I	Legislation Committee, Chair	Karen Mitchoff	12/31/2011
I	Public Protection, Vice Chair	John Gioia until 2/15/11 then Gayle B. Uilkema	12/31/2011
I	Public Protection, Chair	Federal D. Glover	12/31/2011
I	Transportation, Water & Infrastructure Committee, Vice Chair	Karen Mitchoff	12/31/2011
I	Transportation, Water & Infrastructure Committee, Chair	Mary N. Piepho	12/31/2011
I	Airport Committee, Vice Chair	Mary N. Piepho	12/31/2011
I	Airport Committee, Chair	Karen Mitchoff	12/31/2011

Type I: Standing Committees; Type II: Internal appointments; Type III: Regional appointments; Type IV: Special/Restricted appointments; Type V: Ad Hoc Committee appointments.

BOARD COMMITTEE ASSIGNMENTS FOR 2011
RESOLUTION NO. 2011/428

Type*	Committee Name	New Appointee	Term Expiration
II	Bay Area Counties Caucus	John Gioia	12/31/2011
II	Bay Area Counties Caucus, Alternate	Karen Mitchoff	12/31/2011
II	Bay Area Regional Interoperable Communications System (BayRICS) Authority	Gayle B. Uilkema	12/31/2011
II	BayRICS Authority, Alterate	Ed Woo	12/31/2011
II	California Identification System Remote Access Network Board (Cal-ID RAN Board)	Gayle B. Uilkema	12/31/2011
II	Central Contra Costa Solid Waste Authority	Gayle B. Uilkema	12/31/2011
II	Central Contra Costa Solid Waste Authority	Mary N. Piepho	12/31/2011
II	City-County Relations Committee	Karen Mitchoff	12/31/2011
II	City-County Relations Committee	Mary N. Piepho	12/31/2011
II	City-County Relations Committee, Alternate	Federal D. Glover	12/31/2011
II	Contra Costa Health Plan Joint Conference Committee	Federal D. Glover	12/31/2011
II	Contra Costa Health Plan Joint Conference Committee	Karen Mitchoff	12/31/2011
II	Dougherty Valley Oversight Committee	Mary N. Piepho	12/31/2011
II	Dougherty Valley Oversight Committee	Gayle B. Uilkema	12/31/2011
II	East Bay Regional Communication System (EBRCS) Authority Governing Board	Gayle B. Uilkema	12/31/2011
II	EBRCS Authority Governing Board, Alternate	Karen Mitchoff	12/31/2011
II	East Contra Costa County Habitat Conservation Plan Association (ECCCHCP), Executive Governing Board	Mary N. Piepho	12/31/2011
II	ECCCHCP Association, Executive Governing Board, Alternate	Federal D. Glover	12/31/2011
II	East Contra Costa Regional Fee & Finance Authority	Mary N. Piepho	12/31/2011
II	East Contra Costa Regional Fee & Finance Authority, Alternate	Federal D. Glover	12/31/2011
II	East County Water Management Association	Mary N. Piepho	12/31/2011
II	East County Water Management Association, Alternate	Federal D. Glover	12/31/2011
II	eBART (Bay Area Rapid Transit) Partnership Policy Advisory Committee	Federal D. Glover	12/31/2011
II	eBART (Bay Area Rapid Transit) Partnership Policy Advisory Committee	Mary N. Piepho	12/31/2011

Type I: Standing Committees; Type II: Internal appointments; Type III: Regional appointments; Type IV: Special/Restricted appointments; Type V: Ad Hoc Committee appointments.

BOARD COMMITTEE ASSIGNMENTS FOR 2011
RESOLUTION NO. 2011/428

Type*	Committee Name	New Appointee	Term Expiration
II	First 5 Children and Families Commission Alternate Member	Federal D. Glover	12/31/2011
II	Hazardous Waste Management Facility Allocation Committee	Gayle B. Uilkema	12/31/2011
II	Hazardous Waste Management Facility Allocation Committee, Alternate	Karen Mitchoff	12/31/2011
II	Library Needs Assessment Steering Committee	Karen Mitchoff	12/31/2011
II	Medical Services Joint Conference Committee, Vice Chair	John Gioia	12/31/2011
II	Medical Services Joint Conference Committee, Chair	Mary N. Piepho	12/31/2011
II	North Richmond Waste and Recovery Mitigation Fee Committee	John Gioia	12/31/2011
II	State Route 4 Bypass Authority	Mary N. Piepho	12/31/2011
II	State Route 4 Bypass Authority, Alternate	Federal D. Glover	12/31/2011
II	SWAT (Southwest Area Transportation Committee)	Gayle B. Uilkema	12/31/2011
II	SWAT, Alternate	Karen Mitchoff	12/31/2011
II	TRAFFIX (Measure J Traffic Congestion Relief Agency)	Mary N. Piepho	12/31/2011
II	TRAFFIX (Measure J Traffic Congestion Relief Agency), Alternate	Gayle B. Uilkema	12/31/2011
II	TRANSPAC (Central County Transportation Partnership and Cooperation)	Karen Mitchoff	12/31/2011
II	TRANSPAC, Alternate	Mary N. Piepho	12/31/2011
II	TRANSPLAN (East County Transportation Planning)	Mary N. Piepho	12/31/2011
II	TRANSPLAN, Alternate	Federal D. Glover	12/31/2011
II	Tri-Valley Transportation Council	Gayle B. Uilkema	12/31/2011
II	Urban Counties Caucus	John Gioia	12/31/2011
II	Urban Counties Caucus, Alternate	Karen Mitchoff	12/31/2011
II	WCCTAC (West County Transportation Advisory Committee)	John Gioia	12/31/2011
II	WCCTAC, Alternate	Federal D. Glover	12/31/2011
II	West Contra Costa Integrated Waste Management Authority	Federal D. Glover	12/31/2011
II	West Contra Costa Integrated Waste Management Authority, Alternate	John Gioia	12/31/2011

