CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
1115 WAIVER RENEWAL
EXPERT STAKEHOLDER WORKGROUP on DSRIP 2.0

Tuesday, January 13, 2014
10:00am – 3:00pm
USC State Capitol Center
MEETING SUMMARY

Members present: Molly Brassil, County Behavioral Health Directors Association of California; Michelle Cabrera, SEIU; Sarah DeGuia, California Pan-Ethnic Health Network; Catherine Douglas, Private Essential Access Community Hospitals; Susan Ehrlich, San Mateo Medical Center; Jon Freedman, LA Care; Bill Henning, Inland Empire Health Plan; Judi Hillman, Health Access; Manel Kappagoda, ChangeLab Solutions; Barsam Kasravi, Anthem Blue Cross; Sherreta Lane, District Hospital Leadership Forum; David Lown, Safety Net Institute; Anne McLeod, California Hospital Association; Leslie Mikkelsen, Prevention Institute; Erica Murray, California Association of Public Hospitals and Health Systems; Kelly Pfeiffer, California Health Care Foundation; Al Senella, Tarzana Treatment Centers; Richard Thomasson, Blue Shield of California Foundation; Bill Walker, Contra Costa County Health Services.

Members on the phone: Angela Gilliard, University of California Office of the President; Christina Ghaly, Los Angeles County Department of Health Services; Pilar Williams, DHCS.

Members Not Attending: Ken Kizer, UC Davis; Richard Rawson, UCLA.

Others Attending: Neal Kohatsu, DHCS; Sarah Brooks, DHCS; Wendy Soe, DHCS; Hannah Katch, DHCS; Efrat Eilat, DHCS; Tianna Morgan, DHCS; Tricia McGinnis, CHCS; Don Kingdon, Harbage Consulting; Bobbie Wunsch, Pacific Health Consulting Group.
Peter Harbage, Harbage Consulting.

23 Members of the public attended the meeting.

Welcome and Purpose of Meetings; Feedback on Summary of Meeting #2,
Bobbie Wunsch, Pacific Health Consulting Group
Thank you to the California HealthCare Foundation, The California Endowment and Blue Shield of California Foundation for their support. Following introductions, Bobbie Wunsch reviewed the agenda. Discussion will focus on the concept paper for DSRIP 2.0 and this meeting is particularly focused on input and ideas for DSRIP 2.0.

Behavioral Health and DSRIP 2.0
Behavioral Health Inclusion in DSRIP 2.0 Concept Paper and Metrics
Neal Kohatsu, DHCS and David Lown, CAPH-Safety Net Institute
with additional comments by Susan Ehrlich, San Mateo Medical Center and Sherreta Lane, District Hospital Leadership Forum
http://www.dhcs.ca.gov/provgovpart/Pages/Waiver_Renewal_Workgroup_DSRIP.aspx

Neal Kohatsu began by outlining that behavioral health (BH) will be integrated throughout DSRIP 2.0. BH is an overarching focus because it won't be possible to improve and sustain health without addressing BH needs. David Lown outlined project examples that are embedded throughout the DSRIP concept paper. These include specialty care redesign, care transitions, complex care management; foster kids and post-incarceration individuals, chronic pain management and comprehensive advanced illness planning and care

Susan Erlich offered an example of how BH integration has been implemented in San Mateo. The project goal was to provide better care to diabetic patients by improving their depression care. This was a team approach from registration to psychologists. Patients were screened for depression through a self-report questionnaire (PHQ9) administered during wait time for primary care appointments. There were significant reductions in measures of depression over the project. A warm hand off to the co-located psychology team within 30 minutes of screening was identified as a key to the successful outcomes.

Sherreta Lane spoke to the perspective of district hospital members relative to BH. BH is an issue for all district hospitals and even small hospitals are extremely concerned about the many patients with BH needs presenting in their emergency departments. Some are implementing Telehealth as an intervention that shows promise. DSRIP may offer an opportunity to increase collaboration and information sharing between hospitals where current siloes and a lack of information exchange hamper progress.

Comments and Additional Ideas from Workgroup Members

Molly Brassil, County Behavioral Health Directors Association of California: I appreciate the presentation. I especially appreciate the early intervention and screening and the emphasis on screening populations with consideration of their limitations or other special needs. These represent examples of BH integration into physical health settings. Has there been thought to how primary care services might be integrated into BH settings where populations with serious mental illness receive the bulk of their care?

David Lown, Safety Net Institute: We discussed that option although we didn't develop it as a project. We focused on options where there could be direct accountability and impact for all of CAPH members and facilities that participate in DSRIP. Many DSRIP participants do not have responsibility for seriously mentally ill populations.

