DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

MAR 2 5 2014

Toby Douglas
Director, Department of Health Care Services
1501 Capital Ave, MS 0000
P.O. Box 997413
Sacramento, CA 99859-7413

Dear Mr. Douglas:

I am writing to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your evaluation plan for the Delivery System Reform Incentive Payment (DSRIP) component of California's section 1115(a) demonstration (11-W-00193/9), entitled "California Bridge to Reform Demonstration." This evaluation plan was resubmitted December 7, 2013, in response to CMS's initial comments on the draft evaluation plan.

While this evaluation plan reflects the best available qualitative and quantitative data on DSRIP performance, we note that a more robust evaluation could be completed if better data systems were available. We appreciate California's participation as a pilot state in CMS's Transformed Medicaid Statistical Information System (T-MSIS) and encourage the state to continue to explore opportunities to strengthen its data infrastructure to better measure and evaluation delivery system improvement activities.

As specified in special term and condition (STC) 26(g) the state must submit interim evaluation findings by no later than October 1, 2014. As described in this evaluation plan, the interim evaluation findings will include all available data on all aspects of DSRIP projects to date. The state's interim evaluation will be followed by a final evaluation report, which will be submitted to CMS by no later than October 31, 2015.

Your project officer for this demonstration is Mr. Robert Nelb. He is available to answer any questions concerning your section 1115 demonstration and this amendment. Mr. Nelb's contact information is:

Center for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

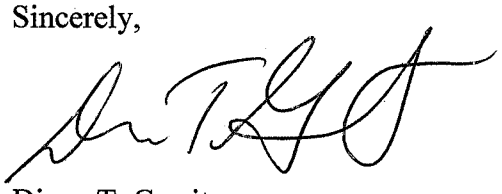
Telephone: (410) 786-1055
Facsimile: (410) 786-5882
E-mail: Robert.Nelb@cms.hhs.gov

Official communications regarding official matters should be sent simultaneously to Mr. Nelb and Ms. Gloria Nagle, Associate Regional Administrator for the Division of Medicaid and Children's Health in our San Francisco Regional Office. Ms. Nagle's contact information is as follows:

Ms. Gloria Nagle
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

If you have any questions regarding this approval, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Centers for Medicaid & CHIP Services at (410) 786-5647.

Sincerely,



Diane T. Gerrits
Director
Division of State Demonstrations and Waivers

Cc: Gloria Nagle, ARA Region IX

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Delivery System Reform Incentive Pool (DSRIP) Program
DSRIP Program Evaluation Plan

Nadereh Pourat, PhD and Gerald Kominski, PhD,
Principal Investigators - UCLA Center for Health Policy Research

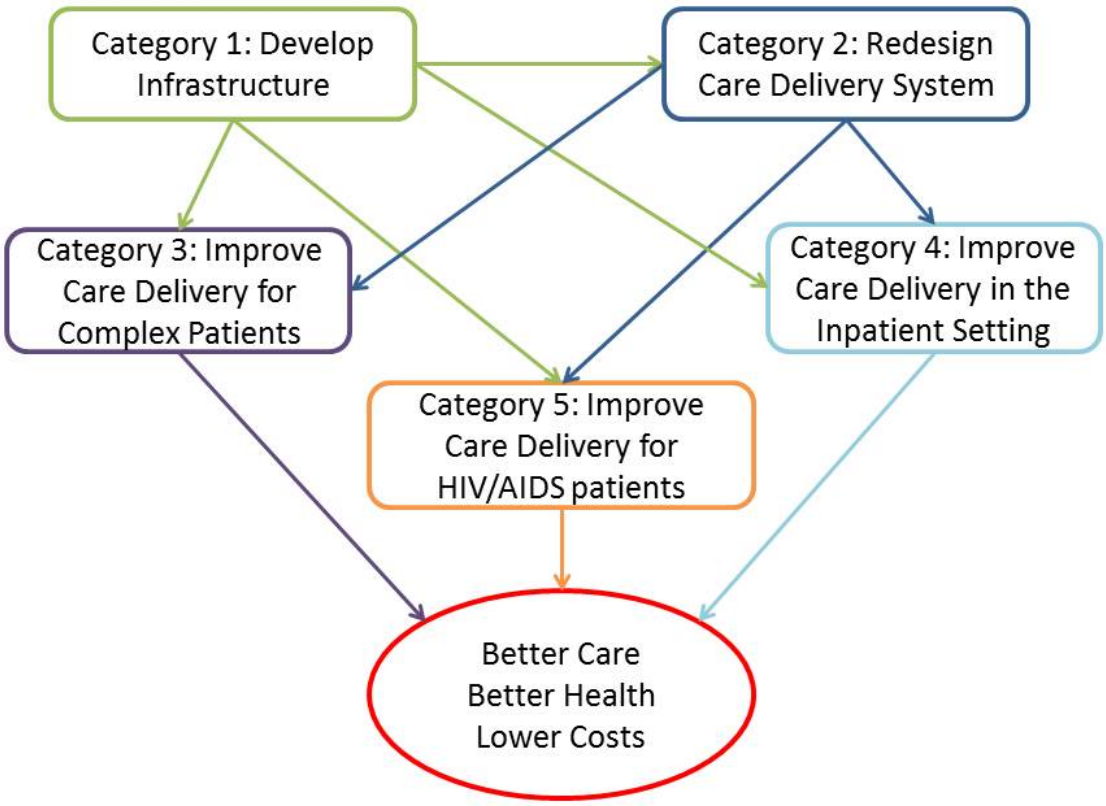
December 7, 2013

DSRIP PROGRAM EVALUATION: OVERVIEW

The California Department of Health Care Services (DHCS) is pleased to submit the enclosed DSRIP External Program Evaluation Plan, prepared by the UCLA Center for Health Policy Research (UCLA). Under California's §1115 "Bridge to Reform" Medicaid Waiver, DSRIP is in its third year of implementation. DSRIP aims to improve quality of care through infrastructure development (Category 1), innovations and redesign of care delivery system (Category 2), enhanced population-focused experiences of care (Category 3), and enhanced urgent care delivery (Category 4). DSRIP also aims to enhance infrastructure, redesign care delivery system, and enhance care experiences for individuals with HIV/AIDS (Categories 5a and 5b). DSRIP facilities represent 21 Designated Public Hospitals (DPH) in 17 California counties. Each hospital has selected targeted areas of improvement from a list of acceptable projects in each category. Ten of the 21 hospitals have implemented Category 5 projects. Category 1-2 projects are to be implemented first to set the foundations for implementation of Categories 3-4. Participating DPHs report their progress in semi-annual and annual reports, which are used to determine their performance and as the basis for disbursement of incentives. The California Health Care Safety Net Institute (SNI) also provides an annual aggregate report.

UCLA has developed the following evaluation plan for DSRIP in California. The DSRIP evaluation plan will assess whether the projects implemented during DSRIP met the requirements of the program and the intended milestones. In addition, the evaluation plan will examine whether the projects resulted in an impact beyond the program requirements, including improved experiences of care (better care), population health (better health), and fiscal impact (lower costs/cost avoidance) for the program overall that is commensurate with the $6.671 billion investment made in DSRIP (Exhibit 1). These program outcomes are expected to be achieved through implementation of changes in infrastructure, system redesign, and delivery of care to patients with complex conditions, those in the inpatient care setting, and those with HIV/AIDS.

Exhibit 1. Conceptual Framework for UCLA's Evaluation of the DSRIP Program



DSRIP categories are interconnected in order to lead to the overall goal of the DSRIP in helping DPHs to become more integrated, coordinated systems of care. Attachment Q of the Waiver's Special Terms and Conditions explain this connection[1]:

- "While they are highly related projects, each improvement project is distinct;
- All of the proposed improvement projects are oriented to create more integrated, coordinated delivery systems; and
- Being an integrated delivery system allows DPHs to more fully enact improved patient experience, population health and cost control."

Accordingly, the evaluation plan proposed that infrastructure development will increase the likelihood of achieving integrated, coordinated delivery systems by providing the resources for redesign of care delivery and delivery of services in the inpatient setting and to complex or HIV/AIDS populations. Similarly, system redesign will increase the likelihood of improved care delivery in the inpatient setting and to complex or HIV/AIDS populations. Improved care

[1] Special Terms and Conditions for California's 1115 Medicaid Waiver, "Bridge to Reform," Attachment Q, page 134, http://www.dhcs.ca.gov/provgovpart/Documents/California%20STCs.pdf

delivery in turn will increase the likelihood of achieving better outcomes. The conceptual framework highlights the anticipated relationships of DSRIP interventions and is used to guide the analyses in this proposal. However, the types of projects implemented by participating DPHs are diverse and a direct link between the interventions and the Triple Aim cannot be established in all cases.

UCLA will use the DPH documents including DSRIP plans, semi-annual, and annual DPH reports as well as the aggregate SNI annual reports to respond to most evaluation questions. UCLA will use the DPH reports of the results of Clinician and Group Consumer Assessment of Health Plans Survey (CG-CAHPS) data specifically to respond to Category 3 evaluation questions. Structured key informant interviews will be used to gather additional data to answer the evaluation question, particularly when DPH reports do not sufficiently illustrate lessons learned and barriers or challenges to implementation of the program overall or for specific projects. In these interviews UCLA will also gather information on the extent to which DPHs were planning on implementing the Category 1-5 interventions in the absence of DSRIP funding and the role DSRIP plays in implementation of these interventions. This information will assist UCLA in determining concurrent programs and trend that may confound the findings. Key informant interviews will be conducted by phone and with individuals most knowledgeable about the specific areas of interest such as medical directors and administrators of the DSRIP projects and or quality improvement initiatives. It is anticipated that some medical directors also provide care directly and the interviews will gather information from their perspectives on the impact of Category 1-5 interventions. Additional interviews (1-2 per DPH) may be conducted with physician champions or other care providers when necessary to obtain the provider perspective. The interviews will be guided by a questionnaire with both open-ended and categorical close-ended questions for a systematic set of responses from all interviewees. UCLA will assess the feasibility of conducting a survey of other comparable hospitals in California (these hospitals are described later in this document). If feasible, UCLA will assess whether these hospitals have conducted interventions similar to DSRIP and if so, for how long. For Category 5, UCLA will supplement available data in the DPH reports with analyses of enrollment and claims data for the HIV/AIDS populations enrolled in the Low Income Health Program (LIHP), when necessary. UCLA is the LIHP evaluator and receives these data from all the counties participating in LIHP. UCLA will collaborate with DHCS to secure the appropriate human subjects protections and waivers to use the LIHP data for evaluating the DSRIP program.

When appropriate and to the degree possible, external data will be utilized, such as Office of Statewide Health Planning and Development (OSHPD) or other existing data to describe the context in which DPHs deliver care in California and identify benchmarks for various DSRIP indicators and measures. While lagged reporting often results in OSHPD utilization and financial data being outdated by 12-18 months, UCLA will explore the use of the data sets to make contextual comparisons and identify trends that complement the evaluation.

The Evaluation Plan includes assessment of the interim and overall progress of DSRIP. The interim evaluation report will be based on DPH reports and aggregate SNI reports as well as key informant interviews and analysis of external data including OSHPD.

The interim evaluation report will highlight infrastructure development and care delivery process intervention in category 1 and 2 projects, as well as implementation challenges reported in interviews of progress reports. The interim report will also provide the findings of the analysis of OSHPD data for California hospitals in general as well as the comparisons of characteristics of DPHs vs. other California hospitals, including non-designated public hospitals with similar characteristics and patient mix when possible. In addition, existing data on implementation of category 3 and 4 interventions will also be included if available.

DSRIP PROGRAM EVALUATION: DESIGN NARRATIVE

In the below analyses, UCLA will examine whether DPHs met DSRIP requirements, and, where appropriate, the degree of impact of DSRIP projects in achieving the Triple Aim of better care, better health, and lower costs. An evaluation of the impact of different types of projects on outcomes will also be conducted when possible. An assessment of impact of projects that are not implemented universally will be completed among DPHs that implemented those projects. A pre-post evaluation design and qualitative analyses will be used to address the majority of the evaluation questions, due to lack of data from an appropriate control group and the nature of the interventions in DSRIP. Specifically, interventions in Categories 1-2 include establishing infrastructure and new models of care delivery. The impact of these interventions requires qualitative analysis of the success of DPHs in implementing these interventions. Similarly, Category 3 interventions focus on gathering specific measures of patient outcomes and reporting of those data. Thus, the success of Category 3 activities also requires assessing whether these data were collected based on pre-post comparisons.

Quantitative analysis of DSRIP interventions is possible under certain circumstances, but significant barriers to those analyses exist. The most rigorous quantitative analyses of the impact of DSRIP interventions require disaggregated patient level data and difference-in-difference (D-in-D) analyses. There are three major reasons why a D-in-D approach to this evaluation will be a challenge to implement. (1) D-in-D requires a comparable group of hospitals in the state of California or similar areas which does not currently exist for DSRIP. All Designated Public Hospitals (DPH) in California are participating in DSRIP. None of the private academic or community hospitals in the state have similar payer mix or patient population comparable to DPHs. Payer mix plays a crucial role in how hospitals are organized and deliver care. DPHs include primary and specialty care clinics which are structured as systems whereas; most private hospitals rely primarily on external contracts for primary and sometimes specialty care. Given the variation in Medicaid, uninsured, and private insurance caseload between DPHs and non-DPH hospitals, even when controlling for academic status, rural/urban location,

surrounding demographics, and capacity, a truly comparable sample of hospitals that are representative of the DPHs involved in DSRIP is not available. Also, hospitals in other states cannot serve as appropriate controls for California DPHs because additional differences in ownership, regulations, state law, Medicaid reimbursement methods and waivers, Medicaid enrollee and uninsured population characteristics, and volume of services exist nationally.

(2) Even if hospitals with a similar payer mix, volume of services, and patient populations are identified, it is unlikely to identify control groups that have not implemented any interventions that are similar to those pursued under DSRIP. A clear understanding of the efforts undertaken in these potential comparison hospitals is required to understand if any differences or lack of differences between DPHs and the control hospitals can be independently attributed to DSRIP. Collection of data from control hospitals requires a significant additional level of effort, including site visits, extensive data collection of billing information, patient registries, surveys, and other data sources.

(3) Even if the above barriers are overcome, disaggregated patient level data is required to conduct accurate D-in-D analyses. Such data are not required from DPHs and gathering such data from comparable hospitals will require additional time and resources that extend beyond the current scope of the DSRIP evaluation.

In the absence of ideal conditions to conduct rigorous D-in-D analyses, UCLA will conduct extensive qualitative analyses as well as a number of aggregate D-in-D analyses as described later in this document. When appropriate and possible, UCLA will compare the achievements of each DPH to other hospitals, to the higher performing peers in DSRIP, to a baseline period, or to absolute targets as specified in Attachment Q. These comparisons will include payer mix, volume, and other hospital characteristics. To provide additional context as to the performance of non-DPH hospitals in California, the evaluation team will examine the peer-reviewed literature, policy papers (e.g., generated by academia, foundations, the California Hospital Association), and opinion from experts. This information will help to characterize the independent impact of the DSRIP Program. The performance of non-designated public hospitals will be examined where comparisons are relevant.

Additionally, the qualitative analysis will go beyond a simple quantification of milestones achieved. Instead it will look at project results as part of a bigger healthcare picture, and aim to determine which projects were most valuable in striving to achieve the triple aim.

For example, the evaluation will examine the connection between categories to assess value beyond program requirements to achieve better care, better health and lower costs is examining the impact of establishing disease registries. UCLA will identify the number of DPHs that established new disease registries (e.g., 14 out of 21) and examine the progress in establishment of these registries (e.g. number of milestones accomplished), their functionality (e.g. type of milestones accomplished), and their utility (e.g. the impact on improving care processes) among all DPHs. Evidence of the impact of newly developed and functional registries

on delivery of care to patients (e.g., incorporation of disease registries in improving diabetes care management and outcomes) and improvements in patient health overall (e.g., improved satisfaction) and reductions in costs (e.g., reduced readmissions) will be further identified. In addition, the challenges to implementation of registries or use of registries in care delivery among DPHs and the impact of these challenges in achieving the Triple Aim will be identified.

UCLA shall provide evaluation instruments, interview content and subjects as well as a detailed timeline for CMS and DHCS to review to ensure evaluation goals are met to satisfaction of the state and CMS.

The following outlines the data and analyses to be used to respond to Category 1-5 program evaluation questions. The responses incorporate the identified relationship among the categories, where appropriate. Category 5 questions include the impact of transition of HIV/AIDS population into LIHP.

DSRIP PROGRAM EVALUATION: QUESTIONS

Categories 1 and 2

Q1. How did the infrastructure and system redesign in Categories 1 and 2 result in more integrated, coordinated delivery systems? Was there additional value of the infrastructure and system redesign in Categories 1 and 2 that influenced improved health, better outcomes, and increased efficiency?

The evaluation of Categories 1 and 2 will include DPH reports, SNI reports, and key informant interviews to conduct the following analyses:

1. Summarize the evidence of achievements of DPHs in Categories 1-2 by examining the number and type of different projects implemented by DPHs and the level of success in developing the infrastructure and improving care delivery processes (better care).
2. Assess the potential of these achievements in promoting the ability of DPHs to provide better care, better health, and lower costs (increased efficiency), by examining the available literature on the anticipated outcomes of the projects selected by DPHs.
3. Assess the association of Category 1-2 projects with patient experiences (better health), by comparing the trends from Category 3 data with progress in implementation of Categories 1-2 projects to assess whether achievements in Categories 1-2 projects coincide with better care during years 7-10 of the demonstration period when Category 3-4 projects are implemented. For example, Category 1 interventions designed to enhance performance improvement and reporting capacity may include Category II- 9- train providers on process improvement programs and implement. When a DPH implements these interventions, we will examine the implementation process, timeline, and success in implementation in relation to changes in Category III-B.3.e.i or Category III-D.2.e.ii measures such as rates of patients who had their diabetes under control or received flu shots. Due to lack of granular

data, we cannot determine if such changes were unequivocally related to the observed Category III outcomes. We will ask for DPH assessments of the consequences of each intervention on prevention of Category III conditions that are targeted.

4. Assess the funding levels for each intervention and the related milestones.
5. Assess and report the obstacles reported across DPHs on meeting performance improvement targets.

Category 3

Q2. How will patients benefit from the activities in Category 3 including the patient care experience data collection?

The evaluation of Category 3 projects will use the DPH reports, and key informant interviews to conduct the following analyses:

1. Compare the trends in Category 3 measures. Assess if changes in patient experiences and care during the demonstration period occurred by examining the change in mean values for specific Category 3 measures such as proportion of patients reporting getting timely care, rates of uncontrolled diabetes, or rates of mammography screening for breast cancer.
2. Compare the trends in Category 3 measures with available data, if available. UCLA will search for external data on trends in Category 3 measures for other comparable California hospitals when available to provide a context for the progress of DPHs in these Category 3 measures. Comparable hospitals are described in Q3 below.
3. Assess whether and how Category 3 projects improved the ability of DPHs to improve patient experiences through examination of the DPH reports and key informant interviews to understand if participating DPHs incorporated the findings of CG-CAHPS surveys and other measures of health and service use in process of care improvement activities. UCLA will also assess how these data were incorporated by DPHs.
   Assess and report the obstacles reported across DPHs on meeting performance improvement targets.

Category 4

Q3. Were Triple Aim outcomes (better health, better care, reduced cost) achieved in Category 4?

Category 4 will be the predominant focus of the overall DSRIP Program Evaluation Plan. The evaluation of Category 4 includes the DPH reports, SNI reports, key informant interviews, and potential surveys of other hospitals to conduct the following analyses:

1. Summarize the results of Category 4 outcomes and evaluate the trends in these measures during the program to assess if changes in Category 4 outcomes occurred.

2. Assess the association of Category 1-2 projects with Category 4 outcomes (better health), by comparing the trends from DPH reports with progress in implementation of Categories 1-2 projects (e.g. applying a process improvement methodology such as Lean, or implementing programs to smooth transitions from inpatient to outpatient care), when possible. Assess whether achievements in Categories 1-2 projects coincide with better health during years 7-10 of the demonstration period. For example, Category 1 interventions designed to enhance performance improvement and reporting capacity may include Category I-12: training, patient experience data gathering; Category II- 9- train providers on process improvement programs and implement, 12—medication management across the system, 14- real-time hospital acquired infection at risk notification systems. When a DPH implements one of these interventions, we will examine the implementation process, timeline, and success in implementation in relation to changes in Category 4 outcomes. Due to lack of granular data, we cannot determine if such changes were unequivocally related to the observed Category 4 outcomes. We will ask for DPH assessments of the consequences of each intervention on prevention of Category 4 conditions that are targeted.
3. Estimate the change in costs associated with Category 4 projects (lower costs). We will use the existing data or literature to identify the treatment costs of Category 4 conditions to characterize potential cost savings through system improvement.

   Identify external sources of data and compare DPHs trends in Category 4 outcomes with other hospitals in California (better care, lower costs). For the two common interventions in this category, severe sepsis detection and management and central line blood stream infections (CLABSI), UCLA will use California hospital financial and discharge data from OSHPD to identify California hospitals that could serve as comparison groups to DPHs. Hospitals will be assessed based on their payer mix, case mix, service mix, average length of stay, and type. Once the best comparison hospitals are identified UCLA will search for alternative data sources that include the same Category 4 outcome measures prior and during DSRIP implementation periods. For example, to assess whether the decline in rates of central line blood stream infections (CLABSI) in DPHs can be attributed to the intervention during DSRIP, UCLA will conduct a difference-in-difference analysis and compare the change in the aggregate rates of CLABSI in DPHs in the period before and during DSRIP with the aggregate rates at comparison hospitals in the same time periods. The data source for such a comparison will be obtained from the OSHPD discharge public use files. A significant disadvantage of OSHPD data is the lag in their release. However, it is the most comprehensive source of such data for California hospitals. For the two elective Category 4 projects, UCLA can use the same methodology as above if all or nearly all DPHs have implemented a given intervention. However, if only some DPHs have implemented an elective project, UCLA will compare those DPHs with the remaining hospitals who are not implementing the given project. If feasible, UCLA will prepare a short survey to be

administered to the comparison hospitals to assess whether and when they may have implemented any of the DSRIP interventions. This information will clarify whether the results of the changes in Category 4 measures can be attributed to DSRIP interventions. However, these findings are subject to the caveats of lack of appropriate comparison hospitals as discussed previously.

4. Assess and report the obstacles reported across DPHs on meeting performance improvement targets.

Category 5

Q4. Above and beyond the DSRIP milestones and requirements, do the Category 5 projects lead to smoother transitions for patients transitioning into LIHP, and in what ways?

DPH plans and reports, SNI reports, available claims data, and key informant interviews will be used to conduct the following analyses:

1. Examine DPH plans for transition of HIV/AIDS populations, by analyzing Category 5a plans for participating DPHs to examine the reasons for choice of specific projects and the intended role of each project in better transition of HIV/AIDS populations.
2. Examine the progress of participating DPHs towards successful transitioning of HIV/AIDS populations into LIHP based on analysis of encounter and claims data submitted by the LIHPs and interviews with key informants about the change in HIV/AIDS patient experience over time.

Q5. Did the projects lead to improved health outcomes for HIV positive LIHP enrollees? What impact has the provision of preventive care and screening services had on health outcomes for HIV positive LIHP enrollees?

DPH plans and reports, SNI reports, LIHP data, and key informant interviews will be used to conduct the following analyses:

1. Summarize the results of Category 5b group 1 outcomes and evaluate the trends (when possible) in these measures to assess if changes in Category 5b group 1 outcomes occurred.
2. Assess the impact of health outcomes of Category 5a projects on Category 5b group 1 outcomes, by examining the available literature on the anticipated outcomes of the Category 5a projects selected by DPHs. UCLA will analyze the potential impact of Category 5a projects aimed at improving infrastructure and redesign of the delivery system on Category 5b group 1 outcomes.
3. Assess the association of Category 5a projects with Category 5b outcomes, by comparing the trends (when possible) from Category 5b group 1 measures with progress in implantation of Category 5a projects to assess whether achievements in Category 5a projects coincide with better health during the demonstration period.

4. Compare selected Category 5b measures in participating DPHs with non-participating DPHs or other hospitals in the LIHP provider networks, when possible. UCLA will identify all hospitals that provide services in LIHP to the HIV/AIDS populations and assess their payer mix, case mix, service mix, average length of stay, and type in order to determine if they can be included in a comparison group. If available, UCLA will explore the LIHP health assessment data as a measure of severity. Assuming UCLA identifies such hospitals in LIHP data, UCLA will compare the Category 5b measures that can be identified in claims data between participating DPH and comparison hospitals. The comparisons will be dependent on the implementation timeline for transition of HIV/AIDS populations into LIHP. In addition, data for the period prior to transition of HIV/AIDS populations to LIHP are not available to UCLA.

Q6. How has the implementation of Category 5a projects improved coordination of services for HIV patients?

DPH plans and reports, SNI reports, LIHP data, and key informant interviews will be used to conduct the following analyses:

1. Summarize the results of Category 5b groups 2 and 3 outcomes and medical case management measures and evaluate the trends (when possible) in these measures to assess if changes in these Category 5b outcomes occurred. Improvements in these Category 5b measures will be assumed to be indicators of better care coordination.
2. Assess the impact of health outcomes of Category 5a projects on Category 5b groups 2 and 3 outcomes and medical case management measures, by examining the available literature on the anticipated outcomes of the Category 5a projects selected by DPHs. UCLA will analyze the potential impact of Category 5a projects aimed at improving infrastructure and redesign of the delivery system on these Category 5b outcomes.
3. Assess the association of Category 5a projects with Category 5b groups 2 and 3 outcomes and medical case management measures, by comparing the trends (when possible) from these Category 5b measures with progress in implantation of Category 5a projects to assess whether achievements in Category 5a projects coincide with receipt of necessary services and improved care during the demonstration period.

Q7. How has the implementation of Category 5a projects improved HIV patient retention and compliance?

UCLA will use the DPH plans and reports, SNI reports, LIHP data, and key informant interviews to conduct the following analyses:

1. Examine the potential of Category 5a projects with HIV/AIDS patients' compliance and retention. UCLA will identify and summarize Category 5a projects and assess their potential impact on patient retention and using the available literature.
2. Examine availability of CG-CAHPS data on HIV/AIDS patients' satisfaction with care with participating DPHs. Provide trends in patient satisfaction reports if available.
3. Examine the association of Category 5a projects with HIV/AIDS patients' compliance and retention, by analyzing rates of HIV/AIDS patients who remain enrolled in LIHP, excluding those patients who dis-enroll due to eligibility for other public programs, and assess whether these rates change during the demonstration period. Assessment will also be conducted of the rates of regular visits, regular prescription refills, and appropriate Category 5b group1 measures such as CD4 screening as proxy measures for level of compliance. An analysis of the association between rates of retention and compliance with progress of Category 5a projects will also be conducted.

Q8. What trends are reported across DPHs on the obstacles to meeting performance improvement targets?

UCLA will use the DPH reports, SNI reports, and key informant interviews to conduct the following analyses:

1. Determine the major challenges of implementing Category 5a and 5b projects and meeting performance targets, including timing of implementation, changes in implementation process, and quality improvement activities.
2. Identify how these obstacles were met.
3. Discuss lessons learned in delivery of care to HIV/AIDS patients, when applicable.

<u>Overall DSRIP Program Evaluation Questions:</u>

Q9. What were the predominant types of infrastructure and system redesign projects selected by DPHs? Why were these projects chosen?

DPH plans and reports, SNI reports, and key informant interviews will be used to conduct the following analyses:

1. Analyze DPH DSRIP plans and reports to identify the most commonly chosen projects and understand the reasons for such choices.
2. Discuss implications for overall impact of DSRIP.

Q10. Did infrastructure and system redesign projects improve the ability of DPHs to enhance care delivery in the inpatient setting and for complex populations? How were these improvements accomplished?

DPH plans and reports, SNI reports, and key informant interviews will be used to conduct the following analyses:

1. Analyze the process of implementation of Category 1-2 projects and how achievements in metrics were accomplished.
2. Assess the implication of Category 1 and 2 projects on delivery of care in general, for the inpatient setting, and for complex populations.

Q11. Did any projects have a greater impact on improving health, care delivery, or efficiency?

UCLA will use the DPH reports and key informant interviews to conduct the following analyses:

1. Compare the relative role of Category 1-4 projects on outcomes.
2. Provide an overall assessment of improvements in care delivery due to interventions.

Q12. What were the major challenges experienced by DPHs in implementing Categories 1-4 projects? What was the impact of these challenges on program sustainability?

DPH reports, SNI reports, and key informant interviews will be used to conduct the following analyses:

1. Determine the major challenges of implementing Category 1-4 projects.
2. Discuss implications of these challenges for sustainability of these efforts.

Q13. What were the lessons learned and innovations by DPHs in implementation of projects in Categories 1-4? How were implementation challenges addressed?

UCLA will use the DPH reports, SNI reports, and key informant interviews to conduct the following analyses:

1. Identify how implementation challenges were met.
2. Examine the lessons learned in implementing Category 1-4 projects.

Staffing:

Nadereh Pourat, PhD, is professor and director of research at UCLA and will serve as principal investigator. She will oversee all aspects of the project. She served as Co-PI on the LIHP, HCCI, and DMPP Evaluations and currently leads the evaluation of the Coordinated Care Management Pilots (CCM) for the Systems of Care Division (Ref: Louis Rico). Ph: 310-794-2201; Email: Pourat@ucla.edu.

Gerald Kominski, PhD, is professor and director of the UCLA Center for Health Policy Research (UCLA) and will serve as co-principal investigator. He will provide overall guidance to the project. He is the PI of the Low Income Health Program (LIHP) and Health Care Coverage Initiative (HCCI) Evaluations (Ref: Jalynne Callori, LIHP), the Disease Management Pilot Project

(DMPP) Evaluation, and the Pediatric Palliative Care (PPC) Waiver Evaluation (Ref: Louis Rico, Systems of Care). Ph: 310-794-2681; Email: kominski@ucla.edu

Jack Needleman, PhD, is professor at UCLA Fielding School of Public Health and a faculty associate of the Center. He will serve as investigator and will focus on evaluation of Category 4 projects. Dr. Needleman is well-known for his work on the impact of nurse ratios on quality of care and preventable mortality, and is a member of the Institute of Medicine of the National Academy of Sciences.

Arleen Leibowitz, PhD, is professor emeritus and leads the policy core of the UCLA Center for HIV Identification, Prevention and Treatment Services. She will serve as investigator and will focus primarily on evaluation of Category 5 projects.

Dylan Roby, PhD, is assistant professor and director of health economics and evaluation research at UCLA. He will serve as an investigator and will focus on Category 1 and 2 projects. Dr. Roby is an expert in guiding evaluation activities for the HCCI, LIHP, and DMPP programs, and is leading evaluations for the Beach Cities Health District and the California Children's Services Pilots (Ref: Louis Rico).

Ying-Ying Meng, DrPH, is senior research scientist at the Center. She will serve as investigator and will focus on Category 2 and 3 projects. She has served on HCCI and LIHP evaluations.

Ana Martinez, MPH, is research associate at the Center. She will serve as project manager, has extensive experience with data, managing multiple site visits and data collection activities, and has worked on two waiver evaluation projects (LIHP and CCS).

Max Hadler, MPH, is research associate at the Center. He will participate in project activities and will be primarily responsible for key informant interviews. He led the data collection and analysis for the delivery system redesign components of the LIHP evaluation.

Adrian Manalang, MPH, is director of finance at the Center. He will be responsible for the financial and human resource management of the project.

Byron Trotter, is director of web information and technology at the Center. He will be responsible for management of computer network infrastructure used by the project personnel and for data transfers related to the evaluation.

Gwen Driscoll, is director of communications at the Center. She will be responsible for all communication needs of the project including web dissemination of the findings.

Timeline (January 1, 2014 to February 29, 2016):

1. September 1-30, 2013 – DHCS and UCLA will collaborate on the creation of an evaluation design document for CMS, incorporating initial feedback based on original proposal

2. October 1, 2013 – DHCS will submit evaluation design document to CMS for review

3. October 1, 2013-December 31, 2013 – DHCS will process interagency agreement with UCLA to conduct DSRIP evaluation

4. October 1, 2013-December 31, 2013 – UCLA will pursue California Committee to the Protection of Human Subjects and UCLA Institutional Review Board approval to conduct evaluation and research activities

5. January 1, 2014 – -Effective date of interagency agreement between UCLA and DHCS, official evaluation activities begin

6. January 1-March 31, 2014 – DHCS will assist UCLA in obtaining materials necessary for the evaluation from the UC Davis Institute for Population Health Improvement

7. January 1-June 30, 2014 – UCLA will conduct data analyses of OSHPD data to understand trends and establish the context in safety net populations over time in the DSRIP hospitals and other hospitals in California with a significant number of uninsured patients.

8. January 1-March 31, 2014 – UCLA will identify and recruit subjects from DSRIP hospitals to conduct qualitative interviews to understand DSRIP implementation

9. January 1-June 30, 2014 – UCLA will obtain, analyze, and categorize previous DPH reports

10. June 30, 2014 – UCLA will develop an internal data entry tool for use in intake and analysis of future DPH reports

11. March 1–June 30, 2014 – UCLA conducts first round of qualitative interviews

12. January 1-August 31, 2014 - Assess Progress of Category 1 and 2 programs based on existing DPH reports, interviews, and contextual OSHPD analysis

13. June 30-September 30, 2014 – Compile and Complete Interim Evaluation Report, including all available data on all aspects of projects to date.

14. October 1, 2014 – September 30, 2015 – Assess Progress of Category 3, 4 and 5 programs based one existing DPH reports, interviews, contextual OSHPD analysis, and LIHP data.

15. December 1, 2014-June 30, 2015 – Second round of qualitative interviews

16 June 30, 2015 - Final Reports submitted by DPHs to DHCS

17. March 1-August 30, 2015 – Complete Draft of Final Evaluation Report for DHCS

18. September 1-September 30, 2015 – Review DHCS feedback on draft Final Evaluation Report

19. October 1-October 31, 2015- Compile and Complete Final Evaluation Report for CMS

20. December 1, 2015-February 29, 2016 – Review feedback from CMS and revise Final Evaluation Report for submission

Gantt Chart of DSRIP Evaluation Tasks based upon above Timeline