TRANSFORMING DHS:
THE RESTRUCTURING OF AMBULATORY AND MANAGED CARE SERVICES WITHIN
THE LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES

Work Plan of the
DHS Ambulatory Care Restructuring Steering Committee

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JULY 16, 2010
**Context**

In April, 2010, the Los Angeles County Board of Supervisors instructed the Office of the CEO and the Los Angeles County Department of Health Services (DHS) to initiate a process that will result in a robust DHS ambulatory system, integrated with managed care services that support the full delivery system. This restructuring is critical to assure the County’s readiness for the renewal of the California 1115 Medicaid Waiver and national health reform, both of which will result in moving large numbers of patients currently cared for by the County into coverage, predominately into a managed care environment. If DHS does not transition from an episodic care focus for all to a planned delivery system for a defined population who will have a choice of providers, it risks losing those patients who contribute financially to DHS operations.

This effort is timely and aggressive; the changes in the approach to caring for many of the existing patients in DHS will begin with the conversion of some complex Medi-Cal patients--Seniors and Persons with Disabilities (SPDs)--into managed care by early 2011 and the proposed significant increase in uninsured patients included in the Coverage Initiative (which is being shaped as a transition to the expansion of Medicaid eligibility under Health Reform in 2014) may begin this fall. All of these changes will require a focused new emphasis on a strong and comprehensive ambulatory system to manage patient care, to minimize unnecessary Emergency Department (ED) and inpatient admissions and to reduce the Length of Stay (LOS) in DHS’ hospitals that are due to the inability to secure a medical home for patients upon discharge. These changes represent the greatest change in health care coverage and organization in more than a generation and they will require a major shift in the focus and organization of DHS.

**Approach**

A Steering Committee of DHS CEOs, medical leaders, ambulatory care practitioners, and DHS senior staff was named and, facilitated by Health Management Associates (HMA), has developed both a vision of what the new approach to ambulatory and managed care will look like within DHS and a framework and timeline for the transformation’s implementation. This effort has been—and will continue to be—a “forced march” to move quickly and thoughtfully and in full recognition of the challenges of accomplishing major change within the current structure. It is the conviction of all of the participants in the process that this work is a priority for both the future of the Department and, more importantly, for the preservation of the health care safety net for the vulnerable residents and communities of Los Angeles County.
Guiding Vision and Principles

The Steering Committee agreed upon the following Vision and Principles for a restructured DHS ambulatory care system:

Vision Statement

The Los Angeles County Department of Health Services (DHS) ambulatory health care system—made up of those services that it provides directly, those it funds and the providers with which it partners—will become a provider of choice for its defined population by:

- assuring patient-centered quality care, thereby contributing to a documentable improvement of health status;

- providing sufficient capacity and, at the same time, addressing barriers to access to assure that demand is met;

- integrating with other levels of the health system to effectively manage, through continuity and coordination, the delivery of care;

- operating efficiently in order to be accountable for cost; and

- serving as the entry point into the DHS delivery system in order to meet the requirements of national and state reform efforts that will demand comprehensive and managed, not episodic, care for a defined population.

Principles

1. Changes in Medi-Cal and national health reform will greatly expand health care coverage while providing a reimbursement mechanism that requires comprehensive management of care for individuals as well as for whole populations.

2. Disregarding the changes to Medi-Cal and national health reform will be deleterious to the DHS delivery system and, as important, to the population it serves.

3. DHS ambulatory care resources should be planned and prioritized based on capacity and the service needs of the defined population.

4. DHS ambulatory care should plan, request, advocate for and, if needed, build the infrastructure necessary for effectively managing the care of the defined patient population.
5. DHS ambulatory care should hold as high a priority and status within the delivery system as that held by other elements of the system, such as hospitals.

6. Each patient member of the DHS delivery system’s defined population should have a Patient Centered Medical Home.

7. The elements of DHS ambulatory care should be built on a firm commitment to customer service and include: primary care Medical Homes, outpatient specialty care consultation, urgent care, outpatient procedures and surgeries, outpatient diagnostics, care management, rehabilitation, pharmacy services, information management and technology, and human resource management.

8. DHS ambulatory care should manage and direct human resources, time, physical space and equipment, and budget related to all its elements.

9. DHS ambulatory care should negotiate, refine and maintain partnerships with Public Private Partners (PPPs) and other community-based services, and assure their inclusion in managing the care of patients and populations.

