CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

ISSUE BRIEF: PRIME

DELIVERY SYSTEM TRANSFORMATION: IMPROVING CARE AND OUTCOMES

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INTRODUCTION

With the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, California's 21 public health care systems (PHS) are continuing to lead the nation in pay-for-performance-based system transformation. They are meeting ambitious yearly performance targets, shifting their care delivery models towards one focused on strengthening patient-centered primary and specialty outpatient care, and providing the right care in more appropriate and cost-effective settings.

The ultimate result is a better health care system with healthier patients.

Federal funding for PRIME is contingent on meeting challenging performance targets and demonstrating continued improvement. If all of California's public health care systems meet all of their performance metric targets over the 5 years of the program, they could earn a total of $3.26 billion in federal funds.

Success in PRIME will also better enable California's public health care systems to succeed in a value-based environment in which payment is more closely tied to performance.

Core Program of the Medi-Cal 2020 Waiver

PRIME is a core program of California's current five year Section 1115 Medicaid waiver, known as Medi-Cal 2020, which was approved on December 31, 2015. PRIME complements two other waiver programs: the Global Payment Program, which encourages more patient-centered and cost-effective care for the uninsured, and Whole Person Care, which aims to improve the health and well-being of high-risk, high-utilizing patients by coordinating services across physical and behavioral health, and beyond.

In 2014 and 2015, CAPH/SNI - in support of the State of California's efforts to develop a new Section 1115 Medicaid waiver - led an extensive research and development process to help design the proposed PRIME projects and identify their associated metrics, working with multiple advisory boards composed of clinical and administrative leaders from across California's public health care systems.

1. CAPH member public health care systems include county-owned and operated health care systems and University of California medical centers. 38 District and Municipal hospitals also participate in PRIME. They have different opportunities and requirements for participation.

2. For more on the Medi-Cal 2020 waiver, visit caph.org/waiver.

About This Brief

This brief will describe the program requirements for the public health care systems, provide an overview of PRIME's structure, and offer in-depth examples of the ways PRIME is transforming delivery systems and improving the health of the patients served by California's public health care systems.

California's Public Health Care Systems

California's public health care systems are a core part of the state's health care safety net. Though they operate just 6% of all hospitals in the state, California's 21 public health care systems serve 15 counties where more than 80% of Californians live and serve more than 2.85 million patients a year. They provide 35% of all hospital care to Medi-Cal beneficiaries and 34% of hospital care to the remaining uninsured in the communities they serve, operate half of the state's top-level trauma and burn centers, and train more than half of all new doctors in the state.

California's public health care systems are integrated systems of care, providing top-quality primary and specialty care on their main campuses and in dozens of community-based clinics, in addition to life-saving hospital-based emergency and inpatient services. They provide 10.5 million outpatients visits annually, and are the primary care provider to more than 560,000 patients who have become eligible for Medi-Cal since California's coverage expansion efforts began.

PRIME PROGRAM OVERVIEW

PRIME provides incentives for health care systems to redesign their delivery systems to focus on primary and preventive care, operating under a model that's based on value, not volume. This effort will require marked improvements in data infrastructure and includes innovative approaches to performance measurement, all resulting in improved patient outcomes. Payment is based on the achievement of ambitious targets for over 100 clinical measures; it is not based on utilization of services.

Organized in three domains, PRIME includes projects that focus on redesigned care delivery in ambulatory settings, coordinated care management for high-risk populations, and efforts to use resources more efficiently while improving patient care.

Funding

PRIME provides the opportunity for California's public health care systems to earn up to $3.26 billion in federal incentive payments over the course of the waiver. These totals include scheduled decreases in annual funding of 10% in year four and 15% in year five.

(See table below for details.)

APM Requirement

PRIME further supports sustainable delivery system reform through a requirement that California's public health care systems use alternative payment models (APMs) in which providers assume some risk for the cost and quality of services provided to the Medi-Cal managed care enrollees who are assigned to these health care systems. APMs aim to further align payments with the goal of value-based care, rather than volume-based care.

The APM requirement stipulates that by January 2018, all of California's public health care systems must contract with at least one Medi-Cal managed care plan in the service area they operate in, using an APM. In addition, by January 2018, 50 percent of the state's Medi-Cal managed care beneficiaries who are assigned to any one of California's public health care systems must receive all or a portion of their care under a contracted alternative payment model. By January 2019, the goal increases to 55%, and to 60% by the end of the waiver renewal period in 2020. In both of these out years, 5% of the statewide yearly allocated PRIME pool amount for all public health care systems will depend on meeting these goals.