Type I: Standing Committees; Type II: Internal appointments; Type III: Regional appointments; Type IV: Special/Restricted appointments; Type V: Ad Hoc Committee appointments.

BOARD COMMITTEE ASSIGNMENTS FOR 2011
RESOLUTION NO. 2011/428

Type*	Committee Name	New Appointee	Term Expiration
III	ABAG Regional Planning Committee	Gayle B. Uilkema	12/31/2012
III	Bay Area Air Quality Management District Board of Directors	John Gioia	6/17/2013
III	Bay Area Air Quality Management District Board of Directors	Gayle B. Uilkema	1/8/2012
III	Water Emergency Transportation Authority (WETA), Community Advisor	John Gioia	12/31/2011
III	WETA, Community Advisory Committee, Alternate	Federal D. Glover	12/31/2011
III	Central Contra Costa Transit Authority (CCCTA) Board of Directors	Gayle B. Uilkema	5/1/2013
III	CCCTA Board of Directors, Alternate	Karen Mitchoff	5/1/2013
III	Contra Costa Transportation Authority (seat 1)	Federal D. Glover	1/31/2013
III	Contra Costa Transportation Authority, Alternate (Seat 1)	John Gioia	1/31/2013
III	Contra Costa Transportation Authority, Second Alternate (Seat 1)	Gayle B. Uilkema	1/31/2013
III	Contra Costa Transportation Authority, Third Alternate (Seat 1)	Mary N. Piepho	1/31/2013
III	Contra Costa Transportation Authority (Seat 2)	Karen Mitchoff	1/31/2012
III	Contra Costa Transportation Authority, Alternate (Seat 2)	Gayle B. Uilkema	1/31/2012
III	Local Agency Formation Commission	Federal D. Glover	5/6/2014
III	Local Agency Formation Commission	Gayle B. Uilkema	5/6/2014
III	Local Agency Formation Commission, Alternate	Mary N. Piepho	5/7/2012
III	Metropolitan Transportation Commission	Federal D. Glover	2/1/2015
III	Regional Airport Planning Committee	John Gioia	12/31/2011

Type I: Standing Committees; Type II: Internal appointments; Type III: Regional appointments; Type IV: Special/Restricted appointments; Type V: Ad Hoc Committee appointments.

