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

Monday, January 26, 2014
10:00am – 3:00pm
DHCS Training Room A, B, C
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; Angela Gilliard, University of California, Office of the President; Judi Hillman, Health Access; Manel Kappagoda, ChangeLab Solutions; Barsam Kasravi, Anthem Blue Cross; Sherreta Lane, District Hospital Leadership Forum; David Lown, Safety Net Institute;; Leslie Mikkelsen, Prevention Institute; Erica Murray, California Association of Public Hospitals and Health Systems; Al Senella, Tarzana Treatment Centers; Richard Thomasson, Blue Shield of California Foundation; Bill Walker, Contra Costa County Health Services.

Members on the phone: Christina Ghaly, Los Angeles County Department of Health Services; Tricia McGinnis, CHCS; Kelly Pfeiffer, California Health Care Foundation.

Members Not Attending: Bill Henning, Inland Empire Health Plan; Ken Kizer, UC Davis; Anne McLeod, California Hospital Association; Richard Rawson, UCLA.

Others Attending: Neal Kohatsu, DHCS; Sarah Brooks, DHCS; Wendy Soe, DHCS; Hannah Katch, DHCS; Efrat Eilat, DHCS; Tianna Morgan, DHCS; Don Kingdon, Harbage Consulting; Bobbie Wunsch, Pacific Health Consulting Group; Adrienne Laurent, Salinas Valley Memorial Hospital, Coby La Blue, Kaweah Delta Health Care District; Mark Turner and Pat Ziegler, San Gorgonio Memorial Hospital.

28 Members of the public attended the meeting.

Welcome and Purpose of Meetings; Feedback on Summary of Meeting #2,
Bobbie Wunsch, Pacific Health Consulting Group
Following introductions, Bobbie Wunsch reviewed the agenda. Today's discussion will focus on ideas about how to incorporate the feedback from the group and align DSRIP 2.0 with existing efforts. Thank you to the California HealthCare Foundation, The California Endowment and Blue Shield of California Foundation for their support.

Aligning DSRIP 2.0 with DHCS Quality Strategy and DHCS Goals
Neal Kohatsu, Department of Health Care Services
http://www.dhcs.ca.gov/provgovpart/Pages/Waiver_Renewal_Workgroup_DSRIP.aspx

Neal Kohatsu set the context for the day by reflecting on potential 1115 Waiver goals and the DHCS Quality Strategy as the blueprint for the work of the waiver and for the state. The quality strategy mirrors the triple aim yet has important differences relevant to California. He mentioned that language in the quality strategy intentionally references the health of all Californians and the entire health care system, although the state has a particular focus on the Medi-Cal population and other vulnerable populations. He reviewed the seven and the alignment of DSRIP 2.0 workgroup discussions with the DHCS quality strategy as well as Let's Get Healthy CA and CalSIM planning process.

Member Questions and Comment

Bill Walker, Contra Costa County Health Services: These are large and admirable objectives. I am wondering if we have feedback from CMS about whether we are on the right track.

Neal Kohatsu, DHCS: We don't have much to report yet, however CMS liked the big ideas and generally were positive. The business model is crucial to tie this all together and how the savings will be generated to finance the objectives.

Wendy Soe, DHCS: We will have an update at the next Stakeholder Advisory Committee meeting in February. We will begin an internal DHCS/CMS workgroup to work to discuss the specifics and refine the concepts. This process will continue to the fall 2015.

Barsam Kasravi, Anthem Blue Cross: One concept that seems missing concept is "accountable" or "integrated." Currently, we do coordinate care but I don't think we have had enough emphasis about moving to the same goals and being responsible for that.

Judi Hillman, Health Access: Can you say more about how the workgroups at CMs will work? How might we monitor those? Also, can we expand the concept of "engage persons" to mean engaging persons and families in their health care? Their input is important to accomplish all the objectives.

Neal Kohatsu, DHCS: When we reference health, we include health care. The web site includes many details not included here on slides.

Wendy Soe, DHCS: The workgroups mentioned are internal staff discussions. There will be meetings and calls to refine various aspects of the proposal. We will have several more touch points between now and the final approval to update stakeholders.

Erica Murray, California Association of Public Hospitals and Health Systems: We are very early in the process. We have been following other states' negotiations with CMS for DSRIP efforts and the indications are that there will be several more iterations.

Michelle Cabrera, SEIU: Looking at the waiver goals from other workgroup meetings, and there are differences in what is specifically highlighted. What is the relationship between this version and others? Specifically, Access and strengthening primary care delivery, is that still a focus?

