CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

CALIFORNIA'S PROGRESS IN PRIME

YEARS 1 – 3

December 17, 2018

Recording link

Today's Agenda

- About CAPH/SNI
- PRIME
  - Background
  - Progress and Themes
- Member Perspectives
  - Alameda Health System
  - Riverside University Health System
- Q&A

ABOUT CAPH/SNI

The California Association of Public Hospitals and Health Systems (CAPH) and the California Health Care Safety Net Institute (SNI) represent California's 21 public health care systems and academic medical centers.

As a trade association, CAPH works to advance policy and advocacy efforts that strengthen the capacity of its members to ensure access to comprehensive, high-quality, culturally sensitive health care services for all Californians, regardless of insurance status, ability to pay, or other circumstance, and educate the next generation of health care professionals.

SNI, the performance improvement affiliate of CAPH, supports California's public health care systems by informing and shaping statewide and national health care policy, by providing performance measurement and reporting expertise, and by accelerating and supporting decision-making and learning, within and across member systems. Because of our work, more people – especially the under-served – receive effective, efficient, and respectful health care regardless of their ability to pay.

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21 Public Health Care Systems

County-owned and -operated health systems and UC medical 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 - Medical Center

San Bernardino County
- Arrowhead Regional Medical Center

San Francisco County

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

San Joaquin County

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

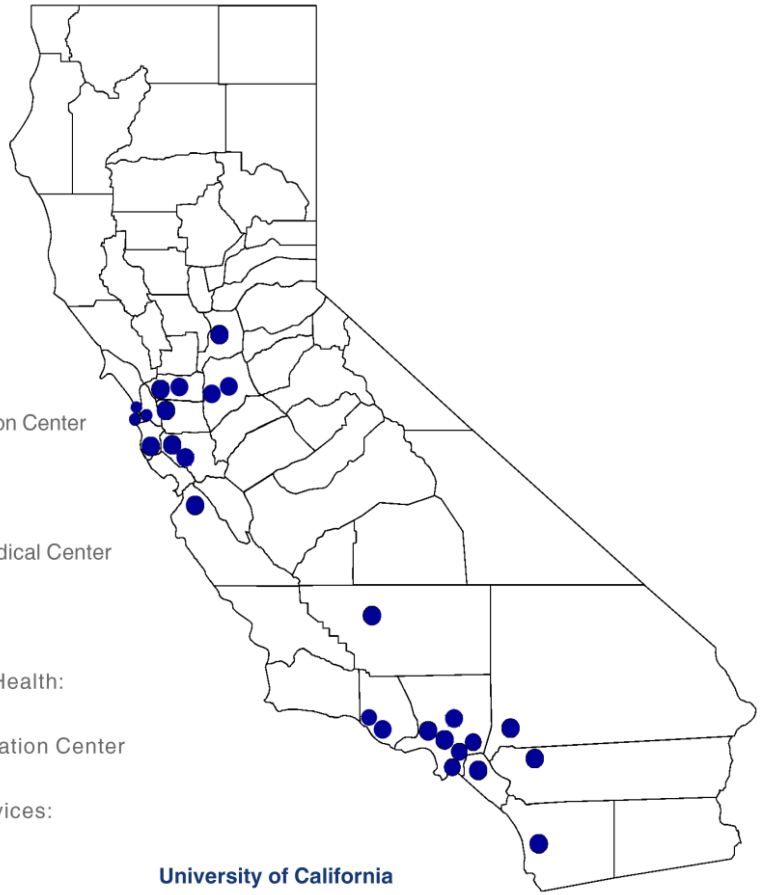
San Mateo County
- San Mateo Medical Center

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 Health:
- UC Davis Medical Center
- UC Irvine Healthcare
- UC San Diego Medical Center
- UC San Francisco Medical Center
- UCLA Medical Center, Santa Monica / Ronald Reagan UCLA Medical Center

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Critical Role of Public Health Care Systems

California's public health care systems operate in 15 counties where

80%

of the state's population lives.

- Safety net: most patients Medi-Cal or uninsured
- Systems of care: provide hospital/inpatient care, primary care, specialty services, trauma care, rehabilitation, etc.
- Provides critical services that patients cannot access anywhere else
- Comprise just 6% of all health care systems in the state:
  - Serve more than 2.85 million patients each year
  - Serve 35% of Medi-Cal beneficiaries in our communities and 40% of hospital care to the state's uninsured

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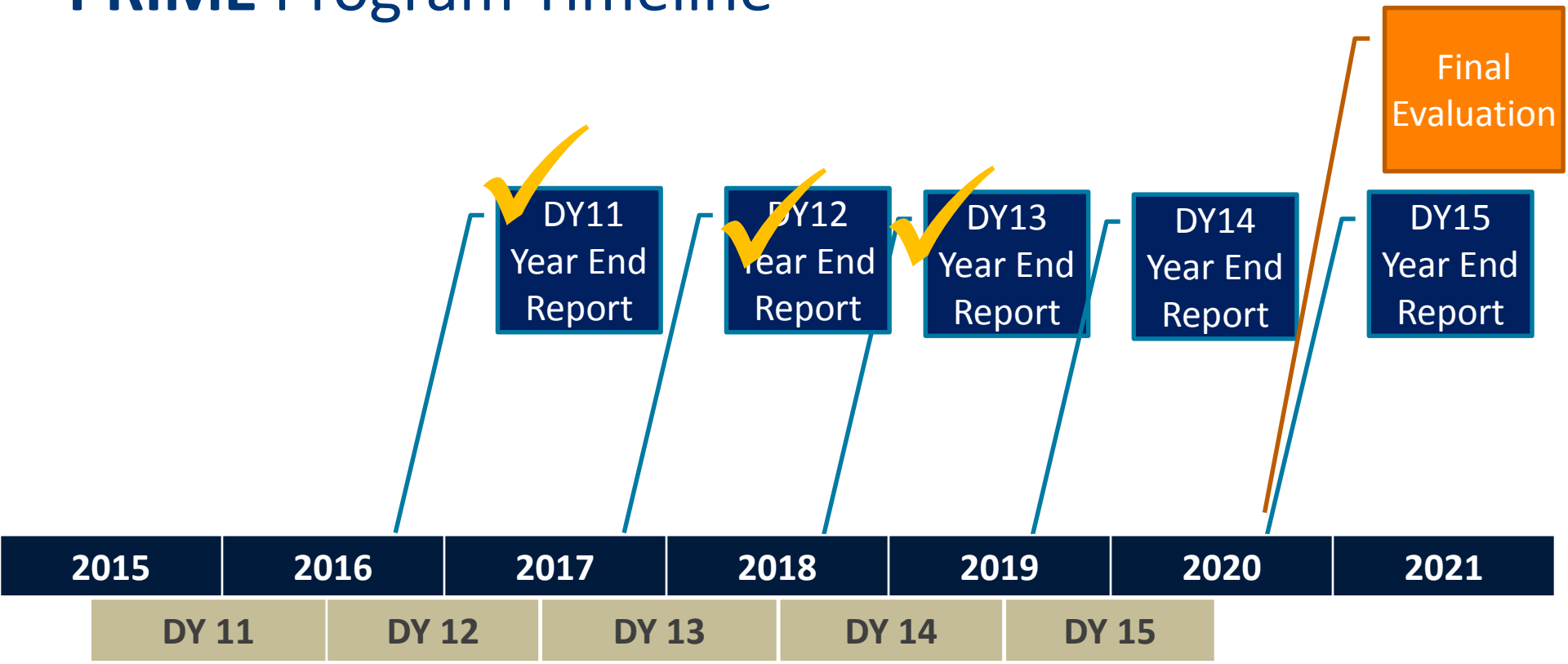
PRIME Background

- One of four Medi-Cal 2020 1115 waiver programs
- Builds on California's first-in-the-nation DSRIP
- Pay-for-performance program worth up to $3.26b in federal funds over 5 years
- 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 entities = public health care systems and district & municipal hospitals

PRIME Program Timeline



PRIME Demonstration Year(DY) 13 Year-End Measurement Period:

July 1, 2017 – June 30, 2018

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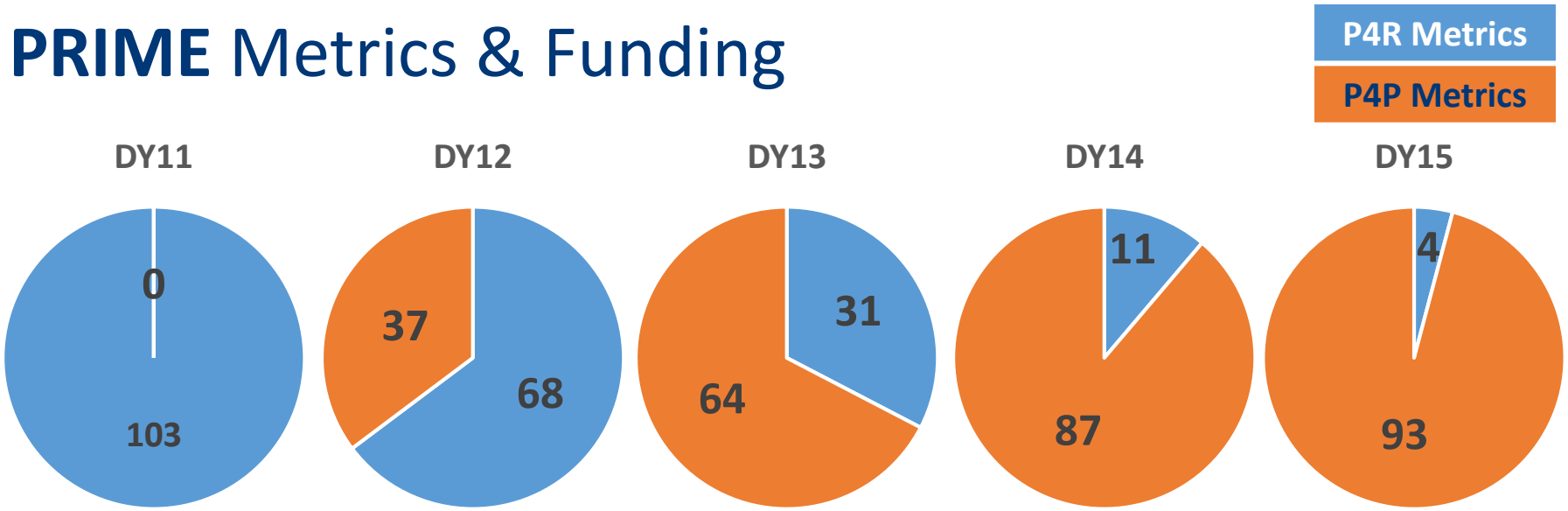
PRIME Structure