BOARD COMMITTEE ASSIGNMENTS FOR 2011
RESOLUTION NO. 2011/428

Type*	Committee Name	New Appointee	Term Expiration
IV	ABAG (Association of Bay Area Counties) General Assembly	Federal D. Glover	12/31/2011
IV	ABAG (Association of Bay Area Counties) General Assembly	Karen Mitchoff	12/31/2011
IV	ABAG (Association of Bay Area Counties) General Assembly, Alternate	Gayle B. Uilkema	12/31/2011
IV	ABAG (Association of Bay Area Counties) General Assembly, Alternate	John Gioia	12/31/2011
IV	ABAG (Association of Bay Area Governments) Executive Board	Gayle B. Uilkema	6/30/2012
IV	ABAG (Association of Bay Area Governments) Executive Board	John Gioia	6/30/2012
IV	ABAG Executive Board, Alternate	Mary N. Piepho	6/30/2012
IV	ABAG Executive Board, Alternate	Karen Mitchoff	6/30/2012
IV	Bay Conservation & Development Commission	John Gioia	12/31/2011
IV	Bay Conservation & Development Commission, Alternate	Gayle B. Uilkema	12/31/2011
IV	CCCERA (Contra Costa County Employees Retirement Association) Board of Trustees	John Gioia	6/30/2014
IV	CSAC (California State Association of Counties) Board of Directors	Federal D. Glover	12/31/2011
IV	CSAC Board of Directors, Alternate	Karen Mitchoff	12/31/2011
IV	Delta Diablo Sanitation District Governing Board	Federal D. Glover	12/31/2011
IV	Delta Diablo Sanitation District Governing Board, Alternate	Karen Mitchoff	12/31/2011
IV	Delta Protection Commission	Mary N. Piepho	12/31/2011
IV	Delta Protection Commission, Alternate	Karen Mitchoff	12/31/2011
IV	Sacramento-San Joaquin Delta Conservancy Board	Mary N. Piepho	Unspecified
IV	Sacramento-San Joaquin Delta Conservancy Board, Alternate	Karen Mitchoff	Unspecified
IV	Doctors Medical Center Management Authority Governing Board	John Gioia	Unspecified
IV	First 5 Children and Families Commission Member	Karen Mitchoff	12/31/2012
IV	Kensington Solid Waste Coordinating Committee	John Gioia*	Unspecified
IV	Law Library Board of Trustees	Mark Armstrong	12/31/2011
IV	Mental Health Commission	John Gioia	12/31/2011
IV	Mental Health Commission, Alternate	Mary N. Piepho	12/31/2011
IV	North Coast Shoreline Joint Powers Authority	Federal D. Glover	12/31/2011
IV	North Coast Shoreline Joint Powers Authority	John Gioia	12/31/2011

** Or his designee*

Type I: Standing Committees; Type II: Internal appointments; Type III: Regional appointments; Type IV: Special/Restricted appointments; Type V: Ad Hoc Committee appointments.

To: **Board of Supervisors**

From: **Russell Watts, Treasurer-Tax Collector**

Date: **October 11, 2011**

Contra Costa County

Subject: Sale of Tax-Defaulted Property by the County Tax Collector

---

RECOMMENDATION(S):

ADOPT Resolution No. 2011/431 authorizing the sale of specified tax-defaulted property at public auction, pursuant to the California Revenue and Taxation Code ("R&T") §3698, as recommended by the Treasurer-Tax Collector.

FISCAL IMPACT:

There is no impact to the General Fund. All costs will be recovered from the proceeds of the sale.

BACKGROUND:

The Tax Collector has the authority to sell tax-defaulted property that is subject to the power of sale (R&T §3691). Written approval of the Board of Supervisors (R&T §(s) 3694 and 3698) is required to sell property at public auction (R&T §3692) to the highest bidder at the time and place fixed for sale (R&T §3706)

Property that has been tax-defaulted for five or more years and is subject to the Tax Collector's power to sell may be sold. All or any portion of a property may be offered for sale, without regard to its boundaries when it became subject to sale (R&T §3691).

☑ APPROVE ☐ OTHER

☐ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ____ NOES ____

ABSENT ____ ABSTAIN ____

RECUSE ____

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of

Contact: Brice Bins, 925-957-5280

Supervisors

By: , Deputy

cc:

BACKGROUND: (CONT'D)

The purpose of the sale is to collect unpaid taxes. Offering property for sale achieves this, either by collecting the unpaid taxes from the proceeds of the sale or through redemption by the assessee.

Any person or entity, including cities, taxing agencies, revenue districts and the State may purchase property at a public auction (R&T §(s) 3691 and 3705). The only exception to eligible purchasers is the Tax Collector, who conducts the sale, or his/her employees (California Government Code § 1090).

If a parcel is redeemed before the close of business on the last business day prior to the date of sale, the power to sell is automatically nullified and the parcel will be withdrawn from the sale. If a parcel is redeemed within 90 days of the scheduled sale, $150 will be collected to reimburse the County for costs incurred in preparing to conduct the sale (R&T § 4112). Properties on which no bids are received during the course of the sale may be re-offered before the close of the sale (R&T § 3698.5(c))

CONSEQUENCE OF NEGATIVE ACTION:

If not approved, the Annual Tax Collector's Public Auction will not proceed and property taxes will not be collected.

CHILDREN'S IMPACT STATEMENT:

None.

THE BOARD OF SUPERVISORS OF CONTRA COSTA COUNTY, CALIFORNIA

and for Special Districts, Agencies and Authorities Governed by the Board

Adopted this Resolution on 10/11/2011 by the following vote:

AYES:

NOES:

ABSENT:

ABSTAIN:

RECUSE:

Resolution No. 2011/431

In The Matter Of Sale of tax-defaulted property by the County Tax Collector

The Board, pursuant to §3698 of the Revenue and Taxation code, having been notified by the County Tax Collector of his intent to sell certain tax-defaulted property and having been provided with a description and minimum purchase price for which each will be sold, and the notice of intended sale of the aforementioned properties be posted or published in accordance with §3702 and §3703 of the California Revenue and Taxation Code.

