Aggregate Public Hospital System Annual Report on California's 1115 Medicaid Waiver's Delivery System Reform Incentive Program Demonstration Year 7

Submitted November 14, 2012
Revised March 26, 2013

EXECUTIVE SUMMARY

I. Introduction

California's Section 1115 Medicaid Demonstration Waiver, entitled "California's Bridge to Reform" (Waiver II-WOO 193/9), was approved by the federal agency, Centers for Medicare & Medicaid Services (CMS), for funding from November 1, 2010, through October 31, 2015.

The timing of Waiver funding is critical, as this five-year, $10 billion, Waiver allows California's public hospital systems to prepare for the implementation of the Affordable Care Act (ACA), most of which takes effect in January 2014. The opportunity, and challenge, presented by the ACA is this: bring millions more Californians into coverage, and dramatically transform the healthcare delivery system to be more coordinated, efficient, and patient-centered, in order to meet the needs and demands of both newly covered and existing patients.

In order to support this transformation, the *Bridge to Reform* Waiver includes multiple components, including early coverage expansion to more than 500,000 low-income people through California's counties, a mandatory shift of Seniors and Persons with Disabilities from Medi-Cal fee-for-service to Medi-Cal managed care, and an incentive program to improve care delivery and patient health outcomes in 21 designated public hospital systems (DPHs).[1] This report addresses the last component listed, entitled *Delivery System Reform Incentive Program* (DSRIP) and is specific to the second year of the DSRIP, called Demonstration Year (DY) 7.[2] DY 7 covers the period July 1, 2011 – June 30, 2012. Additional information on the DSRIP, and the 21 California Public Hospitals that have the opportunity to receive funds through DSRIP, is provided below.

A. Overview of the Delivery System Reform Incentive Program

The DSRIP was developed within the framework of what CMS calls the "three-part aim": (1) better care for individuals, (2) better health for populations, and (3) lower growth in expenditures. The purpose of the DSRIP is to support DPHs' efforts to make meaningful improvements in the quality of care and the health of patients they serve. Up until 2010, DPHs had engaged in pilot projects to improve care and help ensure that patients were receiving quality care in the right setting. For example, prior to DSRIP, DPH clinics participated in improvement programs—often through the California Health Care Safety Net Institute (SNI) – to enhance care for patients with chronic conditions, by empanelling patients and providing them with regular, tailored care that would engage them in strategies to manage their conditions and reduce their usage of the emergency department. These early pilot projects, though successful, were not of the scope or scale needed to sufficiently address the imminent demands of health care reform. Therefore, the Waiver Special Terms and Conditions (STCs) specifically charged DPHs to develop five-year DSRIP plans that encompassed their entire system – outpatient, inpatient, primary, and specialty care – and commit to ambitious plans that will dramatically improve the services provided to patients. The plans were to be rooted in evidence-based medicine and in the lessons

[1] Please see Appendix A for a list of the 21 DPHs in California.

[2] This Demonstration Year (DY) is called DY 7 as Waiver funds build on a previous five-year waiver that covered the time period 2005-2010, and included DYs 1-5. DY 6, a part of this 1115 "Bridge to Reform" was funded from November 2010 – July 2011.

learned about successful ways to improve care in order to make DPHs more efficient, coordinated, and patient-centered.[3]

When approved in 2010, the scope of the DSRIP was unprecedented: if all DPHs meet each of their milestones, they are eligible for a total of $3.3 billion in federal incentive payments from 2010-2015. Each DPH must commit to providing the non-federal share of those incentive payments, meaning that the DPHs themselves have committed to spend more than $3 billion in order to participate in the DSRIP.

CAPH member hospital systems[4] were prime for participation in DSRIP because they are the center of the state's health care safety net, delivering care to more than 2.5 million Californians each year. They deliver 10 million outpatient visits per year and operate more than half of the state's top-level trauma centers and almost half of the state's burn centers. They provide almost one third of the care provided to California's Medi-Cal population and provide nearly half of all hospital care to the state's seven million uninsured residents. Public hospitals also have large residency and training programs, with forty-three percent of new doctors in the state trained in public hospitals. Once STCs for the DSRIP were approved in 2011, California's 21 DPHs submitted 17 five-year DSRIP plans[5] outlining their intended strategies for performance improvement to the State of California's Department of Health Care Services (DHCS) and to CMS. The plans describe in detail each DPH's commitment to demonstrate significant progress across four categories:

Category 1	Category 2	Category 3	Category 4
Infrastructure Development	Innovation & Redesign	Population-Focused Improvement	Urgent Improvements in Care

Within each of these four broad categories, DSRIP plans require each DPH to commit to multiple, large-scale projects that will transform patient care. On average, public hospital systems are carrying out 15 projects simultaneously, which span all four Categories noted above, with an average of 217 milestones per hospital system over five years. Projects in Categories 1 and 2 focus on planning, process

[3] Please see Waiver II-WOO 193/9, Section V(B)(c), at http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/CA%20Special%20Terms%20%20Conditions.pdf.

