



Leading National Efforts to Improve Patient Care

California's 21 public health care systems (PHS) are on a shared journey of continuous performance improvement to achieve the Triple Aim of providing better care with greater efficiency to improve the overall health of the communities they serve. In 2010, California's PHS took a bold step to dramatically expand their existing quality improvement efforts by creating a new federal pay-for-performance initiative as a central component of California's Section 1115 Medicaid Waiver. This five-year initiative, the Delivery System Reform Incentive Program (DSRIP), was designed to leverage the comprehensive range of health care services provided by PHS to achieve better patient outcomes through more integrated and coordinated care delivery across the care continuum—from primary and specialty care to emergency and inpatient services.

Between 2010-2015, the DSRIP offers PHS the opportunity to earn up to \$3.3 billion in federal incentive payments for achieving ambitious milestones that demonstrate system-wide improvements in PHS care delivery for Medicaid (Medi-Cal in California) and uninsured patients. To participate in the DSRIP, PHS submitted five-year plans that were approved by California's Department of Health Care Services (DHCS) and by the federal Centers for Medicare and Medicaid Services (CMS). The plans span five project categories that target distinct but highly inter-related areas of quality improvement (*See box on page 2 for more information*). Each category includes multiple projects, and each project has several milestones that measure progress toward intended project outcomes. Some projects are required of all PHS, while others were selected from an approved project list.

On average, PHS are each carrying out 15 projects simultaneously, with an average of 217 milestones per system over five years. In order to receive the incentive funds, PHS must first: 1) achieve the milestones in their approved plans; and 2) provide the non-federal share to draw down the federal funds. Public health care systems and counties provide all matching funds, as there is no State General Fund in the DSRIP.

Public Health Care Systems: The Foundation for Health Care Delivery in California

As the core of the state's health care safety net, California's 21 public health care systems are:

Integrated Systems of Care:

- Serve more than 2.85 million patients annually with preventive, primary, specialty, pharmacy, emergency and inpatient services
- Operate more than half of the state's top-level trauma centers and two-thirds of the state's burn centers

Leaders in Providing Care to California's Underserved Populations:

- Deliver care to all who need it, regardless of ability to pay or insurance status
- Provide nearly 40% of all hospital care to the state's uninsured
- Provide 10 million outpatient visits per year

California was the first state in the nation to test this model of pay-for-performance in the safety net. The model has since been replicated and adapted across the country, helping providers in six other states make measurable improvements in care, quality and efficiency, even while facing the perpetual fiscal challenges that come along with caring for the state's lowest income and most vulnerable populations. Each state DSRIP has been tailored to reflect the state's unique delivery system, financing structures, and payment reform needs and goals.

Summary of DSRIP Project Categories from Public Health Care Systems' 5-Year Plans

California's DSRIP projects span five key areas, organized by category:

1. 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.

2. 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.

3. 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).

4. 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.

5. HIV Transitions Projects

Systems had the option of focusing on delivering high-quality, coordinated care to low-income HIV patients.

Transformation in Action

Four years into the DSRIP, California's PHS have made remarkable progress in expanding access to essential health care services in their communities and providing better care for their patients. Their achievements highlight the scope and scale of this undertaking and demonstrate PHS commitment to continuous improvement for their patients.

Specific achievements include:

Expanded access to primary and preventive care for low-income communities.

Public health care systems helped California take full advantage of the Affordable Care Act's Medicaid expansion by leading early coverage expansion efforts to enroll more than 650,000 uninsured adults through the Low Income Health Program (LIHP). This early coverage expansion program helped transition enrollees into Medi-Cal in January 2014, which has been critical to the early success of health reform implementation in California.

The DSRIP's corresponding heavy focus on primary care in public health care systems complemented LIHP coverage efforts by connecting LIHP enrollees to a primary care team to help manage their health and address pent-up demand before they, along with more than 1 million others, became eligible for Medi-Cal on January 1, 2014. Altogether, 17 PHS used the DSRIP to expand primary care medical homes: 11 expanded primary care capacity, and seven focused on primary care redesign. These activities included offering more weekend and evening appointments, increasing the number of patients assigned to primary care providers, improving panel management, and instituting navigation programs to connect patients from the emergency department to primary care. For example, through the DSRIP:

- The Los Angeles County Department of Health Services empaneled 388,000 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. For example, as a result of this shift, more diabetic patients are getting phone calls from care managers to help them achieve their self-management goals.
- In 2011, Kern Medical Center launched its Emergency Department (ED) Navigator Program to help ED patients, particularly those seen for non-urgent conditions, better navigate the health care system. The ED Coordinator educates patients about the importance of primary care and coordinates with community and county-run clinics to schedule primary care appointments upon the patient's discharge from the ED. The program also connects patients to care management services, resulting in a 61% reduction in ED visits and 66% reduction in avoidable inpatient admissions in 2012.
- Contra Costa Health Services established a Telephone Consultation Clinic, allowing advice nurses to refer patients for same-day phone consultations with a physician. From January to June 2013, nearly 4,000 patients used the service, with 75% of calls resolved without an in-person visit, leading to improved access by saving clinic appointment slots for patients who truly need them.