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	• Improved Perinatal Care	• Antibiotic Stewardship
• Ambulatory Care Redesign: Primary Care*	• Care Transitions: Integration of Post-Acute Care	• High-Cost Imaging
• Ambulatory Care Redesign: Specialty Care	• Complex Care Management for High Risk Medical Populations	• Therapies Involving High-Cost Pharmaceuticals
• Million Hearts	• Integrated Health Home for Foster Children	• Blood Products
• Cancer Screening & Follow-Up	• Chronic Non-Malignant Pain Management	
• Obesity Prevention & Healthier Foods Initiative	• Comprehensive Advance Illness Planning and Care	

For public health care systems: 6 required projects; must select 3 additional from 12 optional projects (1 from Domain 3) and report on all metrics in each project

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

PRIME Metrics & Funding



Avail. Payment	$700M	$700M	$700M	$630M	$535M

- Total # of metrics for a system ranges from 56-80 metrics
- Includes 80% standard measures and 20% innovative, piloting measurement of new, transformative care practices

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DY13 At-A-Glance

% of **P4P** metrics met for **DY13**

% of **all** metrics met for **DY13**

% **P4P** metrics ↑ in DY13 (35% to 67%)

% of **P4P** metrics met for **DY12**

% of **all** metrics met for **DY12**

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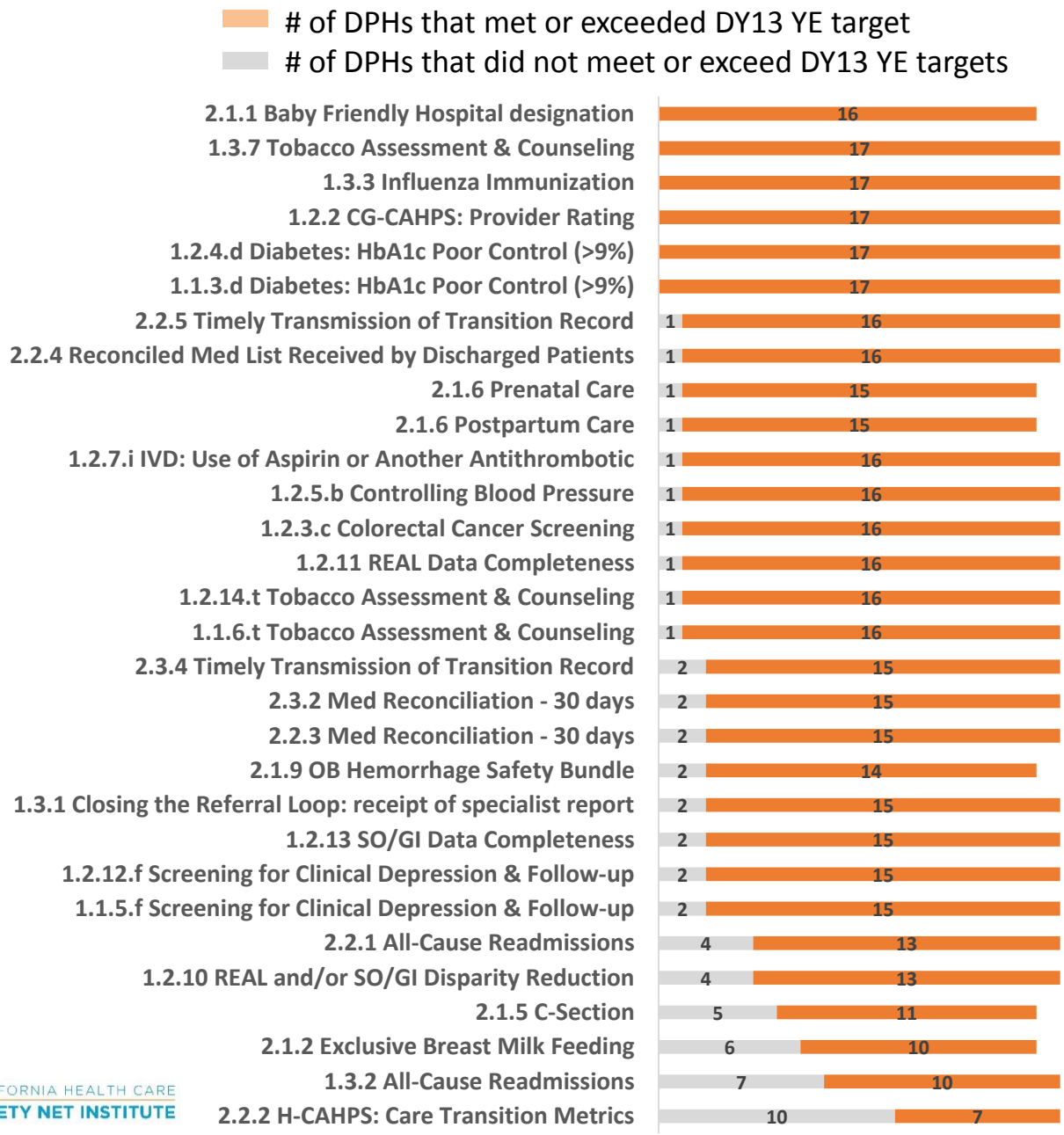
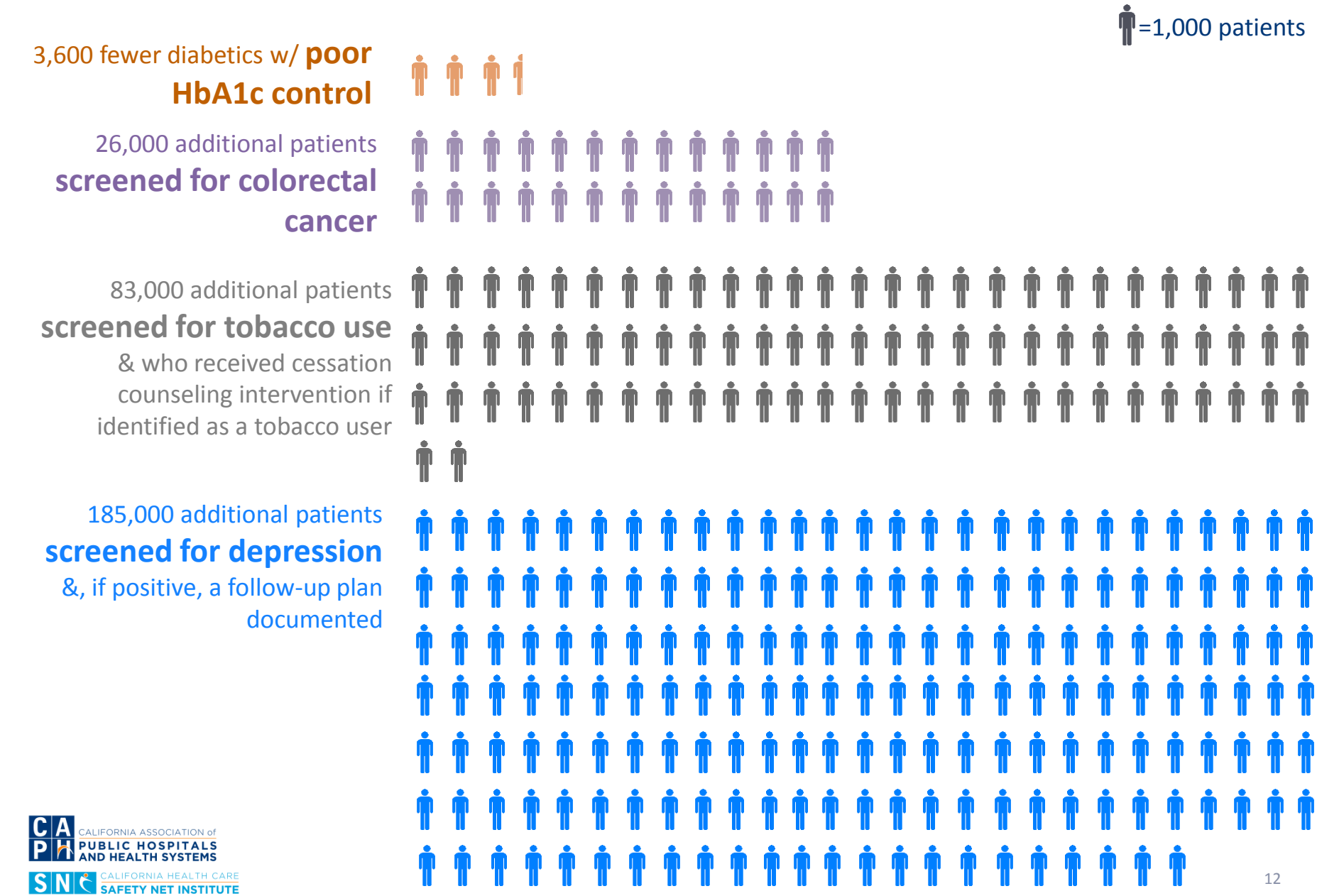
P4P Metrics in Required Projects: # Systems that Met DY13 Year End (YE) Targets



DY13 data has not yet been approved by DHCS.

Additional Patient Impact from DY11 to DY13 (all systems)



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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

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PRIME Progress: Coordination & Partnerships

Improve coordination & partnerships

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

Example

In PRIME, systems must identify and work to reduce a disparity gap. **San Francisco Health Network** is working to close the disparity gap in blood pressure control for African Americans by:

- Partnering with **patient advisors, public health and community organizations**
- Establishing on-site food pharmacies for healthy food access and nutrition education

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 **engage patients for preventative care**, **Contra Costa Regional Medical Center** launched
  - Phone surveys by culturally appropriate staff
  - Targeted flyers
  - Incentives
  - Self-scheduling for screening appointments

PRIME Progress: Develop the workforce

Develop the workforce

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

Example

- **UC San Diego** invested in provider and staff training when launching a patient-centered approach to Sexual Orientation & Gender Identity (SOGI) data collection. In Year 3, 2,740 providers **completed SOGI training** to collect 11,189 more patients' SOGI status

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PRIME Progress: IT & Analytics

Invest in IT & data analytics

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

Examples

- **Santa Clara Valley Medical System** created **readmission predictive tools** with complexity and gap scores to identify high risk patients for care coordination and complex care management

- **Many systems** have increased use of health information **data exchanges** and real-time emergency department visit notifications

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PRIME Progress: New Processes & Workflows

Implement new processes & workflows

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

Examples

- To **improve primary care access for patients discharged from the hospital, Los Angeles County Dept. of Health Services** implemented:
  - "Fond Farewell" discharge process, ensuring patients have what they need before leaving hospital
  - Internal workgroup with medical home, social work and inpatient staff
  - EHR hard stop gap checker

- **UC San Francisco** refined panel management workflows across primary care using automated workflow management software, allowing staff to engage with **3.86 times as many patients**

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PRIME Progress: Strengthening Quality Improvement

Strengthen & standardize performance improvement

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

Example

- **San Mateo Medical Center** used the LEAN method **to standardize the way they both request and receive timely specialty expertise** for primary care, including the Model Cell process that includes patients in rapid cycle improvement work

PRIME Takeaways

- Demonstrated improvement in patient outcomes, quality, and clinical care
- Increased data sophistication
  - Predictive analytics, partner data sharing
- Drives continued improvement
  - Year-over-year improvement, challenging performing targets
- Promotes system integration and coordination
  - Inpatient, outpatient, and specialty care