Non-Federal Share

As Medicaid is a state-federal partnership, the State must provide matching funds in order to receive federal funding. The source of non-federal share can include state general fund revenue or other public funds, such as local funds from counties, public health care systems or district and municipal public hospitals. California's Medicaid matching rate is 50%, which means that every dollar of federal funding must be matched with a corresponding dollar of non-federal share.

In the case of PRIME, all non-federal share is provided by the participants themselves; no state general fund is used for this program.

TIMELINE: DATES, DEADLINES, AND FUNDING

Demonstration Year[3]	Dates	Mid-Year Report Due	Year-End Report Due	Federal Funding Available for PHS
11	Jul 1, 2015 - Jun 30, 2016	N/A	Sep 30, 2016[4]	$700 million
12	Jul 1, 2016 - Jun 30, 2017	Mar 31, 2017	Sep 30, 2017	$700 million
13	Jul 1, 2017 - Jun 30, 2018	Mar 31, 2018	Sep 30, 2018	$700 million
14	Jul 1, 2018 - Jun 30, 2019	Mar 31, 2019	Sep 30, 2019	$630 million
15	Jul 1, 2019 - Jun 30, 2020	Mar 31, 2020	Sep 30, 2020	$535 million

3. Because Medi-Cal 2020 is a renewal of California's Section 1115 Medicaid waiver, which began in 2005, PRIME "demonstration years" start at 11.

4. The DY11 year-end report established baselines for each public health care system.

STRUCTURE

PRIME features eighteen projects, organized into three different domains.

Six of the projects, from the first two domains, are required for all public health care systems. In addition, each public health care system must select at least one optional project from each of the three domains, for a total of at least nine. Several public health care systems are taking on ten or more.

See grid on page 4 to see which public health care systems are taking on which projects.

"DHCS's vision is to preserve and improve the physical and mental health of all Californians. In alignment with this vision, DHCS is committed to continual improvement in population health and health care in all departmental programs. The 2017 DHCS Strategy for Quality Improvement in Health Care provides a blueprint to advance this commitment. PRIME is a key part of our Quality Strategy, and supports the Department's goals by striving for large-scale improvements in quality of care and health through system transformation."

– Dr. Neal Kohatsu, Medical Director for the California Department of Health Care Services

Domain 1: Outpatient Delivery System Transformation and Prevention

Domain 1 projects emphasize strong foundational ambulatory care, particularly primary care and including a focus on preventive services and the early diagnosis and treatment of illnesses. Domain 1 projects also encourage public health care systems to improve integration with ambulatory partners in behavioral health and specialty care, and empower patients with self-management skills.

Required projects for public health care systems:

- **Integration of Physical and Behavioral Health**
- **Ambulatory Care Redesign: Primary Care**
- **Ambulatory Care Redesign: Specialty Care**

PHS must also select **at least one** other Domain 1 project from the list below:

- Patient Safety in the Ambulatory Setting
- Million Hearts® Initiative[5]
- Cancer Screening and Follow-up
- Obesity Prevention and Healthier Foods Initiative

Domain 2: Targeted High-Risk or High-Cost Populations

The second domain is focused on higher risk patients who would benefit most significantly from improved care integration and coordination, especially during the transition from inpatient to outpatient care and in post-acute settings, to help ensure these patients get the care they need to recover, and to prevent readmissions.

Required projects for public health care systems:

- **Improved Perinatal Care**
- **Care Transitions: Integration of Post-Acute Care**
- **Complex Care Management for High Risk Medical Populations**

PHS must also select **at least one** other Domain 2 project from the list below:

- Integrated Health Homes for Foster Children
- Transition to Integrated Care: Post Incarceration
- Chronic Non-Malignant Pain Management
- Comprehensive Advanced Illness Planning and Care

Domain 3: Resource Utilization Efficiency

The third domain seeks to reduce the ineffective and potentially harmful overuse and inappropriate underuse of various diagnostics and treatments, including tests and medications.

Public health care systems must choose at least one of the following projects:

- Antibiotic Stewardship
- Resource Stewardship: High Cost Imaging
- Resource Stewardship: Therapies Involving High Cost Pharmaceuticals
- Resource Stewardship: Blood Products

5. The Million Hearts® Initiative is a project led by the U.S. Department of Health and Human Services aimed at preventing 1 million heart attacks and strokes over a five year period.