- Ventura County Medical Center has 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.

Better use of data to drive delivery system improvement and population medicine.

In tandem with the implementation of electronic health records, many PHS used the DSRIP to develop disease registries, standardize quality data reports for both the inpatient and outpatient setting, and capture race, ethnicity, and language data. Once data systems were accessible, care teams were able to utilize more sophisticated data for population health management, including personal health records for complex care management and self-management. Teams were also able to run reports that identified patients based on condition or assigned provider for panel management efforts. For example, through the DSRIP:

- UC San Francisco (UCSF) Medical Center expanded the avenues by which patients can access their primary care provider by implementing an electronic patient portal called My Chart, resulting in a significant increase in patients requesting and receiving medical advice from their providers. Between July 2012 and June 2013, primary care providers received over 53,000 requests for medical advice from their patients through the portal, and more than 85% of the time, responded within 24 hours of the request.
- San Joaquin General Hospital's (SJGH) primary care clinics implemented the i2i Tracks disease management registry. Between July 2012 and June 2013, more than 20,000 patients were assigned to medical homes using i2i Tracks, enabling medical home teams to more systematically monitor and manage the health of their patient population. For example, the registry helps providers identify diabetic patients with unsafe blood sugar levels for targeted outreach and support.

Improved and tailored care for the systems' highest risk patients with complex medical and social needs, through care management programs.

Building on their strength as integrated systems of care, PHS have improved care coordination for patients by enhancing linkages between primary care, specialty care and inpatient settings. These coordination efforts have included expanding chronic disease management programs, and piloting targeted care management approaches for particularly vulnerable patients who were frequent utilizers of the emergency department. These programs aim to ensure that patients receive the right care, at the right place, at the right time to produce better health outcomes and more efficient use of health care resources. For example, through the DSRIP:

- 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 the work of an interdisciplinary team, utilizing a combination of clinic visits, home visits, and telephone calls to implement individualized care plans, the program has reduced hospital admissions and bed days by 20% and 23%, respectively.

- UC Irvine Medical Center's "Care Connect" patient navigation system assigns patients with complex treatment regimens to chronic disease coaches to ensure a high level of coordination between their providers and services across the care continuum. Coaches work closely with primary care doctors to improve outcomes for high-risk patients identified using risk-stratification algorithms. After just six months of enrollment, the system achieved a 52% reduction in inpatient visits and 60% reduction in emergency department visits.

Improvements in team-based accountability for patient outcomes.

The DSRIP catalyzed a culture shift within each PHS, with care becoming more team-based and interdisciplinary. Whether it is RN case managers coordinating with pharmacists as they target high-risk diabetics, or primary care providers consulting with behavioral health specialists, new care delivery models have dramatically increased collaboration across providers and enhanced shared accountability for patient well-being. Furthermore, system-wide performance management efforts such as LEAN processes, Six Sigma, and the Institute for Healthcare Improvement's Model for Improvement have helped foster organizational cultures that embrace change and empower employees at all levels to continuously make improvements. For example:

- San Francisco General Hospital promotes shared accountability for high quality care and service excellence by posting dashboards with quality metrics for patients and staff to see. Transparency helps drive improvements by facilitating an open dialogue amongst staff and leadership about SFGH's goals, how well the system is meeting those goals, and what can be done to accelerate progress. In 2013, SFGH had 16 service-specific inpatient dashboards, and expanded its range of dashboards to include outpatient specialty care clinics. The specialty care clinic dashboards have helped improve access by giving staff the data feedback they need to evaluate the impact of their improvement efforts. For example, as a result of the Hematology clinic's focus on tracking "Third Next Available Appointment" each month as a proxy measure for the typical patient wait time, the clinic was able to reduce the wait time 87% from September 2012 to August 2013.
- Several California PHS have begun utilizing Lean as a system-wide management strategy to accelerate their quality improvement efforts and improve efficiencies by empowering all levels of staff to drive transformations. In 2012-13, UC Davis Medical Center provided Lean training to 48 staff members and applied the approach to establish an automated process within the electronic health record to identify frequent ED users and connect them with case management support. When a patient is registered who has been seen in the ED four or more times in the last three months, an alert is immediately visible on the ED patient tracking board, triggering assessment by a case manager to help the patient better manage his or her health and prevent the continuation of costly utilization patterns.
- Recognizing the harmful effects that undiagnosed and untreated mental health conditions have on a patient's ability to successfully self-manage their chronic medical conditions, PHS have embraced the integrated behavioral health model of providing mental health screening and treatment within their primary care clinics. For instance, of the 780 diabetic patients screened for depression at San Mateo Medical Center's Innovative Care Clinic,

23% screened positive, triggering seamless referral to a behavioral health clinician on the health care team and embedded in the clinic to receive the support they needed to simultaneously take better control of their physical and mental health.