Alameda Health System

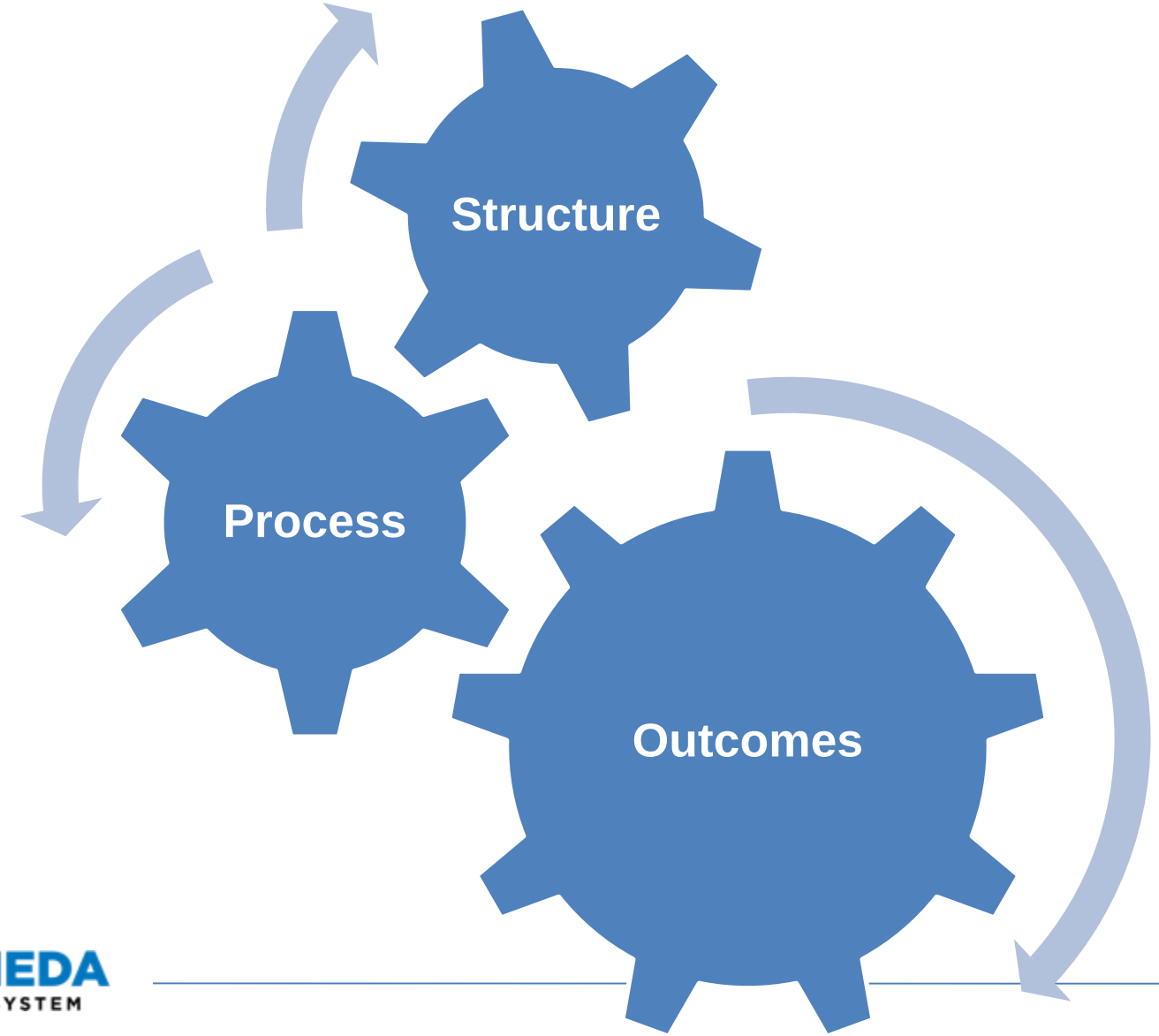
Integrated Health Care Safety Net System including:

- Five hospitals; >800 beds;
  209,000 inpatient days
- Four wellness centers; 40+ specialty clinics; 347,000 outpatient visits
- 131,000 ED visits
- 1300 babies delivered
- ~70% Medi-Cal/HPAC
- 84% non-white patient population

PRIME program:

- >55,000 PRIME eligible patients
- 10 PRIME projects
- 55 metrics

AHS's PFP Framework



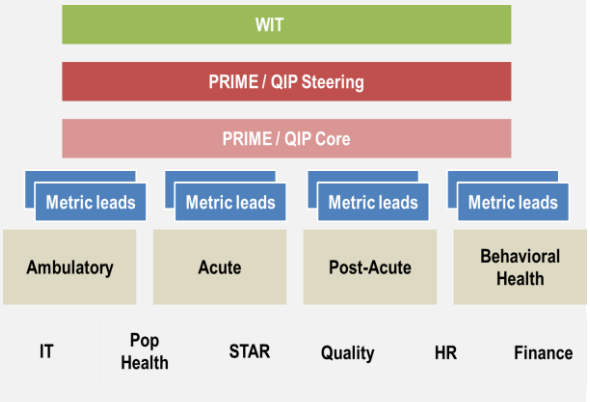
ALAMEDA HEALTH SYSTEM

Structure

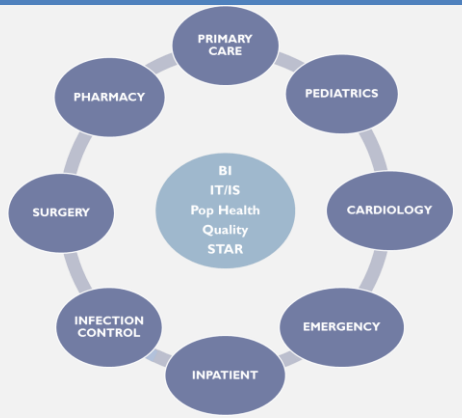
Prioritization

- ✓ Data integrity
- ✓ Clinician engagement
- ✓ Transparency
- ✓ Infrastructure

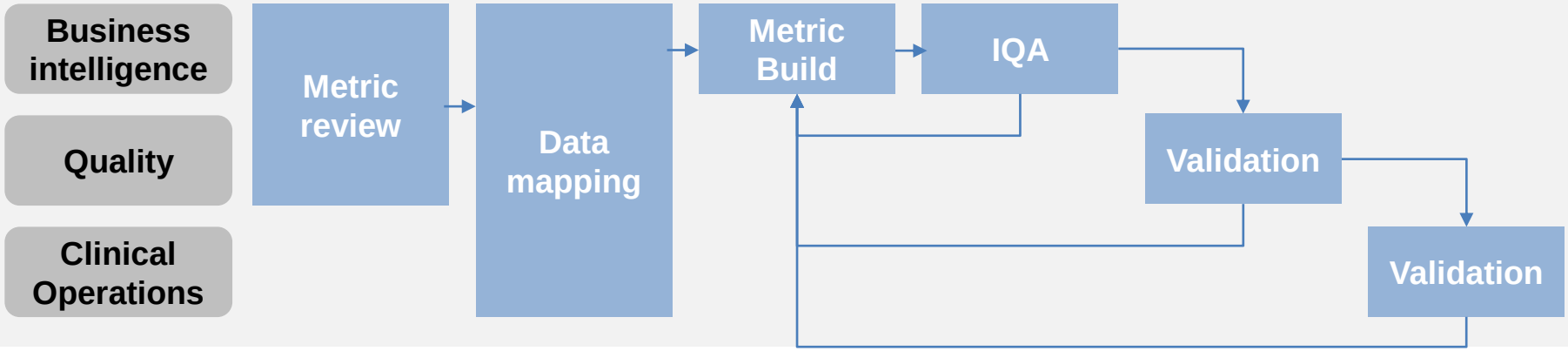
Team Governance



Engaged Stakeholders



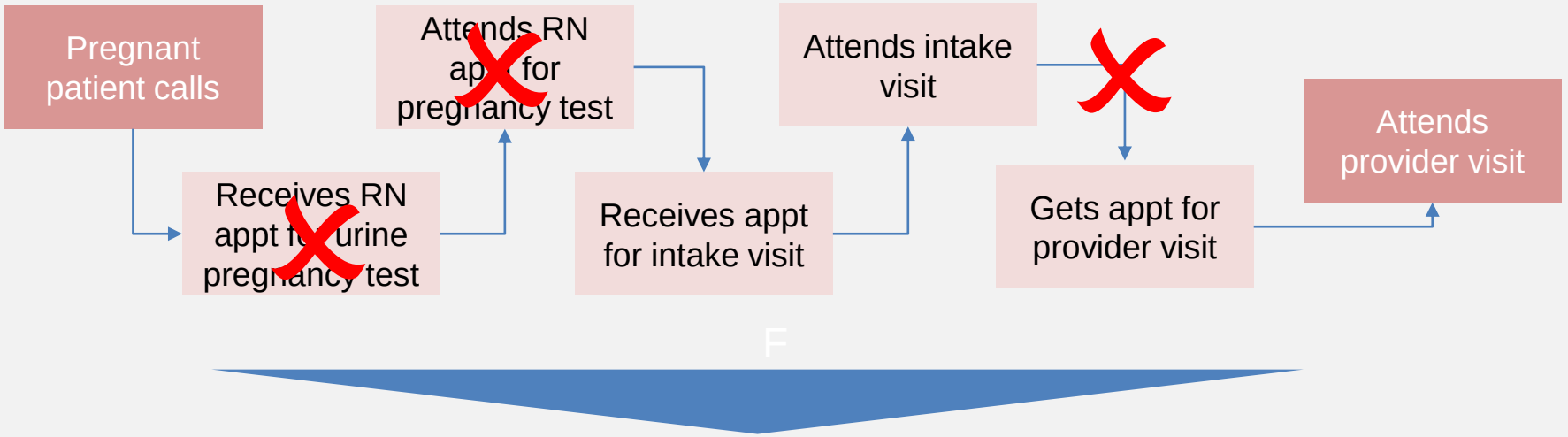
Data Governance



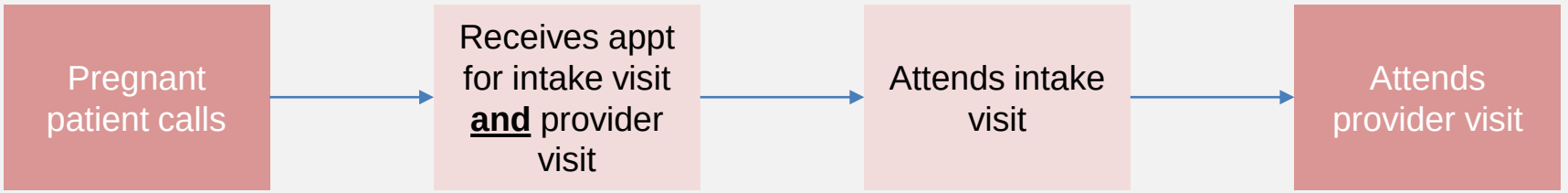
Process Improvement…

Example: Eliminating Waste in Prenatal Appointment Scheduling

Before: From 5 steps between a patient calling and seeing a provider…

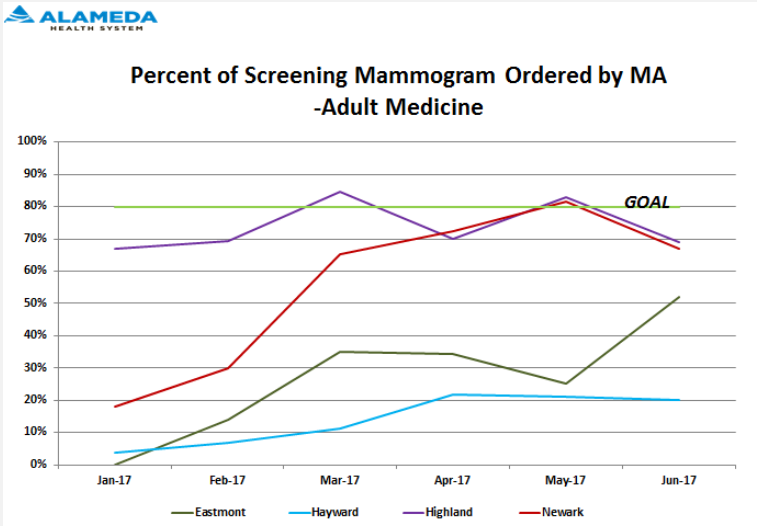


After: Two steps between a patient calling and seeing a provider



…And Process Measures

Example: Percent of mammograms ordered by a medical assistant



Example: Percent of patients seen in last 30 days with SOGI data completed

Performance By Location	Percentages based on all patients seen				Percentages based off of patients that responded									
All Active Patients (Past Year)	Total Patients	% Sexual Orientation Documented	% Gender Identity Documented	% SOGI Completed	% Sexual Orientation Heterosexual	% Sexual Orientation Homosexual	% Sexual Orientation Bisexual	% Sexual Orientation Other	% Sexual Orientation Refused	% Gender Identity CIS Gender	% Gender Identity Transgender	% Gender Identity Genderqueer	% Gender Identity Other	% Gender Identity Refused
EWC - ADULT MEDICINE	6253	24.55 %	6.73 %	6.73 %	98.05 %	0.91 %	0.26 %	0.20 %	0.39 %	99.76 %	0.00 %	0.00 %	0.00 %	0.24 %
HGH - ADULT IMMUNOLOGY	683	56.08 %	56.08 %	55.93 %	55.87 %	30.55 %	8.36 %	2.09 %	3.13 %	97.65 %	0.52 %	0.52 %	0.52 %	0.78 %
HGH - ADULT MEDICINE	7888	13.07 %	12.69 %	12.66 %	87.78 %	2.81 %	1.94 %	2.23 %	4.85 %	96.20 %	0.00 %	0.90 %	0.10 %	2.80 %
HWC - ADULT IMMUNOLOGY	103	0.97 %	0.97 %	0.97 %	100.00 %	0.00 %	0.00 %	0.00 %	0.00 %	100.00 %	0.00 %	0.00 %	0.00 %	0.00 %
HWC - ADULT MEDICINE	5601	5.03 %	2.61 %	2.55 %	89.36 %	2.48 %	0.71 %	0.00 %	7.45 %	98.63 %	1.37 %	0.00 %	0.00 %	0.00 %
NWC - ADULT MEDICINE	5940	47.59 %	47.53 %	47.29 %	96.18 %	1.49 %	1.31 %	0.04 %	0.96 %	99.61 %	0.04 %	0.04 %	0.00 %	0.32 %
Active Patients (Last 30 Days)	Total Patients	% Sexual Orientation Documented	% Gender Identity Documented	% SOGI Completed	% Sexual Orientation Heterosexual	% Sexual Orientation Homosexual	% Sexual Orientation Bisexual	% Sexual Orientation Other	% Sexual Orientation Refused	% Gender Identity CIS Gender	% Gender Identity Transgender	% Gender Identity Genderqueer	% Gender Identity Other	% Gender Identity Refused
EWC - ADULT MEDICINE	1661	37.63 %	22.28 %	22.28 %	96.32 %	1.60 %	0.48 %	0.48 %	0.64 %	99.73 %	0.00 %	0.00 %	0.00 %	0.27 %
HGH - ADULT IMMUNOLOGY	317	62.46 %	62.46 %	62.15 %	56.06 %	32.83 %	7.07 %	3.03 %	1.01 %	98.48 %	0.51 %	0.51 %	0.51 %	0.00 %
HGH - ADULT MEDICINE	2262	26.79 %	26.70 %	26.66 %	90.43 %	1.98 %	1.32 %	1.49 %	4.13 %	97.35 %	0.00 %	0.83 %	0.17 %	1.66 %
HWC - ADULT IMMUNOLOGY	27	3.70 %	3.70 %	3.70 %	100.00 %	0.00 %	0.00 %	0.00 %	0.00 %	100.00 %	0.00 %	0.00 %	0.00 %	0.00 %
HWC - ADULT MEDICINE	1487	10.96 %	8.81 %	8.68 %	84.05 %	1.84 %	1.23 %	0.00 %	12.88 %	100.00 %	0.00 %	0.00 %	0.00 %	0.00 %
NWC - ADULT MEDICINE	1369	81.08 %	80.93 %	80.57 %	95.86 %	1.26 %	1.62 %	0.09 %	1.08 %	99.55 %	0.09 %	0.00 %	0.00 %	0.36 %

Outcomes: AHS DY13 YE Performance

List of Metrics Achieving DY13 YE Target

★ = Better than 90th percentile!

- Diabetes poor control
- Screening for depression
- Tobacco screening / counseling ★
- Screening for high blood pressure ★
- Blood pressure control ★
- IVD – use of antithrombotic ★
- Colon cancer screening
- Antibiotics in acute bronchitis ★
- Influenza immunization ★
- Readmissions ★
- Hospital-acquired c difficile infections ★
- Exclusive Breastfeeding ★
- Cesarean section ★
- Medication reconciliation at 30 days
- Reconciled medication list received
- Timely transmission of transition record
- Prenatal and postnatal care
- CG-CAHPS ★
- SOGI / REAL data completeness


Transformation Spotlight

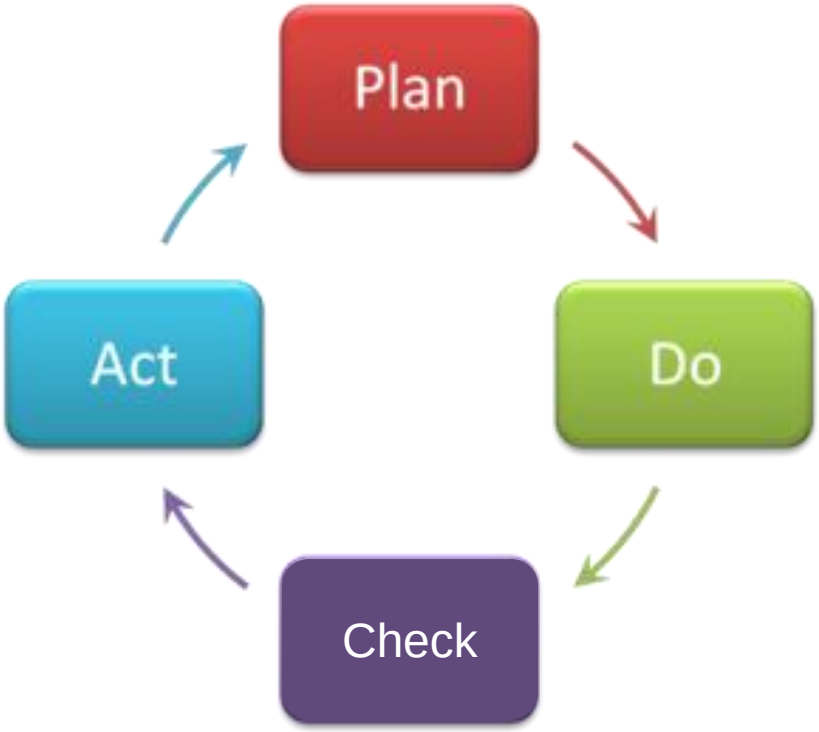

SOGI
123

Before…

…Only **1** in **1000** patients seen in primary care had documented SOGI information

Why ask?

- LGBTQ patients experience **numerous health disparities**
  - Higher rates of mental and behavioral health issues
  - Higher rates of smoking
  - Less likely to receive cancer screening
    - Lesbian / bisexual women are 10 times less likely to get cervical cancer screening
- They are **largely invisible** in the health care system
- Simply asking can be **affirming**


Plan
Do
Check
Act


Plan
Develop the Plan Based on a Needs Assessment
Do
Execute the Plan
Check
Collect Data and Review Performance Indicators
Act
Adjust, Adopt or Abandon

Plan

Planning for SOGI

1 Best practices

NATIONAL LGBT HEALTH EDUCATION CENTER
A PROGRAM OF THE FENWAY INSTITUTE

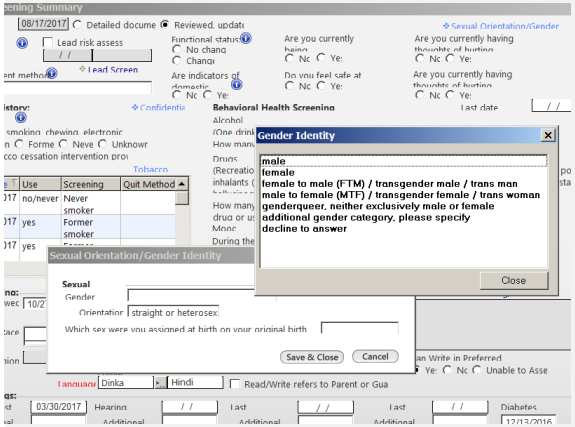
OPEN ACCESS Freely available online — PLOS ONE

Do Ask, Do Tell: High Levels of Acceptability by Patients of Routine Collection of Sexual Orientation and Gender Identity Data in Four Diverse American Community Health Centers

Sean Cahill[1]*, Robbie Singal[2], Chris Grasso[2], Dana King[2], Kenneth Mayer[3], Kellan Baker[4], Harvey Makadon[5]

1 The Fenway Institute, Northeastern University Department of Political Science, Boston, MA, United States of America/New York University Wagner School, New York, NY, United States of America, 2 The Fenway Institute, Boston, MA, United States of America, 3 The Fenway Institute/Beth Israel Deaconess Medical Center/Harvard Medical School, Boston, MA, United States of America, 4 Center for American Progress, Washington, DC, United States of America, 5 The Fenway Institute/Harvard Medical School, Boston, MA, United States of America

