Health and Human Services Policy Committee
Wednesday, November 30, 2011 • 2:00 – 4:00 p.m.
CSAC 117th Annual Meeting • San Francisco County
Hilton San Francisco Union Square
333 O'Farrell Street, San Francisco, CA 94102

Supervisor Kniss, Santa Clara County, Chair
Supervisor Woodrow, Alpine County, Vice Chair

This policy committee meeting is an in-person meeting only and is being held as part of the CSAC 2011 Annual Meeting.

2:00 p.m.	**I.**	**Welcome and Introductions** *Supervisor Liz Kniss, Santa Clara County* *Supervisor Mike McGowan, Yolo County, CSAC 1st Vice President*
2:05 – 2:40	**II.**	**Governor Brown's California Health and Human Services Agency** *Diana S. Dooley, Secretary, California Health and Human Services Agency*
2:40 – 3:20	**III.**	**Health and Human Services: Integral Partners in AB 109 Success** *Susan Mauriello, County Administrative Officer, Santa Cruz County* *Marta McKenzie, RD, MPH, Director, Health and Human Services Agency, Shasta County* *Jo Robinson, MFT, Director, Community Behavioral Health Services, San Francisco City and County*
3:20 – 3:50	**IV.**	**Innovations in Health Care Delivery: Just in Time for 2014** *Wendy Jameson, Executive Director, Safety Net Institute*
3:50 – 4:00	**V.**	**The Campaign For Modern Medicines** *Kathy Miller, Advisor, Global Public Policy, Eli Lilly and Company*
4:00 p.m.	**VI.**	**Adjourn** *Supervisor Liz Kniss, Santa Clara County*

ATTACHMENTS

Attachment One..... CSAC Memo: Governor Brown's California Health and Human Services Agency – Introducing Secretary Diana S. Dooley

Secretary Diana S. Dooley Biography

"Jerry Brown taps trusted former aide for key cabinet position" Los Angeles Times, March 3, 2011.

Attachment Two.....CSAC Memo: Health and Human Services: Integral Partners in AB 109 Success

Excerpt: Santa Cruz County Draft Community Corrections Plan

Excerpt: Shasta County Draft Community Corrections Plan

Excerpt: San Francisco County Draft Community Corrections Plan

Attachment Three.....CSAC Memo: Innovations in Health Care Delivery: Just in Time for 2014

CAPH Policy Brief: "The Delivery System Reform Incentive Program: Transforming Care Across Public Hospital Systems"

Attachment Four.....CSAC Memo: The Campaign for Modern Medicines

CMM: What is at stake with Congressional reauthorization of the Prescription Drug User Fee Act (PDUFA)?

CMM: The Campaign for Modern Medicines' Initiative to Protect Medicare

Attachment One

CSAC Memo: Governor Brown's California Health and Human Services Agency – Introducing Secretary Diana S. Dooley

Secretary Diana S. Dooley Biography

"Jerry Brown taps trusted former aide for key cabinet position" – Los Angeles Times, March 3, 2011

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November 18, 2011

To: CSAC Health and Human Services Policy Committee

From: Kelly Brooks-Lindsey, CSAC Legislative Representative
Farrah McDaid Ting, Senior Legislative Analyst

Re: Governor Brown's California Health and Human Services Agency – Introducing Secretary Diana S. Dooley

Background:
Governor Brown didn't have to search far to find his perfect candidate to head the state's immense health and human services system. Last December, Governor Brown appointed Diana S. Dooley as Secretary of the California Health and Human Services Agency.

Secretary Dooley had served as Brown's legislative secretary during his first stint as Governor. In the intervening years, she graduated from law school, worked as an assistant fire captain in Visalia, founded her own public relations firm, and led the California Children's Hospital Association.

Secretary Dooley has taken the helm of the California Health and Human Services Agency (HHSA) during a difficult time as local, state, and federal fiscal concerns mount. The Agency is the state's second largest, with an annual budget (all funds) of $83.5 billion.

CSAC has invited Secretary Dooley to share her vision for the state's health and human services programs and policy, especially in light of 2011 Realignment and the Affordable Care Act. Counties are also keenly interested in Secretary Dooley's ideas for forming effective partnerships between state and local government.

Speakers:

- **Diana S. Dooley,** Secretary, California Health and Human Services Agency

More Information:
Visit the California Health and Human Services Agency's Web site at www.chhs.ca.gov.

Secretary Diana S. Dooley
Health and Human Services Agency

Secretary Diana Dooley was appointed to lead the California Health and Human Services Agency by Governor Jerry Brown.

As CHHS Secretary, Dooley will serve as a voting, ex officio member of the newly created California Health Benefit Exchange Board. She will also serve as a member or ex officio member of numerous other boards and commissions: First 5 (California Children and Families) Commission, Cal eConnect (Health Information Exchange) Board, Olmstead Advisory Committee, Alzheimer's Disease and Related Disorders Advisory Committee, Child Welfare Council, Managed Risk Medical Insurance Board, State Council on Developmental Disabilities, Technical Services Board, County Medical Services Program Governing Board, State Mental Health Planning Council, California Workforce Investment Board, San Joaquin Valley Partnership, and the Strategic Growth Council.

Prior to leading CHHS, Ms. Dooley was President and Chief Executive Officer of the California Children's Hospital Association, which advocates for children's health on behalf of the eight, non-profit regional children's hospitals in California. These hospitals provide nearly 40 percent of all inpatient care for children in the state.

Dooley began her professional career as an analyst at the State Personnel Board. In 1975, she was appointed to the staff of Governor Jerry Brown for whom she served as Legislative Director and Special Assistant until the end of his term in 1983. Before becoming an attorney in 1995, she owned a successful public relations and advertising agency. Dooley left her private law practice in December, 2000 to accept the appointment as General Counsel and Vice President at Children's Hospital Central California near Fresno where she established an in-house legal services program and directed the Hospital's advocacy, communications and governmental relations programs.

Dooley is active in civic and community affairs, having served on the Boards of Directors of the UC Merced Foundation, Blood Source of Northern California and The Maddy Institute at California State University, Fresno. She is also a past president of Planned Parenthood, the Visalia Chamber of Commerce and the Central California Futures Institute.

Dooley is a native of Hanford, California and graduated from Hanford High School in 1969. She received her bachelor's degree in Social Science from California State University, Fresno in 1972 and her law degree from San Joaquin College of Law in 1995. She is married to Dan Dooley and has two adult daughters.

2/10/2011

Los Angeles Times | ARTICLE COLLECTIONS

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Jerry Brown taps trusted former aide for key cabinet position

Diana Dooley would have one of the toughest jobs in the state as secretary of Health and Human Services, overseeing $6 million in cuts and a new federal mandate to insure 8 million Californians.

March 03, 2011 | By Anthony York, Los Angeles Times

Reporting from Sacramento — When Jerry Brown collided with lawmakers during his first stint as governor — having his vetoes overridden, being ejected from the Senate on an unannounced visit — he relied on his 28-year-old legislative secretary, Diana Dooley, to smooth things over.

"Her job back then was pretty tough," the once-again governor admits.

More than 30 years later, he has chosen Dooley for another pretty tough job: secretary of California's Health and Human Services Agency. In Dooley, who spent her time between Brown administrations as a law student, attorney, fire chief and children's health advocate, he has a trusted confidant to oversee one of the largest and most important agencies of the state while he focuses on the budget.

As one of three former senior Brown appointees to hold high-level positions in the new administration, Dooley heads an agency with a budget of $83.5 billion, roughly the size of the state's general fund. It is a bureaucracy in the midst of two simultaneous transformations: She'll be slashing billions of dollars from healthcare and welfare services for the poor while rushing to implement the 2010 federal healthcare overhaul to provide medical insurance for an estimated 8 million Californians who have no coverage.

Dooley agreed to take the job, she says, because "of my commitment and belief that Jerry Brown is the right person at the right time for this state." She says Brown has the experience to make hard budget decisions but will remain sensitive to how those choices affect the state's most vulnerable citizens.

If, as expected, she is confirmed by the state Senate next month, it will be the latest step in an unlikely journey for Dooley. This native of the small Central Valley town of Hanford who married her high school sweetheart is now, for the second time, one of the most influential people in California government.

Dooley walked away from political life after Brown left office in 1983. She returned to the Central Valley, where she and her husband, Dan, a deputy director of the California Department of Food and Agriculture in the first Brown administration, took turns going to law school while the other worked to support the family.

She worked for a year as an assistant fire captain in the city of Visalia, went on to start her own public-relations firm and later became head of the state association of children's hospitals. There, she helped place on the ballot two bond measures totaling $1.8 billion for expansion and renovation of more than a dozen children's hospitals. Both were approved by voters.

Dooley calls her work with the children's hospitals "as close to God's work as I'll ever get." But she gave it up when Jerry Brown came calling again.

Numerous lobbyists and lawmakers say Dooley is now the administration's point person on all healthcare questions — even those beyond the purview of her agency portfolio. Two months into the new administration, the department that regulates health maintenance organizations is still without a director. Although that department is within the state's Business, Transportation and Housing Agency, lobbyists trying to influence the governor's choice have been directed to Dooley.

Brown is asking that programs she administers be cut by more than $6 billion to help close the state's $25-billion deficit. Making the reductions won't be easy for someone who spent the last decade as a healthcare advocate, but Dooley says they'll be pivotal to the success of the federal law.