	Domain 1 : Outpatient Delivery System Transformation & Prevention *Required for DPH: 1.1, 1.2, 1.3 *At least 1* **Optional: 1.4, 1.5, 1.6, 1.7**							Domain 2: Targeted High Risk or High Cost Populations *Required for DPH: 2.1, 2.2, 2.3 *At least 1* **Optional: 2.4, 2.5, 2.6, 2.7**							Domain 3: Resource Utilization Efficiency *At least 1* **3.1, 3.2, 3.3, 3.4**				Source: 5 Year PRIME Plans
PHS	*1.1-Integration of Physical and Behavioral Health	*1.2-Ambulatory Care Redesign: Primary Care	*1.3-Ambulatory Care Redesign: Speciality Care	1.4-Patient Safety in the Ambulatory Setting	1.5-Million Hearts Initiative	1.6-Cancer Screening and Follow-up	1.7 Obesity Prevention and Healthier Foods Initiative	*2.1-Improved Perinatal Care	*2.2-Care Transitions: Integration of Post-Acute Care	*2.3-Complex Care Management for High Risk Medical Populations	2.4-Integrated Health Home for Foster Children	2.5-Transition to Integrated Care: Post Incarceration	2.6-Chronic Non-Malignant Pain Management	2.7-Comprehensive Advanced Illness Planning and Care	3.1-Antibiotic Stewardship	3.2 -Resource Stewardship: High Cost Imaging	3.3-Resource Stewardship: Therapies Involving High Cost Pharmaceuticals	3.4-Resource Stewardship: Blood Products	**Total Required + Optional Projects by Member**
Alameda	*	*	*		1.5			*	*	*			2.6		3.1				**9**
Arrowhead	*	*	*				1.7	*	*	*			2.6		3.1				**9**
Contra Costa	*	*	*			1.6		*	*	*	2.4		2.6			3.2			**10**
Kern	*	*	*	1.4				*	*	*		2.5				3.2			**9**
Los Angeles	*	*	*	1.4		1.6	1.7	*	*	*		2.5		2.7	3.1		3.3		**13**
Natividad	*	*	*		1.5			*	*	*			2.6					3.4	**9**
Riverside	*	*	*		1.5			*	*	*			2.6				3.3		**9**
San Francisco	*	*	*		1.5			*	*	*			2.6				3.3		**9**
San Joaquin	*	*	*			1.6		*	*	*				2.7		3.2			**9**
San Mateo	*	*	*			1.6		N/A	*	*	2.4		2.6			3.2			**9**
Santa Clara	*	*	*	1.4				*	*	*	2.4						3.3		**9**
UC Davis	*	*	*		1.5			*	*	*			2.6			3.2			**9**
UC Irvine	*	*	*	1.4				*	*	*			2.6		3.1				**9**
UC San Diego	*	*	*		1.5			*	*	*				2.7	3.1		3.3		**10**
UCLA	*	*	*	1.4				*	*	*				2.7			3.3		**9**
UCSF	*	*	*			1.6		*	*	*				2.7			3.3		**9**
Ventura	*	*	*		1.5			*	*	*	2.4							3.4	**9**
TOTAL	17	17	17	6	6	6	2	16	17	17	5	2	8	5	5	5	7	2	**160**

Project selection could change during the course of PRIME

MEASURING SUCCESS

Success in a PRIME project is determined by performance in a specified metric set. The majority of metrics were drawn from state and national metrics. For some projects there were no clinically tested and established metrics that effectively measured the project goals, so PRIME is testing new metrics for potential broader adoption. (See page 7 for more.) For the established metrics, in most cases, performance targets were developed using state or national benchmarks.

Most projects have between four and seven metrics, though this number can range from one to fourteen. PRIME's six required projects have a total of 44 associated metrics. Each public health care system is also measured based on its performance on anywhere between 11 and 30 additional metrics, depending on its selection of optional projects.

For example, success in the Integration of Physical and Behavioral Health project (1.1) will be measured by performance on these six metrics:

Alcohol and Drug Misuse (SBIRT)
Measures the percentage of patients who complete a standardized screening tool and receive appropriate brief treatment and/or referral for treatment of identified substance use

Care coordinator assignment
Measures the percentage of patients with poorly controlled diabetes who have been assigned a care coordinator

Comprehensive Diabetes Care: HbA1c Poor Control
Measures the percentage of patients with diabetes who have poorly controlled blood sugar levels or have not had a test to measure the control of their blood sugar

Depression Remission at 12 Months
Measures the percentage of patients who had screened positive for depression on a standardized screening tool and who had achieved remission at 12 months, as indicated by that same screening tool

Screening for Clinical Depression and follow-up
Measures the percentage of patients who were screened for depression, AND, if positive, had a follow-up plan documented on the date of the positive screen

Tobacco Assessment and Counseling
Measures the percentage of patients who were screened for tobacco use, and who received tobacco cessation counseling intervention

These metrics are standard across all PRIME participants, such that all participants in a given project are accountable for the same metrics, and follow the same procedures to identify numerators and denominators and report performance.

In the first year of PRIME, California's public health care systems reported baseline data for every required project and selected optional projects. In subsequent years, systems are required to improve on their performance from the prior year, meeting minimum performance thresholds (25th percentile of the established benchmark) in order to receive funding.

Gap Closure

Those above the minimum performance threshold must "close the gap" between their current performance on any given metric and a top performance threshold (90th percentile) by at least 10% each year in order to receive full funding. Systems that are already at the 90th percentile or above on a given metric must maintain that level of performance in order to receive funding for that metric.

Example Metric: Colorectal Cancer Screening

According to the National Centers for Disease Control (CDC) colorectal cancer is the third most common cancer among men and women in the United States, and occurs most often in people over the age of 50. When found early, colorectal cancer is highly treatable, but early stages of colorectal cancer often present no symptoms, so screenings are absolutely critical.

Two PRIME projects - Ambulatory Care Redesign (1.2) and Cancer Screening and Follow-Up (1.6) - use a metric that measures the percentage of patients 50-75 years of age (the denominator) who had the appropriate screenings for colorectal cancer (the numerator).

Nationally, the 25th percentile on this measure is approximately 27%, and the 90th percentile is approximately 65%. California's public health care systems have a total of almost 278,000 patients statewide who are being counted in the denominator for this measure.

As a hypothetical example, consider a "**System A**" which has a denominator of 16,000 patients as described above, with a screening rate of 46%, right between the 25th and 90th percentile. If its denominator stays the same, through the year-over-year gap closure methodology "**System A**" must screen a minimum of 1,046 additional patients over the course of PRIME - on top of the thousands it was already doing - to receive full funding.

If "**System A**" achieves *just the minimum improvement required each year by PRIME*, these additional screenings would look like this:

	DY11	DY12	DY13	DY14	DY15	New Screenings
Total patients in the denominator	16,000	16,000	16,000	16,000	16,000	
# of screenings with 90th percentile performance	10,400	10,400	10,400	10,400	10,400	
PHS A patients who received screenings	7,360	7,664	7,938	8,184	8,406	
Additional screenings to achieve 10% gap closure	304	274	246	222	199	1,049

If in this example the interventions developed to make improvements in screening rates enabled "**System A**" to close the gap by a little more each year - 15% instead of 10% - this would result in 1,545 more screenings there over the course of PRIME.

Target Population

A public health care system's overall target population for the PRIME program includes all patients who have had an encounter with the primary care team at least twice in a measurement year, as well as all Medi-Cal managed care patients who are assigned to that public health care system, whether they have been seen or not. Thus, PRIME requires all of California's public health systems to take a more proactive approach to the health and well-being of the populations they serve, by going beyond measuring performance just for patients who are seen for care.

Most metrics have denominators that are a subset of this overall population, depending on relevance to the specific service or activity being measured.

KEY INTERVENTIONS

Each PRIME project identifies several key activities, or "core components," that are critical to health systems' ability to achieve success in hitting metric targets and thus improving care delivery and patient outcomes. Health systems have identified which core components it will be employing as part of its 5-Year PRIME Plan.

For example, a health care system's plan for success in the Integration of Physical and Behavioral Health project (1.1) could include activities such as:

- Integrating appropriate screening tools and decision support into the emergency department to ensure timely recognition of patients with mental health and substance use disorder problems
- Integrating enhanced access to primary care and/or to behavioral health specialists into discharge planning for patients seen in the emergency department with mental health and substance use disorder problems
- Ensuring coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families
- Ensuring systems are in place to support patient linkage to appropriate specialty physical, mental and substance use disorder services

Unlike the project metrics, which are uniform and required across all of PRIME, these interventions are not standardized, and can be created and modified to fit the unique or changing needs of a health care system.

The Special Terms and Conditions of the Medi-Cal 2020 waiver include nearly 200 core components (ranging from 4 to 16 for each project) for participants to consider when designing and refining their interventions as PRIME progresses.

