CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

California's Progress in PRIME

Years 1-4

Recording link (1 hour)

December 16, 2019

Agenda

- About
  - CAPH/SNI
  - California's Public Health Care Systems
- PRIME
  - Background
  - Progress and Themes
- Member Perspectives
  - Los Angeles County Department of Health Services
  - UC San Diego
- Q&A

About

CAPH/SNI

California's Public Health Care Systems

About CAPH/SNI

California Association of Public Hospitals and Health Systems (CAPH)

- Advances policy and advocacy efforts that strengthen the capacity of its members and ensures access to high-quality, culturally sensitive, comprehensive care

California Health Care Safety Net Institute (SNI)

- Informs and shapes statewide and national health care policy, provides performance measurement and reporting expertise, and accelerates decision-making and learning. Because of SNI, more people – especially the under-served – receive effective, efficient, and respectful health care regardless of their ability to pay.

21 Public Health Care Systems

Alameda County
Alameda Health System

Contra Costa County
Contra Costa Health Services:
- Contra Costa Regional Medical Center

Kern County
Kern Medical

Los Angeles County
Los Angeles County Department of Health Services:
- Harbor/UCLA Medical Center
- LAC+USC Medical Center
- Olive View / UCLA Medical Center
- Rancho Los Amigos National Rehabilitation Center

Monterey County
Natividad Medical Center

Riverside County
Riverside University Health System

San Bernardino County
Arrowhead Regional Medical Center

San Francisco County
San Francisco Department of Public Health:
- Zuckerberg San Francisco General Hospital
- Laguna Honda Hospital and Rehabilitation Center

San Joaquin County
San Joaquin County Health Care Services:
- San Joaquin General Hospital

San Mateo County
San Mateo Medical Center

Santa Clara County
Santa Clara Valley Health & Hospital System:
- Santa Clara Valley Medical Center

Ventura County
Ventura County Health Care Agency:
- Ventura County Medical Center

University of California (UC)
UC Health:
- UC Davis Health
- UCI Health
- UC San Diego Health
- UCSF Health
- UCLA Health

Includes county-owned and-operated health systems and UC medical systems

The Critical Role of Public Health Care Systems

- Serve more than **2.85** million patients annually
- Just **6%** of hospitals in the state, but provide **35%** of all hospital care to Medi-Cal beneficiaries in the state
- Provide **10** million outpatient visits each year, and operate more than **200** outpatient clinic facilities
- Serve as the primary care provider to more than **500,000** Medi-Cal expansion enrollees
- Operate **half** of California's top-level trauma and burn centers
- Train **more than half** of all new doctors in hospitals across the state

PRIME

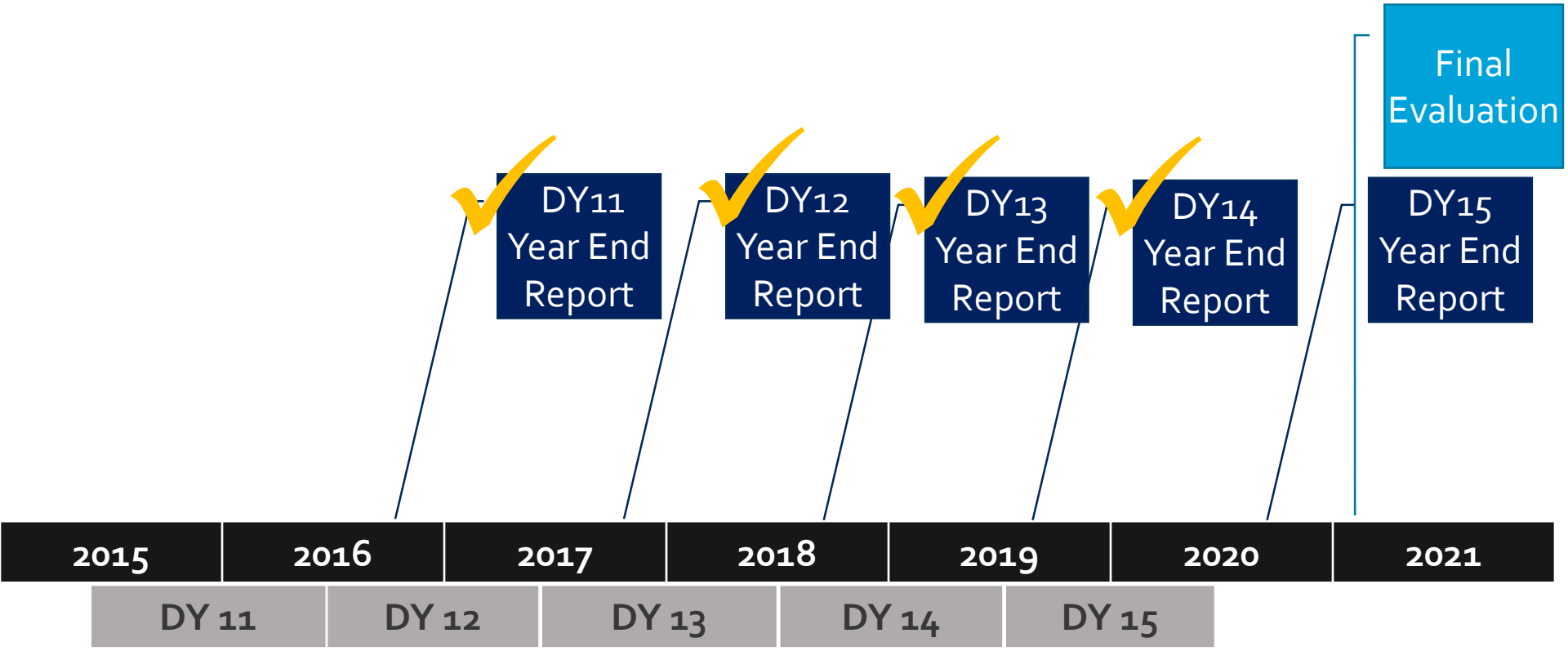
Background

Progress and Themes

PRIME Background

- One of four Medi-Cal 2020 Section 1115 waiver programs
- Builds on California's first-in-the-nation DSRIP
- PRIME entities = public health care systems (designated public hospitals, or DPHs) and district & municipal hospitals
- Pay-for-performance program worth up to $3.26b in federal funds over 5 years
  - Ambitious year-over-year performance improvement targets
  - 10% gap closure between current performance and 90th percentile
  - Must be above 25th percentile to receive payment
  - Performance above 90th percentile must be maintained

PRIME Program Timeline



PRIME Demonstration Year (DY) 14 Year-End Measurement Period:
July 1, 2018 – June 30, 2019

PRIME Structure

Domain 1: Outpatient Delivery System Transformation and Prevention	Domain 2: Targeted High-Risk or High Cost Populations	Domain 3: Resource Utilization Efficiency
• Integration of Physical and Behavioral Health • Ambulatory Care Redesign: Primary Care* • Ambulatory Care Redesign: Specialty Care • Patient Safety in the Ambulatory Setting • Million Hearts • Cancer Screening & Follow-Up • Obesity Prevention & Healthier Foods Initiative	• Improved Perinatal Care • Care Transitions: Integration of Post-Acute Care • Complex Care Management for High Risk Medical Populations • Integrated Health Home for Foster Children • Transition to Integrated Care: Post Incarceration • Chronic Non-Malignant Pain Management • Comprehensive Advance Illness Planning and Care	• Antibiotic Stewardship • High-Cost Imaging • Therapies Involving High-Cost Pharmaceuticals • Blood Products

For public health care systems:

- 6 required projects
- Must select 3 additional from 12 optional projects (including at least 1 from Domain 3)
- Must report on all metrics in each required/selected project

* Includes Race Ethnicity and Language (REAL) and/or Sexual Orientation/Gender Identity (SO/GI) Disparity Reduction