Now, Therefore, Be It Resolved by the Board that the County Tax Collector's proposed sale of tax-defaulted properties listed in Exhibit A attached hereto and made a part hereof, at or above the minimum price indcated is APPROVED pursuant to §3698 of the Revenue and Taxation Code, and the notice of intended sale be posted or published in accordance with §3702 and §3703 of the Revnue and Taxation Code.

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

Contact: Brice Bins, 925-957-5280

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

cc:

WITH APPROVAL OF THE BOARD OF SUPERVISORS, BY RESOLUTION 2011/431 DATED OCTOBER 11, 2011

THE PROPERTY LISTED BELOW WAS OFFERED FOR SALE AT PUBLIC AUCTION ON FEBRUARY 29, 2012, AND WAS DISPOSED OF AS FOLLOWS:

ITEM	Assessor's Parcel Number (APN)	Minimum	Default #	Sales	Transfer Tax	Adv.	Rec.	State	County	Personal	Notice	Redemption	Current	Excess	Purchaser Name
	Assessee	Bid	Notice Rec.	Price	Total	Cost	Fee	Fee	Fee	Contact	Cost	Amount	Taxes	Proceeds	Tax Deed Rec. #, Date Recorded
1	052-061-014	50,000	2005-00093												
	TOM L & BONNIE MAE MASON		2011-174119												
2	053-263-021	50,000	2005-00206												
	JOHN PERRY, MARTIN SCHUYLER		2011-174120												
3	065-143-024	35,000	2005-00008												
	MIGUEL & MARIA VASQUEZ		2011-174116												
	JOSE & BLANCA CRUZ														
4	065-152-010	30,000	2005-00392												
	JOE E VILLARREAL		2011-174121												
5	066-051-006	225,000	2002-00014												
	BEAUBIEN INVESTMENT GROUP		2011-174102												
6	REDEEMED														
7	066-219-001	25,000	2005-00468												
	LUANA L ROBINETT		2011-174122												
	FRANCES M. FERRANTE														
8	067-261-005	100,000	2005-00024												
	JULIO & IRMA CASTANEDA		2011-174118												
9	068-241-069	40,000	2005-00648												
	JIM D ODOM TRE		2011-174123												
10	115-032-008	70,000	2005-02029												
	OHMAR A & LISA M SOWLE		2011-174126												
11	115-096-016	70,000	2003-01522												
	CHARLES Q & PATRICIA A STANLEY		2011-174103												
12	115-272-036	420,000	2004-01559												
	RICHARD A TARANTINO JR		2010-0164148												
13	128-321-011	100,000	2005-02237												
	1121 DETROIT PARTNERS		2011-174127												
14	503-322-046	100,000	2005-02620												
	JAMES CUMMING, IAN CUMMING		2011-174130												
	BRUCE CUMMING EST OF														
15	362-330-004	40,000	2005-02711												
	ROME MUBARAK , COLLEEN RASHAD		2011-174131												
16	370-102-003	18,000	2005-02977												
	MARTINEZ ST MARYS PROPERTY LLC		2011-174132												
17	375-051-028	50,000	2005-03048												
	BRUCE C & KAREN L MASON		2011-174133												
18	402-320-034	35,000	2005-03359												
	SOO J DAIR TRE		2011-174136												

WITH APPROVAL OF THE BOARD OF SUPERVISORS, BY RESOLUTION 2011/431 DATED OCTOBER 11, 2011

THE PROPERTY LISTED BELOW WAS OFFERED FOR SALE AT PUBLIC AUCTION ON FEBRUARY 29, 2012, AND WAS DISPOSED OF AS FOLLOWS:

ITEM	Assessor's Parcel Number (APN)	Minimum	Default #	Sales	Transfer Tax	Adv.	Rec.	State	County	Personal	Notice	Redemption	Current	Excess	Purchaser Name
	Assessee	Bid	Notice Rec.	Price	Total	Cost	Fee	Fee	Fee	Contact	Cost	Amount	Taxes	Proceeds	Tax Deed Rec. #, Date Recorded
19	403-286-009	60,000	2005-03313												
	KAKUBEI & CHIZUKO HIGASHI		2011-174135												
	JULIETTE MEI HIGASHI														
20	085-370-010	50,000	2005-04066												
	NORMITA ROMERO		2011-174143												
21	086-132-007	35,000	2005-03763												
	RICHARD REESE		2011-174139												
22	086-222-002	30,000	2005-03796												
	CHATTEL PROPERTIES INC.		2011-174140												
23	087-212-004	35,000	2005-03857												
	RVEST LLC		2011-174141												
24	094-022-012	40,000	2005-04076												
	PHILLIP MICHAEL & MELANI COOK		2011-174144												
25	097-640-058	90,000	2005-04186												
	ANTHONY J & MERCEDES REESE TRE		2011-174146												
26	414-065-001	20,000	2004-04535												
	NORMAN W LONG, PHILLIP H LONG		2011-174111												
27	435-300-009	75,000	2005-05353												
	TIEN-CHU HAO, SHIEU-WAH HAO		2011-174168												
28	517-160-012	45,000	2005-04405												
	MICHAEL E & MONA S JOHNSON		2011-174153												
29	513-048-015	20,000	2005-04244												
	JOSE MEJIA, JOSE ALVARENGA		2011-174147												
30	513-151-006	10,000	2005-04280												
	MOLLIE L HIGGS TRE		2011-174148												
31	513-224-025	35,000	2005-05596												
	MOLLIE L HIGGS TRE		2011-174174												
32	514-060-017	45,000	2005-04294												
	RICKY & LORRAINE PITRE		2011-174149												
33	514-060-018	25,000	2005-04295												
	RICKY & LORRAINE PITRE		2011-174150												
34	514-280-028	20,000	2005-04334												
	VERSELL JOHNSON		2011-174152												
35	527-111-002	50,000	2005-05415												
	JOSE LEON ALVARADO		2011-174172												
	ELVA ELENA ROGEL														
36	REDEEMED														

