Health Services
LOS ANGELES COUNTY

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July 23, 2014

TO: Each Supervisor

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **DEPARTMENT OF HEALTH SERVICES' (DHS) STRATEGIC PLAN**

Three years have passed since DHS rolled out its strategic plan. In that time, we have made great progress in improving the services we deliver so that we will be successful in attracting and retaining patients in the era of health reform. To properly focus DHS' efforts on the areas most critical to our continued transformation, I have created a new strategic plan to guide our activities over the next three years. This new plan, attached here, adheres to the same five strategic goals that formed the framework of the previous plan. These five goals still serve as our ultimate aim.

As we start work on achieving the individual strategies of the new plan, I am also pleased to share with you a few of DHS' key accomplishments over the last three years.

I would be happy to discuss DHS' goals and initiatives at any time. Thank you for your continued support of DHS.

MHK:jp

Attachments

c: Chief Executive Office
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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

Los Angeles County
Department of Health Services
Strategic Plan
July 2014

MISSION: To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at Department of Health Services (DHS) facilities and through collaboration with community and university partners.

VISION: To be the most effective and innovative county health care system in the country.

GOAL 1: Transform the Los Angeles County DHS from an episodic, hospital-focused system to an integrated high-quality delivery system including community-based primary care and behavioral health providers focused on prevention, early intervention, and primary care with appropriate referrals for specialized services.

Strategies:

1. Expand and deepen the ability of Patient-Centered Medical Homes (PCMHs) to provide patient-centered, longitudinal, coordinated, primary and preventive care within a team-based staffing model.
    a. Establish additional PCMH teams, allocating new capacity based on an objective assessment of demonstrated demand and unmet community need.
        i. Perform regular outreach and recruitment efforts, including primary care residency programs.
        ii. Maximize available loan repayment programs in designated Health Professional Shortage Areas.
        iii. Review and adjust salary range as needed to recruit and retain primary care providers.
    b. Evaluate and implement changes to PCMH staffing composition to support panel management and optimize PCMH panel size.
        i. Hire full contingent of planned PCMH staff across DHS, including care managers, nurse caregivers, service coordinators, and certified medical assistants.
        ii. Evaluate and refine roles and responsibilities of PCMH team members, and design and execute appropriate staff training, with an emphasis on team-based care, reduced reliance on face-to-face provider visits, leadership roles for non-provider staff, and empowerment of non-clinician/non-licensed personnel to provide more clinical care.
        iii. Assess costs and benefits of incorporating community health workers, and other potential PCMH team members, into the medical home team through targeted pilots and broad implementation of successful models.
    c. Increase use of technology to improve PCMH function.
        i. Maximize use of Online Real-Time Centralized Health Information Database (ORCHID), patient portal, and patient registry to manage patient panels and individual patient needs, improve accuracy of clinical and demographic information, facilitate intra-provider communication, etc.
        ii. Complete overhaul of DHS outpatient telephone systems, including transition to the ISD/vendor-hosted contact center, revision of telephone trees/scripts, and development of standardized service reports.
        iii. Implement automated tools (e.g., batch orders, patient reminder calls) to improve patient engagement and make most efficient use of available staff time.
    d. Improve access for empaneled patients by implementing patient-centered scheduling in PCMHs and facilitating phone consultation with PCMH staff during evening/weekend hours.

   e. Expand care management tools and guidelines to assist PCMH staff in effectively managing patients with chronic medical conditions.
2. Enhance outpatient experience through improvements in clinic flow (e.g., evaluation of front-desk registration functions), cycle time, physical environment (e.g., signage, focused facility improvements, waiting room Wi-Fi), customer service training, and by tracking and responding to input from patient comments, satisfaction surveys, and grievances.
3. Continually refine method for prospectively empaneling individuals who would most benefit from primary care, including emphasis on high-utilizers and patients with chronic medical conditions who can be discharged from specialty clinics.
4. Build system of care for managing continuing clinical needs of patients who either do not require empanelment or who cannot be empaneled in a sufficiently timely way to address their immediate issues.
5. Improve processes for managing transitions in care between settings (e.g., inpatient to PCMH, specialty care to primary care, PCMH to ED).
6. Increase primary and specialty care outpatient capacity and available visits through increased reliance on non-face-to-face visits, group visits, timely discharge of patients from clinics when clinically appropriate, and overhaul of scheduling templates and processes to improve provider productivity.
7. Increase availability of specialty care services.
   a. Implement eConsult in 100% of available specialties, referrers (i.e., primary care, ED, urgent care, specialty clinics), and DHS and Community Partner referring sites.
   b. Establish primary care/specialty care workgroups for all medical, surgical, and behavioral health specialties.
   c. Increase availability and use of clinical care/referral guidelines outlining effective practices for commonly encountered clinical situations.
   d. Increase use of alternative models of care (e.g., tele-retinal cameras, sports medicine clinics) and breadth of care providers (e.g., mid-level practitioners, non-clinical licensed personnel, non-licensed personnel) that reduce reliance on face-to-face visits with a physician specialist.
   e. Measure and minimize mismatches between supply of and demand for specialty services.
   f. Establish specialty medical homes for ongoing management of patients with specific, complex medical conditions (e.g., HIV, spinal cord injury).
8. Facilitate efficient management of referrals for specialty and diagnostic services from other County Departments.
   a. Ensure all County Departments who regularly refer patients to DHS specialty care clinics (e.g., LA County Sheriff's Department Medical Services Bureau (LASD-MSB), Department of Mental Health (DMH), Department of Public Health (DPH)) are able to use eConsult.
   b. Eliminate use of current Referral Processing System by developing eConsult or other system/processes capable of managing requests for advanced diagnostic studies and procedures from DHS and community partner sites.
   c. Revise processes for managing referrals from non-contracted community clinics.
9. Develop mechanisms and infrastructure needed to seamlessly refer and coordinate care for patients seeking services in more than one Los Angeles County (LAC) health department.
   a. Implement eConsult to manage requests for specialty consultation and exchange information between providers within/among the Departments.
   b. Develop clear guidance for patients, or their providers, seeking access to short- or long-term health services in another LAC department.
   c. Establish tools, policies, and processes that will facilitate data sharing, performance measurement, and system planning between DHS, DPH, DMH and DPSS.

