MEDICAID INCENTIVE PROGRAMS: HOW WAIVERS ARE IMPROVING HEALTH OUTCOMES

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KEY FINDINGS

Delivery System Reform Incentive Payment (DSRIP) programs consist of multiple improvement projects with associated metrics for data reporting and analysis.

Over time, the Centers for Medicare & Medicaid Services (CMS) has increasingly emphasized the need for rigorous DSRIP program evaluation.

DSRIP programs and improvement projects have resulted in considerable quality improvements and systemwide transformation.

DSRIP funding has been critical to support hospitals in achieving meaningful, sustainable transformation.

Contra Costa Regional Medical Center reported substantial improvements in ambulatory care access and quality, sepsis mortality, and hospital-acquired pressure ulcer rates through its DSRIP.

University Health System was able to achieve meaningful quality improvements in palliative care, medication management, and care coordination through its DSRIP.

RE-EXAMINING DSRIP WAIVERS

Shortly following the implementation of the Affordable Care Act (ACA) in 2010, the state of California established the first ever Delivery System Reform Incentive Payment (DSRIP) Program as a part of its Section 1115 Medicaid waiver. Both Texas and Massachusetts followed with similar waiver-based programs shortly thereafter, creating a new trend in health care reform. After five years of growing popularity, 12 states now have active, approved, or proposed DSRIP waivers.

Since DSRIP waivers have such growing popularity and several years of results, the Centers for Medicare & Medicaid Services (CMS) is beginning to assess the outcomes and value of DSRIP programs. As DSRIP programs have evolved, it has become clear that CMS expects DSRIP states to set more rigorous goals and undertake a more robust evaluation of DSRIP programs. Specifically, addressing how these incentive programs are shaping systemwide transformation, population health, and clinical health outcomes.

America's Essential Hospitals is focusing on waivers in a number of ways (see Our Waivers Work). To address these questions in particular and better understand the evolving DRSIP landscape, Essential

Our Waivers Work

America's Essential Hospitals prioritizes Medicaid waivers research, education, policy, and advocacy. This brief is the fourth installment in a series of waiver-related publications, as listed below:

- *Delivery System Transformation: Section 1115 Medicaid Waiver Demonstration Projects in California, Massachusetts, and Texas*—a research brief that introduces the waiver agreements in these states
- *Medicaid Incentive Programs: Extending the Reach of Health Care Transformation*—a policy brief that provides a more in-depth look at how waiver-based incentive programs support essential hospitals' delivery system reform
- *Medicaid Incentive Programs: Hospital Perspectives from Three States*—a research brief that

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TABLE 1 TRANSFORMATION CATEGORIES AND IMPROVEMENT PROJECTS IN CALIFORNIA AND TEXAS

	CALIFORNIA DSRIP (21 Hospitals)	TEXAS DSRIP (300 Hospitals across 20 Regional Healthcare Partnerships)
Demonstration Term	November 1, 2010 – October 31, 2015 (Renewal Pending)	December 12, 2011 – September 30, 2016 (Renewal Pending)
Transformation Categories	1. Infrastructure Development 2. Innovation and Redesign 3. Population-Focused Improvement 4. Urgent Improvement of Care 5. HIV Transition–Improvements in Infrastructure and Program Design	1. Infrastructure Development 2. Program Innovation and Redesign 3. Quality Improvements 4. Population-Focused Improvement
Projects Highlighted in This Brief	1. Ambulatory Care Redesign (Categories 1, 2, and 4) 2. Sepsis (Category 4) 3. Hospital-Acquired Pressure Ulcers (Category 4)	1. Palliative Care (Category 2) 2. Medication Management (Category 1) 3. Care Coordination (Category 2)

Hospitals Institute—the research and quality improvement arm of America's Essential Hospitals—took a closer look at some improvement projects and related outcomes at two member hospitals.

Through a brief webinar series, Contra Costa Regional Medical Center[1] in Martinez, California, and University Health System[2] in San Antonio, Texas, shared insights and data from their waiver programs. The hospitals' administrative and clinical staff presented information on improvement projects, specifically highlighting significant improvements in clinical outcomes and/or system transformation. The data provided during the webinars informed this brief and are exhibited throughout.

WHY ARE IMPROVEMENT PROJECTS SO IMPORTANT?

Improvement projects are the backbone of every DSRIP Program. Through these projects, hospitals are able to pursue the larger goal of sustainable, systemwide transformation that improves quality while also reducing costs. States and hospitals dedicate a significant amount of planning to their improvement projects.

