Health Services
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Mitchell H. Katz, M.D.
Director

Hal F. Yee, Jr., M.D., Ph.D.
Chief Medical Officer

Christina R. Ghaly, M.D.
Deputy Director, Strategic Planning

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

www.dhs.lacounty.gov

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.

www.dhs.lacounty.gov

February 19, 2013

TO: Each Supervisor

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

SUBJECT: **FEBRUARY 2013 UPDATE ON REPORT ENTITLED, "STEPS REQUIRED TO SUCCESSFULLY ADAPT THE DEPARTMENT OF HEATLH SERVICES (DHS) AND LOS ANGELES COUNTY FOR THE AFFORDABLE CARE ACT (11/27/2012)**

UPDATE

The Affordable Care Act (ACA) will drive substantial changes in the way safety net health systems deliver care. As indicated in my first report, increased patient choice of where to seek care and reimbursement to providers based on a per member per month capitation rather than based on expenses are two of the major ACA provisions affecting health systems like ours. These provisions require us to improve the experience our patients have in our facilities and decrease the cost of care without compromising quality.

To be a provider of choice while providing high quality care at a lower cost, we must transform DHS from an episodic, high-cost, hospital-focused system to an integrated delivery system that includes community-based primary care, specialists, and behavioral health providers focused on prevention, early intervention, and out-patient management of complex conditions. By building an integrated delivery system with a greater emphasis on out-patient services, DHS patients would receive the right care, in the right setting, by the right provider, all with the right kind of teamwork.

For clarity, I will illustrate the benefits of an outpatient-focused integrated delivery system with an example. Foot problems, such as ulcers and infections, are a common complication of diabetes. If not treated early, minor foot ulcerations can lead to serious infections requiring costly hospitalizations, and in some cases, amputation. A diabetic patient who develops a minor foot ulcer in an episodic, hospital focused system, is less likely to receive the early preventative and therapeutic care in the outpatient setting, and, as a result, is at greater risk of ending up in the hospital with a severe complication. In an integrated delivery system, this

same patient would have easier access to their multidisciplinary primary care medical home team. The medical home team will routinely deliver preventative care and counseling to diabetics for foot problems with the help of an electronic registry reminder system. If the patient develops a foot problem that requires early intervention, the medical home team can provide timely appointments in primary care, and, if necessary, electronic consultation (eConsult) or face-to-face visits with podiatry. If after receiving all of the appropriate outpatient primary and specialty care, the patient still requires an inpatient stay, the diagnostic work-up and radiological test interpretation already completed by the patient's medical home team and podiatrist will be accessible to the inpatient team via a system-wide electronic health record (EHR), ensuring safe and efficient transitions between care settings.

In this memo, I will provide an update on a subset of the many operational changes we are making within DHS to transform into an integrated delivery system. It is important to note that operational changes often require reconfiguration of existing resources and, in some cases, significant one-time capital investment. Without investing resources in this transformation, it will not be possible for DHS to be a provider of choice and to create a viable system that reduces the overall costs of care in a capitation-based payment environment.

OPERATIONAL CHANGES FOR INTEGRATING CARE DELIVERY (right care in the right setting by the right provider team)

Building the Patient-Centered Medical Home

As you know, DHS is implementing the Patient-Centered Medical Home model in all of our health centers and, to a certain extent, in our hospital-based outpatient teaching clinics. In a medical home model, each patient is empaneled (assigned) to a specific primary care provider, who anchors and leads her own multidisciplinary team of personnel including nurses, certified medical assistants (CMAs), and clerical staff. Medical homes enable better coordination of care (e.g. decrease unnecessary duplication of tests; improve handoffs between primary care and specialty care; etc.), improved timeliness of care (e.g. better access when patients need it), and more appropriate care in the right setting (i.e. outpatient care early in the course of a problem rather than care in the ER; etc.).

DHS is making progress in operationalizing the key features of the medical home:

- Empanelment: the process of assigning patients to a patient-centered medical home team enables the patient and medical home team to establish a continuity of care relationship. Over 290,000 primary care patients are now empanelled to medical home teams across DHS. Each DHS medical home team is responsible for the care and health outcomes of about 2000 unique patients, who make-up the team's patient panel.
- Electronic Registry (i2i software system): the registry system organizes and tracks information on each patient in the medical home team panel, and provides clinical

decision support (e.g. automatic clinical alert when a patient is due for her mammogram). The registry enables the team to better manage the care needs of each patient, before and during provider visits, as well as between clinic visits. DHS recently completed implementing an enhanced version of the i2i registry application as well as the training of staff on the new registry features.