2 IT infrastructure



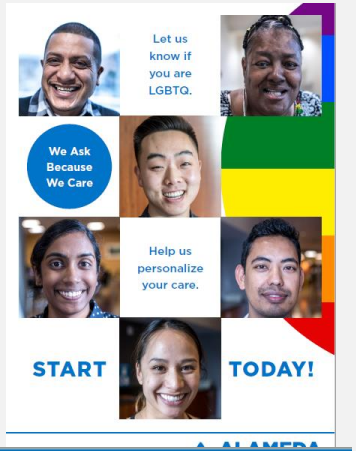
NEXTGEN

Soarian® Clinicals

Soarian® Financials

Epic

3 Communication/training



Do

Two SOGI pilots

Verbal questions at intake

Newark Adult
Highland AIC

- MA asks patient SOGI questions at intake
- Patient answers SOGI questions verbally
- Answers entered into NextGen in real-time

Paper form at registration

Highland Adult

- Paper form given to patient at registration
- Patient completes form
- Form collected at registration
- SOGI data entered into NextGen at end of week

Check

Data driven pilot selection

	Pilot #1 Verbally by MAs at Intake		Pilot #2 Paper form at registration
	Newark	Highland AIC	Highland Adult
Pilot duration	2.5 mo	1.5 mo	1 mo
SOGI completion rate (last 30 days)	79.90%	87.96%	16.26%
Refusal rate (last 30 days)	0.96%	3.16%	7.14%
Registration cycle time impact	0 sec	-	60 sec
Intake cycle time impact	45-60 sec	30 sec (mean) 10 sec (min) 210 sec (max)	0 sec
Post-visit time impact	0 sec	0 sec	60 sec (mean)

ALAMEDA HEALTH SYSTEM

Check

Real-time, online process measure

Performance By Location

	Percentages based on all patients seen				Percentages based off of patients that responded									
All Active Patients (Past Year)	**Total Patients**	**% Sexual Orientation Documented**	**% Gender Identity Documented**	**% SOGI Completed**	**% Sexual Orientation Heterosexual**	**% Sexual Orientation Homosexual**	**% Sexual Orientation Bisexual**	**% Sexual Orientation Other**	**% Sexual Orientation Refused**	**% Gender Identity CIS Gender**	**% Gender Identity Transgender**	**% Gender Identity Genderqueer**	**% Gender Identity Other**	**% Gender Identity Refused**
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HGH - ADULT IMMUNOLOGY	317	62.46 %	62.46 %	62.15 %	56.06 %	32.83 %	7.07 %	3.03 %	1.01 %	98.48 %	0.51 %	0.51 %	0.51 %	0.00 %
HGH - ADULT MEDICINE	2262	26.79 %	26.70 %	26.66 %	90.43 %	1.98 %	1.32 %	1.49 %	4.13 %	97.35 %	0.00 %	0.83 %	0.17 %	1.66 %
HWC - ADULT IMMUNOLOGY	27	3.70 %	3.70 %	3.70 %	100.00 %	0.00 %	0.00 %	0.00 %	0.00 %	100.00 %	0.00 %	0.00 %	0.00 %	0.00 %
HWC - ADULT MEDICINE	1487	10.96 %	8.81 %	8.68 %	84.05 %	1.84 %	1.23 %	0.00 %	12.88 %	100.00 %	0.00 %	0.00 %	0.00 %	0.00 %
NWC - ADULT MEDICINE	1369	81.08 %	80.93 %	80.57 %	95.86 %	1.26 %	1.62 %	0.09 %	1.08 %	99.55 %	0.09 %	0.00 %	0.00 %	0.36 %

Act

SOGI implementation

Standard work

- Integration into existing workflows
- Defined expectations around
  - Scripting
  - Documentation

Title: SOGI Screening - Intake		Date: 1/19/2018
Departments who must adopt: Adult Primary Care	Operators who must adopt: MAs, LVNs, RNs	

Task #	Task description	Reason
	This is an addition to the existing intake standard work. *These questions should be integrated after review of the standing orders and at the beginning of the section entitled "Screening Summary Tab"*	
1	If the PVS alerts that the patient is missing data in the SOGI fields: Ask the patient about their sexual orientation and gender identity (SOGI), using the following script: *We ask every patient a few personal questions so that we can be more effective in providing individualized care. This information is confidential, and only accessible to your healthcare team. At any time you can choose not to answer.* • *What gender do you identify as now (for example, male, female, transgender)* • *What is your sexual orientation (for example, gay, straight, bi)?* • *Is this the same gender as on your birth certificate?* **see below for translation of script in other languages*	Data suggests that patients expect to be asked in a healthcare setting and are unlikely to bring up SOGI unless asked. Asking about SOGI respectfully is affirming for our non-cisgender, non-heterosexual patients.
2	Enter the patient's responses in the relevant fields in NG.	

Spread plan – started Feb 1st!

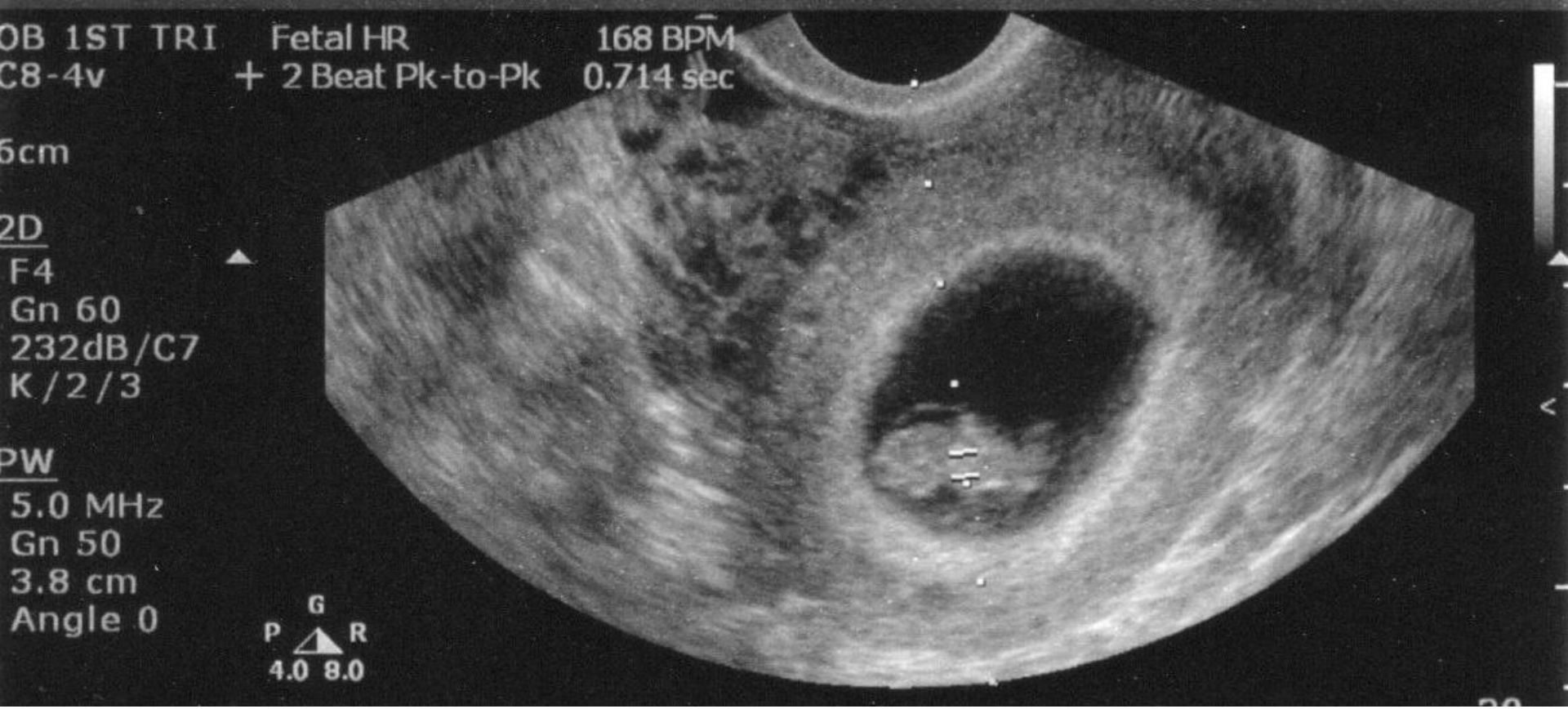
Spread Planning and Monitoring Tool

Project: SOGI

What is being spread?	Collection of SOGI data by MAs in Adult/Family Medicine and AIC clinics
What are the goals?	To collect SOGI data on all patients.
What tools are available?	1) PowerPoint presentation (background and overview) 2) Operator standard work 3) NG screen shots for data entry
What training is available?	Training was offered to all primary staff in October 2017. Primary Care Practice Managers and Nursing Supervisors were offered additional training in January 2018. All primary care MAs/LVNs/RNs were provided follow-up training at January 2018 downtime. Other videos are available online as supplementary training opportunities 1) http://transhealth.ucsf.edu/video/story.html • Includes overview of why we ask, definitions, as well as example clinical scenarios • No log in, registration required! 2) http://doaskdotell.org/ehr/toolkit/resources/ • Resources from the Fenway institute • Includes webinars, FAQs, medical literature on SOGI • Webinars can be viewed for CME or HEI credit • Registration / log in required, but free!
How is progress monitored?	A process monitoring report is available here: http://ahs-bi-rs/Reports/report/Outpatient/NextGen/Nursing/SOGI%20Process%20Measures Progress will also be monitored in the cross-site SOGI check in calls.
Who is the local (site) process owner?	Eastmont – Rene Macias Hayward – Bola Kelani Highland – Anita Roberts Newark – Michelle Binaisa AIC – Heather MacDonald-Fine **Expectations of Process Owner** 1) Serve as local point person 2) Ensure staff are trained and following standard work 3) Monitor site-based performance at least monthly 4) Participate on cross site collaboratives 5) Escalate challenges that can't be resolved locally to the appropriate person/group
Where do questions or concerns get escalated?	Questions/concerns should first be brought to the attention of the site based Process Owner. S/he shall engage the site-based leadership with questions/concerns. Items that can't be addressed by the site can be escalated to the subject matter experts below. Feedback will also be solicited in Ambulatory Quality Council when both the practice managers and RN supervisors are in attendance.
Who are the subject	1) Heather MacDonald-Fine

After…

- We have SOGI data on **~17,000** patients
  - **~5%** identify as **homosexual** or **bisexual**
  - **~0.3%** identify as **transgender** or **genderqueer**
  - **Less than 5% decline to answer**

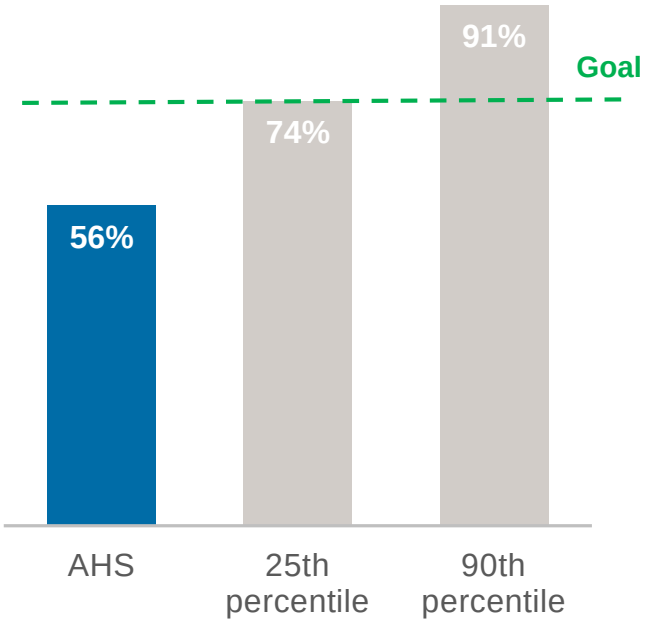


Timely Prenatal Care

Before…

AHS below 25th percentile for timely prenatal care

PRIME Prenatal Care Rate, November 2016



…And some skepticism and resistance to change

"That data can't be right"

"We are already doing everything we can do"

"Those benchmarks are not realistic for our system or our patients"

Transformation Activities:
Improving Access

1

Template standardization & standard work for scheduling

ALAMEDA HEALTH SYSTEM

Resource Template – Master
(20 Minute Template Worksheet)

Template Name:	
Day(s) of the Week:	
Clinic Service:	
Clinic Provider:	
Effective Date Requested:	
Notes:	

Time Slot	Location (Highland – Adult)	Activity Type (New or Return)	Number of Slots	Other Request(s)
8:20 – 8:40			1	
8:40 – 9:00			1	
9:00 – 9:20			1	
9:20 – 9:40			1	
9:40 – 10:00			1	
10:00 – 10:20			1	
10:20 – 10:40			1	
10:40 – 11:00			1	
11:00 – 11:20			1	
12:50 – 13:10				
13:10 – 13:30				
13:30 – 13:50				
13:50 – 14:10				
14:10 – 14:30				
14:30 – 14:50				
14:50 – 15:10				
15:10 – 15:30				
15:30 – 15:50				
15:50 – 16:10				

ALAMEDA HEALTH SYSTEM

Standard Work

Ambulatory Care Services

Title: Scheduling OB intake and First Prenatal Visit With Provider (OBGYN MD or Prenatal providers such as CNMs, Family Doctors, NPs, and PAs)	Date: 5-18-2018
Departments who must adopt: Call Center, Women's clinic sites	Operators who must adopt: ECs, RN, CPSP coordinators, LVN, MA

Task #	Task description	Task Time
1	Patient calls the Call Center requesting prenatal care	
2	Call Center staff verifies insurance. If assigned elsewhere, redirect patient to assigned medical home (or facilitate change of medical home to AHS).	
3	Call Center staff asks if patient has done a pregnancy test (home test or from a clinic). If yes, proceed to Step 4. If patient has not done a pregnancy test, schedule patient for a Nurse Visit in Women's Clinic at the location of their choice (can be enrolled for FPACT by EC at clinic). If pregnancy test is (+), patient is uninsured, and continuation of pregnancy is desired, schedule appointment with ES to secure payor source (**preferably before or day of OBIT to secure payor source to services**). All walk-in requests for a pregnancy test should be seen in a Nurse Visit. If patient is pregnant and pregnancy is desired, clinic staff schedules OB intake appointment and prenatal provider (CNM/PA/NP/Family Doctor) appointment at clinic of patient's choice and per site based guidelines. Patient should be informed that if they miss their OB intake appt and we are unable to reach them to reschedule, their prenatal provider appointment will be cancelled. Prenatal provider appointment should be scheduled 10-14 calendar days after OBIT appointment. If patient is uninsured, an ES appointment shall also be scheduled (**preferably before or day of OBIT to secure payor source to services**). Go to Step 5.	

ALAMEDA HEALTH SYSTEM

Ambulatory Project Summary

Clinic Cancellation Policy

2

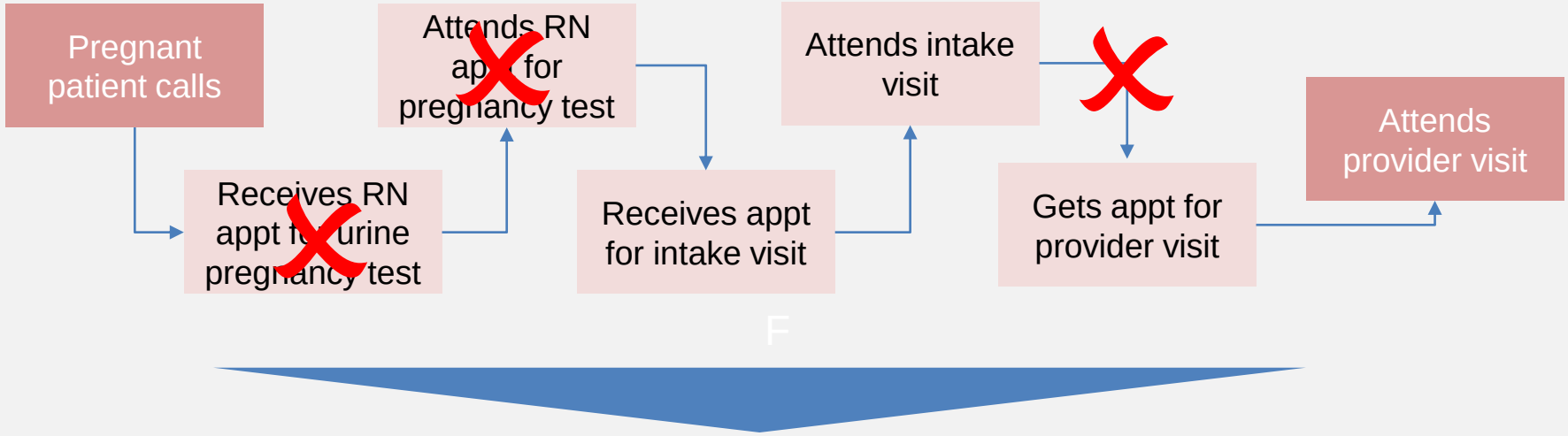
Building capacity with non-traditional visits

Transformation Activities:
Eliminating Waste

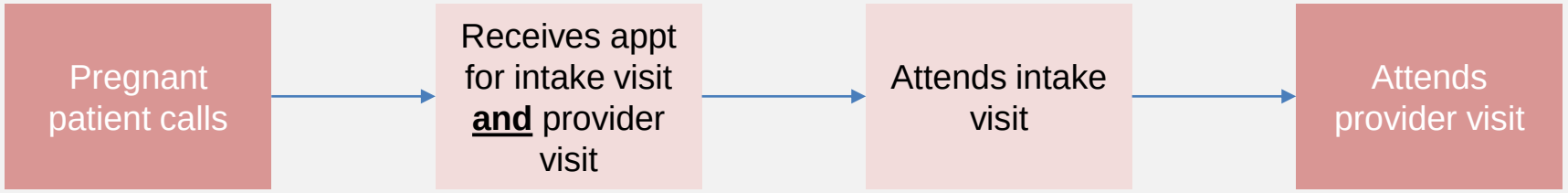
2

Streamlining entry to prenatal care

Before: From 5 steps between a patient calling and seeing a provider…



After: Two steps between a patient calling and seeing a provider



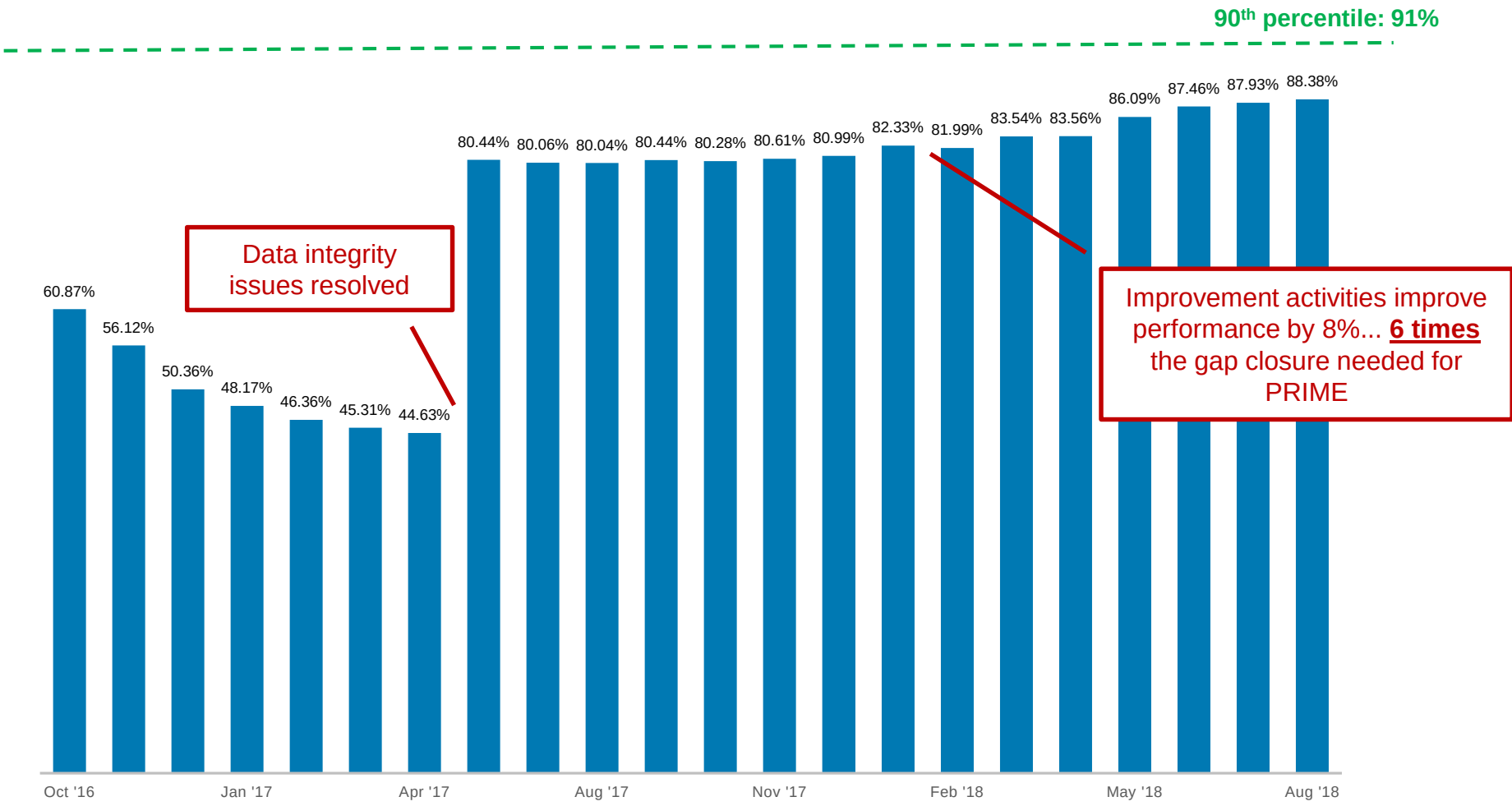
Transformation Activities:
Improving Data Integrity