California and Texas have a similar categorical structure for their improvement projects (see Table 1). During the planning phase, each state established four to five categories of guidelines for improvement project implementation and evaluation. It is important to note a difference in category 3 of the Texas model—the objective of this category is to assess the effectiveness of category 1 and 2 projects.[3] In this way, Texas differs from California by having one category primarily dedicated to evaluating all DSRIP projects. Additionally, both states' metrics are process-oriented in early years and outcome-oriented in later years.

Following the planning phase, hospitals select complementary improvement projects that facilitate both localized and systemwide transformation. Hospitals typically implement multiple projects under each category, touching numerous departments, processes, and patient groups. Defined metrics, established in the planning stages, are used to evaluate these projects as they progress. This data collection is quite rigorous and takes time to show tangible improvements. Indeed, some projects may produce benefits well beyond the waiver term. However, as some projects enter their second and third year of implementation, initial results are becoming more apparent.

Our Waivers Work, continued

details the perspectives of three hospitals working with waivers and their journey through implementation

In addition, we have a robust educational program that includes a number of waiver-related webinars featuring both policy and quality perspectives, as well as the annual, in-person Leadership Summit on State Medicaid Waivers.

TABLE 2 AMBULATORY CARE REDESIGN IMPROVEMENT PROJECTS

Improvement Project Goal	Result
Increase primary care provider visits	Primary care visits increased by 17,000 in 2014 and 2015.
Reduce third next available (TNA) appointment rate[4]	TNA appointments were reduced from 13+ days to 6 days in pilot clinic.
Establish a video interpreting network	Video interpretation services were made available in all 11 clinics.
Empanel Medi-Cal Health Plan patients	Patient empanelment was achieved at more than 99%.
Integrate physical and behavioral health care	Behavioral health services were integrated in three primary care clinics.
Improve population health measures (e.g., cancer screening, substance abuse screening, hypertension reduction, congestive heart failure 30-day readmission reduction)	Screening, brief intervention, and referral to treatment (SBIRT) rates increased to more than 75% at pilot sites.

BUNDLES

A bundle is a selected set of elements of care that, when implemented as a group, have greater impact on health outcomes compared with implementing the individual elements alone. Hospitals are required to meet universal standards for sepsis bundles but are able to implement their own protocol for how this is done. The purpose of creating a bundle, and subsequently a detailed protocol, is to articulate all activities to be conducted within specified time frames for each patient.

More information on sepsis bundles can be found at www.survivingsepsis.org.

The following discussion outlines the results of a handful of improvement projects being implemented at Contra Costa and University Health System.

CONTRA COSTA REGIONAL MEDICAL CENTER OUTCOMES

Contra Costa highlights improvement efforts in three areas that span each of its transformation categories (See Table 1). To assist in coordinating its DSRIP efforts, Contra Costa established a DSRIP Oversight Committee with members comprising a range of hospital and health system staff, including C-suite administrators and improvement specialists. As part of Contra Costa's DSRIP proposal, the Oversight Committee identified and prioritized a variety of quality improvement concerns and projects. While this committee was established later in the five-year DSRIP plan, its efforts have been key in creating visual monitoring platforms and providing additional support structure for improvement projects.

The improvement areas profiled in this brief—ambulatory care redesign, sepsis mortality, and hospital-acquired pressure ulcer rates—were selected to respond to key challenges for the system. These projects were implemented across multiple departments and clinics, with outcomes measured between 2012 and 2015.