"This is a permanent reset of benefit levels and the rates we can pay for services," she says. "We're not going to be able to do more with less. We're going to do less with less. But once that's stabilized, then we can build the foundation for expanding healthcare coverage."

Right now, she says, she spends a lot of time "listening honestly and carefully to the concerns that people express." But those who know her say Dooley does not shrink from difficult decisions.

Pat Johnston, president of the California Assn. of Health Plans, met Dooley more than 30 years ago when he was a freshman Democratic assemblyman from Stockton.

"She is warm and attentive and unfailingly courteous," he says. "But it would be a mistake to conclude that her friendliness is weakness or an inability to say no. She just won't insult anybody in the process."

During Brown's first governorship, Dooley earned a reputation as his affable alter ego — a terrestrial complement to "Governor Moonbeam." And she's still clearly a kindred spirit. She says that although she is now a seasoned government hand, she tries to embrace "that Zen concept of the beginner's mind" and bring a fresh eye to her job.

That is the language of the Jerry Brown who spent time in a Zen monastery and practiced transcendental meditation before reinventing himself as the *eminence grise* of California politics.

Today, the parade of cultural icons, international luminaries and cutting-edge thinkers who swirled around the younger Brown has given way to wonky budget meetings. Dooley says that with his presidential ambitions behind him, Brown is now is more focused on the art of governing than he was as a younger man.

"He has a greater appreciation for the processes required to get things done and ... a certain discipline. That wasn't there before."

For her part, the idealism of the earlier years left its mark. She hopes to help educate, and learn from, a new generation of state workers, even if that sounds "kind of old-fashioned and a little corny."

"I will be 60 in April," Dooley says, "and it is exciting to me to have an opportunity to work with other bright, young people who care deeply about making this a better world."

anthony.york@latimes.com

Attachment Two

CSAC Memo: Health and Human Services: Integral Partners in AB 109 Success

Excerpt: Santa Cruz County Draft Community Corrections Plan

Excerpt: Shasta County Draft Community Corrections Plan

Excerpt: San Francisco County Draft Community Corrections Plan

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November 18, 2011

To: CSAC Health and Human Services Policy Committee

From: Kelly Brooks-Lindsey, CSAC Legislative Representative
Farrah McDaid Ting, Senior Legislative Analyst

Re: Health and Human Services: Integral Partners in AB 109 Success

Background: On June 28, 2011, the California Legislature passed a series of budget-related bills that cemented the transfer of certain public safety services and functions from the state to counties. This transfer had been outlined in AB 109, which was signed by the Governor in April, but the June budget bills – AB 114, AB 117, AB 118, ABX1 17, and SB 89 – provided the fiscal and technical framework for what is now known as "2011 Realignment."

News reports about 2011 Realignment invariably focus on the criminal justice and public safety aspects of this historic shift in responsibility. However, 2011 Realignment provides for almost $5 billion in funding for social services and behavioral health programs, along with the expectation that these services will play a key role in serving the low-level offender population and their families.

Counties are currently in the process of identifying the range and types of services to include in their AB 109 implementation plans, called Community Corrections Plans. These plans vary in their emphasis on and deployment of public safety, social, and behavioral health services, with each county working to craft a comprehensive system that best meets the needs of their communities.

CSAC has invited several counties to share their experience in developing a Community Corrections Plan from the social services and behavioral health services perspective.

Speakers:

- **Susan Mauriello,** County Administrative Officer, Santa Cruz County
- **Marta McKenzie,** RD, MPH, Director, Health and Human Services Agency, Shasta County
- **Jo Robinson,** MFT, Director, Community Behavioral Health Services, San Francisco City and County

Materials: Excerpts from the draft Community Corrections Plans of Santa Cruz, Shasta, and San Francisco Counties.

For More Information:
To view the entire Community Corrections Plans from our panelists' counties (and others), please visit www.calrealignment.org and click on "County Implementation."

Excerpt: Santa Cruz County DRAFT Community Corrections Plan

Note: Pages 5-13 are excerpted below. To read the full Plan, please visit www.calrealignment.org and click on "County Implementation."

4. Evidence-Based Practice

In the decades since Robert Martinson's (1974b) influential "nothing works" essay, however, a growing body of research, including the careful application of meta-analyses, has not only disproved the conclusion that rehabilitation doesn't work, but it has succeeded in distinguishing those correctional interventions that have no effect on offender criminality from those that reduce recidivism up to 25 percent.[1] Both at the level of individual behavior change and broader system-level interventions, it is now possible to increase the effectiveness of the criminal justice system and enhance public safety through the utilization of evidence-based practice (EBP).

The enabling legislation for realignment specifies the use of Evidence-Based Practice (EBP) as a requirement for activities and services funded through AB 109.

- "*Evidence-based practices* refers to supervision policies, procedures, programs, and practices demonstrated by scientific research to reduce recidivism among individuals under probation, parole, or post release supervision.... Consistent with local needs and resources, the *(CCP)* plan may include recommendations to maximize the effective investment of criminal justice resources in evidence-based correctional sanctions and programs, including, but not limited to, day reporting centers, drug courts, residential multiservice centers, mental health treatment programs, electronic and GPS monitoring programs, victim restitution programs, counseling programs, community service programs, educational programs, and work training programs." (AB 109 Sect 458)
- "(a) Notwithstanding any other law and except for persons serving a prison term for any crime described in subdivision (b), all persons released from prison on and after July 1, 2011, after serving a prison term for a felony shall, upon release from prison and for a period not exceeding three years immediately following release, be subject to community supervision

[1] Cullen, F.T. and Gendreau, P. 2000. Assessing Correctional Rehabilitation: Policy, Practice, and Prospects, Criminal Justice.

provided by a county agency designated by each county's board of supervisors which is consistent with evidence-based practices, including, but not limited to, supervision policies, procedures, programs, and practices demonstrated by scientific research to reduce recidivism among individuals under postrelease supervision." (TITLE 2.05. 3451 Postrelease Community Supervision Act of 2011)

Key Elements of EBP.

Considerable guidance is available from research regarding the precise definition and characteristics of EBP. The following description is taken from *Implementing Evidence-Based Policy and Practice in Community Corrections* published by the National Institute of Corrections:

> Evidence-based practice (EBP) is the objective, balanced and responsible use of current research and the best available data to guide policy and practice decisions, such that outcomes for consumers are improved. In the case of corrections, consumers include offenders, victims and survivors, communities, and other key stakeholders. Used originally in the health care and social science fields, evidence-based practice focuses on approaches demonstrated to be effective through empirical research rather than through anecdote or professional experience alone.
>
> An evidence-based approach involves an ongoing, critical review of research literature to determine what information is credible, and what policies and practices would be most effective given the best available evidence. It also involves rigorous quality assurance and evaluation to ensure that evidence-based practices are replicated with fidelity, and that new practices are evaluated to determine their effectiveness.
>
> Current research points to eight principles that, when taken together, increase the likelihood of offender risk reduction. Though not all of the principles are supported by the same weight of evidence, each has a sound empirical or theoretical basis. In addition, new evidence is always emerging, so the state of the art in risk reduction is likely to evolve over time.[2]

Eight principles have been identified for program design and evaluation[3]:

1.	Assess Actuarial Risk/Needs	Develop and maintain a complete system of ongoing offender risk screening and needs assessment. This includes the selection of a "4th Generation" assessment tool which collects both static and dynamic factors and is validated for the target population. Staff must be thoroughly trained, and implementation must be monitored to ensure the highest possible accuracy. The results from this assessment should be updated over time, based on new information.
2.	Enhance Intrinsic Motivation	Programs must focus on increasing intrinsic motivation rather than relying

[2] National Institute of Corrections. 2009. Implementing Evidence-Based Policy and Practice in Community Corrections, 2nd ed. Washington, DC.

[3] National Institute of Corrections and Crime and Justice Institute. 2004. Implementing Evidence-Based Practice in Community Corrections: The Principles of Effective Intervention.

		on punishment and pressure, to achieve behavioral change. Motivation is dynamic and is strongly influenced by interpersonal interactions, including those with staff from corrections, probation, and service providers.
3.	Target Interventions	Five key principles form the heart of effective, evidence-based correctional practice. They are as follows: The Risk Principle: Prioritize supervision and treatment resources for higher-risk offenders. High levels of supervision and services for low-risk offenders are not only wasteful of resources but have been shown to *increase* criminality. Shifting resources to high-risk offenders results in considerably greater improvements in public safety. The Need Principle: Target interventions to criminogenic needs, that is, areas of need which are shown by research to be correlated with criminality. According to meta-analytic research, the eight most significant criminogenic needs are: antisocial behavior; antisocial personality; criminal thinking; criminal associates; dysfunctional family; employment and education; leisure and recreation; and substance abuse. Individual assessments are an essential tool to identify and prioritize needs to be addressed. The Responsivity Principle: Responsivity requires matching services to individual characteristics, including culture, gender, motivation, and developmental stages. The Dosage Principle: Research indicates that high-risk offenders require a minimum of 200 hours of cognitive-behavioral intervention in order to show improvement in outcomes. During the initial three to nine months post-release, 40-70% of high-risk offenders' time should be clearly occupied with delineated routine and appropriate services. The Treatment Principle: Treatment services, particularly cognitive-behavioral interventions, should be integrated into the full sentencing and sanction requirements through proactive, assertive case management.
4.	Skill Train with Directed Practice	Programming should emphasize cognitive-behavioral strategies and should be delivered by well-trained staff who understand antisocial thinking, social learning, and appropriate communication techniques. Skills must be consistently practiced by offenders and positively reinforced by staff.
5.	Increase Positive Reinforcement	Behaviorists recommend a four-to-one ratio of positive reinforcements to negative reinforcements in order to achieve sustained behavioral change. Increasing positive reinforcement should not come at the expense of administering swift and certain responses to unacceptable behavior. Clear expectations and graduated responses allow offenders to learn and change their patterned behavior over time.
6.	Engage Ongoing Support in Natural Communities	Actively recruit and engage family members, spouses, and supportive others in the offender's immediate environment to positively reinforce positive behavior change. This includes 12-step groups, religious activities, and restorative justice initiatives to re-build pro-social community relationships.