Bill Walker, Contra Costa County Health Services: Our County has responsibility for both mild to moderate and seriously mentally ill through the health plan and county. Most of our sites have co-location for both BH and primary care. We also have opened a primary care facility in a program that is a BH setting and this is outside of DSRIP.

Richard Thomasson, Blue Shield of California Foundation: I have a question and suggestion. In our BH integration grant making, we have noted BH improvements through Telehealth. Can we look at how DSRIP might go beyond the public hospital counties to implement Telehealth in

other counties? There are county mental health dollars, district hospitals and other ways this might be included.

Neal Kohatsu, DHCS: I am open to this. We need to figure out the business model comes together but from a perspective of program delivery and population health, I would be supportive of including Telehealth in the waiver and through other mechanisms outside the wavier to advance integration.

Bobbie Wunsch, Pacific Health Consulting Group: Telehealth also has been discussed as a priority in the workforce and plan-provider workgroup discussions.

Ideas from Other States' DSRIP Waivers
Don Kingdon, Harbage Consulting and Tricia McGinnis, CHCS

Don Kingdon presented an overview of BH integration in 1115 waivers in other states and offered a particular focus on the DSRIP waiver in New York. In many states, there are themes of building managed care systems out and capitation.

- In Oregon, there is a focus on integration of both physical health and BH. They are focused on performance withholds to promote the initiation of alcohol and drug services post hospital engagement. Oregon is also working on including schizophrenia as a chronic disease.
- In Kansas, there is a focus on institutionalization and integrating their various waivers to reduce institutionalization for BH populations.
- Texas is working on mental health parity and they are integrating home and community based services (HCBS) into managed care. They are including self-directed care and support, with consumers having a role in determining the services available to them.
- New Jersey also has a focus on HCBS with a particular focus on those with serious emotional disturbance, opioid use and developmental disabilities. They are in the process of carving out their mental health system for adults and using an Administrative Service Organization to manage that.
- New Mexico also is working on consolidation under managed care.

In general, in New York has a focus in the DSRIP on hospital to home care coordination to reduce preventable re-hospitalizations (a key metric of their DSRIP) and community based navigation, with BH as an important component. Under integration of primary care and BH, New York is including bidirectional integration. New York also is working on improving medication adherence through evidence-based practice, particularly for schizophrenia. Some of the proposed DSRIP measures include: screening all hospital admissions for BH conditions, identifying workforce gaps and including BH resources in all high risk care teams working on discharge to community.

Tricia McGinnis presented some high level BH metrics from other states and presented some metrics for consideration to include in California's DSRIP. Pennsylvania requires a tailored patient care plan and includes this as a process measure. New York has not included this as a metric. It is difficult to collect but having a care plan is a key part of successful integration and

could be a process measure of success. New York is focusing on adherence to anti-psychotic medications in its DSRIP. As part of the health home project in New York, it analyzed the prevalence of chronic diseases and found high rates of diabetes, asthma and other chronic disease. Another metric in New York is the initiation and engagement of alcohol and drug (AOD) treatments and tracking this from baseline to measure how it is improving over time. Documenting beneficiaries being served over time is an important metric. Also, as we look to reduce use of emergency room and hospital stays, it could be important to track primary care services as a measure to document the shift – and New York is tracking this as well. The outcome measures already presented for California align well with those from other states. One additional outcome measure might be to include a Patient Activation Measures to gauge patient engagement.

Neal Kohatsu, DHCS: In relation to process and outcome measures, CMS is emphasizing rapid cycle process improvement and not just including one year measures in order to assess early success. Do you have indications from other states that they are using quarter by quarter metrics to guide whether they are on track?

Don Kingdon, Harbage Consulting: Most states are very early in the process. Even in New York, they are in the application process so they are identifying – not implementing.

Neal Kohatsu, DHCS: As we attend webinars and have other conversations, it is clear that CMS wants something ambitious - transformational. We discussed that innovation means that not everything will be successful so that is where the suggestion of rapid cycle improvement was suggested as a way to get back on track. We agree in concept, but there are many counties and huge data flows to get moving, so I am wondering if New York has lessons.

Tricia McGinnis, CHCS: Within similar Medicaid projects, not DSRIP per se, it has been important to develop the intersection between technical assistance and metrics. Integrating the data, observations and information you learn from hospitals implementing the project and feeding that directly into technical assistance and learning collaboratives might be something CMS is looking for.

Don Kingdon, Harbage Consulting: In New York, what holds it all together is the focus on preventable hospitalization as the end goal. Second, one of their early lessons is that there are regulatory barriers in implementation and that is leading to requests for state relief from some regulations.

