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## Testimony to the Little Hoover Commission September 28, 2006 Allen Miller, President & CEO

Little Hoover Commission Commissioners, Staff and Members of the Public:

On behalf of the staff, board members and clients served by COPE Health Solutions, thank you for this opportunity to discuss with you some of the challenges inherent in working with the State of California and local governments to improve the health of Californians. We are very pleased that the Little Hoover Commission takes an active interest in assuring that the State of California leverages public funds in order to get the maximum social return on investment and, in the case of health care, to improve access to care for Californians.

### **Introduction to COPE Health Solutions**

COPE Health Solutions is a non profit health care corporation headquartered in Los Angeles. Our skilled, energetic and caring team is dedicated to providing accessible, culturally sensitive and high quality health care services to diverse communities. The mission of COPE Health Solutions is to make communities healthier.

We have developed core competencies in the areas of strategic planning, hospital and health systems operations, care coordination/care management, health professions pipelines and preventive health services. Dedicated COPE Health Solutions professionals leverage these competencies to support health care systems, safety net hospitals, clinics and other health care agencies in providing accessible, culturally sensitive and high quality health care services to their communities.

The organization is comprised of four divisions:

- Health Workforce Transformation
- Health Systems Integration
- Family Health Services
- Consulting

We are presently engaged in designing, implementing and/or managing solutions for 14 hospitals, along with multiple public health and community

clinic partners, that serve the health care needs of scores of communities throughout the State of California. With the help of private foundations and client hospitals we are building internal capacity to replicate our solutions to an additional 20 to 30 hospitals and/or health systems over the next three years.

## **Goals**

Through the Health Systems Integration Division, COPE Health Solutions partners with public and private safety net hospitals, public health departments and community clinics to address the challenges of today's fragmented delivery system, lack of care coordination and insularity of various parts of what should be one network of safety net services within a given community or set of communities.

In partnership with the LAC+USC Healthcare Network, the Los Angeles County Department of Public Health and a number of community clinics in Los Angeles, COPE Health Solutions has designed, implemented and is managing the first Camino de Salud Network. The Network is a true public-private partnership that is redefining managed care for the safety net in neighborhoods throughout Central and East Los Angeles. Critical components of the Camino de Salud Network include; linkage of every patient in the Network to a primary care home in the patient's local neighborhood; innovative new systems that enable and encourage coordination of care; structured HIPAA-compliant information sharing and plans for the patient to have access to their own Personal Health Record through a specially developed web-based care management/personal health record software; and a special care management/system navigation program for the most challenging chronically ill, under-insured, "frequent user" patients.

All safety net hospitals face the same daunting challenges of crowded emergency rooms, a growing population of uninsured and under-insured in the community and shrinking budgets. However, the challenges for the LAC+USC Healthcare Network are even greater, as the medical center with 750 staffed beds and a million patient visits annually- 250,000 to the emergency department alone- prepares to move to a new facility that will reduce the number of inpatient beds by 20% in 2007. When the transition is complete, fewer beds will mean reduced capacity for inpatient care, despite a growing demand for health care services by uninsured and under-insured patients in Medical Center's large geographic service area.

Like many other public health care systems, LAC+USC and surrounding private clinics in its communities have suffered from decades of misaligned incentives and missed opportunities for collaboration. Both the Los Angeles County Public Private Partnership (PPP) funds and those funds provided to the numerous Federally Qualified Health Centers in Los Angeles have provided funding to increase the availability of primary care services for the uninsured. However, neither of these programs have provided for the coordination of care between the public safety net hospitals and clinics and the private providers, nor have they expanded specialty care and diagnostic services in tandem with the expansion of primary care.

This set the system up for failure. The private clinics, by necessity, were sending patients in need of outpatient specialty care or diagnostic services to the emergency department of a county facility. This

was due to the fact that the wait for impacted services such as cardiology or colonoscopy was often four to six months or longer through the regular referral process. Even when a patient from a private provider eventually received specialty care or a diagnostic test at a county safety net facility, the results would rarely get back to the referring provider and therefore would often be repeated. Also, patients seen in the emergency department or as an inpatient at a county safety net hospital would be referred to a county-run clinic, often one on-site at the hospital, rather than back to a clinic in the patient's community- one that may have referred the patient to the county emergency department in the first place.

In 2004, the CEO of LAC+USC approached the Department of Public Health for assistance with his over-burdened emergency department and waiting areas that were constantly filled to capacity. Patients were waiting for many hours for issues that could be easily handled in a primary care environment, or for medical problems that could have been prevented with regular primary care. Public Health asked COPE Health Solutions to join them in assessing the situation at LAC+USC.

