

# REDUCING HEALTH DISPARITIES AT CALIFORNIA'S PUBLIC HEALTH CARE SYSTEMS

## THROUGH THE MEDI-CAL 2020 WAIVER'S PRIME PROGRAM

April 2018

### INTRODUCTION

Health disparities are an unacceptable element of systemic inequity across all sectors in California, and throughout the nation. These disparities have been well-documented along lines that include race, ethnicity, language, income status, education level, sexual orientation, gender identity, and even zip code.

For example, according to the California Department of Public Health<sup>1</sup>, the state's average life expectancy for African Americans is 75.1 years, compared to 86.3 years for Asian Americans – and within the city of Oakland alone, an African American child born in a low-income neighborhood will die fifteen years earlier than a white child born in a more affluent neighborhood.

California's 21 public health systems serve a diverse, low income patient population who are generally more at risk for poor health outcomes and often experience health disparities. As a result, many public health care systems have been undertaking efforts to identify and reduce health disparities.

Now, for the first time, all of California's public health care systems statewide are undertaking concurrent and harmonized efforts to use data to identify and reduce specific health disparities. These disparity reduction plans can teach us many important lessons about the need to use actionable data to reduce disparities and improve health outcomes.

### PRIME's Disparity Reduction Requirement

Through the Public Hospital Redesign and Incentives in Medi-Cal (PRIME)<sup>2</sup> program, public health care systems must capture granular population data, analyze that data to identify disparities, develop a plan to address a specific identified disparity, and execute that disparity reduction plan.

This work will directly improve the health of patients in the populations identified in these plans. In the process, public health care systems will be designing and testing interventions for disparity reduction efforts that will guide this work long into the future, improving the health of entire communities.

To date, PRIME has required systems to begin collecting sexual orientation and gender identity (SO/GI) data, and improve

the collection and stratification of granular Race, Ethnicity and Language (REAL) data.

Beginning in PRIME's third program year (July 2017 - June 2018), public health care systems began using the REAL data collected in the first two years to identify a specific disparity (e.g., blood sugar control, blood pressure control) for a specific population, and create a plan to reduce that disparity.

Now that the plans have been developed, federal funding will be contingent on demonstrating year-over-year improvements in quality and health outcomes for the target disparity population and "closing the gap" between current performance and a high performance benchmark<sup>3</sup>. This year-over-year target setting methodology should improve care and outcomes among the identified disparity populations as compared to the larger public health care system population, and thus will reduce the performance disparity between the two.

As these plans are implemented, CAPH/SNI will continue to monitor their progress in subsequent issue briefs.

### Timeline and Project Requirements

#### Program Year 1: July 1, 2015 – June 30, 2016

Establish baseline data on the percentage of patients for whom REAL data is collected

#### Program Year 2: July 1, 2016 – June 30, 2017

Collect REAL data for at least 20% of patients in the PRIME population<sup>4</sup>  
Establish baseline data on the percentage of patients in the PRIME population for whom SO/GI data is collected  
Document a plan to improve the health of an identified disparity population

#### Program Year 3: July 1, 2017 – June 30, 2018

Collect REAL data for at least 40% of patients in the PRIME population  
Collect SO/GI data for at least 10% of patients in the PRIME population  
Meet 10% gap closure performance targets for the targeted disparity population as identified in the disparity reduction plan

#### Program Year 4: July 1, 2018 – June 30, 2019

Collect REAL data for at least 60% of patients in the PRIME population  
Collect SO/GI data for at least 25% of patients in the PRIME population  
Meet 10% gap closure performance targets for the targeted disparity population as identified in the disparity reduction plan

#### Program Year 5: July 1, 2019 – June 30, 2020

Collect REAL data for at least 80% of patients in the PRIME population  
Collect SO/GI data for at least 40% of patients in the PRIME population  
Meet 10% gap closure performance targets for the targeted disparity population as identified in the disparity reduction plan

1. [Portrait of Promise: The California Statewide Plan to Promote Health and Mental Health Equity](#)

2. To learn more about PRIME, visit [caph.org/prime](http://caph.org/prime).

3. For more on gap closure methodology, refer to our Issue Brief on PRIME at [caph.org/primebrief](http://caph.org/primebrief)

4. A short explanation of the PRIME population is on the next page; for more see the above brief.

## DEVELOPING DISPARITY REDUCTION PLANS

### Collecting Granular Data

By June of 2017 (the end of PRIME’s second program year) public health care systems had collected granular REAL data for more than 460,000 patients – an increase of nearly 200,000 over the baseline established in the first year of the program<sup>5</sup>.