Ambulatory Care Redesign

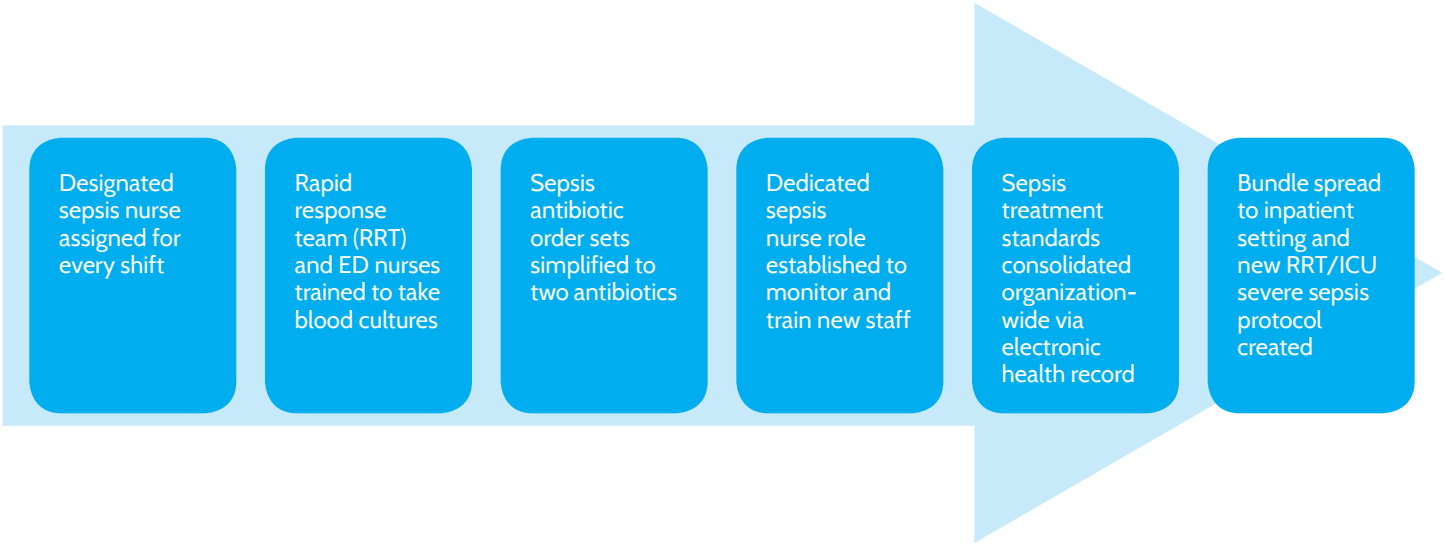
To redesign ambulatory care, Contra Costa identified several improvement goals and interventions that intersected across three of its transformation categories—Infastructure Development, Innovation and Redesign, and Urgent Improvement of Care. Overall, the goal of this initiative is to improve patient access and provide better care for patients, especially those with behavioral health needs. Table 2 presents results from these efforts.

Sepsis Mortality

Contra Costa began taking steps to reduce sepsis mortality in 2008, but efforts were limited to the emergency department (ED). Upon implementation of the DSRIP Program, Contra Costa expanded sepsis interventions beyond the ED by providing additional training, improving upon existing processes, and creating new protocols.

Contra Costa originally began the program after recognizing the importance of improving its ED sepsis protocol and incorporated a one-hour bundle system, enhancing the existing three-hour bundle protocol. The one-hour bundle was chosen based on studies indicating that early

FIGURE 1: SEPSIS MORTALITY IMPROVEMENT PROCESS



implementation and timely antibiotic administration within 60 minutes of suspected infection allow nursing staff to identify potential organ failure earlier and significantly improve sepsis outcomes.

The bundle activities include fluid delivery, blood cultures, and antibiotics administered within one hour of presentation.

Figure 1 outlines the team's sepsis journey from conception within the ED to widespread adoption and implementation.

Through this process, the sepsis improvement team was able to increase bundle compliance by nursing staff from 50 percent in 2012-2013 to 78.8 percent in 2015. Even more significant is the reduction in mortality among sepsis patients, which decreased from 17 percent in 2012-2013 to 7.8 percent in 2015. Contra Costa's sepsis team attributes much of its success to enhancing training and autonomy of frontline nursing staff who are empowered to initiate all treatment orders. In addition, the team emphasized the importance of including the entire range of care providers who may be involved in addressing severe sepsis in a comprehensive, interdisciplinary group.

Hospital-Acquired Pressure Ulcers (HAPUs)

As with the sepsis mortality reduction program, Contra Costa had begun taking steps to reduce HAPUs prior to 2010. Upon implementation of the DSRIP's HAPU reduction program, Contra Costa was able to greatly expand its HAPU reduction efforts beyond the ED. Contra Costa's goal is to identify and employ a sustainable HAPU prevention bundle and ultimately reduce the hospitalwide HAPU rate. The DSRIP Oversight Committee identified the following primary drivers for achieving this goal:

1. preventive interventions
2. improved assessment
3. increased multidisciplinary team engagement and communication
4. improved cultural shift

As early as 2012, the team established five key interventions that were informed by the four primary drivers listed above:

The sepsis improvement team was able to increase bundle compliance by nursing staff from 50 percent in 2012-2013 to 78.8 percent in 2015. Even more significant is the reduction in mortality among sepsis patients, which decreased from 17 percent in 2012-2013 to 7.8 percent in 2015.

- intentional hourly rounding
- 4-eye skin assessments[5]
- unit champions who received an 8-hour training on pressure ulcers
- 5-minute communication huddles to discuss at-risk patients
- clear marking of Braden scores[6]

These activities were initially implemented for ED patients and subsequently rolled out to all inpatient

units as part of an organization-wide effort. Contra Costa developed treatment guides to include stage-specific wound care products and hired a wound care nurse to educate and identify areas of improvement in Contra Costa's processes. This project has successfully reduced the prevalence rate of HAPUs each year since 2012, as outlined in Table 3.

