CALIFORNIA'S DELIVERY SYSTEM REFORM INCENTIVE PROGRAM

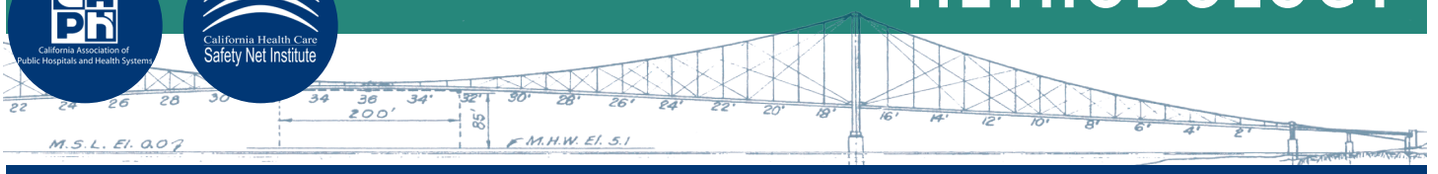
2010-2015

SUCCESSES TO BUILD ON

California Association of Public Hospitals and Health Systems

California Health Care Safety Net Institute

METHODOLOGY



DSRIP 2010-2015: SUCCESSES TO BUILD ON

This report features 6-10 projects from each health care system that participated in California's DSRIP, with descriptions that highlight one or more of the following:

- Impact on patients
- Unique or innovative methods of achieving results
- Scalability and/or replicability of pilot projects within a health care system
- Scalability and/or replicability across the health care landscape (leading by example)

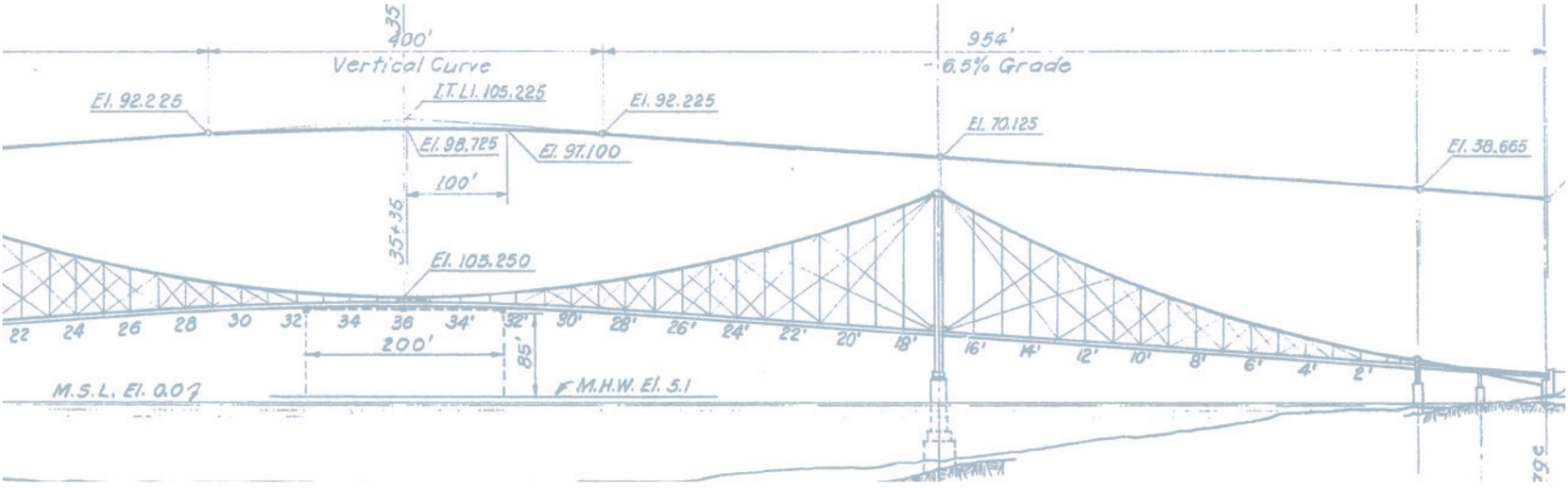
Most of the aforementioned projects allowed for quantitative analysis to determine cumulative impact. When such analysis was possible, the most recent available data was compared to pre-DSRIP or pre-project ("baseline") data. This data was compiled from various sources, including the following federally-filed documents:

- Each participating health care system's initial plan submission (filed in 2011)
- The statewide aggregate report for the first year of the DSRIP, known as Demonstration Year 6 (filed in 2012)
- Each individual system's annual Demonstration Year reports for:
  - DY7 (filed in 2012)
  - DY8 (filed in 2013)
  - DY9 (filed in 2014)
- Each system's first semi-annual report for Demonstration Year 10 (filed in 2015)

Supporting data was also collected from materials created by or about specific health care systems, including:

- Annual Board of Directors and/or Community Reports
- Media Reports
- Communications Briefs
- News Releases

Qualitative data was compiled through interviews at each system, including: senior leadership, communications officers, project leaders, clinicians, and quality improvement officers. Comparative data on county size/population and system capacity was compiled via census data and growth estimates, as well as the most recent available statistics for each health care system.



THE BRIDGE TO REFORM

In 2010, California's 21 public health care systems (PHS) took a bold and collective step to transform and streamline their complex delivery systems through a new federal pay-for-performance initiative. This initiative, called the Delivery System Reform Incentive Program (DSRIP), was the first of its kind in the nation. Since then, the Centers for Medicare and Medicaid Services (CMS) have approved DSRIPs in several other states.

The DSRIP was part of the package of programs that comprised California's 2010 Medicaid Waiver, titled "**The Bridge to Reform**."

The word "reform" in this case referred to the changes coming to American health care thanks to the Affordable Care Act (ACA). The waiver included two core components - the DSRIP and the Low Income Health Program (LIHP) - both of which were critical to California's leadership role in ACA implementation, and both of which had a considerable focus on expanding access to care.

But true reform is not a destination, it is a path. True reform is a much larger and more complicated goal than can be accomplished in five years.

True reform *is itself* a bridge - leading away from a purely reactive way of doing business and toward a model of integrated care that is high value, high quality, patient-centered, efficient and equitable, with an emphasis on patient experience and a demonstrated ability to improve health care and the health status of populations.

While access is certainly a cornerstone of that bridge, it is still only part of a structure that also includes changes in process and culture and a stronger emphasis on results.

To more fully understand where and how that bridge must take California's PHS, we must first understand how far we have come. The 2010 DSRIP has enabled California's PHS to build a solid foundation for continuous delivery system improvement. This brief is intended to help illustrate how California's DSRIP has already resulted in markedly improved processes and health outcomes for patients.

CALIFORNIA'S PUBLIC HEALTH CARE SYSTEMS

- Include county-owned and operated facilities and University of California medical centers
- Serve more than 2.85 million patients annually
- Provide 40% of all hospital care to the state's uninsured
- Provide 10 million outpatient visits each year
- Provide primary care to over ½ million of the state's newly eligible Medicaid enrollees
- Operate more than 100 outpatient primary and specialty clinics
- Operate more than half of California's top-level trauma and burn centers
- Train 57% of all new doctors in the state
- Are located in 15 counties where more than 80% of the state's population lives

COVER PHOTOS

1. Nurse and patient at San Mateo Medical Center in San Mateo, CA

2. Patients (and grandfather) at University of California San Diego Medical Center in San Diego, CA

3. Medical workers at Alameda Health System in Oakland, CA

4. Doctor and patient at Ventura County Medical Center in Ventura, CA

5. Operating room at Natividad Medical Center in Salinas, CA

DSRIP BACKGROUND AND CONTEXT

The DSRIP has both enabled and required PHS to make significant improvements in core delivery across their systems, in primary care, specialty care, inpatient and other settings.

On average, each PHS is carrying out 15 simultaneous projects, with an average of 217 milestones per year, spanning every part of their system.

Each DSRIP project is directly tied to performance milestones in five key categories (see page 6). PHS only receive incentive payments if these milestones are reached.

Each project undertaken by a PHS is reverberating throughout that system, and through peer learning, the effects of these projects are being felt across systems.

TRANSFORMING PRIMARY CARE STATEWIDE

The DSRIP has provided California's PHS a chance to transform their primary care systems from a reactive model focused on treating those who arrive with serious conditions, to a more proactive and preventative model that empanels patients into medical homes, tracks their health status using disease registries, and partners with patients to set self-management goals.

Thirteen of California's PHS undertook specific DSRIP efforts focused on **empaneling patients into medical homes,** meaning that patients are assigned to a primary care team at a clinic, so that their care can be more effectively managed. To date, these programs have empaneled more than **680,000 patients.**

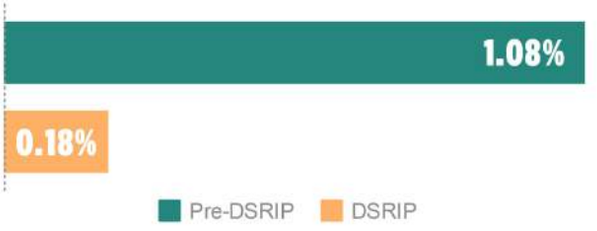
Once assigned to a medical home, patients with chronic conditions are **being entered into disease management registries** so that medical home provider teams can more systematically monitor and manage their patients' health. Eleven of the state's PHS have implemented and utilized such registries through the DSRIP, adding over **1 million patients.**

Seven PHS are further **strengthening their chronic disease management models** through the DSRIP, by improving communication with patients to establish self-management goals, training staff on the chronic disease management model, and offering coaching for diabetic patients. Those that reported self-management goals have increased the number of patients in their chronic disease programs with these goals by **nearly 40%.**

Medical workers at Riverside County Regional Medical Center in Moreno Valley, CA

A doctor and patient at Arrowhead Regional Medical Center in Colton, CA

As an example of how these projects are working together, throughout the course of the DSRIP, all of California's PHS have **decreased the rate of diabetes patients being hospitalized** for short term complications by **more than 20%,** and the percentage of diabetes patients with a diagnosis of "uncontrolled diabetes" dropped from 1% to 0.18% - **more than five times smaller** than what it had been.



Seven PHS embarked on projects focused on **expanding their primary care capacity,** including offering more weekend and evening appointments, increasing the number of patients assigned to primary care providers and improving panel management. Compared to the baselines established at the beginning of the DSRIP, these PHS are now seeing a total of almost **113,000 more patients** annually in a primary care setting – an increase of **18.5%.**

Five PHS have focused DSRIP projects on **expanding specialty care capacity** for services like optometry, dermatology, orthopedics, endoscopy, and many others. These five systems are now seeing **over 20,000** more specialty-care patients annually for a wide range of services, an average increase of **14%.**

BROADENING THE SCOPE OF CARE ACROSS CALIFORNIA'S PHS

All 21 of California's PHS have used the DSRIP as an opportunity to embrace population health by **improving their preventative health programs** within a few specific areas of focus, including pediatric weight screening and mammography.

Seven PHS are improving integration of physical and behavioral health with a focus on increasing screenings and co-locating services. Across these systems, **36 clinics** have successfully made behavioral health services and physical health services available at the same site. Among systems that report screening for behavioral health, **more than 70% of patients** who are seen for a specific physical health issue are now also being screened for depression.

Through their DSRIP programs, PHS have generated a **12% increase** in pediatric weight screening, with PHS now averaging a screening rate of **81%.**

To date, California's PHS have generated an overall **14.2% increase** in mammography screenings, now providing the service to more than **42,000 women** who otherwise would not have been screened based on previous rates.

ADDRESSING URGENT IMPROVEMENTS STATEWIDE

All of California's PHS have used the DSRIP to concentrate on **improving inpatient safety** through a focused effort to reduce hospital-acquired infections and complications.

All systems have undertaken efforts to prevent Central Line Associated Blood Stream Infections (CLABSI) and have averaged a **17% decline** in CLABSI in their Acute Care Units, and a **22% drop** in their Intensive Care Units.

Each PHS has also embarked on landmark efforts to reduce sepsis mortality, which is a unique part of the DSRIP, in that California has acted as a learning laboratory for a nascent national effort.

Sepsis-related activities have included educating and training staff, refining internal structures and systems, adhering to reporting guidelines, and increasing application of the "sepsis bundle," which is a specific set of elements of care, distilled from evidence-based practice guidelines that, when implemented as a group, have an effect on outcomes beyond implementing the individual elements alone.

The typical PHS increased its adherence to the sepsis bundle by **61%,** and experienced a **17% decrease** in sepsis mortality.

Eleven PHS have also focused on preventing Surgical Site Infections (SSI) and have collectively seen their rates more than **cut in half – from 3.4% to 1.4%**; well below the most recent national average of 1.9%.

Residents at Ventura County Health Care Agency in Ventura, CA

SUCCESSES TO BUILD ON

Taking into account the vast improvements that have been made thus far through the DSRIP, it is clear — both from the extensive work being done by these systems, and from the experience of other healthcare organizations across the country that have embarked on system-wide change efforts — that the journey of transformation is one not of just several years of hard work, but rather one that requires a decade or more of continuously focused, intentionally aligned efforts by each public health care system.

The last five years have laid the groundwork for transformation, by proving that delivery system reform incentive programs work, and by doing it in a way that will lead to even stronger outcomes if this momentum is maintained.

The next five years are critical for California's 21 public health care systems to build on this foundation, and more fully transform California's PHS into high performing health systems that provide timely access to safe, high-quality, and effective care for the millions of patients who rely on them.

Rehabilitation specialist and patient at Santa Clara Valley Medical Center in Santa Clara, CA

PROJECT CATEGORIES: CALIFORNIA'S DSRIP 2010-2015

FIVE KEY CATEGORIES OF DSRIP PROJECTS	
INFRASTRUCTURE DEVELOPMENT	Lays the foundation for delivery system transformation through investments in people, places, processes and technology (e.g., implementing disease management registries to enable more proactive, planned care). Each system selected at least 2 projects from a CMS-approved list of 11 project options.
INNOVATION & REDESIGN	Piloting, testing and replicating innovative care delivery models (e.g., expanding medical homes to enable more primary and coordinated care). Each system selected at least 2 projects from a CMS-approved list of 14 project options.
POPULATION-FOCUSED IMPROVEMENT	All systems are required to report on the same 21 measures spanning the following areas: patient experience; effectiveness of care coordination; prevention (e.g., mammogram rates and childhood obesity); and health outcomes of at-risk populations (e.g., blood sugar levels in patients with diabetes).
URGENT IMPROVEMENT IN CARE	All systems are working on reducing sepsis and central line associated blood stream infections, and each has selected at least two additional areas in which to improve inpatient safety.
HIV TRANSITIONS PROJECTS	Systems had the option of focusing on delivering high-quality, coordinated care to low-income HIV patients. Projects in this category were focused on transitioning Ryan White Care Act patients who would become newly-eligible for Medicaid under the Affordable Care Act. These projects only lasted 18 months, and are not included in this report.

For more on the impact and programs of the DSRIP in California, visit www.caph.org/leading to download *Leading the Way*, our September 2014 brief, and watch a short companion video on our homepage at www.caph.org.