Public health care systems’ analyses of this data revealed disparities in the provision of care and health outcomes that previously may have been undetected, and/or confirmed the existence of disparities that were suspected but not yet measured.

By the end of PRIME, public health care systems will have been required to collect REAL data for at least 80% of its PRIME population and SO/GI data for 40% of its PRIME population, and to have closed the gap between current performance and a high performance benchmark by at least 10% in each of the final three program years.

### Themes in Disparity Reduction Plans

Each community served by one of California’s public health care systems has unique demographics, geography, and needs. Consequently, each public health care system developed its disparity reduction plan tailored to those characteristics.

Despite their differences, the disparity plans share a number of common themes. Race was commonly chosen as a defining factor for target populations, with some health systems choosing to refine further by also including factors such as age and health diagnosis. Overall, ten systems chose African Americans as their target population, and five selected Hispanics/Latinos as their target population. Two systems chose their target populations based on language.

With regard to the specific health disparities and health metrics being targeted, public health care systems often identified improved blood pressure control, improved colorectal cancer screening rates, and the delivery of comprehensive diabetes care. (See chart at right.)

Several common themes emerged across the interventions planned by health systems to address these disparities:

### Developing culturally competent and linguistically appropriate materials

Many public health care systems are developing and disseminating culturally competent and linguistically appropriate education materials. For instance, Arrowhead Regional Medical Center is sharing its materials on the importance of colorectal cancer screening at its family health centers that serve a large Hispanic/Latino population, and

### Background – PRIME and the Medi-Cal 2020 Waiver

PRIME is a pay-for-performance program in which California’s 21 public health care systems are using evidence-based quality improvement methods to achieve ambitious performance targets and improve health outcomes for patients, and is a core program of California’s current five-year Section 1115 Medicaid waiver, known as MediCal 2020<sup>6</sup>.

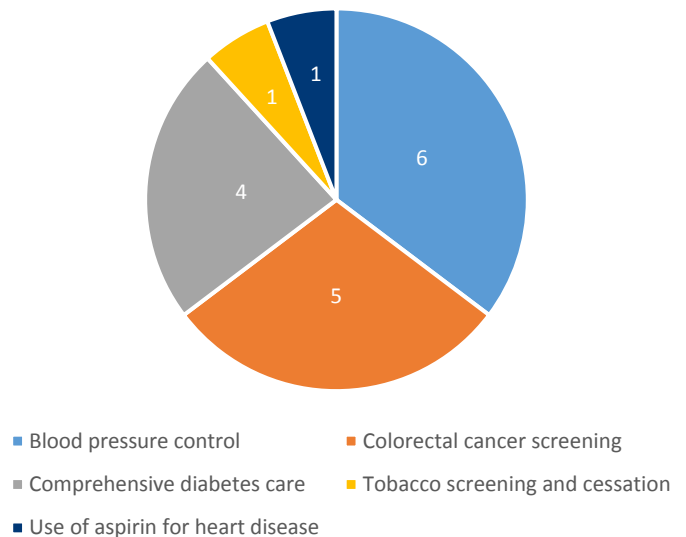
A public health care system’s **PRIME population** includes all patients who have had an encounter with the primary care team at least twice in a measurement year, as well as all Medi-Cal managed care patients who are assigned to that public health care system, whether they have been seen or not.

PRIME features eighteen different performance improvement projects<sup>7</sup>. Six of these projects are required for all public health care systems, including the wide-ranging Ambulatory Care Redesign: Primary Care.

The primary care project focuses on strengthening primary and preventive services, and the early diagnosis and treatment of illnesses. It also encourages public health care systems to improve integration with partners in behavioral health and specialty care, and to empower patients with self-management skills.