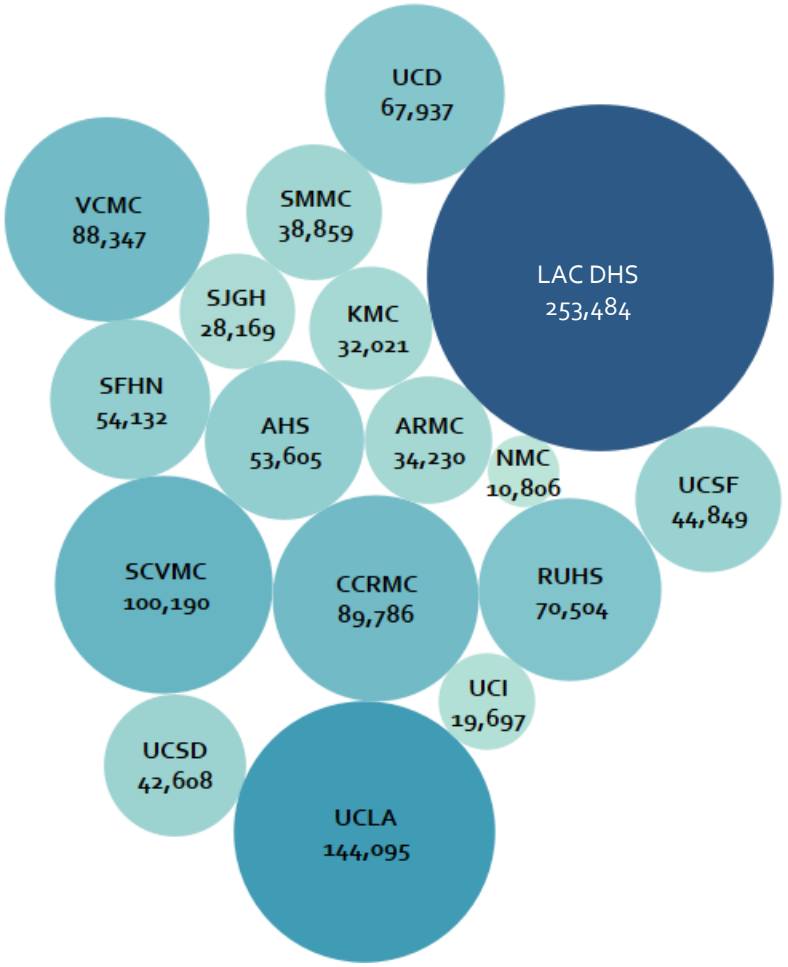
DY14 PRIME Eligible Population

Individuals of all ages who either:

had least 2 encounters with the PRIME Entity Primary Care team during the measurement period,

or

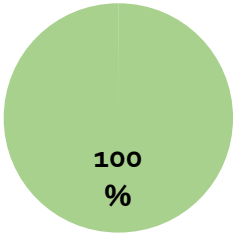
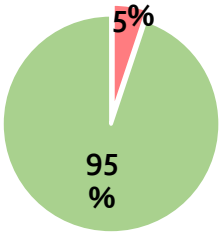
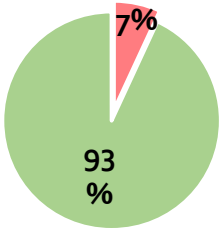
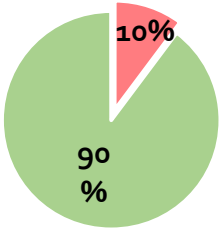
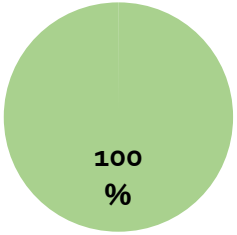
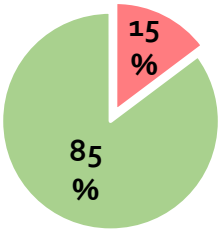
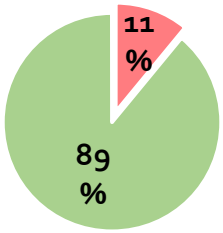
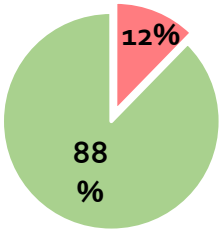
are in Medi-Cal Managed Care with 12 months of continuous assignment to the PRIME Entity during the measurement period.



DY14YE data not yet approved by DHCS.

By DY: % Target Met

YE Target Met YE Target Not Met

	DY11	DY12	DY13	DY14	DY15
Total Available Funding	$700M	$700M	$700M	$630M	$535.5M
% all metrics that are P4P	0%	37%	64%	89%	97%
All Metrics					
P4P Metrics					

DY14 YE data not yet approved by DHCS. Sub-rates are counted as unique metrics. Metrics with denominator <30 were not counted in Target Met/Not Met

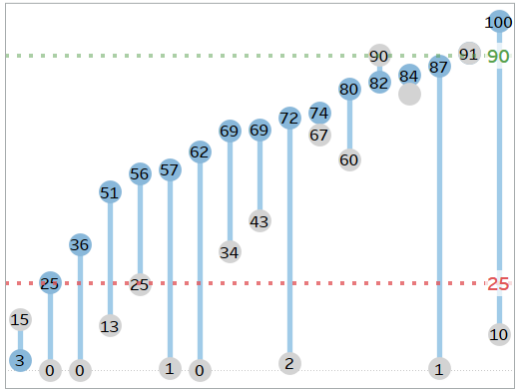
DY14 Additional Lives Impacted

Additional lives impacted since DY 11	Metric
380,900	**Requests for Specialty Care (SC) expertise** for which an individualized response was sent to the referring provider and/or the referring provider's care coordination team **within 5 calendar days** (Request for SC Expertise Turnaround Time)
371,800	Age 18+ with in-person primary care encounters that **had sexual orientation/gender identity (SOGI) as structured data** (SOGI Data Completeness)
281,000	Age 18+ **screened for depression**, & if positive, follow-up plan documented (Screening for Depression & FU)
102,00	**Outpatient SC requests that were managed via non-in-person encounters** (Specialty Care Touches)
92,200	Age 18+ who were **screened for tobacco use** ≥1 times within 24 months & who received cessation counseling intervention if identified as a tobacco user (Tobacco Assessment & Counseling)
72,500	Age 6 month+ seen Oct 1 -Mar 31 who **received an influenza immunization** OR who reported previous receipt of an influenza immunization (Influenza Immunization)
36,300	**Had ≥ 1 full screening, brief intervention, & referral to treatment** (Alcohol Drug Misuse SBIRT)
33,600	Age 50-75 appropriately **screened for colorectal cancer** (Colorectal Cancer Screening)
16,300	Age 18–85, with diagnosis of hypertension, whose **blood pressure was controlled** (Controlling Blood Pressure)

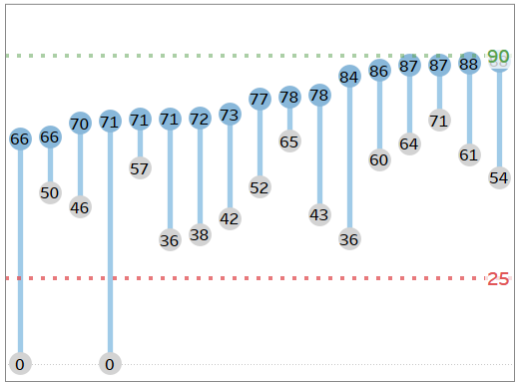
Examples of Progress: DY11→DY14

DY11 rate DY14 YE rate --- DY14 min. benchmark --- DY14 high perf. benchmark

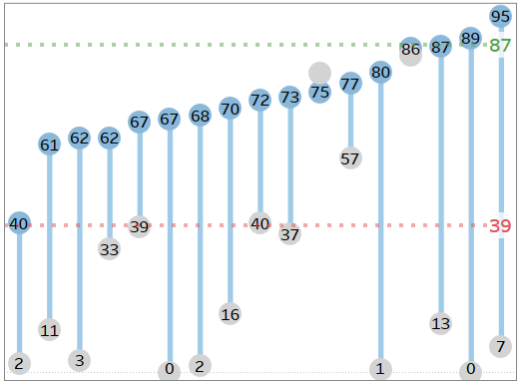
Request for Specialty Care Expertise Turnaround Time (< 5days)



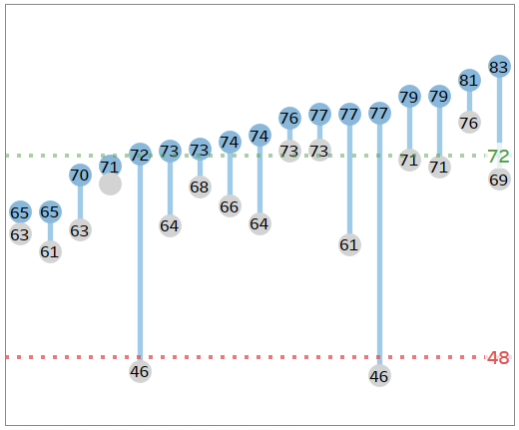
Influenza Immunization (Specialty Care Project)



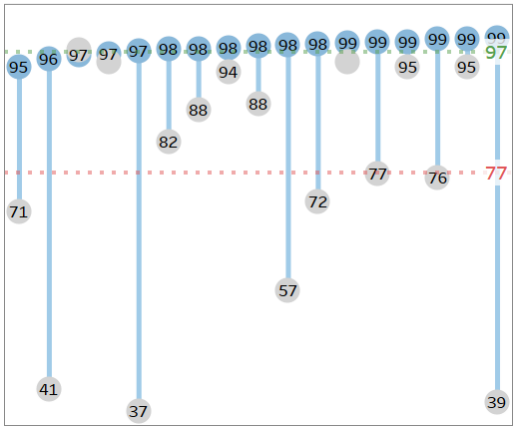
Screening for Depression & Follow-Up



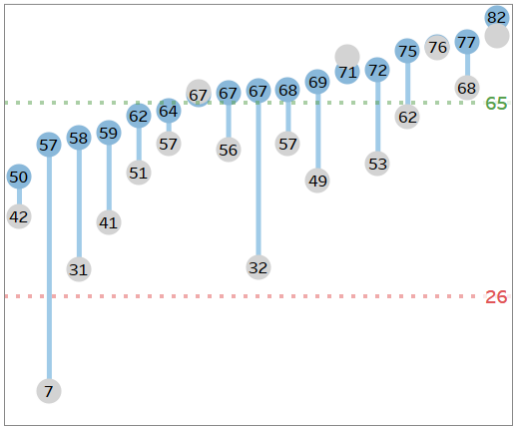
Controlling Blood Pressure



Tobacco Assessment&Counseling



Colorectal Cancer Screening



Disparity Focus in PRIME

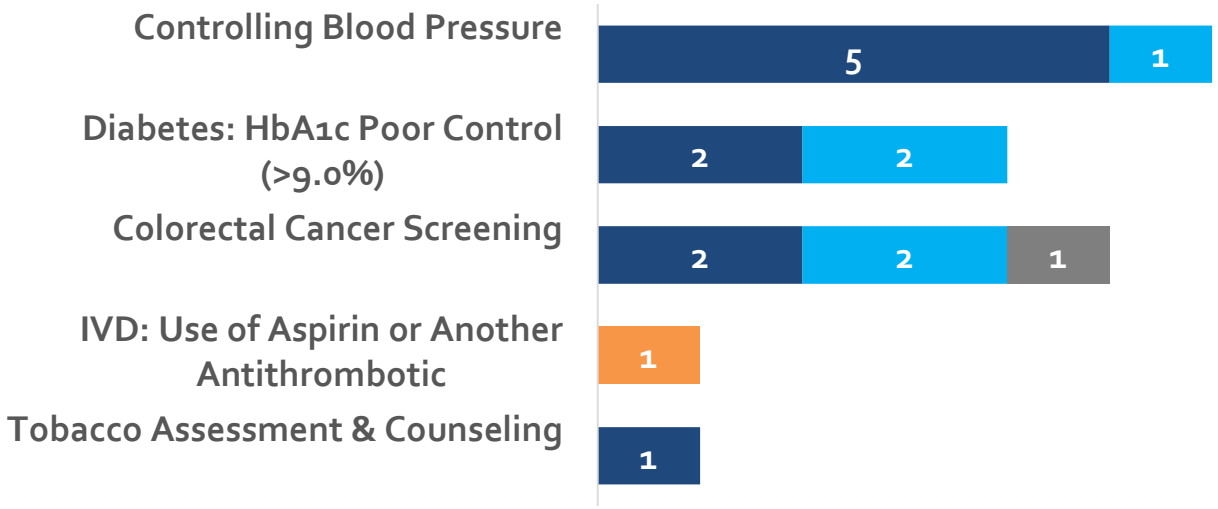
Selected Disparity Population

- African Americans
- Spanish Speakers
- Hispanic/Latinx
- English Speakers

By the end of Demonstration Year 14 (7/1/18 – 6/30/19)

13 out of 17 DPHs met their annual improvement target for their selected metric and disparity population.

Selected PRIME measure



= Number of Designated Public Hospitals focusing on this disparity

PRIME Progress Themes

Improve coordination & partnerships

Enhance patient engagement

Develop the workforce

Improved population health management

Invest in IT & data analytics

Implement new processes & workflows

Strengthen & standardize performance improvement

PRIME Progress:
Coordination & Partnerships

Improve coordination & partnerships

Improving coordination internally and enhancing external partnerships to improve performance and patient care.

Example

Contra Costa Regional Medical Center leads a **multiagency collaborative to improve care** for county's foster children by:

- Improving appointment access
- Facilitating cross-department data sharing
- Sharing commitment and resources to improve health of 1,100 youth

PRIME Progress:
Patient Engagement

Enhance patient engagement

Enhancing patient engagement and touches (outreach and in-reach), including new campaigns and non-traditional services (such as telemedicine and phone visits).

Example

To improve care transitions, **Riverside University Health System** redesigned their system to support patients leaving the hospital, leading to **HCAHPS scores above the national average**. Today, hospital patient advocates:

- Round regularly on newly admitted patients
- Offer warm welcome and orientation
- Collaborate closely with patient experience nurse

PRIME Progress:
Develop the workforce

Develop the workforce

Engaging employees in change, training staff, and adapting staffing models.

Example

Care teams are at the core of the preventive care outreach at **San Joaquin General Hospital**. Pre-visit planning is completed by team of **medical assistants, working closely with primary care providers** to identify and address patient care gaps.

PRIME Progress:
Invest in IT & Analytics

Invest in IT & data analytics

Implementing new infrastructure, such as EHR enhancements, eConsult platforms, dashboards, and customized registries to more effectively care for patients.

Example

- **UC Davis** has **expanded eConsult** to 24 participating clinics for all diagnostic categories, and expanded MyChart video visits to 20 clinics
- Five DPHs have switched enterprise EHRs in the course of PRIME

PRIME Progress:
Implement New Processes & Workflows

Implement new processes & workflows

Implementing new workflows and processes, some of which are tech-enabled, to enhance patient care.

