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
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
Critical Role of Public Health Care Systems

- 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
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
PRIME Structure

Domain 1: Outpatient Delivery System Transformation and Prevention
- Integration of Physical and Behavioral Health
- Ambulatory Care Redesign: Primary Care*
- Ambulatory Care Redesign: Specialty Care
- Million Hearts
- Cancer Screening & Follow-Up
- Obesity Prevention & Healthier Foods Initiative

Domain 2: Targeted High-Risk or High Cost Populations
- Improved Perinatal Care
- Care Transitions: Integration of Post-Acute Care
- Complex Care Management for High Risk Medical Populations
- Integrated Health Home for Foster Children
- Chronic Non-Malignant Pain Management
- Comprehensive Advance Illness Planning and Care

Domain 3: Resource Utilization Efficiency
- Antibiotic Stewardship
- High-Cost Imaging
- Therapies Involving High-Cost Pharmaceuticals
- Blood Products

For public health care systems: 6 required projects; must select 3 additional from 12 optional projects (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
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
DY13 At-A-Glance

% of P4P metrics met for
DY13

89%

% of all metrics met for
DY13

93%

% P4P metrics ↑ in DY13
(35% to 67%)

% of P4P metrics met for
DY12

89%

% of all metrics met for
DY12

96%
### P4P Metrics in Required Projects: # Systems that Met DY13 Year End (YE) Targets

<table>
<thead>
<tr>
<th>Metric</th>
<th># of DPHs that met or exceeded DY13 YE target</th>
<th># of DPHs that did not meet or exceed DY13 YE targets</th>
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<tbody>
<tr>
<td>2.1.1 Baby Friendly Hospital designation</td>
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<td>17</td>
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<tr>
<td>1.3.7 Tobacco Assessment &amp; Counseling</td>
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<td></td>
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<tr>
<td>1.3.3 Influenza Immunization</td>
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<td></td>
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<tr>
<td>1.2.2 CG-CAHPS: Provider Rating</td>
<td></td>
<td></td>
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<tr>
<td>1.2.4.d Diabetes: HbA1c Poor Control (&gt;9%)</td>
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<td>17</td>
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<tr>
<td>1.1.3.d Diabetes: HbA1c Poor Control (&gt;9%)</td>
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<td>2.2.5 Timely Transmission of Transition Record</td>
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<tr>
<td>2.2.4 Reconciled Med List Received by Discharged Patients</td>
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<tr>
<td>2.1.6 Prenatal Care</td>
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</tr>
<tr>
<td>2.1.6 Postpartum Care</td>
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<td>15</td>
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<tr>
<td>1.2.7.i IVD: Use of Aspirin or Another Antithrombotic</td>
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<td>16</td>
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<tr>
<td>1.2.5.b Controlling Blood Pressure</td>
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<td>1.2.3.c Colorectal Cancer Screening</td>
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<td>1.2.11 REAL Data Completeness</td>
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<tr>
<td>1.1.6.t Tobacco Assessment &amp; Counseling</td>
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<td>16</td>
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<td>2.3.4 Timely Transmission of Transition Record</td>
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<td>15</td>
</tr>
<tr>
<td>2.3.2 Med Reconciliation - 30 days</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>2.2.3 Med Reconciliation - 30 days</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>2.1.9 OB Hemorrhage Safety Bundle</td>
<td>2</td>
<td>14</td>
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<td>1.3.1 Closing the Referral Loop: receipt of specialist report</td>
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<td>15</td>
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<td>1.2.13 SO/GI Data Completeness</td>
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<td>1.2.12.f Screening for Clinical Depression &amp; Follow-up</td>
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<td>1.1.5.f Screening for Clinical Depression &amp; Follow-up</td>
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<td>15</td>
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<td>2.2.1 All-Cause Readmissions</td>
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<td>1.2.10 REAL and/or SO/GI Disparity Reduction</td>
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<td>13</td>
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<td>2.1.5 C-Section</td>
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<td>11</td>
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<td>2.1.2 Exclusive Breast Milk Feeding</td>
<td>6</td>
<td>10</td>
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<td>1.3.2 All-Cause Readmissions</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>2.2.2 H-CAHPS: Care Transition Metrics</td>
<td>10</td>
<td>7</td>
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</tbody>
</table>