Success in this project is measured based on performance across fourteen health measures, five of which are related to collecting, analyzing, and using stratified Race, Ethnicity and Language (REAL), and Sexual Orientation/Gender Identity (SO/GI) data to address disparities in care. Federal funding for public health care systems is directly tied to performance.

Number of Health Systems Targeting Each Metric/Disparity



5. PRIME participants were not required to collect SO/GI data in the first year of the program, and this work is just getting off the ground at health systems.

6. To learn more about Medi-Cal 2020, visit [caph.org/waiver](http://caph.org/waiver)

7. For a full list of projects, visit [caph.org/primeprojects](http://caph.org/primeprojects)

is also utilizing social media and text-messaging to issue a “call-to-action” on the importance of testing. Natividad Medical Center is using messaging that targets specific barriers or knowledge gaps, as can occur when a patient is newly insured.

### Training staff

Public health care systems are also training staff to improve cultural competence. For example, Los Angeles County Department of Health Services’ disparity reduction plan targets improvements in colorectal cancer screening for African Americans. They are training providers to address specific concerns that have been raised in academic studies of this specific disparity, including patients’ fear of a bad result and providers’ reluctance to recommend the screening. Santa Clara Valley Health & Hospital System is developing training opportunities for Hispanic nursing students to receive diabetes education and become Certified Diabetes Educators.

### Enhancing patient engagement

Patient engagement is also crucial to all disparity reduction plans, starting with direct outreach. Kern Medical is utilizing letters and personal phone calls from care coordinators to educate patients in its target population on the medical benefits of taking aspirin for heart disease, and UCLA Health is using an automated calling platform to assist patients with scheduling return office visits.

### Seeking guidance from patients affected by these disparities

In addition, many public health systems are seeking direct input and guidance from patients who are directly affected by these disparities. For example, Contra Costa Health Services has recruited African American patients from their target population to be “patient partners,” who attend weekly staff planning meetings and help guide decision-making and interventions. UCSD leverages its patient portal to conduct surveys and questionnaires that can help identify barriers to care among different populations. Similarly, Riverside University Health System, is launching a promotora program to train community members to provide basic health education in the community. UC Davis Health is partnering with faith groups and schools, as well as farmers’ markets and grocery stores, to help patients learn about and manage their diabetes.

### Improving change management strategies

Many plans also call for the use of change management techniques, and improvements to internal workflows and communications practices. San Mateo Medical Center, for example, is implementing workflow changes to help ensure that providers are aware of, and communicate in, a patient’s preferred language. UC San Francisco Health has created a health equity data dashboard that can be used to track progress in achieving their disparity reduction goals.

## DISPARITY PLAN SUMMARIES AND SELECTED HIGHLIGHTS

Although the metric definitions and performance requirements are standardized, each public health care system designed an individual disparity reduction plan based on the trends that emerged from its own data, and the unique needs of each community.

### Alameda Health System

**Population:** African American males with uncontrolled diabetes

**Target:** Comprehensive Diabetes Care

**Plan includes:** putting a chronic care team at primary care sites, developing customized health education materials, expanding modes of service delivery to include group medical visits and phone encounters, and expanding partnerships with community organizations and churches.

### Arrowhead Regional Medical Center

**Population:** Hispanic/Latino males, age 50-75

**Target:** Colorectal Cancer Screening

**Plan includes:** utilizing culturally sensitive educational materials at family health centers, as well as distributing information about the benefits of screenings through social media and text messaging services.

### Spotlight: Patient Photovoice Project

In 2015, Alameda Health System (AHS) conducted a “photovoice” project for African American men with cardiovascular diseases, as part of a disparity reduction effort for congestive heart failure. Patients were given cameras and asked to photograph objects, scenes, or scenarios that made taking care of their condition easy, and those that made it challenging. Patients were interviewed about their photos and spoke about their experiences.

All participants described the experience of struggling, denial of the disease and its complications, and a sense of being overwhelmed by the myriad tasks required to manage their health conditions. They also shared feelings of isolation and a lack of knowledge regarding who to turn to for peer support. Participants also expressed frustration at the frequency and difficulty of visiting providers, and spoke about depression, food instability, and social stigma.

AHS’s PRIME disparity reduction plan continued this focus on African Americans, shifting to diabetes, a key precursor of cardiovascular disease. AHS expects to find similar challenges, and has developed interventions for diabetes care that emphasize convenience, community, education, and empowerment.