Leslie Mikkelsen, Prevention Institute: On the New York theme, they are aware of the influence of stable housing as an important element of improving health. The request to pay for housing was denied, but they are paying for support services – perhaps not in DSRIP but elsewhere in the waiver? How do we tie in metrics that are not strictly about treatment but other support services and housing stability that go hand in hand to achieving better outcomes?

Don Kingdon, Harbage Consulting: The marriage of support services and health care is one of the new areas of work. This is emerging in New York and they are bringing new partners to the discussions, such as the housing and income support community to construct alternatives to

reduce preventable hospitalization. The health care community realizes this can't be successful without including other partners.

Bobbie Wunsch, Pacific Health Consulting Group: There is a workgroup focused entirely on housing and how housing support services can incentivize developers to convert current housing units and create new housing for this populations. The summaries of the meetings are posted on the website.

Molly Brassil, County Behavioral Health Directors Association of California: In the project on medication adherence, is there emphasis on working between primary care and mental health to ensure there are no contraindications or other issues in treatment?

Don Kingdon, Harbage Consulting: We can drill down to examine more specifically what is included in the medication adherence project. There is a focus on reconciliation of medications at hospital discharge.

Bill Walker, Contra Costa County Health Services: In your review, are there successful examples of dealing with the siloed funding we experience? We have Mental Health Service Act, managed care, BH carve out, DSRIP and waiver. There are restrictions to sharing across these funding streams. Have you identified states that have successfully dealt with this, especially for the seriously mentally ill?

Don Kingdon, Harbage Consulting: All states are trying to catch up with California on managed care and capitation. At the same time, most states are trying to deal with the specialty needs of those with serious mental illness. There is a focus is on HCBS and on leaving the more specialized services out of the capitation. They are still evolving but the theme is that this may be a population best served outside of capitation.

Tricia McGinnis, CHCS: In New York, they are developing a specialized managed care product for this population. They are developing specific requirements including a more robust health home for the population. They allow managed care organizations to apply for these services but it is more rigorous requirement to participate. This is not part of the waiver, it is called HARP.

Ideas for DSRIP 2.0 from November 10 Behavioral Health Meeting – Efrat Eilat, DHCS

http://www.dhcs.ca.gov/provgovpart/Pages/Waiver_Renewal_Workgroup_DSRIP.aspx

Efrat Eilat, DHCS presented potential measures developed from stakeholder meetings and research. She presented performance measures for a number of conditions based on CMS measures and other nationally recognized measures from National Quality Forum or others. Areas for measures include co-occurring physical health conditions such as asthma and diabetes; BH conditions; care coordination; access measures as well as substance use and recovery.

Ideas for DSRIP 2.0 from County Behavioral Health Directors
Molly Brassil, CBHDAC

A number of policy initiatives have been implemented over the past few years to increase access to substance use disorders (SUD) and mental health (MH) treatment services. We have expanded coverage and benefits and implemented parity laws and these are increasing access. California includes SUD and MH as one of the ten essential benefits for coverage. We are ten years into implementation of the MHSA which has improved treatment services as well as capacity for prevention and early intervention work. We still recognize that individuals with serious mental illness continue to have higher rates of chronic conditions and that they die 25 years earlier. This disparity is unacceptable and we need to improve the health outcomes for this population. There are key things that could be done to improve outcomes. We need better coordination of care at both system and provider levels and we need to link the population to housing and other supports in the community. Coordination of care should include:

1. Improve medication management
2. Improve screening in Emergency Departments and hospitals for MH conditions
3. Bring primary care into traditional mental health treatment settings.

Ideas for DSRIP 2.0 from SUDS Perspective
Al Senella, Tarzana Treatment Center
http://www.dhcs.ca.gov/provgovpart/Pages/Waiver_Renewal_Workgroup_DSRIP.aspx

Al Senella provided opening comments and spoke about written recommendations that have been provided to DHCS for inclusion in the waiver. The funding for MH is $6.5B and the funding for SUD is less than $500M. Recent years have seen reductions in block grants and other funding rather than infusion of funding. Overall, the system of SUD is weak. There is no part of the system that requires transformation more than the SUD system of care. There is good work in many counties and organizations, but this is isolated and needs to be more widespread. Tarzana has good understanding of the challenges of integration and bidirectional services because it operates primary care, MH and SUD services. Even within large health systems that include SUD services internally, SUD is the weakest part of the system. MH and physical health services are better integrated and available; the most difficult access to services is SUD.

The overall recommendation is that there should be a new Behavioral Health goal and Domain 6 as detailed below.