WITH APPROVAL OF THE BOARD OF SUPERVISORS, BY RESOLUTION 2011/431 DATED OCTOBER 11, 2011

THE PROPERTY LISTED BELOW WAS OFFERED FOR SALE AT PUBLIC AUCTION ON FEBRUARY 29, 2012, AND WAS DISPOSED OF AS FOLLOWS:

ITEM	Assessor's Parcel Number (APN)	Minimum	Default #	Sales	Transfer Tax	Adv.	Rec.	State	County	Personal	Notice	Redemption	Current	Excess	Purchaser Name
	Assessee	Bid	Notice Rec.	Price	Total	Cost	Fee	Fee	Fee	Contact	Cost	Amount	Taxes	Proceeds	Tax Deed Rec. #, Date Recorded
37	530-023-007	40,000	2005-05647												
	JOSE & GABRIELA SANCHEZ		2011-174176												
38	534-012-006	13,000	2005-05651												
	RICHARD LOVATO		2011-174177												
	SUSAN PADILLA LOVATO														
39	534-012-010	185,000	2005-05653												
	RONALD BERRY		2011-174178												
40	534-211-013	45,000	2005-04665												
	AAFIYA AKBAR MUHAMMAD		2011-174155												
41	534-291-001	8,000	2005-04689												
	JUAN CARLOS ALEJANDRE		2011-174156												
42	538-050-008	20,000	2004-03896												
	JOHNNY DAVID LOBATO		2010-0164169												
43	538-050-015	22,000	2004-03897												
	now 538-050-043 & 538-050-044		2010-0164170												
	CONTINENTAL WEST DEVELOPMENT														
44	538-350-004	20,000	2004-03948												
	now 538-350-044 and 538-350-045		2011-174107												
	ANA M KAMP														
45	538-360-010	20,000	2005-04778												
	JERRY DEAN PENN		2011-174157												
46	540-300-022	22,000	2005-04816												
	MICHAEL L CROSKREY		2011-174158												
47	540-320-016	22,000	2005-04818												
	LANCE LING LO		2011-174159												
48	540-320-017	22,000	2005-04819												
	LANCE LING LO		2011-174160												
49	540-320-018	33,000	2005-04820												
	LANCE LING LO		2011-174161												
50	544-021-011	50,000	2005-04839												
	RAYMOND HICKS, VELMA J. DANIELS		2011-174162												
51	544-041-002	46,000	2005-04850												
	DEBORAH WAFER		2011-174163												
52	544-212-013	155,000	2005-04889												
	PERMINDER S PANDAL		2011-174164												
53	544-332-030	13,000	2004-04055												
	TITLE INSURANCE & TRUST CO		2011-174109												
54	550-090-024	75,000	2005-05637												
	NORBERT H & NELLIE M RICKERT		2011-174175												

WITH APPROVAL OF THE BOARD OF SUPERVISORS, BY RESOLUTION 2011/431 DATED OCTOBER 11, 2011

THE PROPERTY LISTED BELOW WAS OFFERED FOR SALE AT PUBLIC AUCTION ON FEBRUARY 29, 2012, AND WAS DISPOSED OF AS FOLLOWS:

ITEM	Assessor's Parcel Number (APN)	Minimum	Default #	Sales	Transfer Tax	Adv.	Rec.	State	County	Personal	Notice	Redemption	Current	Excess	Purchaser Name
	Assessee	Bid	Notice Rec.	Price	Total	Cost	Fee	Fee	Fee	Contact	Cost	Amount	Taxes	Proceeds	Tax Deed Rec. #, Date Recorded
55	550-201-018	45,000	2005-04995												
	CAROLYN G HIGGS		2011-174166												
56	560-600-029	65,000	2005-05548												
	MIGUEL & BEATRICE MENDOZA		2011-174173												
57	561-152-020	15,000	2003-04463												
	DAMON PRESTON		2011-174110												
58	561-161-028	10,000	2005-05702												
	COMMUNITY FUND LLC		2011-174179												
59	140-012-044	100,000	2005-05976												
	STEVEN KELLEY		2011-174181												
60	010-460-032	50,000	2005-06083												
	CARLEY GATES, MEGAN GATES		2011-174182												
61	411-370-010	15,000	2004-05759												
	ADEPT PROPERTIES LLC		2011-174113												
62	419-020-018	47,000	2005-06756												
	CONTINENTAL WEST SALES CO INC		2011-174184												
	HARRY ABRAHAMS														
63	252-011-001	125,000	2005-07403												
	HENRY J & ROSEMARY N JUAREZ		2011-174186												
64	255-072-003	140,000	2005-07468												
	LANA H REICHICK TRE		2011-174187												
65	218-125-015	165,000	2005-07699												
	HAROLD R & DEANNA MILLER		2011-174188												
66	REDEEMED														
67	212-222-007	135,000	2005-07952												
	ALBERT C BELISO		2011-174191												
68	217-430-023	135,000	2005-07962												
	JOHN & LILY CAMPANILE		2011-174192												
69	033-090-003	30,000	2005-08577												
	SERGIO & SOCORRO ORTEGA		2011-174194												
70	033-090-044	110,000	2005-08578												
	SERGIO & SOCORRO ORTEGA		2011-174195												
71	035-311-007	30,000	2004-07157												
	MARIE MCCOY		2011-174114												
72	001-111-015	25,000	2005-08598												
	THOMAS B TROST		2011-174196												
73	004-050-020	100,000	2005-08707												
	JAMIE L CHAPMAN		2011-174198												

WITH APPROVAL OF THE BOARD OF SUPERVISORS, BY RESOLUTION 2011/431 DATED OCTOBER 11, 2011

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	Assessee	Bid	Notice Rec.	Price	Total	Cost	Fee	Fee	Fee	Contact	Cost	Amount	Taxes	Proceeds	Tax Deed Rec. #, Date Recorded
74	011-220-013	135,000	2005-08623												
	LUCKY CLOVER HOLDING LLC		2011-174197												
	ALAMO CAPITAL MGMNT LLC														
75	020-232-002	160,000	2004-07866												
	DANIEL T & YVETTE L SCHUETTE		2011-174115												
76	026-111-007	105,000	2005-09748												
	ROBERT MACDONALD, LOLITA D RAMOS		2011-174211												
77	031-131-017	20,000	2005-09716												
	MICHAEL M & ZIBA F RASOOLY		2011-174210												
78	096-014-010	5,000	2004-08091												
	ROSA LOYA		2010-0164204												
79	098-052-035	20,000	2005-09568												
	CLYDE E BAIRD, LINDA S MARTIN		2011-174208												
	CALVIN R LAWSON REM														
	SHIRELY MAE GRAGG REM														
	DIANNA URELL REM														
80	098-155-015	35,000	2005-09380												
	SANTOS M BARAHONA		2011-174204												
81	125-041-008	115,000	2005-09444												
	THOMAS C & KAMILLE K CAPLE		2011-174205												
82	169-041-005	145,000	2005-09628												
	DENIS MANNING ANDERSON		2011-174209												
83	223-310-048	200,000	2005-09184												
	TUNG HUYNH, CONNIE VUONG		2011-174201												
84	265-180-019	23,000	2005-09758												
	JAMES RADAR LEWIS,		2011-174212												
	MICHAEL STEVEN LEWIS														
	JOAN MENDENALL LEWIS														
85	357-224-002	40,000	2005-08943												
	MARK TARANTO		2011-174200												
86	366-030-013	15,000	2005-09260												
	QUAIL HOLLOW PARTNERS LLC		2011-174202												
87	405-092-012	35,000	2005-10196												
	RONALD CERMENO		2011-174225												
88	409-011-012	13,000	2005-10011												
	CONTINENTAL WEST DEVELOPMENT		2011-174222												
89	409-032-001	35,000	2005-10023												
	CHATTEL PROPERTIES INC.		2011-180320												
90	409-051-001	30,000	2005-10057												
	NICHOLAS ROBLES		2011-174219												

WITH APPROVAL OF THE BOARD OF SUPERVISORS, BY RESOLUTION 2011/431 DATED OCTOBER 11, 2011															
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	Assessee	Bid	Notice Rec.	Price	Total	Cost	Fee	Fee	Fee	Contact	Cost	Amount	Taxes	Proceeds	Tax Deed Rec. #, Date Recorded
91	409-060-044	12,000	2005-10060												
	CONTINENTAL WEST DEVELOPMENT		2011-174200												
92	419-051-024	10,000	2005-10130												
	ROSALINA HERNANDEZ		2011-174223												
93	425-072-013	55,000	2005-09809												
	CASEY JONES		2011-174215												
94	433-020-055	52,000	2005-09767												
	LAURA S MICHIELI		2011-174213												
	9/29/2011														

To: **Board of Supervisors**

From: **Dorothy Sansoe, County Administrator**

Date: **October 11, 2011**

Contra Costa County

Subject: Extension of Emergency Declaration Regarding Homelessness

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RECOMMENDATION(S):

CONTINUE the emergency action originally taken by the Board of Supervisors on November 16, 1999 regarding the issue of homelessness in Contra Costa County.