10. DHS ambulatory care should set expectations, negotiate and contract with, and monitor the performance of relevant physicians, practice groups and medical colleges and other professional schools that provide services for the defined population.

11. DHS ambulatory care should play the leading role in assuring the cost and quality outcomes for the defined population served by DHS.

12. DHS ambulatory care should serve to draw the defined patient population into primary care and aggressively support the transition of patients out of higher levels of care back into ambulatory and primary care.

13. DHS ambulatory care should be overseen through a coordinated structure with clear and consistent expectations.

14. DHS ambulatory care should have a mechanism that is closely aligned, collaborates with and supports the efforts of other DHS, DMH and Public Health organizations and programs.
15. DHS should determine its defined patient population and that defined population should be agreed to by the BOS.

16. DHS ambulatory care should be led by people with experience and expertise in large system ambulatory care services and should be staffed by managers trained to meet the challenges of operating such an ambulatory care system.

17. DHS ambulatory care should be based on a clear staffing plan (centered on team-based care) and population-focused productivity expectations, with training and education provided to be able to meet those expectations.

18. DHS ambulatory care should be planned in cooperation with the other components of the system to assure synergies and avoid isolation.

19. DHS ambulatory care should work closely with finance to assure that incentives are, whenever possible, designed to support best practices and sound patient management.

20. DHS ambulatory care should provide a better experience for physicians in training, as the “real world” will be much more managed and ambulatory care focused than most students and residents receive within DHS today.

What Must be Done to Achieve This Vision?

The following are the key issues to be addressed, within the next year, in the restructuring of the ambulatory and managed care services within DHS:

- Create, elevate and expand a “division” within DHS to oversee its ambulatory and managed care services. This division would significantly alter the current DHS Table of Organization, with the leadership of the restructured entity at the level of their hospital counterparts. Specifically, the unit would:
  - provide centralized leadership and accountability for the development and maintenance of a strong and well-directed ambulatory service within the DHS system (although certain functions-to be defined-could be delegated to either existing regional networks or other structures for implementation);
  - establish and implement an ambulatory staffing model based on best practices and assuring productivity and effective care;
- assure accountability to and collaboration with the other components of the DHS system-reinforced by an organizational structure that maximizes interaction of ambulatory and hospital leadership at the system level in both planning and problem-solving-- to assure continuity of care and efficient use of resources;

- determine the scope of diagnostic and ancillary services needed to support the ambulatory system, assure that current services are utilized to maximum efficiency, and plan for assuring access to additional capacity as needed;

- control ambulatory budgets, space and resources;

- provide for system-wide support and education to ambulatory services to assure best practices and patient-centered care (i.e., Rancho Los Amigos should train all centers on the effective care of patients with disabilities);

- define the scope of services to be offered to those who seek and require only episodic care;

- provide the leadership for a transition to a managed care focus for DHS and serve as the primary point of contact with DHS’ managed care plan partner(s);

- restructure and lead ongoing collaboration with the PPPs and other system partners;

- seek creative partners and strategies to enhance recruitment efforts for providers (and other hard-to-secure positions) to serve the DHS patient population, including, but not limited to, exploring opportunities such as loan repayments for primary care physicians who chose to remain in the system after completing their residencies;

- work with the DHS finance leadership to secure favorable arrangements (such as Federally Qualified Health Center status) to help sustain the system’s ambulatory services; and

- plan for, secure and monitor primary, specialty and managed care infrastructure needs for the system.
• Identify the Medical Homes—and the operational and practice infrastructure to support them—for a defined population of 400,000-450,000 patients that DHS will manage in its system, expanded to include the Public Private Partner (PPP) clinics. This managed population will include Medi-Cal patients, enrollees in the Coverage Initiative that will convert to Medi-Cal or insurance under Health Reform, IHSS workers and those that will remain uninsured but will require management to assure effective use of resources within DHS. Further, it is critical to understand that there will be a set of services, predominately urgent care, that will need to be made available and, in some cases, developed, for patients who will utilize the system more episodically. Specifically, the Medical Homes within DHS will include:

- primary care medical homes within DHS and through the PPPs, whose inclusion in the DHS system is critical to meeting demand;
- “enhanced” Medical Homes within DHS, most likely within the CHCs, with additional specialty services to meet the needs of more complex patients; and
- “specialized” medical homes within DHS focusing on patients with co-morbidities utilizing a high degree of specialty care and SPDs, including people with disabilities and those with behavioral health issues, particularly building upon the unique opportunities inherent in expanding the outpatient services and partnerships affiliated with Rancho Los Amigos Medical Center.