Example

To improve care for mothers and babies, **Kern Medical Center** has **increased the exclusive breastfeeding rate** 16% in the past program year, through:

- Increasing inpatient lactation support
- Launching donor breast milk program
- Educating staff and standardizing workflows

PRIME Progress:
Strengthen Performance Improvement

Strengthen & standardize performance improvement

Utilizing improvement principles and methods, such as Lean Management or Model for Improvement, to identify areas for improvement and to test changes.

Example

San Francisco Health Network improved performance in PRIME's all-cause readmission metric through QI interventions that targeted the top contributor, heart failure:

- Developed inpatient standard work to ensure consistent care
- Created a heart failure clinic and trained outpatient providers
- Improved care coordination through follow-up call or appointment within 7 days

Member Perspectives

Los Angeles County Department of Health Services

UC San Diego

Los Angeles County Department of Health Services and PRIME

Paul Giboney, MD

Associate Chief Medical Officer

Los Angeles County Department of Health Services

- 4 Hospitals
- 24 outpatient centers and clinics
- 2 Ambulatory Surgery Centers
- Jail Health Services & Juvenile Courts Health Services
- 650,000+ unique patients and 3 million + visits annually

Los Angeles County Department of Health Services

PRIME Program:

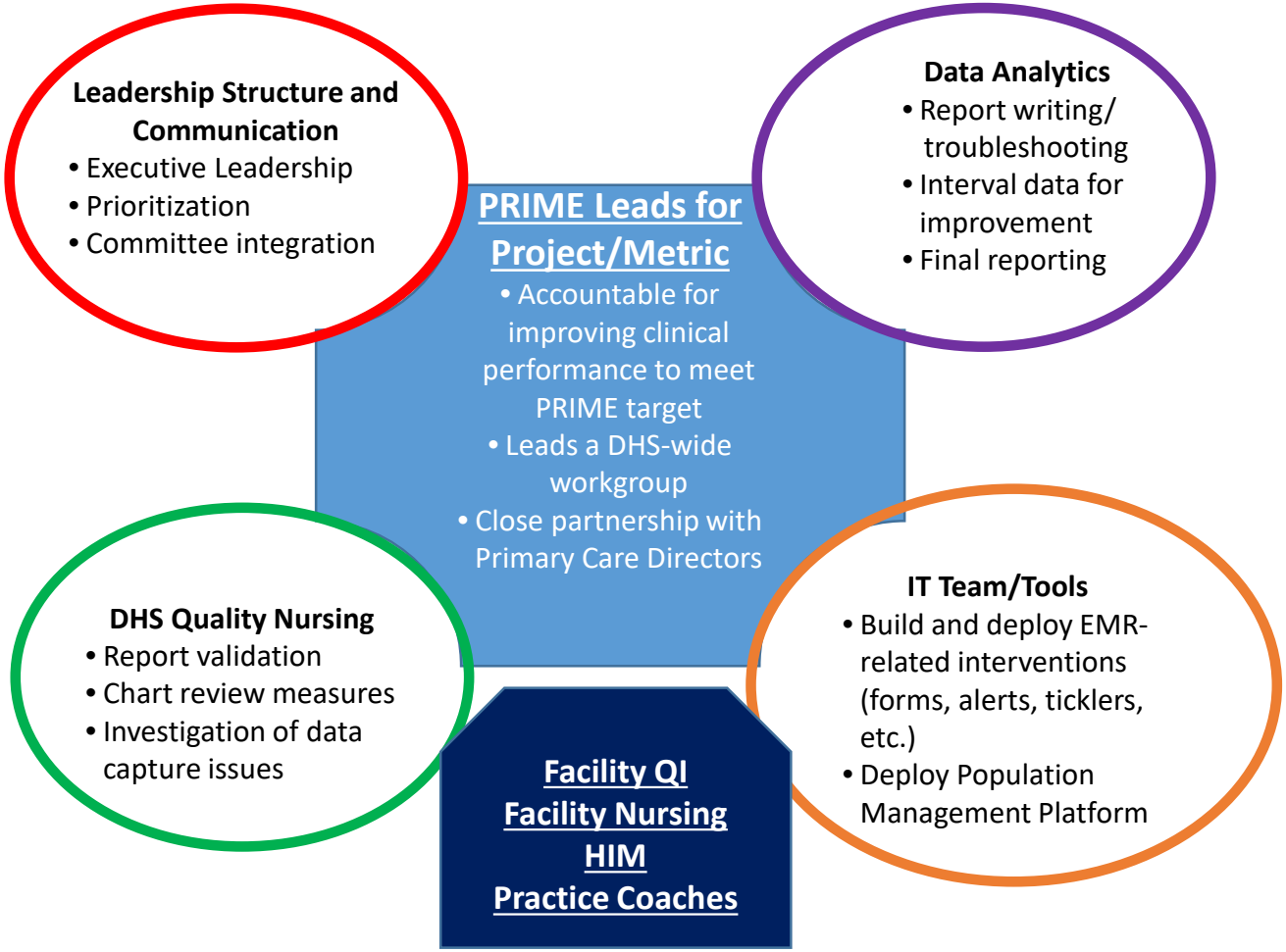
- ~ 220,000 PRIME Eligible Patients
- 13 Projects
- 66 measures

PRIME points health systems toward design changes that emphasize:

- Team-based care
- Population management
- Chronic disease management
- Prevention
- Safety
- Continuity/ownership
- “Upstream” activity (social determinants of health)
- Behavioral health integration
- Growth of new service lines (e.g. Palliative Care)
- Developing Partnerships with other County Departments (e.g. Sheriff’s)

Opportunities in PRIME

PRIME – It takes a village (*or a health system in this case*)…



PRIME Implications for our health system

- Primary Care is front and center
  - Ownership/Responsibility for our patients
  - Continuity/Empanelment
  - Take advantage of every touch-point
  - Use the tools
    - Health Maintenance tab in EMR
    - Population Health registries and reports
  - Document refusals/declinations
  - Team approach – the provider can't (shouldn't) do it all
  - Non-Face to Face touches
  - Stay Patient – Centered (what would you want?)