FISCAL IMPACT:

None.

BACKGROUND:

Government Code Section 8630 required that, for a body that meets weekly, the need to continue the emergency declaration be reviewed at least every 14 days until the local emergency is terminated. In no event is the review to take place more than 21 days after the previous review.

On November 16, 1999, the Board of Supervisors declared a local emergency, pursuant to the provisions of Government Code Section 8630 on homelessness in Contra Costa County.

With the continuing high number of homeless individuals and insufficient funding available to assist in sheltering all homeless individuals and families, it is appropriate for the Board to continue the declaration of a local emergency regarding homelessness.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☑ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ☐ NOES ☐

ABSENT ☐ ABSTAIN ☐

RECUSE ☐

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Lavonna Martin, 925-313-6736

cc:

CONSEQUENCE OF NEGATIVE ACTION:

The Board of Supervisors would not be in compliance with Government Code Section 8630.

CHILDREN'S IMPACT STATEMENT:

None.

To: Board of Supervisors

From: David Twa, County Administrator

Date: October 11, 2011

Contra Costa County

Subject: REPORT ON STATUS OF UPDATE TO THE COUNTY "GARAGING OF COUNTY VEHICLES AT AN EMPLOYEE'S HOME" POLICY

RECOMMENDATION(S):

ACCEPT status report regarding update to the County's "Garaging of County Vehicles at and Employee's Home" policy, as recommended by the County Administrator.

FISCAL IMPACT:

No impact.

BACKGROUND:

On October 5, 1993, the Board of Supervisors adopted a policy statement titled "Garaging of County Vehicles at an Employee's Home" (Board Agenda Item No. FC.1), as recommended by the Finance Committee (Supervisors Gayle Bishop and Tom Powers). The policy essentially provides approval authority to Department Heads to authorize certain employees to take home and garage a county vehicle if one or more of the following conditions were met:

1) The employee's duties are such that check-out of a County vehicle from a County facility at the start or end of a normal workday would be both impractical and uneconomical due to lost productive time or increased fuel consumption;

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☐ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ☐ NOES ☐

ABSENT ☐ ABSTAIN ☐

RECUSE ☐

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: Timothy Ewell, 925-335-1036

cc:

BACKGROUND: (CONT'D)

2) The employee has been directed to be on continuous availability for callback during off duty hours and the task to be performed will require immediate travel to the job location; or,

3) The employee's duties require regular off duty emergency assignments.

In cases where vehicles are authorized to be taken home, the county is to be reimbursed at the rate of $0.28 per mile "…for round trip home commute" in the following situations:

1) Employee lives in Contra Costa County: Reimbursement for every mile in excess of 25 miles; and/or,

2) Employee lives outside of Contra Costa County: Reimbursement for every mile

The policy does not apply to the following individuals or conditions:

1) Department Heads

2) Employees driving vehicles used in the County sponsored van and van pool programs;

3) Employees utilizing specialized vehicles that carry tools or parts for repair of emergency vehicles; or

4) Employees driving vehicles which cannot be garaged at a County facility which is secure – as determined by the General Services Director

On June 7, 2011, the Board of Supervisors approved a response to Grand Jury Report No. 1103 "County and City Vehicle Maintenance and Usage." In the response, the Board referred the update to the above policy to the Internal Operations Committee and directed the County Administrator to return to the Board no later than October 15, 2011 with a status report.

On September 12, 2011, the Internal Operations Committee reviewed the policy and directed staff to update the current vehicle policy, circulate a revised copy of the policy to impacted department heads for comment, direct the County Administrator to inform department heads of the revision process at the next regularly scheduled Department Head Meeting, and return to the Committee for a presentation of proposed revisions to the policy. Currently, staff is working to update the existing policy for review by the Internal Operations Committee.

CONSEQUENCE OF NEGATIVE ACTION:

The report will not be received by the Board of Supervisors.

CHILDREN'S IMPACT STATEMENT:

No impact.