• Assure that accessible, timely and appropriate specialty outpatient care—a critical component of service for the SPD and chronically ill population that will transition into the Coverage Initiative and, under Health Reform, into Medi-Cal—is planned for and made available to the patients managed by DHS. Specifically, DHS must:

- determine what scope and volume of specialty services should be available to the defined population;
- ensure full utilization of specialty services—including outpatient surgery—at all DHS sites;
- assure that current DHS specialty services are appropriately utilized and full capacity is made available;
- create within the DHS agreements with medical schools a clearly delineated requirement for outpatient specialty services;
- address the challenges for the delivery of specialty care within the teaching environment, which is the dominate model for specialty care outpatient activity in
DHS’ hospital-based clinics, and develop and implement strategies for maximizing specialty care capacity in non-teaching environments like MACCs and CHCs;

- identify system-wide specialties (such as those provided by Rancho Los Amigos and the other DHS hospitals) that could serve all regions and set expectations and provide support for the availability to those services; and

- develop and implement a plan for filling existing gaps and eliminating duplications throughout the system to be able to meet access requirements under managed care.

• **Assess diagnostic capacity throughout the DHS system and determine gaps and duplications based on anticipated need of the defined managed patient population.** The plan should include those services offered at both DHS ambulatory centers and hospitals. It is conceivable that several ambulatory centers should be identified and built out as diagnostic hubs serving several regional DHS clinics as well as those PPPs related to the region.

• **Integrate Management Services Organization (MSO) functions into the restructured Ambulatory Care services within DHS and secure a partnership to assure inclusion in and growth with a managed care plan or plans.** Specifically, DHS should:

  - determine the capitation model or models that it will pursue for its services (recognizing that there may be differences depending on geographic and network challenges);

  - create (through a vendor relationship, at least initially) an MSO for DHS—and, perhaps, its PPPs—to oversee the transition of its operations to managed care readiness;

  - define its primary care, specialty, inpatient, SNF, DME, home health, hospice and diagnostic capacity and identify and address gaps for the defined managed population;

  - directed centrally, define the model for managed care leadership and structure at the regional network level (including PPPs);

  - assure, in collaboration with the CEO and Board of Supervisors, an ability to enter into, refine and terminate contractual agreements in a timely manner through increased delegated contracting authority and expedited contracting processes;
identify operational infrastructure and delivery network priorities to support the transition of the DHS system to managed care (IT, utilization management, practice management, PPP integration, care management, specialty care enhancement, hospital partners to assure coverage and access, etc.);

- set a timeline to implement the above priorities based on the targets of both the California 1115 Waiver and Health Reform; and

- work with LA Care to transition patients out of the Community Health Plan (if negotiations are successfully completed) and reassign current CHP employees as possible.

How Do We Make This Happen?

One Year Work Plan

The following steps are priorities that must be taken within the next year to implement the restructured ambulatory care system:

- **DHS should appoint, within 30 days, an ambulatory/managed care central leadership team with the authority to oversee and implement the work plan.** While these positions may be interim, they should be appointed immediately, be relieved of other duties to devote full-time to this effort, given the stature on par with hospital leadership teams, and work with the Ambulatory Care Restructuring Steering Committee to implement the elements of the work plan. New positions should be created to assure that this effort is a permanent restructuring within DHS, not a temporary “project.” The first iteration of the leadership team should include: a CEO, COO, CMO, Managed Care Director and CNO, as well as the staff necessary to support these positions. In addition, DHS staff from finance, human resources, IT, facilities management (to assure attention to the vast capital needs of the DHS ambulatory facilities) and planning should be identified who will be dedicated to support the creation of this new unit. Ambulatory-focused programs within the DHS (including PPP and Healthy Way LA) should be integrated into this new Division. Finally, the Office of the CEO should appoint a full-time liaison who will work with the new team to resolve any issues that involve the Board of Supervisors, contracting, interaction with County HR, or other County level issues.