   d. Enhance depth and breadth of co-located physical and behavioral health services.
   e. Engage in joint care planning in order to develop and implement case management and/or care navigation programs to address specific needs of complicated, high-risk patients shared by DHS, DMH, and DPH.
   f. Outline and implement strategy for integrating and optimizing services provided to individuals in County correctional facilities (i.e., jails, juvenile halls/camps).
10. Enhance PCMH staff capabilities and capacity to directly address behavioral health and substance abuse issues.
   a. Evaluate cost/benefit of adding behavioral health or other staff to PCMH team.
   b. Perform behavioral health and substance abuse Screening, Brief Intervention, and Referral to Treatment (SBIRT) within the PCMH.
   c. Expand use of pharmacologic interventions for substance use disorders (e.g., extended-release naltrexone, buprenorphine, and methadone).
11. Assess and address deficiencies in DHS central and facility-based managed care infrastructure, including claims processing, case management, care transitions, utilization management, provider credentialing, grievances and appeals, member services and network management.
12. Build a system of care for residually uninsured individuals seen by Community Partners that has a transparent provider of record, capitated payment, and prompt referrals for necessary specialty services.
13. Increase number of homeless individuals who are high-utilizers of County services who are transitioned to permanent supportive housing.
14. Reduce outpatient pharmacy wait time by completing roll-out of Central Fill initiative, implementing mail order of refill medications, and improving facility-based pharmacy operations.
15. Use clinic/unit-based operational, quality, and finance metrics to drive decisions on resource allocation, staff training needs, performance improvement projects, and adoption of effective practices.

GOAL 2: Assure sufficient capacity of hospital-based services to meet the needs of the people of Los Angeles County.

Strategies:

1. Optimize allocation and use of inpatient bed capacity to improve clinical care, reduce length of stay and reduce cost/bed-day.
   a. Diversify and increase flexibility of inpatient and observation bed allocation to match capacity with patient demand across the continuum of care (e.g., step-down, telemetry, observation, NICU/peds).
   b. Expand use and availability of outpatient services (e.g., evening/weekend diagnostic services, infusion services) and community-based/lower level of care placements in place of inpatient admission when clinically appropriate.
   c. Improve efficiency of inpatient operations (e.g., timeliness of ancillary and consultative services).
   d. Ensure 100% concurrent utilization review of all inpatients.
   e. Improve care transitions and discharge planning procedures, including prompt and regular communication with medical home team, warm hand-offs at time of discharge, and timely outpatient follow-up appointments.
2. Build lower level of care capacity through roll-out of MLK recuperative care beds, permanent supportive housing initiatives, and skilled nursing facility pilot contract.
3. Address high Psychiatric Emergency Services (PES) volumes by reducing the inflow of patients into the PES (e.g., expand use of psychiatric urgent care centers) and accelerating placement options for patients unable to be discharged home (e.g., expand community-based lower levels of care).

4. Increase surgical, advanced diagnostics, laboratory and procedure-area capacity through both supply- (e.g., increased productivity, focused capacity increases) and demand-related (e.g., clinical decision support) strategies; modify ancillary schedules to accommodate time-sensitive clinical requests.
5. Improve care provided to incarcerated populations seen within DHS through expansion of co-located services, expanded use of data/information-sharing, and overhaul of referral processes and care transitions.
6. Decrease emergency department cycle time through referral to urgent care/clinics, prompt transfer to inpatient beds or observation units, and expedited outpatient scheduling of non-emergent diagnostic tests.
7. Maintain and continuously improve the LA County trauma system; in particular, evaluate opportunities to expand trauma hospital network into populated areas of the county without a trauma center within a 10 mile radius.
8. Complete the contracting process for Emergency Ambulance Transportation Services to ensure the continuance of quality emergency ambulance transportation at no additional cost to the County.
9. Provide assistance to assure the successful opening of Martin Luther King, Jr. (MLK) hospital, including the development of rational and effective linkages between MLK and County services.

GOAL 3: Create a modern IT system that improves the care of our patients and assures efficient use of resources.

Strategies

1. Successfully implement an integrated electronic health record (EHR) able to achieve meaningful use at all DHS facilities.
    a. Empower facility-based leadership to own EHR implementation and change management processes.
    b. Complete capital projects, facility upgrades, and hardware refresh as needed to support EHR launch.
    c. Complete design and build process, including linkages to DHS legacy IT systems.
    d. Consolidate systems that will remain outside of ORCHID, including patient accounting and FUJI PACS.
    e. Develop, test, and refine a new DHS chargemaster able to fulfill DHS' financial and operational responsibilities.
    f. Assess and adapt facility-specific policies, procedures, and workflows as needed to ensure standardized EHR roll-out.
    g. Conduct comprehensive workflow and IT training sessions across DHS classifications; develop process for ongoing training of new and existing staff.
    h. Develop master provider database linked to provider credentialing system.
    i. Manage data resolution to create a trusted source of unique patient identifier that links to ORCHID and Enterprise Patient Data Repository (EPDR).
    j. Hire and train a highly competent Enterprise Service Desk able to address system-wide IT needs.
2. Evaluate registration processes, IT interfaces, and new technologies that can minimize the creation of duplicate medical records at the point of an in-person visit, outside referral, or e-consultation from DHS and Community Partner sites.
3. Perform network and data-center enhancements as needed to ensure a reliable backbone for IT applications that continue to be locally hosted.
4. Support County-wide efforts to secure Health Information Exchange including data sharing with other county departments, Community Partners, and local hospitals.
5. Complete the build of the EPDR, which integrates data from all major DHS IT systems into one well-

defined and rigorously maintained database system to enable timely and accurate reporting of clinical, and operational, and financial data.