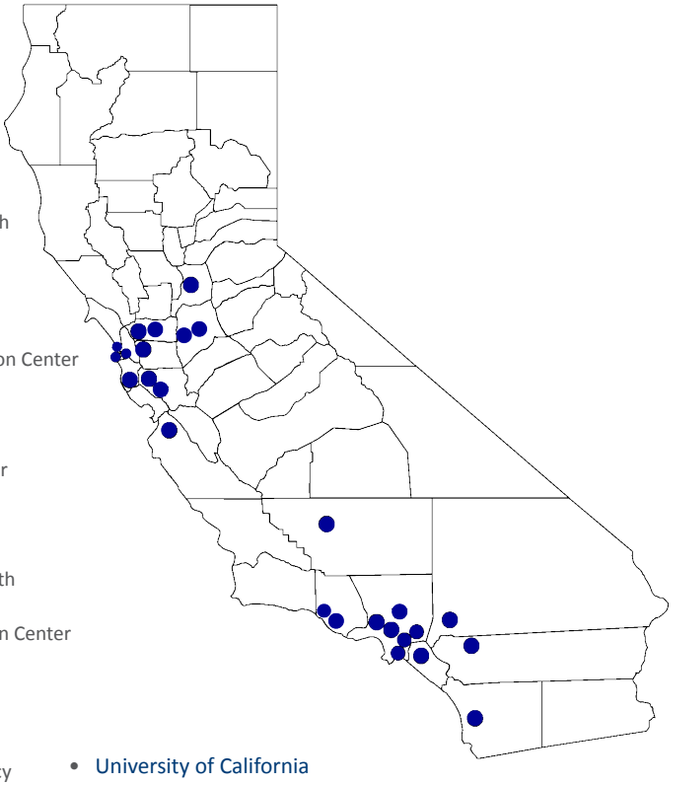
INDIVIDUAL REPORTS

The benefits of the DSRIP are evident across all of California's public health systems (PHS), but each system has made unique advancements, and each of these projects has touched the lives of the patients they serve in different ways. The following pages highlight these stories and successes, and tell a more complete story of the impact DSRIP has had throughout California.

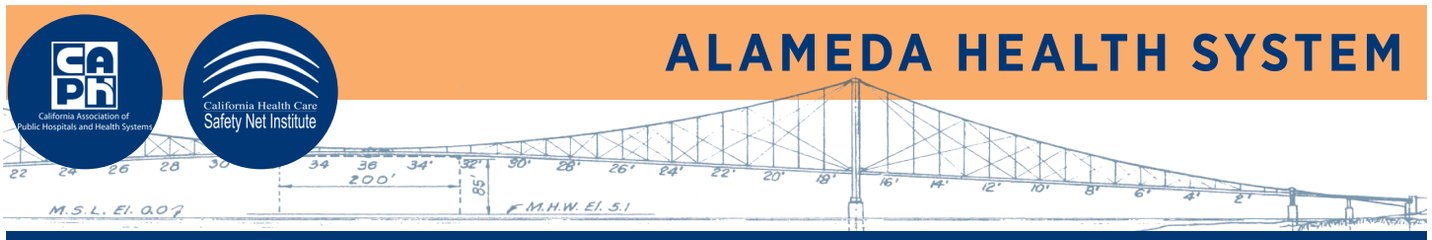
OUR MEMBERS

CAPH members include county-owned and operated facilities and University of California medical centers:

- Alameda County
  - Alameda Health System
- Contra Costa County
  - Contra Costa Health Services
  - Contra Costa Regional Medical Center
- Kern County
  - Kern Medical Center
- Los Angeles County
  - Los Angeles County Department of Health Services
  - Harbor/UCLA Medical Center
  - LAC+USC Medical Center
  - Olive View/UCLA Medical Center
  - Rancho Los Amigos National Rehabilitation Center
- Monterey County
  - Natividad Medical Center
- Riverside County
  - Riverside County Regional Medical Center
- San Bernardino County
  - Arrowhead Regional Medical Center
- San Francisco County
  - San Francisco Department of Public Health
  - San Francisco General Hospital
  - Laguna Honda Hospital and Rehabilitation Center
- San Joaquin County
  - San Joaquin County Health Care Services
  - San Joaquin General Hospital
- San Mateo County
  - San Mateo County Health Services Agency
  - San Mateo Medical Center
- Santa Clara County
  - Santa Clara Valley Health & Hospital System
  - Santa Clara Valley Medical Center
- Ventura County
  - Ventura County Health Care Agency
  - Ventura County Medical Center



- University of California
  - UC Health
  - UC Davis Medical Center
  - UC Irvine Healthcare
  - UC San Diego Medical Center
  - UC San Francisco Medical Center
  - UCLA Medical Center, Santa Monica
  - Ronald Reagan UCLA Medical Center



DSRIP 2010-2015: SUCCESSES TO BUILD ON

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Through the DSRIP, California's 21 public health care systems have expanded upon their existing quality improvement efforts and made them large-scale. Each individual health care system's DSRIP plans have included projects aimed at making improvements across the inpatient and outpatient setting in five major categories:

1. Developing and strengthening their infrastructures
2. Implementing innovative models of care
3. Advancing the health of the populations they serve
4. Continuing to make improvements in quality and patient safety
5. Improving care coordination for patients with HIV/AIDS

Alameda Health System (AHS) took on 30 projects with a total of 169 milestones across the five years of the DSRIP.

AHS used its DSRIP projects strategically, not just to pave the way for Affordable Care Act implementation, but to assist in its transformation into a more-integrated health system. Alameda County targeted projects on this integration through a focus on expanding specialty care services, improving communication with patients, and creating a culture of improvement.

Here are some of the system's accomplishments.

Visit caph.org/DSRIPsuccess to see cumulative results for the entire state, as well as for each other individual health system.

EXPANDING CAPACITY AND INTEGRATING CARE

AHS has been piloting "no-show" prevention programs in several clinics. One clinic has worked on offering earlier appointments to patients whose appointments had been scheduled far in advance. Another has replaced automated reminder calls with live calls. A third is following up with patients who miss their appointments to determine why. These three clinics have **increased their annual encounters by 18%**, and their efforts will lead to the development of best practices to be shared across the system.

Alameda also used DSRIP support on projects intended to increase specialty care outpatient encounters, and saw a **29% increase in cardiology, an 87% increase in orthopedics, and a 219% increase in dermatology**.

Beginning in 2011, Alameda Health System launched the Hope Center, a complex care management program targeting their top 5% most costly, highest risk patients. Through a combination of clinic visits, home visits, and telephone calls to implement individualized care plans, the program has **reduced hospital admissions by 9%** and **ED visits by 16%** per patient per year.

Through one of its DSRIP projects, AHS partnered with a local homeless shelter and the County Health Care Services Agency (HCSA) to establish Crossroads; **a new, 10-bed respite unit for homeless men**. The shelter is regularly full to capacity, providing medical support and assistance to patients who have long-term housing needs and who no longer require hospitalization. The Respite Unit also has a chemical dependency counselor who is available to all patients..

Patient and care team at Highland Hospital

STANLEY RILEY

"The nurses and the doctors there fussed over me. But after they got through helping me, and it was time for me to go, I didn't have anywhere to stay."

Stanley Riley was Alameda Health System's first Crossroads patient. He had been taken to AHS for severe trauma, after he had been badly beaten.

"I hope that anyone who is in the predicament that I was in will have what I had in the respite home."

"I was scared and I was hurt, but (they) guaranteed that if I went and I didn't like it, they'd find me somewhere else. So I went, and I loved it," says Stanley.

Stanley, like many patients, didn't have a social safety net to rely on once he left the hospital; like a safe place to rest, or friends or family members who were able to help him recover.

He says "I hope that anyone who is in the predicament that I was in will have what I had in the respite home. That program saved my life."

Crossroads gives patients like Stanley the chance to continue the healing process comfortably, and the support and encouragement they need to get back on their feet and stay healthy. Stanley now has both a primary care provider and permanent housing.

"The future is bright," says Stanley.

Stanley Riley

"That program saved my life."

CULTURE OF IMPROVEMENT

A large part of AHS's work towards building a culture of improvement has been done through DSRIP projects aimed at harm reduction. In the most recent data year, Alameda Health System has:

- Reduced its aggregate rate of deep surgical site infections **by more than four times over baseline, from 0.056 to 0.013**

4 X

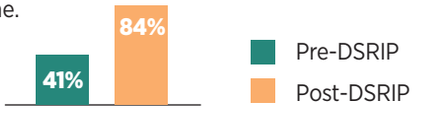
- Cut its acute care unit central line-associated bloodstream infection (CLABSI) rate **nearly in half, from a baseline of 1.14 to 0.62**

1/2

- Reduced its intensive care unit CLABSI rate by **more than 600%, from a baseline of 1.76 to 0.26**

600%

- Doubled its compliance with the sepsis bundle, from a baseline of **41% to 84%**, while cutting its mortality rate **nearly in half** compared to baseline.



STATISTICS

ALAMEDA HEALTH SYSTEM
Beds: 849
Hospitals: 3
Outpatient Facilities: 3
Annual Inpatient Discharges: 17,000
Annual Outpatient Visits: 311,000
Est. DSRIP Funding Earned: $157.1M

ALAMEDA COUNTY
Population: 1.6M
Municipalities: 20, including Oakland, Fremont and Berkeley

ARROWHEAD REGIONAL MEDICAL CENTER

DSRIP 2010-2015: SUCCESSES TO BUILD ON

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1. Developing and strengthening their infrastructures
2. Implementing innovative models of care
3. Advancing the health of the populations they serve
4. Continuing to make improvements in quality and patient safety
5. Improving care coordination for patients with HIV/AIDS

Arrowhead Regional Medical Center took on 15 projects with a total of 244 milestones across the five years of the DSRIP.

In 2010, San Bernardino County ranked 45th of 58 counties in California, in terms of poor health outcomes. Arrowhead Regional Medical Center (ARMC) acknowledged in its DSRIP plan that it faced enormous challenges in improving the health of its community. ARMC recognized that its existing primary care system could be improved and that DSRIP would help make some much-needed changes.

Here are some of the system's accomplishments.

Visit caph.org/DSRIPsuccess to see cumulative results for the entire state, as well as for each other individual health system.

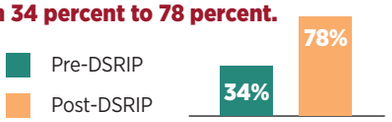
IMPROVING CARE

Arrowhead Regional Medical Center has **increased by more than tenfold** its use of a disease registry to track and more effectively manage patients with chronic conditions, **from 400 patients at the outset of the DSRIP to more than 4,400 now.**

A large part of ARMC's DSRIP strategy has been to better connect patients with the specialty care they need by reducing wait times at five pilot clinics. All five have seen their average wait times at least cut in half, with one **cut by more than 75 percent – from 130 days to just 31.**

In ARMC's first year of tracking, 57 percent of diabetes patients had self-management goals. In the most recent data year, that number has **increased to 85 percent.** These goals are critical in helping patients manage and take control of their health.

ARMC has made significant gains in targeted areas of preventative health care. The percentage of the pediatric population that had BMI assessed within the previous year has **increased from 34 percent to 78 percent.**



ARMC's Primary Stroke Center continues to provide the latest treatment advances for stroke, while improving internal processes to make care more efficient and effective. ARMC has improved its lab panel turnaround time **by 1/3rd, from 45 minutes to 29 minutes,** and is now providing stroke education to **96%** of stroke patients, up from 83%. ARMC's Primary Stroke Center meets all seven stroke measures and has been certified by the Healthcare Facilities Accreditation Program.

Nurses and staff at Westside Family Health Center

DAMON LOPEZ

Damon Lopez became a patient at Arrowhead Regional Medical Center in 2009, when a workplace accident left him with his ribs broken into his spleen. Doctors at ARMC performed a splenectomy and saved his life. This wouldn't be the only time he would credit ARMC with doing so.

"Everybody has taken care of me with a lot of heart. I really appreciate that, and I think a lot of it is due to what I call 'our team.'"

"Everybody has taken care of me with a lot of heart."

Lopez was empaneled into a medical home as part of Arrowhead's DSRIP, and was assigned to a team of healthcare professionals tasked with helping him continue to heal from his injuries, while helping him stay healthy in other ways. His relationship with his team, and the trust they had earned from him, allowed him to open up about his life.

"I'm an alcoholic. I drank for 36 years – the past 20, very hard, every day ... my insides were getting deteriorated, and damaged, and poisoned."

Lopez's healthcare team gave him medication and found him support groups and facilities that would work for him. Perhaps more importantly, they treated him with compassion, and gave him the encouragement he needed to take care of himself.

"Today I'm sober, and for me to say that, that's a miracle."

"Today I'm sober, and for me to say that, that's a miracle."

Damon Lopez with his care team

ADDRESSING URGENT IMPROVEMENTS

- ARMC has improved its Central Line Insertion Practice (CLIP) compliance **from 87.9 percent to 98.33** percent resulting in a substantial decrease in Central Line-Associated Bloodstream Infection rate in the acute care unit from 1.25 to 0.6 per 1,000 patient days, and a massive drop in the intensive care unit **from 3.75 to 0.2.**

11%

- The Hospital-Acquired Pressure Ulcer (HAPU) team demonstrates the culture of performance improvement at ARMC. The team analyzes gaps in care for each pressure ulcer. HAPU prevention awareness has been embedded throughout the system. As a result, caregiver prevention bundles are widely understood and hardwired from the point of patient entry and throughout the hospital stay. As a result, the HAPU rate **has decreased from 5 percent to 1.6 percent.**

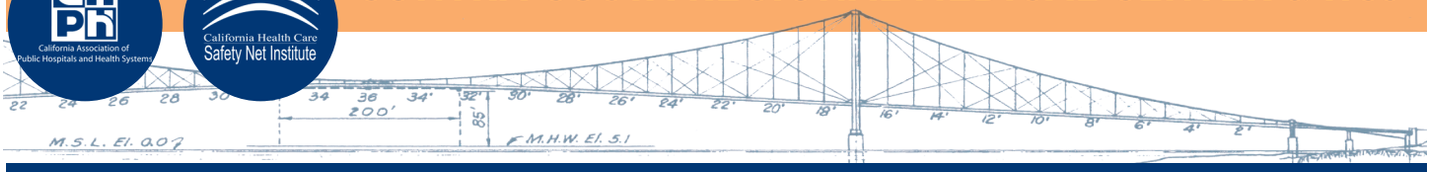
- ARMC launched the severe sepsis campaign, a coordinated effort to standardize treatment of sepsis across the delivery system. The campaign included modifying physician and nurse staff training and embedding sepsis guidelines into care delivery to more effectively respond and treat patients with sepsis. As a result, compliance with sepsis protocols **increased from 38 percent to 90.2 percent** and the mortality rate **dropped from 35.4 percent to 14.2 percent.**

STATISTICS

ARROWHEAD REGIONAL MEDICAL CENTER
Beds: 456
Hospitals: 1
Outpatient Clinic Facilities: 4
Annual Inpatient Discharges: 24,300
Annual Outpatient Visits: 254,000
Est. DSRIP Funding Earned: $175.1M

SAN BERNARDINO COUNTY
Population: 2.1M
Municipalities: 51, including San Bernardino, Fontana, and Ontario

CONTRA COSTA REGIONAL MEDICAL CENTER & HCs



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5. Improving care coordination for patients with HIV/AIDS

Contra Costa Regional Medical Center and Health Centers (CCRMC & HCs) took on 29 projects with a total of 183 milestones across the five years of the DSRIP.

