San Francisco Section Meeting

Thursday, February 2, 2017
6:30 – 8:30 p.m.

And

CHPAC Reception
5:00 – 6:30 p.m.

Pillsbury Winthrop Shaw Pittman LLP
Four Embarcadero Center, 22nd Floor
San Francisco, CA

OUR VISION
The vision of the Hospital Council is to be the premier healthcare association by providing leadership for change and expertise on issues affecting the delivery of health care services.

OUR MISSION
The Hospital Council of Northern and Central California’s mission is to help our members to provide high quality health care and to improve the health status of the communities they serve.

“Effective, Efficient, Safe, Timely, Patient-Centered, Equitable and Affordable”
ANTITRUST STATEMENT
TO BE READ AT MEETINGS OF THE
HOSPITAL COUNCIL OF NORTHERN AND CENTRAL CALIFORNIA

The Hospital Council of Northern and Central California’s mission is to help our members to provide high quality health care and to improve the health status of the communities they serve. Consistent with our mission, it is the policy of the Council to comply with all applicable laws, including federal and state antitrust laws.

Because our meetings and activities bring competing members together, it is important that all communications are conducted with sensitivity to antitrust considerations. Members should avoid discussing certain topics – both at formal meetings and in informal contacts with other members: Topics to avoid include: prices, fees, rates, profit margins, or other matters of competitive sensitivity; allocation of markets; or refusals to deal with suppliers, customers or other third parties.

Antitrust laws are not violated by collective efforts to obtain governmental action, such as lobbying. However, it is important that such efforts remain confined to obtaining results through the government rather than directly through members’ coordinated conduct in the marketplace itself.
# San Francisco Section Meeting Agenda

Pillsbury Winthrop Shaw Pittman LLP, Four Embarcadero, 22nd Floor  
Thursday, February 2, 2017, 6:30 –8:30 p.m.

**Meeting Objectives:**
- Inform Supervisor Sheehy on hospital issues, enhance relationship
- Advise on Behavioral Health ED Task Force, Post-Acute Care Collaborative
- Adopt 2017 S.F. Advocacy Plan

<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
<th>Page</th>
<th>Presenter</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:30</td>
<td>I. Call to Order, Introductions</td>
<td></td>
<td>Browner</td>
<td></td>
</tr>
<tr>
<td>6:45</td>
<td>II. Review of Agenda/Request for Additions</td>
<td></td>
<td>Browner</td>
<td>Approve</td>
</tr>
<tr>
<td></td>
<td>III. Approval of September 7 and November 9, 2016 minutes</td>
<td>11</td>
<td>Browner</td>
<td>Approve</td>
</tr>
<tr>
<td>6:45</td>
<td>IV. Supervisor Jeff Sheehy, District 8</td>
<td>17</td>
<td>Members</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>DISCUSSION FORMAT/TOPICS:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To facilitate the discussion, Members introduce themselves with:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Name/title, 1-2 facts about your hospital, an important issue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7:20</td>
<td>V. Post-Acute Care Collaborative (PACC)</td>
<td>19</td>
<td>Ruth</td>
<td>Update, Discussion</td>
</tr>
<tr>
<td></td>
<td>DISCUSSION QUESTION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Advise PACC Co-Chair on their efforts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7:50</td>
<td>VI. Behavioral Health ED Task Force</td>
<td>21</td>
<td>DSS</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>DISCUSSION QUESTIONS:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. What advice do you have for the ED Task Force as it makes its recommendation?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Are you comfortable with the framework they will use to make its recommendation?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Do you wish to provide additional data?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>RECOMMENDED ACTION:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Advise staff and ED Task Force</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7:50</td>
<td>VII. Advocacy – Local, State, Federal</td>
<td>25</td>
<td>DSS</td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>A. CHPAC – 2017 Goals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DISCUSSION QUESTION:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>What can we do to help you in meeting this goal?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
RECOMMENDED ACTIONS:
1. Join the CHPAC as an individual
2. Identify two new potential President’s Club Corporate Partners
3. Appoint a hospital CHPAC campaign leader and conduct a campaign

B. 2017 San Francisco Advocacy Plan

DISCUSSION QUESTIONS:
1. Do you have reservations/concerns about the plan?
2. Does the plan complement your advocacy priorities?

RECOMMENDED ACTIONS:
Adopt the 2017 S.F. Advocacy Plan:
1. Act on the ED Task Force and the Post-Acute Care Collaborative recommendations.
2. Participate in the ED Report briefing with City, business, and health care leaders.
3. Participate in the City Budget hearing on ACA changes and local impact.
4. Prepare for a special election.
5. Attend and/or direct staff to participate in the CHA Sacramento Legislative Day on March 14-15.
6. Attend and/or direct staff to participate in the CHA Congressional Days in District Office.

D. State and Federal
1. ACA changes (local impact charts, talking points)
2. Medi-Cal Managed Care Task Force – 2016 October report
3. Developing state legislation

8:20 VIII. Future Agenda Topics
IX. Education Opportunities for your Leaders
8:30 X. Adjourn

Special Note to Members:

Supervisor Sheehy is scheduled to arrive at 6:30 p.m., so we talk with him first or adjust the calendar when the Supervisor arrives.

Bonnie Graham is on assignment as the Acting CEO for the Pacific Islands VA in Honolulu. She has asked that Paul Crews, Deputy Director, serve as her designee while on assignment. His biography is attached. We appreciate VA’s involvement.

Brenda Yee is unable to attend and has also asked that Jian Zhang, Chief Operating Officer, serve as her designee for this meeting. Her biography is attached.
<table>
<thead>
<tr>
<th>Event Description</th>
<th>Date and Time</th>
<th>Location</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHA POLICY LEGISLATIVE DAY</td>
<td>Tuesday-Wednesday</td>
<td>Sacramento, CA</td>
<td>March 14-15, 2017</td>
</tr>
<tr>
<td>AHA ANNUAL MEETING &amp; CHA CCAP</td>
<td>Sunday, Monday, Tuesday, Wednesday</td>
<td>Washington, D.C.</td>
<td>May 7-10, 2017</td>
</tr>
<tr>
<td>S.F. SECTION MEETINGS</td>
<td>Thursday, April 20, 2017</td>
<td></td>
<td>Dinner - 6:00 – 9:00 p.m.</td>
</tr>
<tr>
<td></td>
<td>Tuesday, June 6, 2017</td>
<td></td>
<td>Breakfast - 8:00 – 10:30 a.m.</td>
</tr>
<tr>
<td></td>
<td>Wednesday, September 6, 2017</td>
<td></td>
<td>Dinner - 6:00 – 9:00 p.m.</td>
</tr>
<tr>
<td></td>
<td>Tuesday, November 7, 2017</td>
<td></td>
<td>Dinner - 6:00 – 9:00 p.m.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Locations TBD</td>
</tr>
<tr>
<td>REPRESENTATIVE NANCY PELOSI EVENT</td>
<td>August, 2017</td>
<td></td>
<td>5:00 – 7:00 p.m.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Location and exact date TBD with Representative Pelosi</td>
</tr>
</tbody>
</table>
HOSPITAL COUNCIL HEALTHCARE
LEADERSHIP SUMMIT 2017
Resort at Squaw Creek

Wednesday, Thursday, Friday
Sept. 27-29, 2017

For more Information:
http://www.hospitalcouncil.org/annual-summit

EDUCATION OPPORTUNITIES

HOSPITAL COUNCIL LEAD ACADEMY

Sacramento
UC Davis Health System 4800 2nd Avenue, Room
2030, Sacramento

February 28, March 29, May 9, June 6, June 22,
July 20

Walnut Creek
John Muir Medical Center 1601 Ygnacio Valley Road,
Walnut Creek

June 20, July 18, August 15, September 19, October
17, November 14

For more Information:
http://www.hospitalcouncil.net/Lead-academy
SAN FRANCISCO SECTION HOSPITAL CEO
2017 Contact Information (Revised 12-02-16)

Warren Browner, M.D., Chair, SF Section
CEO, California Pacific Medical Center
2351 Clay Street
San Francisco, CA 94115
BrowneW@sutterhealth.org
Assistant: Linda Dodge - dodgel@sutterhealth.org
(415) 600-1400  Fax: (415) 600-1409

Mark Laret, CEO
UCSF Medical Center
505 Parnassus Avenue, Box 0208
San Francisco, CA 94143-0208
mark.laret@ucsfmedctr.org
Assistant: Ailish McVeigh
(415) 353-2548 Fax: (415) 353-2765
ailish.mcveigh@ucsfmedctr.org
Shelby Decosta, Designee – (415) 353-2734
shelby.decosta@ucsf.edu

Susan Ehrlich, M.D., CEO
Zuckerberg San Francisco General Hospital
1001 Potrero Avenue, Room 2A35
San Francisco, CA 94110-3594
susan.ehrlich@sfdph.org
Assistant: Vickey Beltran - Vickey.beltran@sfdph.org
(415) 206-3517 Fax: (415) 206-3434

Pamela Lindemoen, President
St. Mary’s Medical Center
450 Stanyan Street
San Francisco, CA 94117-1079
pamela.lindemoen@dignityhealth.org
Assistant: Shauntel Murphy
(415) 750-5798 Fax: (415) 750-4893
Shauntel.Murphy@DignityHealth.org

Bonnie S. Graham, Director
VA Medical Center
4150 Clement Street
San Francisco, CA 94121-1545
bonnie.graham@va.gov
Assistant: Michael Grauer
(415) 750-2041 Fax: (415) 750-2185
Michael.Grauer@va.gov

Daniel Ruth, President/CEO
Jewish Home of San Francisco
302 Silver Avenue
San Francisco, CA 94112-1596
druth@jewishseniorlivinggroup.org
Assistant: Diane Glas dglas@jewishseniorlivinggroup.org
(415) 562-2675 Fax: (415) 405-0255
Kevin Hogan, Designee - (415) 562-2670
KHogan@jewishseniorlivinggroup.org

Ron L. Groepper, Senior V.P./Area Manager
Kaiser Foundation Hospitals/Health Plan
2425 Geary Blvd., L-140
San Francisco, CA 94115-3358
Ron.L.Groepper@kaiser.org
Assistant: Annabelle Majillo
(415) 833-2204 Fax: (415) 833-3063
Annabelle.C.Majillo@kp.org

Todd Strumwasser, M.D.
SVP Operations, S.F. Bay Area
Dignity Health
185 Berry Street, Suite 300
San Francisco, CA 94107
todd.strumwasser@dignityhealth.org
Assistant: Elena Abueva
Elena.Abueva@dignityhealth.org
(415) 438-5586

Mivic Hirose, Executive Administrator
Laguna Honda Hospital and Rehabilitation Center
375 Laguna Honda Boulevard
San Francisco, CA 94116
mivic.hirose@sfdph.org
Assistant: Alyah Allen- Alyah.Allen@sfdph.org
(415) 759-4510 Fax: (415) 759-2374

Lauren Suarez, CEO
Kentfield Rehabilitation & Specialty Hospital
450 Stanyan Street
San Francisco, CA 94117
lsuarez@kentfieldrehab.com
Assistant: Michelle Buhler-mbuhler@kentfieldrehab.com
(415) 485-3641 Fax: (415) 485-3696

David G. Klein, M.D., M.B.A., President/CEO
Saint Francis Memorial Hospital
900 Hyde Street
San Francisco, CA 94109-4899
david.klein@dignityhealth.org
Assistant: Miriam Schleicher - Miriam.Schleicher@dignityhealth.org
(415) 353-6624 Fax: (415) 353-6631

Brenda Yee, CEO
Chinese Hospital
845 Jackson Street
San Francisco, CA 94133-4899
brenday@chasf.org
Assistant: Angie Tam - Angiet@chasf.org
(415) 677-2494 Fax: (415) 217-4188
2017 San Francisco Section Hospital Leaders

CHAIR, SF SECTION, Warren Browner, M.D.
Chief Executive Officer
California Pacific Medical Center