Domain 6 – Behavioral Health

- Project 1.1 Increase access to SUD care and system-wide SUD treatment capacity
  - Project 1.2 Expand the SUD Continuum of Care and provide the needed infrastructure to address chronic nature of disease
    - DMC coordinated care initiative authorizes some of the treatment continuum, but not the infrastructure support needed by providers and counties to make it happen.

- Homelessness: Active Outreach and Engagement in Community Setting & transportation Assistance for Linked Referrals
- Case Management
- Care Coordination – Behavioral Health Homes
- Medication Assisted Treatment: There are many options beyond methadone and this requires significant expansion
- Whole person care to address other chronic medical diseases (e.g., diabetes, asthma, obesity) in conjunction SUDs. This requires significant attention for SUD beyond what has been discussed.

• Project 1.3 Enhance quality of SUD care providers and professional staff
• Project 1.4 Expand Use of EHR and Information Technology in SUD Treatment (as MHSA did for MH)

Integration of Behavioral Health, Primary Care & Acute Care
• Two-way Integration: Also bring primary Care into Behavioral Health as demonstrated and supported by SAMHSA grants
• Remove barriers to care integration in residential SUD treatment regulations
• Beyond Primary Care: Strengthen cooperation and coordination of care between SUD and MH treatment providers and acute care hospitals - in Emergency Departments and beyond. The hospital setting may be the only opportunity to contact homeless and severe SUD cases.
• Reduce hospital bed days for SUD related care
• Reduce unnecessary Medical and Psychiatric ER use for SUD related crisis
• SBIRT in Hospitals
  Staffing by behavioral health specialists will assure capacity to do brief intervention and referral – not just screening
• Improve access to psychiatric evaluations in hospitals (Telehealth) to reduce hold times and increase ED capacity
• Improve linkages (e.g., staff and transportation) between hospitals and ERs to community-based providers of SUD
• Expanded behavioral health role in discharge planning
• Electronic communication of admissions and discharges to assure timely notification

Erica Murray, California Association of Public Hospitals and Health Systems: I really appreciate the thoughtfulness of all the input. It shows the work we need to do through the waiver and in other vehicles. Rather than offering an immediate opinion about adding an SUD domain, my question is to ask the state about the question of what is the relationship between the aspects of the waiver and what are we trying to achieve? What are the overarching goals for the waiver to accomplish by 2020? How does this all tie together?

Neal Kohatsu, DHCS: I echo that this thoughtfulness is great. My initial reaction is that this extends beyond DSRIP and the waiver. We need to think about this in the waiver and beyond. We also need to sort out the legal and policy barriers to address this. We will be thinking very carefully about the DSRIP implications, implications outside the waiver and across the department and Medi-Cal.

David Lown, Safety Net Institute: I really appreciate the specificity of the recommendations from Molly and Al. As a clinician, I agree we need all of these services and changes. How to fit this together; what is the right vehicle for initiating the change so they will be successful is the question?

Al Senella, Tarzana Treatment Center: One point to reiterate, is that the Drug Medi-Cal benefit will expand services to people and there will be reimbursement. The problem is that there is heavy lifting of infrastructure to get that system up and running. That is where DSRIP can help, so it can be successful. The MH system is a carve-out but there is the mild to moderate benefit for services that managed care plans are responsible for and that increases access and services. SUD is a 100% carve out and plans are not responsible.

Judi Hillman, Health Access: I am very open to a Domain 6. There is a parallel here to the discussions of disparities. California has a strong office of health equity to advocate for disparities and many believe there are advantages of being separate in order to drill down on capacity challenges, such as data issues. We like to think of health equity as a fourth, triple aim. Having that fourth aim does not meant it needs to be embedded in all other "aims" but can be a separate focus. It doesn't need to be either/or.

Jon Freedman, LA Care: Al framed it well that the SUD benefit is atrophied. We are in the process of fixing this. We have multiple layers of reform simultaneously and they are positive in the right direction. It is very complex with carve outs and multiple models of managed care. In the Duals Demonstration, we have had to work out the operational relationships. The SUD is administratively weak; they are not in an ICD 9 world. The data intensive needs in the DSRIP proposal will be hard if we go beyond the public hospitals. There is game changer in medication assisted treatment – it is irresponsible not to think about expanding this further. We should be working hard on that. What I see the DSRIP doing is to facilitate. The individuals targeted here are largely outside managed care and all systems. The touch points are ER, public hospitals, child welfare, jails, and DSRIP can help with infrastructure to make this actually happen.