To: Board of Supervisors

From: Transportation, Water and Infrastructure Comm

Date: October 11, 2011

Contra Costa County

Subject: Maintenance Assessment District for Shipping Channel Improvements

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RECOMMENDATION(S):

AUTHORIZE the Department of Conservation and Development to study the feasibility of establishing a San Francisco-to-Stockton Maintenance Assessment District for channel dredging purposes in the Pinole Shoal Channel, Suisun Bay Channel, New York Slough, and Concord Naval Weapons Station shoreline areas, as recommended by the Transportation, Water and Infrastructure Committee.

FISCAL IMPACT:

NONE to the General Fund. The feability assessment will be conducted by existing County planning staff. In the future, further costs may be incurred for (1) an Engineer's Report concerning potential projects, and (2) an election to obtain approval to establish such a district, but no funds are being allocated for either of these purposes at this time.

☑ APPROVE ☐ OTHER

☑ RECOMMENDATION OF CNTY ADMINISTRATOR ☑ RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: **10/11/2011** ☐ APPROVED AS RECOMMENDED ☐ OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYES ☐ NOES ☐

ABSENT ☐ ABSTAIN ☐

RECUSE ☐

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: October 11, 2011

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: , Deputy

Contact: John Greitzer, 925-335-1201

cc:

BACKGROUND:

Contra Costa County was the administrative agency for a five-year assessment district that assessed property owners for a dredging-related project on a segment of the shipping channel along the County's northern shore. Known as the San Francisco-to-Stockton (Suisun Bay Channels/New York Slough) Maintenance Assessment District, the district was in existence from 1999 to 2004, when it reached its pre-determined sunset date. All of the property owners were private industrial firms except for the Concord Naval Weapons Station, owned by the federal government.

The purpose of the district was to finance the creation of an on-land ("upland") disposal site for dredged material taken from the shipping channel. The disposal site would be in a location close to the shipping channel to minimize transport costs. Some potential sites were identified on Sherman Island and Winter Island, but due to liability concerns on the part of the state and federal governments, no disposal site was ever established. Approximately $2.3 million in assessment funds remain unused in the previous district's account. Staff, on September 14, 2011, reviewed this project with the Transportation, Water and Infrastructure Committee. Staff informed the Committee that the potential scope of the district -- in terms of the navigation projects it will pay for, and the geographical boundaries of the district -- may warrant expansion.

The Department of Conservation and Development is seeking Board approval at this time to proceed with a feasibility study to examine options to re-establish a San Francisco to Stockton Maintenance Assessment District. If the Board authorizes staff to proceed with this project, the first step will be to meet with all the affected entities to discuss the proposal and determine if there is enough interest to proceed with detailed technical steps to actually establish such a district, such as developing an Engineer's Report and conducting a ballot election of affected property owners. The possible Engineer's Report and the possible ballot election of affected property owners are not being authorized under this Board Order but will be the subject of future requests for authorization, as circumstances warrant.

An Engineers Report would cover the technical details of the assessment district such as the potential navigation projects to be funded, the cost of those projects, the geographical scope of the district, the benefits the projects provide to the property owners, any technical or legal constraints or obstacles that must be addressed, and recommended assessment rates.

The entities who could be affected by the potential new Assessment District include, at a minimum, the industrial property owners who would benefit from the navigation projects, the U.S. Army which now uses the northern portion of the Concord Naval Weapons Station, the Army Corps of Engineers who would be involved in implementing or overseeing the navigation improvement projects, and the Port of Stockton, which was our partner in creating the original assessment district and has partnered with us on other navigation projects over the years.

The original assessment district covered the shoreline properties from just east of the Benicia-Martinez Bridge to Antioch.

None of the industries who participated in the original assessment district still exist. All of the properties in the district have turned over to new industrial owners, except for the Concord Naval Weapons Station.

If the property owners are interested in the concept of an assessment district, staff will seek their input on the navigation projects that should be included in the district's funding plan.

As a result of the discussion on September 14, the Transportation, Water and Infrastructure Committee recommends the Board of Supervisors authorize staff to study the feasibility of establishing a new San Francisco to Stockton Maintenance Assessment District. Staff will provide frequent updates to the Committee at its monthly meetings.

If the decision ultimately is made to initiate a new assessment district and the property owners approve it through the required ballot election, the funds currently in the district account would be rolled over into the new district, if possible.

If our outreach discussions determine there is not sufficient interest in restarting the assessment district, staff will develop an alternative plan for using the $2.3 million in assessment funds, subject to any applicable restrictions.

CONSEQUENCE OF NEGATIVE ACTION:

Without Board approval, staff cannot evaluate the feasibilty of establishing a new San Francisco to Stockton Maintenance Assessment District. In that case, DCD staff would develop an alternate plan for how to use the $2.3 million currently in the assessment district account subject to any applicable restrictions. Any proposed reallocation of these funds would be brought to the Transportation, Water and Infrastructure Committee for review before being brought to the Board of Supervisors.

CHILDREN'S IMPACT STATEMENT:

Not applicable.