Susan Ehrlich, M.D.
Chief Executive Officer
Zuckerberg San Francisco General Hospital

Ron Groepper
Sr. Vice President/ Area Manager
Kaiser Permanente

Mivic Hirose, RN
Executive Administrator
Laguna Honda

David G. Klein, M.D., M.B.A.
President/CEO
Saint Francis Memorial Hospital

Mark Laret
Chief Executive Officer
UCSF Medical Center

Pamela Lindemoen
President
St. Mary's Medical Center

Daniel Ruth
President/CEO
Jewish Home

Todd Strumwasser, M.D.
SVP Operations
S.F. Bay Area
Dignity Health

Lauren Suarez
Chief Executive Officer
Kentfield Rehabilitation Hospital San Francisco

Brenda Yee, RN
Chief Executive Officer
Chinese Hospital

Shelby Decosta *
Chief Strategy Officer
UCSF Medical Center

Kevin J. Hogan *
Chief Operating Officer
Jewish Home

* Designees approved by S.F. Section action, delegated authority to bind their hospital on policy/fiscal matters.
Paul S. Crews, MPH, CPHQ, FACHE
Deputy Director,
San Francisco VA Health Care System

Paul S. Crews, MPH, CPHQ, FACHE came onboard as the Associate Director of the San Francisco VA Health Care System (SFVAHCS) in January 2016 and was promoted to Deputy Director (Chief Operating Officer) in July. The SFVAHCS is a comprehensive network that provides health services to over 60,000 Veterans through the San Francisco VA Medical Center (SFVAMC) and six community-based outpatient clinics in Santa Rosa, Eureka, Ukiah, Clearlake, San Bruno and downtown San Francisco. It has a long history of conducting cutting-edge research, establishing innovative medical programs, and providing compassionate care to Veterans. SFVAMC has 124 operating beds and a 120-bed Community Living Center.

He previously served as the Associate Director of the Tennessee Valley VA Health Care System (TVHS) in Nashville, TN. Before that, he served as the Chief of Quality, Safety, and Value at TVHS for over four years. Prior to joining the Veterans Health Administration, Mr. Crews was Associate Administrator for the Riverside Health System's Tappahannock Hospital in Virginia, Vice President of the Virginia Rural Health Association, and served as the Chair of the State's Rural Health Workgroup on Quality. Mr. Crews has over 29 years of healthcare experience which includes rural emergency medical services, hospital emergency medicine, military medicine with both the Navy and Army, rural community health planning, rural health policy analysis, healthcare quality and patient safety, and healthcare administration.

Crews earned his Bachelor of Healthcare Administration degree from Texas State University and received his Master of Public Health in Management and Policy from the School of Public Health at Texas A&M University. Mr. Crews served seven years in the United States Navy. He is active in his community, supporting local efforts for the Tennessee Fisher House and is a former member of the Board of Examiners for the Tennessee Center for Performance Excellence. He is a member of the National Association for Healthcare Quality and a Fellow of the American College of Healthcare Executives.
Jian Qing Zhang, DNP, MS, FNP-BC  
Chief Operating Officer,  
Chinese Hospital, San Francisco  
Associate Clinical Professor, UCSF  
Professor and Associate Dean  
Sun Yat-Sen University, Xinhua College, Guangzhou, China

Dr. Zhang is the Chief Operating Officer of Chinese Hospital and Clinics. She has extensive experience in business development, operation, marketing, growth, innovation, clinical practice and research. She has strong expertise in organizational strategic planning, leadership development, teambuilding, healthcare delivery system design, implementation and evaluation, practice model and payment design, quality improvement and patient safety, patient experience, and health care regulations. Dr. Zhang is a national board certified family nurse practitioner who has been teaching Nurse Practitioner students as an associate clinical professor of University of California, San Francisco since 2004. She has been actively collaborating with Stanford University as a co-principal investigator on Hepatitis B studies at the Chinese Hospital site. She has been a consultant for Gilead Sciences and BMS as a professional and community speaker since 2005. She is also a professor of Sun Yat-Sen University, Xinhua College since December 2014.

Dr. Zhang earned a doctor degree in healthcare system executive leadership at University of San Francisco in 2012; a Master Degree of Science and a Post-Master Family Nurse Practitioner Certificate in University of California, San Francisco in 1992 and in 1996 respectively; and a Bachelor Degree of Nursing in Sun Yat-Sen University of Medical Sciences in China in 1989

Dr. Zhang strongly believes population-based, patient-centered health management to improve health and care while reducing cost. She has written numerous grants to bring funding to implement innovative initiatives to improve quality of care and promote the well being of the San Francisco Bay Area Chinese community. She utilizes multimedia including TV, Radio, newspaper and Websites to educate the San Francisco Bay Area Chinese Community on health issues and serves as the speaker. She serves in many professional associations including Chinese Community Cardiac Council, American Cancer Society, and American Heart Association. Dr. Zhang is also a member of American Health Care Executives, American Organization of Nurse Executives, MGMA and American Telemedicine Association.
SAN FRANCISCO SECTION
MEETING SUMMARY
Tuesday, September 7, 2016
6:00 – 9:00 p.m.
One Market Restaurant
Atrium Room
1 Market Street

Present: Susan Ehrlich, San Francisco General Hospital; David Klein, M.D., M.B.A., Saint Francis Memorial Hospital; Jay Harris, UCSF Medical Center; Ron Groepper, Kaiser Permanente; Mivic Hirose, Laguna Honda Hospital; Kevin Hogan, Jewish Home; Ann Gors, Kentfield Rehabilitation and Specialty Hospital; Todd Strumwasser, M.D., SF Bay Area Dignity Health; Wade Rose, Dignity Health; Hamila Kownacki, California Pacific Medical Center (for WB); Abbie Yant, Saint Francis Memorial Hospital

Staff: Art Sponseller, Hospital Council; David Serrano Sewell, Hospital Council;

Excused Absence: Warren Browner, M.D., California Pacific Medical Center; Brenda Yee, Chinese Hospital; Mark Laret, UCSF; Daniel Ruth, Jewish Home; Michael Carter, St. Mary’s Medical Center; Bonnie Graham, VA Medical Center;

Guests: Dimitrios Alexiou, Hospital Association of San Diego and Imperial Counties; Igor Belokrinitsky, Christoph Dankert, Purvang Mirani, and Susan Maerki, PricewaterhouseCoopers Advisory LLC; Laura Lane, UCSF; Alan Ashworth, UCSF

<table>
<thead>
<tr>
<th>DISCUSSION</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Ron Groepper called meeting to order</td>
<td>Meeting was called to order at 6:20 p.m.</td>
</tr>
<tr>
<td>II. Approval of Meeting Summary of June 16, 2016</td>
<td>It was moved, seconded and passed to approve the minutes of the June 16, 2016 meeting as distributed.</td>
</tr>
</tbody>
</table>
### DISCUSSION

**III. Report on improving San Francisco Emergency Services**

After much discussion, in June the CEOs decided to take bold action on an issue that is impacting all San Franciscans, especially the most vulnerable, ED overcrowding.

PwC took a deep dive into the publically available data, interviewed of 50 stakeholders (ED physicians, nurses, discharge staff, EMSA), and surveyed best practices in presenting their initial Report. The Report points to gaps in avoidance, prevention, transportation, coordination and access to the continuum of care. Further, the Report noted the major investments made by the members in capacity and alternate treatment options but there remains a need for sustained leadership and action in the City. The Report proposed a solution framework (workgroup, additional mental health capacity).

**ACTION**

The Report generated a lively policy discussion and final action is expected soon while the members provide additional review of Report and the draft framework for action.

### IV. S.F. Health Improvement Partnership (SFHIP)

**A. SFHIP**

SFHIP is a coalition comprising S.F. Hospitals, Department of Public Health, UCSF and Community Equity Partners to pool resources to close health inequities in the City. Further, SFHIP ensures that the assessments required under law for hospitals and the health department are fully aligned, this is achieved through gathering and analyzing local health data and working with community organizations.

**ACTION**

The CEOs voted to continue to provide financial support for 2017 ($151,600) for consultant and data services to assist SFHIP’s efforts.

- **Chinese Hospital** $6,064
- **CPMC** $34,110
- **Kaiser Permanente SF** $34,110
- **Saint Francis Memorial Hospital** $17,055
- **Saint Mary’s Medical Center** $17,055
- **UCSF Medical Center** $34,110
- **Jewish Home** $9,096
<table>
<thead>
<tr>
<th>DISCUSSION</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. CHNA Breakfast – Tuesday, September 27</td>
<td>Also, in connection with the assessment year and its’ findings, on September 27, the S.F. Hospitals are the sponsors for the SFHIP 2016 Community Health Needs Assessment Breakfast, an event that will be attended by the City’s top health leaders, supporters, senior Department staff as well as elected officials.</td>
</tr>
</tbody>
</table>

V. S.F. Cancer Initiative (SF-CAN)  
Alan Ashworth, PhD, made a brief presentation on their efforts. They have made similar presentations to other groups.  
The S.F. Section voted to join the initiative’s goal to reduce the cancer burden and address disparities of incidence and outcome in the City through engagement with the City, community and health care institutions throughout San Francisco. The initiative will focus its prevention efforts on four cancers – lung, liver, prostate and colorectal.

VI. Member Issue: Employee Housing And Transportation issues  
Jay Harris spoke about the employee transportation problems at UCSF and asked members for ideas on how to solve this problem.  
Ron Groepper mentioned Kaiser is already looking into a budget from MTA and will send Jay the information.

VII. Ballot Initiatives  
Art Sponseller spoke briefly about information in the packet on the health related state propositions and CHA’s position on each. Proposition 52 is the highest priority as it is our own measure to make the hospital fee program permanent.

VIII. Hospital Council 2016 Summit – September 28-30 - Napa  
David informed members about the Summit dinner for Bay Area hospital attendees.

IX. Adjournment  
Meeting was adjourned at 8:30 p.m.
SAN FRANCISCO SECTION
MEETING SUMMARY
Wednesday November 9, 2016
6:00 – 9:00 p.m.
Spruce Restaurant
Laurel Room
3640 Sacramento Street

Present:
- Warren Browner, M.D., California Pacific Medical Center;
- Susan Ehrlich, San Francisco General Hospital;
- David Klein, M.D., M.B.A., Saint Francis Memorial Hospital;
- Jay Harris, UCSF Medical Center;
- Brenda Yee, Chinese Hospital;
- Mivic Hirose, Laguna Honda Hospital;
- Wade Rose, Dignity Health;
- Abbie Yant, Saint Francis Memorial Hospital;
- Lauren Suarez, Kentfield Rehabilitation and Specialty Hospital;

Staff:
- Art Sponseller, Hospital Council;
- David Serrano Sewell, Hospital Council;

Excused Absence:
- Ron Groepper, Kaiser Permanente;
- Mark Laret, UCSF;
- Daniel Ruth, Jewish Home;
- Pamela Lindemoen, St. Mary’s Medical Center;
- Bonnie Graham, VA Medical Center;
- Ann Gors, Kentfield Rehabilitation and Specialty Hospital;
- Todd Strumwasser, M.D., SF Bay Area Dignity Health;
- Kevin Hogan, Jewish Home;

Guests:
- Mayor Ed Lee;
- Director Barbara Garcia, S.F. Department of Public Health;
- Aneeka Chaudhry, Senior Health Advisor, Office of the Mayor;
- Naomi Kelly, S.F. City Administrator;
- John Grgurina, San Francisco Health Plan;
- Drs. Steven Polevoi and Susan Lambe, S.F. Emergency Physicians Association;
- Dr. Clement Yeh, Medical Director, S.F. Fire Department;
- Igor Belokrinitsky, PricewaterhouseCoopers;

<table>
<thead>
<tr>
<th>DISCUSSION</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Dr. Warren Browner called meeting to order</td>
<td>Meeting was called to order at 6:20 p.m.</td>
</tr>
<tr>
<td>II. Welcome</td>
<td>DISCUSSION</td>
</tr>
<tr>
<td>-------------</td>
<td>------------</td>
</tr>
</tbody>
</table>
| III. Report and discussion on the: “Protecting San Francisco Emergency Services: Diagnosing and Addressing the Challenges of San Francisco’s EDs" | There was an informal discussion about the ED Report commissioned by the San Francisco Section, titled "Protecting San Francisco Emergency Services: Diagnosing and Addressing the Challenges of San Francisco's EDs". The evening generated a lively discussion, the guests agreed with the ED Report recommendations:  
  - CONTINUE to support/promote lower-acuity settings/services that serve substance abuse-related as well as psychiatric needs (i.e. Sobering Center, Dore Urgent Care Center)  
  - CATALYZE the creation of additional lower-acuity behavioral/mental health capacity necessary to alleviate the strain on the ED while ensuring high-quality care in an appropriate setting  
  - As a first step towards this objective, ESTABLISH a Behavioral Health ED Task Force whose charter is to evaluate how much and what type of additional lower-acuity capacity serving substance abuse-related and psychiatric conditions and/or services is needed in the city, where it should be located, and how it should be funded. The task force should make its recommendations to the Council by April 2017.  
  - EMPOWER the Local Emergency Management Agency to triage and transport patients in a way that optimizes care continuity and capacity  
  - DIRECT the Post-Acute Care Collaborative Members adopted the recommendations that will advance the collective interests of the hospitals and demonstrate the convening power of the Hospital Council. | Dr. Browner welcomed and thanked the guests for attending the meeting. |
<table>
<thead>
<tr>
<th>DISCUSSION</th>
<th>ACTION</th>
</tr>
</thead>
</table>
| to focus on programs that will speed the discharge and transition of patients ready to move to a post-acute care site  
- INFORM key stakeholders on the Report findings | Meeting was adjourned at 8:20 p.m. |

IV. Adjournment
DATE: February 2, 2017
TO: Hospital CEOs
FR: David Serrano Sewell
SUBJECT: Conversation with Supervisor Jeff Sheehy

SUMMARY
Newly appointed District 8 Supervisor Jeff Sheehy will be at the meeting for a discussion on hospital and health care issues. The Supervisor is making health care a centerpiece of his legislative priorities, consistent with his biography.

Supervisor Sheehy made a presentation to the S.F. Section at the February 2015 meeting about joining the “Getting to Zero” coalition, which we did. So, he is familiar with us, but we will use the discussion format to reacquaint him.

This is a unique opportunity to strengthen our relationship with the Supervisor.

DISCUSSION FORMAT/TOPICS:
To facilitate the discussion, we will use the following format:

I. Members introduce themselves, please state your:
   A. Name, title
   B. 1-2 facts about your hospital
   C. One important issue to you

   II. Supervisor Sheehy introduction

As a topic, please note the Supervisor is assigned the Budget Federal Select Committee to advise on the fiscal impacts to the City under the Trump Administration, especially in health care, ACA. It is possible he will hold a hearing on ACA impacts on City.

Supervisor Jeff Sheehy

Jeff Sheehy is a respected public policy leader, state commissioner, and patient advocate. On January 6, Mayor Lee appointed him as District 8’s new Supervisor.

He is a public school parent living in Glen Park with his husband and daughter.

Appointed to the governing board of the California Institute of Regenerative Medicine at its inception by Senator John Burton in 2004, Jeff Sheehy was reappointed in 2012 by Senator Darryl Steinberg to serve a second term. On the board, he is Vice-Chair of the Scientific and Medical Research Funding Working Group and Chair of the Science Sub-Committee.
Sheehy is communications director at the UCSF AIDS Research Institute. A longtime HIV/AIDS and LGBT human rights activist and a person living with HIV, he served as HIV/AIDS advisor to San Francisco Mayor Gavin Newsom. He is a member of the Industry Collaboration Group of the International AIDS Society’s Towards an HIV Cure Project.

As a member of ACT-UP Golden Gate, he played a key role in obtaining $3 million in research funding in California in 1999 for solid organ transplants for people with HIV. This initiative led to a NIH funded protocol. The subsequent findings helped in the reassessment of the norm in 1996 that “the great majority of U.S. renal transplant centers will not transplant kidneys to HIV-infected patients with end-stage renal disease, even if their infection is asymptomatic” and also supported insurance reimbursement for the procedures. He worked to advance SB 443 in 2007, which allowed HIV positive men to use advanced assisted reproduction techniques that facilitate safe conception with their HIV negative partners.

In 1996, Sheehy helped to draft and lobby through San Francisco’s historic Equal Benefits Ordinance, which requires that companies contracting with the City provide the domestic partners of employees the same benefits that spouses of employees receive.

To support the legislation, he founded and led Equal Benefits Advocates, which conducted the successful national boycott of United Airlines that resulted in U.S. airlines offering domestic partner benefits to their employees worldwide in 1999. Over 3500 companies complied with the law and over 100,000 lesbians and gay men around the country obtained health insurance and other benefits for their domestic partners.

Sheehy has been the recipient of the HRC Leadership Award from The Human Rights Campaign, the Cape Crusader Award from Equality California, the Tomas Fabregas AIDS Hero Award, the UCSF Chancellor’s Award for Public Service, and was named in 1999 to OUT Magazine’s OUT 100 list of the most influential members of the LGBT community and to POZ Magazine’s “POZ 100” in 2012, its list of people making a significant contribution to speeding up the end of AIDS.

**District 8**
District 8 comprises the Castro, Noe Valley, Diamond Heights, Glen Park, Corona Heights, Eureka Valley, Dolores Heights, Mission Dolores, Duboce Triangle, Buena Vista Park, and part of Twin Peaks.
DATE: February 2, 2016
TO: Hospital CEOs
FR: David Serrano Sewell
SUBJECT: Post-Acute Care Collaborative (PACC)

SUMMARY
The PACC will begin their work in late February. Daniel Ruth, CEO of Jewish Home, Co-Chair of the PACC, will share his thoughts and solicit your feedback. The PACC meeting agenda topics will be distributed that evening.

DISCUSSION QUESTION
Advise PACC Co-Chair on their efforts.

BACKGROUND
In 2016, the members voted to provide financial support to retain a consultant for project management support. With the assistance of hospital staff, we selected Monique Parrish as the consultant.

This is positive outcome; Ms. Parrish was the consult for the report adopted by the Health Commission in February 2016 that lead to creation of the PACC, thus, she is familiar with the topic and the local experts.

PACC
The San Francisco Section of the Hospital Council will convene the Post-Acute Care Collaborative (PACC), a public-private partnership of stakeholders that seeks to:
- Promote information sharing
- Improve patient referrals and care navigation
- Identify and guide/recommend implementation of viable post-acute alternatives for vulnerable post-acute care patients, i.e. those with behavioral health problems

The PACC will include key leaders from SFDPH, private NFP hospitals, San Francisco Department of Aging and Adult Services, SF Health Plan, skilled nursing facilities, home health agencies, and in-home supportive services. The PACC begin its work in 2017.

The PACC’s purpose is identify solutions to improve the availability and accessibility of post-acute care services, i.e. long term residential care, for vulnerable populations and Medi-Cal beneficiaries in San Francisco, and those community-based long term services and support that allow for community based (non-SNF) care for some that would otherwise be in a SNF.

The goal is to advance policy, research, and operational recommendations. Upon completion, it will make a report to the Health Commission and the Hospital Council.
The PACC is a result of the SF Post-Acute Care Project that started in August 2015 at the SFDPH.

In February 2016, the Health Commission heard the project report, “Framing San Francisco’s Post-Acute Care Challenge” that addresses the impact of reduced skilled nursing facility beds on the need, supply, and gaps in post-acute care in the City, now and in the future. The key report findings are:

- San Francisco is at risk for an inadequate supply of skilled nursing beds due to a growing older population coupled with the high-cost of doing business in the City and low reimbursement rates.
- Medi-Cal Beneficiaries with skilled nursing needs have limited options.
- Vulnerable populations are difficult to place in skilled nursing and long-term care.
- The creation of Post-Acute Care Collaborative to convene interested parties and make recommendations.
DATE: February 2, 2016  
TO: Hospital CEOs  
FR: David Serrano Sewell  
SUBJECT: Behavioral Health Emergency Department Task Force

SUMMARY
This memorandum summarizes the first meeting of the Behavioral Health Emergency Department Task Force (ED Task Force) held on Friday, January 20. Your advice is sought as the ED Task Force continues their work.

Their charter is to identify the right way to add lower-acuity capacity and to make a recommendation to the Hospital Council at the April Section meeting. Please see task force membership list.

DISCUSSION QUESTIONS:
1. What advice do you have for the ED Task Force as it makes its recommendation?
2. Are you comfortable with the framework they will use to make its recommendation?
3. Do you wish to provide additional data?

REQUESTED ACTION:
Advise staff and ED Task Force.

BACKGROUND
The challenges posed by behavioral health patients in the ED are a focus of the report1 and one of its’ chief recommendations – the creation of the ED Task Force.

First Meeting – Establishing a Common Approach
The first meeting was January 20, for ninety minutes, with one hundred percent attendance. We were fortunate that Igor Belokrinitsky, PwC, attended to answer questions and provide expert advice.

The objective was to establish a consensus approach to developing the recommendations, to have common understanding of the source material. To reach consensus, they answered “what would your work look like to you if it were an expression of your highest values?”

<table>
<thead>
<tr>
<th>VALUES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Make a difference – value added</td>
</tr>
<tr>
<td>• Dedicated to work on BH issues</td>
</tr>
<tr>
<td>• Public service</td>
</tr>
<tr>
<td>• Serving - everyone is family</td>
</tr>
<tr>
<td>• Move the public policy needle</td>
</tr>
<tr>
<td>• Humanism/compassion for people in waiting room, BH patients, and staff</td>
</tr>
<tr>
<td>• Advocacy for patients and families</td>
</tr>
<tr>
<td>• Helping people realize their potential</td>
</tr>
<tr>
<td>• Improve patient experience, outcome, flow</td>
</tr>
<tr>
<td>• Be mindful of patient in front, resources, and needs of other patients</td>
</tr>
<tr>
<td>• Minimize unnecessary institutionalization of mentally ill</td>
</tr>
<tr>
<td>• Political decisions got us here, e.g. Lanterman-Petris Act unchanged</td>
</tr>
<tr>
<td>• Everyone deserves an advocate and an opportunity (legal lens)</td>
</tr>
<tr>
<td>• Operational: living values (mission-driven); re-engineer health with patient/family at the centers</td>
</tr>
</tbody>
</table>
Next, they outlined the guiding principles that should be honored in making the recommendation:

**GUIDING PRINCIPLES**

- Excellence in care
- Compassionate and client centered
- Explicit outcome, specificity in recommendation, financial sustainability
- Care in the right time, right place
- Minimize recidivism of ED use
- Respect family and staff
- ED Safety for all patients and staff
- Recovery focus and wellness
- Continuity of care
- Increase equity and access
- Multicultural embrace – resilience/diversity respect
- Prioritized care with the sick patient
- Support for professional development for ER Staff

Other issues covered at the meeting include:

**Information/Data/Case Studies**
The task force has indicated that their work will require a more in-depth look at the current length of stay, arrival and discharge information for a subset of patients. This information was requested during the creation of the original report, but not every hospital submitted it.

It will be critical to fill the gaps quickly. If the data is currently not being tracked, or if a hospital does not wish to share the information for competitive or other reasons, the recommendations of the task force are likely to be less timely and less rigorous.

Also, the task force wants to explore successful efforts that were identified in the ED Report, such as John George Psychiatric Hospital, and exploring the current step-down system and what needs to be done to align public-private forces.

**Abbie Yant**, RN (V.P. Mission, Advocacy Community Services, Saint Francis Memorial Hospital) has agreed to serve as Co-Chair.