DY13 data has not yet been approved by DHCS.
3,600 fewer diabetics with poor HbA1c control

26,000 additional patients screened for colorectal cancer

83,000 additional patients screened for tobacco use & who received cessation counseling intervention if identified as a tobacco user

185,000 additional patients screened for depression & if positive, a follow-up plan documented

= 1,000 patients
PRIME Progress themes

- Improve coordination & partnerships
- Enhance patient engagement
- Develop the workforce
- Invest in IT & data analytics
- Implement new processes & workflows
- Strengthen & standardize performance improvement

Improved population health management
PRIME Progress: 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

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
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.
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.
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**
PRIME Progress: Strengthening Quality 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

Structure

Process

Outcomes
Structure

Prioritization

- Data integrity
- Clinician engagement
- Transparency
- Infrastructure

Team Governance

- WIT
- PRIME/QIP Steering
- PRIME/QIP Core

Engaged Stakeholders

Data Governance

- Business intelligence
- Quality
- Clinical Operations

- Metric review
- Data mapping
- Metric Build
- IQA
- Validation
**Example: Eliminating Waste in Prenatal Appointment Scheduling**

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

- Pregnant patient calls
- Attends RN appt for pregnancy test
- Receives RN appt for urine pregnancy test
- Receives appt for intake visit
- Attends intake visit
- Gets appt for provider visit
- Attends provider visit

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

- Pregnant patient calls
- Receives appt for intake visit **and** provider visit
- Attends intake visit
- Attends provider visit
Example: Percent of mammograms ordered by a medical assistant

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

1. Best practices
2. IT infrastructure
3. Communication/training
Two SOGI pilots

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

Newark Adult
Highland AIC

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

Highland Adult
## Data driven pilot selection

<table>
<thead>
<tr>
<th>Pilot Duration</th>
<th>SOGI Completion Rate (last 30 days)</th>
<th>Refusal Rate (last 30 days)</th>
<th>Registration Cycle Time Impact</th>
<th>Intake Cycle Time Impact</th>
<th>Post-Visit Time Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pilot #1</strong></td>
<td><strong>Newark</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbally by MAs at Intake</td>
<td>2.5 mo</td>
<td>79.90%</td>
<td>0.96%</td>
<td>0 sec</td>
<td>0 sec</td>
</tr>
<tr>
<td><strong>Highland AIC</strong></td>
<td>1.5 mo</td>
<td>87.96%</td>
<td>3.16%</td>
<td>30 sec (mean)</td>
<td>210 sec (max)</td>
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<td><strong>Pilot #2</strong></td>
<td><strong>Highland Adult</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Paper form at registration</td>
<td>1 mo</td>
<td>16.26%</td>
<td>7.14%</td>
<td>60 sec</td>
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</table>

### Other Impact Times
- Intake cycle time impact: 45-60 sec (min) - 210 sec (max)
- Post-visit time impact: 0 sec
Real-time, online process measure

### Performance By Location

<table>
<thead>
<tr>
<th>Location</th>
<th>Total Patients</th>
<th>% Sexual Orientation Documented</th>
<th>% Gender Identity Documented</th>
<th>% SOGI Completed</th>
<th>% Sexual Orientation Heterosexual</th>
<th>% Sexual Orientation Homosexual</th>
<th>% Sexual Orientation Bisexual</th>
<th>% Sexual Orientation Other</th>
<th>% Sexual Orientation Refused</th>
<th>% Gender Identity CIS Gender</th>
<th>% Gender Identity Transgender</th>
<th>% Gender Identity Genderqueer</th>
<th>% Gender Identity Other</th>
<th>% Gender Identity Refused</th>
</tr>
</thead>
<tbody>
<tr>
<td>BWG - ADULT MEDICINE</td>
<td>6253</td>
<td>24.55%</td>
<td>8.72%</td>
<td>6.73%</td>
<td>99.05%</td>
<td>0.91%</td>
<td>0.26%</td>
<td>0.20%</td>
<td>0.39%</td>
<td>99.76%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.24%</td>
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<tr>
<td>HGH - ADULT IMMUNOLOGY</td>
<td>683</td>
<td>56.08%</td>
<td>56.08%</td>
<td>56.08%</td>
<td>55.87%</td>
<td>10.55%</td>
<td>3.35%</td>
<td>2.09%</td>
<td>3.11%</td>
<td>97.65%</td>
<td>0.52%</td>
<td>0.52%</td>
<td>0.78%</td>
<td>0.78%</td>
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<td>HGH - ADULT MEDICINE</td>
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<td>13.07%</td>
<td>12.69%</td>
<td>12.66%</td>
<td>87.78%</td>
<td>2.81%</td>
<td>1.94%</td>
<td>2.23%</td>
<td>4.85%</td>
<td>96.20%</td>
<td>0.00%</td>
<td>0.90%</td>
<td>0.10%</td>
<td>2.80%</td>
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<td>103</td>
<td>0.97%</td>
<td>0.97%</td>
<td>0.97%</td>
<td>100.00%</td>
<td>0.00%</td>
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<td>2.65%</td>
<td>89.36%</td>
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<td>7.45%</td>
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<td>1.37%</td>
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<td>1.21%</td>
<td>0.04%</td>
<td>0.96%</td>
<td>98.61%</td>
<td>0.04%</td>
<td>0.04%</td>
<td>0.00%</td>
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### Active Patients (Last 30 Days)