DATA FOR IMPROVEMENT

Success in PRIME – in terms of both meeting performance targets and meeting the reporting requirements to receive funding for having met the targets– requires that a health care system have a strong data collection, analytics, and reporting infrastructure.

Data plays several central roles in the PRIME program. First, PRIME entities must both achieve their performance targets, and accurately and comprehensively report on that performance in order to receive funding.

Since PRIME's targets are based on year-over-year performance improvement, systems must also be able to internally monitor their own performance at frequent intervals, as well as the effectiveness of their improvement interventions, in order to achieve and maintain a positive trajectory and continually identify areas for further improvement.

Additionally, access to consistent and accurate information allows providers and care teams to coordinate care delivery and standardize that care across their system. Timely access to accurate data also enables teams to track the progress of individual patients as well as identify and perform outreach to patients who are in need of care, whether they have already had encounters with the system or they have been assigned to that system for primary care through Medi-Cal but have not yet been seen.

Strengthening Data Infrastructure: Santa Clara Valley Health & Hospital System

In the early years of PRIME, California's public health care systems have been making the improvements necessary to their systems' data infrastructures to meet the program's reporting requirements. As they do so, they are experiencing other benefits of strengthened data for their delivery systems.

"We haven't just been reporting, we've been expanding collaboration, improving standardization, enhancing data integrity, and building our capacity to provide better health for all," said Jennifer Tong MD, Chief Medical Information Officer at Santa Clara Valley Health & Hospital System (SCVHHS).

Like all of California's public health care systems, SCVHHS is working on Project 1.1: Integration of Physical and Behavioral Health. In addition to key interventions such as improving the cultural competence of patient engagement efforts and cross-training staff, SCVHHS' data infrastructure improvements have enabled it to make other changes, including: moving from a paper referral system for primary care behavioral health to an electronic referral process, using electronic medical records to track care coordination, and improving the standardization of workflows and screening tools for depression and substance use.

SCVHHS also appreciates the need for strong data in its population health efforts. "As physicians, we're used to taking care of the patients who are sitting in front of us. Improved access to data about care gaps will allow us to identify the patients who aren't coming in. It leads us down the path towards really transforming the system and becoming proactive," said Dr. Tong.

SCVHHS has created a new role specifically for PRIME: *Transformation Coordinator.*

Each Transformation Coordinator is assigned to at least one PRIME project, and acts as the steward of those projects, both from a data standpoint and relationship standpoint. Transformation Coordinators work with executive and clinical sponsors to oversee and meet regularly with project teams, and communicate with others (e.g., clinic staff and pharmacy staff) about their projects' metrics, as well as the core components that they will need to focus on.

"It's exciting for us to start using this data that we've collected and these structures we've set up to start putting some of our ideas into practice," says Dr. Tong. "This program really resonates with clinicians in terms of the importance and the benefit to the patients."

INNOVATIVE METRICS

In most cases, PRIME metrics were chosen from state or national measures that have been clinically vetted by a recognized, authoritative entity. In some cases however, either the established metrics weren't appropriate or applicable for the target population, or there were no established metrics that adequately assessed success in achieving those specific clinical objectives. In these cases, "innovative metrics" were developed, accounting for 20% of PRIME metrics.

Many innovative metrics measure activities such as technology-based visits, targeted care coordination for high risk patients, and specialty care consultation – and enable PRIME entities to demonstrate the transformation of health care delivery towards coordinated, team-based, patient-centered care, in a manner not afforded by many of the standard metrics.

These types of activities and services are critical, both to the health of patients, and to an efficient and effective delivery system. The establishment of appropriate metrics and benchmarks for these activities and services could enable health care systems throughout the country to measure and improve performance.

"PRIME's innovative metrics are ambitious contributions to how we evaluate care. NCQA applauds the PRIME program's efforts in these important measurement areas and we look forward to the continued refinement and evolution of the PRIME program."

– Margaret E. O'Kane, President, National Committee for Quality Assurance (NCQA)

PRIME participants are playing a key role in a rigorous testing and vetting process, governed by the California Department of Health Care Services (DHCS), to assess the validity of these new innovative metrics. The processes for creating and testing innovative metrics were developed and are being implemented in close collaboration with DHCS and the National Committee for Quality Assurance (NCQA).

NCQA brings expertise on national measure development to help inform the testing process, and is working with DHCS, the California Health Care Safety Net Institute (SNI) and the program's "measure stewards" to continuously assess and support refinement of each innovative metric.