**Next Steps**
It is anticipated the ED Task Force will have 2-3 meetings before making their recommendation. We propose the following decision-making matrix to guide the recommendation, please see attachment.

Attachments:
- Decision-making matrix
- ED Task Force roster, bios

\(^1\) Report titled “Protecting San Francisco Emergency Services: Diagnosing and Addressing the Challenges of San Francisco’s EDs”
Our Values and Objectives

Our Approach / Process

Historical, Current and Expected Demand
for lower-acuity behavioral health services being met at the ED

Historical, Current and Expected Supply
of lower-acuity behavioral health services, including utilization and gaps in supply

Option A
E.g., optimize utilization of current available capacity

Option B
E.g., selectively add capacity to existing facilities

Option C
E.g., create a new facility

Enablers (Regardless of Chosen Option)
e.g., measurement system

Dependencies
e.g., implications on transport, law enforcement

Next Steps
e.g., detailed business case (financial viability, regulatory hurdles)
BEHAVIORAL HEALTH EMERGENCY DEPARTMENT TASK FORCE

Brett Andrews
Chief Executive Officer
Positive Resource Center

John R. McQuaid, Ph.D.
Acting Chief, Mental Health
San Francisco VA Healthcare System
Co-Director of Psychology, Langley Porter UCSF

Steve Fields, MPA
Executive Director
Progress Foundation

Alan W. Newman, M.D.
Director of Psychiatry
California Pacific Medical Center

Victor Garcia, RN
Director ED Nursing
California Pacific Medical Center

David Pating, M.D.
Chief, Addiction Medicine
Kaiser San Francisco Medical Center
Chemical Dependency Recovery Program

Kavoos Ghane Bassiri
Director of Behavioral Health Services
San Francisco Department of Public Health

Maria C. Raven, MD, MPH, MSC
Associate Professor of Emergency Medicine
UCSF School of Medicine

Susan Lambe, M.D.
Co-Chair S.F. Emergency Physicians Association
UCSF Medical Center

Jeffrey Schmidt, RN, MPH
Director, Clinical Operations
Zuckerberg San Francisco General
Hospital and Trauma Center

Mark Leary, M.D.
Deputy Chief of Psychiatry and Interim
Director of PES at ZSFGH

Abbie Yant, RN
Vice President, Mission, Advocacy and
Community Health Services
Saint Francis Memorial Hospital

Ex Officio Member

Daniel R. Ruth
Co-Chair of Post-Acute Care Collaborative (PACC)
President & CEO
The Jewish Senior Living Group
DATE: February 2, 2016
TO: Hospital CEOs
FR: David Serrano Sewell
SUBJECT: California Hospital Political Action Committee (CHPAC) 2016 Report and 2017 Goals

SUMMARY
Your involvement will ensure the San Francisco Section meets the 2017 CHPAC goals.

DISCUSSION QUESTION:
What can we do to help you in meeting this goal?

RECOMMENDED ACTIONS:
1. Join the CHPAC as an individual
2. Identify two new potential President’s Club Corporate Partners
3. Appoint a hospital CHPAC campaign leader and conduct a campaign

BACKGROUND
CHPAC met and exceeded its $1,100.00 goal in 2016. CHPAC enjoyed the support of over a thousand individuals who contributed to our PAC. Also, 178 hospitals ran CHPAC campaigns. 2016 highlights include:

- Over $500,000 in support of candidates for the California legislature
- $229,150 to American Hospital Association PAC.
- $220,000 was raised outside of CHPAC directly for candidates

The San Francisco Section has done an outstanding job in referring President’s Club Corporate Partners to donate to the CHPAC. 2016 referrals include:

<table>
<thead>
<tr>
<th>Company</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crothal</td>
<td>$6,800</td>
</tr>
<tr>
<td>Pillsbury, Winthrop, Shaw Pittman</td>
<td>$6,800</td>
</tr>
<tr>
<td>Degenkolb Engineers</td>
<td>$6,800</td>
</tr>
<tr>
<td>True North Custom</td>
<td>$6,800</td>
</tr>
<tr>
<td>Herrero Builders</td>
<td>$6,800</td>
</tr>
<tr>
<td>Valley Emergency Physicians</td>
<td>$6,800</td>
</tr>
</tbody>
</table>

Additionally, some of you personally donated to the CHPAC, totaling $6,350. In 2016, the S.F. Section raised $47,150 for the CHPAC.

CEO Contributions
See the form to fill out at different levels. This year, we seek 100% participation at any level.

CHPAC Campaign Coordinator
Campaign coordinators are responsible for distributing all CHPAC collaterals and information regarding CHPAC events to hospital management staff. They also convey local political information to CHPAC (i.e., local fundraisers, issues and current events).
**2017 Federal Contribution Form**

Yes, I wish to support the federal activities and causes of the California Hospital Association Political Action Committee Federal (CHPAC-FED) by making a contribution of:

**Amount**
- □ Presidents’ Club Platinum Level ($5,000)
- □ Presidents’ Club Diamond Level ($1,750)
- □ Presidents’ Club ($1,500)
- □ Leadership Board Challenge ($850)
- □ Golden State Club ($500)
- □ Other ($________ )

**Recurrence**
Pledges must be paid in full by December 31
- □ One-time  □ Monthly  □ Quarterly  □ Payroll (association staff)

**Personal Information**
Federal law requires this information accompany all contributions:

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupation/Title:</td>
</tr>
<tr>
<td>Full Name of Employer:</td>
</tr>
<tr>
<td>Physical Address:</td>
</tr>
<tr>
<td>City:</td>
</tr>
<tr>
<td>State:</td>
</tr>
<tr>
<td>Zip:</td>
</tr>
<tr>
<td>Telephone:</td>
</tr>
<tr>
<td>Email:</td>
</tr>
</tbody>
</table>

**Payment Information**
- □ Check enclosed. Make payable to CHPAC-FED
- □ Billing address same as Personal Address
- □ I verify that this is a personal donation for which I will not be reimbursed by my employer or any other entity

| Name on Card:                  |
| Card Number:                   |
| Expiration Date:               |
| Billing Address:               |
| City:                          |
| State:                         |
| Zip:                           |

**CHPAC Goal Credit**
Name of hospital(s) or regional association to receive credit:

Please give recognition to my professional organization
- □ ACNL  □ CSHE  □ HCE  □ HHRMAC  □ Volunteers

---

**Federal PAC Guidelines for Contributing to CHPAC-FED**

The purpose of CHPAC-FED is to support the election of candidates to the U.S. House of Representatives and U.S. Senate who recognize the vital role of hospitals.

Contributions or gifts to CHPAC are completely voluntary and not deductible as charitable contributions for federal or state income tax purposes.

Contribution levels are suggestions — you may contribute more or less. You have the right to refuse to contribute to CHPAC-FED without reprisal. The decision to participate will in no way affect your employment or job status.

CHPAC-FED may accept contributions from individuals up to $5,000 per calendar year.

CHPAC-FED is prohibited by federal law from accepting contributions from corporations, labor unions, federally chartered corporations, federal government contractors, foreign nationals and persons who are not members of the solicitable class.

CHPAC-FED may solicit only individuals who are officers, directors, shareholders or management employees of member corporations and their families. As an officer, director, shareholder or management employee of a member corporation or a family member of such persons, please complete the required contributor information.

CHPAC-FED will not accept any contribution until it has confirmed that the contributor is a member of the CHPAC-FED solicitable class. Any contributions received from persons who are not members of the CHPAC-FED solicitable class will be transferred to the CHPAC state account.
Please Designate a Campaign Coordinator Today!

CHPAC needs your help in making our $1,100,000 goal this year. It is important for every hospital to run a CHPAC campaign or we will not succeed. We understand some hospitals have concerns about running a campaign. It can be a time consuming process but CHPAC is equipped to run your entire campaign from our office! This is especially useful for 501(c)(3) and public hospitals that cannot use hospital resources and time. We only need you to designate a campaign coordinator and provide a list of names and home addresses for your solicitable employees. This small task can be performed after work or at a break in 501(c)(3) or public hospitals. This is in full compliance with all laws and election regulations.

Once you designate a campaign coordinator:

- CHPAC employees will contact your coordinator for names and home addresses.
- CHPAC employees will draft a letter for your approval, print and mail to the list of hospital-provided recipients.
- CHPAC will pay postage. This is especially useful for 501(c)(3) and other hospitals that are unable to use hospital assets or staff time for solicitation.
- CHPAC employees will communicate with the appointed campaign coordinator about campaign progress.

Please designate a campaign coordinator below:

Hospital: 
Contact Name: 
Mailing Address: 
City:  State:  Zip: 
Telephone:  Email: 

A CHPAC staff member will contact the appointed coordinator to complete your mailing. In the meantime, please begin preparing an Excel spreadsheet with the mailing list of your solicitable employees (salaried, exempt). Home addresses will be required.

Please return this form by mail, fax or email to:

CHPAC
1215 K Street, Suite 800
Sacramento, CA 95814
Phone: (916) 552-7533
Fax: (916)552-7692
Email: chpac@calhospital.org
DATE: February 2, 2016
TO: Hospital CEOs
FR: David Serrano Sewell
SUBJECT: 2017 San Francisco Advocacy Plan

SUMMARY
2016 was a successful year. In 2017, we will build on that success by:
  • Leading, informing and convening on issues of critical importance, e.g. ED, post-acute care, ACA impacts on S.F.
  • Remaining active on local, state, and federal matters
  • Preparing for a special local election

It is never a dull moment in our City. Speaking with one voice on issues of mutual concern will ensure our success.

DISCUSSION QUESTIONS:
1. Do you have reservations/concerns about the plan?
2. Does the plan complement your advocacy priorities?

RECOMMENDED ACTIONS:
Adopt the 2017 S.F. Advocacy Plan, with:
  1. Act on the ED Task Force and the Post-Acute Care Collaborative recommendations.
  2. Participate in the ED Report briefing with City, business, and health care leaders.
  3. Participate in the City Budget hearing on ACA changes and local impact.
  4. Prepare for a special election.
  5. Attends and/or direct staff to participate in the CHA Sacramento Legislative Day on March 14-15.
  6. Attends and/or direct staff to participate in the CHA Congressional Days in District Office.

BACKGROUND
Behavioral Health ED Task Force, Post-Acute Care Collaborative recommendations

We will discuss the ED Task Force and their actions under Agenda item VI and PACC under item V.

Brief others on the ED Report
To date, we have shared the ED Report with a select group of City policymakers, elected officials, hospital staff (community benefit directors, government affairs), coalition partners as well as members of the ED Task Force.
This year, we want to inform the broader community, including City policymakers (department leaders, City Hall staff), business leaders (Chamber of Commerce, business associations) and health care providers (clinic consortium).

We are planning a breakfast event.

**Participate in City Budget Hearing on ACA Changes**
The Trump Administration policies are generating discussion and press in San Francisco. It is foreseeable that the Board of Supervisors will have a hearing on the proposed changes to the ACA and Medicaid on City residents and health care sector.

Further, the City will want to hear from hospitals to identify common goals and opportunities for partnership. In fact, the Hospital Council was asked to participate in a discussion with Mayor Lee, senior City policymakers, and providers on how the group was preparing for such changes.

If there is such a hearing, we should participate and provide data to inform the discussion without appearing partisan.

**Prepare for Special Election**
While there is no scheduled election in 2017; that can change if approximately 18,000 signatures are obtained for a local ballot measure. Upon certification, the Board of Supervisors would schedule the election date.

Influencing the movement for a special election are two related issues:
- Oppose Trump policies, response to the (assumed) decrease in federal support and the tax cuts for the business and the wealthy
- Shift the power balance at the Board of Supervisors from moderate to progressive (conventional wisdom is 6 moderates, 5 progressives).

A special election would force the newly appointed District 8 Supervisor Sheehy to stand for election at that time, as opposed to the next regularly scheduled election in June 2018. The “progressives” would support a candidate to challenge Supervisor Sheehy.