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<thead>
<tr>
<th>Location</th>
<th>Total Patients</th>
<th>% Sexual Orientation Documented</th>
<th>% Gender Identity Documented</th>
<th>% SOGI Completed</th>
<th>% Sexual Orientation Heterosexual</th>
<th>% Sexual Orientation Homosexual</th>
<th>% Sexual Orientation Bisexual</th>
<th>% Sexual Orientation Other</th>
<th>% Sexual Orientation Refused</th>
<th>% Gender Identity CIS Gender</th>
<th>% Gender Identity Transgender</th>
<th>% Gender Identity Genderqueer</th>
<th>% Gender Identity Other</th>
<th>% Gender Identity Refused</th>
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<tbody>
<tr>
<td>BWG - ADULT MEDICINE</td>
<td>1661</td>
<td>37.63%</td>
<td>22.28%</td>
<td>22.28%</td>
<td>95.32%</td>
<td>1.60%</td>
<td>0.48%</td>
<td>0.48%</td>
<td>0.64%</td>
<td>95.73%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.27%</td>
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<tr>
<td>HGH - ADULT IMMUNOLOGY</td>
<td>317</td>
<td>62.46%</td>
<td>62.46%</td>
<td>62.46%</td>
<td>55.06%</td>
<td>12.83%</td>
<td>7.07%</td>
<td>3.03%</td>
<td>1.01%</td>
<td>98.48%</td>
<td>0.51%</td>
<td>0.51%</td>
<td>0.51%</td>
<td>0.00%</td>
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<tr>
<td>HGH - ADULT MEDICINE</td>
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<td>26.79%</td>
<td>26.79%</td>
<td>90.42%</td>
<td>1.98%</td>
<td>1.82%</td>
<td>1.49%</td>
<td>4.13%</td>
<td>97.35%</td>
<td>0.00%</td>
<td>0.83%</td>
<td>0.17%</td>
<td>1.66%</td>
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<tr>
<td>HWC - ADULT IMMUNOLOGY</td>
<td>27</td>
<td>3.70%</td>
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<td>8.68%</td>
<td>84.05%</td>
<td>1.84%</td>
<td>1.23%</td>
<td>0.00%</td>
<td>12.88%</td>
<td>100.00%</td>
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<td>NWC - ADULT MEDICINE</td>
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<td>80.57%</td>
<td>95.86%</td>
<td>1.28%</td>
<td>1.62%</td>
<td>0.09%</td>
<td>1.08%</td>
<td>95.55%</td>
<td>0.09%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.26%</td>
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</table>
**SOGI implementation**

**Standard work**

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

**Spread plan – started Feb 1st!**

### Project: SOGI

**What is being asked?**
Collection of SOGI data by AAs 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. NB 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 MA/ LVN/RNs were provided follow-up training at January 2018.