Reduction in adverse events.

Making hospital care safer has been a critical component of the DSRIP. All PHS are working on reducing sepsis and central line associated blood stream infections (CLABSI), and each has selected at least two additional areas in which to reduce patient harm. These focus areas have been critical in helping address preventable hospital acquired conditions. For example, through the DSRIP:

- Santa Clara Valley Medical Center launched a hospital-wide educational campaign to improve the early detection and treatment of sepsis. Guided by a multidisciplinary committee and several physician champions, the campaign trained providers in utilizing evidence-based practice guidelines and enabled teams to practice in a safe environment through simulation-based learning. As a result, SCVMC reduced its sepsis mortality rate by more than 50% from 2011 to 2013.
- In 2010, Riverside County Regional Medical Center brought together all levels of the hospital team, from housekeeping to physician leaders, to reduce the incidence of surgical site infections through more robust data monitoring, staff education, and the application of best practice guidelines. As a result, infections have plummeted by more than 60%, and the effort is being replicated in other areas, such as reduction of urinary catheter related infections.
- A multidisciplinary task force meets monthly to evaluate and assess all aspects of Arrowhead Regional Medical Center's CLABSI prevention. The prevention strategies implemented include a focus on bedside nursing techniques, and have yielded a dramatic reduction in CLABSI, from 4.9 infections per 1,000 central line days in 2011 to just 1.2 in 2013.

Increased patient engagement and enhanced patient experience.

With millions of Californians eligible for new coverage as a result of the ACA, it is critical for PHS to not only provide high quality care, but also provide the best experience for their patients to effectively compete as providers of choice. Strategies such as the use of interpreters to improve patient-provider communication, to involving patients on improvement teams to understand care delivery from the patient perspective, ensure that PHS are putting patients at the center of their own care.

Recognizing that health systems must first measure what they seek to improve, the DSRIP included a new data reporting requirement for patient experience. While PHS were already reporting patient experience scores in the inpatient setting, the DSRIP expanded this reporting to the ambulatory care setting, where patients receive primary and specialty care services. As a result of the DSRIP, all PHS are now utilizing the Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey (CG-CAHPS) to better understand and improve patient experience. Other examples of enhancing patient engagement and experience through the DSRIP include:

- Natividad Medical Center expanded access to in-person medical interpreters and remote interpreting technologies, in their efforts to best serve the more than 50% of patients who self-identify as Limited English Proficient. By June 2013, the number of encounters facilitated by qualified health care interpreters had increased to an average of 1,575 per month, a 48% increase compared to 2011-2012.
- To help address the state shortage of culturally competent primary care physicians, UCLA Medical Center developed and implemented a program to enable International Medical Graduates to gain admittance to a California family residency training program and subsequently serve in one of the state's medically underserved areas. The most recent 16 graduates were from five Latin American countries, utilizing their bilingual, and even trilingual skills to ensure more patients receive care in the language they understand.
- UC San Diego Medical Center expanded its palliative care program to relieve suffering and enhance patient and family experience in the midst of a serious, advanced illness. By adding physician and nursing specialists to the palliative care team, working to increase patient engagement in care decisions, and establishing triggers that activate a palliative care consultation, palliative care visits rose from 500 to nearly 1,000 per year over the first three years of the program.

Looking Ahead

The achievements described above, in addition to many others, demonstrate how PHS are transforming their systems to more effectively and efficiently provide care to their patients and communities. While PHS have made significant strides to improve access, quality, and patient safety over the last four years, the journey is far from over. Building on the foundation and lessons learned from the DSRIP, a successor program would be more standardized, with a heavier emphasis on outcomes, and a comprehensive approach to the advancement of Triple Aim goals. California's public health care systems are eager to continue the important work that began under the state's 2010 Section 1115 Medicaid Waiver, and advance further along the trajectory of becoming models of integrated systems of care that are high value, high quality, patient-centered, efficient, and equitable, with great patient experience and a demonstrated ability to improve the health care and health status of populations.

About CAPH & SNI

CAPH is a non-profit trade association that represents California's 21 public health care systems - comprised of county-owned and operated facilities, and University of California medical centers. In partnership with our quality improvement affiliate, the California Health Care Safety Net Institute (SNI), we work to strengthen the capacity of our members to advance community health, ensure access to high-quality, culturally sensitive health care services for all Californians, and educate the next generation of health care professionals.