6. Further develop data governance infrastructure, policies, and procedures and establish a Business Intelligence Competency Center to develop key performance metrics and optimize data integrity, transparency, and information sharing across DHS.
7. Prioritize support to key clinical and administrative initiatives, including empanelment, i2i, e-Consult, managed care services, electronic documentation management, ICD-10 implementation, coded data capture, scheduling/template modification, contractor on/off-boarding, and PAR processing.

GOAL 4: Assure the long-term financial well-being of the safety net health services in Los Angeles County.

Strategies:

1. Implement an electronic eligibility and enrollment system for use by Community Partners and DHS providers that is able to verify eligibility for public insurance programs and financing prior to enrollment in County-funded indigent programs.
2. Right-size facility budgets through consideration of historical and targeted expenditures and appropriations across budget categories; implement strategies to prevent recurrence of structural deficits.
3. Develop, implement, and track unit-based budgets, fully allocated costs, and workload statistics in order to assist with improving capacity utilization, expenditure management, and overall DHS priority-setting activities.
4. Assess costs, benefits, and effectiveness of different staffing models to support management decision-making and drive organizational performance (e.g., evaluation of part-time vs. full-time vs. contract staff, physician employment models, value of new PCMH team member roles).
5. Decrease per unit costs of service by increasing visits and reducing administrative overhead.
6. Increase number of DHS patients with third party public or private coverage.
    a. Expand revenue contracting, business development, and marketing initiatives, with a priority focus on attracting new patients to those services with existing capacity and/or specialized capabilities.
    b. Improve performance on Healthcare Effectiveness Data and Information Set (HEDIS) measures that impact default-enrollment algorithms at the level of the health plan.
    c. Attract and retain dual-eligible enrollees.
    d. Maximize number of patients screened for Medi-Cal presumptive eligibility.
7. Improve processes for managing costs of caring for individuals insured by third party health plans.
    a. Reduce out of network expenditures through targeted outreach to high out-of-network utilizers, selective contracting with facilities in specific geographic locations, modifying provider assignment criteria, prompt repatriation of patients seen in outside EDs or inpatient units who are stable for transfer, and evaluation/audit of submitted claims.
    b. Develop processes for reducing write-offs for out-of-plan individuals (e.g., develop uniform and simplified policies governing provision of non-emergency services to out-of-plan patients).
8. Improve patient experience, ensure access for County patients, and maximize financial reimbursement through overhaul of financial screening, front-desk registration, and clinical service approval practices at hospital- and non-hospital based sites.
9. Evaluate methods for simplifying existing County financial programs (e.g., ATP, pre-payment program) for residually uninsured patients.
10. Decrease full scope medical-surgical and psychiatric denied inpatient days to ≤10% and ≤20%, respectively.
11. Maximize existing and new state/federal funding streams.
    a. Maximize available Delivery System Reform Incentive Program (DSRIP) Category 1-5 funding

in existing 1115 waiver.
   b. Negotiate successor 1115 waiver that maximizes core funding and aligns financial streams to focus on high-quality, whole person care.
   c. Maximize participation in Eligible Provider EHR Incentive Payment program.
   d. Investigate feasibility of certifying DHS clinics as drug Medi-Cal sites.
12. Align financial incentives/processes between DHS, DPH, and DMH to improve reimbursement, reduce costs (e.g., shared formularies, maximize 340b pricing), and maximize drawn-down of federal funds for behavioral health services.
13. Implement nurse staffing model and achieve targeted reductions in overtime and registry use.
14. Successfully transition to ICD-10.
15. Improve ICD-9/10 coding accuracy and completeness to improve reimbursement, risk-adjustment, and quality reporting.
16. Improve DHS contracting, contract monitoring, and procurement processes to identify opportunities to decrease costs and accelerate access to products and services.
   a. Complete steps required for successful DHS-wide implementation of GHX/e-CAPS, including development of a new item master.
   b. Investigate opportunities to further decrease pharmaceutical costs through formulary management and changes to purchasing processes.
   c. Increase use of bulk purchasing and use of master agreements for frequently used services.
   d. Invest in inventory management solutions and processes that demonstrate the ability to reduce waste and costs associated with expired, excess, and lost supplies.
   e. Increase central oversight of contract monitoring activities, including fiscal, administrative, and programmatic elements.
17. Mitigate exposure to malpractice and workplace claims.
   a. Improve clinical workforce awareness of risk management processes and strategies to reduce risk (e.g., role of medical record documentation), improve patient engagement, and minimize patient dissatisfaction after adverse events
   b. Evaluate possibility for early settlement offers when appropriate.
   c. Continue implementation of safe patient handling management initiatives for acute care facilities.
   d. Establish quality control and claim management verification process for Return-to-Work Coordinators in accord with internal and statutory requirements.
   e. Adopt best practices for pre-employment background checks and physical exams.
   f. Ensure mechanism and infrastructure for timely notification of workforce member due for updates to licensure, credentials, health clearance, or other certifications.
   g. Implement technology solutions and dashboards to improve claim tracking and risk analysis (e.g., Absence Management System, Performance Management Tracking System).
   h. Collaborate with County CEOP as needed to support the timely investigation and resolution of workplace harassment and discrimination complaints.