## METRICS

Public health care systems' disparity reduction plans each include one of the following five metrics:

**Blood Pressure Control:** Reducing the percentage of patients with “poor control” (as defined by age and other health diagnoses) of their blood pressure.

**Colorectal Cancer Screening:** Increasing the screening rate for colorectal cancer

**Comprehensive Diabetes Care:** Reducing the percentage of patients with “poor control” of diabetes, as defined by an HbA1c level above 9.0

**Use of Aspirin for Heart Disease:** Increasing the percentage of Ischemic Vascular Disease (IVD) patients with an active medication of aspirin or another antiplatelet to reduce the risk of clots and serious vascular events

**Tobacco Screening and Cessation:** Increasing the percentage of patients screened for tobacco use, and who received cessation counseling if identified as a tobacco user.

### Contra Costa Health Services

**Population:** African Americans

**Target:** Blood Pressure Control

**Plan includes:** creating a “patient partner” program, utilizing group medical visits, conducting phone outreach to patients with uncontrolled blood pressure, and conducting improvement tests to reduce no-show rates.

### Kern Medical

**Population:** Spanish-speaking patients with Ischemic Vascular Disease (IVD)

**Target:** Use of Aspirin for Heart Disease

**Plan includes:** care coordinators providing Spanish language culturally competent outreach, and a community education campaign with letters targeted to specific communities explaining the benefits of taking aspirin for IVD.

### Los Angeles Department of Health Services

**Population:** African Americans

**Target:** Colorectal Cancer Screening

**Plan includes:** training providers to address specific concerns and highlight the benefits of screening, and the increasing utilization of postage-paid testing fecal immunochemical test (FIT) kits to avoid patients having to return to the clinic to turn in their completed kits.

### Natividad Medical Center

**Population:** English-speaking patients in need of colorectal cancer screening

**Target:** Colorectal Cancer Screening

**Plan includes:** addressing low screening rate (compared to overall population) through streamlined workflows, increased access to testing and screening, and culturally targeted education.

### Riverside University Health System

**Population:** Hispanic/Latino, Spanish-speaking diabetic patients, age 18-39

**Target:** Comprehensive Diabetes Care

**Plan includes:** conducting patient focus groups to identify barriers to success, increasing collaboration with community partners, initiating a “Promotora” program to assist with health education, and connecting patients with health coaches.

### Santa Clara Valley Health & Hospital System

**Population:** Hispanic/Latino diabetic patients, age 19-60

**Target:** Comprehensive Diabetes Care

**Plan includes:** creating classes and education materials that are culturally sensitive and available at multiple literacy levels, facilitating one-on-one visits with a comprehensive diabetes care team for a subgroup of patients, and launching community engagement efforts through community health workers.

### San Francisco Health Network

**Population:** African Americans with a diagnosis of hypertension, age 18-85

**Target:** Blood Pressure Control

**Plan includes:** creating a Hypertension Equity Workgroup to develop tools for outreach and home blood pressure monitoring, partnering with nurses who provide chronic care visits, and implementing “food pharmacies” in primary care clinics.

## Spotlight: Food Pharmacies

As part of an effort to address hypertension and improve blood pressure control among its target disparity population, San Francisco Health Network is piloting “Food Pharmacies” at several primary care clinics to help patients with their nutritional needs. Patients referred to food pharmacies receive healthy groceries and cooking supplies for themselves and their families at no cost.

The program also provides nutrition and cooking education – such as how to blanch and freeze vegetables, or how to prepare healthy food in a microwave if patients lack a stove. The class also introduces patients to healthy foods they may not have tried, such as tofu. The food pharmacy fosters community and patient interaction, encouraging patients to share skills and recipes with each other.

**San Joaquin General Hospital**

**Population:** African American patients in need of colorectal cancer screening, age 50-75

**Target:** Colorectal Cancer Screening/Blood Pressure Control

**Plan includes:** dissemination of culturally appropriate educational materials, physician education about patient engagement, targeted outreach to churches, community-based organizations and appropriate events, and personal telephone follow-up reminders from patient navigators.

