CALIFORNIA’S PROGRESS IN PRIME
Today’s Agenda

- About CAPH/SNI
- PRIME
  - Background
  - Progress and themes
- Member Perspectives
  - Contra Costa Regional Health Center
  - Ventura County Medical Center
- 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.
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
The Critical Role of Public Health Care Systems

- Safety net – majority of patients are Medi-Cal or uninsured
- Systems of care: provide hospital/inpatient care, primary care, specialty services, trauma care, rehabilitation, etc.
- Providers of 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
  - Operate more than half of the state’s top-level trauma and burn centers
  - Clinical education: together they train 57% of all new doctors in the state
Medi-Cal 2020 Waiver (2015-2020)

• Public Hospital Redesign & Incentives in Medi-Cal (PRIME)
  – Pay-for-performance successor to DSRIP
  – Focus on high quality care that is integrated and coordinated
  – Strengthening use of data

• Global Payment Program (GPP)
  – Combines existing funding streams to align incentives
  – Improved access to services for the remaining uninsured

• Whole Person Care (WPC)
  – County-based pilot program
  – Coordinated and targeted care for high users of multiple systems

• Dental Transformation Initiative (DTI)
  – Improved and more consistent dental care for children
PRIME Background

- Successor to – and 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 Structure

- Three domains
  1. Outpatient Delivery System Transformation and Prevention*
  2. Targeted High-Risk or High Cost Populations
  3. Resource Utilization Efficiency

- Six Required Projects
  1. Integration of Physical and Behavioral Health
  2. Ambulatory Care Redesign: Primary Care
  3. Ambulatory Care Redesign: Specialty Care
  4. Improved Perinatal Care
  5. Care Transitions: Integration of Post-Acute Care
  6. Complex Care Management for High Risk Medical Populations

- Must select 3 additional projects from 12 optional projects

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Report</th>
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</thead>
<tbody>
<tr>
<td>2015</td>
<td>DY 11</td>
</tr>
<tr>
<td>2016</td>
<td>DY 12</td>
</tr>
<tr>
<td>2017</td>
<td>DY 13</td>
</tr>
<tr>
<td>2018</td>
<td>DY 14</td>
</tr>
<tr>
<td>2019</td>
<td>DY 15</td>
</tr>
<tr>
<td>2020</td>
<td>Final Evaluation</td>
</tr>
<tr>
<td>2021</td>
<td>Final Evaluation</td>
</tr>
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</table>

**DY11** Year End Report

**DY12** Mid Year Report

**DY12** Mid Year Report

**DY13** Year End Report

**DY14** Year End Report

**5 Year Plan**

**Final Evaluation**
PRIME Changes in metrics over time

<table>
<thead>
<tr>
<th>Year</th>
<th>P4R Metrics</th>
<th>P4P Metrics</th>
<th>Avail. Payment</th>
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<tr>
<td>DY11</td>
<td>0/96</td>
<td>35/63</td>
<td>$700M</td>
</tr>
<tr>
<td>DY12</td>
<td>32/65</td>
<td>9/86</td>
<td>$700M</td>
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<td>DY13</td>
<td>32/65</td>
<td>7/88</td>
<td>$700M</td>
</tr>
<tr>
<td>DY14</td>
<td>9/86</td>
<td>7/88</td>
<td>$630M</td>
</tr>
<tr>
<td>DY15</td>
<td>9/86</td>
<td>7/88</td>
<td>$535M</td>
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PRIME Emerging themes of member progress

- Improved population health management
- Improve coordination and partnerships
- Develop the workforce
- Invest in IT and data analytics
- Enhance patient engagement
- Implement new processes and workflows
- Strengthen and standardize performance improvement
PRIME Progress

Investing in IT and data analytics

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

Examples:
- Kern implemented a new software system that administers patient screenings and surveys electronically.
- Ventura created health maintenance tools and reminders in their EHR to flag for providers when screenings are needed.

Strengthening and standardizing 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:
- Riverside’s Ambulatory Care Redesign team implemented PDSAs (Plan-Do-Study-Act) at 10 of the 13 primary care clinics on SBIRT*, tobacco cessation counseling, diabetes control, hypertension control, REAL* data completeness, and patient experience.

SBIRT = Screening, Brief Intervention, and Referral to Treatment for alcohol and drug use
REAL = Race, Ethnicity and Language
PRIME Progress

Developing the workforce

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

Examples:

- UCSF established multidisciplinary behavioral health integration workgroups with representation from primary care, psychiatry, nursing, social work, population health, and IT teams.
- Alameda Health System enhanced team-based care by training medical assistants to order labs and hiring additional clinic nurses and pharmacists.

Implementing new processes and workflows

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

Example:

- San Francisco developed a standard set of REAL categories, created an intake form (now translated into the 5 threshold languages), trained staff and implemented new workflows to collect data.
PRIME Progress

Improving coordination and partnerships

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

Examples:

- Many systems are improving coordination between primary and specialty care through the use of e-consult.
- LA County partnered with the local health information exchange, LANES, to upload complete specialty visit notes in real-time so that they are readily available to partners.