An analysis of 2003 patient data collected from LAC+USC Medical Center's Affinity Health Information System and analyzed by the COPE Health Solutions and the Department of Public Health identified a small number of adult, uninsured patients with disproportionately frequent utilization of high intensity emergency and inpatient services. These patients often experience multiple hospitalizations and emergency visits at the LAC+USC Medical Center for preventable conditions that are the result of sporadic and fragmented treatment of a chronic condition. For instance, approximately 6% of the inpatients in 2003 represented a bed utilization of 16% of all bed-days that year.

It became evident that the LAC+USC Medical Center's emergency department and inpatient services served as the "de facto" primary care home for this population. This group of patients tends to lack the skills and knowledge to properly manage their chronic health conditions. The resultant inappropriate and preventable over-utilization of emergency and inpatient services decreases the availability of beds within the hospital, decreases the availability of emergency department resources for true emergencies and is a great burden on the limited safety net resources available.

It was postulated that with a change in health seeking behavior such that the patients actively engage in care management with a regular primary care provider and receive necessary social support services, the patients' health would improve and the patients would not utilize expensive emergency department and inpatient services as frequently. This in turn would decrease the financial and utilization burden on the safety net.

#### Frequent User Goals for the System:

1. Integrate personal, public and community health with other public/private social services.
2. Reduce inappropriate and unnecessary utilization of high intensity hospital services, both emergency department and inpatient.
3. Improve communication and coordination of services between LAC+USC Medical Center and local non-profit primary care clinics.

4. Decrease in unnecessary duplication of testing due to enhanced coordination of care between primary, specialty, emergency and inpatient care providers.
5. Sharing of best practices amongst the clinics and sharing/co-designing of disease management and clinical pathways between the clinics and the LAC+USC Medical Center.

Frequent User Goals for the Patients:

1. Improved Health Literacy. (The ability to communicate with, self-advocate through and understand health providers and health messages)
2. Improved ability to self-navigate the health care and social services systems.
3. Increased access to, and appropriate utilization of, public and private primary health, specialty health and diagnostics and social support services.
4. Creation/strengthening of social support systems for clients and families (social or faith-based)
5. Improved knowledge of personal illnesses/conditions and ability to self-manage these conditions.
6. Improved health and development of protective health factors.

The COPE Health Solutions team worked with the medical center and clinics to develop a number of critical systems and tools to ensure that:

1. All “frequent user” patients are linked to a local primary care home and receive assistance with navigation of the complex health care and social services systems.
2. Those patients linked to a primary care provider who re-access any of the LAC+USC Healthcare Network facilities are identified and re-directed to their community clinic with an appointment. (After medical screening in the emergency department) For inpatients, the community clinic follow-up primary care appointment must be within one week of discharge.
3. Information, such as test results and discharge summaries, is shared in a HIPAA compliant manner between the medical center and clinics.
4. Specialty care and diagnostic services are strategically expanded and decentralized in order to enhance geographic and overall access, decrease unnecessary utilization and improve the financial sustainability of the Network partners. (Examples include: A partnership with community clinic partners to increase perinatal services at the clinics and deliveries at the medical center- improving financial sustainability for the entire safety net. Partnerships with health professions training programs to provide new optometry and ultrasound services at select community clinics. Mini-fellowships for primary care providers in Rheumatology, thus enhancing availability of rheumatology care and decreasing inappropriate referrals.)

In working with the medical center and community clinic staff and physicians to implement key systems, it became clear that one reason projects like this fail is that providers are required to take different actions for different sets of patients and that when special actions are required for a small group of patients, it is less likely those actions will be completed correctly. This is due in part to a lack

of experience with the special actions for any one staff member or physician, in part to a general resistance to change, and in part due to a lack of time. At the same time, it became apparent that many of these tools would be useful for all patients who are cared for by the Camino de Salud Network providers, not just the frequent users.

Therefore, it was decided that the Frequent User project would become a subset of the larger Camino de Salud Network:

#### Camino de Salud Network Aims:

- Local, patient centered, culturally competent care
- Coordination of primary, specialty and hospital care
- Improved health outcomes for the indigent patients in the Network
- Improved patient, staff and physician satisfaction
- Long-term financial sustainability of the Network

#### Key Strategies:

- Develop an integrated Network to facilitate the coordination of care
- Expand capabilities to support the Network
- Increase brand awareness of the new Camino de Salud Network
- Ensure financial sustainability by decreasing inappropriate utilization of services, by strengthening revenue generating lines of business and by improving payer mix.
- Implementation of a web-based electronic case management/personal health record system that will both:
  1. Allow specially trained Community Health Specialists to help the “frequent user” subset of patients to manage their care and navigate the complex health care and social services systems.
  2. Empower all Network patients to view and access their personal health record, all pending appointments and obtain health information in Spanish or English from any internet connection.