Neal Kohatsu, DHCS: This is not an update based on input from all workgroups. It is meant as a reminder of the overall waiver – not to determine specific focus. We need the input of CMS to guide the overall input.

Wendy Soe, DHCS: I don't think these are very different from the July version or other presentations. The access element you mention remains.

Reflections on Stakeholder Feedback During and After Last DSRIP 2.0 Meeting
Neal Kohatsu, DHCS and David Lown, CAPH/SNI
http://www.dhcs.ca.gov/provgovpart/Pages/Waiver_Renewal_Workgroup_DSRIP.aspx
Neal Kohatsu and David Lown presented suggested themes that represent feedback from the stakeholder process for discussion. Going forward there will be a written document and that will have more details and will tie the overall waiver together. Four themes were presented for DSRIP 2.0 and the workgroup offered input and additional detail for each of the themes.

Theme 1:

- Advance Team-Based Care Including Non licensed Providers licensed Providers: Frontline non-licensed workers including CHW/Promatores/IHSS were highlighted; peer providers in the MH/SUDS and other domains; cultural and linguistic competency and using data to inform needs; ensuring safety for the workforce itself is also important here.

Member Questions and Comment
Barsam Kasravi, Anthem Blue Cross: Will we require hospitals to collect data on race/ethnicity as MA is doing? We need to begin to think about how to collect this on the provider side. Can we include the use of video or in person translators be included (not just telephonic)?

Neal Kohatsu, DHCS: Do you have experience of how it is proceeding in MA? I like the idea of including the data collection and would like to have a conversation of its feasibility. On translators, that is a good addition.

David Lown, Safety Net Institute: Race/ethnicity/preferred language is a requirement for MU stage 1 and all CAPH members are doing this. There is a huge difference in collecting data in a perfunctory manner and doing a thorough job collecting and analyzing the data.

Susan Ehrlich, San Mateo Medical Center: We do need to adopt best practices to collect this data. We have a project in the current waiver and it is helpful. On staff translators, we use the Health Care Interpreter Network (HCIN) which is a video-voice system that has greatly improved our access and uses resources effectively. I would be cautious about requiring in person staff.

Bill Walker, Contra Costa County Health Services: I agree with the comments on the HCIN. We can never have sufficient in-person capacity, but linking through the interpreter network has

worked well. On data, we have been at the issue of collecting real data for a while now. We ask upfront at registration and I don't think the claims data is the place for doing that accurately.

Michelle Cabrera, SEIU: Thank you for including all the previous feedback. On the race/ethnicity topic, if plans are driving toward certain quality requirements (e.g. plan/provider workgroup) and we don't include the race/ethnicity information in that analysis, then there may not be an overall approach. We need to be driving from the top down to increase the accountability and achieve a concerted effort to really change, reduce the gaps.

Neal Kohatsu, DHCS: That is an excellent point and we all agree. We haven't yet pulled together the big picture. We have tasked Patricia Lee at DHCS to pull together the full range of data needs across the various department efforts. Also we need to assess, Is the data valid? Is it used?

David Lown, Safety Net Institute: As important as REAL (Race, Ethnicity and Language) data is, that is the tip of an iceberg for SDOH. We need to focus on the broad scope and the full list of 12 SDOH overall.

Leslie Mikkelsen, Prevention Institute: To achieve the full integration of population health and health care here will require a better system of data collection and building better capacity to exchange data. While there are challenges of privacy, this is essential to achieve progress.

Themes 2 and 3:

- Increase Behavioral Health Capacity
- Integrate Behavioral and Physical Health

Neal Kohatsu provided an introduction to both themes. Increasing BH capacity includes medication assisted treatment and increasing referrals for this service, needs assessment and dashboards to address progress, making sure there is access to a medical home that is comprehensive, especially for frequent users. For theme 3, he highlighted that this include understanding the linkage of bi-directional integration; tracking long-term outcomes of drug and alcohol treatment; looking at the patient activation measure; addressing stigma through surveys (ISMI) to reduce barriers to care.

Member Comments

Al Senella, Tarzana Treatment Centers: Given all the recommendations reviewed in the previous meeting, what has been included here?

Neal Kohatsu, DHCS: Thank you for submitting comments. We are going through those detailed recommendations now and will include as many as possible. I can't provide a line-by-line answer today. Some things in the recommendations may be appropriate for the waiver or something better implemented through managed care and elsewhere in DHCS priorities and operations.