GOAL 5: To foster a culture of empowered staff and community, organized labor, and university partners constantly looking for opportunities to improve the care we deliver.

Strategies:

1. Improve patient safety, clinical quality, and reduce risk by embedding principles of Safe & Just Culture across DHS staff and by pursuing targeted initiatives related to patient identification, care transitions, and event reporting.
   a. Transition from current patient safety event reporting system to an integrated patient safety event reporting, claims management, and complaint tracking system.
   b. Educate workforce to increase volume of "near-miss" reporting and improve quality of data

that can be tracked in the new system.

c. Utilize integrated claims, complaint and safety event data to develop proactive safety and risk mitigation strategies.
d. Standardize clinical and operational practices such as antibiotic use, outpatient pain management, primary care management of common specialty conditions, use of equipment and supplies to improve patient safety.

2. Develop comprehensive patient, staff, and external communications that can effectively reinforce the DHS mission, offer descriptions of available programs/services, and provide timely updates on major events or initiatives.
3. Actively engage patients in performance improvement activities through use of survey tools and membership on facility workgroups/committees.
4. Partner with labor union leadership in order to improve staff satisfaction and engagement, enhance patient experience, and accelerate DHS' overall transformation.
5. Develop organizational and technology infrastructure for continuously improving clinical and operational performance, including development of labor-management partnerships that serve as an effective mechanism to increase engagement of front-line staff and middle-management.
6. Develop a business performance system with associated dashboards/tools that aligns systemwide priorities throughout DHS and facilitates greater accountability for facility/unit/individual performance.
7. Expand skill, career, and leadership development opportunities with an emphasis on skill-building for front-line management.
8. Develop best practices on security protocols and training to improve patient/staff/visitor safety, patient experience, and access.
9. Align DHS Human Resources processes to support organizational and employee effectiveness.
    a. Prioritize support for key clinical and administrative recruitments by developing business owner examination plans, efficient examinations, external media recruitment opportunities, and insight tools to capture how applicants learned of DHS job opportunities.
    b. Improve physician recruitment and retention tools via incorporation of Physician Specialties designation in the County's electronic application process, compensation studies, contingent offer development, and providing support to Labor-Management review of the physician pay plan.
    c. Perform manpower shortage reviews and studies for priority classifications.
    d. In collaboration with DHS IT, implement an electronic process and database to effectively on-board and off-board non-County workforce (e.g., contractors, affiliation agreement workforce, students, and volunteers).
    e. Improve the in-processing of new employees, including the implementation of a portable document packet for DHS forms and policies with electronic signature.
    f. Improve the performance evaluation process by establishing work plans specific to DHS job classifications and implementing the County's on-line PerformanceNet system.
    g. Support Safe & Just Culture by reviewing the consistency and effectiveness of Performance Management and Audit & Compliance measures.
    h. Develop training and on-line tools for frontline supervisors regarding performance management and employee relations.
    i. Provide timely advice and support in administering the various labor MOUs and pay practices.
    j. Consistently seek opportunities to enhance the effectiveness of County processes in support of DHS needs, such as organizational review, recruitment, LearningNet, and mandated trainings.
    k. Implement County solutions (e.g., electronic Outside Employment reporting, Mileage

Permittee Reimbursement, and Absence Management and Performance Management Tracking Systems) to achieve efficiencies, comply with mandated activities, and/or improve analytic tools for personnel operations.

10. Promote accountability, increase transparency, and ensure responsible use of County funds through contractual changes and relationship-building initiatives with University partners.
11. Deepen relationships with academic institutions, foundations, and non-profit entities to increase opportunities for research and investigation projects within DHS that are of benefit to DHS patients.
12. Support and promote high-quality, fully-accredited GME training programs that can attract the highest quality medical school applicants, deliver top tier graduate medical education, and meaningfully engage trainees in clinical quality and operational initiatives, including those related to patient safety, quality, health disparities, resident supervision, transitions in care, duty hours and fatigue management, and professionalism.
13. Consistently seek opportunities to enhance the quality and efficiency of services provided in partnership with other County departments (e.g., DCFS, DMH, DPH, DPSS, Probation, and Sheriff).

Los Angeles County Department of Health Services

Major Accomplishments from the 2011 Strategic Plan

July 23, 2014

Following is a summary of major milestones and achievements from the 2011 Department of Health Services (DHS) Strategic Plan.

GOAL 1: Transform the Los Angeles County DHS from an episodic, hospital-focused system to an integrated delivery system including community-based primary care and behavioral health providers focused on prevention, early intervention, and primary care with appropriate referrals for specialized services.