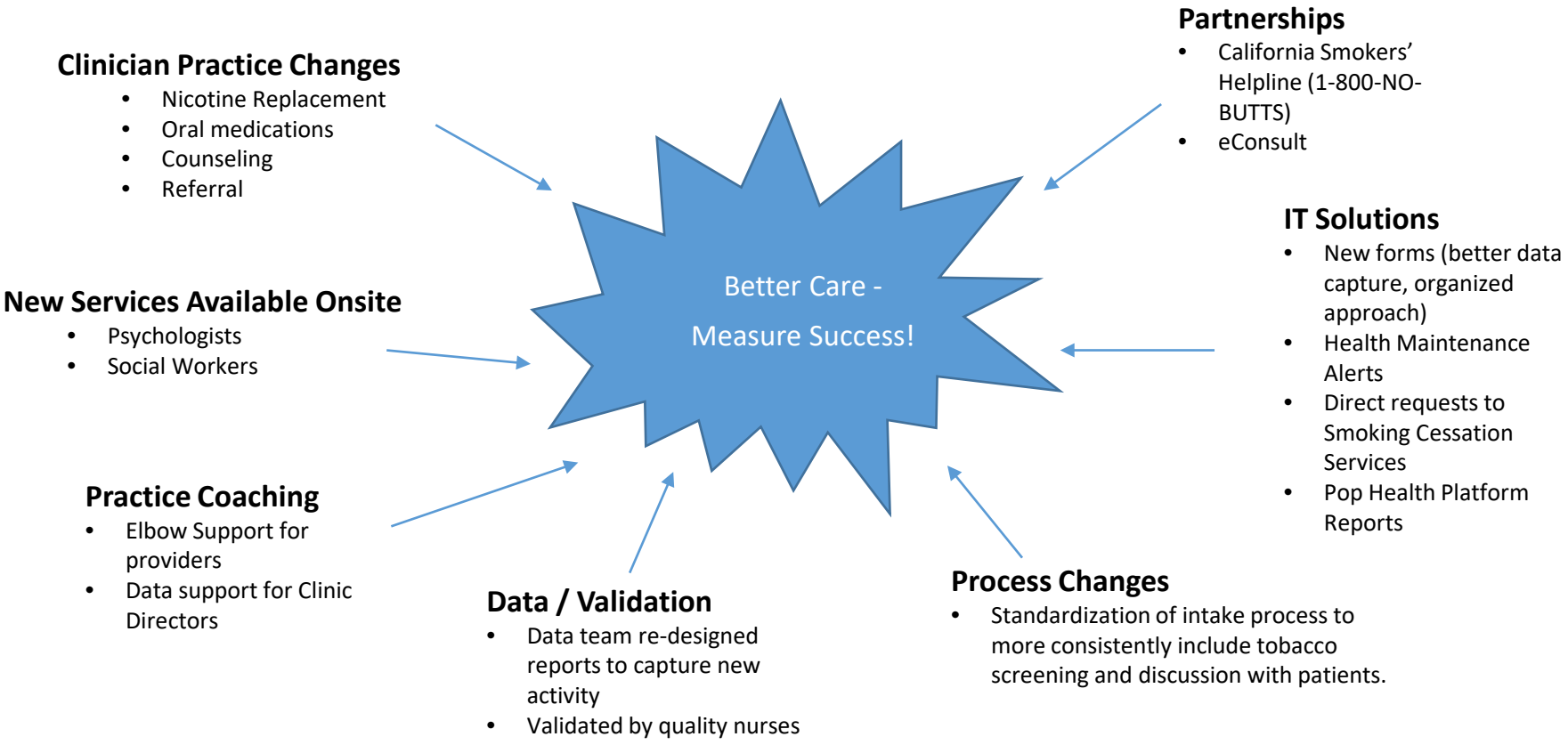
Care Delivery Improvement – Example 1

Tobacco Assessment and Counseling

- Did you screen for tobacco use?
- If the screening was positive, did you do something about it?

PRIME Year	Performance
Baseline	70%
DY 12	87%
DY 13	91%
DY 14	95%

Tobacco Assessment and Counseling –
system-wide redesign



Care Delivery Improvement – Example 2

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

- Does the patient have acute bronchitis? (usually viral)
- Did you NOT give antibiotics?

PRIME Year	Performance
Baseline	25.67%
DY 12	29.93%
DY 13	51.26%
DY 14	55.46%

Antibiotics and Bronchitis

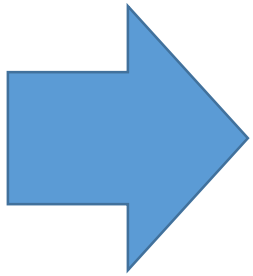
- **Initial Plans (before data)**
  - Massive DHS-wide effort
  - All providers
  - Signage - (aimed at both providers and patients)
  - Screen-savers
  - Workgroups/meetings
  - "Viral Illness" prescription pads in clinical settings

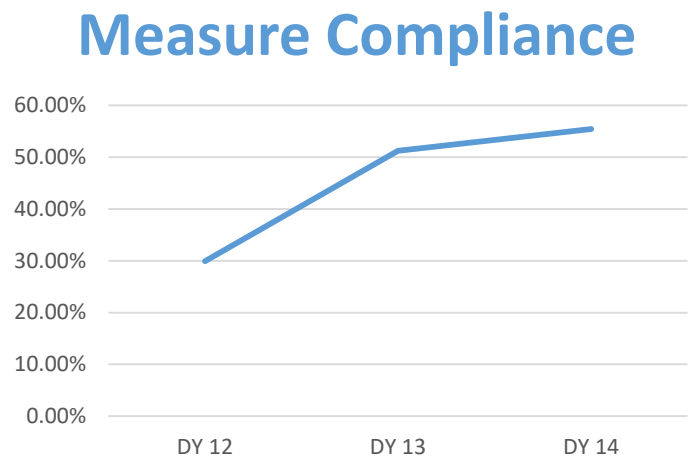
- **What the initial data revealed:**
  - Total possible prescribers ~ 500
  - Prescribers who gave antibiotics for bronchitis = 143
    - Only 27% of possible prescribers failed the measure.
  - Prescriptions written = 532 (some providers saw multiple patients with bronchitis)
  - "High Volume" Prescribers with ten or more prescriptions = 16
  - Prescriptions written by High Volume Prescribers = 244
    - **(46% of all prescriptions were written by 16 providers!)**

Antibiotics and Bronchitis –

targeted interventions

- **Revised Plans (after data)**
  - Congratulate and reinforce optimal behavior by most providers!
  - Focused effort to coach High Volume prescribers locally.
    - Some were not aware of the evidence against antibiotics for bronchitis
    - Some were responding to perceived patient expectations for antibiotics
    - Some had just fallen into a “habit” of antibiotic prescribing.
  - Antibiotic stewardship programs continued their usual work
  - Expected Practice (EP) published on the DHS Clinical Care Library to clarify when to use (or not use) antibiotics in common conditions (including acute bronchitis).
    - This has been downloaded over 300 times in the past year.
  - Practice “coaches” kept an eye on prescribing habits and flagged outliers for their local medical directors.





Patient Impact

Tobacco Use

- The entire system is now designed to ask about and offer multiple interventions to quit smoking.
- By staying connected to community partners, like the California Smokers' Helpline, patients get a more coordinated effort to help them.
- By successfully quitting smoking, patients reduce their risk of a large number of health complications.

Antibiotics and bronchitis

- More informed use of antibiotics decreases resistance and increases the potential for antibiotics to work more effectively when patients really need them.
- Patients learn more about what illnesses do not need antibiotics.

- **Continuous Performance Improvement requires improving capability in multiple domains.**
  - Data and Reporting
  - Population Management solutions – registries, etc.
  - Practice Coaching
  - EMR - based forms/alerts/dropdowns
  - Team-based care / Collaboration
  - Standardization across locations and service lines
  - Communication – rolling out new ideas/solutions
  - Culture change – challenging long held assumptions/preferences
- **Not every "tool" is needed for each measure**
- **The application of a given "tool" may look different from measure to measure.**