With the implementation of the Affordable Care Act and the expansion of Medi-Cal on the way, Contra Costa Regional Medical Center and Health Centers designed and implemented its DSRIP programs to equip the system to handle an influx of newly-covered patients, and improve the care it provides to all patients. With the DSRIP as a catalyst, CCRMC & HCs has redesigned its ambulatory care, is providing staff with cutting-edge training, and has embarked on a journey towards "zero harm" care delivery.

Here are some of the system's accomplishments.

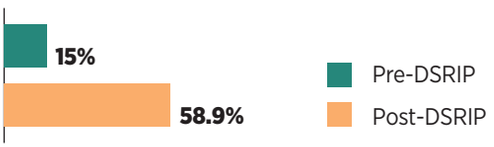
Visit caph.org/DSRIPsuccess to see cumulative results for the entire state, as well as for each other individual health system.

TRANSFORMING PRIMARY CARE

Contra Costa Regional Medical Center and Health Centers has increased the number of patients empaneled into medical homes by more than half its previous total; from **54,650 pre-DSRIP to 87,650** in the most recent available data.

CCRMC & HCs used DSRIP support to implement "PCP Central," a database that matches patients with providers that are convenient to them, which has enabled CCRMC & HCs to immediately assign a primary care provider to **99%** of its empaneled Medi-Cal patients.

CCRMC & HCs piloted the integration of physical and behavioral health by co-locating personnel, services, and screening tools in both primary care and behavioral health care. As a result, the percentage of pilot PCP panels screened for depression and substance abuse **nearly quadrupled from 15% to 58.9%.**



CCRMC & HCs redesigned its appointment system, resulting in third-next available appointment rate (the industry standard for measuring appointment access, to account for cancellations) dropping in half, from 16 days to 8 days at one primary care clinic, with average telephone hold times **falling from 15 to 4 minutes.**

At the beginning of the DSRIP, CCRMC & HCs developed a new data collection system for REAL (Race, Ethnicity, and Language) data that has since achieved **95 %** of patients with REAL data on record compared to 37% at the beginning of DSRIP. CCRMC is analyzing the data to identify disparities and develop targeted care for specific populations.

CCRMC & HCs implemented a landmark program through the DSRIP that links patients in need of non-medical services that can impact health -- including transportation, housing, food and heat -- to community resources that can help. This program enables physicians and other primary care providers to "prescribe" basic resources such as food, and then patients take this prescription to a designated desk located on site at the West County health center. In the most recent data year, there were **232 referrals** to the program.

CCRMC & HCs Sepsis Team

TIM TARMAN

"Getting up in the morning, tying my shoes was a challenge. It was tough. I wasn't in a good place. I was depressed," says Tim Tarman, a patient at Contra Costa Regional Medical Center & Health Centers. "In my mind, my life was not supposed to be like this."

Tarman is a self-described Type A personality, whose life was turned upside down by two strokes.

"Getting up in the morning, tying my shoes was a challenge. It was tough. I wasn't in a good place. I was depressed."

Through its DSRIP, CCRMC & HCs piloted the integration of physical and behavioral health by co-locating personnel, services, and screening tools in both primary care and behavioral health care. As a result, the percentage of patients in the pilot screened for depression and substance abuse has nearly quadrupled from 15% to 58.9%. And having both behavioral and physical health services in one center means patients can access the care they need, when they need it.

Learning to live with the limitations that come from a stroke can be a long and frustrating process, even for patients who aren't suffering from depression. Tarman's primary care physician at Concord Health Center recognized that physical health care alone might not be enough for him, and that Tarman would benefit greatly from the help of a therapist and group support. All of these services are in the same location, all working together to help Tarman with his recovery.

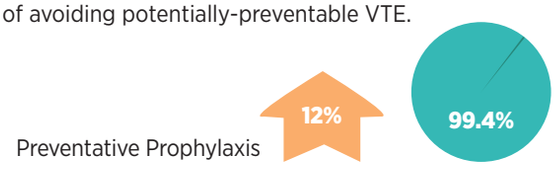
"My strokes were life-changing but so is the care I have received here."

"I have gotten the care I need, and even more critical are the people here. This is a wonderful place," says Tarman. "My strokes were life-changing but so is the care I have received here."

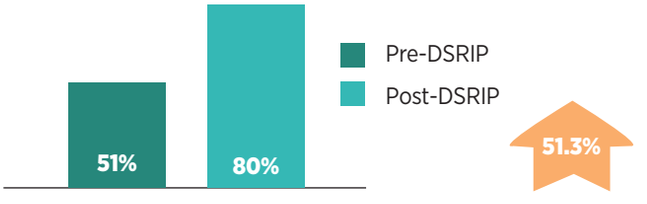
Tim Tarman (right) with Dr. Ori Tzvieli

IMPROVING PATIENT SAFETY

- CCRMC & HCs has taken great steps to protect patients from venous thromboembolism (VTE), a life-threatening blood clot. Compression devices have been made more comfortable for patients, increasing compliance, and new technology and procedures have cut wait time for access to these devices down from five hours to just five minutes. CCRMC & HCs has increased its rate of administering preventative prophylaxis to patients at risk for VTE by **more than 12%, to 99.4%,** and has maintained a **100%** rate of avoiding potentially-preventable VTE.



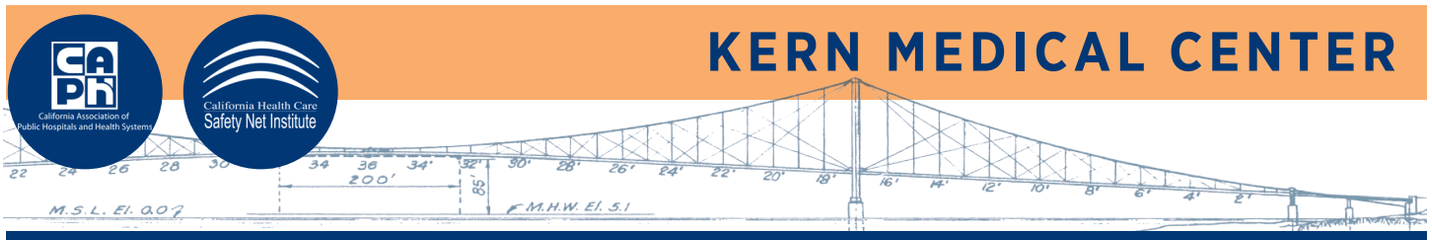
- CCRMC & HCs increased its one-hour sepsis bundle compliance rate **by more than half – up from a baseline of 51.3% to 80%,** according to the most recent data. Its sepsis mortality rate has been **cut in half** since the start of DSRIP, from a baseline of **18% to 7.4%** according to the most recent data.



STATISTICS

CONTRA COSTA REGIONAL MEDICAL CENTER AND HEALTH CENTERS
Beds: 166
Hospitals: 1
Outpatient Clinic Facilities: 11
Annual Inpatient Discharges: 10,000
Annual Outpatient Visits: 450,000
Est. DSRIP Funding Earned: $158.6M

CONTRA COSTA COUNTY
Population: 1,111,000
Municipalities: 53, including Richmond, Concord, and Antioch



DSRIP 2010-2015: SUCCESSES TO BUILD ON

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1. Developing and strengthening their infrastructures
2. Implementing innovative models of care
3. Advancing the health of the populations they serve
4. Continuing to make improvements in quality and patient safety
5. Improving care coordination for patients with HIV/AIDS

Kern Medical Center (KMC) took on 30 projects with a total of 209 milestones across the five years of the DSRIP.

Kern Medical Center faced a big challenge in preparing for the implementation of the Affordable Care Act, due to its large low-income and uninsured patient population, many of which have complex medical needs. Kern County is one of the poorest counties in California and the DSRIP was essential in KMC's efforts to prepare for coverage expansion, expand primary care capacity and adequately address the health needs of their patients. KMC's DSRIP efforts focused on improving access to same day appointments and reducing no-show rates, increasing support and care coordination for patients who were using the Emergency Department for episodic care, strengthening communication support between behavioral and physical health, and tackling the epidemic of childhood obesity.

Visit caph.org/DSRIPsuccess to see cumulative results for the entire state, as well as for each other individual health system.

EXPANDING CAPACITY AND ACCESS

As part of its effort to expand its capacity, KMC established a nurse advice line, targeted at patients who would otherwise visit the Emergency Department. In the last data year, almost **67%** of patients who called the nurse advice line, with the intent to go to the ED, **were redirected to non-ED resources.**

Prior to DSRIP, access to primary care at KMC was very limited. Clinics were only open during weekdays with no evening hours. Now, primary care clinic hours have expanded to 59 hours, over a baseline of 40 hours – a **47.5% expansion.** This has resulted in the third next available appointment **dropping from 60 calendar days to fewer than 30.**

Average visit cycle times in primary clinics **dropped from nearly 100 minutes to less than 60,** without reducing face time between patient and provider. The percentage of patients who received a same-day appointment when requested has **increased from 15% to nearly 100%.**

Through the DSRIP, KMC established a Care Navigation Program to provide support to high utilizers of the ED and/or Inpatient Services. In the most recent data year, among active and graduated care management program participants, there was a **50% drop in ED visits and a 60% decrease of inpatient admission pre- and post-enrollment.** Furthermore **48%** of patients in the emergency department who met with the ED Care Coordinator and did not have a primary care provider were referred to one, and **23%** left the ED with an appointment.

Doctor and patient at Kern Medical Center

TAKING ON CHILDHOOD OBESITY

"Five years ago the program was … well, there wasn't a program," says Peggy Aten, a physician assistant in pediatrics at Kern Medical Center. What a difference DSRIP has made.

"We found programs like cooking classes and nutrition classes, and used our knowledge of how kids work."

KMC's rate of children with a BMI above the 85th percentile has **plummeted from 52% to just 20%** according to the most recent data, all thanks to a comprehensive and much more hands-on approach.

Before DSRIP, physicians addressed childhood obesity issues during yearly check-ups, but that's it. DSRIP gave KMC the chance to develop a program that would make meaningful changes in the lives of its youngest patients.

"We talked to pediatric endocrinologists, we found programs like cooking classes and nutrition classes, and we used our own knowledge of how kids work," says Aten. The result is a program that celebrates the process of improving health, right alongside the outcomes. And KMC stays with a family every step of the way.

Staff identify families for intervention, and spur them into action by giving them concrete information about the negative effects of obesity and educating them about how change is possible.

Staff then see families once a month, and assign a small and manageable lifestyle change each time. First it's cutting down on soda, then marginally reducing portion size, then cutting fast food to once a week, then going for walks, then cutting out sugary drinks entirely, and so on. Every step, staff and family celebrate their success, even if the results might be slow. But the results do come.

"There's funding to treat patients once they become diabetic. DSRIP has given us the support we need to keep our kids from getting there."

"We have a patient who had to go next door to get weighed, because our scale wouldn't go that high," says Aten. "She's lost 20 pounds already, and she will keep getting healthier, because her family has made changes that they can live with."

Pediatrician and patient at Kern Medical Center pediatric clinic

"There's all kinds of funding to treat patients once they become diabetic," says Aten. "DSRIP has given us the support we need to keep our kids from getting there."

ADDRESSING URGENT IMPROVEMENTS

- As part of KMC's effort to reduce sepsis mortality and improve adherence to best practices in treating sepsis , KMC focused on garnering buy-in from the entire care team, in particular physicians. This work included using a combination of physician champions, best-practice education, positive affirmation, and – believe it or not – a music video. (Viewable at caph.org/kmcvideo) KMC has **more than doubled its sepsis bundle compliance from its pre-DSRIP baseline of 32% to its most recent level of 84%, while cutting its mortality rate by more than a third.**
- As part of its DSRIP, KMC developed a multidisciplinary process improvement team that worked to reduce the hospital-acquired pressure ulcers (HAPU) prevalence rate. Newly-implemented processes included: consistently assessing risk; routinely inspecting skin and standardizing wound care; employing strategies that decrease or remove pressure; supporting efforts in progressive mobility; and educating and training health care providers. Using rapid-cycle process improvement, Kern Medical Center saw a massive decrease in its HAPU prevalence rate, **from a baseline of 7.8% to 0.6% in the most recent data year.**

STATISTICS

KERN MEDICAL CENTER
Beds: 222
Hospitals: 1
Outpatient Clinic Facilities: 3
Annual Inpatient Discharges: 11,400
Annual Outpatient Visits: 147,000
Est. DSRIP Funding Earned: $125.4M

KERN COUNTY
Population: 807,000
Municipalities: 58, including Bakersfield, Delano, and Oildale

DSRIP 2010-2015: SUCCESSES TO BUILD ON

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4. Continuing to make improvements in quality and patient safety
5. Improving care coordination for patients with HIV/AIDS

Los Angeles County Department of Health Services (LACDHS) took on 30 projects with a total of 243 milestones across the five years of the DSRIP.

Los Angeles County is the most populous county in the United States, and before the Affordable Care Act and the expansion of Medi-Cal, had more uninsured people (2 million) than the population of many entire states. With such a massive number of people about to gain access to coverage, the Los Angeles County Department of Health Services needed to quickly expand its capacity, and saw an opportunity to do so by keeping patients healthier, with safer and more coordinated care.

Here are some of the system's accomplishments.

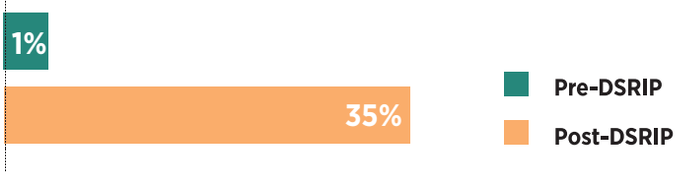
Visit caph.org/DSRIPsuccess to see cumulative results for the entire state, as well as for each other individual health system.

EXPANDING MEDICAL HOMES

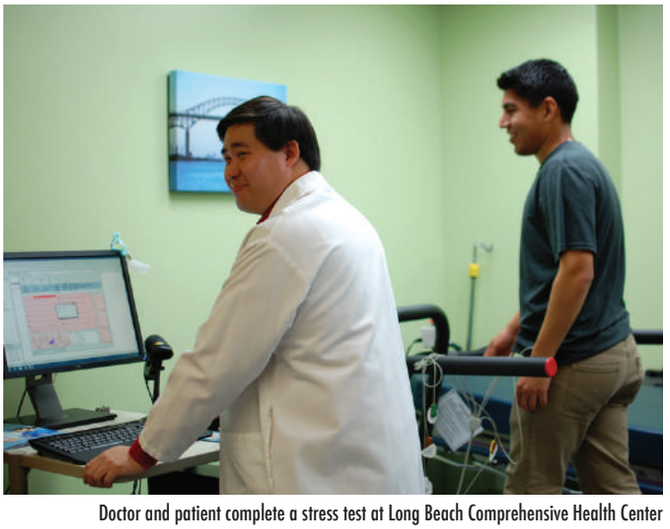
The Los Angeles County Department of Health Services empaneled more than **400,000 patients into medical homes,** to connect patients with a dedicated primary care team that takes responsibility for coordinating the array of services required to not only heal patients when they are sick, but shift the paradigm to focus on keeping them healthy.