SEIU 1021, the City’s largest public employee union, and its coalition partners, are floating several possible measures for a special election this year to help with the City’s budget.

**Possible 2017 Measures**

**Tax Intangible Assets:** Change state law to add intangible property, e.g. stock.

**Executive Pay Surcharge:** Based on a law passed in December by the Portland City Council requiring businesses to pay an additional 10% in business taxes if a business’ CEO earns more than 100 times the median pay of their workforce.
Companies with pay ratios greater than 250 times the median will face a 25% surcharge. The pay ratio determination will be based on filings with the SEC which will begin collecting the information this year.

SEIU 1021 has suggested that the “100 times” threshold is lowered to 25 times and that the rate be increased to 50% for those with CEOs making 25 times the median (also, finding ways to include stock compensation in that calculation).

**Increase Gross Receipts Tax Rates**: After the “Tech Tax” failed last year, advocates want to pursue increasing the Gross Receipts tax rates on tech-related companies, or any other type of business that their polling supports should pay its “Fair Share.”

**City Income/Wage Tax**: While State law prohibits taxing income based on where people live, SEIU 1021 suggests the City tax the income that is earned here in San Francisco. After exempting a base income of $50,000, the income on the next $50K would be taxed at lower rate (.05%), the next $200K at a higher rate (1 or 2%), and people who earn more than $500K a year pay 3% or more.

**Vehicle License Fee**: A move to locally reinstate the “car tax” of 2% of the market value of the vehicle.

**Tax on Vacant Real Estate**: A 15% tax on all foreign investment in residential property or all vacant residential and commercial properties/units.

**Restore the Payroll Tax**: In an effort to go after revenue lost from companies with high payrolls but low Gross Receipts within San Francisco after the transition to the new Gross Receipts Tax, SEIU would like to reinstate the old Payroll Tax in a “progressive” fashion. The City could tax the first $500K in payroll at 0.5%, the next $500K at 1%, and payrolls of more than $10 million at 3%.

**Tax Airbnb Listings**: Increase the hotel tax (the “Transient Occupancy Tax”) for anyone who doesn’t have a business license to operate a hotel.

**Repeal All Existing Corporate Tax Breaks**: Immediately end the Mid-Market Business Tax Exclusion, Cap on Stock Compensation and others.

**CHA Legislative Day March 14-15**
California hospital leaders meet in Sacramento to learn about pending hospital related legislation and to meet with Legislators and their staff. The direct advocacy of hospital leaders makes the difference.

San Francisco has one of the strongest delegations. We meet with Assemblymember Phil Ting, Assemblymember David Chiu, and Senator Scott Wiener.

The Hospital Council will host a dinner on March 14, and visits will occur on March 15. Governor Brown is invited to speak at the opening breakfast. Please join us and/or direct your staff to attend.
CHA Congressional Days in District Office
In addition to the CHA/AHA advocacy effort in Washington D.C. on May 7-10, we coordinate with CHA on a local Congressional Action Day in the Representatives Pelosi and Speier local office. The date has yet to set.

Other Section Activities
In addition to above, this office will continue a strategy of:

Monitoring emerging local issues
For example, issues such as hospital appointments to the advisory committee on fees derived from tax on surgery beverages, safe injection sites.

Health Commission vacancy
We will seek to support candidate for appointment by Mayor.

Effective local partnerships
Maintain membership and attend relevant meetings of like-minded organizations, e.g. SPUR, Chamber of Commerce, Alliance for Jobs & Sustainable Growth, San Francisco Medical Society, and San Francisco Health Improvement Partnership.

Sponsorships
Sponsorship of events that promote and enhance hospital relationships with others.

Convening Stakeholders to Solve Problems
Examples include Government Affairs Work Group, Community Benefit Directors Work Group, and exploring interest for CNO work group, and meeting with key health leaders.

Political Giving
Donations to elected officials, ballot measures, political organizations.

Lastly, I want to thank your staff for their involvement and support of our common objectives.
TUITION

This program is for executives of CHA member hospitals only and the deadline to register is February 15. To encourage members to register by the deadline, registration fees are discounted.

Member rate by February 15 .................................................. $245
Member rate after February 15 .............................................. $345

CONFIRMATIONS

A confirmation will be emailed to all registrants. Participants will be emailed their schedule of appointments with the legislators one week prior to the program.

CANCELLATION POLICY

A $50 non-refundable processing fee will be retained for each cancellation received in writing by March 8. No refunds will be made after this date. Substitutions are encouraged. Cancellation and substitution notification may be emailed to education@calhospital.org.

AMERICANS WITH DISABILITIES ACT

If you require special accommodations pursuant to the Americans with Disabilities Act, contact CHA at (916) 552-7637.

TRANSPORTATION

Cab fare from the Sacramento International Airport to the hotel is approximately $40 one way and takes about 30 minutes.

QUESTIONS

Please call the CHA Education Department at (916) 552-7637.
Three ways to register

**ONLINE**
Register online at www.calhospital.org/Legislative-Day

**MAIL**
California Hospital Association
Education Department
1215 K Street, Suite 800
Sacramento, CA 95814
Make check payable to CAHHS/CHA.

**FAX**
Fax your registration to (916) 552-7506 with your credit card information.

Tuition:
This program is for executives of CHA member hospitals only. To facilitate the scheduling of appointments with the Legislature, please register by **February 15**.
- Member rate by February 15 ...................................................... $245
- Member rate after February 15 ................................................... $345

Payment:
- Check enclosed. Make check payable to CAHHS/CHA.
- Credit card (check one): ☐ VISA  ☐ MC  ☐ AMEX
- Card Number: _______________________
- Name on Card: _______________________
- Expiration Date: __________/________
- Security Code: ___________
- Billing Address: 
  - City: _____________________________
  - State: ____________________________
  - Zip: _____________________________
- Authorizing Signature: _______________________

Cancellation Policy:
A $50 non-refundable processing fee will be retained for each cancellation received in writing by March 8. No refunds will be made after this date. Substitutions are encouraged. Cancellation and substitution notification may be emailed to education@calhospital.org.

Special Accommodations or Questions:
If you require special accommodations pursuant to the Americans with Disabilities Act or have other questions, please call CHA at (916) 552-7637.

CHA will Schedule Legislative Meetings on Your Behalf

CHA’s advocacy staff will schedule appointments with members of the Legislature on your behalf — primarily group meetings with other hospital executives from your area. Scheduling will be coordinated with input from the Regional Associations. Hospital executives are asked not to schedule meetings directly with representatives.

If you would like appointments with specific legislators from districts other than your own, please indicate your requests below. Every effort will be made to accommodate your requests.

☐ Do Not Schedule Meetings. If you will not attend the meetings with legislators on Wednesday afternoon, please check the box and CHA will not schedule appointments on your behalf.

Questions: If you have questions about the appointments or have other special requests, contact your regional hospital association vice president or Patricia Ward at the CHA office at pward@calhospital.org or (916) 552-7526.

Registrant Information:

Name: _____________________________
Title: _____________________________
Hospital / Organization: _____________________________
Address: _____________________________
City: _____________________________
State: _____________________________ Zip: _____________________________
Telephone: _____________________________
Email Address (required): _____________________________
CC Email Address (optional): _____________________________
Dietary Request: ☐ Vegetarian
Food Allergies: _____________________________

Events on Tuesday, March 14:
- ☐ New Participant Briefing
- ☐ Team Leader Briefing
- ☐ VIP Tour of the State Capitol
- ☐ Government Relations/Welcome Reception

Events on Tuesday, March 14:
- ☐ New Participant Briefing
- ☐ Team Leader Briefing
- ☐ VIP Tour of the State Capitol
- ☐ Government Relations/Welcome Reception
DATE: February 2, 2016
TO: Hospital CEOs
FR: David Serrano Sewell
SUBJECT: State and Federal issues

SUMMARY
At the meeting, Art Sponseller, President/CEO, Hospital Council, will update the members on:

Affordable Care Act changes
Please see the charts for Congressional District 12 (Pelosi) and 14 (Speier):
  • “Impact of ACA Medicare Productivity & Other Market-Based Reductions for the
    Inpatient Prospective Payment System and Total ACA Medicare and Medicaid DSH
    Reductions: FY 2018-206”

And ACA repeal/replace talking points.

Medi-Cal Managed Care Task Force
The Task Force, thirty-one members, was comprised of local Medi-Cal managed care health plans
(Local Initiatives and County Organized Health Systems - COHS), community health centers
represented by their consortia, medical groups, county health systems and hospitals. The Task Force
convened to identify best practices and highlight areas for continuing focus at local and state levels to
improve the delivery of coordinated, high quality, appropriate and efficient health care.

In October 2016, they issued their report, “Medi-Cal Task Force: Promoting Accessibility and
Sustainability of Medi-Cal in Local Communities”.

Please see the attachment, the recommendations are highlighted.

Pending State Legislation
Presently, CHA is monitoring 30 plus bills that impact hospitals for this legislative season. We
expect legislation targeting executive compensation and community benefit.
Impact of ACA Medicare Productivity & Other Market-Basket Reductions for the Inpatient Prospective Payment System and Total ACA Medicare and Medicaid DSH Reductions: FY 2018 – 2026

January 2017

Rep. Nancy Pelosi – 12th District

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Sum of Impact of ACA Medicare Productivity and Other Market-Basket Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>California Pacific Medical Center - Davies Campus</td>
<td>-$21,189,780</td>
</tr>
<tr>
<td>California Pacific Medical Center - Pacific Campus</td>
<td>-$142,051,587</td>
</tr>
<tr>
<td>California Pacific Medical Center - St. Luke's Campus</td>
<td>-$20,215,310</td>
</tr>
<tr>
<td>Chinese Hospital</td>
<td>-$8,297,699</td>
</tr>
<tr>
<td>Kaiser Permanente San Francisco Medical Center</td>
<td>-$18,108,674</td>
</tr>
<tr>
<td>Laguna Honda Hospital and Rehabilitation Center</td>
<td>-$458,124</td>
</tr>
<tr>
<td>Saint Francis Memorial Hospital</td>
<td>-$37,297,921</td>
</tr>
<tr>
<td>St. Mary's Medical Center San Francisco</td>
<td>-$50,783,228</td>
</tr>
<tr>
<td>UCSF Medical Center</td>
<td>-$343,857,954</td>
</tr>
<tr>
<td>Zuckerberg San Francisco General Hospital and Trauma Center</td>
<td>-$75,308,311</td>
</tr>
<tr>
<td><strong>District Total</strong></td>
<td><strong>-$717,568,588</strong></td>
</tr>
<tr>
<td><strong>Total Impact of ACA Medicare and Medicaid DSH Reductions in California (millions)</strong></td>
<td><strong>-$23,199</strong></td>
</tr>
<tr>
<td><strong>California State Total</strong></td>
<td><strong>-$14,024,880,821</strong></td>
</tr>
</tbody>
</table>
## Impact of ACA Medicare Productivity & Other Market-Basket Reductions for the Inpatient Prospective Payment System and Total ACA Medicare and Medicaid DSH Reductions: FY 2018 – 2026

January 2017

Rep. Jackie Speier – 14th District

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Sum of Impact of ACA Medicare Productivity and Other Market-Basket Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Permanente Redwood City Medical Center</td>
<td>-$3,556,284</td>
</tr>
<tr>
<td>Kaiser Permanente South San Francisco Medical Center</td>
<td>-$4,203,967</td>
</tr>
<tr>
<td>Mills-Peninsula Health Services</td>
<td>-$66,972,535</td>
</tr>
<tr>
<td>San Mateo Medical Center</td>
<td>-$4,695,596</td>
</tr>
<tr>
<td>Seton Medical Center</td>
<td>-$49,236,448</td>
</tr>
<tr>
<td><strong>District Total</strong></td>
<td><strong>-$128,664,830</strong></td>
</tr>
<tr>
<td><strong>Total Impact of ACA Medicare and Medicaid DSH Reductions in California (millions)</strong></td>
<td><strong>-$23,199</strong></td>
</tr>
<tr>
<td><strong>California State Total</strong></td>
<td><strong>-$14,024,880,821</strong></td>
</tr>
</tbody>
</table>
Revisiting the Affordable Care Act - Talking Points

California hospitals have long supported affordable health coverage for all Californians. CHA’s priority is preserving coverage for the 3.7 million Californians and 21 million Americans who gained coverage under the Affordable Care Act (ACA) through the Medicaid expansion, and millions more who purchased insurance because of the premium subsidy.