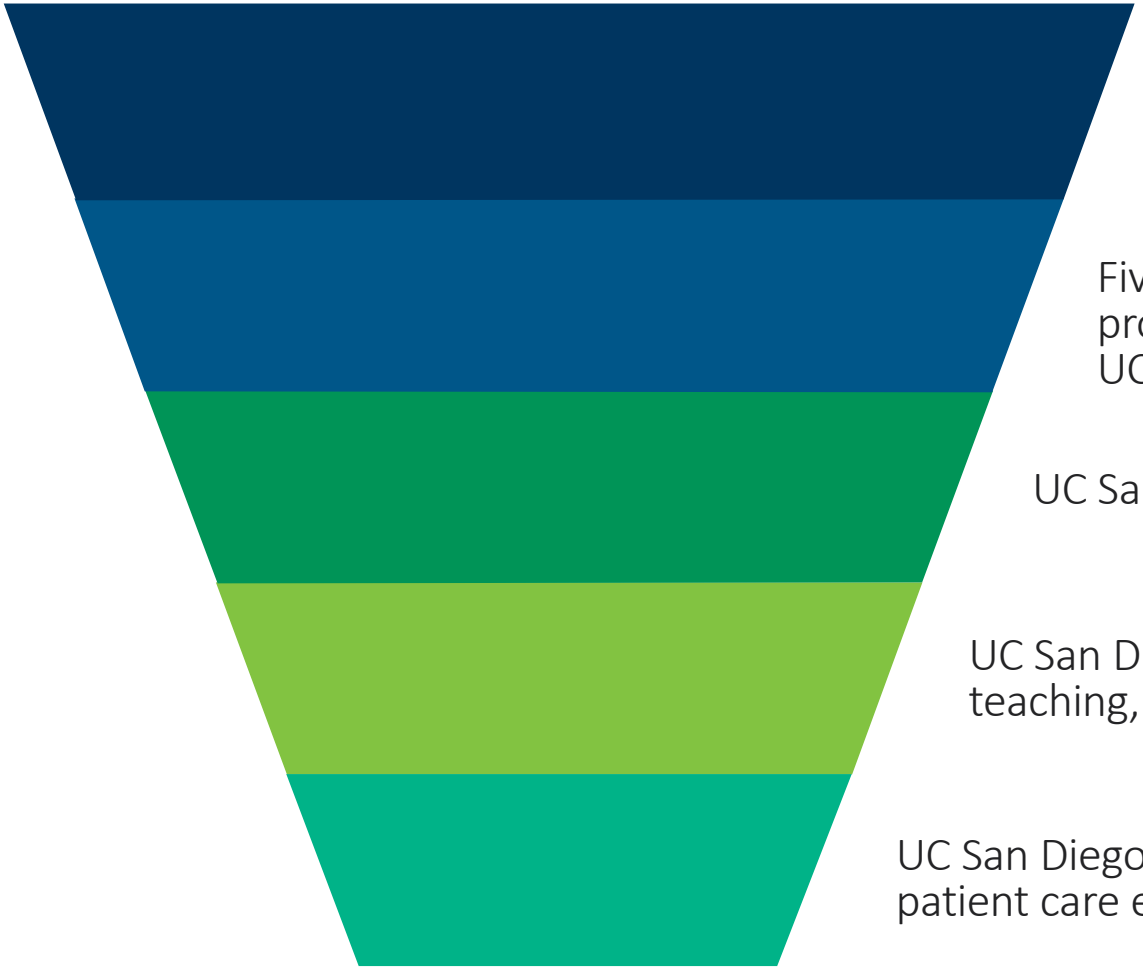
*** Innovation / creativity is usually a more powerful improvement strategy than trying to wring more efficiency out of an already maxed-out process.**

What DHS has been learning

PRIME – THE IMPACT

UC San Diego Health

UC San Diego Health – One of Five Medical Centers within the UC System



10-campus University of California system

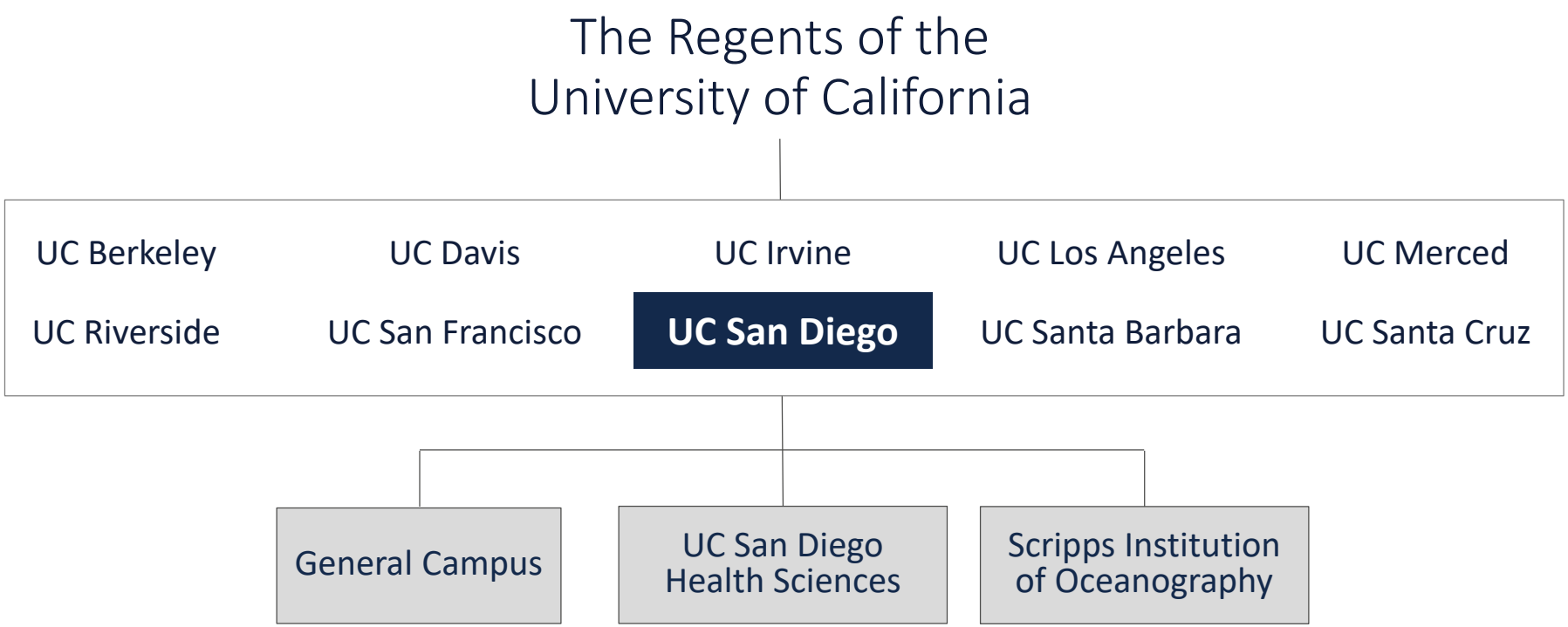
Five medical centers and 18 professional schools, collectively UC Health

UC San Diego

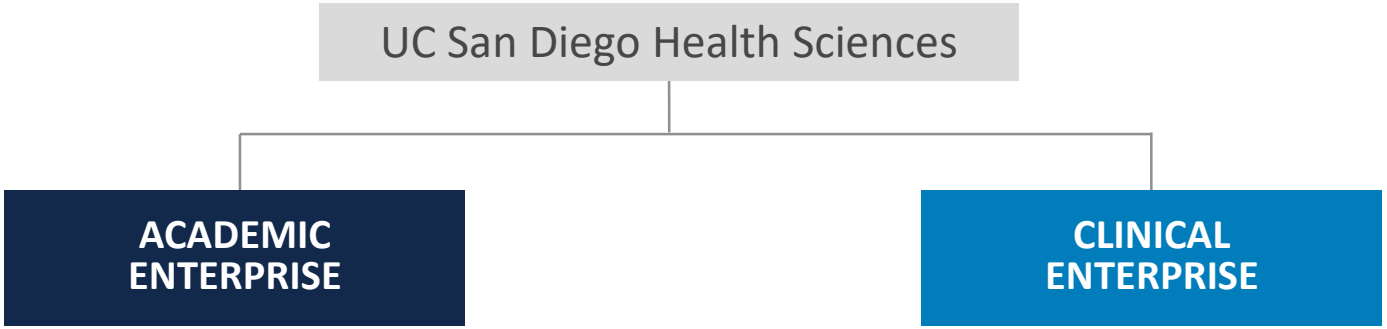
UC San Diego Health Sciences, includes teaching, research and clinical enterprises