Bill Henning, Inland Empire Health Plan: I am happy to see SUD at table and agree it is the most under resourced system in our counties. The intersection of SUD/BH in public hospitals is not yet being discussed. It is really about access to care. Patients sitting in hospitals waiting for a transfer to a psych hospital and there is no bed for them. On an average in my area, there are 8 waiting every day. Over a year, that is a lot of money spent. Also, there are poor connections between ER and services in the community for those who are consistently revisiting in the ER/inpatient. We need resources and connections in the community to solve the patients revisiting. The numbers are actually small; it is a small number of individuals and this is a solvable problem if we can bring people into the right services with follow up.

Barsam Kasravi, Anthem Blue Cross: The input is helpful. In our SPD population, up to 50% of our beneficiaries have some BH diagnosis. I looked at the report from the previous DSRIP and one of our goals is not to repeat the milestones from the last DSRIP. The last DSRIP was co-

location, e-consult and others. I think that we should identify SUD measures and align them to the overall measures like ER, connection to a PCP, length of stay, access, readmission and not silo SUD. The carve out challenges the plans in managing the entire continuum of care. Integrating the funding stream as much as we can is beneficial.

Susan Erlich, *San Mateo Medical Center*: Until recently, I wasn't aware of medication assisted therapy. We are expanding a small pilot on medication assisted therapy. They piloted a long acting form of naltrexone, called Vivitrol, for chronic inebriates of alcohol who show up in the ER often. We offered them a chance for this monthly injection. We found reduced use of ER by 50% in a small pilot. This was very exciting and we want to expand it. We worked with the health plan to cover the medication Vivitrol and we feel like this has great promise.

Al Senella, Tarzana Treatment Center: That is exactly what is intended in the recommendations offered. Vivitrol use is effective for both alcohol and opiate. Every person presenting should be screened for this medication – it is anti-craving medication and has no abuse potential. LA County has rolled it out effectively. Also, Methadone is very effective for opiate addicts.

Demonstrating DSRIP 2.0 Outcomes Effectively: Exploring the Proposed Metrics
Neal Kohatsu, DHCS and David Lown, CAPH-Safety Net Institute
http://www.dhcs.ca.gov/provgovpart/Pages/Waiver_Renewal_Workgroup_DSRIP.aspx

Neal Kohatsu and David Lown presented slides on proposed metrics. They reviewed sources, such as other DSRIPs, Let's Get Healthy California Task Force and Meaningful Use. They also presented some criteria for considering metrics, such as being nationally vetted through NQF/ NCQA and feasible to report. They reviewed criteria for the framework of metrics and mentioned the experts involved in advising on possible metrics. Clinical event outcomes, potentially preventable events and patient experience is the rubric used for each project. There are 152 metrics in the current proposal. There are a number of novel metrics under discussion that would need to be tested if CMS is supportive of this approach.
Questions to guide the discussion:

- Are there any broad themes missing?
- Is there an appropriate balance between ambitiousness and feasibility in project metrics to ensure their success?
- Are there any projects and/or metrics missing across the domains?
- Within each domain are there any metrics to remove?

Bobbie Wunsch, Pacific Health Consulting Group: We will review these domain by domain. The presentation to follow will include many comments relevant to this area and those will be discussed later in the meeting.

Judi Hillman, Health Access: Do you have observations about the potential to dashboard metrics so we can make this available to stakeholders. A community might ask, "how are we doing as a community?" and have a stake in the changes we seek; use the metrics as a call to action.

David Lown, Safety Net Institute: I think that any metric is dashboard-able. There is no reason why we can't display them. There are many proposed metrics that would not be of use in a community call to action e.g. blood products, yet others would.

Sarah Brooks, DHCS: We are moving toward increased data transparency and sharing of information. For example, we will come out with a quality dashboard for Cal MediConnect for feedback. With so many metrics, it is about tailoring and targeting to provide relevant information and direction for care coordination. Additionally, there is always a lag in the data.

Barsam Kasravi, Anthem Blue Cross: On the Medi-Cal side, we have lots of metrics on the outpatient side. In choosing, I would like to see more emphasis on the hospital and integration metrics and a consistent set of metrics for everyone to participate. There is less on the hospital side and less on integration of inpatient with community or outpatient setting.

David Lown, Safety Net Institute: Everyone participates in domain 1 and anyone who participates in a project must participate in all the metrics.

Manel Kappagoda, ChangeLab Solutions: I am wondering about metrics for the domains under the current DSRIP? How do they relate to the proposed metrics? What did you learn from that implementation?

David Lown, Safety Net Institute: Yes, a number of category 3 (pay for reporting) metrics from DSRIP 1.0 are being included in DSRIP 2.0. Some are being modified. We learned a lot about data infrastructure needs to report on a standardized data set. This proposal builds on that.