- **The DHS ambulatory/managed care leadership team should be charged to, within 30 days of their appointment, report back to the DHS Director with a detailed schedule of activities to be completed over the next year, consistent with this work plan.** This focus should include aligning and integrating current DHS efforts related to ambulatory and managed care, clearly identifying responsibilities for accomplishing targets and, with the system leadership and defining the new division within a restructured DHS organizational chart that sets ambulatory/managed care at the same level as its hospitals.
The DHS Ambulatory Restructuring Steering Committee should be kept in place over the next year to work in a transitional advisory role with the ambulatory leadership team to address and resolve key remaining issues, including (but not limited to):

- assisting the leadership of DHS and the new ambulatory/managed care division with the organizational transition, including coordinating activities between DHS hospitals and ambulatory care areas of joint accountability;

- monitoring and, as necessary, refining assumptions about the scope of the defined population to be managed by DHS;

- establishing the care management model(s) for the systems defined population;

- determining PPP and DHS roles in meeting the system’s primary care Medical Home capacity needs;

- defining options and priorities for financial incentivization of ambulatory care focused practice (within DHS and through the Coverage Initiative, PPP program, etc.);

- assisting in the implementation of a system-wide review of DHS specialty capacity, starting with priorities for the defined population;

- determining the scope of services that will be available for those patients likely to receive primarily urgent/episodic care, and collaborating with the system’s EDs in determining policies for addressing the disposition of these patients;

- recommending ambulatory-specific criteria for the negotiation of medical school agreements;

- initiating priority pilots between DMH/DPH/DHS;

- establishing a mechanism to assure accountability between DHS hospitals and ambulatory services;
- integrating managed care delivery system elements into DHS at the system, regional and facility levels; and

- assuring active operational participation in DHS planning efforts related to the 1115 Waiver and Health Reform.

• **Initiate, within 30 days, Medical Home training in the DHS system through a collaborative model.** Several sites (CHCs, MACCs, hospital-based specialty clinics, partner PPP) should be chosen to begin training for Medical Home readiness (paneling, care management integration, patient flow, quality, etc.). These initial sites will generate teams that will train others in DHS over the next months. It should be clear that this training will continue over at least the next year (and probably longer) and will need ongoing support and resources.

• **Integrate, within 90 days, managed care delivery system infrastructure, secured through DHS negotiations with LA Care, into the restructured ambulatory care system.** Priorities for the development of managed care infrastructure to be supported (either directly or through the provisions of resources) through negotiations with LA Care include:

  1) **Consultant assistance to DHS.** Priority areas for managed care-related consultation would include: Medical Home training throughout the system; conversion of finance approaches from fee-for-service to capitation and other managed care payment mechanisms; development of contracting models, delivery system planning and best practices in managed care delivery; communications messaging and dissemination to support the transition of the Department to a more patient-centered and managed-care focus.

  2) **Information Technology Support.** A priority list of IT requirements (including—but not limited to—disease registries, care management, practice management, utilization management (including concurrent review, prior authorization, referral management) and expanded communication bandwidth between the system’s facilities for a sharing of medical information) should be generated by DHS focused on the delivery system requirements of managed care. Support from the Internal Services Department (ISD) will be required to accomplish some of these priorities.

  3) **Staff/leadership.** There may be holes in the current staff available to DHS to make up its ambulatory/managed care leadership position that will need to be provided, at least short term, through a contractual relationship.
4) **MSO for the DHS.** DHS will need to secure an MSO to perform certain services for its delivery system in both preparing for managed care and performing the related ongoing operational functions (eligibility, concurrent review, appointment, care management, disease registry, claims management, contracting, pharmacy management, compliance, etc.). While this is optimally a function that will be built—all or in part—within the DHS, these services will need to be established and aligned with the new division as soon as possible...

- **Implement, within 30 days, a comprehensive communication plan describing the transition to the new ambulatory/managed care structure.** The transition from a delivery system that is heavily focused on episodic care for patients that come through its EDs to one that is patient-centered and focused on providing patients, as much as possible, a comprehensive system of care based in primary care medical homes and involves partnerships with other providers is a dramatic change for DHS. Early and ongoing communication to and with key stakeholders (DHS administration and front line staff, physicians and medical schools, provider partners, unions, the Board of Supervisors and other County departments, relevant state and federal authorities, the community at large and, most importantly, DHS patients) will be vitally important as this transformation progresses. DHS should secure consulting assistance in establishing and disseminating its message and tailoring it specifically to individual stakeholders.