Beginning with the creation of the Ambulatory Care Network (ACN), DHS has consistently fostered a system that prioritizes outpatient services in the context of longitudinal patient-provider relationships and efficient, targeted use of specialty services. Specific major accomplishments are described below:

1. **Development of Patient-Centered Medical Homes (PCMHs).** Since 2011, DHS has re-envisioned the structure and function of primary care at DHS. At an organizational level, this included the creation of the ACN governing DHS' 19 standalone clinics and which serves as the lead for the evolution of primary care at DHS. In support of PCMH development, DHS has:
    a. Empaneled over 380,000 individuals in PCMHs.
    b. Established a team-based PCMH structure, defined roles and responsibilities for various nursing classifications and created a new County classification, Certified Medical Assistant, which was approved by the Board on September 18, 2012.
    c. Rolled out a new Disease Management Registry, i2i, to assist PCMH teams with panel management.
    d. Established a new process for prospectively empaneling individuals with chronic medical conditions to medical homes.
    e. Implemented patient-centered scheduling at all staff-model PCMH sites, increasing patient access to their chosen provider; future roll-out will extend to the resident-led clinics as well.
    f. Rolled out a new DHS telephone system within standalone outpatient clinics. All ACN clinics and Harbor-UCLA Medical Center's Lomita Family Medicine Clinic are using vendor-hosted call manager software to route calls to the appropriate area, with substantial reduction in call wait times. Subsequent phases will expand roll-out to remaining DHS sites.
    g. Facilitated transitions in care from DHS inpatient and ED sites to a patient's PCMH.
    h. Restructured registration and front-desk functions to improve patient experience and reduce clinic cycle time.
    i. Implemented in all DHS PCMHs use of the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS), a widely accepted, standardized outpatient satisfaction tool.
2. **Expansion of non-ED outpatient services for non-empaneled individuals.** For those individuals without a medical home, DHS launched the continuing care clinic model in which individuals can

see the same provider on an ongoing basis for management of issues which require multiple visits. DHS has also streamlined access to urgent cares to reduce reliance on the Emergency Department as a site of care for individuals without medical emergencies.

3. **Transition of Healthy Way LA to Medi-Cal.** DHS enrolled over 325,000 individuals into Healthy Way LA (HWLA), Los Angeles' Low Income Health Program, exceeding its goal of enrolling 300,000 members. The Department's success was made possible with focused eligibility and enrollment efforts by Community Partner, DPSS, and DHS staff, and was facilitated by the use of the web-based enrollment system called Your Benefits Now (YBN), which interfaced with DPSS' Los Angeles Eligibility, Automated Determination, Evaluation and Reporting system (LEADER). HWLA enrollees made a successful transition to Medi-Cal) in January 2014, with a large population remaining with DHS as their medical home of choice. Had we not enrolled all of these individuals ahead of time, the start of the expanded Medicaid program in January 2014 would have been chaotic and many fewer persons would have received coverage.

4. **Enhanced focus on outpatient quality.** DHS increased its focus on measuring, reporting, and improving outpatient quality. Efforts centered on improving performance on Healthcare Effectiveness Data and Information Set (HEDIS) and waiver measures, such as mammogram screening rates and optimal care for patients with diabetes. As one example, DHS has improved mammogram screening rates from 59% to 69% of empaneled patients over the past six months.

5. **Greater availability and efficiency of specialty care services.** DHS re-envisioned its approach to specialty care service delivery through the creation of primary care/specialty care workgroups and through the launch of eConsult, an electronic web-based platform that enables communication between a referring provider and specialist. As of June 30, 2014, over 95,000 eConsults have been performed, involving 30 specialties, and more than 2,000 submitting providers. Through eConsult, referring providers can receive timely advice from a specialist on proper management of a given patient, including continued management in the primary care environment, referral for a face-to-face specialty care visit, or requests for additional testing. Through the primary care/specialty care workgroups, providers from across DHS have created more than 100 guidelines for managing specific conditions, with 14 currently posted for viewing on the DHS Clinical Care Library.

   In addition, DHS has developed innovative models for increasing capacity and availability of high-cost specialties/procedures. Two examples include FIT testing, a lab test used in place of screening colonoscopy, and the tele-retinal screening program, which has to date screened 2,588 patients in a low-cost, non-specialty setting, thus avoiding an otherwise unnecessary ophthalmology visit for over 64% of whom do not have a condition that requires specialty consultation. In another program focused on low-cost provision of specialty care, 20 DHS RNs who participated in a workforce training program recently graduated from a nurse practitioner program and will be hired into specialty care clinics across DHS.

6. **Improved efficiency of outpatient pharmacies.** DHS launched its Central Fill initiative in 2013 in which refill prescriptions are routed to an off-site location for processing, freeing up pharmacy staff time to manage new prescriptions or refills that need to be handled on site. This, along with the implementation of a new outpatient pharmacy system and the pending implementation of a mail order refill option, have helped to decrease pharmacy wait times and improve service levels.

7. **Development of core managed care infrastructure.** On March 29, 2011, the Board approved the transition of the Community Health Plan (CHP) staff to serve as the Medical Service Organization for DHS, enabling DHS to focus on delivery system reform. All of CHP's lines of business were successfully transferred to LA Care as of October 2012. DHS will retain a restricted Knox-Keene license to facilitate its role as a capitated Medi-cal provider.
8. **Integration of physical and behavioral health.** DHS has continuously emphasized the importance of integrated physical and behavioral health services that address the needs of the whole person. Working in close collaboration, DHS and DMH have established 8 DHS clinics as sites for co-location of mental health services in which DMH social workers evaluate individuals identified by their primary care provider as being in need of mental health services. DHS is also planning to locate a primary care team at the MLK Psychiatric Urgent Care Center, so that patients who are more comfortable in a mental health environment may receive the primary care many such patients need.

GOAL 2: Assure sufficient capacity of hospital-based services to meet the needs of the people of Los Angeles County.

DHS' hospitals provide a high volume and wide array of emergency, trauma, and specialty/tertiary care services. Improving the efficiency, quality, and experience of these services for Los Angeles County residents is a major priority. Specific major accomplishments related to provision of hospital-based services are described below.