Susan Erlich, San Mateo Medical Center: We can't underestimate the effort, investment and infrastructure needed to report these measures. We are trying to uniquely identify people across systems and this is a multi-million dollar project lasting 1.5 years – just to identify them not implement care.

Barsam Kasravi, Anthem Blue Cross: We don't have access to lots of data and PCP and other partners don't have access to our data. Can we encourage data sharing and exchange? One of the challenges is that we don't have access to data across the system. EMR data exchange would help greatly with integration.

Catherine Douglas, Private Essential Access Community Hospitals: We applaud all the effort to bring forward this proposal. As private DSH hospitals, we will not be participating in DSRIP, yet we are providing 66% of the care for MH patients. How will this help us follow patients as they access care in multiple places that may be outside the DSRIP system? How will we be able to share data since we are outside of the DSRIP system?

David Lown, Safety Net Institute: Good question. We chose metrics based on accountability and ability to capture data. There are process elements of the project that include connections to external, community resources, providers, transitions of care and don't depend on the external partners for the reporting of the metrics.

Catherine Douglas, Private Essential Access Community Hospitals: if we are looking for avoidable ED visits and hospital admissions, will you work with health plans to follow the patient in order to see if the patient is being admitted outside your system?

David Lown, Safety Net Institute: This goes to the umbrella of overall waiver and how the pieces fit together - what is the right part of the waiver to focus on each measure. There may be other aspects of the waiver that bring in the data you are looking for. DSRIP metrics will be for public systems but perhaps there are other areas that bring in the health plans.

Sarah Brooks, DHCS: It is a good question. We do need to be sure that the overall umbrella captures the consumer moving through the health system. DHCS is working to integrate the different parts of the waiver. So, it is a good question – more to come.

Bobbie Wunsch, Pacific Health Consulting Group: Let's go through each domain. We will not have a response today but will focus on this for the next meeting. Please forward specific measures, sources and other information for DHCS to be able to consider your recommendation by Friday.

Comment on Domain 1:

Richard Thomasson, BSCF: On broad themes missing: There is a growing interest in measuring and assessing SDOH aspect of patients from our grantees. We supported an IOM report that came out in November on SDOH in Meaningful Use that recommended measures such as social isolation and IPV and could be helpful in the BH aspect of DSRIP. Is there interest in including such measures in this part of DSRIP? I can forward the report.

David Lown, Safety Net Institute: We would be interested in including aspects of those. There are areas such as care transitions, post incarceration that reference the use of data analytic systems and bring in SDOH that are part of the national tool set for risk assessment. Separate from DSRIP, the FQHC payment reform tests those SDOH measures.

Neal Kohatsu, DHCS: We are very interested in the waiver, DSRIP and more broadly in how to manage SDOH. There have been more concrete pathways developed in housing. For example, the Veterans Administration developed an assessment for every ER visit and admission. Also this is particularly important for super utilizers.

Molly Brassil, County Behavioral Health Directors Association of California: Under BH project 1.4 patient experience: It can be difficult to capture, but we would like to measure reduction in stigma and discrimination, perhaps through incorporating peers on site, waiting rooms are comfortable for those with serious mental illness or SUD.

Susan Ehrlich, San Mateo Medical Center: We use HCAPs to measure consumer experience and would appreciate your input on how to add a proxy there to measure stigma and discrimination.

Catherine Douglas, Private Essential Access Community Hospitals: How can those outside DSRIP begin to participate and learn from the DSRIP process?

Judi Hillman, Health Access: In 1.1 and 1.4, the patient activation measure. It has been well tested and, with the loss of Cal SIM, including this measure will provide a community linkage. It is an expensive measure to use but now is the time to discuss resources for how to include something like this.

Barsam Kasravi, Anthem Blue Cross: On 1.1, PCMH: the core components of PCMH certification are similar but the outcome measures here are not aligned to PCMH. Are they going to be submitting core components reporting and outcome reporting? How do we measure PCMH if it is not tied?

David Lown, Safety Net Institute: The advisory group discussed included PCMH designation as a measure. The decision was that certification does not mean transformation is accomplished and we want to focus on patient outcomes. How will reporting of the components fit into the projects and how does it relate to achieving the goals? There is more to work out, but the entities need to report on all components to be eligible for a payment. Every entity would have to report on activities and progress on every component to be considered for payment.

Bill Henning, Inland Empire Health Plan: On domain 1.1: Do I understand the metrics report is separate from the components?

David Lown, Safety Net Institute: They relate to each other. If you achieve success on the components, it is directly related to achieving the outcome metrics.

Bill Henning, Inland Empire Health Plan. In 3A Meaningful Use, there is no metric to support that, so would they independently be reporting on that?