UC San Diego Health, refers to the branded patient care enterprise

University of California System – UC San Diego



Organizational Structure



UC San Diego
School of Medicine

Skaggs School
of Pharmacy and
Pharmaceutical
Sciences

School of Public Health

UC San Diego Health

UC San Diego Medical Center

Jacobs Medical Center

Sulpizio Cardiovascular Center

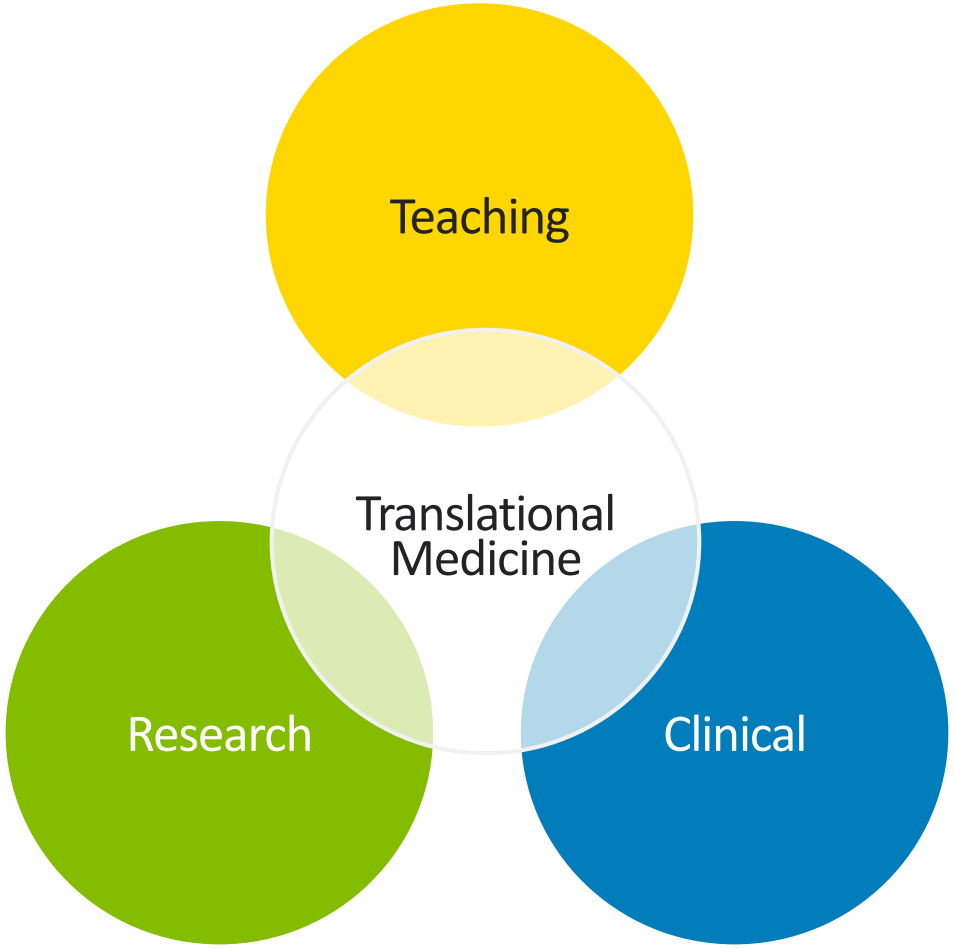
Moores Cancer Center

Shiley Eye Institute

Koman Family Outpatient Pavilion

Student Health

UC San Diego Health Sciences – Mission



Committed to achieving national excellence in each area

UC San Diego Health – World-Class Care

9,161
Employees

808
Licensed Beds

31,715
Annual Hospital Admissions

943,856
Outpatient Visits & Surgeries

~$1.85B
Operating Budget

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

NCI
Designated Comprehensive Cancer Center

HEALTHCARE EQUALITY INDEX
2019 LGBTQ HEALTHCARE EQUALITY LEADER

CHIME
HealthCare's most wired
2019

UC San Diego Health

PRIME at UC San Diego Health

PRIME Facts:

- ✓ ~ 42K PRIME Eligible Patients
- ✓ 55 Measures
  49 P4P
- ✓ 38 Metrics in DY14 were above Nation 90th%ile or 2x State target

Our focus is to improve patient health outcomes, integrate physical and behavioral health, and increase access to healthcare services, particularly for our complex care population.

PRIME Governance

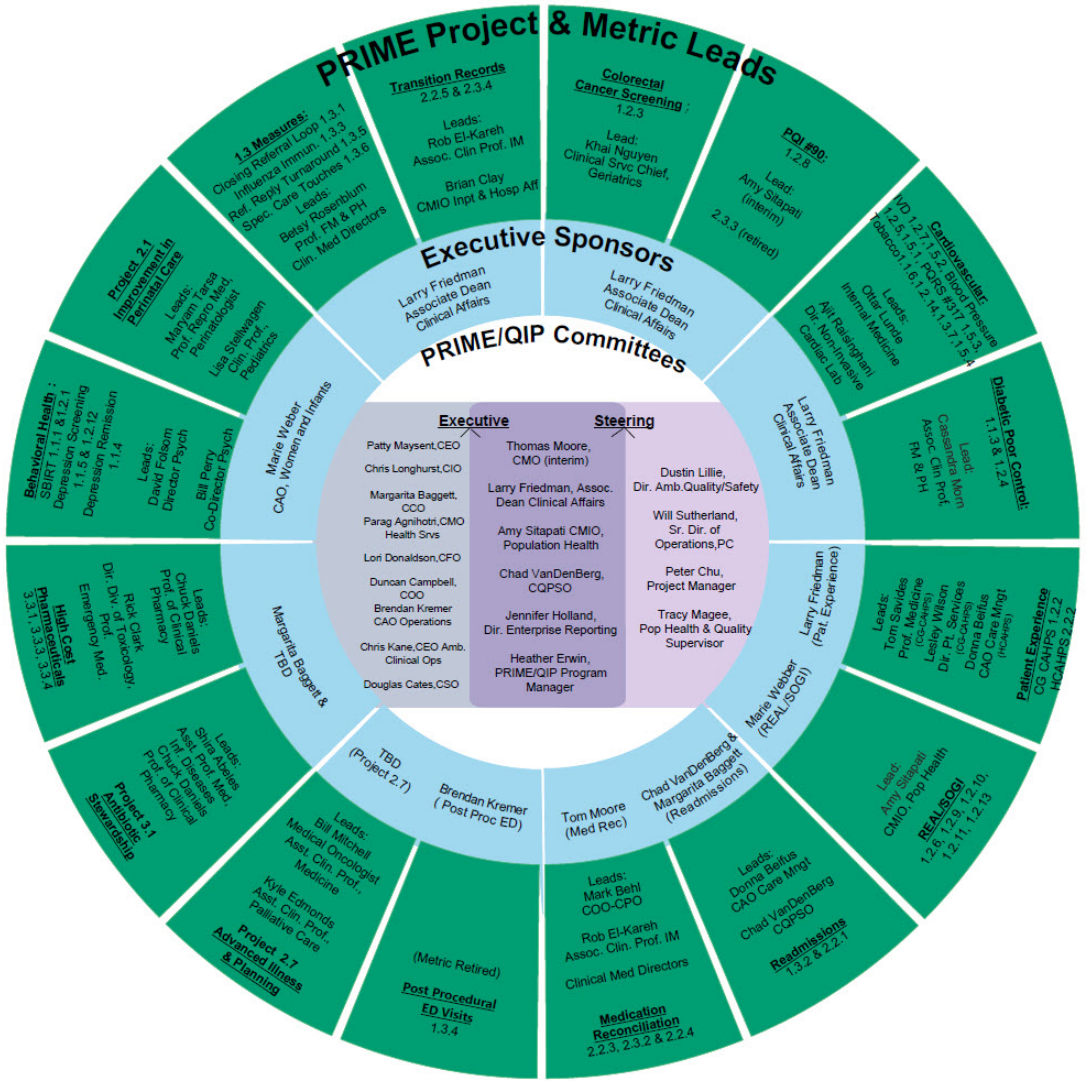
PRIME Leads

PRIME Executive Sponsors

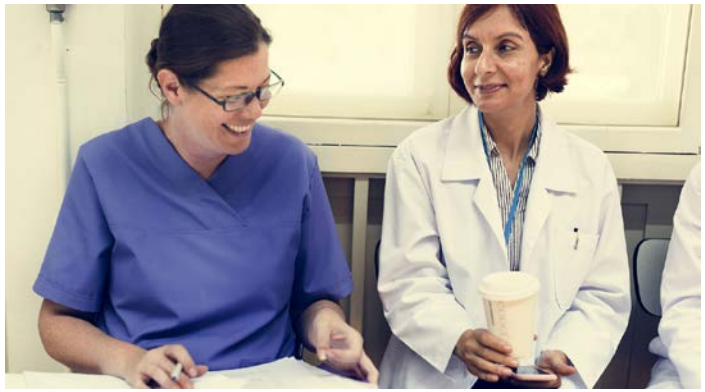
PRIME Executive Committee

PRIME Steering Committee

Members on PRIME Executive & Steering



A New Standard of PI Approach



Metric Improvement Teams

Each area of patient care has an improvement team, an executive owner in leadership and reports progress to the PRIME and QIP Steering and Executive committees.