Enhancing 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:

- Santa Clara Valley Medical Center developed a care transitions program with a team of registered nurses who initiate interactions with patients while they are hospitalized and facilitate their transition into ambulatory care.
DY12 At-A-Glance

% of P4P metrics met for DY12
89%

% of all metrics met for DY12
96%

Additional 25,000 patients screened for tobacco

Additional 16,000 patients screened for colorectal cancer
# Designated Public Hospitals (DPHs) that Met DY12 Year End (YE) Targets

<table>
<thead>
<tr>
<th>Metric Description</th>
<th># of DPHs that met or exceeded DY12 YE target</th>
<th># of DPHs that did not meet or exceed DY12 YE targets</th>
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<tbody>
<tr>
<td>1.3.7 Tobacco Assessment &amp; Counseling</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>1.1.6.t Tobacco Assessment &amp; Counseling</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>1.2.14.t Tobacco Assessment &amp; Counseling</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>1.2.3.c Colorectal Cancer Screening</td>
<td>17</td>
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<tr>
<td>2.1.9 OB Hemorrhage Safety Bundle</td>
<td>16</td>
<td></td>
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<tr>
<td>2.1.1 Baby Friendly Hospital Designation</td>
<td>16</td>
<td></td>
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<tr>
<td>1.1.3.d HbA1c Poor Control (&gt;9.0%)</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>1.2.4.d HbA1c Poor Control (&gt;9.0%)</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>1.2.5.b Controlling Blood Pressure</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>1.2.2 CG-CAHPS: Provider Rating</td>
<td>1</td>
<td>16</td>
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<tr>
<td>1.2.7.i IVD: Use of Aspirin or Another Antithrombotic</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>1.2.11 REAL data completeness</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>1.3.2 DHCS All-Cause Readmissions</td>
<td>3</td>
<td>14</td>
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<tr>
<td>2.2.1 DHCS All-Cause Readmissions</td>
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</tr>
<tr>
<td>2.2.2 H-CAHPS: Care Transition Metrics</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>2.1.5 Cesarean Section</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>2.1.2 Exclusive Breast Milk Feeding (PC-05)</td>
<td>8</td>
<td>8</td>
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</tbody>
</table>

DY12 YE data has not yet been approved by DHCS.
PRIME APM Requirement

- Alternative Payment Methodologies (APMs) tie payment to value, not volume and encourage patient-centered care provided in the right place at the right time
- Aligned with goals of PRIME – encourages movement towards primary and preventive care
- Individual and aggregate requirements
PRIME Takeaways

- Already demonstrating an impact, eg
  - Tobacco assessment and counseling (90% to 94%)
  - Colorectal cancer screening (59% to 65%)

- Importance of data (coding, infrastructure, sharing, reporting and analytics capabilities)

- Comprehensiveness and ambitiousness of PRIME
  - Year over year improvement, challenging performing targets

- Looking ahead
  - Spread, sustainability and continued improvement
Contra Costa Regional Health Center

* County owned Integrated Healthcare Safety Net System including Hospital & Clinics, Health Plan, Public Health, Behavioral Health, EMS

* 166 Bed Hospital, 10 Ambulatory clinics, 5 Detention Health Centers

* 125K+ unique patients annually

* 50K+ annual Emergency Room Visits
* 10K+ annual Inpatient admissions
* 500K+ annual Outpatient Visits

PRIME Eligible Population of 84,000
10 PRIME Projects and 60+ metrics
Unlocking potential

Select Topic

Participates (10-100 teams)

Prework

Develop Framework & Changes

Expert Meeting

LS 1 → LS 2 → LS 3

AP 1 → AP 2 → AP 3

Hold the Gains

CONTRA COSTA 2020

Institute for Healthcare Improvement: Breakthrough Series
Improvement Framework

Driver Diagrams

Process Measures

PRIME 1.6 - Cancer Screening Driver Diagram

Contra Costa Health Services will increase cancer prevention and survival thru early detection by improving cancer screening rates to 88.6% for breast cancer screening, 57.7% for colorectal cancer screening, and 54.3% for cervical cancer screening by April 2017.

Access

Patient Convenience

Lack of scheduling and ordering

Standard Workflow for Outreach

Identify Patients Needing Screening Tests

Mail in FIT tests

Saturday and evening appointments

Wellness Clinics

Staff assist patients to make screening appointments—talking at visit etc.

Point of Care Screening—Mammography, PAP

Colorectal Cancer Smart form Gudac

EHR tools to make ordering easier

Follow up to patients who did not show.