David Lown, Safety Net Institute: We want to assess each recommendation submitted that was received carefully for how it aligns with overall DHCS strategy, waiver goals and understand who has the authority to enact each recommendation. Finally, we are engaging our advisory groups to gain their input about the recommendations to gauge feasibility and get their experience with the issues raised in the comments.

Bill Walker, Contra Costa County Health Services: We are working on new requirements to care for mild-to-moderate BH populations. We are trying to build up our capacity in primary care to accomplish this. In some cases, we are relying on Beacon type systems for this work. How does that integration of BH and primary care work?

Neal Kohatsu, DHCS: That is a good example of looking at models to evaluate which approach is achieving the defined outcomes.

Sarah DeGuia, California Pan-Ethnic Health Network: As we integrate BH and physical health, race/ethnicity data and cultural competency should be a thread throughout this effort as well.

Bobbie Wunsch, Pacific Health Consulting Group: There are several upcoming opportunities where DHCS to review how the waiver is progressing. The first will be a presentation of the integrated approaches moving forward at the February 11th Stakeholder Advisory Committee and there will be at least one statewide webinar to update all of you.

Don Kingdon, Harbage Consulting: Harbage is playing a role in determining how to focus on BH in the overall waiver.

Barsam Kasravi, Anthem Blue Cross: It would be good to see research included on how other states are collecting data at the hospital, plan and provider level.

Judi Hillman, Health Access: Thank you for including the input on medical home. There are challenges in collecting the race/ethnicity data but the beginning of a five year cycle in a waiver is a good time to begin, establish goals for this work and set expectations for the data. We should come up with a good definition in this waiver cycle of a patient centered medical home as we see happening nationally. What seems to be weak is the connection back out to the community. We need to increase the focus on population health. Now is the time to influence AHRQ and make progress on integration health and health care.

Neal Kohatsu, DHCS: Those comments resonate with us. Yes, people do use the PCMH loosely to mean different things. The chronic care model has an arrow to community but it is the least talked about. I am very committed to this work. Health care may only be 10-20% of health outcomes, yet it is critical if you have chronic disease. Our commitment is to have the best "health system" in the country. A health system includes health care but also community health and community engagement. We want to be aspirational at the beginning of the waiver and if they don't fit in DSRIP or in the waiver, we remain committed to achieving this larger goals.

Theme 4:

- Integrate Health Care, Population Health and Advance Prevention

David Lown highlighted that input included comments about whether this should frame the DSRIP 2.0 projects overall. They are included throughout the waiver and beyond the waiver.

Neal Kohatsu, DHCS: thank you so much for the creativity and dialog. We will call upon you as we work through the discussion with CMS.

DSRIP 2.0 and District Hospitals: Presentation and Panel Discussion
Sherreta Lane, District Hospital Leadership Forum
Adrienne Laurent, Chief Strategic and Communications Officer, Salinas Valley Memorial Hospital, Salinas, California
Coby La Blue, Director of Financial and Logistical Planning, Kaweah Delta Health Care District, Visalia, California
Mark Turner, CEO and Pat Ziegler, RN, Director of Performance Improvement, San Gorgonio Memorial Hospital, Banning, California
http://www.dhcs.ca.gov/provgovpart/Pages/Waiver_Renewal_Workgroup_DSRIP.aspx

Sherreta Lane introduced the District Hospital leaders attending the workgroup meeting and offered an overview of district hospitals. Many district hospitals are rural, also run rural clinics and long term care as well as participating in medical resident education. There are many challenges in financing district hospitals and in some cases, local residents tax themselves to maintain access to the hospital. Other challenges are the transition to DRGs and Medi-Cal managed care expansion. Considerations about DSRIP 2.0 include that district hospitals have not participated previously and require planning. Potential DSRIP 2.0 projects might include BH integration, specialty and primary care access expansion, transitions of care, chronic disease management, resource utilization and prevention. There is discussion of having a tiered approach to incorporate the various capacity differences among district hospitals. The hospitals appreciate being included in DSRIP 2.0.

Member Questions and Comment:
Leslie Mikkelsen, Prevention Institute: As a registered dietician, I know the importance of it going hand in hand with the efforts you mentioned. Would that fit with what you are thinking?
Sherreta Lane, District Hospital Leadership Forum: Yes

Bill Walker, Contra Costa County Health Services: Did I understand correctly that expansion of Medi-Cal managed care had an adverse impact?

Sherreta Lane, District Hospital Leadership Forum: It remains to be seen what the impact is but it is a big change and hospitals are working through the reimbursement differences.