Quality Improvement Collaboration

Quality improvement teams collaborate between the UC systems as well as with systems in the PRIMEd collaborative.

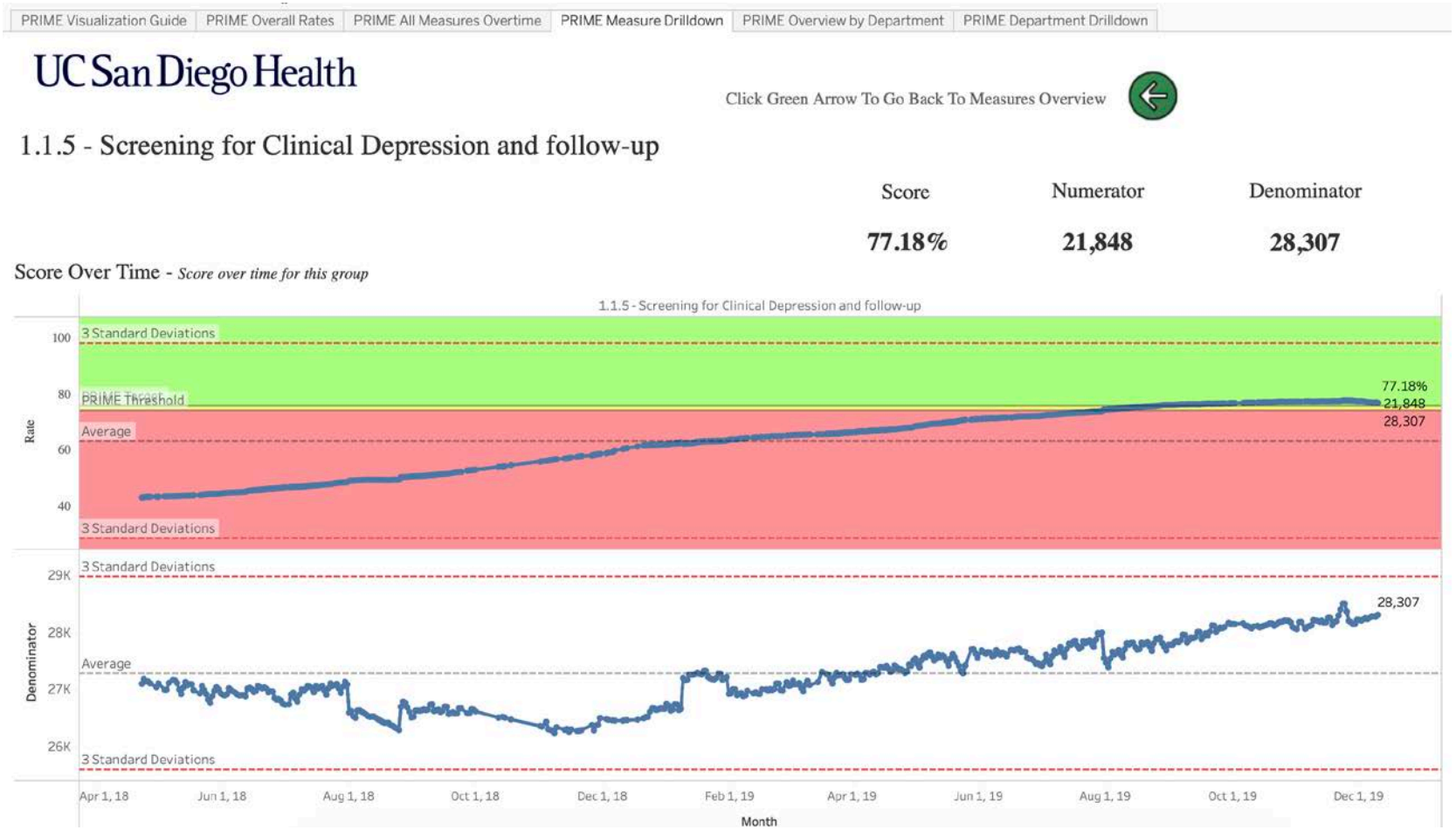
Interactive Data through Tableau

For PRIME and QIP metrics reporting Epic EMR data Tableau dashboards were built to provide updated rates on a daily basis. Drilldown is possible at a clinic and provider level.

Quarterly Training and Updates for Teams

Lean Six Sigma training and tools provided to teams and Quality team is available to help develop charters, A3s, root cause analysis and other project improvement tools.

A New Way to Visualize Data



The Impact – Our Patients

Exclusive Breast Milk Feeding

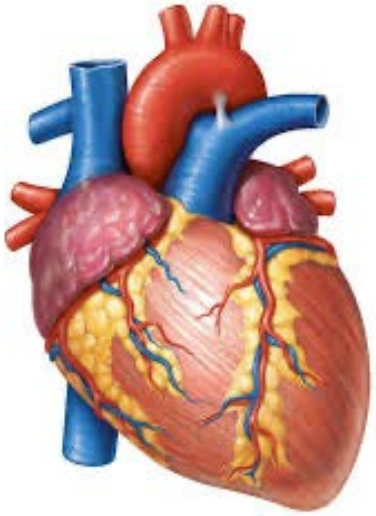
118 more babies were exclusive breast milk fed in DY14 compared to the prior year.

68% to 72%

How?

- ✓ **Passionate and committed clinical lead**
- ✓ **2 year journey for Milk Bank**
- ✓ **Fully committed and aligned clinical teams and leadership**

The Impact – Our Patients



Anticoagulants for IVD

94% of eligible PRIME patients were placed on the appropriate anticoagulant.

84% to 94%

How?

- ✓ **Passionate and committed clinical leads**
- ✓ **Heavy investment in outreach and data validation**
- ✓ **Committed team with 90 min weekly meetings and PI cycles**
- ✓ **Link to other collaboratives**

The Impact – Our Patients

Depression Screening

7340 more patients were screened for clinical depression and follow-up.

40% to 72%

How?

- ✓ **Passionate and committed clinical leads**
- ✓ **Investment in care integration model**
- ✓ **Significant workflow design and optimization**

THANK YOU

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PRIME Takeaways & Looking Ahead

- Continued demonstrated improvement in patient outcomes, quality, and clinical care
  - Several systems above national Medicaid 90th percentile performance benchmarks
- Data analytics and population management are core health system capabilities
- Continues to promotes system integration and coordination
  - Inpatient, outpatient, and specialty care
- Focus on hard-wiring improvements & spreading successes
- Looking ahead
  - Alignment with DHCS priorities
  - Leveraging PRIME lessons learned

Q&A

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More Information

Webinar deck and & recording to be posted
https://safetynetinstitute.org/membersupport/primesupport/

CAPH/SNI Publications

Reducing Health Disparities through PRIME

Improving Quality of Care Through PRIME

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