LACDHS embarked on a coordinated system-wide effort that spanned hospitals and clinics, using electronic data to cut down on overdue preventive care. LACDHS has more than doubled its rates across several preventative measures, including **mammography screening (from 30% to 71%)** and **child BMI screening (from 17% to 36%).**

LA County has also dramatically increased its percentage of empaneled diabetes, heart failure or asthma patients with documented self-management goals, **from a baseline of less than 1% to now 35%.**



Through the DSRIP, Los Angeles' Department of Health Services and Department of Mental Health collaborated on co-location of physical and behavioral health at nine target clinics, with an emphasis on depression screening for diabetic patients. In the last data year, these clinics **screened more than 13,000 diabetes patients**, to help ensure these patients have the tools and the confidence they need to help manage their own health.



Doctor and patient complete a stress test at Long Beach Comprehensive Health Center

LAURIE AVILES

Laurie Aviles became a patient at the Edward Roybal Comprehensive Health Center, run by Los Angeles County Department of Health Services, before any of the county's DSRIP programs had taken effect.

She has experienced firsthand the county's efforts to empanel patients into medical homes with primary care teams, more effectively manage the care of patients with chronic diseases, and streamline its processes.

"When the staff saw me, they knew something was wrong. My doctor asked me if something was wrong, and I just broke down."

She says when she first started visiting Roybal, wait times would often be several hours, and there was not the consistency she needed. "When I started coming to Roybal, it was frustrating to me, because I would see different doctors every time I came, and I had to start all over with my history. When I got my primary care physician, I started building a rapport with him. I would see him consistently. He was my doctor."

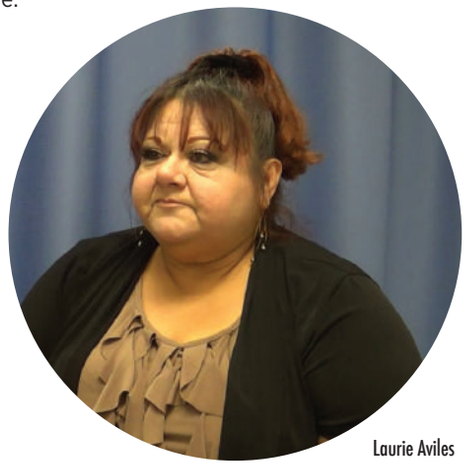
That rapport was the key to Aviles feeling like she could open up about her struggles.

"When the staff saw me, they knew something was wrong. My doctor asked me if something was wrong, and I just broke down. I said I was having problems with my housing, and my diabetes, and I felt like I had no control. I said I need help.

That same day, he got everything that I needed. He brought someone in to help with housing. He got me into the pharmacy to help with my diabetes. They encourage me here. That's what I needed, and I found it here."

This deeper level of care was only possible because of Los Angeles County's commitment, through its DSRIP projects, to transforming its primary care process.

"Ever since then, my diabetes has really dropped, and they give me kudos for that. It may sound phony, but it's a joy for me to come here."



Laurie Aviles

"They encourage me here. That's what I needed, and I found it here."

POPULATION HEALTH AND URGENT IMPROVEMENTS

Making necessary changes within a system as vast as LACDHS can be an incredibly daunting task, but DSRIP projects aimed at improving population health and addressing urgent improvements were incredibly successful and yielded results across the entire system, despite its size and scope.

- LA County's DSRIP project to reduce 30-day readmission rate for patients with congestive heart failure was able to **cut the rate nearly in half, from 5.3% to 2.7%.**

1/2

- LA County's participation in the statewide DSRIP project focused on reducing sepsis mortality led to its Sepsis Bundle compliance increasing from 36% to 83% during the course of the DSRIP, and its **sepsis mortality rates have been cut by more than a third.**

1/3

STATISTICS

LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
Beds: 1,220
Hospitals: 4
Outpatient Clinic Facilities: 19
Annual Inpatient Discharges: 67,000
Annual Outpatient Visits: 2,500,000
Est. DSRIP Funding Earned: $1.17B

LOS ANGELES COUNTY
Population: 10.1M
Municipalities: 88, including Los Angeles, Long Beach, Glendale, and Pasadena

NATIVIDAD MEDICAL CENTER

DSRIP 2010-2015: SUCCESSES TO BUILD ON

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4. Continuing to make improvements in quality and patient safety
5. Improving care coordination for patients with HIV/AIDS

Natividad Medical Center (NMC) took on 13 projects with a total of 203 milestones across across the five years of the DSRIP.

Natividad Medical Center, located in Monterey County, was facing a unique challenge at the outset of California's DSRIP, when thinking about preparing for the implementation of the Affordable Care Act and the expansion of Medi-Cal. The county is one of California's strongest agricultural producers, and has a significant population of low-income individuals from diverse backgrounds. With 82% of its patients identified as Hispanic/Latino and more than 40% identified as having Limited English Proficiency, NMC needed to expand its capacity and improve safety in a way that ensured cultural competency.

Here are some of the system's accomplishments.

Visit caph.org/DSRIPsuccess to see cumulative results for the entire state, as well as for each other individual health system.

IMPROVING PATIENT CARE AND EXPERIENCE

NMC's Emergency Department Patient Experience Project involved remapping ED processes and applying performance improvement principles. Focus groups of patients participated side-by-side with ED staff to redesign the ED to be more patient-centered. As a result, the percentage of patients who rated ED radiological services as excellent **nearly doubled from 34.3% to 64.3%**, and the percentage of patients who rated ED overall quality of care as excellent **increased from 46.4% to 54%.**

Natividad Medical Center's efforts around care coordination have included the implementation of an ambulatory diabetic education center, which has since been accredited by the American Academy of Diabetic Educators. In the most recent data year, NMC cut its rate of short-term complications from diabetes **by two-thirds, from 0.42% to 0.13%** and slashed its rate of "uncontrolled diabetes" by **more than fifteen times, from 2.1% to 0.13%**

CULTURAL COMPETENCE

Natividad embarked on a massive program to improve its cultural competency, especially around language. Through the DSRIP, NMC brought real-time interpretation technology (via wheeled audio or video conferencing terminals) to patients in 23 key departments, none of which had this capacity before.

Before DSRIP, NMC averaged 160 encounters per month that were facilitated by qualified healthcare interpreters. That number has now grown to 3300; more than twenty times its previous size. NMC has increased its roster of qualified interpreters from a total of four to now more than 200 in its network. Natividad Medical Center is now working with other hospitals to provide its interpretation services to patients across the entire state.

Doctors and Staff at Natividad Medical Center

BUILDING BRIDGES

Farmworkers in California's Salinas Valley can speak any number of languages and dialects indigenous to different parts of Mexico and Central America, and often speak limited Spanish, if any at all. Natividad's DSRIP-supported indigenous interpretation program has been nothing short of groundbreaking, and is one of the first interpreter trainings in the country tailored to individuals that speak languages of lesser diffusion, including Mixteco, Zapoteco, K'iche' and Triqui.

But interpretation isn't just about language; it's about concepts and context.

"For me as a doctor, it's very comforting. For me as a member of this community, I feel relieved."

Dr. Chad Harris, Chair of Clinical IT at NMC, is one of several members of Natividad's indigenous interpretation team who traveled to Oaxaca, Mexico to discuss health and health care experiences with a Zapateco interpreter, to understand how Natividad's patients from that region experience disease.

"They described (tuberculosis) as the devil strangling them," says Dr. Harris.

By building this bridge between languages and cultures, Natividad is not just giving patients more confidence in the medical team, it's giving the medical team more confidence in themselves, and a deeper connection with the patients they serve.

"For me as a doctor, it's very comforting. For me as a member of this community, I feel relieved," says Dr. Minerva Perez-Lopez, whose father picked lettuce in the Salinas valley for 40 years, and who herself was born at Natividad. "It's a tremendous care to the community."

Thanks to this program, Natividad Medical Center is not just forging stronger relationships with patients and improving the care that they receive, it is building a model that countless other hospitals and health systems can follow.

Members of NMC Indigenous Interpretation Team in Oaxaca, Mexico

"It's a tremendous care to the community."

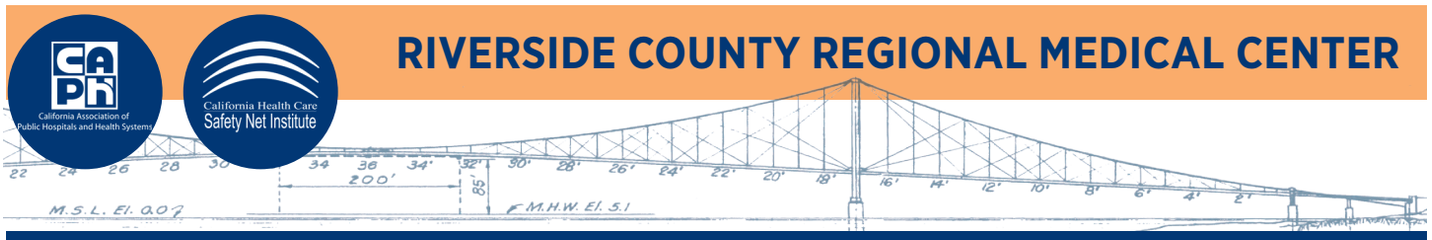
ADDRESSING URGENT IMPROVEMENTS

NMC is committed to improving patient safety. Through increased compliance with Central Line Insertion Practices (CLIP) protocol, NMC saw **77% reduction** in Central Line-Associated Bloodstream Infections (CLABSI) in the Intensive Care Unit from **3.2 CLABSI's per 1,000 central line days to 0.75** and has maintained a **0% CLABSI rate in Acute Care Units.**

STATISTICS

NATIVIDAD MEDICAL CENTER
Beds: 172
Hospitals: 1
Outpatient Clinic Facilities: 5
Annual Inpatient Discharges: 10,700
Annual Outpatient Visits: 127,860
Est. DSRIP Funding Earned: $48.6M

MONTEREY COUNTY
Population: 431K
Municipalities: 29, including Salinas, Seaside, and Monterey



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Riverside County Regional Medical Center (RCRMC) took on 29 projects with a total of 220 milestones across the five years of the DSRIP.

Riverside County, an expansive 7,300 square miles that encompasses both dense urban centers and rural pockets of entrenched poverty, is the tenth most populous county in the United States. RCRMC, the county's 122-year-old safety net, set out to prepare for the implementation of the Affordable Care Act by expanding access to services, and embedding quality and efficiency into its processes; knowing that efforts to achieve and surpass these milestones would lead to significant and sustainable system-wide improvements.

Here are some of the system's accomplishments.

Visit caph.org/DSRIPsuccess to see cumulative results for the entire state, as well as for each other individual health system.

EXPANDING PRIMARY CARE

■ Clinic staff has received training on patient-primary care physician assignment and scheduling guidelines to promote the patient's visit continuity with their medical home team. In the most recent data year, there were 34,877 visits to the Family Care Clinic, representing an increase in patient access of **more than 14,000 visits over baseline data.** Of this total, more than **4,200** were virtual telephone visits, allowing even greater capacity for in-person visits.

■ Among adult diabetic patients of RCRMC's Family Care Clinic, **74% of patients** now have self-management goals to help them improve their health, an increase of **more than seven times the 2010 baseline of 10%.** Diabetic telephone interactions, texting platforms, health coaches and self-management goals have been incorporated into clinic workflow as a catalyst to improving patient outcomes.

7X

■ Riverside has more than doubled the percentage of Family Care Clinic diabetes patients in its disease registry, **from 42% to more than 88%.**

■ Nearly 800 underserved individuals from some of the county's most remote communities received primary care annually from RCRMC's mobile health clinic. **63%** of those seen are return patients.

■ One of RCRMC's DSRIP projects was aimed at achieving excellence in stroke care. More than **300 nurses** received certification on the National Institute of Health Stroke Scale. Training on stroke program protocols was also provided to code team nurses, plus ED and critical care nursing staff. Stroke program leaders from RCRMC founded a growing statewide stroke collaborative to share best practices with their peers. In 2014, RCRMC's stroke program earned Joint Commission Certification for its consistent quality, and a Gold Standard from the American Heart Association. RCRMC now serves as a recognized Primary Stroke receiving center, where interventional therapies save and preserve the quality of lives of stroke victims.

RCRMC's first annual Health Innovations Fair

COMMITMENT TO STROKE EXCELLENCE

Riverside's commitment to Stroke Excellence through its DSRIP projects is not only saving lives, it's creating advocates. In 2013, a patient named Ms. Hill was a 56 year-old woman without insurance, medications, or a primary medical provider, and with a history of High Blood Pressure and Diabetes. She presented to the Emergency Room at Riverside County Regional Medical Center with full right-sided paralysis, slurred speech, and her face was drooping. The emergency department determined immediately that she was having a stroke, and was able to provide her with the "clot busting" drugs quickly.

"Ms. Hill is back to work, able to use both arms and legs to complete her job duties, is actively participating in marathons and not taking life for granted." said Annette Greenwood, former Ambulatory Director at Riverside.

Ms. Hill now has obtained insurance, a regular medical provider, has medications sent to her home, and possesses a great understanding of the signs and symptoms of stroke. More importantly, she's alive today, and is now sharing her story with others, to encourage rapid medical attention at the first sign of a stroke. Riverside's Stroke Excellence project might be saving even more lives, through Ms. Hill's advocacy.

Ms. Hill shared the value of better stroke interventions with hundreds of thousands of Inland residents who read about the success of this DSRIP project and her experience at RCRMC on the front page of The Press-Enterprise newspaper in 2013. She has been a source of inspiration for her community, and for every member of RCRMC's team.

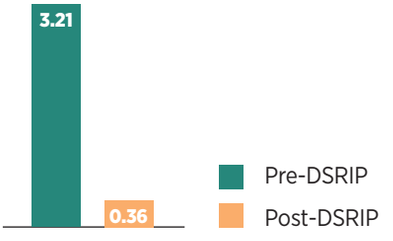
Members of the RCRMC Stroke Intervention Team

"Ms. Hill is back to work... is actively participating in marathons and not taking life for granted."

CULTURE OF IMPROVEMENT

- RCRMC also took aim at sepsis, and more than doubled its compliance with the sepsis bundle, **from a baseline of 24% to 56%,** according to the most recent data available. RCRMC has **decreased its sepsis mortality by nearly one third – from a baseline of 22% to 15% in the most recent data available.**

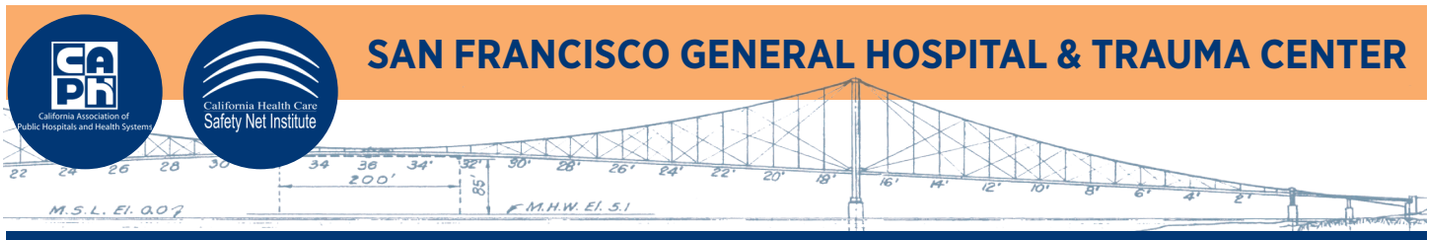
- RCRMC has maintained **99% compliance** with the Central Line Insertion Practices (CLIP) bundle throughout the DSRIP, but has cut its hospital-wide Central Line-Associated Bloodstream Infection (CLABSI) rate **from a baseline of 3.21 infections per 1000 catheter days to just 0.36 infections per 1000 catheter days.**



STATISTICS

RIVERSIDE COUNTY REGIONAL MEDICAL CENTER
Beds: 439
Hospitals: 1
Outpatient Clinic Facilities: 12
Annual Inpatient Discharges: 19,400
Annual Outpatient Visits: 189,000
DSRIP Funding Earned $189M

RIVERSIDE COUNTY
Population: 2.3M
Municipalities: 28, including Riverside, Moreno Valley, and Corona



DSRIP 2010-2015: SUCCESSES TO BUILD ON

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2. Implementing innovative models of care
3. Advancing the health of the populations they serve
4. Continuing to make improvements in quality and patient safety
5. Improving care coordination for patients with HIV/AIDS

San Francisco General Hospital (SFGH) took on 28 projects with a total of 207 milestones across the five years of the DSRIP.

San Francisco General Hospital is part of the San Francisco Health Network, operated by the San Francisco Department of Public Health. The system had a jumpstart on the Affordable Care Act's coverage expansion, thanks to the Healthy San Francisco program - started in 2007 to make health care services available to residents who were, at the time, uninsured. In 2010, SFGH still needed to further expand its capacity, to address increased demand and improve access to care. In addition, SFGH challenged itself to improve the quality of patient care and experience.

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TRANSFORMING PRIMARY CARE

Through the DSRIP, a nurse advice line was established, to help assess health care needs of patients, and help schedule appointments if needed. SFGH created "Access dashboards" to ensure that patients received timely access for urgent care needs at their medical homes. The dashboard has added a level of accountability to the system that did not previously exist. Building on the success of the nurse advice line, a new "telephone provider" visit program had immediate success, with more than **20,000 distinct callers,** resulting in **82% of all patient healthcare needs resolved over the phone.**

Through the DSRIP, SFGH has established a system-wide patient centered medical home initiative that now has 24 panel managers and health coaches trained to manage patients who have a chronic disease or illness. For example, **more than 10,300 patients** are now managed through SFGH's colorectal cancer screening registry, and **almost 6,300 patients** are managed through its chronic care registry.

SFGH identified **177 high risk patients,** and assigned them to care manager teams as part of its Complex Care Management Program. These patients, with a history of multiple admission and ED visits, demonstrated a **40-50% average decrease** in hospital stays and ED visits after enrolling in the program.

High Risk Patient ED Visits

Patients who are at high risk of heart failure were enrolled in a Transitional Care Nursing Program involving motivational interviewing and teach-back, the recognition of various symptoms, medication education, goal-setting, and review of personalized transitional care plan. The readmission rate of these high-risk heart failure patients **dropped from 18% to 10%** through the Program.

Nurse and patient at San Francisco General Hospital

eREFERRAL

Through the DSRIP, San Francisco General Hospital expanded its landmark integrated electronic referral and consultation system, known as eReferral, allowing seamless communication and coordination between all the different providers that might be needed to assess a patient's needs, and to help determine the best course of action for that patient's care.

"Our program connects (a patient's) primary care provider with specialists to determine the next best step."

With eReferral, primary care and specialty providers can communicate online about a patient who might need a specialty visit, or whose problems may be handled by the primary care doctor, in consultation with the specialist. This streamlines referrals, improves primary care and ensures patient access to specialists.

"Let's consider a patient with poorly controlled diabetes," says Delphine Tuot, Director of eReferral at SFGH. "Our program connects their primary care provider with specialists to determine the next best step for the patient. Is the next step a change in the diabetes treatment plan executed in the medical home with virtual co-management by an endocrinologist, a group visit in Spanish or in English for self-management support, or a one-on-one in-person visit with a nurse practitioner to start insulin? Or is the next best step an in-person visit with an endocrinologist?"

By changing the focus from access to specialty visits to access to specialty expertise, SFGH leverages eReferral to ensure that patients receive the right level of care in a timely fashion. This process reduces the demand for in-person specialty visits and provides pre-visit guidance to ensure that specialty-care visits are more effective. As a result, SFGH has seen its wait times plummet for specialty services. In one study, wait times for non-urgent visits declined in seven of eight clinics by up to 90%. Additionally, the percentage of new medical and surgical specialty referrals without a clear consultative question was cut by more than half.

Physician checking eReferral system at San Francisco General Hospital

Wait times for non-urgent visits declined in seven of eight clinics by up to 90%.

CULTURE OF IMPROVEMENT

- As with all public health care systems in California, San Francisco General Hospital (SFGH) set out to reduce mortality from severe sepsis and septic shock as part of its DSRIP. SFGH brought together a multidisciplinary team to launch the Sepsis Mortality Reduction Initiative, a multi-pronged intervention involving provider education, screening protocols, and the use of real-time data. SFGH has experienced a **52% reduction in the sepsis mortality rate and 170% increase in bundle compliance.**

Sepsis Bundle Compliance **Sepsis Mortality**

STATISTICS

SAN FRANCISCO GENERAL HOSPITAL
Beds: 598
Hospitals: 1
Outpatient Clinic Facilities: 50
Annual Inpatient Discharges: 106,000
Annual Outpatient Visits: 592,000
Est. DSRIP Funding Earned: $206.8M

SAN FRANCISCO COUNTY
Population: 852K
Municipalities: 1, San Francisco

SAN JOAQUIN GENERAL HOSPITAL

DSRIP 2010-2015: SUCCESSES TO BUILD ON

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5. Improving care coordination for patients with HIV/AIDS

San Joaquin General Hospital (SJGH) took on 12 projects with a total of 122 milestones across the five years of the DSRIP.

In 2010, as Medi-Cal was getting set to expand through the implementation of the Affordable Care Act, the number of San Joaquin County residents who would be relying on Medi-Cal and the health care safety net was expanding too. At the outset of the DSRIP, San Joaquin County – which already had one of the lower per-capita incomes in the state – was saddled with an unemployment rate of 17%, nearly double what the national average was. At the same time, studies were showing inordinately high percentages of county residents with chronic and largely preventable diseases (8% with heart disease, 13% with diabetes, 17% with asthma). San Joaquin General Hospital set out to not only expand its capacity, but shift away from a reactive model, towards the idea of proactively managing the health of its patients. DSRIP has given San Joaquin the opportunity to make lasting changes to its culture.

Here are some of the system's accomplishments.

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PATIENT-CENTERED HEALTH CARE

Through increased physician recruitment, extended clinic and imaging hours, and a redesigned clinic flow that allows and encourages walk-ins, SJGH has managed a **53% increase in its primary care visits, up to nearly 72,500 annually from a pre-DSRIP number of around 47,300.**

Prior to DSRIP, San Joaquin General Hospital did not have a medical home model, meaning that an undetermined number of patients rotated among different providers, including the ED, for their primary care needs. Now, thanks to DSRIP efforts, SJGH has established medical homes, enrolling **over 20,000 new patients annually.**

San Joaquin General Hospital studied patterns in primary care no-show rates, and redesigned its hours to accommodate more schedules. SJGH implemented a population management system to track and reach out to patients who missed a scheduled appointment, and over the course of the DSRIP has **decreased its no-show rates to 8.7%** in the most recent available data, **down from as high as 25%.**

All six of San Joaquin's primary care sites are using a disease management registry to identify, communicate with, and schedule patients needing preventive services. In particular, SJGH identified a need for increased tobacco cessation counseling for its diabetes patients, with **70% of applicable patients now receiving counseling, up from 55%.**

Nurse checks test results at San Joaquin General Hospital

DIABETES MELLITUS TITRATION CLINIC

One of SJGH's greatest DSRIP successes was the creation of its Diabetes Mellitus Titration Clinic for patients with "uncontrolled" diabetes.

Before the DSRIP and the creation of this clinic, patients with uncontrolled diabetes received care through their primary care physician, likely worked with a pharmacist but just to get prescriptions filled, may have been asked to get a retinal scan, and may have been referred to a dietician – though access to these services could differ greatly.

"We teach them how to get control of their disease. We teach them that their role is bigger than ours."

The Diabetes Mellitus Titration Clinic combines all of that expertise in one place. And more importantly, it teaches patients how all of those elements can work together to get a patient healthy again.

"The key is in the education," says Dr. Satinder Singh, the physician in charge of the clinic. "When patients show up, they tell us their stories, and we teach them how to get control of their disease. We teach them that their role is bigger than ours."

By bringing all of these services and all of that expertise under one roof, and by ensuring that patients learn about their own role in managing their health, the clinic has shown amazing results.

"They see those numbers drop, and it means something real to them. Hopelessness turns into hope."

Patients often enter with blood sugar levels around 300-400, and after an average of eight weeks, see that number drop to 100 – which is back to normal. Patients learn how to maintain that level, then "graduate" from the program, knowing that they can take charge of their own health.

"They see those numbers drop, and it means something real to them. Hopelessness turns into hope," says Dr. Singh.

Diabetes Mellitus Titration Clinic team

ADDRESSING URGENT IMPROVEMENTS

- San Joaquin General Hospital has taken dramatic steps in harm reduction, decreasing its standardized infection ratio (SIR) for surgical site infections by 30%, increasing its Central Line Insertion Practice (CLIP) compliance from 92 to 97.6%, and most impressively, reducing its acute care Central Line-Associated Bloodstream Infection (CLABSI) rate **from 2.06 infections per 1,000 central line days to just 0.25 – a decrease of more than 800%.**

- SJGH has increased its compliance with the widely-recommended sepsis resuscitation bundle for patients with severe sepsis and septic shock to **80%, from a baseline of 34%,** according to the most recent available data. SJGH has **cut its sepsis mortality rate nearly in half, from 23.2% to 12.8%**

Sepsis Mortality Rate 1/2

STATISTICS

SAN JOAQUIN GENERAL HOSPITAL
Beds: 196
Hospitals: 1
Outpatient Clinic Facilities: 6
Annual Inpatient Discharges: 9,211
Annual Outpatient Visits: 148,086

SAN JOAQUIN COUNTY
Population: 715,000
Municipalities: 28, including Stockton, Tracy, and Lodi

SAN MATEO MEDICAL CENTER

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5. Improving care coordination for patients with HIV/AIDS

San Mateo Medical Center (SMMC) took on 29 projects with a total of 158 milestones.

San Mateo Medical Center targeted its DSRIP projects at two broad goals to prepare for the implementation of the Affordable Care Act and the expansion of Medi-Cal; partnering with and empowering patients, and piloting methods for making dramatic quality improvements quickly in targeted areas, including patient experience. SMMC has been incredibly successful in giving patients the care and the tools they need to help manage their own health and health care.

Here are some of the system's accomplishments.

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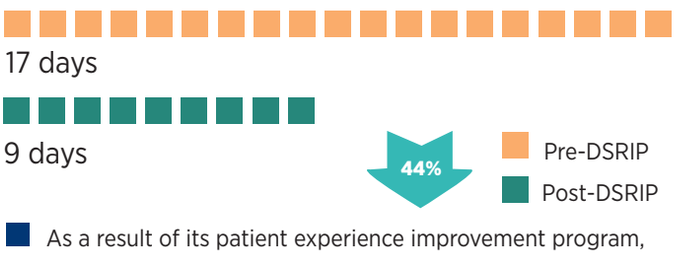
PARTNERING WITH AND EMPOWERING PATIENTS

San Mateo's DSRIP projects to expand primary care capacity and assign medical homes to patients have resulted in **97% of the total patient population** now empaneled to a provider/care team, with Race, Ethnicity, and Language (REAL) data being collected for **99% of those patients**.

San Mateo focused on expanding specialty care capacity by shifting to a faster and all-electronic referral system. **100%** of SMMC's referrals to specialty care are now generated electronically, and almost all referrals (**99.8%** according to most recent data) are being evaluated electronically within 30 days, compared to just 13% before DSRIP. SMMC's overall Time to Third Next Available Appointment (TTNAA) has **dropped by 44%, from almost seventeen days to around nine** – with one target clinic dropping from an average of twenty days to just over one.



As a result of its patient experience improvement program, San Mateo's Emergency Department has improved its patient experience scores **from the 7th percentile to nearly the 50th**.

SMMC's integration of physical and behavioral health programs are being piloted in two clinics, where diabetic patients who screen positive for depression are now receiving a warm handoff to a medical psychiatry service **within an hour.** Before DSRIP, San Mateo did not routinely screen these patients for depression, and did not have the capacity to provide a warm handoff to a medical psychiatry service.

A nurse and patient at San Mateo Medical Center

BEHAVIORAL HEALTH INTEGRATION

"In San Mateo, it's not about 'I'm going to treat the physical, you treat the behavioral side,' it's more like 'how are we going to treat these patients together?' There's a partnership."

That's according to David Lin, Psy.D., Chief of Outpatient Medical Psychiatry Services at SMMC. And he says it wasn't always like that.

"When I was in training, it felt very segregated."

"In San Mateo, it's not about 'I'm going to treat the physical, you treat the behavioral side' ... there's a partnership."

Dr. Lin says before this program, patients would have to get referrals back and forth, they'd have to wait to be called by the office, messages could get lost, the "phone tag" process could go on for weeks, and even in ideal scenarios, care would be delayed by at least a day or two. Now, patients don't feel like they're lost in the shuffle, they feel like they are being cared for. The warm handoff DSRIP pilot has made all the difference.

"I can think of one diabetes patient who had PHQ-9 (depression screening) scores in the twenties, which is dangerously high. After receiving care for both his diabetes and depression, not only were his glucose levels improving, but his PHQ-9 score was down to three or four."

Just as untreated behavioral health issues can negatively impact a patient's ability to care for his or her physical health, having those issues acknowledged and treated can lead to positive physical health outcomes. The pilot has expanded now to two clinics, with plans to expand to all four.

Now, patients don't feel like they're lost in the shuffle.