[4] Designated Public Hospitals (DPHs), as defined under the 2010 Section 1115 Medicaid Waiver, include the 18 CAPH member public hospital and health systems and three University of California Medical Center non-CAPH member hospitals that were not historically Disproportionate Share Hospitals (DSH) (i.e. UC Irvine, UC Davis, and UC San Diego). CAPH's membership is comprised of 18 public hospitals members eligible for DSH plus Laguna Honda. This includes only those UC medical centers that were historically eligible DSH.

[5] California's 21 DPHs submitted 17 DSRIP plans, as some were joint plans submitted by more than one DPH. For example, Los Angeles County Department of Health Services submitted one DSRIP plan encompassing Harbor/University of California Los Angeles Medical Center, Olive View/ University of California Medical Center, and Rancho Los Amigos National Rehabilitation Center. Similarly, University of California Los Angeles Medical Center submitted one DSRIP plan encompassing University of California Los Angeles Medical Center – Ronald Regan, and University of California Los Angeles Medical Center – Santa Monica. Throughout this report, language describing 21 DPHs and/or 17 DSRIP plans will be used interchangeably to reflect full participation in DY 7.

improvements and infrastructure building, while projects in Categories 3 an 4 are designed to address population health and outcomes. The DSRIP STCs specify that DPHs should emphasize projects in Categories 1 and 2 in the earlier years of the Waiver program, and Categories 3 and 4 in later years, so that the necessary structures and processes are in place to enable improved care and outcomes. As a result, in DY 6 and DY 7, plans tend to focus on projects that lay the groundwork for important delivery system transformation. In DY 8, 9 & 10, projects are more heavily tilted toward population health and outcomes milestones.

The DSRIP was intentional in setting expectations that individual projects within these four categories are interconnected, and oriented toward integrated care delivery. The STCs state that while "each improvement project is distinct, all of the proposed improvement projects are oriented to creating more integrated, coordinated delivery systems; and being an integrated delivery system allows DPH systems to more fully enact improved patient experience, population health and cost control."

To support cross-project connections, the STCs specifically require all DSRIP plans to describe how projects are related to and support the work of one another. In particular, for each Category 1 and 2 project, DPHs are required to describe how the project "supports, reinforces, enables, and is related to other projects and interventions within the DPH system plan."

The DSRIP is structured so that incentive payments are made only after a DPH reports achievement (or partial achievement) of a milestone. To measure ongoing progress, DPHs are required to submit three reports to the State for review each year (two semi-annual reports and one annual report). The reports include submission of data for each milestone, and are accompanied by a narrative description of overall project implementation progress. Together with the quantitative data, the report narratives provide insight regarding approaches taken to test, refine and improve upon specific interventions, as well as lessons learned, barriers that have been encountered, how those barriers have been addressed, and how projects have informed the modification and scaling up of other projects. Also, included in the annual report is a description of the degree to which each project contributed to the advancement of broad system reform, relevant to the patient population that was included in the DPH's DSRIP plan, and includes a section for highlighting each DPH's participation in shared learning.

For a list of California's DPHs, please see Appendix A: California's 21 Designated Public Hospital Systems.

B. Purpose of This Report

DSRIP protocols require an Aggregate Annual Report documenting progress made across all 21 DPHs, summarizing metric reporting, shared learning activities, outcome data (if applicable) and system-level change supported by the DSRIP.[6] This DSRIP Aggregate Report for DY 7 was written for this purpose. As such, this report is neither an evaluation nor an audit of the DSRIP; rather, it provides aggregate-level information based on the individualized DSRIP reports submitted to the State by the DPHs for the demonstration year, and illustrative examples from individual DPH reports.

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[6] Please see Waiver II-WOO 193/9, Attachment P, Section IV(3), at http://www.dhcs.ca.gov/Documents/CA_3_17_AttachmentP_DSRIP0001.pdf.

In addition to this introductory section, the DSRIP Aggregate Report for DY 7 includes the following sections:

- Section II describes the DPHs' reported aggregate results of progress for DY 7, including milestones accomplished for Categories 1-2, data reporting for some Category 3 measures, as well as baseline data and data reporting for Category 4 interventions
- Section III lists the multiple shared learning and innovation activities reported by the DPHs for DY 7; and
- Section IV draws general conclusions about the progress made toward system reform for DY 7, including conclusions reported by the DPHs.