Other videos are available online as supplementary training opportunities:
1. [http://www.learner.org/courses/family.html](http://www.learner.org/courses/family.html)
   - Includes overview of who we ask, definitions, as well as example clinical scenarios
2. [http://oonline.learner.org/courses/family.html](http://oonline.learner.org/courses/family.html)
   - Resources from the Family Institute
   - Includes webinars, FAQs, medical literature on SOGI
   - Webinars can be viewed for CME or CEU credit
   - Registration (login required, but free)

**How is progress monitored?**

**Who is the local (site) process owner?**
Eastmont – Renee Macias
Hayward – Babs Keliari
Highland – Anita Roberts
Hayward – Michelle Rivas
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 in cross site collaboration
5. Escalate challenges that can’t be resolved locally to the appropriate person or group

**Where do questions or concerns get escalated?**
Questions or concerns should first be brought to the attention of the site based Process Owner. If they cannot be addressed by the site, they can be escalated to the subject matter experts below. Feedback will also be solicited in the Ambulatory Quality Council when both the practice managers and RN supervisors are in attendance.

**Who are the subject?**
1. Heather MacDonald-Fine
• 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

<table>
<thead>
<tr>
<th>Time Slot</th>
<th>Duration (Alphabetical Order)</th>
<th>Activity (Alphabetical Order)</th>
<th>Number of Beds</th>
<th>Shift Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 - 9:00</td>
<td>2418 Duration</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>9:00 - 10:00</td>
<td>2418 Duration</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>10:00 - 11:00</td>
<td>2418 Duration</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td>11:00 - 12:00</td>
<td>2418 Duration</td>
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<tr>
<td>12:00 - 13:00</td>
<td>2418 Duration</td>
<td>1</td>
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<td>1</td>
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<tr>
<td>13:00 - 14:00</td>
<td>2418 Duration</td>
<td>1</td>
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<td>1</td>
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<tr>
<td>14:00 - 15:00</td>
<td>2418 Duration</td>
<td>1</td>
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<td>1</td>
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<tr>
<td>15:00 - 16:00</td>
<td>2418 Duration</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

2. Building capacity with non-traditional visits

Transformation Activities:
Improving Access

Ambulatory Care Services

**Title:** Scheduling Initial and First Prenatal Visit With Provider (OB/GYN MD or Family Practice, such as OBX, Family Doctor, NMs, and PLC)

**Departments who must adopt:** Call Center, Obstetrics Clinic, patient’s clinic visits

**Operators who must adopt:** OBX E0, CPW coordinators, LN, NM

**Date:** S/10/2018

<table>
<thead>
<tr>
<th>Task #</th>
<th>Task Description</th>
<th>Task Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Patient calls the Call Center requesting prenatal care</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Call Center staff verifies insurance. If assigned to another, redirect to assigned medical home (or facilitate change of medical home to AFH).</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>If patient has not done a pregnancy test, schedule patient for a Home Visit to patient’s Clinic at the location of their choice (can be cancelled via phone by OBX or clinic). If pregnancy test is not patient’s choice and continuation of pregnancy is desired, schedule appointment with OBX secure payer source (preferably before or day of 08/0 to secure payer source for services).</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>All calls in sequence. If a pregnancy test is done, schedule patient for a prenatal visit to patient’s clinic at the location of their choice (can be cancelled via phone by OBX or clinic). If pregnancy test is not patient’s choice and continuation of pregnancy is desired, schedule appointment with OBX secure payer source (preferably before or day of 08/0 to secure payer source for services).</td>
<td></td>
</tr>
</tbody>
</table>

**Ambulatory Project Summary**

**Clinic Cancellation Policy**
Streamlining entry to prenatal care

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

- Pregnant patient calls
- Receives RN appt for urine pregnancy test
- Attends RN appt for pregnancy test
- Receives appt for intake visit
- Attends intake visit
- Gets appt for provider visit
- Attends provider visit

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

- Pregnant patient calls
- Receives appt for intake visit and provider visit
- Attends intake visit
- Attends provider visit

Transformation Activities: Eliminating Waste
Transformation Activities: Improving Data Integrity

Clinical validation: Relentless chart audits and clinical validation

---

<table>
<thead>
<tr>
<th>Audit</th>
<th>Notes</th>
<th>DelEnc</th>
<th>WorkingEDD</th>
<th>FirstTrimesterStartDT</th>
<th>FirstTrimesterEndDT</th>
<th>FirstTrimesterVisitDT</th>
</tr>
</thead>
<tbody>
<tr>
<td>x</td>
<td>Ok</td>
<td>20020122204 10/20/2016</td>
<td>1/14/2016</td>
<td>4/27/2016</td>
<td>NULL</td>
<td></td>
</tr>
</tbody>
</table>

Pt had early prenatal care with AHS, then transferred to CHCN site (Tibicino 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.