Measuring the Timely Receipt Of Specialty Care Expertise: Los Angeles County Department Of Health Services

"Health care is constantly changing. There's new technology, there are new treatments, and there's new research into what works and what doesn't. Traditional metrics that have evolved out of decades-long processes fail to include emerging health care delivery methods," says Dr. Paul Giboney, Director of Specialty Care for the Los Angeles County Department of Health Services (LACDHS). "What the innovative metrics are attempting to do is to capture that much more quickly and accurately than the traditional health metrics."

In recent years there has been a tremendous growth in the use of technology to better meet the needs of patients, whether through the convenience of non-face-to-face visits, or through systems like eConsult, with which a primary care provider can quickly communicate with a specialty care provider regarding a patient.

Two of PRIME's innovative metrics are aimed at measuring the delivery of specialty care expertise: Specialty Care Touches, which measures specialty expertise requests managed via non-face-to-face encounters, and Referral Reply Turnaround Rate, which measures the percentage of requests for specialty care expertise replied to within four calendar days.

"We don't have a metric to assess the success of these new and evolving ways of caring for our patients," says Dr. Giboney. "This is about measuring whether we're providing specialty care in the most patient-centric and rapid manner, and figuring out what our benchmarks should be."

Dr. Giboney says that so far, much of LACDHS's work has been geared towards clarifying measure specifications and helping other health care systems deploy the interventions and solutions that will help ensure the timely receipt of specialty care expertise.

"We will have to develop, based on the cumulative experience of PRIME, targets that take into account the variation in individual disease presentations, the fact that there are some conditions that are more urgent than others, and the fact that the number may vary by specialty. It will be very interesting to see how this process captures what's going on across the state."

IMPACT ON PATIENTS

PRIME projects and interventions are making a direct impact on the health and well-being of their target patient populations. All eighteen PRIME projects measure success by looking for real impacts on patients.

"The improvement work underway in PRIME is transforming the delivery systems that are taking part – and is vital towards improving the quality of life for low-income patients across California."

– Sarah de Guia, Executive Director, California Pan-Ethnic Health Network

For example, success in PRIME's Ambulatory Care Redesign project (1.2), which is required for public health care systems, is determined based on performance in 14 metrics, focused on patient outcomes and disparity reduction.

To succeed in this project, health care systems must demonstrate a consistently increased use of standardized screening tools for clinical depression, meaning more patients with this very common but often untreated mental health issue are being identified, and receiving access to the help they need.

Systems are being measured on whether they increase their rate of patients with hypertension whose blood pressure is under control – patients who, as a result, will have a lower risk of coronary artery disease, kidney disease, heart failure and stroke.

Success in PRIME's Ambulatory Care Redesign project will also depend on PHS lowering their rates of patients with diabetes whose HbA1c (blood sugar) level is in poor control; increasing their rates of tobacco cessation counseling for patients who smoke; increasing the rates of colorectal cancer screening and expanding the use of aspirin for patients with ischemic vascular disease.

Identifying And Reducing Disparities

Health disparities can only be addressed if they are identified, and they can only be identified if detailed information is collected. PRIME's Ambulatory Care Redesign project includes five metrics related to the expanded collection, analysis, and use in stratification efforts of granular Race, Ethnicity and Language, and Sexual Orientation/Gender Identity data – known collectively as "REAL SO/GI" data.

While the interventions and improvements at the heart of the PRIME program are intended to reach a broad patient population that is generally more at-risk for poor health outcomes than the average person, deeper and more specific disparities exist within that population, and PRIME directs California's public health systems to identify and work to reduce those disparities.

PRIME's REAL SO/GI requirements and targets change over the course of the program. In general, public health care systems must do the following:

	DY11	DY12	DY13	DY14	DY15
REAL Data Completeness	Establish baseline data on the percentage of patients for whom REAL data is collected	Collect REAL data for at least 20% of patients in the target population	Collect REAL data for at least 40% of patients in the target population	Collect REAL data for at least 60% of patients in the target population	Collect REAL data for at least 80% of patients in the target population
SO/GI Data Completeness		Establish baseline data on the percentage of patients in the target population for whom SO/GI data is collected	Collect SO/GI data for at least 10% of patients in the target population	Collect SO/GI data for at least 25% of patients in the target population	Collect SO/GI data for at least 40% of patients in the target population
Stratification of Primary Care metrics		Stratify performance on Primary Care Redesign (1.2) project metrics according to REAL and SO/GI data			
Disparity Reduction Plan		Document a plan to improve the health, health outcome, or health care delivery of an identified REAL and/or SO/GI disparity population			
Disparity Reduction			Meet 10% gap closure performance targets for the targeted disparity population as identified in the disparity reduction plan	Meet 10% gap closure performance targets for the targeted disparity population as identified in the disparity reduction plan	Meet 10% gap closure performance targets for the targeted disparity population as identified in the disparity reduction plan

Culturally Competent Care: UC San Diego Health

San Diego is the eighth-largest city in the United States and features broad ethnic diversity, with more than half its population identified as Hispanic, Asian/Pacific Islander, or African-American. About 4% of San Diegans identify as part of the LGBT community.