As outlined above, DSRIP was intentionally designed such that each year of the program would build on work completed in prior years. Therefore, the specific information provided in each Aggregate Annual Report will vary slightly, depending on the specific project work of DPHs during the reporting year. For more detailed information on the DPHs' next steps (i.e., milestones and report content for DYs 8-10), please reference individual five-year DSRIP plans for each DPH.[7] Final results of the DSRIP program, including whether DPHs' initial goals were achieved, will be summarized in the Annual Aggregate Report for DY 10.

C. About the California Health Care Safety Net Institute

The STCs require that, annually, the State must compile reports documenting progress made detailing system change supported by DSRIP, and may retain a non-profit entity with the necessary expertise to do so. The State selected the California Health Care Safety Net Institute (SNI), who is providing the DSRIP Annual Aggregate Report based on SNI's expertise on California public hospital systems' quality improvement efforts, and experience in managing quality data. Established in 1999, SNI supports California's public hospital systems in the development and spread of innovative strategies, and helps DPHs obtain expertise and peer support, thereby enabling them to fully achieve their potential as integrated delivery systems.[8] For example, SNI conducts quality improvement programs with California DPHs specifically aimed at accelerating delivery system transformation in specific areas aligned with DSRIP such as Patient Experience, Patient-Centered Medical Homes, Building Performance Improvement Capacity, Lean, and reducing hospital acquired infections such as CLABSI and Sepsis.

SNI has vast experience working with DPH's quality and efficiency data, including publicly reported data. For purposes of benchmarking, trending and measuring progress toward meeting statewide public hospital system goals in quality improvement, SNI collects public hospital system data on clinical, process and outcome measures.[9] SNI regularly shares this data with public hospital systems and helps them analyze and interpret the data to identify opportunities for improvement.

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[7] Please see http://www.dhcs.ca.gov/provgovpart/Pages/DSRIP1.aspx.
[8] For more information, please see http://www.safetynetinstitute.org.
[9] Per the Waiver Terms and Conditions, "The State, in collaboration with the participating DPH systems, may retain a non-profit entity with the necessary expertise on California public hospital systems' quality improvement efforts and capacity to manage

II. Aggregate Results of Progress

A. Executive Summary

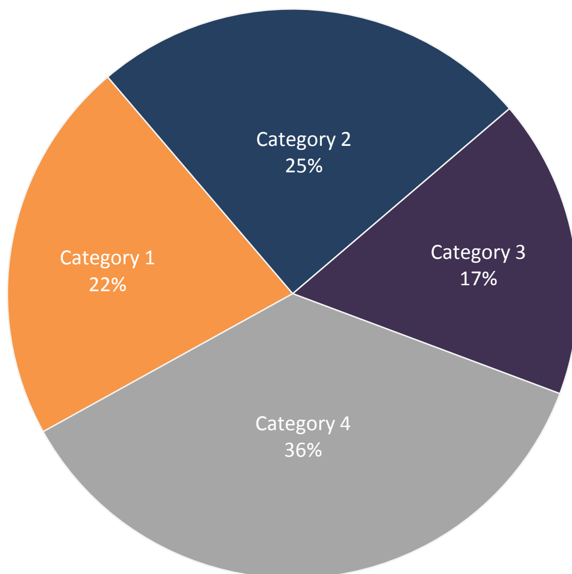
DPH reports submitted in DY 7 of the DSRIP reveal considerable progress toward the defined project goal of enhancing the quality of care and health of patients and families that are served by California's public hospital systems. Congruent with the original intent of DSRIP, during DY 7 investments were made to prepare staff and systems for change, laying necessary groundwork and building a strong foundation for accelerated progress in years 3-5 of the Waiver. As summarized by one DPH in their annual report, "looking back on DY 7 activities and accomplishments, it has been a year of preparing the ground and sowing seeds, with some early harvesting. There is still much work ahead to cultivate and tend these projects in years 8, 9 and 10; we look forward to realizing major system-level changes by 2015.[10]"

This Aggregate Report summarizes DY 7 progress by DPHs toward defined within each of the four DSRIP Categories, including:

- Category 1: Infrastructure Development
- Category 2: Innovation & Redesign
- Category 3: Population-Focused Improvement; and
- Category 4: Urgent Improvement in Care.

As illustrated in Figure 1 below, work was distributed across all four Categories during DY 7; a change from DY 6 which excluded work in Category 3.