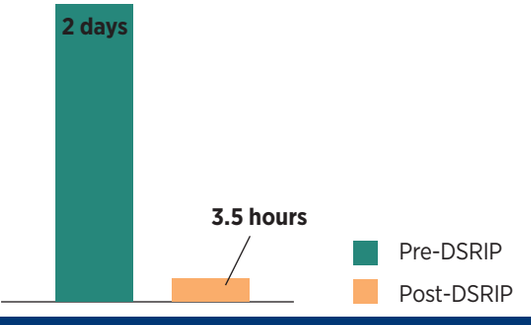
David Lin, Psy.D., Chief of Outpatient Medical Psychiatry Services at San Mateo Medical Center

ACCELERATING QUALITY IMPROVEMENTS

- The presence of "Low Quality Safety Plans" in the Acute Psych unit has been **cut by more than 80% - from 41% to 8%.**

- SMMC has achieved a **25% increase** in compliance with the Sepsis bundle, and a **77% reduction in Sepsis mortality.**

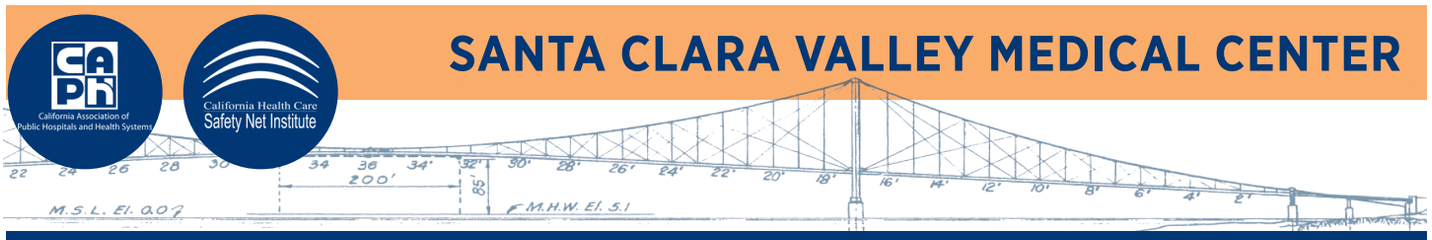
- Fax prescription refill times at one target clinic now take an average of **3.5 hours to complete**, a massive drop from the pre-DSRIP average of more than two days.



STATISTICS

SAN MATEO MEDICAL CENTER
Beds: 509
Hospitals: 1
Outpatient Clinic Facilities: 10
Annual Inpatient Discharges: 3,588
Annual Outpatient Visits: 246,118
Est. DSRIP Funding Earned: $67.9M

SAN MATEO COUNTY
Population: 720K
Municipalities: 16, including Daly City, Redwood City, and South San Francisco



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5. Improving care coordination for patients with HIV/AIDS

Santa Clara Valley Medical Center (SCVMC) took on 19 projects with a total of 262 milestones across the five years of the DSRIP.

Santa Clara Valley Medical Center is located in San Jose, the heart of Silicon Valley and the tenth most populous city in the country. Despite the region's wealth in the high-tech industry, Santa Clara is home to a large low-income population, including an estimated 40,000 who have become eligible for Medi-Cal through the Affordable Care Act (ACA). SCVMC needed to prepare for ACA implementation by expanding its primary care capacity, and improving both access and patient experience to compete as a provider of choice to the county's newly-insured.

Here are some of the system's accomplishments.

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EXPANDING CAPACITY AND ACCESS

Prior to DSRIP, Santa Clara Valley Medical Center's adult primary care was serving 38,000 empaneled patients and SCVMC did not have any data-driven method for managing patient health needs. In an effort to expand capacity and better organize care delivery, the Office of Panel Management was established to more effectively connect patients with available primary care providers and clinical teams. This new system, along with a stronger IT infrastructure, allowed SCVMC to better assess which providers could see more patients, and more quickly connect new patients with clinical care teams. As a result, adult primary care capacity has **increased to over 63,000 patients, a 66% jump.**

SCVMC also expanded access to primary care services through hiring of additional providers and support staff, the construction of a new health center in an under-served downtown area, expanded clinic hours, and a redesigned schedule to accommodate urgent needs. The results were dramatic. The annual number of primary care visits **increased from approximately 103,000 to 155,000.** The "third next available appointment" (industry standard for measuring wait times, to account for cancellations) **dropped from 53 days to less than 48 hours across all six primary care sites.**

Through the DSRIP, SCVMC implemented a chronic care model throughout every medical home to target patients with chronic conditions in a proactive, patient-centered, evidenced-based manner. At one site, the Valley Homeless Healthcare Program, the chronic care model was applied to frequent emergency department utilizers. Through community health workers that are a critical component of the care team, patients are able to quickly access primary and specialty services they need outside the emergency department, and they learn how to more proactively manage their own chronic diseases. In the last available data year, emergency department **use among 70 tracked patients dropped from 226 visits to just 46.**

Nutrition class at Santa Clara Valley Medical Center

VALLEY HOMELESS HEALTHCARE PROGRAM

Through the DSRIP, Santa Clara Valley Medical Center has collaborated with clinic staff at the Valley Homeless Healthcare Program (VHHP) and peer advocates to improve its efforts to remove barriers to care among patients who are chronically homeless. DSRIP efforts to standardize panel management and reporting have meant that patients are now being more efficiently connected with primary care teams.

"We went from treating him for a leg wound, to helping him turn his life around."

The application of the chronic care model has meant more effective care management for patients with chronic conditions, especially frequent emergency department utilizers, who now have better access to additional supports and services they need.

This commitment to better overall health – not just immediate care – can mean the world to the program's patients. Dominga Villagomez, RN, tells the story of a 56 year-old man, J.S., who was treated by the program's mobile clinic in a homeless encampment in San Jose known as "The Jungle."

"We went from treating him for a leg wound, to helping him turn his life around," says Villagomez.

The mobile clinic helped stabilize J.S.'s wound so that he could be transported to the hospital for proper care. There, his care team discovered a myriad of other physical health concerns, including anemia and syphilis, as well as behavioral health issues and struggles with addiction. And a case manager discovered that he was eligible for – and not receiving – social security.

The strengthened and more robust care coordination among SCVMC staff helped J.S. transition from the hospital to SCVMC's medical respite program, where his team could continue to care for his physical and behavioral health needs even after his leg was healed, and where his community health worker could keep helping him apply for social supports, including housing assistance.

"J.S. went from the clinic, to the hospital, to the respite, to a real home," says Villagomez. "Now his girlfriend is moving in with him."

"We've always cared about keeping our most vulnerable patients healthy, but these improvements have allowed us to do more for them."

"J.S. went from the clinic, to the hospital, to the respite, to a real home."

Inside SCVMC's Valley Homeless Healthcare Program mobile clinic

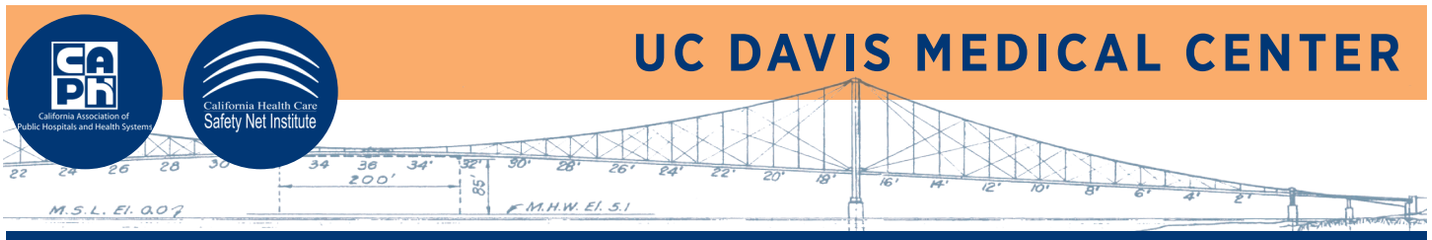
ADDRESSING URGENT IMPROVEMENTS

- Santa Clara Valley Medical Center has made dramatic improvements in addressing sepsis, **increasing its compliance with the sepsis bundle from 19% to 68%, while cutting its mortality rate in half, from 14.6% to 7.3%.**
- Through improved practices and procedures, including a new blood culture policy and an increased emphasis on education about central line maintenance and insertion, SCVMC has **cut its rate of central line-associated bloodstream infection (CLABSI) in its intensive care units from a baseline of 0.46% to 0.28%.**

STATISTICS

SANTA CLARA VALLEY MEDICAL CENTER
Beds: 574
Hospitals: 1
Outpatient Clinic Facilities: 9
Annual Inpatient Discharges: 24,700
Annual Outpatient Visits: 778,000
Est. DSRIP Funding Earned: $286.8M

SANTA CLARA COUNTY
Population: 1,894,000
Municipalities: 24, including San Jose, Santa Clara, and Sunnyvale



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University of California Davis Medical Center (UCD) took on 14 projects with a total of 196 milestones across the five years of the DSRIP.

By 2010, UC Davis Medical Center had already gotten a jumpstart on many of the activities that its fellow public health systems would be undertaking through the DSRIP, like the utilization of a disease management registry. But DSRIP enabled UC Davis to enhance these efforts and better prepare for implementation of the Affordable Care Act. UCD's DSRIP projects built upon existing progress to improve care for patients with chronic conditions and expand critical harm reduction efforts.

Here are some of the system's accomplishments.

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TRANSFORMING PATIENT CARE AND EXPERIENCE

UC Davis Medical Center implemented a care transitions program to help manage patients with chronic conditions who were at risk of readmission to the emergency department, either because of other conditions, or because of a lack of access to post-discharge care. In the most recent data year, clinical case management staff provided interventions to **62% of patients** who had made at least four visits to the ED in three months.

UC Davis Medical Center utilized a Patient Flow Improvement Initiative, intended to provide inpatient care quicker and increase hospital capacity. As of the most recent data year, the number of patients with stays greater than twenty days has been **cut from 90 to 54,** and the average daily admission rate has been **increased by 5 patients per day.**

Through the DSRIP, UC Davis Medical Center began collecting and analyzing REAL (Race, Ethnicity, and Language) data through its electronic health records system. UCD is now collecting REAL data for **90% of its patients**, and is analyzing the data to identify health disparities and develop targeted care for specific populations.

Many of these patients are now also receiving education on medication management. In the most recent data year, UCD provided medication education to **75% of the target patient population.**

Doctor and patient at UC Davis Medical Center

E-WOUND WEBSITE

Many DSRIP projects undertaken by California's public health systems employed multidisciplinary teamwork. Perhaps no project exemplifies this strategy better than UC Davis Medical Center's "SWA-T" (Skin Wound Assessment-Treatment) team, which consists of a nurse practitioner, a physical therapist, a dietician, a plastic surgeon, a bariatric specialist, and five wound certified nurses.

This team is not only able to provide expert care on-site. Thanks to UCD's "e-Wound" website, some patients are receiving expert-guided care without even having to leave home.

The patient lived far away from the hospital, and couldn't easily return nearly as often as he'd need to.

For example, UC Davis Medical Center treated a 26 year old spinal cord-injured male in the emergency department, who had fallen asleep in his wheelchair the night before. His ($600) seat cushion had deflated, leaving him with a large deep tissue injury that would require months of specialized treatment. But the patient lived far away from the hospital, and couldn't easily return nearly as often as needed.

UCD staff taught the patient's father how to photograph the wound and upload the photos to the system's "e-Wound" website. The hospital had dressings delivered to the patient's home, and each week, staff would monitor the patient's injury, and instruct his father on how to treat the wounds based on the progress he had made.

He received 3 months of skillful care, despite only spending a few hours in the emergency department.

The patient needed three months of skillful care to heal his pressure ulcer, which he received – despite only spending a few hours in the emergency department.

UC Davis Medical Center SWA-T Team

ADDRESSING URGENT IMPROVEMENTS

- Leaders in peri-operative care have joined with the "SWA-T" team to identify patients at risk for pressure ulcers and to implement interventions during procedures to decrease the incidence of deep tissue injury. UC Davis Medical Center's Hospital-Acquired Pressure Ulcer (HAPU) rate has been **nearly halved, from 1.36% to 0.7%**.

- UC Davis Medical Center increased its compliance with the sepsis bundle by **more than 20%** over its baseline, and **reduced its sepsis mortality rate by more than 25%.**

STATISTICS

UC DAVIS MEDICAL CENTER
Beds: 619
Hospitals: 1
Outpatient Clinic Facilities: 16
Annual Inpatient Discharges: 32,300
Annual Outpatient Visits: 946,000
Est. DSRIP Funding Earned: $151.8M

UC IRVINE MEDICAL CENTER

DSRIP 2010-2015: SUCCESSES TO BUILD ON

In 2010, California helped develop the nation's first Delivery System Reform Incentive Program (DSRIP), a pay-for-performance initiative for public health care systems to achieve delivery system-based performance milestones and earn a portion of up to $3.3 billion in federal incentive payments. The DSRIP was an unprecedented opportunity to expand capacity and transform care, and was included as part of California's five-year Section 1115 **"Bridge to Reform"** Medicaid Waiver.

Through the DSRIP, California's 21 public health care systems have expanded upon their existing quality improvement efforts and made them large-scale. Each individual health care system's DSRIP plans have included projects aimed at making improvements across the inpatient and outpatient setting in five major categories:

1. Developing and strengthening their infrastructures
2. Implementing innovative models of care
3. Advancing the health of the populations they serve
4. Continuing to make improvements in quality and patient safety
5. Improving care coordination for patients with HIV/AIDS

University of California Irvine Medical Center (UCI) took on a total of 19 projects with a total of 262 milestones across the five years of the DSRIP.

UC Irvine Medical Center found itself in a unique position when the Affordable Care Act was set to roll out, thanks to decades of experience under Orange County's "Medical Services Initiative" (MSI), which provided health care services to about 60,000 medically indigent patients. The MSI program was established in 1983. UCI knew what to expect when coverage would expand – and could begin making the necessary improvements to their system well in advance of ACA implementation. Learnings and patient care models, implemented as a result of Orange County's participation in Low Income Health Program (LIHP) under the first three years of the "Bridge to Reform" Medicaid Waiver, contributed to facilitating this expansion and transition. This knowledge led to UCI focusing its DSRIP efforts on shifting its model of care away from traditional disease-based interventions, and more toward a population-based care delivery model, while making needed improvements in harm reduction.

Visit caph.org/DSRIPsuccess to see cumulative results for the entire state, as well as for each other individual health system.

TRANSFORMING CARE AND EMPOWERING PATIENTS

UCI developed and implemented risk stratification measures and methods for assessing at-risk patients and instituting effective chronic disease care. Risk stratification scoring was integrated into the EHR and chronic disease registries, and is utilized for identification of patients with the greatest need for chronic disease coaching and additional support from the care team. As a result, the percentage of diabetic patients with controlled Hemoglobin A1c levels has **increased from 31% to 51%**, the percentage of diabetic patients with controlled LDL-C levels **increased from 25% to 39%,** and the rate of Congestive Heart Failure has **decreased nearly six fold - from 2.77% to 0.47%.**

UCI piloted several methods of reducing emergency department visits for medical home-managed seniors with chronic conditions, including empaneling those patients to a primary care physician and encouraging a minimum of two visits annually, doing additional education for patients at high risk of readmission, and even performing remote home monitoring, using iPads, for a handful of patients. As a result, emergency department utilization has **fallen by 27% among the targeted group.**

UCI has used the DSRIP to begin a volunteer program called "Health Connectors" at its federally qualified health center sites, which includes health coaching services. In the most recent data year, chronic disease coaching was provided to **55% of eligible heart failure patients and 98% of eligible diabetes patients.** The Health Connectors program also includes bilingual volunteers who connect patients to valuable community health resources, assist patients in making first contact with these resources and offer healthy lifestyle classes on topics such as cooking, exercise and mindfulness.