CHA supports keeping existing coverage for millions of Californians until a viable replacement is passed by Congress and signed into law.

Key delivery system reforms, adequate payment rates and quality improvement efforts must be maintained.

If policymakers choose to repeal the ACA without offering a replacement bill, it is essential that they either put the savings from repeal into a reserve fund to be used for future replacement efforts, or eliminate the payment reductions for hospital services that were part of the ACA.

- A new study from Dobson|DaVanzo found that, if the ACA is repealed without an accompanying bill providing simultaneous coverage, the net impact to hospitals nationwide from 2018 to 2026 would be $165.8 billion from the loss of coverage.

- Hospitals also sustained reductions — as did other stakeholders — under the ACA that were redeployed to help fund coverage for millions of Americans. The Dobson | DaVanzo study found that, if the ACA is repealed and Medicare inflation update reductions for inpatient and outpatient hospital services are not restored, funding would be reduced by $289.5 billion between 2018 and 2026 nationwide (more than $50 billion in cuts to California hospitals)

- On top of that, failing to fully restore both Medicare and Medicaid disproportionate share Hospital (DSH) payments would add another $102.9 billion in cuts to hospitals.

- The combined losses from the Medicare and Medicaid cuts cited above, $50 billion in California, would be devastating. Many hospitals’ viability would be threatened, and millions of Californians would lose access to care.

- The Medicare Payment Advisory Commission estimated in March 2016 that hospital Medicare margins would drop to an all-time low of negative 9 percent in 2016. Cuts described above could push the losses to an estimated negative 15 percent margin by 2026.

For many hospitals and health systems, these cuts are not sustainable.
Californians Gained Stability and Access to Health Care From the Medicaid Expansion

- 1 in 3 California residents rely on Medi-Cal for coverage
- 3.7 million children, family members and seniors gained coverage through the Medi-Cal expansion
- The Medi-Cal expansion provides coverage for more than an estimated 1 million children, nearly a half million seniors, and more than 1 million low-income working individuals
- The Medi-Cal expansion covers a diverse population, including nearly 2.4 million Latinos, African Americans and Asian Californians

December 8, 2016 coverage estimates include estimated allocations and distribution information from DHCS enrollment by county, age and ethnicity found on the DHCS website at www.dhcs.ca.gov.
PROMOTING ACCESSIBILITY AND SUSTAINABILITY OF MEDI-CAL IN LOCAL COMMUNITIES

Medi-Cal Task Force Report

Organized by Hospital Council of Northern and Central California And Hospital Association Of Southern California

OCTOBER 2016
ACKNOWLEDGMENTS

This task force is an example of the power to achieve change that starts with a common table where individuals who share in a mission, goal, or activity but work in separate sectors of endeavor come together. At the common table, the perspectives, experience, and knowledge of the participants combine to create comprehensive solutions with greater potential for successful implementation.

This effort required many people working together including coordinating significant activity behind the scenes. We offer special thanks to the following individuals.

Task Force Members

Project Facilitator, Guide, and Mentor
Bobbie Wunsch
Founder and Partner Pacific Health Group
bwunsch@pachealth.org/www.pachealth.org
415.459.7813

Project Managers
Martin Gallegos
Sr. Vice President, Policy Development and Communications
Hospital Association of Southern California
Mark Gamble
Sr. Vice President/COO
Hospital Association of Southern California
Art Sponseller
President/CEO
Hospital Council of Northern and Central California

Project Coordinators
Jeanne McAuliffe
Executive Office Coordinator
Hospital Council of Northern and Central California
Margaret O’Donnell
Executive Assistant
Hospital Association of Southern California

Project Advisors
Lynn Baskett
Special Projects Officer
Rebecca Rozen
Regional Vice President
Hospital Council of Northern and Central California
Amber Kemp
Vice President, Health Care Coverage
California Hospital Association
TABLE OF CONTENTS

EXECUTIVE SUMMARY ................................................................. 4

TASK FORCE REPORT ............................................................... 7

TOPICS AND DISCUSSION QUESTIONS ................................... 8

TASK FORCE DISCUSSION SUMMARY ..................................... 9

  Topic 1: Population Health and Social Determinants of Health
  Topic 2: Access and Workforce
  Topic 3: Patient Navigation, Care Coordination, and Patient Education
  Topic 4: Behavioral Health

NEXT STEPS AND RECOMMENDATIONS ............................... 11

  Recommendation 1: Local Coalitions
  Recommendation 2: Data Sharing, Analysis and Exchange and Expanded Use of Technology
  Recommendation 3: Population Health Management, Social Determinants of Health and Care Coordination
  Recommendation 4: Workforce Development Training and Education
  Recommendation 5: Behavioral Health

CONCLUSION .............................................................................. 14

2016 MEDI-CAL TASK FORCE MEMBERS ............................... 16
PROMOTING ACCESSIBILITY AND SUSTAINABILITY OF MEDI-CAL IN LOCAL COMMUNITIES

Medi-Cal Task Force Executive Summary

Purpose and Background:
The Medi-Cal program in California provides insurance for more than 13.5 million Californians – one in every three people. The current period of great change within health care is an opportunity to forge a future that brings diverse organizations together, acknowledges the strengths of all, and builds on those strengths.* Given a history of convening stakeholders on a variety of issues broader than those affecting just hospitals, the Hospital Association of Southern California (HASC) and the Hospital Council of Northern and Central California (Hospital Council) convened a broad stakeholder task force to strengthen ties among the participating stakeholders and deepen support for effective population health management models in the Medi-Cal program.

The Medi-Cal Task Force: Promoting Accessibility and Sustainability of Medi-Cal in Local Communities is comprised of local Medi-Cal managed care health plans (Local Initiatives and County Organized Health Systems - COHS), community health centers represented by their consortia, medical groups, county health systems and hospitals.

*Discussion and recommended actions in this report concluded in October 2016 before the election.

Task Force Structure and Topics:
The Task Force was organized as two simultaneous efforts: 1) a Southern California Task Force hosted by Hospital Association of Southern California, and 2) a Northern and Central California Task Force hosted by Hospital Council of Northern and Central California. After each Task Force meeting, the state associations represented by local Task Force Members received summaries and met to stay informed of the proceedings.

Both task forces identified the same topics for discussion at their first meeting. All subsequent meetings were organized around these issues.

Discussion Topics

- Population health and social determinants of health
- Access and Workforce
- Behavioral health
- Patient education, navigation and coordination

Cross-cutting topics:

- Data and metrics
- Health information exchanges (HIE)
- Financial incentives and new payment models.
Next Steps and Proposals for Moving Forward

There was strong consensus about the need for both local and state action in follow up to this series of meetings. There is work that each community can undertake with their local public Medi-Cal managed care health plan(s), their local hospitals, county health systems, community clinics and consortia as well as physician groups serving large numbers of Medi-Cal beneficiaries. Some solutions discussed by the Task Force rely on state level collaboration and policy action.

Recommendation #1 - Local Coalitions:

The task force agreed that local collaboration is an essential tool to improve the efficiency and effectiveness of systems of care. Locally, hospitals, community clinics, physician groups, county health systems and health plans can identify collaborative opportunities to improve local Medi-Cal systems and health outcomes. Building on existing local coalitions or convening a new local coalition to meet and act together is essential to strengthen coordination and address challenges identified.

Recommendation #2 - Data Sharing, Analysis and Exchange and Expanded Use of Technology:

The next frontier of technology improvement is to link and share information across health care organizations to improve care delivery. Local or regional data systems to collect, share and jointly analyze data are needed in every community to improve health care access and outcomes. Training for health care workforce is also essential to use technology tools effectively within their workflow. Beyond health care, technology-based tools and systems to identify, assess, and share information on beneficiaries’ social determinants of health, health status, and current access to social services are needed.

Recommendation #3 - Population Health Management, Social Determinants of Health and Care Coordination:

Health care systems are developing new approaches to assess social determinants of health, connect clinical and community services and implement non-traditional partnerships such as health and housing to improve outcomes. Partners can collaborate to create a local road map among hospitals, county health systems, community clinics, physician groups and health plans to move to a population health management agenda. The DHCS Coordinated Care Initiative, Health Homes program and Whole Person Care pilots are important near-term opportunities to gain experience.

Recommendation #4 - Workforce Development:

Local coalitions can address the region’s most pressing workforce needs by creating a local workforce priorities action plan and collaborating on its implementation. Workforce challenges will benefit significantly from state leadership as well as federal and state investment in the health career pipeline in schools. In addition, expanded intern and residency programs for physicians and mid-level providers, and expansion of the National Health Service Corps and loan repayment programs will help overcome workforce shortages. An ambitious yet significant opportunity rests in state level collaboration to change policy related to the scope of practice for certain members of the care team. There is also an opportunity to identify strategies to expand training and career tracks to increase the impact of the current workforce.
**Recommendation #5 - Behavioral Health:**

The high prevalence of behavioral health conditions and the fragmentation of physical health, mental health and substance use disorders services results in high costs and poor health. Local partners can identify promising practices for adoption across systems to clarify roles and responsibilities of counties, health plans, hospitals, and community clinics, and to coordinate, provide and pay for mental health and substance use disorders services. State leadership is essential to clarify behavioral health regulations and definitions and accelerate local integration of behavioral health services into primary care and primary care into behavioral health settings to improve outcomes.

**Conclusion**

The time for action is now. The next steps proposed by the Medi-Cal Task Force represent a road map of practical steps for change that are feasible and important. Even in this time of heightened uncertainty, the recommendations serve as an important guide to health system improvements. The work begins with the convening of local community partners to identify areas of collaboration and joint action. Partners can address and improve local health systems through coalition-building with social service agencies to address social determinants of health, participating in health information exchange, streamlining care coordination locally, improving behavioral health integration and supporting workforce pathways into health care. There is no better group to meet the challenge of this urgent work than the local providers and local health plans in our diverse communities around the state.

*NOTE: Discussion and recommended actions in this report concluded in October 2016 before the election.*
PROMOTING ACCESSIBILITY AND SUSTAINABILITY OF MEDI-CAL IN LOCAL COMMUNITIES

Medi-Cal Task Force Report

Purpose and Background:

The Medi-Cal program in California provides insurance for more than 13.5 million Californians – one in every three people. Nearly 80 percent of the Medi-Cal beneficiaries are in managed care plans and most of those in are in local public plans. Safety net providers and traditional Medi-Cal providers provide most of the care to the beneficiaries; and their role is growing. Over the coming years, payment reform will move reimbursement from visit-based payments to a focus on value. The ability of the partners in the health care system locally to succeed in effectively managing care for this population is critical to creating a sustainable and comprehensive delivery system that is coordinated, integrated and promotes health and wellness across the care continuum.

The current period of great change within health care is an opportunity to forge a future that brings diverse organizations together, acknowledges the strengths of all, and builds on those strengths.* With this in mind, and given a history of convening stakeholders on a variety of issues broader than those affecting just hospitals, the Hospital Association of Southern California (HASC) and the Hospital Council of Northern and Central California (Hospital Council) convened a broad stakeholder task force to strengthen ties among the participating stakeholders and deepen support for effective population health management models in the Medi-Cal program.