Figure 1: Percentage of DY 7 Milestones per Category



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the data reports to assist in the development and management of the annual DPH aggregate progress report to be submitted to CMS." (Waiver II-WOO 193/9, Attachment P, Section IV(A)(3), at http://www.dhcs.ca.gov/Documents/CA_3_17_AttachmentP_DSRIP0001.pdf.

[10] Alameda County Medical Center, DY 7 Annual Report. Submitted 10/31/2012.

The deliberate design of DSRIP is to emphasize process-oriented work in the early years of the program, (largely within Categories 1 and 2), with a shift to outcome-oriented (largely Category 3 and 4 work) occurring in later years. The DSRIP is structured to emphasize the inter-relationship among projects within each DPH plan across the categories. For example, 13 DPHs in DY 7 achieved milestones to build, improve and spread medical homes, through empanelling patients with the aid of registries, and restructuring their clinics around the Care Model by bringing high risk patients in for visits before their medical conditions worsen. Many of those projects will be reflected in subsequent demonstration years in Category 3, which tracks progress in diabetes control, and other chronic conditions, for patients who have been seen at least twice in the prior year[11].

While only 47 percent of milestones in DY 7 reflect Category 1 and 2 projects, it is important to note that many of the Category 3 and 4 milestones in DY 7 are also process-oriented. Many Category 1, 2 and 3 milestones require DPHs to build the capacity to report outcome results to the State. This is an important process step that will facilitate outcomes-improvement in later years. For example, investment in registry implementation in DY 6 and 7 will pay off in spades and is integral to the success of many other related projects. Functional and user friendly registries will foster a culture of data driven improvement leading to improvement in category 3 metrics such as A1c and LDL control and inpatient admissions for diabetics. The registry will be a critical tool for medical homes as they transition to true population management. The registry will also be critical to the achievement of milestones in Expand Chronic Care Management projects. As another example, the Expand Medical Homes projects are multifaceted in nature. Significant time and effort in the early years of DSRIP is devoted to developing new job descriptions, creating new staffing models and ratios, and training staff on health coaching. These efforts will reap benefits in later years as non-provider staff will be skilled and empowered to take responsibility for population management through outreach, in-reach, and health coaching both within and outside the context of the PCP visit. This degree of population management, with the aid of registries and EHRs, is what will drive improvement in the category 3 population health and prevention measures in the latter years of DSRIP.

Separately, but concurrently, almost all DPHs in DY 7 were working to achieve meaningful use of electronic health records. Infrastructure development and optimization of EHRs/EMRs are efforts that are tied to incentive funding through the American Recovery and Reinvestment Act and are separate from the DSRIP itself. Most DPHs are in the beginning stages of Meaningful Use[12]. However, in many cases the adoption of EHRs had a demonstrable impact on DPH's delivery system reform efforts. For example, the University of California San Diego Health System established an electronic process to ensure that patients receive necessary preventive health screenings. Their EHR now contains alerts to providers regarding patients who are due for mammogram and pap smear screening. With the implementation of this electronic process, UCSD is able to promptly and accurately identify abnormal

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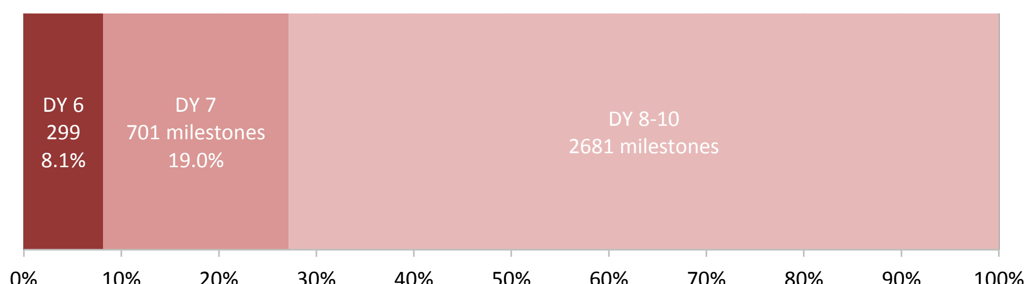
[11] Due to the fact that most DPHs are in the process of implementing electronic health records, it is not possible to track the relationship precisely between the patients seen in primary care medical homes and the data reported in Category 3 at this time.

[12] Please see Appendix D for a listing of inpatient and outpatient EHRs and disease registries in use among CA public hospitals. Please also see section 1.1 of this report for further information on DPH progress on implementing utilizing disease registries.

screening mammograms requiring clinical follow-up. In another example, San Mateo Medical Center (SMMC) has worked to streamline collection of Race Ethnicity and Language (REAL) data through the use of their EMR. Utilizing their EMR to collect this data has allowed SMMC to develop a process to ensure these data fields are not skipped during the registration process, thus providing a comprehensive data set upon which to target specific improvements in care.