7.	Measure Relevant Processes/Practices	Maintain accurate and detailed documentation of case processing, along with a formal and valid measure of outcomes. Routinely re-assess offender needs and pre-cursors to recidivism. Also conduct routine and objective assessments of staff performance and systemic fidelity to EBP. Implementation of EBP requires a commitment to administering routine fidelity studies to determine if actual practices are matching the protocols for the evidence-based practices that the department has instituted.
8.	Provide Measurement Feedback	Use program data to monitor process and change, including both feedback to individual offenders as well as system-wide feedback for accountability for EBP implementation and outcomes.

Systemic Interventions and Evidence-Based Practice.

Evidence-based policies and practices are essential in order to achieve desired outcomes such as reducing recidivism and victimization in our communities. Several examples of EBP have been successfully employed in Santa Cruz County to reduce offender risk and subsequent recidivism, including the use of effective assessment and cognitive-behavioral treatment strategies designed to change offender behavior.

It is worth noting that the dramatic increase in rates of incarceration over the past thirty years is only partially explained by crime and offender behavior. Systemic policies and practices have often resulted in an over-dependence on incarceration as the primary response to violations of law and community supervision. Unraveling this reliance requires a combination of interventions at both the offender and systems levels. The application of EBP needs to encompass both of these perspectives in order to reduce recidivism and achieve the best possible public safety outcomes.

During the last two years, the Santa Cruz Probation Chief has worked with the Chief Probation Officers of California (CPOC) and the Crime and Justice Institute (CJI) to develop a data-driven framework and guiding principles for Systemic Interventions. Below are some of the guiding principles and strategies for this work. See also the attached matrix "Sample Menu of Opportunities for Systemic Interventions: Data-Driven Solutions for Justice Improvement," which illustrates where and how Systemic Interventions can be applied throughout the criminal justice process.

1. Leadership, Collaboration, and Self-Critique

Reducing reliance on prison requires committed and strong leadership and a capacity for critique of system inefficiencies and ineffective practices. Key justice stakeholders must be willing to methodically examine system outcomes, identify areas for improvement, and implement necessary changes. Joint planning and oversight are essential, as is a willingness to broaden the role of community-based partners.

2. A Systemic Perspective

In this context, a systemic perspective looks into aggregate data that identifies clear trajectories to incarceration and how interventions can be applied to reduce failures that lead to incarceration. A continuum of lesser restrictive interventions can be implemented to intercept the need for

incarceration. Parolees returning to jail and the increases of non-serious offenders at the local level will impact local jails, many of which are already overcrowded. In this instance, Systemic Interventions should look at the entire probation and jail populations to determine ways to alleviate the pressures that realignment presents.

3. Commitment to Thoughtful Planning and Data-Driven Practices
Systemic interventions are based on a data-driven process that relies on objective data, rather than anecdote, to guide system improvement planning, policy development, and continuous improvements in practice. Three components are essential:

a) Baseline Data: the development of baseline aggregate and disaggregated data that provides a portrait of the system outcomes and processes.
b) Continuous management of a data-driven process, where system bottlenecks, inefficiencies, and unwanted results are identified; questions and hypotheses are formed as to what might be leading to the problem, which may require digging deeper into the problem; procedural and programmatic solutions are developed and implemented to have the maximum impact with the resources available; and ongoing evaluation is conducted.

c) Communication of Results: data-driven practices are most powerful when all system stakeholders are engaged, capacity is built within organizations to use data-driven practices, and successes are visible to practitioners, stakeholders, and the public.

4. Examination of Key Decision Points
Systemic Interventions are premised on the understanding that at each stage of the justice process (pretrial, sentencing, and community supervision) discretionary decisions are made that greatly influence system outcomes. Some systemic practices are conducive to offender success, while others may actually compound failures that may not even be linked to criminogenic risk. By disaggregating data at each system decision and process point, problems to be addressed and successes to be championed are illuminated.

5. Build Capacity through a Continuum of Options to Safely Reduce Reliance on Incarceration
A continuum of less restrictive options are developed and tailored for the pretrial, sentencing, and community supervision stages of the criminal process. Evidence-based efforts recognize that incarceration, while necessary in some cases, is costly, provides a contagion factor for deviancy and future recidivism, and may escalate future revocation and imprisonment. A continuum of lesser restrictive options provides the systemic interventions in which evidence-based programs can operate at the local level. These options are developed, implemented, and monitored to ensure that public safety is maintained and net-widening does not occur.

6. Innovation and Replication
EBP promotes the replication of strategies proven to achieve desired outcomes and encourages the creation of research-based system improvements. Systemic interventions promote both the replication of strategies that have improved systemic outcomes and the implementation of locally designed innovations that would appear promising after careful data analysis. With ongoing monitoring, effective

interventions are identified that can become new evidence-based practices. Ineffective interventions are improved or aborted depending on the outcomes.

7. Moving From Policy to Practice
The discovery of a data-driven opportunity for a systemic intervention is only part of the battle. The implementation of systemic interventions requires attention to change management and a strategic approach to implementation efforts. Leadership, collaboration, communication, data feedback and the overall alignment of business practices are critical elements in facilitating systemic change.

8. Commitment to Research-Based Practices
Data-driven techniques must be supported by research. A commitment to research helps justice administrators create learning organizations that wisely use resources for maximum public benefit.

The Santa Cruz County Community Corrections Plan will incorporate EBP at all levels, not just in the selection of treatment services. Best practices in offender reentry make it clear that services and supports must begin during custody, and that release planning needs to be completed early during the period of incarceration so that the inmate and the community can start at once to prepare for successful community reintegration. The engagement of natural supports requires that correctional facilities implement policies and procedures that allow safe access for family members and community service providers to conduct assessment, reconciliation, and planning meetings with offenders during custody. All staff who work directly with offenders need to be trained to support motivational enhancement and cognitive-behavioral interventions.

5. A System Ready to Act: History of Local Efforts

History of Successful Reforms and Systemic Interventions

The Public Safety Realignment Act represents the most significant and sweeping reform to the California criminal justice system since determinant sentencing law was enacted in the late seventies. This legislation poses significant challenges to local jurisdictions that must now build capacity to house and manage a new offender population at the local level through a combination of incarceration, alternatives to incarceration, community supervision, and the delivery of evidence-based interventions targeted to reduce the risk of recidivism.

While these challenges are formidable, Santa Cruz County is well equipped to address them and has been building system capacity for reform throughout the justice system long before AB 109 became a reality. Most notable and enduring has been the juvenile justice reform in Santa Cruz County that has been in place for well over a decade and which has produced dramatic decreases in local and state incarceration of juveniles and has helped reallocate resources to community-based alternatives which have withstood the test of time with positive public safety results in the aggregate.

Like AB 109, the juvenile justice reform was spurred by crisis. In the mid 1990s there was local concern over an overcrowded juvenile hall that disproportionately held Latinos in custody for lesser crimes. The juvenile hall was deemed unsafe. Instead of building a way out of the problem with a new juvenile hall,

the Probation Department worked with county leaders and departments, other law enforcement agencies, and non-profits to adopt the core strategies of the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative (JDAI) to greatly reduce reliance on incarceration and reduce racial disparity. These strategies include collaboration among justice stakeholders; data-driven decisions; objective admissions criteria and instruments; non-secure alternatives to detention; case processing reforms to expedite case processing and reduce unnecessary delay; special strategies to address cases or clusters of cases of youth who are detained unnecessarily; reducing racial disparities by eliminating system bias; and monitoring and reporting on conditions of confinement. Santa Cruz County became the first replication site of the original demonstrations sites of the initiative in 1997. Now, 14 years later, there are approximately 120 jurisdictions in 40 states that have adopted JDAI core strategies.

The JDAI strategies assisted in a local criminal justice transformation that began in the mid 2000s. In the face of community concern and an overcrowded jail, the Sheriff sought technical assistance from the National Institute of Corrections to examine the jail population and local criminal justice practices and to provide recommendations to address the crowding problem. Subsequent to the NIC report, the Sheriff's Office convened a Jail Overcrowding Committee consisting of local leaders and justice stakeholders and instituted a new classification system to better manage the jail populations between facilities and help alleviate pressure to the main jail population. The Probation Department also sought technical assistance through the Vera Institute of Justice. Vera consultants worked closely with probation officers to study the impact of the probation population to the jail and to study probation trajectories (the outcomes during a probation grant that is typically ordered for a three-year period). This study helped the probation department identify systemic interventions, including improved pretrial services and an innovative warrant reduction program that used non-profit personnel through the nationally recognized Friends Outside program to improve probation compliance and success while averting the costly processing of warrants and associate jail time as a consequence. These effective jail alternative programs administered by the Sheriff and Probation have saved an estimated 90 jail beds on a daily basis without jeopardizing public safety.