**Spotlight: Workforce Engagement**

San Joaquin General Hospital (SJGH) identified a disparity in colorectal cancer screening rates and uncontrolled blood pressure among its African American patient population.

SJGH providers are conducting targeted community outreach and education efforts at African American churches, community-based organizations and events. Notably, several SJGH African-American physicians and nurses are engaged in this work, and the plan includes an organization-wide effort to recruit more diverse physicians and staff.

**San Mateo Medical Center**

**Population:** African Americans with a diagnosis of hypertension

**Target:** Blood Pressure Control

**Plan includes:** increasing coordination with primary care providers on hypertension plans, providing clinics with monthly stratified hypertension data, and conducting hypertension improvement events.

**UC Davis Health**

**Population:** African Americans

**Target:** Comprehensive Diabetes Care

**Plan includes:** developing culturally appropriate and language-sensitive patient education materials, working with community partners to provide health education, and developing new clinic workflows and electronic medical record (EMR) tools to capture information on social determinants of health and health literacy.

**UC Irvine Health**

**Population:** Hispanics/Latinos

**Target:** Colorectal Cancer Screening

**Plan includes:** launching a patient stakeholder engagement panel, creating patient engagement tools for use during ambulatory care encounters, and developing outreach tools for patients who are identified as being in need of screening, but do not have an upcoming appointment.

**Spotlight: Patient Advisory Groups**

The UC Irvine Health Policy Research Institute regularly engages patient advisory groups to discuss community perceptions of health issues and possible solutions. UC Irvine Health's PRIME disparity reduction plan includes convening a group of Spanish-speaking patients to help improve the rate of colorectal cancer screenings among this population, identify key points to improve communication, and develop recommendations for effective outreach.

**UCLA Health**

**Population:** African Americans

**Target:** Blood Pressure Control

**Plan includes:** utilizing specialists, researchers, and a care coordination team to reach patients, assisting patients in following-up with providers and pharmacists, and utilizing an automated calling platform to facilitate scheduling return visits.

**UC San Diego Health**

**Population:** African Americans

**Target:** Tobacco Screening and Cessation

**Plan includes:** connecting patients with resources such as the No Butts campaign and the California Smokers' Hotline, providing culturally competent outreach to patients, and launching specific new roles and workflows.

**Ventura County Health Care Agency**

**Population:** Hispanic/Latino males without diabetes mellitus, age 18-64

**Target:** Blood Pressure Control

**Plan includes:** creating a hypertension clinic, engaging in cultural competence efforts, including training and hiring processes targeting a linguistic and culturally representative staff, and outreach by community health workers.

**Spotlight: Hypertension Clinic**

Ventura County Health Care Agency (VCHCA) developed a hypertension clinic model at the Las Islas Family Medical Group, a VCHCA Federally Qualified Health Center, for Hispanic/Latino males without diabetes mellitus, age 18-64.

The clinic provider team includes a nurse practitioner, a dietitian, and several community health workers, who work together to provide health education and care coordination, manage follow-up visits, medication compliance efforts, and linkages to appropriate community resources.

Patients are offered a home visit by a community health worker to assess patients' living conditions to identify any contributing factors, locate community resources for exercise options, provide healthy eating education and assistance in complying with nutrition plans, and provide any other needed community/health referrals.

## LOOKING AHEAD

The implementation of these disparity reduction plans will strengthen California's public health systems' capacity to collect and analyze granular data, develop effective intervention strategies, engage with and empower different patient populations, improve their workflows, and – ultimately – improve the health of their entire communities.

Public health care systems are already meeting and embracing the challenge of PRIME, achieving 89% of their pay-for-performance targets in the program's second year, including 93% of targets in the Ambulatory Care Redesign: Primary Care project, which contains these disparity reduction efforts.

California's public health care systems have made huge investments in collecting the data needed to identify and measure health disparities. Now these systems will be held accountable for putting that data into action, and delivering on the promise of their plans, to reduce disparities and improve the health of the communities they serve.

### 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 accelerating 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 550,000 Californians who gained Medi-Cal coverage through the expansion, and provide more than 10.5 million outpatient 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 roughly 35% of hospital care to Medi-Cal beneficiaries and 40% of hospital care to the remaining uninsured in the communities they serve.