The HAPU team attributes its successes to a committed, multidisciplinary team and the use of validated assessment tools by frontline providers.

KEY LEARNINGS FROM CONTRA COSTA

The DSRIP Program allowed the hospital to more effectively implement a strategic quality improvement plan, including both short- and long-term goals. In particular, the Oversight Committee found that in addition to improving clinical outcomes as outlined above, the DSRIP Program provided financial incentives that were critical to ensure consistent momentum throughout the development and implementation process. DSRIP efforts to date have set the stage for establishing organizational priorities and supporting key initiatives including training and education programs. Furthermore, as the examples in this brief show, specific improvement initiatives are spreading beyond singular departments to all clinics, the ED, and other non-DSRIP teams within the hospital.

The Oversight Committee also learned the importance of involving all organization leaders, providers, and frontline staff early on in the development and implementation process to achieve large, systemic change and population health improvement.

[Contra Costa's] DSRIP efforts to date have set the stage for establishing organizational priorities and supporting key initiatives including training and education programs.

Finally, the improvement work conducted as part of this DSRIP created a standardized commitment to quality improvement across all hospital units and clinics. This effort set the stage for participation in other public and private grants and partnerships to continue quality improvement initiatives outside of the DSRIP Program.

While the initiatives described here demonstrate the positive impact of DSRIP waivers, it's important to note that these are only a few examples of the many initiatives Contra Costa has undertaken. Some of these projects, such as those under the population-based improvement category (3), have a longer-term impact that may not be measurable during the term of the waiver. These initiatives are focused on the following:

- improving chronic care management and outcomes
- enhancing access to preventive health care
- improving care quality with attention to reliability and effectiveness

UNIVERSITY HEALTH SYSTEM OUTCOMES

As part of the Texas DSRIP Program, University Health System serves as the anchor hospital for its Regional Healthcare Partnership (RHP).[7]

TABLE 3 HAPU PROGRAM RESULTS

Year	HAPU Rate
2012	2.40%
2013	2.04%
2014	1.06%
2015	0.13%

Like Contra Costa, University Health System established a DSRIP Oversight Team to guide improvement projects and transformation progress. The Oversight Team comprises executive-level staff who interact with many other governing groups that coordinate DSRIP activities for their RHP. As of spring 2015, the Oversight Team had implemented and measured outcomes from many projects across the four categories listed in Table 1. This brief provides details and results from three improvement initiatives—palliative care, medication management, and care coordination. These initiatives span two transformation categories—Infrastructure Development and Program Innovation—and comprise five improvement projects.

Palliative Care

The purpose of the palliative care project is to provide patients with serious illness access to comprehensive supportive care services; improve their quality of life; and provide pain and symptom management, advanced care planning, and care coordination. One key element of this project is educating primary care specialists in providing palliative care and increasing awareness among clinical staff of the availability of palliative care.

Since implementation of the project in 2012, the team has been successful in educating 436 primary care specialists. Measured outcomes of this education include the following:

- percentage of patients who screened positive for pain and received a clinical assessment of pain within 24 hours of screening
- percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns
- percentage of patients with documentation that an interdisciplinary family meeting was conducted on or before day five of a medical intensive care unit (ICU) admission (results not analyzed as of this publication)

While the project team experienced challenges related to physicians' availability for training, outdated data collection mechanisms, and lack of spiritual support resources, the team has successfully achieved its goals in addressing palliative care for hospital patients. In addition, the team has promoted standardization of the hospital's electronic health records (EHRs) to better track patients receiving palliative care and ensure high-quality care delivery.

Medication Management

The primary purpose of the medication management program is to increase providers' access to clinical pharmacists within the ambulatory and hospital settings. The program also helps providers better serve patients by reconciling multiple medications, identifying misuse, and avoiding potential medication errors. Additionally, this intervention aims to improve chronic disease management among diabetic patients. In 2014, a total of 1,601 patients received medication management consults, and an additional 1,431 patients have received consults as of April 2015.

The project team's biggest challenge has been recruiting additional pharmacists to the ambulatory setting to support the higher number of medication management consults with patients. As a result of limited staff resources, the team learned the importance of developing a strategy for identifying which patients will benefit most from medication management.