3

Clinical validation: Relentless chart audits and clinical validation

Audit	Notes	DelEnc	WorkingEDD	FirstTrimesterStartDT	FirstTrimesterEndDT	FirstTrimesterVisitDT
x	Ok	20020122204	10/20/2016	1/14/2016	4/27/2016	NULL
x	Ok	20020151377	11/10/2016	2/4/2016	5/18/2016	4/18/2016
x	Pt had early prenatal care with AHS, then transferred to CHCN site (Tiburcio Vasquez). Is she still considered "ours"? Where in the system can we identify these cases? If we're able to establish a mechanism, then this case would be excluded. The specs have a Denominator exclusion for Continuous Accountability cases where we can provide evidence that the patient is no longer with us for Primary Care.	20020171003	10/24/2016	1/26/2016	5/9/2016	NULL
x	Ok	20020229074	10/30/2016	1/21/2016	5/4/2016	NULL
x	Ok	20020782551	11/28/2016	2/28/2016	6/11/2016	NULL
x	Ok	20020797435	12/17/2016	3/12/2016	6/24/2016	NULL
x	EDC 6/9/16, initial prenatal visit 12/2/15 (source EDM) **10/29 at HGH WS** **CPT: 99211 after 10/24/15; Dx: Z33.1** It looks like this EDD was pre-NG, which means we're unable to capture it. It looks like there was an earlier visit (within first trimester) for this patient.	20016919605	NULL	8/12/2015	11/24/2015	10/29/2015
x	EDC 5/28/16 It looks like this EDD was pre-NG, which means we're unable to capture it.	20017083880	NULL	8/20/2015	12/2/2015	NULL

After



ALAMEDA HEALTH SYSTEM

Future Directions

- Integrating other P4P requirements in PRIME infrastructure
  - PRIME set stage for success
  - De-emphasis on “programs”
- Implementation of enterprise EHR
  - Fall 2019
- Continuous quality improvement
  - Alignment with best practice
  - Reduction in variation

Riverside University Health System

County Owned Integrated Health Care Safety Net System including:

- 439-bed Medical Center with 60+ hospital based primary and specialty care clinics
- 11 Federally Qualified Health Centers
- Departments of Behavioral and Public Health

ANNUAL UNIQUE OUTPATIENT VISITS: 110,328

ANNUAL ED VISITS: 75,390

ANNUAL ED ADMISSIONS: 18,175 (not including Obs)

PRIME ELIGIBLE POPULATION: DY13 55,484

PRIME PROJECTS AND # OF METRICS: 9 Projects 50 Metrics

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Infrastructure Enabled By PRIME

- EPIC, EPIC Reporting and Data Capture
- Data Analytics, Dashboards and Proactive Care Gap Reports
- Waiver Wednesdays and Metric Workgroups
- PRIME Core Team – Director of Incentive Payments Program , PRIME nurse coordinators, PRIME analysts
- Clinical Leads and Nurse Coordinators
- Steering Committee
- Lean training and implementation system-wide

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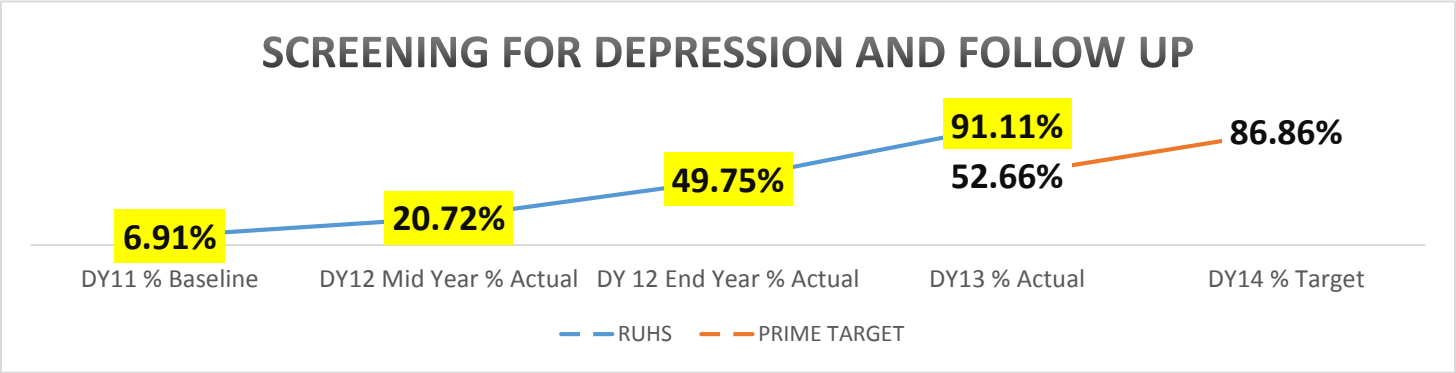

Care Delivery Improvements: Patient Impact

ROOMING DRIVEN CHANGES

IMPACT: DY11 to DY13 → 84.2% change with **20,235** receiving depression screening and follow up

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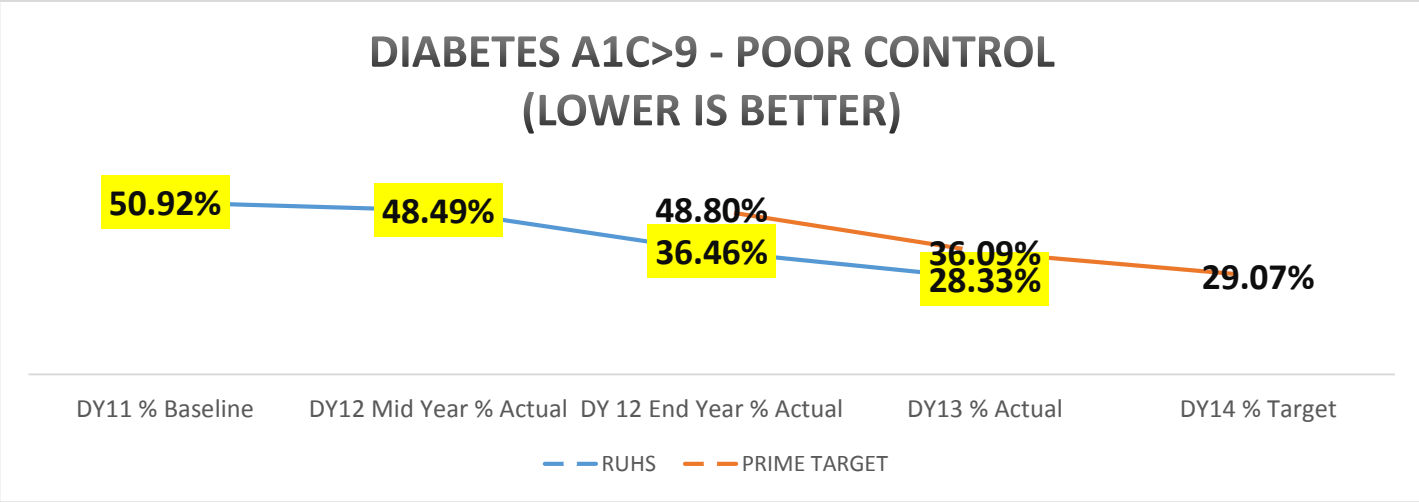

Care Delivery Improvements: Patient Impact

PROVIDER AND CARE TEAM DRIVEN CHANGES

IMPACT: DY11 to DY13 → 22.59% change with **1448** patients achieving better Diabetes Control

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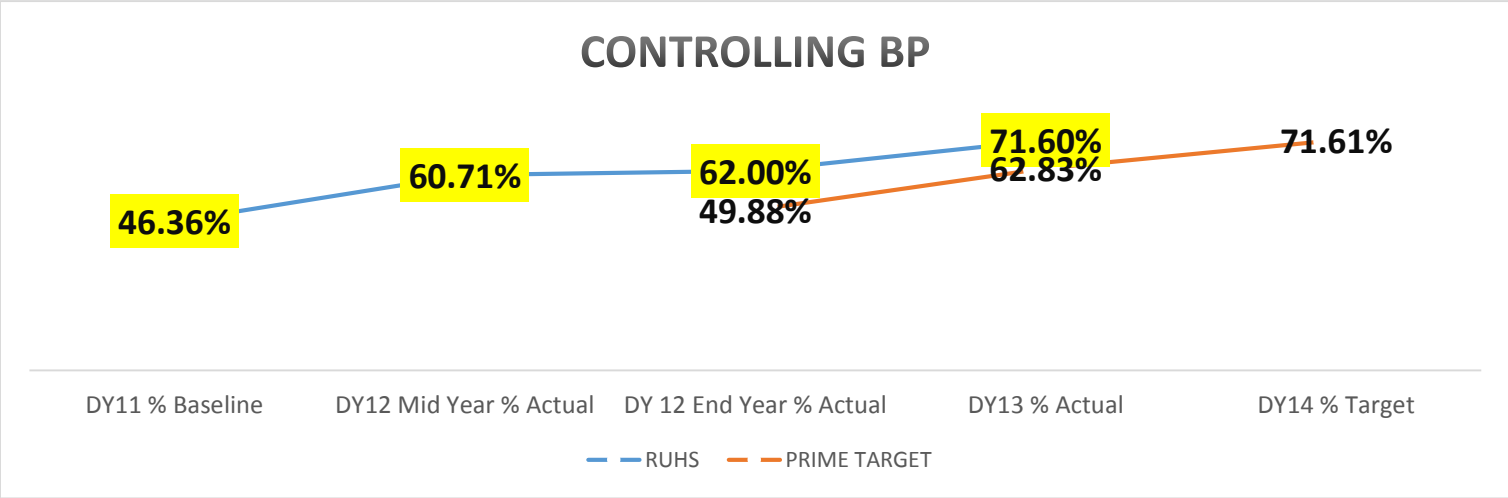

Care Delivery Improvements: Patient Impact

PROVIDER AND CARE TEAM DRIVEN CHANGES

IMPACT: DY11 to DY13 → 25.24% change with **1573** patients achieving better Blood Pressure Control