<table>
<thead>
<tr>
<th>Audit</th>
<th>Notes</th>
<th>DelEnc</th>
<th>WorkingEDD</th>
<th>FirstTrimesterStartDT</th>
<th>FirstTrimesterEndDT</th>
<th>FirstTrimesterVisitDT</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1/26/2016</td>
<td>5/9/2016</td>
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<tr>
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<td>Ok</td>
<td>20020129074 10/30/2016</td>
<td>1/21/2016</td>
<td>5/4/2016</td>
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<tr>
<td>x</td>
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<td>2/28/2016</td>
<td>6/15/2016</td>
<td>NULL</td>
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<tr>
<td>x</td>
<td>Ok</td>
<td>200201797435 12/17/2016</td>
<td>3/12/2016</td>
<td>6/24/2016</td>
<td>NULL</td>
<td></td>
</tr>
</tbody>
</table>

EDC 6/9/16, initial prenatal visit 12/2/15 (source EDM)
10/29 at HGH WS
CPT: 99211 after 10/24/15; Dx: 233.1
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.
EDC 5/28/16
It looks like this EDD was pre-NG, which means we’re unable to capture it.

<table>
<thead>
<tr>
<th>Audit</th>
<th>Notes</th>
<th>DelEnc</th>
<th>WorkingEDD</th>
<th>FirstTrimesterStartDT</th>
<th>FirstTrimesterEndDT</th>
<th>FirstTrimesterVisitDT</th>
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<tbody>
<tr>
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<td>8/12/2015</td>
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<td>x</td>
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<td>20017683880 NULL</td>
<td>8/20/2015</td>
<td>12/2/2015</td>
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</tr>
</tbody>
</table>
After

Data integrity issues resolved

Improvement activities improve performance by 8%... 6 times the gap closure needed for PRIME

90th percentile: 91%
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
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
Care Delivery Improvements: Patient Impact

**ROOMING DRIVEN CHANGES**

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

<table>
<thead>
<tr>
<th></th>
<th>DY11 % Baseline</th>
<th>DY12 Mid Year % Actual</th>
<th>DY 12 End Year % Actual</th>
<th>DY13 % Actual</th>
<th>DY14 % Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUHS</td>
<td>50.92%</td>
<td>48.49%</td>
<td>48.80%</td>
<td>36.46%</td>
<td>28.33%</td>
</tr>
<tr>
<td>PRIME TARGET</td>
<td>48.49%</td>
<td>36.09%</td>
<td>29.07%</td>
<td>29.07%</td>
<td>29.07%</td>
</tr>
</tbody>
</table>
**CONTROLLING BP**

<table>
<thead>
<tr>
<th></th>
<th>DY11 % Baseline</th>
<th>DY12 Mid Year % Actual</th>
<th>DY 12 End Year % Actual</th>
<th>DY13 % Actual</th>
<th>DY14 % Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUHS</td>
<td>46.36%</td>
<td>60.71%</td>
<td>62.00%</td>
<td>71.60%</td>
<td>71.61%</td>
</tr>
<tr>
<td>PRIME TARGET</td>
<td>49.88%</td>
<td></td>
<td></td>
<td>62.83%</td>
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</tr>
</tbody>
</table>

**Impact:**

- **DY11 to DY13 → 25.24% change with 1573 patients achieving better Blood Pressure Control**
Care Delivery Improvements: Patient Impact

**PROVIDER AND CARE TEAM DRIVEN CHANGES**

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

RUHS Acknowledgements:
Corinne Matthews – Director of Incentive Payments Program
Angela Simpkins – Executive Director of Quality
Geoffrey Leung – Chief of Medical Staff
Gary Thompson – Medical Director of Quality
Bertha Long – Data Analyst Extraordinaire
Kirsten O’Dell – PRIME Nurse Coordinator
Gift Nguru – PRIME Nurse Coordinator
Gretchen Page – PRIME Nurse Coordinator
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

safetynetinstitute.org
caph.org
@CAPHSystems