David Lown, Safety Net Institute: Presumably the project report they submit will indicate they have achieved meaningful use.

Comments on Domain 2: Care Coordination

Jon Freedman, LA Care: On 2.2, foster care is worthy regardless of the waiver. In my view it needs to be scaled down or scoped very carefully. For example, placements are not in the purview of county hospital and may go across county lines so I offer a caution on this one.

Domain 3: No comments

Domain 4: Prevention

Richard Thomasson, Blue Shield of California Foundation: How do we align this domain to the Safety Net Care Pool and payment reform discussion?

Barsam Kasravi, Anthem Blue Cross: There are measures health plans report, specific to provider preventable conditions, which could be aligned to this.

Al Senella, Tarzana Treatment Center: On preventing readmissions: medication assisted treatment is a prevention tool for preventable readmissions.

Domain 5: Patient Safety: No Comments

DSRIP 2.0 Perspectives on Prevention, Access, and Cultural Competence
Leslie Mikkelsen, Prevention Institute
Sarah de Guia, CPEHN
Michelle Cabrera, SEIU
Manal Kappagoda, ChangeLab Solutions
Judi Hillman, Health Access
http://www.dhcs.ca.gov/provgovpart/Pages/Waiver_Renewal_Workgroup_DSRIP.aspx

Sarah de Guia provided an overview of the presentation and offered definitions and examples of disparities, social determinants of health and inequities in health. These include systemic barriers such as lack of access to parks by communities of color that are avoidable. She offered a framework for health equity that depicts upstream approaches and health care efforts along a continuum. She offered overarching recommendations:

- Integrate data collection and analysis into all domains
- Focus efforts on the identification and reduction of health disparities
- Ensure health systems are providing culturally and linguistically appropriate services
- Better integrate identification and addressing of social determinants of health

Bill Henning, Inland Empire Health Plan: All the health plans are embracing SDOH as a contributor to health. What tends to be missing is the root cause analysis by determinant. For example, African Americans have high rates of preterm birth, but it is not enough to say African Americans and PTB, we need the evidence-based reasons so we can close the disparities.

Michelle Cabrera, SEIU: It may not be one determinant. Sometimes it pops up in multiple elements. There is low hanging fruit; single issues to tackle that can move quickly to close disparities. Where are there other issues that are more complex and require a different approach?

Michelle Cabrera presented a recommendation that Access, Integration and Equity could be the overall theme for the waiver. This requires not only a strong health care system but also a strong workforce. She presented background data on California diversity to underscore the importance of disparities as an overall theme. She presented details of how workforce strategy can be integrated into the DSRIP 2.0 concept and offered specific examples and recommendations:

- Clearer commitment to culturally and linguistically appropriate workforce grounded in communities served
- More consistent commitment to workforce training and engagement in planning
- Support shift to team-based care delivery models
- Expand the role of the IHSS worker through enhanced IHSS workers as members of the care team

Don Kingdon, Harbage Consulting Kingdon: It seems to me that the disparities will be magnified in the public hospital systems because of the remaining uninsured. How do we acknowledge that unique role public systems play in care for uninsured?

Al Senella, Tarzana Treatment Center: The workforce issue is tremendously important and I agree it should move up on the list.

Sarah Brooks, DHCS: I appreciate the presentations. DHCS is committed to this. I want to understand how does the proposal here differ from what is currently in place related to cultural competency? Where are we trying to go from where we are now?

Michelle Cabrera, SEIU: Some counties are working on transformed models of care and some health plans are thinking about it too. For the frontline worker elements to be successful, it needs to be close to community. This needs to be accelerated and it requires a more clear commitment to a changed workforce on the care team.

Sarah DeGuia, California Pan-Ethnic Health Network: There are specific populations DSRIP is focusing on; how do we improve health those populations through cultural competency strategies. Boys and men of color and post incarceration represent good examples to look to for how to make this relevant and successful. Is a text message more likely to be responded to; have male-only clinic hours; how we can use the expertise from community to improve delivery of care for populations where our systems don't work currently?

Christina Ghally, Los Angeles County Department of Health Services: I want to acknowledge the importance of including disparities in the metrics. From the current DSRIP, I know it would be useful to highlight the workforce changes needed. It would be good to bring forward the work required to train and transition the workforce. One way to do this is to make the milestones very transparent.

Susan Ehrlich, San Mateo Medical Center: I appreciate this perspective. I have two observations. On the High Reliability Organizations (HRO), my observation is that unless we involve frontline staff in a deep way, we cannot become a HRO. We are doing LEAN transformation and this relies on frontline staff. We have to be relying on many types of providers on our teams because it is so hard to keep primary care providers.