Coby La Blue, Kaweah Delta Health Care District: I work on Medicare and Medi-Cal cost reporting. We are a municipal hospital (581 beds) and offer a wide breath of services. We are in

a two-plan Medi-Cal managed care system and a very impoverished area. Our revenue is one third Medi-Cal and there are significant barriers to access. We participated in the Low Income Health Program.

Adrienne Laurent, Salinas Valley Memorial Health Care System: We are in Salinas, one of two hospitals. The county hospital Natividad Medical Center is the other. We are licensed for 269 beds. Salinas Valley has about 25% Medi-Cal, 40% Medicare. We work closely with Stanford on cardiac surgery and neonatal intensive care and try to complement services at Natividad Medical Center. For example, they have in patient psych and are building a trauma center; we have cardiac, oncology, surgery and ortho. We take their patients who need those services. We have discussed the DSRIP 2.0 projects we have in mind and they want to participate in the diabetes care center we are developing.

Mark Turner and Pat Ziegler, San Gorgonio Memorial Hospital: We are located in Banning in Riverside County. We offer primary and secondary hospital care and rely on Loma Linda University Medical Center for specialty and tertiary care. We are 18 miles from the county hospital, the closest hospital to our community. We are in rapid growth throughout the county and the health care system is playing catch up. In particular, we need more primary care, acute beds and psych beds. We work well with our Medi-Cal managed care plans, Molina and IEHP. Medi-Cal is about 20% of our revenue and 5% uninsured (declining). We are adjacent to a senior living community and this impacts our services, especially mental health and chronic disease.

DSRIP Projects:
Kaweah Delta: Adequate access to primary and specialty care are a challenge in our remote areas and we want to expand. We are looking at high utilizer chronic disease management and pharmacist consultant service to improve adherence for patients with high number of medications and we also have a special interest in BH integration and access to BH services.

Salinas Valley: DSRIP Projects: We rank 11th out of 58 counties for rates of diabetes and we have high obesity rates. If we can reduce inpatient care, ancillary, ED and other utilization by 15%, we can save $25M for the community. Our endocrinologists are over 60 years of age and have limited outpatient services and linguistic services. We have a diabetes educator and the demand is overwhelming. We want to develop a diabetes care center with cultural competency and community outreach and support. We want to develop a registry and incorporate ambulatory care management to target early interventions. Finally, we want to expand professional education related to diabetes care. We want to expand primary and specialty care by recruiting and improving efficiency through assigning patients to medical homes. This will improve outcomes and transitions. We will establish a primary care clinic in Gonzales and then expand to 2-3 other communities. Finally, a transitions of care program to facilitate pre and post discharge through protocols and communication between new multidisciplinary care teams focused on high risk patients.

San Gorgonio Memorial Hospital: DSRIP Projects: We based the priorities on our community needs assessment. Two of these priorities will be included in DSRIP: BH and improved chronic care, focused on heart disease prevention. Heart failure readmissions has been an issue locally and we need outpatient programs for seniors affected. There is a co-morbidity of cardiac conditions and depression so we will focus on both simultaneously through a rehab center that also includes nutrition and exercise. Our second project, if resources allow, is to address the shortage of psych beds that is currently causing access problems and back-up in the ER. This would be a crisis stabilization unit to reduce the ER challenges.

Bobbie Wunsch, Pacific Health Consulting Group: How can the lessons from the experience of public hospitals during DSRIP 1.0 best be communicated to help you as you implement these projects?

Sherreta Lane, District Hospital Leadership Forum: We are having discussions with public hospital partners about their challenges and held a specific meeting to hear from them about implementation challenges.

Adrienne Laurent, Salinas Valley Memorial Health Care System: We are lucky to have a hospital CEO who participated in DSRIP 1.0 in LA County.

Mark Turner, San Gorgonio Memorial Hospital: We have met with Arrowhead Regional Medical Center in San Bernardino to learn about their efforts and our proximity to public hospitals will help us as we move forward.

Member Questions and Comment

Erica Murray, California Association of Public Hospitals and Health Systems: All the public hospital DSRIP plans, reports and other information are on line and publicly available. We have tried to be aware of going first in this national endeavor and intentionally offered lessons learned documents on BH integration, primary care, patient experience and sepsis in ways that explore the implementation as well as the outcomes.

Judi Hillman, Health Access: Can you talk about race/ethnicity/preferred language data collection and MU of that data and how you might draw on public hospitals experience in this?