The Medi-Cal Task Force: Promoting Accessibility and Sustainability of Medi-Cal in Local Communities is comprised of local Medi-Cal managed care health plans (Local Initiatives and County Organized Health Systems - COHS), community health centers represented by their consortia, medical groups, county health systems and hospitals. The Task Force convened to identify best practices and highlight areas for continuing focus at local and state levels to improve the delivery of coordinated, high quality, appropriate and efficient health care.

*Discussion and recommended actions in this report concluded in October 2016 before the election.

Task Force Structure and Membership:

The Task Force was organized as two simultaneous efforts: 1) a Southern California Task Force hosted by Hospital Association of Southern California (HASC), and 2) a Northern and Central California Task Force hosted by the Hospital Council of Northern and Central California (Hospital Council). The two efforts operated consistently in terms of meeting planning, meeting agendas, and topics. The Task Force met four times between June and October 2016. Organizations were generally represented by their CEO. A list of the Task Force members is included as Attachment A. The Task Force report is issued jointly to represent the work of both groups.
After each Task Force meeting, the state associations represented by local Task Force Members received summaries and met to stay informed of the proceedings. This group included California Primary Care Association (CPCA), California Children’s Hospital Association (CCHA), California Association of Physician Groups (CAPG), Local Health Plans of California (LHPC), Private Essential Access Community Hospitals (PEACH), California Association of Health Plans (CAHP), California Medical Association (CMA), California Association of Public Hospitals and Health Systems (CAPH), California State Association of Counties (CSAC), California Association of Health Facilities (CAHF), District Hospital Leadership Forum (DHLF) and California Hospital Association (CHA).

**Topics and Discussion Questions**

Members of the Task Force held an initial meeting to identify shared challenges and opportunities for collaboration. Many consistent issues surfaced through small group discussions across sectors, including:

- Complex care management
- Data sharing
- Provider availability
- Social determinants of health
- Health literacy/patient education
- Behavioral health integration
- Financial models
- Payment reform and value-based outcomes
- Population health best practices
- Skilled nursing facility arrangements
- Disease management and care coordination
- Care transitions
- Technology to look at managing patients across systems of care
- Emergency Department navigation and discharge planning
- Work with counties on Substance Use Disorder Services Waiver

The issues were grouped into four topics for in-depth discussion through a series of Task Force meetings. In addition, three cross-cutting issues were discussed as part of each topic. Task Force meeting discussions were informed by best practice presentations identified by Task Force members and advance reading materials. The following section outlines highlights of these discussions.

**Discussion Topics**

- Population health and social determinants of health
- Access and Workforce
- Behavioral health
- Patient education, navigation and coordination
Cross-cutting topics:

- Data and metrics
- Health information exchanges (HIE)
- Financial incentives and new payment models.

Task Force Discussion Summary

**Topic 1: Population Health and Social Determinants of Health**

**Discussion Questions:**

- How do population health and social determinants of health impact the health status of our Medi-Cal members and patients from your perspective?
- What are the key issues we should focus on in this area?
- In what ways, can our sectors work together to improve population health for our Medi-Cal members and patients?

**Discussion Highlights:** Social and environmental factors are significant determinants of health and lead to potentially preventable morbidity and premature mortality. Access to services is essential, however, to be effective, we need to be strongly committed to population health and social determinants of health. This means moving from an episodic approach to a continuous model of care. New payment methodologies and payment reform are needed to address social determinants of health. Comments included:

- Local leadership is necessary to bring stakeholders together to move from the way health care is delivered today to a population health management approach.
- Shared understanding and clear definitions of population health are needed.
- Broad screening tools to assess needs are critical.
- Payment reform pilots offer an opportunity to learn about financing to support population health.
- Sharing information and data across systems, HIE, is critical.
- Role of case managers and care coordinators needs to be clarified. The health plan is accountable but many members/patients have multiple care managers and fragmented, overly complicated care coordination resulting in less effective care.
- Patient navigation in the emergency department is needed.
- The Whole Person Care pilots, Health Homes program (ACA 2703) and the Coordinated Care Initiative (CCI) are key to starting this work together.
- Local EMS agencies (LEMSA) need to be incorporated into the discussion.

**Topic 2: Access and Workforce**

**Discussion Questions:**

- How do issues of workforce supply impact access to care?
- What key issues in workforce and access are most important for us to focus on together?

**Discussion Highlights:** Workforce shortages are impacting every level of health care. There is a shortage of primary care providers, specialists and care team workforce. The resulting barriers to
primary care access leads to patient frustration, delays in treatment, inappropriate ED visits, provider burn-out and competition for existing workforce. Comments included:

- Regular collaborative meetings are needed to develop a local plan of action on workforce.
- Collective advocacy for an increase in National Health Service Corps and loan repayment programs should be considered.
- Health plan subsidies to recruit providers may work.
- Current financing methodologies do not support team-based care.
- Specialty care access is a challenge and telehealth/e-consult expansion is needed.
- Workforce shortages in key specialties, such as cardiology, pulmonary medicine, vascular surgery and neurology are growing and will further limit access to prompt outpatient care. These shortages exacerbate efforts to intervene early. Poor access to care can lead to disease progression, higher morbidity and increased hospitalization.
- Explore the scope of practice for members of care teams; more clearly define appropriate functions within care management teams; utilize local training for medical assistants to create career tracks.
- Work with educational partners to increase capacity to train health care workers at all levels including physicians, nurses and other staff.
- Work with schools to increase the number of students in the pipeline for health careers.
- Engage community leaders to work with and support recruitment and retention of provider candidates including, but not limited to, Chambers of Commerce, Rotary and other service organizations, law enforcement, and banks who may provide discounted home mortgages.

**Topic 3: Patient Navigation, Care Coordination, and Patient Education**

**Discussion Questions:**

- How can improved patient education, navigation and coordination improve appropriate access to care?
- What key issues in the area are most important for us to focus on together?
- In what ways, can our sectors work collaboratively to improve access to care through changes in how we implement patient education, navigation and coordination programs?

**Discussion Highlights:** It is important to focus on high utilizers through data driven identification and we need high touch care coordination for high need patients. Hospitals have begun to document the need for patient education and navigation as well as identify solutions. Hospitals report that a small number of patients (3-5%) can represent high levels of ED visits and costs. Presenting conditions are hypertension, anxiety, diabetes, abdominal pain, chest pain, asthma, smoking-related diseases and drug and alcohol abuse, and 70 percent of the patients in the report were Medi-Cal. Comments included:

- Identify and implement tools to connect providers, navigators and care coordinators/managers.
- Focus on specific populations and identify the high need utilizers.
- Think about new ways to engage and educate the patients to navigate the system, e.g. promotoras or care navigators.
- Develop standard protocols to work with the high utilization patients.
- Notify primary care providers and health home of patients upon hospital admittance and discharge.
• Use data to drive changes and where case managers/care coordinators focus their work.
• Hold case conferences between sectors monthly to talk about common patients and systems problems sectors and re-emphasize the cross-sector sharing of information as it goes beyond health services to keep the patients stable.
• Share data between hospitals, clinics, health plans and others using HIPAA compliant systems.
• Coordinate across health and social support services.
• Offer adult care through school based health centers.
• Ensure individuals discharged from jail are released with sufficient medication to last until they can see a provider.

**Topic 4: Behavioral Health**

**Discussion Questions:**

- How do behavioral health conditions impact the health status of our Medi-Cal members, patients and our institutions from your perspective?
- What are the key issues we should focus on in this area?
- In what ways, can our sectors work together to improve access to behavioral health services for our Medi-Cal members and patients?

**Discussion Highlights:** The prevalence of mental health needs is staggering - about 20% of adults face mental health issues and 1 in 7 over age 12 have drug issues. These are complex conditions and diseases to treat. Siloed funding and access to care are challenges. Comments included:

- Stigma exists for both patients with behavioral health conditions and providers.
- Look at co-location whether it is primary care or behavioral health and where patients can be treated.
- Needs include psychiatric consultations to support the PCP, expanding the role of tele-psych and tele-health, data sharing, and incentivizing training for PCPs.
- Many isolated efforts were described. There is a need to cross barriers, and find ways to overcome data exchange barriers. There is also need to address the stigmas in the mental health arena and workforce issues. How can the health plans leverage their role in all of this? How can we leverage resources to better address these issues?
- FQHC payment limitations that prohibit reimbursement for behavioral health and primary care services on the same day are a barrier to continuity of care and effective, timely delivery of behavioral health services.
- Payment structures and other regulatory differences between counties increase the difficulty and complexity in coordinating care.

**Next Steps and Proposals for Moving Forward**

Many common themes and proposals for moving ahead emerged across the northern and southern California task force meetings stimulated by the discussion topics.

There was strong consensus about the need for both local and state action in follow up to this series of meetings. Members voiced a sense of urgency that the momentum, collaboration across the health care systems and open exchange of best practices evident in this series of meetings should continue locally.
There is work that each community can undertake with their local public Medi-Cal managed care health plan(s), their local hospitals, county health systems, community clinics and consortia as well as physician groups serving large numbers of Medi-Cal beneficiaries.

Some of the potential solutions discussed by the Task Force rely on state level collaboration and policy action. Particularly in the areas of workforce, health information exchange and behavioral health, state policy and leadership are required. Regular communication from local partners to state associations, especially about local successes and challenges, is important to connect state policy to local efforts.

These recommendations represent the work of the entire task force. The recommendations are not binding on any individual participating or on any association to which they may belong. To the extent that recommendations may either directly or indirectly require governmental advocacy at the local, regional, state, or federal level, each organization represented on the task force and its respective associations must independently decide whether to pursue such changes in governmental policy.

**Recommendation #1 - Local Coalitions:**

- The task force agreed that local collaboration is an essential tool to improve the efficiency and effectiveness of systems of care. Locally, hospitals, county health systems, community clinics, physician groups, county public hospital and health systems and health plans can identify collaborative opportunities to improve local Medi-Cal systems and health outcomes for Medi-Cal beneficiaries.
- Building on existing local coalitions or convening a new local coalition to meet and act together is essential to strengthen coordination and address the challenges identified. These coalitions can be co-convened to signify the coming together of the sectors represented on the task force and different coalitions might be necessary to bring different voices to the table. Whenever possible, existing groups can be used or expanded for this purpose.

**Recommendation #2 - Data Sharing, Analysis and Exchange and Expanded Use of Technology:**

- Technology has greatly advanced health care delivery within organizations. The next frontier is to link and share information across health care organizations to improve care delivery. To accomplish this, local or regional data systems to collect, share and jointly analyze data are needed in every community to improve health care access and outcomes. Moreover, training the health care workforce to use technology tools effectively within their workflow is essential. For example, the ability to provide beneficiary information routinely to contracted providers that includes emergency department utilization data, encounter data relative to primary care services, notice of pending care transitions, opportunities for case conferences, and similar notices and data sharing to support care coordination will improve outcomes. Beyond health care, implementing technology-based tools and systems to identify, assess, and share information on beneficiaries’ social determinants of health, current health status, and current access to needed social services is needed.
- Full participation of all Medi-Cal contracted hospitals, health plans, provider organizations and clinics in data sharing and exchange is an essential step to ensure that efforts to collect, share and jointly analyze data to improve health care access and outcomes are robust. A specific focus on reducing the barriers to data sharing of behavioral health information also is needed to realize effective service integration.
Both state and local attention is required to implement widespread telehealth strategies to expand access to timely patient care through telemedicine, more efficient workforce development and distance learning, and physician-to-physician consultation to improve care. The local health plans are key leaders in assuring that telehealth strategies can be successful.

**Recommendation #3 - Population Health Management, Social Determinants of Health and Care Coordination:**

- There is intense interest in improving population health and developing new strategies to address social determinants of health. Partners can collaborate to create a local road map among hospitals, county health systems, community clinics, physician groups and health plans to move to a population health management agenda. Health care systems are learning together and developing new approaches to assess social determinants of health, connect clinical and community services and implement non-traditional partnerships such as health and housing to improve outcomes. The DHCS Coordinated Care Initiative, Health Homes program and Whole Person Care pilots are important near-term opportunities to gain experience and spread best practices locally on population health management. Active exchange about the successes and challenges locally and statewide will improve population health across the state.