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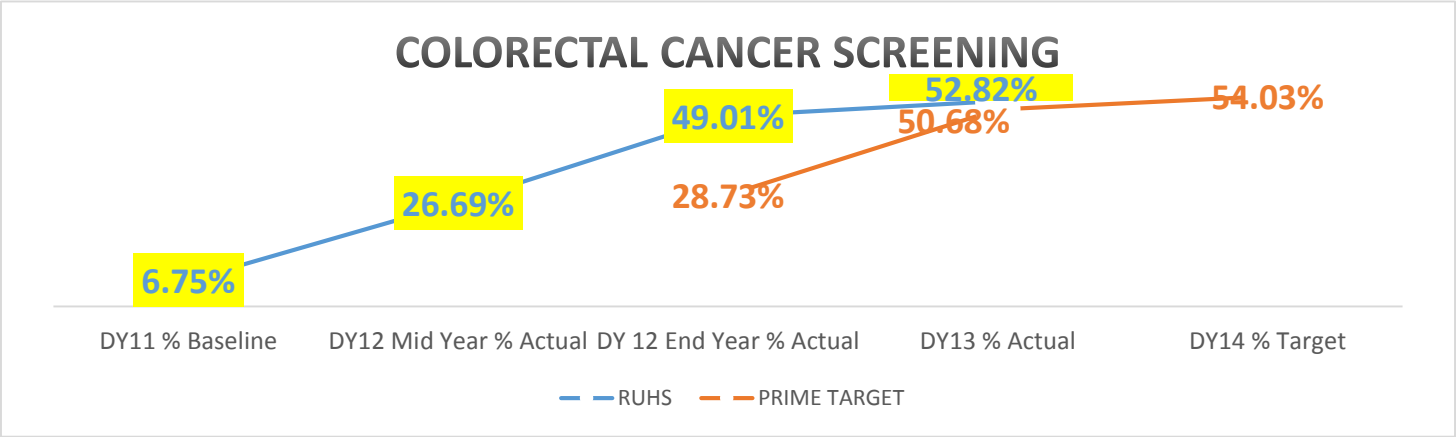

Care Delivery Improvements: Patient Impact

PROVIDER AND CARE TEAM DRIVEN CHANGES

Impact: DY11 to DY13 → 46.07% change with an additional **5891** patients screened

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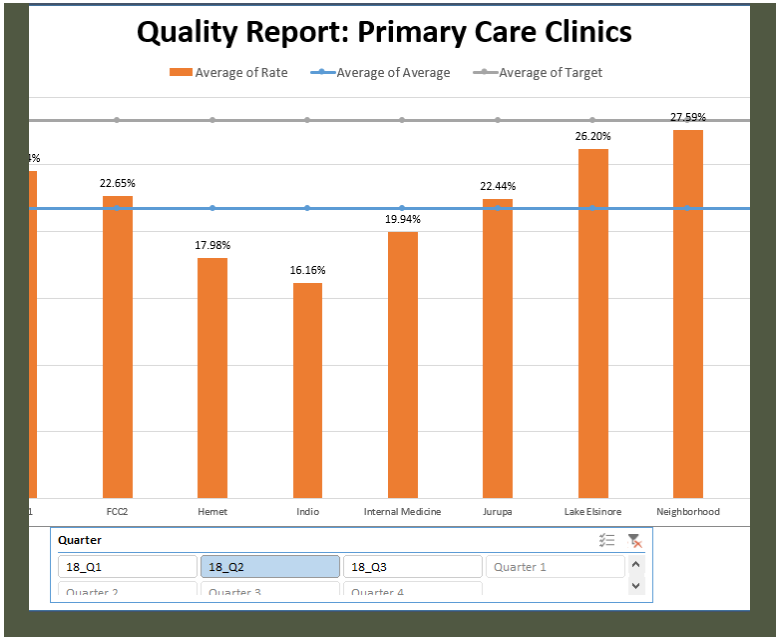

PRIME Driven Innovations

- **Investment in Data Science**
  - Single EHR across the Med Center and FQHCs
  - Data Analysts with specialized skills
  - Dashboard development
  - Clinic and provider level “drill down” reporting capacity
  - Data Driven Decision making
  - Data sharing with managed care plans

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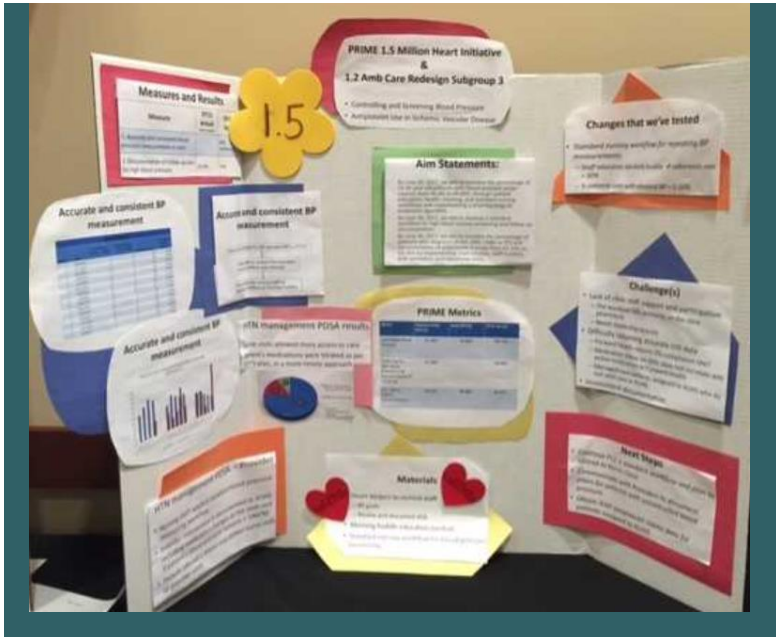

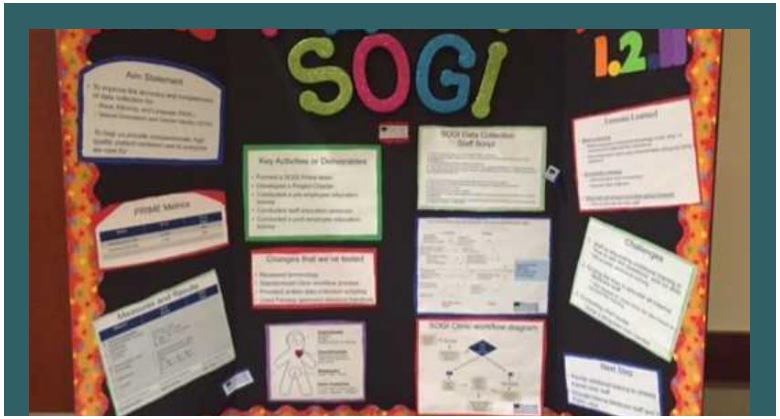

PRIME Driven Innovations

- **Workforce Development**
  - Front line staff engagement
  - Lean training (>1000ppl), lots of PDSAs
  - Customer service training
  - Empanelment team
  - Development of non-traditional clinic leaders

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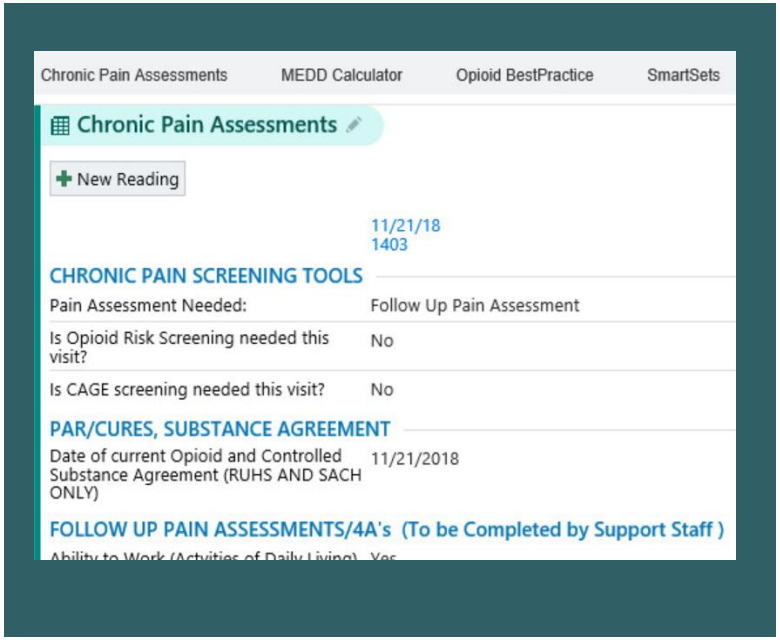

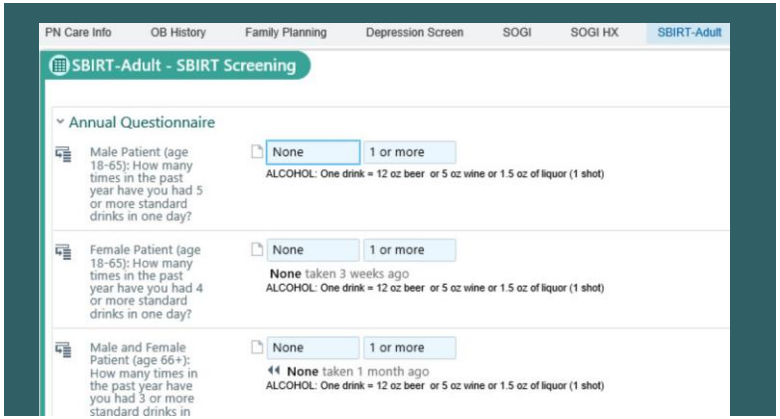

PRIME Driven Innovations

- **Developed new toolsets in EPIC**
  - Tobacco Smartset
  - Chronic pain tools
  - SBIRT templates
  - PHQ2/9 optimization
  - SOGI forms
  - BPAs for depression follow up
  - Alignment of UDS and PRIME data collection within EPIC
  - Prenatal OB navigator changes

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PRIME Driven Innovations

Workflow optimizations

- Prenatal workflow standardization in EPIC
- A1C standardized documentation
- Alignment and expansion of rooming processes
- Sharing of best practices (and some friendly competition)
- Care team pending of orders
- Complex care coordination
- Focus on patient experience

Riverside University HEALTH SYSTEM

PRIME Driven System Design Impact

- Alignment with other quality programs (UDS, P4P, QIP)
- Implementation of Trifecta teams at the clinic level (physician in charge, nurse coordinator, site manager)
- Multidisciplinary Dedicated Teams to work on Performance Improvement
- Focus on utilization of lean methodology and data to inform change
- De-Silo-ing
  - With Data
  - Within the organization/system
  - With partners – SACHs, Loma Linda University, Arrowhead, IEHP

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PRIME FUTURE IMPACT

- Further alignment of quality metrics (and hopefully definitions) with focus on preventive and population health
- Faster, more real time data availability at clinic finger tips
- Data driven culture
- More De-Silo-ing
  - With Data (across different systems, programs and health plans)
  - Within the organization/system
  - With partners – SACHs, LLU, Arrowhead, IEHP

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Thank you

RUHS Acknowledgements:
Corinne Matthews – Director of Incentive Payments Program
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Gift Nguru – PRIME Nurse Coordinator
Gretchen Page – PRIME Nurse Coordinator

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PRIME Looking ahead

- Continued focus on high performance as systems build on prior year's improvement
- Aligning with additional P4P requirements
  - Leveraging PRIME lessons learned
- Standardizing, strengthening, and spreading successful interventions

Q&A

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More Information

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

CAPH/SNI Publications

Medi-Cal 2020 Waiver Brief

PRIME Brief

Reducing Health Disparities through PRIME

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