In addition to an increase in the number of DSRIP Categories, DY 7 ushered in a significant expansion in the number of projects taken on by DPHs across the State.

Figure 2: Percent of Total DSRIP Milestones Completed in DY 6 and DY 7



As illustrated in Figure 2 above, work by DPHs to complete 701 project milestones in DY 7 represents 19% of the total project work that will be completed during the five years of the waiver (a total of 3,681 milestones have been identified for completion). In DY 7, the 21 participating DPHs reported an achievement value of 1 for 97 percent of the 701 milestones that they committed to achieving in their plans in DY 7. The deepened level of engagement by DPHs in DSRIP work for DY 7 is evident; the total amount of project work for DY 7 represents 234% of project work addressed by DPHs during the prior year (DY 6) when only 299 milestones were addressed.[13]

A review of DY 7 Annual Reports indicates that DPHs were successful in laying a strong foundation from which to build during the additional years of the DSRIP. Among many achievements, a sample of aggregate results achieved during the DY 7 reporting year, include:

- A nearly 30,000 increase in the number of primary care encounters provided
- Opening a total of 40 additional exam rooms
- Hiring over 35 additional primary care staff
- Assigning more than 300,000 patients to a medical home and/or primary care provider (PCP)
- Entering over 1 million patients into disease registry information technology (IT) systems

Achieving these results required DPHs to take a disciplined approach to quality improvement. DY 7 reports reveal that a variety of models were used across DPHs to expand and implement improved care processes, and that a primary driver of success was the ability to focus staff efforts on specific goals and objectives. For many systems, developing capacity to effectively use data to determine current performance levels was a critical component of DY 7 work. For others, effort was devoted to producing standard referral guidelines, which support panel management in primary care clinics as well as referrals

[13] Please see Appendix B for a complete listing of projects selected by DPHs, and the number of milestones completed in DY 7.

to specialty care. For DPHs without fully-functional Electronic Health Records (EHRs) or disease registry capabilities, focus was devoted to developing this necessary technology capacity.

There was also evidence of the DSRIP serving as a catalyst for greater cohesiveness across a DPH. One example is Alameda County Medical Center's (ACMC) System Transformation Center (STC), created to improve access and coordination of care across their system. The STC is responsible for ensuring that DSRIP projects and other system transformation projects are coordinated, synergistic, well documented, and spread throughout the organization. By aligning improvement efforts and improving communication across the organization, ACMC anticipates increased efficiency, a reduction in redundancy, and an opportunity to turn the frustration of multiple uncoordinated change efforts into the satisfaction of successful progress towards objectives. In DY 7, the STC was created, staffed and facilitated ACMC's participation in 3 non-mandated statewide learning collaboratives.

In another example, San Francisco General Hospital (SFGH) established a 10 month Quality and Leadership Academy with the goal of increasing the hospital's internal capacity for driving performance improvement and patient safety, as well as to provide on-site leadership development for key hospital staff in a multidisciplinary setting. Teams included in the training were selected based on alignment with Category 4 DSRIP projects and/or the SFGH Strategic Plan. The curriculum of the academy alternated sessions focused on leadership development with those focused on providing useful performance improvement tools.

Further, specific themes emerged across all four DSRIP Categories in DY 7, which reflect deliberate work by DPHs to develop the foundational capacity and operating systems necessary to support the level of delivery system transformation work outlined by the DSRIP. These include:

- Creating the necessary infrastructure to collect performance data and guide improvement efforts
- Analyzing data to focus and guide performance improvement work
- Clearly defining staff roles and responsibilities
- Adding staff and/or re-designing existing roles when necessary
- Conducting necessary staff training
- Standardizing (processes, protocols, workflows, checklists, order sets, alerts, etc.) when possible to ensure consistent, high-quality performance from all staff members, all of the time
- Identifying cross-project connections, using information gathered in one project area to inform work in another

In addition to the outcomes noted above, DPHs made a significant investment in shared learning activities during DY 7, by participating in educational and collaborative sessions designed to accelerate the rate of improvement while adding discipline and focus to DSRIP project work.

Viewed as a whole it is clear that the 701 DSRIP milestones completed through DY 7 lay a meaningful foundation that will support DPHs in providing patients with "the right care, at the right time, and in the

right setting[14]", by expanding access to care, enhancing quality, improving population health, and containing costs.

The full report can be found on the SNI website at www.safetynetinstitute.org.

[14] Riverside County Regional Medical Center, DY 7 Annual Report. Submitted 10/31/2012.