1. **Enhancement in efficiency of inpatient services.** Many initiatives have focused on improving the efficiency of inpatient services within the four DHS hospitals. A critical step was the transition from the Treatment Authorization Request (TAR) process for determining medical necessity for Medi-Cal patients to InterQual, an evidence-based criteria set that provides greater transparency and more timely insight into system deficiencies, facilitating their correction. Examples of specific improvements include:
    a. Developed process to ensure that all admissions to acute medical and psychiatric beds are medically necessary.
    b. Rolled out use of observation units for appropriate patients.
    c. Established process to manage transitions in care, including direct admissions, scheduled admissions, discharge/re-admit programs, ED to inpatient hand-offs, and post-discharge coordination with a patient's medical home.
    d. Optimized diagnostic and procedural unit capacity through, for example, adjustment of staff schedules, development of patient transport teams, and revision of scheduling templates.
    e. Improved timeliness of consulting service visits.
2. **Reduction of unnecessary inpatient days through the use of non-hospital alternatives.** Recuperative care options are vital because they help facilitate the timely discharge of homeless patients from hospital inpatient stays. Until recently, DHS was limited to 25 beds of recuperative care within the Bell Shelter. Within the last six months, DHS has opened 18 new beds operated by People Assisting the Homeless (PATH), 25 beds operated by LAMP, and an additional 40 recuperative care beds located in South Los Angeles, which will open up in late summer, bringing the total to 108 beds. On June 17, 2014, DHS received board approval to

further expand recuperative care options on the Martin Luther King, Jr. Medical Center campus, which will add approximately 108 new beds and essentially double our current capacity. Once the MLK site opens, DHS will have access to a total of 216 beds that will serve as immediate discharge options.

In addition to its recuperative care expansion, DHS has continued to increase its supply of permanent supportive housing for homeless patients with complex medical and behavioral conditions through the Housing for Health division (HFH). As of June 30, 2014, 375 patients have been placed in permanent housing. HFH utilizes a wide array of housing options such as non-profit owned supportive housing, affordable housing, master lease buildings, scattered site housing, and private market housing.

3. **Reduction in ED crowding and wait times.** Lengthy ED wait times are a reflection both of the number of patients seeking care in ED settings as well as challenges in obtaining timely inpatient medical and psychiatric beds. To address this problem, DHS has employed a variety of strategies to divert patients to non-ED settings (e.g., urgent care, outpatient clinic-based services, etc.) as well as to accelerate the availability of inpatient beds. Efforts to enhance inpatient operations and reduce length of stay are also critical to meeting this goal. With respect to the demand for psychiatric services, DHS has continued to work closely with DMH to identify strategies to decrease census in the psychiatric emergency rooms. These include intensified placement efforts by DMH to move long-stay patients off of DHS inpatient psychiatric wards and the use of teams participating in "placement rounds" to secure placement for specific hard-to-place patients so that patients in the PES can move to an inpatient bed.

4. **Development of a standardized nurse staffing model.** DHS developed a standardized nurse staffing model covering inpatient units, operating rooms, emergency department, procedure areas, hospital- and non-hospital-based clinics, nursing management, nursing education, and utilization review. Full implementation of these models will ensure compliance with state regulations without excessive use of overtime or registry, improve clinical quality and patient satisfaction, and increase throughput and operational efficiency.

5. **Completion of key capital projects.** Construction on the Harbor-UCLA's Surgery and Emergency Replacement Project was completed in January 2014. The $322 million project consists of a 190,300 square foot building with 80 treatment bays (including five adult and two pediatric trauma bays), 16 operating rooms, and new pre- and post-operative areas. The project also includes a 17,000 square foot central sterile processing department, a heliport, and a 3 story parking structure with 544 parking spaces. The new Surgery and Emergency Department building began accepting patients on April 20, 2014.

   In addition, DHS also has the following major projects in development:
   a. The new Martin Luther King, Jr. Outpatient Center was substantially completed in October 2013 and opened for services on June 17, 2014.
   b. The new High Desert Regional Health Center was substantially completed in February 2014 and opened for services on June 23, 2014.
   c. Martin Luther King Jr. Recuperative Care Facility is currently in design, and received Board approval on June 17, 2014.
   d. The San Fernando Valley Family Support Center (SFVFSC) broke ground in September 2013 and is scheduled to be completed in the summer of 2015.

e. The design for the Olive View-UCLA Psychiatric Emergency Room Expansion Project has been completed and the renovation work is scheduled for completion in summer 2015.

6. **Baby-Friendly designation.** In April 2012, both Harbor-UCLA Medical Center and LAC+USC Medical Center received notification that they had received a "Baby Friendly" designation by a U.S. accrediting agency sponsored by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). Joining Olive View-UCLA Medical Center, which received the designation in 2011, all three DHS hospitals providing obstetric services now are recognized as being "Baby Friendly" based on their adherence to the "10 Steps of Successful Breastfeeding".

7. **Opening of the Wellness Center at the Historic General Hospital.** The Wellness Center, which opened for services in March 2014, brings together 18 health-oriented non-profit organizations from across the County, with a particular focus on Boyle Heights, to provide services in a convenient, connected fashion to LAC+USC referred patients and the broader community.

8. **Preparation for the opening of the MLK Jr., Community Hospital.** DHS has supported MLK Jr, Community Hospital's leadership team in achieving the milestones necessary for an anticipated 2015 hospital opening. Once open, the 131-bed facility will host a state-of-the-art emergency room, inpatient ward, obstetrics unit, and operating suites. It will work closely with DHS's MLK Outpatient Center, which will move into its own new and beautiful clinic space in June 2014. Together the private hospital and the County-operated outpatient center will provide high quality, easily accessible medical services to residents of South Los Angeles.