Sherreta Lane, District Hospital Leadership Forum: In our previous effort to be part of DSRIP 1.0, we began the conversations on the topic of data capacity. Many moved forward and have begun to collect and analyze the data to inform their projects for DSRIP 2.0.

Coby La Blue, Kaweah Delta Health Care District: We do collect and analyze that data as we consider services. We have used the information to identify diabetes in Hispanic population and respond to that need.

Adrienne Laurent, Salinas Valley Memorial Hospital: That information is collected and used.

Pat Ziegler, San Gorgonio Memorial Hospital: We do a lot of data collection but have to use abstract information in labor intensive ways. Unfortunately, we don't have the capability to collect the information you are referring to electronically.

Bobbie Wunsch, Pacific Health Consulting Group: what do you see as the major challenges to your participation in DSRIP 2.0?

Mark Turner, San Gorgonio Memorial Hospital: Money is an issue. Being rural, it is more difficult to recruit the right labor, partly due to volume and partly attracting them to a rural area. We have capital needs and other challenges for the resources we have so we are looking to access DSRIP funding upfront in order to ramp up and implement quickly.

Pat Ziegler, San Gorgonio Memorial Hospital: Another issue is that it takes a lot of collaboration and effort to get improvement projects going. We did begin to work on three projects discussed in DSRIP 1.0 (e.g. ED flow and catheter infections) and we continue those efforts. I look forward to working with others on these projects.

Adrienne Laurent, Salinas Valley Memorial Hospital: The biggest challenge is human resources. We will need outside resources and expert workforce to accomplish the projects.

Coby La Blue, Kaweah Delta Health Care District: To the earlier discussion, we need to reach out to the health plans and coordinate with others to be successful.

Neal Kohatsu, DHCS: Many of the challenges you describe were faced by the public hospitals in 1.0. Centralized data reporting to the state and on to CMS was even more of challenge than we envisioned. Perhaps a SNI type entity could be helpful on the centralized side.

Sherreta Lane, District Hospital Leadership Forum: We have looked at the reports from our colleagues at UC and County hospitals. It is clear the significant effort required to participate. We have discussed establishing a quasi-SNI entity. We don't have details yet but agree it would be a help to the hospital.

Adrienne Laurent, Salinas Valley Memorial Hospital: We are working with three hospitals on a mutual platform for a data repository for HIE.

Bill Walker, Contra Costa County Health Services: A question for Adrienne on payer mix, to what extent will the DSRIP 2.0 projects be structured to benefit the entire population including Medicare and commercial?

Adrienne Laurent, Salinas Valley Memorial Hospital: I do think it will benefit all our populations.

Coby La Blue, Kaweah Delta Health Care District: This is a Medicaid driven program but our hope is to benefit all patients. With Medicare, we are over 70% government payer.

Mark Turner, San Gorgonio Memorial Hospital: Agree, all the efforts will address the whole population.

Manel Kappagoda, ChangeLab Solutions: Outside of DSRIP 2.0, you mentioned local projects related to children's health and reaching out to schools. We are struggling to do that through DSRIP. Can you talk more about that?

Mark Turner, San Gorgonio Memorial Hospital: In Banning and Beaumont, the city and school leaders formed a coalition to deal with obesity rates of 50%. We are working on exercise, information and nutrition. We are accessing federal funding to start a farmer's market, working with dieticians on how to cook and eat the food in ways that is tasty. It is getting the food into local hands and encouraging healthy consumption.

Catherine Douglas, Private Essential Access Community Hospitals: I am impressed with Salinas Valley working across providers in the region for HIE and with Natividad on diabetes. Will the funding help build the HIE project you described? We didn't' see as much of this in 1.0 – working across all hospitals, plans and providers.

Adrienne Laurent, Salinas Valley Memorial Hospital: It is not yet clear how we will work together but have agreement to figure it out.

Richard Thomasson, Blue Shield of California Foundation: Much of our grant making is focused on building those collaborations among county, clinics and across hospitals in local areas. How are you thinking about joint planning or accountability measures that may cross county systems of mental health and physical health, public hospitals and clinics to integrate and improve health as well we work on other goals? How do we coordinate all to grow in similar directions?

Neal Kohatsu, DHCS: I think this resonates with my opening comments about benefits to all Californians. This is critical to a community and statewide to improve health. It is also important from a pragmatic point of view because CMS has that expectation to look beyond the public hospital system.

Sherreta Lane, District Hospital Leadership Forum: I think we are seeing this at the community level. Through the LIHP, there has been work across health providers in counties. Mark mentioned work they are doing with Loma Linda as an example.

Barsam Kasravi, Anthem Blue Cross: We welcome this collaboration. As an example of how health plans collaborate, we have an onsite nurse at Kaweah Hospital; we have a field team in Visalia to identify high risk clients and we share that data with hospitals and clinics.

Susan Ehrlich, San Mateo Medical Center: On lessons learned, I want to add to the information. One thing we learned quickly that may not be captured in the papers is that to approach these as individual projects is a mistake. Yes, it is important to get the resources and address infrastructure issues, but just as important is the focus on culture change and transformation of

systems. It has to be a performance improvement approach – in DSRIP 1.0, we had 74 milestones to reach across projects. We are bound to fail if we try to do these individually. Spreading LEAN in our hospital helped us make the fundamental changes we needed to make. I agree with Pat that this does require loving performance improvement as a whole organization.

Michelle Cabrera, SEIU: I remain concerned about the smaller district hospitals, those areas with the least resources. How do you pull resources together in a very under resourced area to work on these without abandoning everything else? Will they even participate? How will this spread to all district hospitals?

Sherreta Lane, District Hospital Leadership Forum: That is exactly why we hope there will be a funded planning period. That will help to hire staff and consultants. There may be some who do not participate, but many very small hospitals like San Gregorio are participating.

DSRIP 2.0 and Health Plans: Integration Across the Health System
Neal Kohatsu, DHCS and David Lown, CAPH/SNI
Facilitated by Bobbie Wunsch
http://www.dhcs.ca.gov/provgovpart/Pages/Waiver_Renewal_Workgroup_DSRIP.aspx

Neal Kohatsu and David Lown offered introductory comments. Dr. Kohatsu emphasized the integration across the health system broadly, including Covered CA. As people leave an inpatient or ED visit from a public hospital, we are going to do our best to link them into other resources and care across the health system even beyond the public hospital system. David Lown mentioned that there is a specific component in DSRIP to work on care transitions across physical health, mental health and substance abuse systems (health plans, other providers) and across providers (BH, PCP). There are multiple projects described that increase the coordination across health plans and providers. As we think about metrics, some criteria we are considering include: Are these metrics already used by the state? Reported by health plans? What are the P4P programs from plans that are already in place and how do these link and align with DSRIP? How do the goals link together across the entire waiver? Finally, how do we coordinate with CMOs from plans and health systems?

Bill Walker, Contra Costa County Health Services: To mention examples, high utilizers use all hospitals frequently – not just public hospitals and to work on this requires we collaborate. Another example, BH involves many contracts with many private providers and other health systems far beyond the public hospital system that means we work together on individual patients. There are ways to bring this together, work across departmental lines and with external systems, but it does take effort.

Jon Freedman, LA Care: What is critical on DSRIP and health plans is alignment on the endpoint. Within managed care, we have a specific set of operational objectives that health plans are accountable for through our state contracts. We need to be mindful that we do not create conflict through misalignment with these accountabilities. We need to be specific and more granular. One opportunity we have with public hospital systems is to pool DSRIP and health

plan resources locally to create global types of arrangements, however, we don't have global arrangements with nonpublic hospitals. In addition, there are fundamentally different concepts in some of these arrangements; like FFS payments that can be in conflict with DSRIP objectives. Harmonizing as best as possible toward the managed care dashboard would be most helpful.

Barsam Kasravi, Anthem Blue Cross: As a health plan, we can't coordinate care without working with the hospital and providers. For example, in order to address preventable readmissions, it goes beyond a single entity. We are working to verify HEDIS measures through chart reviews for data that is not collected at the health plan. This is a chance to align and to work more efficiently to collect data.

Neal Kohatsu, DHCS: One challenge in the states working on dual eligible populations is that they have over 100 metrics to track. This is one example of why it is important to align, because of the time it takes to track and report. We do need to align between hospitals and plans. Given the large number of FFS births in CA, this extends even more broadly than managed care. Improving maternal quality requires that we have to align beyond managed care as well.

David Lown, Safety Net Institute: The metrics need to align, however, if the state managed care dashboard has a different outcome in mind than the local DSRIP outcome, it may not be possible. DSRIP metrics are also very specific at a local level that don't apply to the state level. We should align where we can.

Catherine Douglas, Private Essential Access Community Hospitals: Private DSH are very interested in super utilizers and coordinating BH needs across DSRIP. I hear the issue of using managed care dashboards. I am wrestling with BH issues, given mild-to-moderate care in plans and SMI care with counties but all presenting in hospital EDs? How can we measure improvement?

Sarah Brooks, DHCS: That is the role of the managed care health plan, to coordinate care and focus on increasing the access to primary care in co-located settings. On Jon's comments, are we are looking at the set of metrics related to outcomes?

Jon Freedman, LA Care: It is a good point to keep in mind those issues beyond managed care. Keep in mind that DSRIP is less than one percent on the overall spend, so we need to be careful about what we are adding/looking to change based on that.

Sarah Brooks, DHCS: Yes, what are the higher level metrics that allow us to achieve the goals? There are opportunities and it is necessary that when we have overlap, we agree on one measure so we don't have duplication measuring very similar things.

Erica Murray, California Association of Public Hospitals and Health Systems: The work now is to put this all together between the various workgroups. In provider/plan incentives, there is a discussion of flexible payments for community services into capitated arrangements. Whole person care integrates this together. It is beginning to come together. One of the underpinnings

is data – it is essential to capture accurate reliable data and to report up to decision makers. California is not as far along as other states. We are working individually on HIT and we don't have HIE. We can't have serious conversation about joint accountability until we have HIE.

Michelle Cabrera, SEIU: I agree and it is further complicated by managed care in California and having to add that into our story topics like capitation, sub capitation and how the data meshes. I have yet to find the thinkers who understand how the data really works in a cap arrangement.

Don Kingdon, Harbage Consulting: I think there is a bit of a misconception about the mild-to-moderate benefit. DHCS and the legislature created access through a managed care system because it was not available on the FFS side. The plans created access for the first time that was not available on the FFS side. From a policy perspective, access has been created and now the challenge is to make that work and coordinate systems. There are proposals in the plan/provider incentives that moves this responsibility up to plans and has potential to do what we need plans to do.

Barsam Kasravi, Anthem Blue Cross: Maternity is another area we have not discussed much. Given the quality strategy, we are working to coordinate postpartum care and other improvements. We might want to have some metrics there.

Bill Walker, Contra Costa County Health Services: Referencing the overarching goals of a healthy California and SDOH. Although part of CalSIM planning, CDPH is not at this table. I don't know how the health care system, absent public health work on violence prevention and the other funding streams to accomplish this work.

Sarah Brooks, DHCS: I agree with you. CDPH is represented on the plan/provider workgroup and we have been meeting to identify the data available that can inform this process.

Judi Hillman, Health Access: We are in a new legislative cycle and budget. We are in a basic stage on HIE and data collection. There are decisions to be made in this budget cycle that could have a bearing on the barriers and priorities we have identified here, such as the all payer claims database; the question of reimbursement rates and the managed care tax. It is important to think how we interface with those tracks.

Feedback on Palliative Care and Patient Safety Domains, Projects and Metrics
Neal Kohatsu, DHCS and David Lown, CAPH/SNI
Facilitated by Bobbie Wunsch
http://www.dhcs.ca.gov/provgovpart/Pages/Waiver_Renewal_Workgroup_DSRIP.aspx

Bobbie Wunsch, Pacific Health Consulting Group asked the group about projects and metrics in the concept paper on palliative care and patient safety.

Neal Kohatsu, DHCS asked for any input to refine the concepts here and to add information or ideas that are not yet included in the concept paper on palliative care. He acknowledged there

are nuances to this topic that are very important and further refinements may be needed. In particular, there are cultural differences in the way palliative care should be approached and we want to be sure we do this in a way that makes sense for DSRIP and for DHCS.

Neal Kohatsu, DHCS provided context on patient safety. The patient safety is critical and almost everyone has been touched by unfortunate incidents. However, this issue has faded from view. Up to 200K die every year die due to incidents and many feel we have not made much progress to improve the status of patient safety. It is difficult to collect the right data to identify patient safety concerns and what to do. Again, this is relevant for DSRIP and for DHCS overall.

Wendy Soe, DHCS: Can the district hospitals comment about whether these two domains are appropriate for district hospitals to focus on?

Sherreta Lane, District Hospital Leadership Forum: I do think these projects are needs and there is interest from the hospitals although our major focus has been on the other proposed projects. Our focus on patient safety has been less due to very small numbers.

Adrienne Laurent, Salinas Valley Memorial Hospital: We do have a palliative care physician who is overwhelmed so this might be a way to do what is really needed in our hospital. I agree that emphasis on patient safety has lessened so projects on this are very valid as a focus.