Current Initiatives Compatible with AB 109

SB 678. A related precursor to the Realignment Act (AB 109) was Senate Bill 678, which called for the local implementation of Evidence-Based Practices to reduce the number of probation failures resulting in prison commitments. SB 678 provides financial incentives based on a redirection of a portion of the state savings in prison costs to counties based on their rate of prison reductions. Additionally, so that counties were not unfairly punished by having lower prison rates to begin with, "high performing counties," defined by a probation failure prison commitment rate of half or less of the state average, would share in a distribution of five percent of the savings. Santa Cruz County qualified as a high performance county in 2010, which led to a $1.1 million distribution to the county of SB 678 funds.

To date, SB 678 funds have been used to purchase the STRONG assessment (an evidence-based actuarial risk and needs assessment), train staff to implement the assessment, provide for a modest amount of intensive supervision, and build capacity within the probation department to implement "Thinking for a Change," a cognitive behavioral training for probationers. Given that the future allocation of these funds

Excerpt: Shasta County DRAFT Community Corrections Plan

Note: Pages 27-33 are excerpted below. To read the full Plan, please visit www.calrealignment.org and click on "County Implementation."

Assessment, Programs, and Services

One of the legislative intents of AB 109 is to maximize the role of evidence-based intervention strategies to effectively reduce criminal recidivism. Correctly assessing the needs of this new offender population and then providing appropriate services are key to addressing public safety and recidivism concerns in Shasta County. Because the specific needs of this offender population are somewhat unknown until the offenders begin arriving, specific implementation strategies are difficult to enumerate in this Plan. However, criminal justice research and our public safety experience suggest some core program elements that should be addressed for most if not all offenders. In addition, a longer list of anticipated service needs is included, and as these are identified and quantified in the new population, service agreements, community collaboration, and program development efforts will be initiated to meet these needs.

Assessment Center: A co-located Assessment Center (Center) where assessment, community services, intensive programming, and supervision can occur in a coordinated fashion is a cornerstone of this Public Safety Realignment Plan. The Center will include, at a minimum, assessments of criminogenic and other needs, including physical and mental health, drug and alcohol risk, cognitive-behavioral therapy (individual and group), eligibility and employment services, housing, and referrals to other community resources or service providers. The CCP Executive Committee will examine options for initiating this Center, including in-house development and staffing or contracting with private local or other vendors for some or all of these services. Most likely the Center will be developed with a combination of county workers, contracted service providers, and co-located community staff.

In addition to Probation employees, a Mental Health Clinician, an Eligibility Worker, and an Employment and Training Worker will be assigned to the Center as much time as needed per week to assess and meet the basic housing, financial, health, and other needs of this offender population. Some of the costs of this work will be attributed to existing Social Service or Mental Health allocations or funding streams if appropriate, and residual costs will be attributed to the Public Safety Realignment budget. Other contracted service providers and community agencies that can assist in meeting the criminogenic needs of this offender population will be co-located on a prioritized basis when possible within the Center. The location of the Center has not been determined, but existing County owned space would be desired to lessen the budgetary impact. As the CCP Executive Committee gains more experience with this population, the most important program delivery strategies and client volumes will be determined.

Staff Projections (Health and Human Services Agency)

1 Mental Health Clinician

1 Eligibility Worker for CalWORKS, General Assistance*, Medi-Cal, County Medical Services Program (CMSP), CalFresh

1 Employment and Training Worker

2011-12 costs

$334,308

* A word about General Assistance: Offenders returning from state prison are eligible for General Assistance. However, only those offenders serving an alternative custody sanction through electronic monitoring, work release or home confinement will be additional to those currently eligible and served through the General Assistance program. With the support of the offender's probation officer to ensure compliance in the alternative custody and other aspects of their supervision, General Assistance payments will be made consistent with the eligibility standards otherwise in place (employable or disabled). Therefore the cost of the General Assistance payments attributable to the Public Safety Realignment population in alternative custody will be supported through this Public Safety Realignment budget.

Other Programs & Services: Many other criminogenic services will be needed to meet the varied needs of this offender population. As the CCP gains more experience in assessing this group, resources will be sought to fill those needs. Therefore, decision making flexibility, initial sole source contractual arrangements with both existing local and/or other providers, and claims/vendor payment options will be necessary to enhance the CCP's ability to provide services and implement programs quickly. This flexibility, especially in this initial start-up period, is imperative to provide for this population's needs and optimally protect the citizens of Shasta County. The expected service needs will include, but not be limited to the following:

- Anger management/aggression therapy/domestic violence treatment
- Housing, including detoxification or recovery bed arrangements
- Alcohol and drug treatment
- Family therapy/Parenting
- Vocational or other educational and GED preparation
- Immediate medical care/health professional to assess and prescribe
- Other miscellaneous (transportation, temporary housing, payee services, adult education, psychiatric care, landlord assistance, etc.)

2011-12 costs

$396,341

- End of excerpt -

Excerpt: San Francisco County DRAFT Community Corrections Plan

Note: Pages 18-23 are excerpted below. To read the full Plan, please visit www.calrealignment.org and click on "County Implementation."

Community Assessment & Service Center

Central to improving outcomes for the postrelease community supervision population is ensuring access to an array of services for these offenders, and creating a one-stop model of service delivery. To accomplish this goal APD is proposing creation of a Community Assessment and Service Center (CASC), a model patterned after day reporting programs emphasizing collaborative case management and pairing the expertise of Adult Probation staff with center staff in the provision of assessments and services (delivered both in-house and on a referral basis). The CASC will also serve as an alternative to revocation of supervision with offenders sanctioned to program participation in response to violation of supervision conditions. Adult Probation staff will conduct COMPAS assessments, deliver cognitive skill building curriculum (designed specifically for the high-risk offender population to address criminogenic needs and criminal thinking), obtain UA samples for analysis, monitor GPS equipment and conduct regular office visits with offenders at the Center.

It is anticipated that assessment center services will be contracted to a community-based organization, and that staff functions would include assessments and referrals to a host of community-based programs including education, 5 Keys Charter School, mental health services, substance abuse treatment (outpatient and long-term residential), medical services, HIV/AIDS prevention and education, housing services, food and nutrition resources, and parenting skills services.

VI. DEPARTMENT OF PUBLIC HEALTH - TREATMENT AND HEALTH SERVICES FOR OFFENDERS UNDER POSTRELEASE COMMUNITY SUPERVISION

It is expected that a significant number of probationers will present with substance abuse and/or mental health problems that will need to be treated as a part of the individual's integration into community life and to prevent recidivism. Recent data analysis indicates nearly 80% of the incarcerated populations have substance abuse problems requiring treatment interventions. Arranging treatment services in advance of an offender's release is a critical risk reduction activity.

Central to this success is the establishment of a matrix of services that will provide an appropriate level of intervention to those probationers with a diagnosable behavioral health condition. The Department of Public Health has a history of serving the offender and ex-offender population with innovative and evidence based treatment services targeting the myriad of health related needs that affects this population.

The Department of Public Health will provide care coordination, individualized client based services, treatment and transitional housing to some of the anticipated 700 individuals who will be out-of-custody and under postrelease community supervision.

PROJECTED ADDITIONAL NUMBER OF OFFENDERS IN NEED OF TREATMENT OF HEALTH SERVICES

The Department of Public Health estimates that 600 of the 700 total number of probationers will present with a behavioral health condition that will warrant a treatment intervention. A system of care comprising the following is proposed:

- Residential mental health treatment
- Residential substance abuse treatment
- Short term residential treatment
- Intensive outpatient treatment
- Day treatment
- Transitional housing
- Medication management

PROPOSED STRATEGIES FOR TREATMENT AND HEALTH SERVICES

The Department of Public Health (DPH) has identified several programs that can be made available to AB109 offenders who have untreated substance abuse and mental health issues. DPH's health care delivery system is evolving to become the reformed, integrated system outline in the federal Affordable Health Care Act.

The client's "Health Home," will act as a portal of entry into the larger system of care and will guide the client through their identified treatment plan. If a probationer has a primary care medical concern they will be enrolled in Healthy San Francisco, the county's program to provide medical care to uninsured and underinsured residents. Those receiving MediCal entitlements will be enrolled in the San Francisco Health Plan, the county's program to serve the uninsured mentally ill.

Care Coordination: Through a complement of experienced clinicians, the DPH proposes to create a Care Coordination entity that will assist probationers in navigating the health service system, which is especially important when a client has multiple chronic conditions.

With well-coordinated patient centered care, clients can transition between providers, programs, and levels of treatment more easily, their preferences for treatment are respected, and their treatment histories made available to all of those involved in their health care. Poorly coordinated care can lead to errors, higher costs, and treatment failures. It will also be the Care Coordinators responsibility to assess and refer the probationer to an appropriate level of care, and work closely with the Adult Probation Department in ensuring that the client meets all minimum treatment expectations.

Basic Treatment Path: Data indicates that clients with behavioral health problems have done well in intensive outpatient settings. These programs are matched to appropriate service elements within the program. Clients may attend daily, stay at the site most of the day, have meals, and participate in a range of group treatment activities addressing addiction, mental health and illness, trauma, domestic violence, and anger management. A small percentage of this population will require a more intensive program that includes 45 days of residential treatment/stabilization, followed by a longer period in the intensive outpatient program. The probationer will enter the spectrum of services depending on their presenting problem.

VII. HUMAN SERVICE AGENCY - HOUSING AND HUMAN SERVICES FOR OFFENDERS UNDER COMMUNITY SUPERVISION

Central to the success of individuals and their families are individualized housing and support services provided by the Human Services Agency (HSA). HSA will provide services, access to benefits, and housing to some of these 700 people who will be out of custody on postrelease community supervision.

PROJECTED ADDITIONAL NUMBER OF PEOPLE IN NEED OF HOUSING AND HUMAN SERVICES

Of the 700 individuals estimated to be shifted to local supervision, the Adult Probation Department estimates that 25% of this population, or 175 individuals, will be in need of housing assistance. Based on the data cited below however, HSA roughly estimates that 13%, or 91 individuals, will require housing assistance and that 12% will seek other types of public assistance.*

The recent "Homeless Triangle" series reported on SF Gate cited California Department of Corrections and Rehabilitation (CDCR) point-in-time data on the number of parolees whose address is listed as either "transient" or "homeless." For San Francisco, this data yielded an estimate that one in seven (13%) of released state inmates are homeless. This would be a conservative estimate given that some parolees likely listed an address at which they are temporarily staying, couch surfing or merely receiving mail.7

Another source, the 2011 San Francisco Homeless Point-In-Time Count and Survey Report, identified 6,455 homeless individuals in the City. Based on data compiled from 1,024 surveys conducted from February 1st to March 15th, 2011, an estimated 15% of the homeless population is on parole or probation. When divided by the total parolee and probationer population in San Francisco, this yields an estimate that 13% of that population is homeless at any point in time.

An April 2009 data match found that there were 894 ex-offenders receiving public assistance through a subset of the programs administered by HSA. The benefit programs include County Adult Assistance Programs (CAAP), CalWORKs, Food Stamps and Medi-Cal. When divided by the total estimated parolee and probationer population in San Francisco, this yields an estimate that 12% of that population receives public aid through HSA. This estimate may be off if the total size of the City's parolee and probationer population has changed significantly since 2009.

The AB109 population will access residential treatment programs and supportive housing for individuals with high physical and behavioral health needs through the Department of Public Health. Risk/needs assessments suggest a portion of the AB109 population will require (and benefit from) independent housing (i.e., no onsite staffing or supervision, but the client still has an assigned case manager). Consequently HSA's rent subsidy model (described in the attachment) emerges as a superior alternative to their transitional housing program for addressing the needs of this group, particularly as regards increasing opportunities for this population to access more permanent housing. CASC will refer to access points for new and existing housing programs.

**AB109 offender population estimates are based upon data provided by CDCR; however, the Community Corrections Partnership Executive Committee anticipates the actual population to be greater than the State projections.*

PROPOSED STRATEGIES FOR HOUSING AND HUMAN SERVICES

Housing-Related Services

Multiple Agencies administer and service housing programs that will service the AB109 population. HSA administers three main types of housing programs:

- Emergency shelter. Shelter reservations are required and must be made in person at one of four locations around the city. Shelter stays range from one night to 6

months. Shelters offer meals and service linkages. The AB109 population will have the same access to shelters as any other homeless resident of San Francisco. HSA does not need new resources to serve this population.

- Rental assistance and rent subsidies. Several HSA-funded service providers offer rent subsidies of up to $800/month and/or one-time rental assistance grants of up to $1500 that can cover items such as back rent, security deposit, moving costs, utility assistance and housing-related legal services. Clients must meet eligibility criteria, including income criteria, and be homeless or at imminent risk of homelessness.

  Rent subsidy clients must also be able to cover the difference between the subsidy amount and the market rent rate on their unit. The AB109 population will have very limited access to these programs as most restrict eligibility to families with dependent children, are operating at maximum capacity, and/or are short-term programs that will sunset within the next year.

  However, this is a program model with demonstrated success that the City might want to consider developing for the ex-offender population. New resources would be needed to serve this population and a new contract would need to be put in place.

- Permanent supportive housing. HSA contracts with several nonprofit service providers who lease renovated single-room occupancy (SRO) hotels and rent rooms to formerly homeless clients. Homeless CAAP and Supplemental Security Income (SSI) clients have priority for placement. Each site has onsite property management and case managers who provide service referrals.

  HSA's Housing First programs operate at capacity and no new sites are expected to come online in the near future. Unit availability is driven by turnover of existing tenants. A limited number of the ex-offenders paroled to San Francisco under AB109 may be able to access this housing through the regular referral process, but HSA cannot guarantee that a particular number will be served or that ex-offenders in need of housing will be able to access it in a timely fashion. DPH will also potentially provide limited transitional housing for the AB109 population connected to their services.

Non Housing-Related Services

HSA administers a range of other services and benefits, including:

- County Adult Assistance Programs (CAAP). CAAP offers cash assistance to low income adults without dependent children through four separate programs: General Assistance (GA) provides a benefit of up to $342/month. Personal Assisted Employment Services (PAES) provides a benefit of up to $421/month, as well as employment services and transportation benefits for participants who are engaged in an employment plan. SSIP provides a benefit of up to $421/month for clients with a disability who have a pending application for federal SSI benefits. Cash Assistance Linked to Medi-Cal (CALM) provides a benefit of up to $421/month for aged and disabled immigrants who do not qualify for federal or state assistance. CAAP clients also have access to SSI screening and application assistance.

- CalWORKs. Cash assistance and welfare-to-work services for low-income adults with dependent children.

- CalFresh (formerly Food Stamps). A monthly benefit that can be used to purchase food.

- Medi-Cal. Health coverage for low-income children, pregnant women, seniors and persons with disabilities. Individuals who are screened for Medi-Cal and determined to be ineligible are referred to other state and local subsidized health care programs.

- Services for seniors and persons with disabilities. A range of community-based services including in-home supportive services, meals programs, transportation, legal services, socialization programs and naturalization services.

Most of these services and benefits are mandated by federal, state or local law, meaning that anyone who meets the program eligibility criteria is entitled to be served. Applications are accepted in person, by mail, fax, phone and/or online, depending on the program. The online portal at www.BenefitsCalWIN.org can be used to apply online for CalWORKs, CalFresh and Medi-Cal, and there are several community-based organizations whose staff are trained to help clients submit online applications. The AB109 population will have access to all services for which they are eligible.

HSA does not need new resources to serve this population through its regular processes. It would also be possible for HSA to arrange a one-time training for community–based organizations designated to work with the AB109 population on how to use the BenefitsCalWIN tool. However, new resources will be needed if any sort of special access to services is required for the AB109 population, (e.g., pre-release eligibility determinations or scheduling of intake appointments).

PROPOSED OUTCOMES

This policy initiative (and the intervention strategies articulated in the local Public Safety Realignment plan) is intended to improve success rates of offenders under supervision resulting in less victimization and increased community safety. Accomplishing this in the most cost efficient manner and employing proven correctional and justice system practices,is emerging as the primary strategic goal of the initiative.

Attachment Three

CSAC Memo: Innovations in Health Care Delivery: Just in Time for 2014

CAPH Policy Brief: "The Delivery System Reform Incentive Program: Transforming Care Across Public Hospital Systems"

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November 18, 2011

To: CSAC Health and Human Services Policy Committee

From: Kelly Brooks-Lindsey, CSAC Legislative Representative
Farrah McDaid Ting, Senior Legislative Analyst

Re: Innovations in Health Care Delivery: Just in Time for 2014

Background: California's current five-year Section 1115 Medicaid Waiver offers public health care providers an opportunity for transforming health care models to better focus on integration and organization, all with the goal of improving patient outcomes.

The Waiver and recent trends in health care delivery have converged to give birth to a new health care services delivery philosophy, one that is committed to providing patients the right care, at the right time, in the right place. Public health systems are now exploring models based on creating outpatient efficiencies, behavioral health integration, and innovative ways to bring both primary and specialty care to patients in a "medical home" setting.

It is no coincidence that these models also result in health care system cost savings, which is why the new Waiver includes fiscal incentives for public systems to transform care.

CSAC has invited Wendy Jameson, the Executive Director of the Safety Net Institute, to speak about innovations in health care delivery in public hospital systems and to explain the challenges and opportunities that lie ahead on the eve of national health care reform. The Safety Net Institute is a non-profit affiliate of CSAC affiliate California Association of Public Hospitals and Health Systems [CAPH]).

Speaker:

- **Wendy Jameson,** Executive Director, Safety Net Institute

Materials: CAPH June 2011 Policy Brief: *The Delivery System Reform Incentive Program: Transforming Care Across Public Hospital Systems*

More Information:
Safety Net Institute: www.safetynetinstitute.org
CAPH: www.caph.org

California Association of Public Hospitals and Health Systems

June 2011

POLICY BRIEF

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The Delivery System Reform Incentive Program: Transforming Care Across Public Hospital Systems

Summary

California's new five-year Section 1115 Medicaid Waiver created the Delivery System Reform Incentive Program,[1] a federal pay-for-performance initiative that is the first of its kind in the nation in terms of its structure and scope. The Incentive Program offers an unprecedented opportunity for California's 21 public hospital systems to transform care delivery to be more integrated and organized, and improve patient health outcomes.[2] The program creates incentives for public hospital systems to dramatically expand upon recent quality improvement initiatives, and make them system-wide. These large-scale efforts embody the principles of health care reform — expanding access to care, enhancing quality, improving population health and containing costs.

The performance-based structure of the Incentive Program represents an effort to align health care delivery with achieving system-wide improvements and better health outcomes, a dramatic shift from traditional health care financing. In order to receive the Incentive Program's designated federal funding of up to $3.3 billion over five years, public hospital systems must each achieve hundreds of ambitious project milestones and provide a local funding match. To accomplish this, they are each undertaking 12-19 major delivery system improvement projects simultaneously. Nearing the end of the first year of the Waiver, public hospital systems have achieved 100% of their 298 Incentive Program Year One milestones.

California's public hospital systems are embracing both the opportunities and risks in the Incentive Program because it underscores their deep commitment to providing patients the right care, at the right time, in the right place. In addition, the intensive learning that will result from this experience can inform policy makers and health systems throughout the country seeking to adopt innovative and systemic quality improvements.

Public Hospital Systems: Foundation for Health Care Delivery in California

As the core of the state's health care safety net, California's public hospital systems are:

- **Coordinated Systems of Care:**
  - Serve 2.5 million patients annually with preventive, primary, specialty, pharmacy, emergency and hospitalization services
  - Deliver 10 million outpatient visits a year, and operate more than half of the state's top-level trauma centers and almost half of its burn centers
- **Leaders in Providing Care to California's Underserved Populations:**
  - Pioneers in expanding coverage to more than 100,000 uninsured adults over the last three years, with expected growth to reach 500,000 adults statewide by 2014
  - Provide about 30% of all hospital-based care to the state's Medi-Cal population and nearly half of all hospital care to the state's 7 million uninsured
- **Leaders in Providing Culturally Competent Care**
  - Our patients speak more than 120 languages, and many speak a primary language other than English. Public hospital systems are national leaders in expanding language access through onsite interpreters, multi-lingual staff and remote video and voice technologies

1 The Incentive Program has also been referenced as DSRIP, Incentive Pool and Incentive Payments. The protocols of the Incentive Program and the five-year plans submitted by the public hospital systems are available on the California State Department of Health Care Services' website: http://www.dhcs.ca.gov. Please note the funding amounts in the plans are gross amounts, which include the federal funding and the matching funds the public hospitals themselves will be providing.

2 These 21 public hospitals include CAPH's 19 members and the University of California, Los Angeles Health System and University of California San Francisco Medical Center.

"The Incentive Program represents an important opportunity to achieve enhanced quality and clinical outcomes in public hospital systems. The Department is committed to working in partnership with public hospital systems to realize this critical goal."

— Neal D. Kohatsu, MD, MPH, Medical Director, California Department of Health Care Services

Overview

In November 2010, California's Section 1115 Medicaid Waiver was approved by the state and federal governments, an agreement that will extend from November 1, 2010 to October 31, 2015. The Waiver is the major source of core funding for public hospital systems and allows them to deliver health services to low-income populations. In addition to the Incentive Program, major components of the Waiver include the Low Income Health Program, a county-based coverage expansion program, and a mandatory shift of Seniors and Persons with Disabilities from fee-for-service Medicaid into managed care.[3]

The Incentive Program is a central element of the Waiver that supports public hospital systems in improving access, quality and coordination across their systems. To participate in the Incentive Program, public hospital systems in California submitted five-year plans that were approved by the state and federal governments. The plans span four categories of the Incentive Program that target distinct areas of quality improvement, but are highly inter-related (See below: Incentive Program Categories: Improving Health and Quality).

Within all four categories, the plans include multiple projects. Each has several milestones, which serve as a guide to measure progress toward intended project outcomes. On average, public hospital systems are each carrying out 15 projects simultaneously, with an average of 217 milestones per hospital system over five years.

The plans also include the testing of new quality improvement models. It is anticipated that successes and challenges with these models will provide broad learning and unfold best practices and opportunities for replication throughout the broader industry.

Bold, New Ground

The quality improvement projects and milestones of the Incentive Program are structured to increase integration and improve patient care system-wide, throughout the hospital's primary care clinics, specialty clinics, urgent care centers, emergency departments and inpatient services. The foundation for this program was built over the past decade as public hospital systems began implementing effective methods for improving care

The California Health Care Safety Net Institute

Since 1999, the California Health Care Safety Net Institute (SNI), a non-profit affiliate of CAPH, has facilitated quality improvement initiatives for public hospital systems in areas such as chronic care improvement, outpatient efficiency, language access, palliative care and health information technology. Through these intensive programs, SNI has become a national leader in quality improvement, fostering innovation and replicating best practices.

As California's public hospital systems implement their Incentive Program plans, SNI will provide expertise and facilitate shared learning on an expanded and deeper level in order to help facilitate system-wide transformation. With a strong emphasis on testing and innovation, Incentive Program projects will likely identify practices that can lead to better patient outcomes. SNI will also serve a critical role in dissecting and analyzing the data for the purposes of helping drive ongoing quality improvement within, among and beyond public hospital systems.

3 For more information on elements of the Waiver that pertain to California's public hospital systems, please see CAPH's November 2010 Policy Brief: *The New Section 1115 Medicaid Waiver: Key Issues for California's Public Hospital Systems,* caph.org/AssetMgmt/getDocument.aspx?assetid=190.

coordination, patient safety, access and efficiency. The Incentive Program helps expand and hardwire this work on a massive scale. Through the achievement of their milestones, public hospital systems will demonstrate results that will improve integration, patient care and outcomes. The scope and potential impact of the Incentive Program on quality and population health is unprecedented.

Incentive Program Categories: Improving Health and Quality

Public hospital system plans include multiple projects in all four of the following categories:

1. **Infrastructure Development:** Category 1 lays the foundation for delivery system transformation through investments in people, places, processes and technology. Projects include implementing disease management registries, expanding primary care capacity and increasing training of the primary care workforce.

2. **Innovation & Redesign:** Category 2 includes the piloting, testing and replicating of innovative care models. Many plans include projects to expand medical homes, integrate physical and behavioral health care, expand chronic care management models, redesign primary care and improve patient experience.

3. **Population-Focused Improvement:** Category 3 requires all public hospital systems to report on the same 21 measures across four domains: (1) the patient's experience, (2) the effectiveness of care coordination (e.g., measured by hospitalization rates for heart failure patients), (3) prevention (e.g., mammogram rates and childhood obesity), and (4) health outcomes of at-risk populations (e.g., blood sugar and cholesterol levels in patients with diabetes). Because population health measures are still being refined across the nation, lessons learned through Category 3 reporting will help guide the ongoing national dialogue.

4. **Urgent Improvement in Care:** Category 4 requires all public hospital systems to achieve significant improvement in targeted quality and patient safety measures that are particularly meaningful to safety net populations and have a strong base of evidence. All public hospital systems will improve severe sepsis detection and management, and increase prevention of central line associated bloodstream infections. These two conditions can be acquired while a patient is in the hospital and can cause significant harm. Public hospital systems are also required to choose two additional measures from a list of five, and the majority of hospitals are focusing on reducing surgical site infections and achieving a less than 1.1% hospital-acquired pressure ulcer prevalence, which would place them in the top quartile based on state data.

Public Hospital System Plans: Broad Scope & Innovation

Below are examples of two proposed plans. The first highlights an innovative project that is being tested by public hospital systems through the program, and the second demonstrates the scope and breadth of these plans.

Innovative Project: University of California, Irvine & San Diego Medical Centers

The Incentive Program promotes testing groundbreaking methods to improve health care. Through separate projects in their plans, UC Irvine Medical Center and UC San Diego Medical Center will be at the forefront of piloting a real-time electronic surveillance system that alerts clinicians to the presence of patient conditions and medical devices that increase the risk of hospital-acquired infections. The system also triggers interventions to prevent hospital-acquired infections. By testing this innovation to see whether it results in increased detection and prevention, these hospitals will be contributing to national efforts to reduce hospital-acquired infections.

Highlighted Plan: Alameda County Medical Center

Alameda County Medical Center (ACMC), which is located in the East Bay region of the San Francisco Bay Area, has 17 projects and 189 milestones. Through its Incentive Program plan, ACMC is moving from a disease-focused model of episodic care to a model of patient-centered, coordinated, proactive care that helps patients manage their own conditions. To support this, ACMC recognizes the need for increased patient access to primary and chronic care, and a culture of ongoing transformation and innovation. Therefore, over five years, ACMC proposes to make significant systemic improvements that will strengthen both outpatient and inpatient care:

Public Hospital System Patients

Public hospital systems treat approximately 2.5 million Californians each year, a diverse, multilingual patient population that is 48% Hispanic/Latino, 29% White, 12.5% Black, 6.5% Asian and 3.9% Other. Our patient population has disproportionately high rates of chronic disease and is predominantly low-income. While public hospital systems provide 69% of their care to patients who receive Medi-Cal benefits or are uninsured, all other California hospitals together provide only 25% of their care to the same populations.

Table 1: ACMC Plan

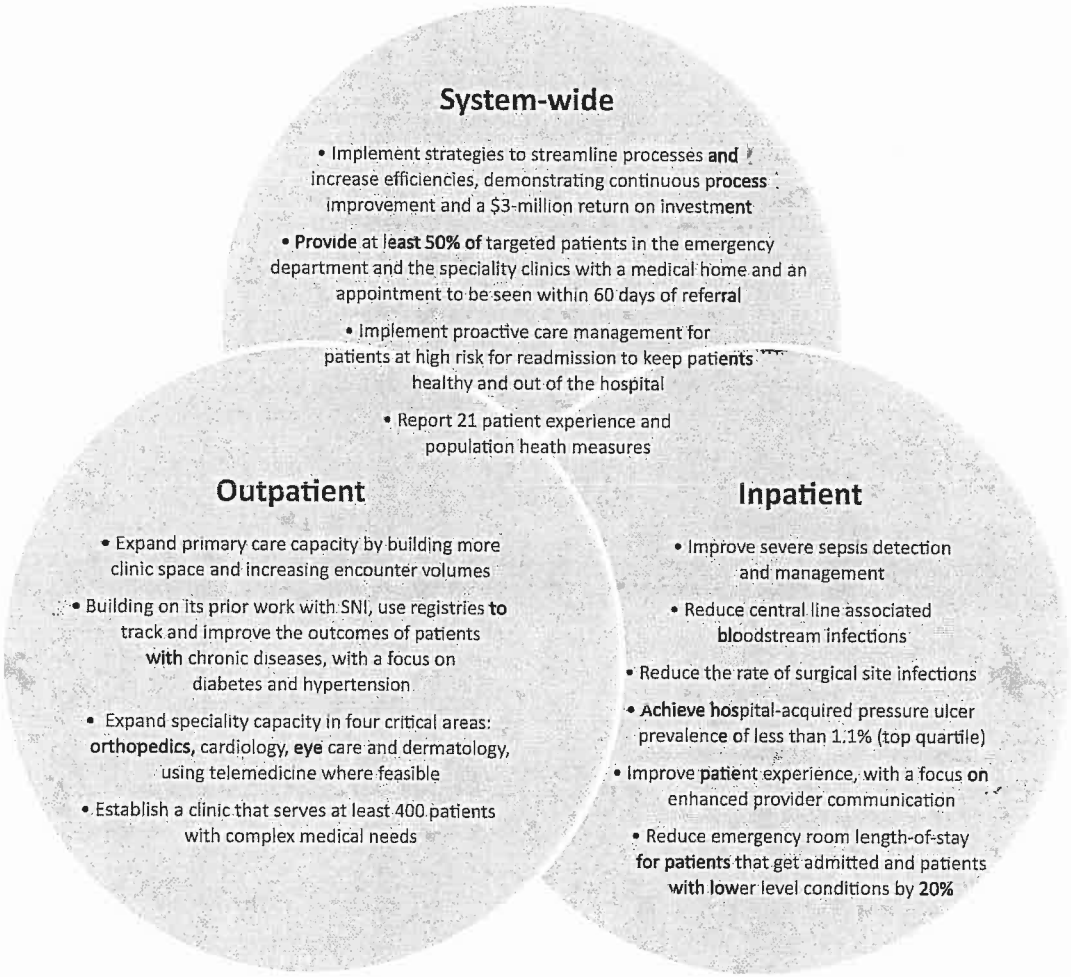

Table 2: Summary of Public Hospital Systems' 5-Year Plans

Below is a summary of the Incentive Program projects selected by the 21 public hospital systems.[4] In the first year of the program, public hospital systems met 100% of their 298 first year milestones, resulting in them being eligible to receive 100% of their Year One (2010-2011) federal funding.

INCENTIVE PROGRAM	PUBLIC HOSPITAL SYSTEMS	
	Number of hospitals that selected specific projects	Percentage of hospitals that selected specific projects
Category 1: Infrastructure Development *(must choose at least 2 projects, which include multiple milestones)*		
Implement and Utilize Disease Management Registry Functionality	14	67%
Expand Primary Care Capacity	11	52%
Increase Training of Primary Care Workforce	9	43%
Enhance Performance Improvement and Reporting Capacity	8	38%
Expand Specialty Care Capacity	7	33%
Enhance Interpretation Services and Culturally Competent Care	5	24%
Enhance Urgent Medical Advice	5	24%
Enhance Coding and Documentation for Quality Data	5	24%
Collect Accurate Race, Ethnicity and Language (REAL) Data to Reduce Disparities	3	14%
Introduce Telemedicine	2	10%
Develop Risk Stratification Capabilities/Functionalities	1	5%
Category 2: Innovation & Redesign *(must choose at least 2 projects, which include multiple milestones)*		
Expand Medical Homes	17	81%
Expand Chronic Care Management Models	10	48%
Integrate Physical and Behavioral Health Care	10	48%
Redesign Primary Care	7	33%
Redesign to Improve Patient Experience	7	33%
Implement/Expand Care Transitions Programs	6	29%
Conduct Medication Management	5	24%
Increase Specialty Care Access/Redesign Referral Process	4	19%
Apply Process Improvement Methodology to Improve Quality/Efficiency	3	14%
Establish/Expand a Patient Care Navigation Program	2	10%
Improve Patient Flow in the Emergency Department/Rapid Medical Evaluation	2	10%
Use Palliative Care Programs	2	10%
Implement Real-Time Hospital-Acquired Infections (HAIs) System	2	10%
Redesign for Cost Containment	1	5%
Category 3: Population-Focused Improvement *(all projects required, includes 70 milestones)*		
Patient/Care Giver Experience *(required)*	21	100%
Care Coordination *(required)*	21	100%
Preventive Health *(required)*	21	100%
At-Risk Populations *(required)*	21	100%
Category 4: Urgent Improvement in Care *(2 projects required; must choose at least 2 additional)*		
Severe Sepsis Detection and Management *(required)*	21	100%
Central Line Associated Blood Stream Infection Prevention (required)	21	100%
Surgical Site Infection Prevention	16	76%
Hospital-Acquired Pressure Ulcer Prevention	13	62%
Venous Thromboembolism (VTE) Prevention and Treatment	9	43%
Stroke Management	3	14%
Falls with Injury Prevention	1	5%

4 Table 2 represents only the projects included in public hospital systems' Incentive Program plans; it does not reflect all of the other projects public hospitals are working on within their systems.

Investment and Risks

While the Incentive Program offers significant opportunities to improve care for patients, its funding is not guaranteed and will require significant local investment. All federal funding in the Incentive Program is tied to the public hospital systems first: (1) achieving the milestones in their approved plans; and (2) providing the non-federal share. Public hospital systems are providing all the matching funds for the Incentive Program. Because Medicaid is a joint federal-state program, federal dollars can only be drawn down after the state/local funding match is provided. As with other areas of the Waiver, there is no State General Fund for public hospital systems in the Incentive Program.

If all milestones are met and public hospital systems contribute the required matching dollar-for-dollar funds, then they may receive a total of $3.3 billion in federal funding over the five-year term of the Waiver. However, if a public hospital system does not meet its milestones, it will not receive its full allocation of federal funding even if it invested significant local resources toward achieving those goals. Additionally, if the State of California does not achieve projected cost savings in the Medi-Cal program agreed to by the State and the federal government as part of the Waiver (i.e., through the shift of Seniors and Persons with Disabilities into managed care), the Incentive Program and other funds to the State would be reduced.

It is also important to note that the Incentive Program is being implemented in the context of severe budget reductions at the national, state and local levels. Thus, while these investments are being made in their systems, in other areas, many public hospital systems are having to make painful cuts. Another challenge for public hospital systems stems from the financing structure of the Waiver: For a significant number of services public hospital systems provide, the reimbursement will continue to be limited to 50 cents for every dollar they spend to care for low-income patients.

Although these milestones may be very challenging to achieve, public hospital systems are taking a leadership role in publicly committing to this ambitious effort. Through the Incentive Program, they will be at the forefront of the nation in aligning performance and financing.

Looking Ahead

Despite the risk-based, arduous nature of the Incentive Program, most of California's public hospital systems are going above and beyond minimum requirements because their Incentive Program plans are aligned with their overall strategic objectives which reflect their deep commitments to providing better care and improving their patients' health. Furthermore, such transformation will help prepare public hospital systems for national health reform by increasing their capacity through improvements in integration and efficiency.

The experiences of California's public hospital systems in implementing their Incentive Program plans can contribute to the national discourse on how to provide more integrated, effective and value-added health care to safety net populations. The gains made and lessons learned through the Incentive Program can establish a new standard for quality improvement and delivery system transformation that can serve as a model for the health care industry nationwide.

About CAPH

The California Association of Public Hospitals and Health Systems is a non-profit trade organization representing 19 public hospital systems that collectively serve more than 2.5 million patients annually. Together, CAPH works to strengthen the capacity of our members to advance community health; ensure access to comprehensive, high-quality, culturally sensitive health care services for all Californians; and educate the next generation of health care professionals. Our passionate belief that everyone deserves an equal opportunity to enjoy good health – regardless of their insurance status or ability to pay – drives our policy and advocacy agenda.

Attachment Four

CSAC Memo: The Campaign for Modern Medicines

CMM: What is at stake with Congressional reauthorization of the Prescription Drug User Fee Act (PDUFA)?