UC San Diego Health provides about 650,000 outpatient visits each year across its clinics, and works closely with community organizations like Health Center Partners, which represents the Federally Qualified Health Centers (FQHCs) in San Diego County.

UC San Diego Health's work around disparities reduction represents a true community effort. The system plans to leverage its award winning HERE (Health + Education + Research = Empowerment) Initiative, which is a collaboration of more than eighty organizations promoting health awareness, accessibility of healthcare, workforce diversity, research, and higher education for the underserved.

Dr. Amy Sitapati, Chief Medical Information Officer for Population Health at UC San Diego Health, says getting the project off the ground required a similar collaborative spirit even within the health system itself.

"To get the collection of REAL SO/GI data implemented, we needed more than fifty stakeholders from within our system to come to the table and agree. Every workflow is involved: operations, physicians and clinical staff, registration teams, all the research teams, and lots more. Projects of this scope can be incredibly hard to take on, but PRIME gave us the incentive to do it, and it's going to make a big impact on our patients."

"This work is vital to our ability to be culturally competent, and we're looking at the big picture through a new lens," says Dr. Sitapati. "When you think about the foundation for good health care, it really is about understanding your patients – which means not just knowing about their health, but also knowing who they are."

Life-Saving Screenings: Contra Costa Health Services

Six of California's public health care systems are participating in the optional Cancer Screening and Follow-Up (1.6) project, including Contra Costa Health Services (CCHS). This project aims to increase screening rates and ensure that patients receive appropriate follow-up care for cervical cancer, colorectal cancer, and breast cancer.

Annette Harris became a primary care patient at one of CCHS's health centers in 2016. At her first visit, Annette's doctor noticed that she was not up-to-date on many health tests and screenings and scheduled some for her, including a mammogram. After Annette's screening mammogram showed signs of potential cancer, she underwent a diagnostic mammogram, then an ultrasound and a biopsy.

Her doctors found two lumps under her breast, much too deep and small to have been detected with a self-exam. One was benign; the other was early cancer, stage 1. Annette had surgery to remove the breast, alleviating any future concerns about recurrence. "It was all so quick," she said. "The care has been excellent."

One of the Cancer Screening and Follow-Up project's metrics measures the percentage of women age 50-74 from the overall PRIME population who have had a mammogram to screen for breast cancer within the last two years and three months.

Looking at baseline data and using the 10% gap closure methodology described on page 5, we can see that across the PHS[6] participating in this project, nearly 1,800 more women like Annette will have received breast cancer screenings if these participants reach just the minimum improvement target required to receive funding .

Baseline denominator	72,123
90th percentile performance	51,503
Current screenings	46,312
5-year 10% gap closure	**1,785**

Complex Care Management for High Risk Medical Populations: San Joaquin General Hospital

Another required PRIME's project for public health systems is Complex Care Management for High Risk Medical Populations (2.3), which addresses the fact that a disproportionate share of resources in the Medi-Cal program is used to provide care to a relatively small number of patients. Nationally, it has been estimated that 1% of patients account for the top quartile of total Medicaid expenditures.

"We've been doing care coordination work, but PRIME is helping us move from a reactive 'pull' model where patients are referred individually to the program by their primary care physicians, to a proactive 'push' model, where we'll be using data and predictive analytics to make sure we've got the right patients," says Dr. Farhan Fadoo, Chief Medical Information Officer at San Joaquin General Hospital.

SJGH's Complex Care Management project is overseen by the system's recently-established population health unit, and relies on care coordinators who serve as a central point of contact for adult patients with four or more chronic medical conditions and who are considered "high-risk." These care coordinators help those patients navigate the complexities of the health care system, and help develop strong linkages with other community resources to help address non-clinical barriers to care, like the lack of transportation, or unstable housing.

At SJGH, this work coincides with the rollout of a new electronic health records (EHR) system and a series of data infrastructure and governance improvements which were needed to meet PRIME's reporting requirements. These changes will enable greater use of data to both identify these high-risk patients and monitor their progress.