GOAL 3: Create a modern IT system that improves the care of our patients and assures efficient use of resources.

Successful transformation requires a renewed focus on health information technology (IT) tools that can enhance the quality and efficiency of care delivery. DHS' efforts in this regard have centered on preparation for the pending roll-out of a new, integrated Electronic Health Record (EHR). Specific major accomplishments related to health IT initiatives are described below.

1. **Preparation for go-live of a single, system-wide, integrated EHR.** Over the last three years, DHS has taken a number of important steps to prepare our staff, operations, and IT system for implementation of EHR. Major milestones include:
    a. Completion of a competitive RFP process and successful contract negotiation with the top ranked vendor, Cerner Corporation.
    b. Near completion of the EHR design and build process, development of interfaces with legacy systems, design of a staff training plan; initiation of system testing and validation.
    c. Development of a unique patient identifier across DHS made possible through resolution of several hundred thousand duplicate medical records and implementation of processes to reduce the number of new duplicates created during the patient registration or referral process.
    d. Comprehensive refresh of IT hardware and enhanced data center infrastructure.
    e. Completion of various physical renovations needed to support a system EHR.

    We anticipate a go-live of DHS' new EHR, ORCHID (Online Real Time Centralized Health Information Database) at Harbor-UCLA Medical Center and off-site clinics, Long Beach Comprehensive Health Center, Gardenia School-Based Health Center, Lomita Family Health

Clinic, Bellflower Health Center, and Wilmington Health Center in November 2014, with other DHS sites to follow.

2. **Implementation of niche health IT systems.** Beyond an emphasis on EHR implementation, DHS has also rolled out specific niche systems, replacing older legacy systems. These include a new outpatient pharmacy system, a centralized physician credentialing system, and a new patient chronic disease registry. These systems will be interfaced with ORCHID and provide improved capabilities in the post-ORCHID environment.

3. **Support for information exchange.** DHS is a major partner on the Los Angeles Area Network for Enhances Services (LANES), the health information exchange initiative that will improve the sharing of DHS data with sister County departments and community partner clinics. Improved sharing of data through LANES will enable better coordination of services for our patients and safer and higher quality of care. To date, LANES has achieved a Technical Go-Live and proof-of-concept of the health information exchange system.

   DHS is also working on enhancing information-sharing between Sheriff Medical Services Bureau (MSB), and DHS in order to support care coordination and care transitions as patients move in and out of custody. The focus will be on incarcerated patients who are high utilizers of specialty and diagnostic services at LAC+USC Medical Center.

4. **Completion of first phase of Enterprise Patient Data Repository (EPDR).** The EPDR project is designed to bring together and integrate clinical, utilization, financial, and managed care data into one well-defined and rigorously maintained database system. The EPDR project is nearing completion of Phase 1, in which utilization and financial data is loaded. Phase 2, which will load clinical, managed care, and pharmacy data, will kick-off in June 2014.

GOAL 4: Assure the long-term financial well-being of the safety net health services in Los Angeles County.

DHS has taken several important steps to securing the Department's long-term financial sustainability through both improved management of costs, particularly administrative costs, and by making the delivery system changes needed to secure patient revenue streams. As evidence, over the past three years, DHS has eliminated historical budget deficits and now projects a surplus in coming fiscal years. Specific notable accomplishments related to DHS' fiscal accountability are provided below.

1. **Development of capitated agreements with managed Medicaid plans.** DHS negotiated a capitated payment contract and Division of Financial Responsibilities with both of LA County's managed Medi-Cal plans operating in the two-plan model, LA Care and Health Net, for assignment of lives in the Medi-Cal expansion. DHS also holds agreements regarding other lines of business (e.g., Seniors and Persons with Disability). In these agreements, DHS bears full risk for the majority of inpatient and outpatient services.

2. **Increased share of patients with third party public or private coverage.** An improved payer mix has helped DHS increase revenue from state and federal sources. This was made possible through intense eligibility determination, enrollment, and re-determination efforts.

   a. Low Income Health Program: DHS took advantage of the 1115 Medicaid waiver's Low Income Health Program by enrolling over 325,000 individuals in Healthy Way LA who

would otherwise have been uninsured, receiving reimbursement for 50% of costs. These individuals transitioned to Medicaid on January 1, 2014. Initial reimbursement for these new Medicaid enrollees is at a 100% Federal Medical Assistance Percentages (FMAP), in which the federal government pays for 100% of costs; federal reimbursement will decline to 90% by 2020.

b. Seniors and Persons with Disability (SPD): DHS was assigned over 26,000 individuals in the SPD line of business into DHS medical homes.
c. Presumptive eligibility: New ACA rules allow individuals to be temporarily or permanently covered under full-scope Medicaid if they qualify for presumptive eligibility. As a result, DHS has vastly reduced the number of patients who are unable to qualify for some degree of public coverage.
d. Commercial contracts: DHS has executed contracts with 13 third party payers for specialty care services including Rehabilitation, Burn, and Obstetrics/Pediatrics and continues to work toward additional contracts with health plans and regional Independent Physician Association.

3. **Decline in Medi-Cal denied days.** As mentioned above, DHS transitioned from the TAR process to InterQual in FY12-13, a critical step in helping to better understand and track reasons for denied inpatient days and improve in-the-moment decision-making and documentation by providers. Since implementation of InterQual, DHS' denial rates for full-scope Medi-Cal have fallen below 10%.