Judi Hillman, Health Access made remarks about best practices for DSRIP Domains. One of the first is to use the community needs assessment process. It should include data on SDOH, stratification on demographics (including gender identity and sexual orientation). We need to make everything as transparent as possible with dashboard tools and as a first step, test them out with communities. There are good tools offered by Office of Health Equity and the Healthy Cities web site. She mentioned the need to connect this to the all payer claims database and use this to track uninsured data as well as insured. Illustrating the story of successful counties is very helpful.

Leslie Mikkelsen, Prevention Institute and Manal Kappagoda, ChangeLab Solutions presented background on primary prevention, upstream solutions to support the health system. The

tobacco program success is a good story with a 5000% return on investment to the health care system. Leslie Mikkelsen underscored that the root causes of poor health outcomes related to disparities and behavior are well documented. She presented a framework and examples of how Accountable Communities for Health are beginning to be implemented in California. Finally, she drew the implications of Adverse Childhood Experiences in frequent user populations.

Manal Kappagoda presented specific ideas for including more prevention in the domains outlined in the DSRIP 2.0 Concept. She outlined several counties that are already advancing this work such as Santa Clara, San Francisco and San Diego in partnership with public hospitals. She suggested an assessment of these existing efforts and reminded the group that there were specific recommendations for domain four submitted by ChangeLab.

Bobbie Wunsch commented that the presentations have very useful information and suggested that presenters offer DHCS specific metrics, case studies on how the metrics are used and present the information by domain.

Bill Walker, Contra Costa County Health Services: Our public health department is heavily involved in community prevention. What is difficult is to parse out is what pieces can be included in the DSRIP vs broad community initiatives. We work with cities, other health systems in broad efforts. However, we do need to reference prevention in DSRIP. Given the struggle to identify measurable outcomes that CMS would approve, it is difficult to identify how to incorporate this.

Manel Kappagoda, ChangeLab Solutions: Some small steps, starting places might be to include advocating for smoke free policies and implementing healthy food policy inside health organizations.

Leslie Mikkelsen, Prevention Institute: CMS is interested in a CMMI initiative on Accountable Communities for Health. We have heard that CMS wants innovation. Can we find a way to include measures and practices about the systems and community linkages?

Jon Freedman, LA Care: In reading domain four projects, it seems they need to be linked to a policy agenda. Tobacco reduction had little to do with the health system. It was changing the environment through policy. I don't think we are prepared to do this in a waiver proposal. The alternative is to figure out how the safety net can be exemplars of best practice. I don't think changing the food policy in hospitals will move the needle for the community. That is the scope problem I see. The perinatal one is not aligned because I don't think we need DSRIP to reduce C-sections. There are other things related to perinatal that are missing – home visitation, maternal depression, inter-conception care. Maybe a smaller group could refine this and I think federal officials would be enticed by this but it has to work.

Bill Henning, Inland Empire Health Plan: I echo this. I am having trouble connecting this to DSRIP, as much as I believe in the issue. As much as we believe in SDOH affecting overall outcomes, we are limited. There are structural limitations.

Richard Thomasson, Blue Shield of California Foundation: As I understand DSRIP, we can have mandatory and optional elements. There could be population health metrics for BMI or tobacco use as an optional item that can provide an incentive in the waiver for counties who are working on this.

Neal Kohatsu, DHCS: Thank you for this. This is near and dear to our hearts at DHCS. The issue of how to connect this up is difficult but there are ways to make the connection on things like tobacco. We need more discussion of DSRIP and DHCS initiatives beyond DSRIP.

Hannah Katch, DHCS: These themes health inequity and SDOH are arising through all the workgroups and we are looking forward to how we can weave it into the waiver.

Judi Hillman, Health Access: Going back to a comment by Mitch Katz in a previous DSRIP forum. He said that every patient going through an ER should be assigned to a medical home. If we can articulate that as a focal point and framework for DSRIP 2.0, then I believe that could get us to SDOH.

Neal Kohatsu, DHCS: We need the policies, programs and case studies with the metrics to make the case for CMS.

Bobbie asked for volunteers to work on a small workgroup on domain four before the next meeting.

Manal Kappagoda, ChangeLab Solutions, Leslie Mikkelsen, Prevention Institute, Judi Hillman, Health Access, Richard Thomasson, Blue Shield of California Foundation, Jon Freedman, LA Care

Public Comment

There was no public comment.

Next Steps and Next Meeting #4 (January 26, 2015, DHCS Training Rooms A, B, C, 1500 Capitol Avenue, Sacramento)
DHCS and Bobbie Wunsch

- Next meeting is January 26th, 2015
- There will NOT be a Meeting #5: February 3, 2015