Doctor and patient at UC Irvine Medical Center

INNOVATION IN HARM REDUCTION

As one of its DSRIP initiatives, UC Irvine implemented a series of interventions to improve early detection of patients at high risk for Central Line-Associated Bloodstream Infection (CLABSI) and to encourage removal of central lines at the earliest opportunity. Chief among these was the creation of an innovative "central line insertion site assessment" (CLISA) score.

"Communication between nurses and doctors about the condition of central lines was inconsistent," says Dr. Shruti K. Gohil, MD, MPH; a specialist in Infectious Disease and Internal Medicine.

Like most hospitals, UC Irvine was relying on nonstandard descriptive terms that were open for interpretation. (One nurse's "pink" might be another nurse's "red," and so forth.) There was also no clear directive on what clinicians should do when they found signs of inflammation or infection, and no set method of conveying information.

Each patient's insertion site is given a score, which is electronically embedded on a daily basis.

UCI's CLISA program requires each care team member to assess each patient's insertion site and assign it a numeric score, based on clear guidelines. This score is now electronically embedded into nursing flowsheets and physician progress notes on a daily basis. If the score is above a certain level, or if a patient has had a central line in place for more than ten days, physicians are automatically alerted.

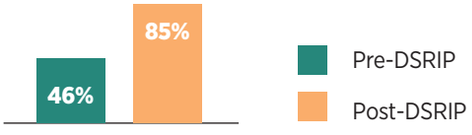
"It's about identifying high risk patients, detecting problems at the earliest possible moment, and taking action swiftly. We know that proactive prevention practices can save lives," says Dr. Gohil.

"We know that proactive prevention practices can save lives."

UCI CLABSI performance improvement team

ADDRESSING URGENT IMPROVEMENTS

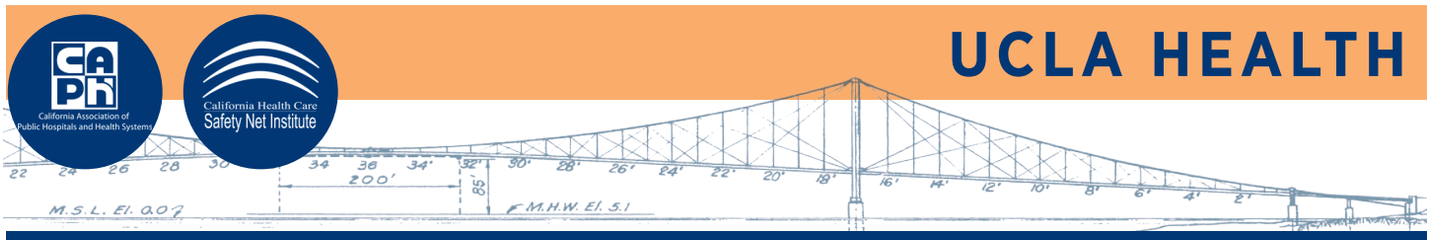
- In addition to its groundbreaking CLISA program, UCI has improved its Central Line Insertion Practice (CLIP) compliance **from 46% to 85%**. As a result of both of these interventions, UC Irvine has achieved an **80% drop in CLABSI rates in its intensive care unit, and a 67% drop in its non-intensive care units.**



- UC Irvine's commitment to harm reduction extends to other areas as well. In an effort to reduce Hospital Acquired Pressure Ulcers (HAPU), UCI implemented new policies and procedures to assess, document and monitor patients' skin and wounds. As a result, in the most recent available data year, UCI **decreased its rate of HAPU from 5.74% to 1.66%**

STATISTICS

UC IRVINE MEDICAL CENTER
Beds: 411
Hospitals: 1
Outpatient Clinic Facilities: 6
Annual Inpatient Discharges: 19,300
Annual Outpatient Visits: 595,000
Est. DSRIP Funding Earned: $91.3M



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5. Improving care coordination for patients with HIV/AIDS

UCLA Medical Center took on 14 projects with a total of 131 milestones across the five years of the DSRIP.

At the start of the DSRIP, UCLA Medical Center found itself wanting to address the coming challenge of Affordable Care Act implementation and Medi-Cal expansion – but UCLA decided not just to aim at expanding capacity and improving conditions within its own system. Studies showed that California would soon be facing a massive physician shortage. Worse, those studies showed that the pool of physicians did not accurately reflect the diversity of California's population, and this gap would likely get wider. UCLA worked on transforming its primary care, and also decided to build on its own reputation as a world-class teaching hospital, and set out to help build a stronger workforce for the entire state.

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EMBRACING DIVERSITY IN PRIMARY CARE WORKFORCE

California's population is roughly 40% Latino. Among California's primary care physicians, that number is about 6%. Across the state, there is a severe lack of Spanish-speaking, culturally adept primary care physicians. "Before our program, these professionals were sidelined," says Michelle Anne Bholat, M.D., M.P.H., executive director of UCLA's Internal Medical Graduate (IMG) program and vice chair of the UCLA Department of Family Medicine.

"Before our program, these professionals were sidelined."

Through the DSRIP, UCLA developed and implemented a landmark program to educate unlicensed Hispanic/Latino IMG physicians who had practiced medicine in Latin America and who were legally residing in the US. The UCLA program helped prepare these physicians so they could pass US licensing exams, and obtain positions in Family Medicine residency programs in California.

Graduates of the IMG program are required to commit to two to three years of postresidency employment at a community health center in one of California's more than 500 federally designated shortage areas for primary care.

"There's been a brain waste," says Dr. Bholat. This program, which had existed as a pilot project but was accelerated through the DSRIP, is trying to change that.

UCLA's program has become a model for health care systems across the country.

Over the course of the DSRIP, 41 culturally competent International Medical Graduates have entered family residency training programs in California, and UCLA's program has become a model for health care systems – not just in California, but across the country. Interest is growing in replicating the program elsewhere, with inquiries coming from other states, including Texas and Illinois.

Class of 2014, UCLA IMG program

TRANSFORMING PRIMARY CARE

UCLA Medical Center initiated a medical home model for pediatric patients with complex conditions, assigning care coordinators to manage their cases. This extra level of coordination has resulted in **28% fewer all-cause 30-day readmissions, 40% fewer hospitalizations, 49% fewer emergency department visits, and 15% more visits to general pediatrics.**

UCLA's pilot medication management program has enabled more than 3,000 consultations between primary care physicians and pharmacists for the purposes of identifying and correcting potential medication-related problems, such as drug-drug and drug-disease interactions. These consultations have led to **more than 1,000 medication adjustment recommendations.**

1,000
medication adjustment recommendations

A project called MyMeds identifies diabetic patients with one or more uncontrolled cardiovascular risk factors, and works to identify and remove barriers to medication adherence. **All 300 of the program's initial participating patients experienced an improvement in blood pressure rates, regardless of risk factors.**

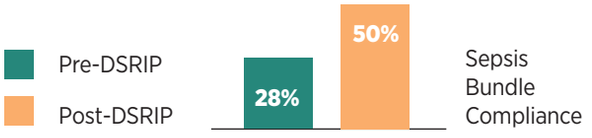
300 **participants experienced improvement**

UCLA sought to transform care provided to patients with specific chronic diseases known to pose a high risk of readmission and other care coordination challenges. Focusing on heart failure patients, UCLA developed and implemented the care transition protocols that are now applied to **nearly 90% of all heart failure patients aged 50 and over.** Patients receive enhanced care, additional heart failure education materials, telephone follow up calls post-discharge, and/or remote tele-monitoring. Building on that success, the protocol is expanding to acute myocardial infarction patients.

Patient with care team at UCLA Medical Center

ADDRESSING URGENT IMPROVEMENTS

- UCLA Medical Center has increased its compliance with the sepsis bundle, **from a baseline of 28% to nearly 50%.** UCLA has experienced a similar drop in mortality rates among patients coded with septic shock and severe sepsis, **from 41% to 26%.**



- UCLA has increased its compliance with Central Line Insertion Practices (CLIP) compliance rate **from 96.5% to almost 99%,** and has **decreased its Central Line-Associated Bloodstream Infection (CLABSI) rate by 20% in its acute care units.**

- UCLA Medical Center has **nearly halved its rate of Hospital Acquired Pressure Ulcers (HAPU) from a baseline of 3.92% to 2.09%** according to the most recent data.

STATISTICS

UCLA MEDICAL CENTER
Beds: 805
Hospitals: 2
Outpatient Clinic Facilities: 29 separate facilities, 150 clinics
Annual Inpatient Discharges: 42,100
Annual Outpatient Visits: 706,000
Est. DSRIP Funding Earned: $127.5M

UC SAN DIEGO HEALTH SYSTEM

DSRIP 2010-2015: SUCCESSES TO BUILD ON

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4. Continuing to make improvements in quality and patient safety
5. Improving care coordination for patients with HIV/AIDS

UC San Diego Health System (UCSDHS) took on 32 projects with a total of 329 milestones across the five years of the DSRIP.

At the outset of the DSRIP, the county of San Diego found itself near the very beginning of a massive growth period, with experts predicting the population would increase by 15% between 2008 and 2020. This boom, coupled with a large population of low-income individuals and families who would become newly-eligible for Medi-Cal under the Affordable Care Act, meant that UCSDHS would need to build upon its infrastructure and redesign some of its core delivery systems in order to keep pace with the growing needs of the community it serves. UC San Diego Health System focused many of its efforts on innovative uses of technology, and on better understanding the needs of its patients.

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UTILIZING TECHNOLOGY AND IMPROVING EMERGENCY CARE

UCSDHS recognized that leveraging its electronic patient portal, MyUCSDChart was critical to improving primary care capacity, preventative services, and care coordination. Through patient education and engagement efforts, enrollment in MyUCSDChart **has nearly doubled, from 37% to 66%.**

UC San Diego Health System used DSRIP to vastly expand its telemedicine program, which links UCSDHS specialists with community partners (like the San Diego County Jail and Temecula Valley Hospital, located 58 miles away) in order to provide emergent care services remotely. In the most recent data year, UCSD averaged ten of these consultations per week, **a 362% increase over baseline.**

UC San Diego Health System embarked on multiple organization-wide efforts to improve patient flow in the emergency department and reduce wait times. UCSDHS's "Triage Re-design and Implementation Pod Project (TRIPP)" led to a streamlined check-in and triage system, and the reassignment of nurses in physical configurations that gave them easier access to ED patients. The median time from arrival to room has been **more than halved, from 22.2 minutes at the outset of the project to just 9.9 minutes.**

In an effort to better serve its diverse patient population, UC San Diego Health System worked to strengthen the work of its on-site interpreters and phone interpreters, and added video remote interpretation services, which has been particularly helpful for the hearing impaired. With more access and improved services, interpreter services have **expanded by 220%** over the baseline **to an average of 3,369 interpreter encounters each month.**

Physicians at UC San Diego Health System

EXPANDING PALLIATIVE CARE

Palliative care is specialized medical care for people with serious illnesses, which focuses on holistically providing patients with relief from the symptoms and pain caused by those illnesses, and providing patients and their families with additional support associated with a patient's illness. Palliative care is often provided alongside curative treatment for serious illnesses, and can help patients and their families make decisions about those treatments.

"No patient lives in a vacuum," says Dr. William Mitchell, Medical Director of Palliative Care at UC San Diego Health System.

"No patient lives in a vacuum."

UCSDHS already had a well-established palliative care program, but DSRIP provided the opportunity to greatly expand its reach. By increasing the size of its staff and focusing on building relationships with individual physicians who care for patients with severe illness, UCSDHS has more than doubled the number of annual palliative care consults since the start of the DSRIP. This can mean a deep sense of comfort to twice as many patients and their families.

Dr. Mitchell describes the case of a man in his 30s suffering from advanced Leukemia, despite multiple treatments spanning several years. "He was exhausted, but wanted to maintain a brave face, and felt responsible to continue fighting. His family wanted to maintain a supportive attitude, but they were struggling watching him suffer. Each had doubts about the ongoing therapy, but couldn't discuss it with each other.

"When we talked about it together, there was a huge wave of relief that passed through the entire room."

With patients who have serious illnesses, "we often keep providing care because we can," says Dr. Mitchell, "even if sometimes in these cases it's not what patients and their families want."

"When we talked about it together, there was a huge wave of relief that passed through the entire room."

William Mitchell, MD, director of the Palliative Medicine program at UCSDHS

ADDRESSING URGENT IMPROVEMENTS

- UC San Diego Health System focused on enforcing the consistent application of surgical site infection (SSI) prevention strategies, including pre-operative bathing and restricting operating room traffic among providers and saw its SSI percentage **plummet from 4.3% to 1.03%**
- UCSDHS used DSRIP to pilot an early intervention system that equips clinicians with tools for preventing hospital-acquired infections. The pilot was focused specifically on CAUTI (catheter associated urinary tract infection) and involved intensive education on proper preventative procedures, regular monitoring and overall improved patient care. As a result, **the adult Intensive Care Unit (ICU) CAUTI rate has fallen from an average of 7.42 per 1,000 urinary catheter days to 3.5.**

STATISTICS

UC SAN DIEGO HEALTH SYSTEM
Beds: 563
Hospitals: 2
Outpatient Clinic Facilities: 10
Annual Inpatient Discharges: 27,900
Annual Outpatient Visits: 656,000
Est. DSRIP Funding Earned: $99.3M

UC SAN FRANCISCO MEDICAL CENTER

DSRIP 2010-2015: SUCCESSES TO BUILD ON

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4. Continuing to make improvements in quality and patient safety
5. Improving care coordination for patients with HIV/AIDS

University of California San Francisco Medical Center (UCSF) took on 14 projects with a total of 190 milestones across the five years of the DSRIP.

UCSF had a major task ahead of it to prepare for the implementation of the Affordable Care Act. UCSF's DSRIP strategy was focused on streamlining processes to enhance patient experience and expand capacity, and implementing population health measures to keep new and existing patients healthier – all through improvement processes that could be replicated in other areas of the system.

Here are some of the system's successes.

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TRANSFORMING PRIMARY CARE

One of UCSF's DSRIP projects was to create, maintain, and encourage patient use of an electronic portal called "MyChart," resulting in a significant increase in patients requesting and receiving medical advice from their providers. In the most recent data year, primary care providers **received over 87,000 requests** for medical advice from their patients through the portal.

Patients can do more than seek and receive medical advice electronically; in the most recent data year, UCSF registered **more than 3,800 "virtual" primary care encounters via the portal.**

UCSF focused several DSRIP projects on expanding primary care capacity, including the launch of "In-Quicker," an internet based direct scheduling system for same-day in-person visits. UCSF is now seeing **over 12,200 more patients annually, an increase of 12% over their pre-DSRIP baseline.**

UCSF also used DSRIP support to focus on several preventative health projects. UCSF increased its influenza immunization rate by **53% of its baseline, with almost half of patients now receiving flu shots, and increased its mammography rates by 15%.**

To transform the practice of medical homes, all primary care clinics adopted a 'teamlet' model for care delivery, expanding the role of medical assistants. The percentage of clinicians who reported high confidence in staff to do panel management **increased by 75%** for immunizations and **increased by 100%** for diabetes care and cancer screening.