CUN Panel Coordinators perform Outreach

Image, Birthday, cancer from clinic

Eliminate Wasted of Duplicate Outreach

Multilink Outreach

Clinic has accurate HCM

Still correctly IDed or denied screening

Tours and patient education for PAP

Providers know their screening rates

FIT Tests Ordered and Not Completed

Select one of the filters

Define

Select one of the filters

Define
# Data Governance

![Image of a group of people in a meeting]

**PRIME Data Validation Checklist**

**Setup Process:**
- The programming was completed based on specifications received from SNF. The programming is tested by IT for technical design. Before the data can be used for official purposes, the Data Steward needs to validate the data and report results prior to sign-off.
- Please use this check list to document the validation process and your findings for each measure and save the file in the PRIME team site on Sitecore in the PRIME: Evidence > PRIME Data Validation folder with the following naming convention: `<measure Name>_<DataSteward>_<ccbi>.doc`. Please also save the Excel spreadsheet containing the MRNs reviewed in the same folder with the same file name.
- After saving the file, please email Leslie.Ocampo@concordcc.org to notify her if issues were found or that the validation has been signed off.

**Measure Name:** Colorectal Cancer Screening HOF 0034  
**Project Name:** Cancer Screening and Followup

<table>
<thead>
<tr>
<th>Quality Assurance Requirements</th>
<th>Reviewed Notes</th>
<th>Report Writer Notes</th>
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</thead>
<tbody>
<tr>
<td>1. Review 20 charts at a minimum using data from the most recent complete month. Use random function in Excel to select the charts to review. If issues found, report to IT. Else, continue to review at least 30 charts if 30 consecutive charts have no issues, then sign off.</td>
<td>In the first review, I reported 2 patients who had colorectal cancer in 2018 but were not included in the numerator. IT feedback: The procedures were only noted in the physician notes, so could not be included.</td>
<td></td>
</tr>
<tr>
<td>2. Confirm report matches inclusion/exclusion criteria.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>3. Confirm all appropriate data sources and workflows have been used (e.g., billing claims, problem list, unit diagnoses, flow sheets, external data source, etc.)</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
Connecting the Data

CFS
Foster Child List

Every Monday

Electronic Medical Record

+ Eligibility
+ Behavioral Health
+ Rx Data

Case Manager
PRIME At A Glance

PRIME Executive Dashboard

Domain 1: Outpatient Delivery System Transformation and Prevention

- Measures Net: 23
- $6.27 M Funding At Risk
- $35.1 M

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

- Measures Net: 19
- $10 M Funding At Risk
- $78.1 M

Domain 3: Resource Utilization Efficiency

- Measures Net: 6
- $0 M Funding At Risk
- $1.53 M
How Low Can You Go?

Average SBP
10 Patients

↓ = Good

First Measure
Last Measure

Average SBP

125
130
135
140
145
150
155
Sustainable Return on Investment
Understanding and Measuring
Ventura Regional Medical Center

- A County Health Care Agency consisting of 40 clinics, 2 hospitals, Behavioral Health, Public Health, and Human Service Agency.
  - 180 beds (VCMC) and 49 beds (SPH).
- Serving the residents of Ventura County—over three quarters of population served are those who are underserved and face barriers to access of care.

PRIME Eligible Population: 85,000+
PRIME Projects and # of metrics:
- 9 projects
- 60+ metrics
Pre-PRIME Integration

- Health Care system consisting of 40 clinics, two hospitals, Behavioral Health, Public Health and Human Services Agency working parallel to each other but rarely integrated.
- Efforts to improve patient care occurred at individual sites, with minimal effect due to limited ability to spread universal and standard health goals.
PRIME in Progress

- Focused improvement goals throughout hospitals and clinics.
- Monthly meetings and working groups to bring front-line staff and leaders together to monitor improvement and standardize processes.
- Increased presence of co-located Behavioral Health clinicians to assist with depression screening, coordination of care, and follow up.
- Public Health partnership including well-child visits, outreach and education, influenza immunization collaboration, access to preventive screenings, and referral for tobacco cessation resources.
- Outreach by Human Services Agency to foster children for well-child visits and care coordination.
Ambulatory Care Quality Alliance (ACQA)
1.2.4.d Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
1.2.14. Tobacco Assessment and Counseling

DY13 Target: 93.66%

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>DY11</td>
<td>57.47%</td>
</tr>
<tr>
<td>MY12</td>
<td>86.81%</td>
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<tr>
<td>DY12</td>
<td>93.38%</td>
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</table>
PRIME – The Future

ENVISION 2021: THE FUTURE

- Seamless transition of patient care across the agency regardless of location or reason for care provided.
- Consistent high-quality patient care focused on prevention and improving outcomes at all points of care.
- Improvement efforts will be sustained universally in the system and driven by data that highlights optimal patient outcomes and experience.
Q&A

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Theresa Cho, MD
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Theresa.Cho@ventura.org
More Information

Webinar Deck and & Recording to be posted with additional resources available here:

https://safetynetinstitute.org/membersupport/primesupport/