Coby La Blue, Kaweah Delta Health Care District: We have a palliative care program as well. We find there is a stigma with providers and some cultural stigma with patients and we would like to address that.

Al Senella, Tarzana Treatment Centers: We don't often think of BH in patient safety but access issues, medication reconciliation, the hopping from one physician to another to seek meds - are all important to include in this domain.

Michelle Cabrera, SEIU: We submitted detailed recommendations on this. If we consider the worker aspect of patient safety more, we are excited about how to change the culture.

Sherreta Lane, District Hospital Leadership Forum: The comments on worker safety resonate with our members as well.

Angela Gilliard, University of California, Office of the President: On the issue of patient safety and palliative care, these are high priority for UC Hospitals. We have a system wide Center for Health Quality and Innovation and one project was on palliative care. The numbers are positive from the project and we are trying to expand it across the system. I think DSRIP is absolutely the right place for patient safety and palliative care. A number of the DSRIP projects are clinical and a number of our providers participate in SNI on these topics as well as system wide projects beyond CAPH. Some of the projects may not seem as innovative but these are the ways that medicine improves care. We need DSRIP as a resource for these activities.

Bill Walker, Contra Costa County Health Services: Patient safety is all about culture change and this needs to involve frontline workers. As Neal pointed out, patient safety has receded but it certainly hasn't been solved. I worry that CMS will say "been there, done that." It is not done. It requires ongoing effort to continue training and maintain a focus on improvement.

Bobbie Wunsch, Pacific Health Consulting Group: Are there any topics you have not heard in DSRIP that you want to be included?

Angela Gilliard, University of California, Office of the President: With the current DSRIP, the University and public hospitals have made significant investments. Some areas did not result in reimbursement. We hope that the next DSRIP will build on this investment, continue and expand to reap the ultimate results during DSRIP 2.0.

Sarah Brooks, DHCS: Are there opportunities through DSRIP to promote and encourage existing and new relationships between hospitals and health plans?

Erica Murray, California Association of Public Hospitals and Health Systems: There is enormous opportunity. Medi-Cal managed care is the foundation. How can we make managed care more managed, more accountable for more value? To DSRIP, there are clearly provider based projects to accomplish this.

Susan Ehrlich, San Mateo Medical Center: I don't know how the objectives get accomplished without health plans. For example, we don't have data on high utilizers without the health plan so that we can bring them into appropriate care. This will only grow over time.

Angela Gilliard, University of California, Office of the President: The relationship between UC and health plans includes successes and some not success. One area for more collaboration is Telehealth, e-RX and all the things that extend access and services. To the extent that health plans can embrace the need for reimbursement in some areas where it is not currently available, this is where we can expand the partnership.

Barsam Kasravi, Anthem Blue Cross: Unless we tie the dollars to collaboration between health plans and hospital, it may not happen on its own. We have tried incentives, ideas and we have talked, but in many cases, it hasn't happened. This is a good chance to have financial model to move ahead.

David Lown, Safety Net Institute: Thinking about Susan's comment, work with health plans requires a project by project review and an overall structure for collaboration. Data, data, date - HIE would impact every project.

Erica Murray, California Association of Public Hospitals and Health Systems: to Barsam's point, this is where we need to put it all together for the waiver. How are we structuring it overall? How are these aligned? It may not be in DSRIP – it may be throughout.

Next Steps and Follow-Up
DHCS and Bobbie Wunsch

This is the last meeting of the workgroup although we are at the beginning of the overall waiver process. We would not have gotten this far without all of your willingness to put ideas forward. January 30th there will be a budget neutrality presentation. We will send a survey evaluation to ask for your feedback on the workgroup process and would appreciate you taking time to complete that survey. The feedback from 2010 was very helpful in planning this process. We want to thank the foundations, The California Endowment, California HealthCare Foundation and Blue Shield of California Foundation for their support of the workgroups. The state could not have taken on this process without their support and their thought partnership. The work of state staff and the partnership between DHCS and SNI has been extremely valuable.

Wendy Soe, DHCS: Our thanks to the workgroup members and to the foundations for all of the support.

Public Comment

Jack Iams, 3M: I congratulate you all on the work in all of the workgroups. My comment is a historical one. I have been involved in this work since the beginning of DRGs. I want to emphasize the comments about simplifying, working across the various systems. The federal government and state government have an opportunity to create incentives and let the work to be done locally. One thing we learned is that there is great ingenuity at the local level to figure this out. The state can set simple but powerful incentives to let the local level figure it out. That is the history of what has worked.