- Care Management: protocols provide a proactive care program for medical home team personnel to maximize disease-specific interventions, improve delivery of preventive care, and ensure appropriate utilization for patients in the panel. Care Managers (RNs) oversee the use of protocols in the medical homes. About 75% of the Care Managers needed are now in place, and have completed a series of trainings on topics such as end of life planning, self-management goals, preventive health maintenance, and utilization management.
- Team-based care: is the coordination of activities and the distribution of tasks/responsibilities among medical home team members, consistent with their license and skills, to meet patient needs. Each team member participates in delivering care to the patients in the panel. We are well under way in completing the staffing of DHS medical home teams. In addition to RN Care Managers, DHS medical home teams in the Ambulatory Care Network (ACN) require about 205 Certified Medical Assistants to perform care coordination functions. We have hired 81 new CMAs and expect 71 existing personnel to complete CMA training in the next few months. We are continuing our aggressive recruitment efforts, and anticipate having the full complement of needed CMAs for ACN-based medical home teams by Summer 2013.

Improving Access to Care through Better Patient Scheduling

Recently, a lead medical home team from primary care clinics at each DHS hospital and ACN facility completed a 6-month training collaborative entitled Patient-Centered Scheduling (PCS). The PCS collaborative was developed under the guidance of Coleman Associates Inc., a consulting firm specializing in healthcare process and workflow redesign. The overall goals of the PCS collaborative are to increase patient access to primary care and improve patient satisfaction with the process of scheduling clinic appointments. The PCS collaborative enabled pilot medical homes to reduce no-shows, simplify patient schedule templates, incorporate same-day access appointment slots, increase the number of patients seen per session, and implement non-traditional visits such as group visits and telephone advice line. Early results indicate that medical homes participating in PCS had 25 to 50% reductions in no-show rates and 10 to 50% reductions in average wait time for an appointment. We are in the process of establishing a comprehensive evaluation and monitoring strategy and plan to expand PCS to all DHS primary clinics by December 31, 2013.

Improving Telephone Access

DHS is also working to improve the telephone systems through which patients contact outpatient clinics and their medical home teams. In early 2012, we initiated a pilot telephony initiative at Long Beach Comprehensive Health Center with the specific goals of a) reviewing best practices for outpatient telephony services and b) implementing and evaluating a pilot telephony services program. By the fall of 2012, we identified and procured the services of a cost-effective vendor for the pilot program and began enhanced telephony services at Long Beach. In the first full month of operations, Long Beach received over 5,500 calls, which had an average wait time of less than 5 minutes, resulting in resoundingly positive patient and staff feedback. Specific improvements of the new telephony system include the capability to handle 50 calls at a time (previous system could only handle 10 calls), a call back option when patients leave their phone number (instead of waiting on hold), the capability to assign language concordant staff with patient's language preference, and the capability for supervisors to monitor metrics such as the number of calls per day, the average wait time for calls, etc. Building on the success of the Long Beach program, in December 2012 we started the work of implementing the same telephony program at the MLK MACC. Our next goal is to expand this kind of telephony program to all ambulatory care network clinic sites. We anticipate developing a procurement approach for the vendor services and a project plan for the ACN by June 2013.

eConsult System Improves Specialty Care Integration, Access, and Capacity

The new eConsult system enables primary care providers to more effectively utilize specialty care services. This system is a secure, web-based platform that facilitates clinical dialogue between DHS and Community Partner Primary Care Providers (PCPs) and DHS Specialists for the purpose of providing timely and coordinated specialty care services for patients with specialty care needs. Key aims of eConsult are facilitation of:

- Dialogue between Primary Care Providers (MD, NP, PA) and DHS Specialty Reviewers around the needs of a specific patient.
- When needed, a timely face to face visit with a specialist with a clear clinical question and appropriate pre-visit evaluation– allowing the first specialty visit to be a definitive one.
- The ability to offer "co-management support" to PCPs caring for patients with complex, chronic conditions while allowing the patient to remain in a culturally and linguistically optimal, geographically convenient medical home.