- This effort may include adopting models of “high touch” care and coordination for high utilizers that are data-driven, address underlying causes of poor health, expand local patient navigation programs and activate patients in their own health improvement. Collaborative investment in technology-based systems that identify, assess and share information on social determinants of health and population health across health and social services are essential for success.

- A streamlined and more efficient approach to care for high need populations also requires that case managers, discharge planners and care coordinators across the health system continuum of care meet regularly and decrease the siloed focus and overlapping responsibilities of multiple case managers. For care coordination to be effective, there is urgent need to address temporary shelter, permanent housing, safe places to discharge and provide follow up care for high need patients that include co-located supportive services, behavioral health and addiction medicine.

- Special emphasis should be placed on timely communication among health plans, hospitals, clinics, physicians, Emergency Medical Services (LEMSA) Agency (ies) and, where appropriate, law enforcement at the points of transition and warm handoffs. For example, local partners could work with local EMS agency (ies) to identify opportunities to implement alternative destinations and treatment models for beneficiaries entering the 911 system without true emergencies, such as referral to local nurse advice line. Timely communication and alternative destinations for EMS will require state legislation and leadership from the respective state associations of task force members will be needed if this approach is to be successful.

**Recommendation #4 - Workforce Development, Training and Education:**

- Local coalitions can help address the region’s most pressing workforce needs by creating a local workforce priorities action plan and collaborating on its implementation. Strategies could include increasing the health career pipeline at local schools, health plan incentives for recruitment of new providers to local areas, discounted home mortgages in collaboration with local banks, and engagement of community leaders and civic organizations to attract local health care workforce.
Workforce challenges will benefit significantly from state leadership as well as federal and state investment in the health career pipeline in schools. In addition, expanded intern and residency programs for physicians and mid-level providers, expansion of the National Health Service Corps and loan repayment programs will also help overcome workforce shortages. Identifying statewide and regional workforce needs by professional category and connecting this information to the State Master Educational Plan will benefit all.

Conducting workforce education and training across sectors on social determinants of health, and population health management strategies as well as beneficiaries’ mental health and substance use conditions to reduce stigma with providers is an important local strategy. The Substance Use Disorders Services (SUDS) waiver is an opportunity to connect systems of care previously fragmented and very limited to achieve significant gains in overall health; however, workforce challenges and service gaps were identified that require both local and state attention in the immediate future. For example, many communities report a paucity of substance use disorders service options for youth; others do not have residential programs or detox options; still others lack sufficient provider capacity to meet local needs.

An ambitious yet significant opportunity to address workforce challenges rests in state collaboration to change policy related to the scope of practice for certain members of the care team. There is also an opportunity to identify strategies to expand training and career tracks to increase the impact of the current workforce.

**Recommendation #5 - Behavioral Health:**

- The high prevalence of behavioral health conditions and the fragmentation of physical health, mental health and substance use disorders services results in high costs and poor health. There is a role for both local and state attention to these challenges.
- Local partners can identify promising practices for adoption across systems to clarify roles and responsibilities of counties, health plans, hospitals, and community clinics, and to coordinate, provide and pay for mental health and substance use disorders services.
- State leadership is essential to clarify behavioral health regulations and definitions and accelerate local integration of behavioral health services into primary care and primary care into behavioral health settings to improve outcomes.

**Conclusion**

Bringing together at the local level Medi-Cal managed care health plans, community clinics, county health systems and hospitals and physician groups was long overdue, evidenced by the strong interest and enthusiasm in this Medi-Cal Task Force. Over the course of meetings, participants engaged in ever-deepening interaction and growing inspiration about the significant impact to be achieved through more coordinated, efficient local health systems, local alignment of county and state initiatives (such as homeless efforts) and consumer-centered care. With one in three Californians enrolled in the Medi-Cal program, there is a clear imperative for action.

The time for action is now. The next steps proposed by the Medi-Cal Task Force represent a road map of practical steps for change that are feasible and important. Even in this time of heightened uncertainty, the recommendations can serve as an important guide to health system improvements. The work begins with the convening of local community partners to identify areas of collaboration and joint action.
Partners can address and improve local health systems by building coalitions with social service agencies to address social determinants of health, participate in health information exchange, streamline care coordination locally, improve behavioral health integration and support workforce pathways into health care. There is no better group to meet the challenge of this urgent work than the local providers and local health plans in our diverse communities around the state.

NOTE: Discussion and recommended actions in this report concluded in October 2016 before the election.
Southern California

- John Baackes, LA Care Health Plan
- Ron Boatman, Arrowhead Regional Medical Center
- Patrick Brilliant, Riverside Community Hospital
- June Collison, Community Hospital of San Bernardino and IEHP
- Steve Foster, Barstow Community Hospital
- Bob Freeman, CenCal
- Brad Gilbert, MD, Inland Empire Health Plan
- Deneen Hadley, Dignity Health
- Rodney Hanners, Keck Hospital USC
- Yair Katz, Long Beach Memorial Medical Center
- Mayla Krebsbach, Aurora Vista Del Mar Hospital
- Alex Li, MD, Los Angeles County Department of Health Services
- Darren Lee, St. John’s Regional Medical Center/St John’s Pleasant Valley Hospital
- Tom Loats, St. Joseph Hospital, Orange
- Tarek Mahdi, Inland Empire Health Plan
- Louise McCarthy, Community Clinic Association of Los Angeles County
- John McNamara, MD, Torrance Memorial Medical Center
- Taryn O’Connell, Cottage Health System
- Mark Refowitz, Orange County Healthcare Agency & CalOptima Chairman of the Board
- Suzanne Richards, KPC Health/Orange County Global Medical Center
- Sandra Reilly, Pomona Valley Hospital Medical Center
- Michael Rembis, Avanti Hospitals
- Joe Ruggio, MD, CalOptima Physician Network
- Zareh Sarrafian, Riverside University Health System - Medical Center
- Michael Schrader, CalOptima
- Martin Serota, MD, Alta Med Corporation
- Deanna Stover, Community Clinic Association – San Bernardino
- Doug Sturnick, Cedars-Sinai Medical Center
- LuAnn Talley, Providence Health & Services – Southern California
- Henry Tuttle, Health Center Partners of Southern California
- Gus Valdespino, Valley Presbyterian Hospital
- Dale Villani, Gold Coast Health Plan
- Beth Zachary, Adventist Health, Southern California Region/AH/Southern California Network
Northern and Central California

- Hakeem Adeniyi, Jr., MD, La Clinica Great Beginnings, North Vallejo - Vallejo Medical
- Maya Altman, Health Plan of San Mateo
- Dolores Alvarado, Community Health Partnership (Santa Clara)
- Lynne Ashbeck, Community Medical Centers
- Doreen Bradshaw, Health Alliance of Northern California
- Scott Coffin, Alameda Alliance for Health
- Cathy Frey, Central Valley Health Network
- Elizabeth Gibboney, Partnership Health Plan of California
- John Gressman, San Francisco Community Clinic Consortium
- John F. Grgurina, San Francisco Health Plan
- Doug Hayward, Kern Family Health Care
- Gregory Hund, CalViva Health
- Mary Jo Jacobson, San Joaquin Valley Rehab Hospital
- Daryn Kumar, Memorial Medical Center
- Bert Lubin, MD, UCSF Benioff Children's Hospital Oakland
- Alan McKay, Central California Alliance for Health
- Robert Minkin, Saint Louise Regional Hospital
- David O’Brien, MD, St. Joseph Health
- Lex Reddy, St. Rose Hospital
- Rene G. Santiago, Santa Clara Valley Health & Hospital System
- Shelly Schlenker, Dignity Health
- Sandy Sharon, Kaiser Permanente
- Amy Shin, Health Plan of San Joaquin
- Suzie Shupe, Redwood Community Health Coalition
- Ralph Silber, Alameda Health Consortium
- Todd Suntrapak, Valley Children’s Hospital
- Patricia Tanquary, Contra Costa Health Plan
- Christine Tomcala, Santa Clara Family Health Plan
- Melanie Tuberville, Bakersfield Memorial Hospital
- Bill Walker, MD, Contra Costa Health Services
- Louis Ward, Mayers Memorial Hospital
- Daniel Wolcott, Lodi Memorial Hospital
For Newly Appointed, Recently Hired Health Care Managers and Supervisors

SACRAMENTO
UC Davis Health System
4800 2nd Avenue, Room 2030, Sacramento
Sessions: February 28, March 29, May 9, June 6, June 22, July 20
8:00 am - 5:00 pm

LEAD Academy Trains Managers To Be Successful Leaders

LEAD Academy empowers recently hired, newly appointed or previously untrained health care leaders to better understand and use their strengths. Designed for health care supervisors and managers, LEAD is built on the underlying principle that effective leadership requires productive relationships to support excellence in patient care, sustainable business objectives and a safe patient environment.

LEAD Academy utilizes innovative tools and experiential learning, over a comprehensive six-session, 12-module course, to provide a safe environment to practice newly learned skills and align work goals and actions to support the broader vision of the organization. Engaging activities guide participants through the process of understanding differing leadership styles and overcoming the distinct challenges of being a leader.

Specific program focus areas include:
• Self-development
• Supporting the development of others
• Managing and developing a successful organization

Registration Fees
Hospital Council Members
Entire Track (six sessions): $1,950
Non-acute Stakeholders (post-acute facilities, community clinics)
Entire Track (six sessions): $2,500

Questions
If you have questions about this program, please call Constance Cheong at (925) 746-1552 or email ccheong@hospitalcouncil.org.

Register Today, Space is Limited!
www.hospitalcouncil.org/lead-academy
LEAD Academy Trains Managers To Be Successful Leaders

LEAD Academy empowers recently hired, newly appointed or previously untrained health care leaders to better understand and use their strengths. Designed for health care supervisors and managers, LEAD is built on the underlying principle that effective leadership requires productive relationships to support excellence in patient care, sustainable business objectives and a safe patient environment.

LEAD Academy utilizes innovative tools and experiential learning, over a comprehensive six-session, 12-module course, to provide a safe environment to practice newly learned skills and align work goals and actions to support the broader vision of the organization. Engaging activities guide participants through the process of understanding differing leadership styles and overcoming the distinct challenges of being a leader.

Specific program focus areas include:
- Self-development
- Supporting the development of others
- Managing and developing a successful organization

Registration Fees

<table>
<thead>
<tr>
<th>Hospital Council Members</th>
<th>Non-acute Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entire Track (six sessions): $1,950</td>
<td>Entire Track (six sessions): $2,500</td>
</tr>
</tbody>
</table>

Questions

If you have questions about this program, please call Constance Cheong at (925) 746-1552 or email ccheong@hospitalcouncil.net.

Registration opens February 1

www.hospitalcouncil.net/lead-academy
Mark your calendar and plan to join us at the Annual Summit in 2017.

09/27-29/17

You are invited to join us for the 2017 Summit.

Network with your colleagues over three days with the Sierras as your backdrop and scenic Lake Tahoe just minutes away.

The Summit will convene national experts and industry thought leaders who recognize that we have the opportunity to influence change, challenge conventional wisdom, encourage new ways of thinking and develop a visionary approach to the future of health care.

The Hospital Council has a negotiated group rate of $219/$249/$269 (depending upon type of room) with the Resort at Squaw Creek. There are a limited number of discounted rooms available until sold out or September 5, 2017. Please note that the Resort requires one nights’ deposit to make a reservation and it is refundable up to 72 hours before arrival date. To make a reservation click here or call 1-800-403-4434.

Please note the Summit kicks off with the Welcome/CHPAC Reception on Wednesday, September 27 at 5:00 PM and ends Friday, September 29, at 11:00 AM.

For more information and to register to attend, visit: www.hospitalcouncil.net/annual-summit