UNIVERSITY HEALTH SYSTEM CARE COORDINATION PROJECTS[8]

Care Model: 1,154 Patients Served

This interdisciplinary, evidence-based model focuses on chronic disease management for patients within an ambulatory network. It is designed for more complex patients with high-acuity needs.

Navigation: 2,519 Patients Served

This new patient navigation model comprises ancillary services along with clinical providers, including social workers and case managers, in an effort to assist patients in accessing their next point of care. This program is primarily for patients with lower-acuity needs but who are at high risk of disconnect from institutionalized health care.

Transitions: 25,097 Patients Served

This care transitions program works to improve patient engagement following discharge. It consists of a postdischarge call system to address patient questions and identify gaps when patients are transitioning from inpatient to outpatient services.

TABLE 4 PALLIATIVE CARE OUTCOMES

Project Goal	Results
Palliative Care Patients Receiving Pain Screening	Screening rates exceeding 95% since 2013
Patients Receiving Palliative Care Consults	More than 900 patients per year, from 2013 to 2015, receiving consults

In 2014, a total of 1,601 patients received medication management consults, and an additional 1,431 patients have received consults as of April 2015.

Care Coordination

University Health System's care coordination efforts consist of three projects—Care Model, Navigation, and Transitions. Together, these projects create a comprehensive care delivery model that has improved patient navigation throughout the system. See University Health System Care Coordination Projects for details and results of this initiative.

The most challenging aspect of implementing care coordination projects throughout University Health System has been logistics. For example, involving a range of providers including hospitalists, primary care physicians, long-term and palliative

care providers, home health care providers, community supports, and external pharmacists in care coordination efforts has been difficult. In addition, the project team learned to utilize EHRs more effectively to accurately track patients and collect data by acuity and patient need.

KEY LEARNINGS FROM UNIVERSITY HEALTH SYSTEM

The University Health System DSRIP Oversight Team found that the DSRIP Program allowed the health system to make clinical improvements in a number of different areas and has increased collaboration and partnerships among health care providers from within and outside of the health system, leading to greater population health management.

DSRIP PROGRAMS LEAD TO HEALTH OUTCOME AND DELIVERY SYSTEM IMPROVEMENTS

DSRIP programs are a powerful catalyst for delivery system transformation, especially among essential hospitals. Throughout the webinars, both hospitals emphasized the importance of DSRIP programs for implementing delivery system transformation and quality improvement efforts. It is clear to see from their results that DSRIP dollars have both initiated and sustained important health care interventions that are benefitting a vast number of patients. In addition, these improvement projects have led to greater systemwide transformation, collaborations, and population health efforts.

Contra Costa and University Health System provide a small glimpse of the transformation occurring across the nation through DSRIP programs. Going forward, we expect to see similar outcomes as other providers in California, Texas, and participating DSRIP states continue in their transformation projects and data reporting. America's Essential Hospitals and Essential Hospitals Institute are committed to investigating and disseminating these results so the true impact of DSRIP programs may be better understood and can inform future policies and programs.

Notes

1. America's Essential Hospitals. California's DSRIP: Results from Contra Costa (webinar). June 3, 2015. http://essentialhospitals.org/webinar/californias-dsrip-results-from-contra-costa/.

2. America's Essential Hospitals. DSRIP Results: Findings from University Health System (webinar). July 15, 2015. http://essentialhospitals.org/webinar/dsrip-results-findings-from-university-health-system/.

3. State of Texas. Category 3 Quality Improvements. https://www.hhsc.state.tx.us/1115-docs/RHP/Category-3-RHP.pdf. Accessed August 2015.

4. Third next available (TNA) appointment is a measure used to determine the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine, or return visit exam. TNA is used rather than the "next available" appointment as it is a more sensitive reflection of true appointment availability. More information on TNA can be found at http://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx.

5. The 4-eye skin assessment is a wound and pressure ulcer assessment tool used by nursing staff. Developed as part of hospital quality improvement measures in the 1990s, this tool is used to check for the presence of wounds and pressure ulcers on emergency department and admitted patients.

6. The Braden Scale for Predicting Pressure Ulcer Risk is a tool developed in 1987 to help providers assess a patient's risk for developing a pressure ulcer.

7. In Texas, DSRIP improvement goals apply to regions rather than individual participating hospitals and are identified by community needs assessments. There are currently 20 Regional Healthcare Partnerships (RHP), which include hospitals, health centers, local health departments, and physician groups. Each RHP is coordinated by an anchoring entity. More information can be found at https://www.hhsc.state.tx.us/1115-RHP-Plans.shtml.

8. These numbers do not reflect unique patients. Providers are allowed to count the same patients across years.