4. **Identification of savings from pharmaceutical, supplies, and equipment procurement.** Through greater emphasis on product standardization, value analysis, formulary management, and contract negotiations, DHS has identified savings across a range of products. In DHS' supply chain division, thousands of medical products have been assessed for their clinical efficacy and suitability for addition to DHS' medical/surgical formulary; this represents the first phase of DHS' move toward enterprise-wide standardization of medical products and equipment. In our pharmacy unit, DHS centralized pharmaceutical procurement, leading to greater system discounts and more timely invoice processing. Finally, DHS also increased recovery on pharmaceutical patient assistance programs (PAPs).

5. **Award of competitive grant opportunities.** Since 2011, DHS has been the direct recipient of over $3.6 million in grant awards, not including those grants submitted by DHS staff through fiscal intermediaries. These awards have been critical to the development of new programs within DHS, including eConsult, HWLA, primary care medical homes, and improvement of prenatal services to high-risk mothers.

6. **Maximization of California's Section 1115 Medicaid waiver.** DHS has taken advantage of the Section 1115 waiver as a means of supporting our overall transformation and safeguarding revenue sources needed to support our mission. Highlights of the waiver and DHS' role include:
    a. SPD Transition: The waiver transitioned Seniors and Persons with Disability from fee-for-service to managed Medi-Cal, of which DHS was assigned over 25,000 lives.
    b. Safety Net Care Pool (SNCP): The waiver established a SNCP for covering the costs of providing care to uninsured individuals; DHS received over $800 million in revenue over a five year period.
    c. Delivery System Reform Incentive Program (DSRIP): The DSRIP is a pay-for-performance initiative that challenges public hospital systems to meet specific benchmarks related to

improving health care access, quality, safety, and patient experience. In the first 3 years of the DSRIP, DHS achieved 151 out of 153 performance metrics (98.7%) for a net payment of $639 million.

GOAL 5: To foster a culture of empowered staff and community, organized labor, and university partners constantly looking for opportunities to improve the care we deliver.

DHS' transformation relies on a committed, empowered, and engaged staff and broader stakeholder community. Specific major accomplishments in this area are described below.

1. **Increase in cross-system communications.** Historically, DHS' large scale has prevented staff from connecting with DHS or acting as a member of a larger system. Over the past three years, DHS has used a variety of different modalities to promote communication across DHS, including Fast Facts, Dr. Katz YouTube videos, virtual town halls, and an email suggestion portal for staff to share their ideas with the DHS Director.
2. **Renewed focus on continuous performance improvement.** High functioning health systems are focused on continually improving services at every unit and location. Through a variety of tools, DHS has started on this path of continuous performance improvement. Highlights include:
    a. Completion of Innovations Award project, a joint SEIU/DHS initiative which sought to empower front-line staff to work alongside management to develop and implement new ways to improve service to DHS patients. DHS received over 250 applications for Innovation Awards in July 2012; a total of 16 projects were won available funding and completed projects.
    b. DHS and SEIU have jointly formed over 25 Care Improvement Teams (CIT) which are now working in various DHS divisions to promote involvement of front line staff and labor-management interaction at the unit level. The CITs have focused on issues related to medical home implementation, registration, appointments, and health information management, with substantial success in reducing cycle times and improving patient and staff engagement.
    c. Individual facilities have completed a number of performance improvement projects on topics ranging from reorganization of patient financial service processes to clinic cycle time reduction to reduction of pressure ulcers on inpatient units.
3. **Improvement of Human Resources (HR) processes.** DHS' transformation will only proceed at a rate that can be supported by key administrative functions, particularly HR. Examples of accomplishments in streamlining operations in this critical area include:
    a. Launched a simplified electronic Personnel Authorization Request (PAR) approval process, including electronic routing of transactions requiring CEO Classification Compensation approval.
    b. Developed a structure to support mandatory trainings and new employee orientation in collaboration with DHS Divisions.
    c. Established competencies, performance work plans, and an on-line performance evaluation system for the RN I, II, and III series with other classes to follow.
    d. Established manpower shortage recruitment rates for key classifications, including Primary Care Providers, Radiation Therapy Technologist, Physical Therapy Assistant, Physical and Occupational Therapists.

e. Reduced application and certification timelines for nursing positions through a series of technological enhancements.
f. Facilitated on-boarding and off-boarding processes for County and non-County workforce, including a particular focus on ensuring timely onboarding of Medical Students, Residents, and Fellows.
g. Established policies and procedures to manage Department-wide loan/borrow program for position control.

4. **Support for career advancement opportunities for staff.** Career advancement opportunities can increase staff capabilities and ultimately staff and patient satisfaction. Specific accomplishments include:
    a. Trained over 112 DHS Nursing Attendants to be Certified Medical Assistants, positioning them for a new potential role in PCMHs.
    b. Graduated 20 RNs from an Advanced Practice Nurse Practitioner class at Charles Drew University, in a program jointly managed by the Worker Education & Resource Center; these nurses are specially trained to provide services in various specialty care clinics across DHS.
    c. Provided mentoring/tutoring services to five local community colleges; since the program's inception, 297 participating nurses have been hired by DHS.
    d. Implemented an Internal Nurse Registry pilot at LAC+USC Medical Center, a cost-effective solution for temporary staffing. As of June 30, 2014, 41 Relief Nurses have been hired from the Internal Registry Pilot. Other facilities are scheduled to follow.
    e. Developed a pilot program for 30 pool nursing positions that can be processed prior to a vacancy so that when a vacancy occurs, a new nurse can immediately be hired.