UCSF's Care Support project was aimed at improving the health and health care experience of medically and psychosocially complex patients, by providing patient-centered education, care coordination, and psychosocial support in the primary care setting. As a result, the percentage of those patients who did not utilize the ED **rose from 40% to 54%**, and the percent who did not utilize the hospital **rose from 33% to 60%**. Among those who did have inpatient stays, the average length-of-stay was **reduced from 6 days to 5,** and patients' self-reported "good health" was significantly better after enrollment.

UCSF representatives receiving an award for complex care management

LIFESAVING TESTS

One of UCSF's DSRIP projects was to empower panel managers/ health coaches to actively manage registries for colorectal cancer screening for primary care patients using FIT (fecal immunochemical test) kits. One of these kits, and the care of a dedicated team, may have saved a patient's life.

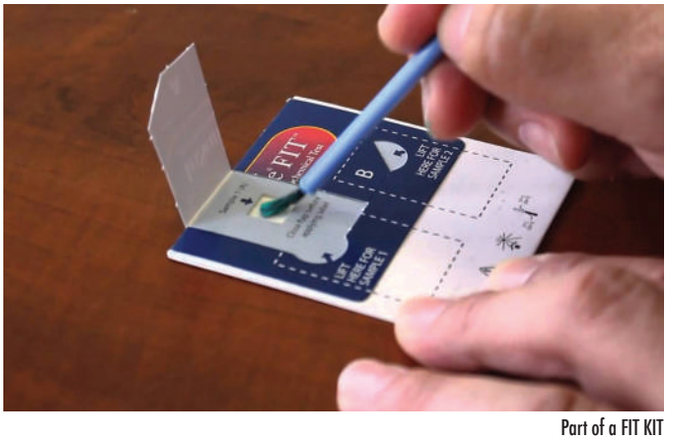
The patient had what could have been a life-threatening 4 cm invasive colon cancer removed in January.

A patient at UCSF's Lakeshore clinic, Ms. White, was targeted by this DSRIP project, and was reminded to complete her FIT by a Licensed Vocational Nurse as part of a system-wide campaign. Her test came back positive, and a colonoscopy was scheduled almost immediately by a Medical Assistant who was part of this patient's medical team. The patient had what could have been a life-threatening 4 cm invasive colon cancer removed from her sigmoid colon in January.

Because it was caught early, doctors were able to remove Ms. White's whole tumor surgically; it had not grown through the wall of the colon, and all of the lymph nodes were negative.

Had staff not taken this proactive approach with Ms. White when they did, it might have been too late.

This DSRIP project enabled UCSF to focus on preventative health and screening, and to shift away from a strictly reactive way of doing business. Had staff not taken this proactive approach with Ms. White when they did, it might have been too late.

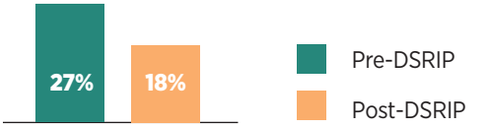


Part of a FIT KIT

ADDRESSING URGENT IMPROVEMENTS

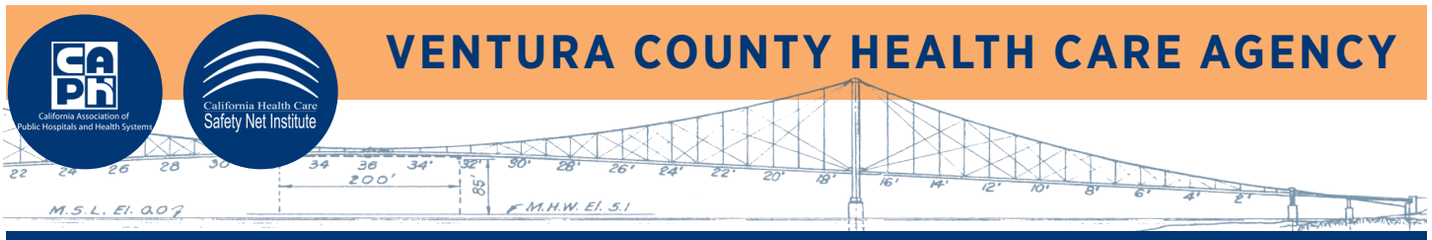
- UCSF has increased its compliance with Central Line Insertion Practices (CLIP) protocol to 99.6% and has seen a **19% reduction** in Central Line-Associated Bloodstream Infection (CLABSI) rate in acute care, and a **50% reduction** in CLABSI rate in critical care.

- UCSF created a screening tool to allow for the early identification of sepsis patients, developed a trigger notification mechanism to alert care providers when sepsis was suspected, and has more than doubled its compliance with the sepsis bundle, **from 39% to 83%**. As a result, UCSF has **reduced its sepsis mortality by one third, from a pre-DSRIP baseline of 27% to 18%.**



STATISTICS

UC SAN FRANCISCO MEDICAL CENTER
Beds: 720
Hospitals: 2
Outpatient Clinic Facilities: 16
Annual Inpatient Discharges: 29,000
Annual Outpatient Visits: 1,536,000



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Ventura County Health Care Agency (VCHCA) took on 27 projects with a total of 187 milestones across the five years of the DSRIP.

Ventura County Health Care Agency found itself facing two challenges at the outset of the DSRIP. Like all California's public health care systems, VCHCA had to prepare for the implementation of the Affordable Care Act and the expansion of Medi-Cal, which meant a need to increase capacity, with a special emphasis on expanding its chronic care management models to keep patients healthier. But Ventura County had an additional challenge, which was a dire shortage of local primary care providers. VCHCA aimed its DSRIP projects at all of these targets.

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CHRONIC CARE MANAGEMENT

VCHCA developed the "Transitions Clinic," which serves as a critical transition for patients who have been discharged, but need follow-up care before their next primary care visit in order to avoid readmission. The Transitions Clinic, which originally piloted with an emphasis on patients with congestive heart failure and chronic obstructive pulmonary disease, has expanded its scope to include other patients at moderate to high risk of readmission to provide linkage with outpatient continuity care. The care is provided frequently and as often as daily, if needed. The clinic is seeing an average of **66 patients per month,** 10% of whom are receiving care multiple times before their next primary care visit. There has been measurable improvement in readmission rates in VCHCA hospitals through these efforts. In addition, due to the success of the Transitions Clinic, its scope has also been expanded to include high risk patients discharged from the emergency room who need linkage with outpatient primary care.

In order to expand access, VCHCA piloted methods of reducing "no-show" appointments in three clinics, including increasing staff awareness of the need for reminder calls, utilization of its EHR's appointment cancellation report, and improved communication between the patient and the clinic during a patient's scheduled appointments. In the three pilot clinics, "no-show" rates **fell from an average of 8.25% to an average of 3.1%.**

At the beginning of the DSRIP, VCHCA developed a Chronic Care Management Model for diabetes to help patients better manage their chronic condition. The Model involved the formation of multidisciplinary teams and the use of a disease registry. Since its inception, the diabetic registry tracks over 70% of patients seen in the Diabetic Center. Of the patients in the registry, **over 81%** have completed two of three tests (LDL, retinal screening, HgbA1c), and **93%** have self-management goals. Across these patients, LDL levels have improved by **an average of 12%.**

Doctor and resident with patient at Ventura County Health Care Agency

DIABETES GROUP MEDICAL VISITS

"I actually have recommended the classes to friends," says Linda Villegas, a patient at Ventura County Health Care Agency's Las Islas Diabetes Center. She's talking about the group medical visits instituted at Las Islas as part of VCHCA's DSRIP work on expanding chronic care management models.

Linda had just been diagnosed with diabetes upon starting the group visits, so hearing about other patients' experiences with their diabetes really helped. "Patients are encouraged to come together and socialize with the goal that they will offer support to one another," says Karla Alcaraz, RN, CDE, the case manager who organizes group visits. "Many maintain friendships beyond the scope of the class."

"Patients are encouraged to come together and socialize with the goal that they will offer support to one another."

Alcaraz says the programs are showing incredible results. Three quarters of patients who were not at their LDL goal when starting the class did get to an LDL less than 100 upon completion. More than half of patients who were not at their A1c goal achieved an A1c less than 7, or **at least a 1-point drop**. Some patients have lowered HbA1c by **more than 2 points** over the course of these visits, and several have **lost 15-20 pounds**.

"The classes put you on track to manage and improve self-care," says Villegas.

Diabetes group visit at VCHCA's Las Islas Diabetes Center

"The classes put you on track to manage and improve self-care."

TEACHING AND TRAINING

VCHCA implemented a Family Medicine Faculty Development Fellowship program to expand the pool of physicians qualified to train new primary care residents. With a faculty to resident ratio of 1:6, each new fellow trained by the program allows for the training of 6 additional residents, expanding the primary care workforce pipeline. In September 2014 the VCHCA Family Medicine Residency program was named the #1 family medicine program in the United States by US News and World Report and Doximity.

ADDRESSING URGENT IMPROVEMENTS

Ventura County Health Care Agency is embedding a culture of improvement through successful harm reduction efforts.

- Through the guidance of its Surgical Site Infection (SSI) Taskforce, VCHCA saw SSI **drop in half** with its standardized infection ratio decreasing from **2.315 to 1.060.**
- The prevalence of hospital-acquired pressure ulcers also dropped **in half from 3.85% to 1.57%.**

STATISTICS

VENTURA COUNTY HEALTH CARE AGENCY
Beds: 208
Hospitals: 2
Outpatient Clinic Facilities: 20
Annual Inpatient Discharges: 11,500
Annual Outpatient Visits: 418,000
Est. DSRIP Funding Earned: $114.5M

VENTURA COUNTY
Population: 846K
Municipalities: 23, including Oxnard, Thousand Oaks, and Ventura

ABOUT CAPH AND SNI

The California Association of Public Hospitals and Health Systems (CAPH) and the California Health Care Safety Net Institute (SNI) represent California's public hospitals, health care systems and academic medical centers.

CAPH MISSION

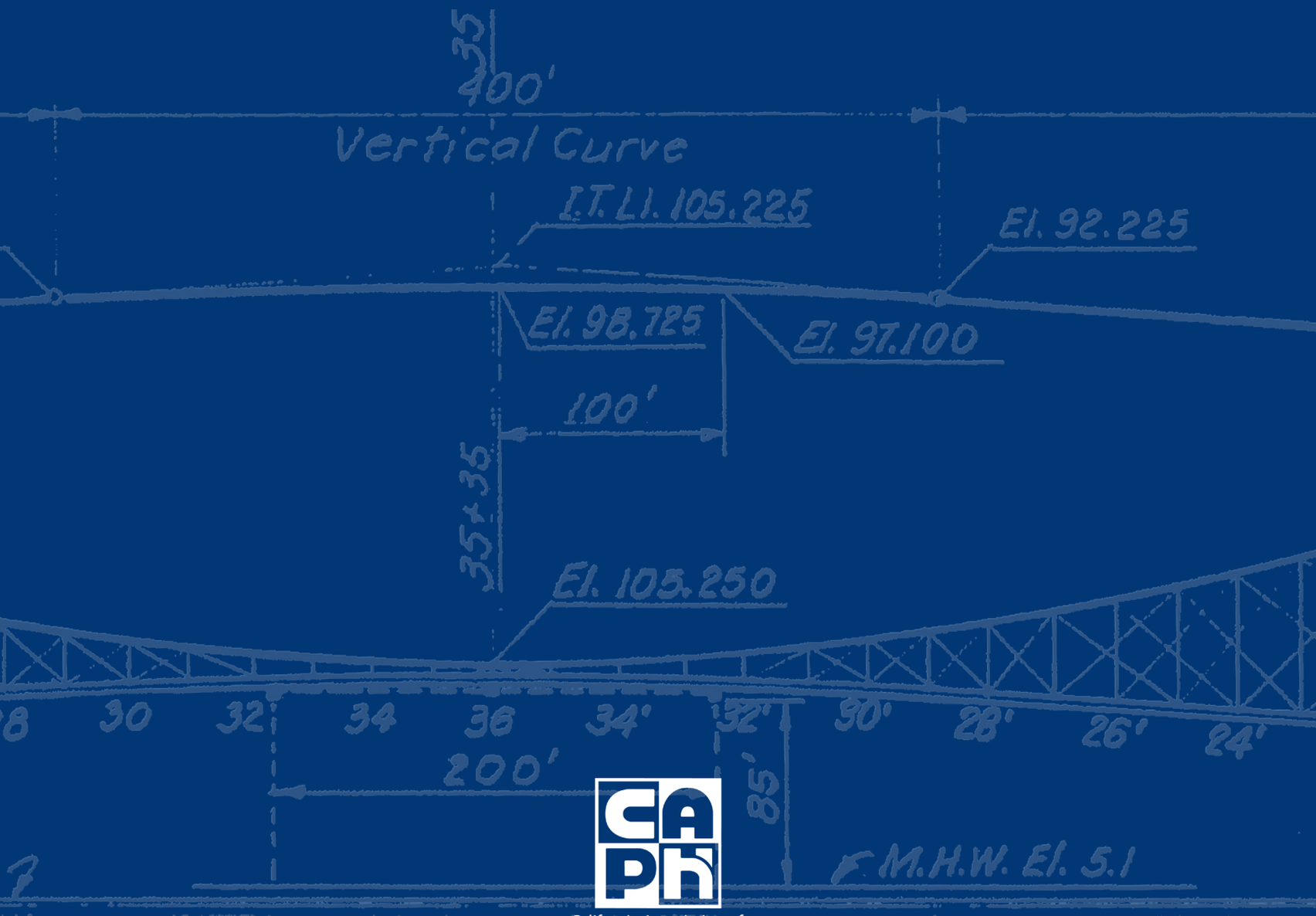
For 30 years, CAPH has passionately believed that everyone deserves an equal opportunity to enjoy good health, regardless of their insurance status or ability to pay, and this belief is what drives our policy and advocacy agenda. As a non-profit trade organization representing California's public health care systems, CAPH works to strengthen the capacity of its members to advance community health; ensure access to comprehensive, high-quality, culturally sensitive health care services for all Californians; and educate the next generation of health care professionals.

SNI MISSION

The California Health Care Safety Net Institute (SNI) is the quality improvement partner of the California Association of Public Hospitals and Health Systems (CAPH). SNI designs and directs programs that accelerate the spread of innovative practices among California's public hospitals, public clinics and beyond. Because of SNI's work, more people — especially those most affected by health disparities — receive effective, efficient and respectful health care regardless of their circumstances.

VISIT CAPH.ORG OR SAFETYNETINSTITUTE.ORG FOR MORE INFO

Nurse and patient at San Mateo Medical Center in San Mateo, CA



California Association of
Public Hospitals and Health Systems

California Health Care
Safety Net Institute

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