Under the Camino de Salud Network procedures, all patients who are referred to the LAC+USC Medical Center for specialty care or diagnostics are now linked to the referring clinic. The clinic serves as the patient’s primary care home in their neighborhood and as the central point for all referrals so that one provider has access to all of the patient’s care information. This enables LAC+USC to send emergency department and inpatients back to their neighborhood primary care home, with an appointment. Primary care clinics have access to medical data from LAC+USC, thereby eliminating duplication of expensive tests and specialty care consults. Thousands of patients now have a medical home to manage their health care needs, thereby avoiding unnecessary ER visits.

The potential for the first replication of this system is being discussed with St. Mary Medical Center in Long Beach and Harbor-UCLA Medical Center in Torrance.

## **Challenges and Strategies for Moving Forward**

Inefficient and irrational expenditures of the overall health care and particularly the Medi-Cal dollar:

Chris Perrone from the California HealthCare Foundation talked with the Commission in July about how costly health care for the indigent is to federal, state and local governments and how those expenditures are divided up in terms of community clinics, physicians and hospitals.

Current inefficiencies in spending are limiting the potential value of the massive expenditures being made. I would like to address ways in which the money could be spent in a manner that would assure a greater value in terms of system costs and community health. The point is that if health care were more efficient and better coordinated, then more people would be able to access care appropriately and state and local safety net programs would be able to offer care to more people.

Challenge 1) Hospitals and clinics have misaligned financial incentives. Medi-Cal, like Medicaid nationally, has not kept up with advancements in health care. As opposed to encouraging regular primary care, preventive health, group education for the chronically ill and other proven managed care tools, Medi-Cal's design tends to reward more intensive hospital-based care.

Solution 1) COPE Health Solutions is currently working to address this through the Camino de Salud Network concept, but we require help from Medi-Cal. Patients are assigned to primary care homes in their neighborhoods, which improves continuity of care and decreases utilization of the emergency department and inpatient services. However Medi-Cal needs to give incentives to hospitals to partner with clinics in order for this to really work financially. Currently, the hospital is incentivized to provide more inpatient care, as that is all some Medi-Cal patients are eligible for. The State should figure out how to align incentives through Medi-Cal such that both patients and providers win when regular primary care is used and so that inpatient and emergency department care is funded but not incentivized. This may require assistance at the federal level to ensure that the entire system is adequately funded and primary care does not have to compete with critical emergency department services for funding.

Challenge 2) Medi-Cal tends to drive care toward more expensive interventions, encouraging episodic care and limiting providers' ability to be reimbursed for preventive and primary care. This incentivizes the system to provide more expensive interventions and disincentivizes regular, preventive care that would lead to improved health and wellness for patients and be less expensive in the long term. For instance, under the current Medi-Cal rules, if an uninsured patient is hospitalized that patient's hospitalization will likely be paid for through limited scope Medi-Cal. However, that patient, even after being enrolled in limited scope Medi-Cal, will not be eligible for payment for much less expensive outpatient services. This has been magnified under the current Medi-Cal waiver.

Solution 2) The state needs to redesign the payment system so that individuals can receive consistent care. (This may involve working with the federal government) If primary care is properly funded, patients can access quality care in their own neighborhood as opposed to

traveling to a more expensive emergency department for episodic care that may even end up in an admission.

Challenge 3) Information sharing needs to be developed such that safety net hospitals and community clinics can share patient information in a HIPAA compliant manner, while at the same time providing patients with access to combined and updated personal health records. This allows for the system to provide for better continuity of care and enhanced care management for patients who need it, while empowering many patients to take charge of their own care and better manage their use of the system and their health behaviors in order to improve their overall health.

Solution 3) COPE Health Solutions has created a web-based care management and personal health record system aimed at overcoming these information sharing challenges. The state needs to support and nurture the development and testing of products like this and reward patients who access and use their personal health record and health information to better manage their care and have a lower impact on the most expensive parts of the health care system.

Challenge 4) A major cost driver is a shortage of diverse, local nurses, allied health workers or physicians who are committed to working with the safety net.

Solution 4) The state needs to better address the health care workforce challenge by supporting pipelines, such as COPE Health Solutions' Health Workforce Transformation program. These pipelines assure that local youth are introduced to health care from an early age, are provided with active mentoring and volunteering opportunities in high school, internships in college and hospital-funded training spots for nursing and allied health after proving themselves. It is a local, economy-boosting model that assures a workforce whose diversity matches the local community and therefore increases access, as opposed to a model that relies heavily on registry, traveling nurses, and the importation of nurses and others from other countries.