"Using a robust population health management platform planned to be integrated with the EHR, care teams won't just have access to dashboards and data retrospectively, they'll get the intelligence and the decision support they need while the patient is in front of them," says Dr. Fadoo. "We'll also be able to use claims data to see what services they're accessing – whether they're going to other hospitals or clinics in the community."

Dr. Fadoo says that soon, SJGH's complex care management work will also be able to incorporate user-generated data from things such as wearable sensors and monitors. "It's part of our road map and our visioning that for certain high-risk patients, we'll be able to leverage technologies like remote glucometry, ambulatory blood pressure monitoring devices, and electronic medication dispensers. PRIME has provided a critical opportunity for us to transform the way we take care of our most vulnerable patients."

6. This number includes minimum improvements for just four of the project's six participants (Alameda Health System, Contra Costa Health Services, Los Angeles Department of Public Health Services and San Joaquin General Hospital) because baseline data indicated that the other two (San Mateo Medical Center and UC San Francisco Health) are already performing above the 90th percentile nationally, and PRIME requires that they maintain that level of performance rather than improve upon it. If they do increase their rates, or if the other four increase theirs beyond the minimum, this number will be higher.

7. Bodenheimer, Tom. *Strategies to Reduce Costs and Improve Care for High-Utilizing Medicaid Patients: Reflections on Pioneering Programs.* Center for Health Care Strategies, Inc.

Early Results - Measuring Trust

PRIME entities are in their second year of the program. Last year, they were required to submit baseline data on all of their project metrics. This data demonstrates that California's public health care systems are already performing at high levels on several metrics, and will need to maintain that performance over the course of the program.

For example, the "Clinician and Group Consumer Assessment of Healthcare Providers and Systems" (CG CAHPS) survey measures patients' perceptions of outpatient care and is one of the metrics for Project 1.2: Ambulatory Care Redesign. PRIME measures the percentage of patients who give their clinician (including doctors, nurse practitioners, physician's assistants and clinical nurse specialists) the highest possible ratings – a 9 or 10 out of 10.

Nationally, the 90th percentile for performance on this measure is for 70% of patients to rate their clinicians this highly. PRIME baseline data shows that on average, California's public health care systems are already five points above this high performance goal.

Most systems currently meet or exceed the 90th percentile, and the rest are all within striking distance, indicating the high level of trust that our members have earned from their patients. Going forward through PRIME, they must maintain or increase that trust, in order to receive funding for this metric, and to be competitive systems of care.

CONCLUSION

PRIME's ambitious system-focused projects and metrics are challenging California's public health care systems to make sweeping transformations in their delivery systems and achieve dramatic improvements.

These systems are improving their data infrastructures to meet the program's reporting requirements, and to more proactively manage their patient population, achieve better health outcomes, and address specific disparities.

Public health care systems are quickly adopting and measuring innovative methods of delivering care, and the information being gathered will become a part of the national performance measurement landscape.

PRIME's performance targets require year-over-year advancement for public health systems to continue to receive funding, leading to both cumulative positive effect on the health of the communities they serve, and the development and cultivation of continuous improvement capabilities.

All of these improvements are working together, along with PRIME's APM requirement, in helping California's public health care systems continue to move towards a care delivery model that is truly based on value to the patient.

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, and educate the next generation of health care professionals.

SNI, a 501c3 affiliate of CAPH, informs CAPH's policy and advocacy efforts, and helps California's public health care systems deliver more effective, efficient and patient-centered health care to the communities they serve by providing performance measurement expertise, and by supporting and accellerating decision-making

ABOUT CALIFORNIA'S PUBLIC HEALTH CARE SYSTEMS

California's public health care systems are true systems of care, providing a comprehensive range of health care services, including primary care, outpatient specialty care, emergency and inpatient services, rehabilitative services, and in some instances, long-term care. They offer life-saving trauma, burn and disaster-response services, provided by expert medical staff.

These health care systems serve more than 2.85 million patients each year. They are the primary care provider for more than 560,000 Californians who gained Medi-Cal coverage through the expansion, and provide 10.5 million outpatients visits annually. They operate half of the state's top-level trauma and burn centers, and train more than half of all new doctors in the state.

California's PHS operate in 15 counties where more than 80% of Californians live. Despite accounting for just 6% of the state's hospitals, they provide 35% of hospital care to Medi-Cal beneficiaries and 34% of hospital care to the remaining uninsured in the communities they serve.