CMM: The Campaign for Modern Medicines' Initiative to Protect Medicare

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November 18, 2011

To: CSAC Health and Human Services Policy Committee

From: Kelly Brooks-Lindsey, CSAC Legislative Representative
Farrah McDaid Ting, Senior Legislative Analyst

Re: The Campaign for Modern Medicines

Background:
CSAC has invited Eli Lilly and Company to provide an update on the status of the reauthorization of the federal Prescription Drug User Fee Act (PDUFA). This Act was originally passed in 1992, allowing the Food and Drug Administration (FDA) to collect fees from drug manufacturers to fund a streamlined drug approval process.

Congress has reauthorized the PDUFA three times in the last 19 years, and Congress must next reauthorize it in 2012. However, with fiscal concerns pervading Washington, D. C. and Congress seeking significant cost savings, the FDA's share of the federal budget is expected to shrink. This may increase the time it takes the agency to approve or renew pharmaceutical products, which in turn will affect the availability of pharmaceuticals and treatments for consumers, health plans, and drug companies. Counties, as health care providers and health plan purchasers, may also be affected by any delay in reauthorization of the PDUFA.

Eli Lilly and Company, the world's 10th largest drug manufacturer, is mounting an advocacy campaign titled "The Campaign for Modern Medicines" to urge Congress to reauthorize the PDUFA.

Speakers:

- **Kathy Miller,** Advisor, Global Public Policy, Eli Lilly and Company

More Information:
Eli Lilly has created a comprehensive Web site for The Campaign for Modern Medicines that includes information about the intersect between the PDUFA and Medicare Part D. Visit www.modernmedicines.com.

Lilly Pad (Eli Lilly's blog): www.lillypad.lilly.com

CMM The Campaign for Modern Medicines

What is at stake with the Congressional reauthorization of the Prescription Drug User Fee Act (PDUFA)?

Congress must reauthorize PDUFA no later than 2012 in order to keep the program operational. The current user fee relationship between the biopharma industry and the FDA under PDUFA has allowed the FDA to hire a significant number of new employees to work on drug application review and new drug safety. The implementation of PDUFA initially led to a drop in review times for new drug applications and allowed new medicines to reach patients more quickly.

However, over recent years, the original successes of PDUFA have slipped, partly due to additional requirements placed on the FDA during prior PDUFA reauthorizations.

The campaign believes that without the proper regulatory environment in place, America will lose the innovation race and will fail to realize all of the critical health and economic benefits that new medicine research, manufacturing, and delivery can bring.

The campaign will be advocating to Congress that the PDUFA reauthorization is an opportunity to advance innovation from U.S. companies and bring new medicines to patients faster.

What happens when PDUFA works?

When PDUFA works, it creates a regulatory environment that is predictable, transparent, and institutes accountability for the FDA. This allows the pharmaceutical industry to deliver safe and innovative cures and treatments that will help people live longer, healthier, and more productive lives. It also facilitates the expansion of America's position as the global leader in drug innovation.

Since PDUFA was implemented in 1992, we've seen how it can work, and its 18-year history has paralleled our country's most productive and innovative generation of new drug development. Congress needs to be reminded how well PDUFA can work if it's structured right.

For example:

- More than 2,900 medicines are in clinical trials today or being reviewed by FDA, up from 1,800 in 1999.
- More than 50% of new drugs are launched in the U.S. now, compared to 8% pre-PDUFA.
- America currently has more potential treatments in clinical trials than the rest of the world combined.
- The U.S. accounts for 80% of the world's biotechnology.
- Since 1993, over 1,000 new drugs have been approved, including 90 new cancer drugs, 139 drugs for metabolic and endocrine disorders, 125 anti-infective drugs, 138 drugs for neurological and psychiatric disorders, and 106 new drugs to treat cardiovascular and renal disease.

More specifically:

- PDUFA user fees have enabled the FDA to significantly increase scientific review staffing to work on drug application review and new drug safety.
- Median review times for priority review drugs has been cut in half and for standard applications has been cut by 37%.
- PDUFA has decreased review times while not reducing patient safety.
- Previous PDUFA reauthorizations have increased drug and patient safety.

What happens when PDUFA doesn't work correctly?

With Congress reauthorizing PDUFA every five years since 1992, changes have been made to the program that have unintentionally reduced its effectiveness and impaired the FDA's ability to review new drug applications quickly and efficiently. This ultimately means unnecessary delays in getting new, safe and innovative medicines to the patients who need them. It also means the United States risks its position as a leader in drug discovery and innovation as other countries might bring equivalent medicines to market before the U.S.

As Congress looks to reauthorize PDUFA next year, it needs to know that previous changes to PDUFA have helped slow down the regulatory process at the FDA. Right now new medicines are taking longer to get to patients and fewer new drugs are being approved by the FDA than in past years.

For example:

- The last PDUFA reauthorization (PDUFA IV) mandated many new performance commitments and process improvements that have placed new demands on the FDA. These have hindered the FDA's ability to meet review

goals. In FY 2008, the FDA only met 1/3 of review performance goals as outlined in PDUFA IV.
- Median review times for new drug applications have increased for the first time in five years.
- Median review times for priority drugs almost doubled from 6 months to 11 months between FY 2007 and FY 2008, partly due to new requirements included in the Food and Drug Administration Amendment Act (FDAAA).
- New drug review times, which decreased by 63% in PDUFA I & II, began to rise under PDUFA III. Under PDUFA IV (in FY2008) median review times rose further.
- PDUFA fees – which are intended to supplement FDA appropriations – not replace them, have almost doubled between FY2007 and FY2011, and made up 65% of FDA's drug review budget in FY2010.

How Congress gets the PDUFA reauthorization right

When Congress votes to reauthorize PDUFA next year, they need to remember that PDUFA has brought about tremendous advances to the FDA and has helped spur new drugs to patients faster. However, Congress must show caution when reauthorizing PDUFA. It should not be a legislative vehicle for unnecessary and costly new mandates on the FDA, which in the past have only slowed the pace of innovation in the U.S. and delayed the delivery of new medicines to patients.

The reauthorization of PDUFA gives Congress the opportunity to fix problems with the new drug review process at the FDA. The CMM has formed to educate Congress on how best to do that.

- Streamline the regulatory review process for new drugs and make it predictable.
- Expand the transparency of the science-based review process for new drugs.
- Increase the FDA's accountability.
- Reduce conflict with the FDA's mission of ensuring the safety and efficacy of medicine.
- Ensure people's confidence in what their government, and in this case, the FDA can accomplish in helping provide safe and effective medicines.
- Focus on PDUFA. During previous reauthorizations, PDUFA has acted as a vehicle for other measures that actually undermine and impair the FDA's ability to deliver on PDUFA. For example, when FDAAA was added to PDUFA IV, it set up new regulatory responsibility for the FDA that had nothing to do with PDUFA. However, that responsibility caused the FDA to cannibalize resources and almost doubled the review time for priority drugs.

How can you help make sure Congress gets the PDUFA reauthorization right?

Join the Campaign for Modern Medicines and help us urge Congress to reauthorize PDUFA with changes that will speed the delivery of safe and innovative medicines to the patients who need them most, and expands the US position as the global leader in the delivery of these cures and treatments.

The Campaign for Modern Medicines is a group of individuals, advocacy organizations, and businesses who are working toward these goals.

CMM The Campaign for Modern Medicines

The Campaign for Modern Medicine's Initiative to Protect Medicare

Congress is now considering a proposal to change Medicare that would increase premiums of older Americans by up to 40% through significant changes to the prescription drug program (Part D). This is one of the proposals before the "super committee" that would increase costs to Medicare beneficiaries.

Weakening Medicare Part D will increase costs for older Americans by levying billions of dollars in new prescription drug costs onto them, many on fixed incomes who can least afford it

Currently, the average Part D premium is set to decrease in 2012. This proposal would increase annual premiums for all beneficiaries by 20% - 40% according to a study by a former director of the non- partisan Congressional Budget Office (CBO).

Changing Medicare Part D will negatively impact the quality of healthcare for older Americans by reducing access to medicines

This proposal threatens to change Medicare Part D into a Medicaid-style program and restrict older Americans' access to new and innovative medicines and treatments.

Medicare Part D already saves money across Medicare

The Journal of the American Medical Association found that improved access and adherence to medicines through Part D saves Medicare about $1,200 per year in hospital, nursing home and other costs for each older American who previously lacked comprehensive prescription drug coverage. According to other experts, this equals about $12 billion per year in savings across Medicare.

Stifle Drug Innovation and Eliminate Jobs

According to CBO, Medicaid rebates on Part D prescription drugs "would reduce manufacturers' incentives to invest in R&D on products that would be expected to have significant Medicare sales." This could halt potentially breakthrough discoveries to treat Parkinson's, Alzheimer's, arthritis, osteoporosis, and other diseases that disproportionately affect older people, and lead to immediate job cuts in the U.S.

Congress, through the newly created 12 member super committee, are seriously considering this change to Medicare now and will vote on a final proposal by November 23rd.

We need your help now to tell members of the super committee not to change Medicare because it already works. If Medicare is important to you or your family, please sign our petition telling Congress not to change Medicare Part D.

The Campaign for Modern Medicines is building a coalition of individuals, advocacy organizations, and businesses who believe that changes to Medicare will have serious consequences for Medicare beneficiaries, for businesses, and for state governments.