- **Initiate, over the next year but starting immediately through a collaborative and focused effort, the transition to a standardized ambulatory staffing model that assures greater efficiency and effectiveness in the DHS ambulatory settings.** Work is already well underway to both assess the current staffing in DHS clinics and target activities that will transition the department to greater consistency, productivity and effectiveness. The work to date—which has focused on the primary care services delivered within the Department, has preliminarily concluded that there may be the capacity (both with current space and current providers) to increase the number of patient visits generated and, with additional providers, to achieve even greater capacity increases. A major component in achieving this increase, however, is a redesign of the staffing model. Based on work done to date and work projected for the future, it is recommended that DHS:

  - seek and receive acceptance of the new staffing model for primary care from the Office of the CEO and initiate the transition process under the direction of the ambulatory leadership team;

  - work with HR and the CEO to create the job classification for “Certified Medical Assistant” (CMA), a position that will play a significant role in the clinic staffing model;

  - work with HR and the CEO to redesign current job descriptions to meet the specific needs of the ambulatory environment (i.e., nurses moving into care management—
a job description that will need to be developed when the care management model is defined);

- address the current difficulty in recruiting newly trained primary care physicians by granting the DHS CMO the authority to authorize the advanced step placement for these physicians to close the market disparity gap and allow a competitive salary for these critical positions;

- involve the unions in position redesign efforts;

- identify training needs and secure resources to facilitate the transition to new job descriptions and staffing models;

- start to implement the new staffing model in DHS primary care clinics this year;

- complete the staffing model analysis for DHS specialty clinics during the next three months; and

- move toward the creation of panels and team-based care in DHS clinics.

• **Evaluate short and long term IT solutions.** While the evolution to a common Electronic Health Record (EHR) is critical, there are short-term initiatives that can significantly improve DHS’ ability to manage a defined population and enhance the communication between system providers and should be initiated. Issues which must be addressed include developing the capacity to assign and manage panels of patients for primary care providers. DHS must either significantly redesign or replace the current DHS specialty referral system (RPS). to support managed care requirements for timely and appropriate access to specialty services will be critical as complex patients move into managed care. In addition, DHS and ISD should work to establish robust linkages between DHS facilities for a medical information exchange system. Disease registries should be evaluated and secured. Any long-term solutions should be thoroughly evaluated for both their ambulatory effectiveness and their potential for connectivity to other provider partners.

• **Implement a new relationship with the PPPs, resulting in a strong and integrated alliance with the DHS system, particularly focused on preparation for the California 1115 Waiver and Health Reform.** These discussions should include:

  - integrating approaches to the Coverage Initiative population, SPD managed care and current Medi-Cal managed care patients assigned to the PPPs who could better utilize the DHS specialties and hospitals;
- moving toward risk-adjusted capitation payments for the uninsured patients assigned to PPPs, aligning with the approach taken for the Medi-Cal population;

- restructuring the assignment of PPP patients to better meet the needs of the DHS system to assure that they have primary care providers for their patients inappropriately utilizing EDs or specialty clinics who should be in Medical Homes;

- exploring joint approaches to managed care (including management services) and IT infrastructure; and

- establishing a formal process for ongoing assessment and joint planning for the future.

- **Begin a specialty care capacity assessment process at all DHS specialty care sites (hospitals, MACCs, CHCs).** Starting with those specialty services in greatest demand by the primary care system (including PPPs), the process should review current utilization for appropriateness (including chart reviews) and assess the existing referral system and procedures and make changes to assure greater efficiency.

- **The DHS medical school agreements should be reviewed and a plan developed to assure that ambulatory services required by the system are supplied (or a mechanism established to allow them to be attained elsewhere).** This process should begin immediately.

- **Escalate discussions with DMH/DPH regarding pilots integrating medical and behavioral health services.** Finalize the development and implementation of the collaborative project with DMH to provide integrated and coordinated prevention and early intervention mental health services at selected DHS MACCs and CHCs. Collaborate with DMH and DPH to develop integrated models for physical and behavioral health services under the renegotiated 1115 Waiver, whose implementation plan calls for integrated models by January 2011.

- **Prioritize ambulatory/managed care inclusion in the DHS Strategic Planning process.** Develop and implement a strategic plan for DHS as an integrated and coordinated delivery system that provides care using managed care principles. The strategic plan should include input from internal and external stakeholders and be consistent with the California 1115 Waiver and national health reform. The strategic plan should pay particular attention to the transformation of the DHS ambulatory care system and its relationship with all of the other components of the health care delivery system.