



THE DELIVERY SYSTEM REFORM INCENTIVE PAYMENTS PROGRAM: INCREASING ACCESS, ENHANCING QUALITY OF CARE IN CONTRA COSTA COUNTY

Contra Costa Regional Medical Center and Health Centers (CCRMC & HC) has embarked on an ambitious plan to expand access to care and enhance quality through a robust effort called the **Delivery System Reform Incentive Payments** (DSRIP) program. The program was created by the Section 1115 Medicaid waiver, sometimes called the “Bridge to Health Care Reform,” a joint federal/state agreement with California’s public hospital systems that waives certain Medicaid requirements in order to test improvements in health care.

This pay-for-performance program will allow public hospitals to receive up to \$3.3 billion statewide if they achieve multiple specified milestones. Below is a summary of the program’s aims and specifically of CCRMC & HC’s plan over the five-year period, which began on July 1, 2010 and runs through June 30, 2015. This critical work builds on the quality-improvement initiatives already achieved by CCRMC & HC as part of its dedication to the continuous improvement of care.

The Goal:

The program is a bold five-year plan designed to build on our current efforts to:

- Expand access to timely and appropriate care
- Enhance the quality of health care
- Improve the health of patients and communities
- Help us prepare for Health Care Reform in 2014

The Need:

CCRMC & HC has worked for many years to expand access and improve quality with significant success, but a lack of resources has hampered our ability. In the past we have received funding to treat patients, not to develop systems or to manage care. Support from this program will allow us to develop the infrastructure and processes needed to make care more coordinated and integrated, so that we can build the foundation necessary to implement improvements and turn successful pilots into system-wide efforts.

What It Means for Contra Costa County:

The Incentive Program will enable us to:

- See more patients in a timely manner and in the right place
- Reduce avoidable Emergency Department visits and hospital admissions
- Keep patients healthier and better able to manage their health
- Improve patient safety
- Identify and address health care disparities
- Enhance the patient experience
- Improve the community’s health (e.g., obesity, diabetes, heart disease)
- Improve communication and coordination between the patient and provider
- Help ensure a sufficient number of primary care doctors for the future

The Plan:

The plan crosses five categories that recognize the breadth of change we need:

<p>1. Infrastructure Development <i>What investments must we make in people, places, processes, tools and technology?</i></p> <ul style="list-style-type: none">• Increase primary care capacity through new clinic space and training• Increase training of primary care workforce in low-income, diverse communities• Increase timely access to health care interpreter services• Collect race, ethnicity and language (REAL) data to identify and address health care disparities at	<p>2. Innovation and Redesign <i>What changes in design or methods can we make to expand access and improve quality?</i></p> <ul style="list-style-type: none">• Expand medical homes• Improve the medication refill process• Enhance patient experience of care• Begin to integrate behavioral and physical health care
<p>3. Population-Focused Improvement <i>What can we do to improve the health of our population as a whole?</i></p> <p>Reporting 21 patient experience and population health measures across the following domains:</p> <ul style="list-style-type: none">• The Patient's Experience• Effectiveness of Care Coordination (e.g., measured by hospitalization rates for heart failure patients)• Prevention (e.g., mammogram rates are childhood obesity)• Health Outcomes of At-Risk Populations (e.g., blood sugar and cholesterol levels in patients with diabetes)	<p>4. Urgent Improvement in Care <i>How can we improve quality to ensure our patients' safety?</i></p> <ul style="list-style-type: none">• Improve sepsis detection and management• Prevent central line-associated bloodstream infections (CLABSI)• Prevent hospital-acquired pressure ulcers (HAPU)• Prevent and treat venous thromboembolism (VTE)
	<p>5. HIV Transition Projects <i>How can we improve coordination of HIV care?</i></p> <ul style="list-style-type: none">• Improve access to wrap around services• Create clinical decision support tools• Enhance public health data sharing• Monitor core clinical performance measures

At the end of five years:

When we achieve all of our milestones under the Incentive Program, we will have:

- Constructed two new buildings with more than 60,000 sq ft of clinic space
- Significantly increased the number of clinic visits and reduced appointment wait times
- Assigned at least 95% of eligible patients to a primary care provider in a medical home
- Reduced sepsis mortality through improved compliance with validated interventions
- Reduced central line-associated bloodstream infections through improved compliance with validated protocols
- Reduced hospital-acquired pressure ulcers to 1.1% prevalence or below by implementing and adhering to standardized processes
- Improved the prevention and treatment of venous thromboembolism (VTE) through improved compliance with evidence-based protocols