We are making good progress in rolling out eConsult. A total of 68 primary care clinic locations are using eConsult, including all DHS locations and 28 Community Partner clinic locations. To date, the specialties on eConsult include Cardiology, Dermatology, Obstetrics, Gynecology, Ophthalmology, and Neurology. Gastroenterology and Podiatry are anticipated to come online soon. Since fall 2012, over 400 PCPs have been on the system and have received specialty care assistance for over 3500 patients. Of the total eConsults requested by PCPs, 68% required a face-to-face visit with the specialist. For the remaining 32% of eConsults, the PCPs were able to deliver care under the advice of the specialists, without requiring the patient to visit the specialist in-person.

An Integrated Care System Optimizes Use of Hospital Care

As illustrated in the diabetic foot example, delivering the right care in the right setting by the right provider enables health systems to improve patient outcomes, prevent complications that are expensive to treat, and reduce avoidable hospitalizations. An important feature of integrated care is ensuring safe and efficient transitions between different care settings (e.g. inpatient to outpatient clinic; inpatient to nursing home). Safe and efficient care transitions require good access to medical records, open communication channels, and the ability to coordinate care plans across settings. DHS is investing in a modern enterprise-wide electronic health record (EHR) that will provide our hospitals and clinics a vital tool for safe and efficient delivery of care across our diverse care settings. Because the new EHR implementation will not be completed throughout the system until 2016, we have recently added the capability to provide a pop-up screen indicating a patient's medical home location and contact information on our existing Affinity EHR system. This pop-up screen alerts our ER and inpatient providers when a patient has a DHS medical home, facilitating coordination of care.

Even in an integrated health system with strong primary care services, hospital care remains an essential and high-demand resource for patients. Because the most expensive care to deliver occurs in the hospital setting and our DHS hospitals are almost always running a patient census close to full capacity, it is important that we reduce the number of days that patients who are not acutely ill are in our hospitals. To address this, DHS has instituted a new State of California endorsed system of determining in real-time whether hospital admissions and continued hospital stays are medically appropriate. This system has been in place at LAC+USC Medical Center and Olive View-UCLA Medical Center since fall 2012 and just went live on February 1, 2013 at Harbor-UCLA Medical Center and Rancho Los Amigos National Rehabilitation Hospital. With the help of this system, we have improved our ability to identify patients in the Emergency Room and on our inpatient wards who would be more appropriately and more safely treated in a less expensive, more appropriate level of care setting (i.e. nursing home, rehab facility, etc.) rather than in the hospital. As we make progress in linking these ER and hospitalized patients with more appropriate levels of care, we are better able to utilize our existing hospital capacity for the patients who most need it.

Homeless individuals are particularly prone to frequent emergency room visits and hospitalizations in our system. Homeless patients often remain in the hospital long after an acute episode at an unreimbursed cost of $3,000 or more a day because there are limited community-based housing options. If homeless high utilizers have permanent supportive housing with accessible health services provided on the premises, they won't need to go to the hospital in the first place, or as frequently; if they do require hospitalization they will be released sooner. DHS recently created the Housing for Health (HFH) Division, which focuses on creating such permanent supportive housing opportunities for DHS' homeless patients. Consistent with the vision of the Los Angeles County Interdepartmental Council on Homelessness, the HFH Division is forming strong partnerships in the community by working with funders such as municipal and nonprofit agencies with the aim of building thousands of housing units linked to the County health system. Three hundred housing units will be

opening by summer 2013 and another 600-1000 units planned for operation by end of the next fiscal year. DHS is in the process of organizing a new centralized referral system to ensure those patients with the greatest need and who have continued overuse of expensive hospital care resources are identified for these emerging housing options.

CONCLUSION

I am pleased to share information about some of the operational changes we are making to transform DHS into an integrated health system that can address the challenges presented by the ACA. We are grateful to the Board and the CEO in helping us to accomplish these changes. In future memos, I look forward to describing other system transformation initiatives, our continuing progress with the Healthy Way LA Program, and policy developments related to health reform.

If you have any questions or need additional information, please contact me or Anish Mahajan, Director of System Planning at (213) 240-8416.

MHK:jp

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors