DISTRICT HOSPITAL LEADERSHIP FORUM

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Neal D. Kohatsu, MD, MPH, Medical Director
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Dear Dr. Kohatsu:

California's district hospitals appreciate the leadership of the Department of Health Care Services (DHCS) and willingness to collaborate with the District Hospital Leadership Forum (DHLF) relative to the Delivery System Reform Incentive Program (DSRIP). This partnership has been effective as we have worked together to ensure the DSRIP for district/municipal hospitals is successful for all parties, especially the patients who receive care in these hospitals.

As you know, district/municipal hospitals have expressed some concerns about operationalizing the DSRIP in recent meetings. While we recognize some of these will have to be addressed with the Centers for Medicare and Medicaid Services (CMS), we include them here in an effort to ensure this program is successful for all stakeholders.

Since the Forum and member hospitals began meeting with DHCS almost a year ago, the elapsed time has contributed to some of our concerns. We recognize the delays in obtaining CMS feedback and ultimately approval, is the primary reason for the delays, but the challenges remain.

Specifically, district/municipal hospitals began work on patient safety projects when AB 1467 was enacted. At that time, specified hospitals were not in the top quartile of patient safety projects, however due to the advances made over the last year, they now are. Being able to use the period that ended June 30, 2012 as the baseline period will be imperative for many district/municipal hospitals. A more current baseline would put them in the top quartile and we understand CMS's concerns relative to "maintenance" as an appropriate milestone in the first year (more on this below). Somewhat similarly, other district/municipal hospitals would need to use the period ending June 30, 2011 as their baseline period based on work done to date. The baseline period identified in Attachment Q seems unclear on Category 4, but we urge flexibility to allow hospitals that have already implemented patient safety efforts not be penalized.

As an overall comment, non-designated public hospitals (NDPHs) are using as the framework for the DSRIP, a program that was designed primarily by and for designated public hospitals (DPHs) and these hospitals are very different than district/municipal hospitals. As such, additional concerns stem from the differences among NDPHs and DPHs and are outlined below.

As we have discussed, some small district/municipal hospitals do not have the patient volume associated with designated public hospitals. The differences among DPHs and NDPHs must be recognized and small patient volumes is one difference that is key. In addition to including long-term care patients in the patient population, it is important that maintenance (and putting in place tools, etc. to work on any decline of the current levels) must be an appropriate milestone for district/municipal hospitals.

While many small district hospitals facing the challenges of not only one, but two, category 4 projects, can identify projects in category 3. Unfortunately, this isn't a one-size-fits-all possible substitution as there are some small hospitals that cannot identify projects in either category. Again, flexibility will be imperative for both DHCS and affected hospitals to ensure the NDPH DSRIP is successful.

Finally, we are concerned that due to the delays of the last few months, hospitals may be forced to react quickly to edit and revise plans. There must be appropriate timelines to ensure adequate response time by hospitals. Many of these hospitals already are very resource-challenged and are relying upon staff with numerous other responsibilities but with an interest in the DSRIP to ensure plans and subsequent implementation and reporting are completed. And unlike DPHs, there isn't the infrastructure, such as the Safety Net Institute in place to provide support.

Also regarding timing, we are concerned about how logistically to implement a DSRIP plan in this current fiscal year. As you know, a key discussion relative to this transition is cash flow. Since DSRIP payments are tied to implementing the plan and completing reports regarding progress, member hospitals are unclear as to how that can work as we are near the end of the current fiscal year. It bears repeating, that NDPHs are very resource challenged so we urge you to take this into account when determining the timing of the program.

We look forward to continuing to work with you and appreciate the opportunity to identify the current challenges district/municipal hospitals have identified relative to implementing a successful DSRIP program for all NDPHs.

Sincerely,

Sherreta Lane

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