CALIFORNIA’S PROGRESS IN PRIME YEARS 1 – 3

December 17, 2018

Recording link
Today’s Agenda

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

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

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

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Demonstration Year (DY)</th>
<th>Measurement Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>DY 11</td>
<td>July 1, 2017 – June 30, 2018</td>
</tr>
<tr>
<td>2016</td>
<td>DY 12</td>
<td></td>
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<tr>
<td>2017</td>
<td>DY 13</td>
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<tr>
<td>2018</td>
<td>DY 14</td>
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<td>2019</td>
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<td>2020</td>
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<tr>
<td>2021</td>
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</tbody>
</table>

Final Evaluation

- DY 11 Year End Report
- DY 12 Year End Report
- DY 13 Year End Report
- DY 14 Year End Report
- DY 15 Year End Report
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
PRIME Metrics & Funding

- 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>Met or Exceeded DY13 YE Target</th>
<th>Did Not Meet or Exceed DY13 YE Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.1 Baby Friendly Hospital designation</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>1.3.7 Tobacco Assessment &amp; Counseling</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>1.3.3 Influenza Immunization</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>1.2.2 CG-CAHPS: Provider Rating</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>1.2.4.d Diabetes: HbA1c Poor Control (&gt;9%)</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>1.1.3.d Diabetes: HbA1c Poor Control (&gt;9%)</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>2.2.5 Timely Transmission of Transition Record</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>2.2.4 Reconciled Med List Received by Discharged Patients</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>2.1.6 Prenatal Care</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>2.1.6 Postpartum Care</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>1.2.7.i IVD: Use of Aspirin or Another Antithrombotic</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>1.2.3.c Colorectal Cancer Screening</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>1.2.11 REAL Data Completeness</td>
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<td>16</td>
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<tr>
<td>1.2.14.t Tobacco Assessment &amp; Counseling</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>1.1.6.t Tobacco Assessment &amp; Counseling</td>
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<td>16</td>
</tr>
<tr>
<td>2.3.4 Timely Transmission of Transition Record</td>
<td>2</td>
<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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<tr>
<td>1.3.1 Closing the Referral Loop: receipt of specialist report</td>
<td>2</td>
<td>15</td>
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<tr>
<td>1.2.13 SO/GI Data Completeness</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>1.2.12.f Screening for Clinical Depression &amp; Follow-up</td>
<td>2</td>
<td>15</td>
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<tr>
<td>1.1.5.f Screening for Clinical Depression &amp; Follow-up</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>2.2.1 All-Cause Readmissions</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>1.2.10 REAL and/or SO/GI Disparity Reduction</td>
<td>4</td>
<td>13</td>
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<tr>
<td>2.1.5 C-Section</td>
<td>5</td>
<td>11</td>
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<tr>
<td>2.1.2 Exclusive Breast Milk Feeding</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<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>
</tr>
</tbody>
</table>

DY13 data has not yet been approved by DHCS.
Additional Patient Impact from DY11 to DY13 (all systems)

3,600 fewer diabetics w/ 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
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
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.
PRIME Progress: IT & Analytics

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

Examples

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

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

- Metric leads
- Metric leads
- Metric leads
- Metric leads

- Ambulatory
- Acute
- Post-Acute
- Behavioral Health

- IT
- Pop Health
- STAR
- Quality
- HR
- Finance

Engaged Stakeholders

- PRIMARY CARE
- PEDIATRICS
- CARDIOLOGY
- SURGERY
- IT/IS
- Pop Health
- Quality
- STAR
- INFECTION CONTROL
- INFATENT

Data Governance

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

**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
...And Process Measures

Example: Percent of mammograms ordered by a medical assistant

Example: Percent of patients seen in last 30 days with SOGI data completed
Outcomes: AHS DY13 YE Performance

List of Metrics Achieving DY13 YE Target
★ = Better than 90th percentile!

- Diabetes poor control
- Screening for depression
- Tobacco screening / counseling ★
- Screening for high blood pressure ★
- Blood pressure control ★
- IVD – use of antithrombotic ★
- Colon cancer screening
- Antibiotics in acute bronchitis ★
- Influenza immunization ★
- Readmissions ★
- Hospital-acquired c difficile infections ★
- Exclusive Breastfeeding ★
- Cesarean section ★
- Medication reconciliation at 30 days
- Reconciled medication list received
- Timely transmission of transition record
- Prenatal and postnatal care
- CG-CAHPS ★
- SOGI / REAL data completeness
Transformation Spotlight
SOGI
123
Before…

…Only 1 in 1000 patients seen in primary care had documented SOGI information
Why ask?

• LGBTQ patients experience numerous health disparities
  – Higher rates of mental and behavioral health issues
  – Higher rates of smoking
  – Less likely to receive cancer screening
    • Lesbian / bisexual women are 10 times less likely to get cervical cancer screening

• They are largely invisible in the health care system

• Simply asking can be affirming
Check

Plan

Act

Do

Check

Plan

Develop the Plan Based on a Needs Assessment

Do

Execute the Plan

Act

Adjust, Adopt or Abandon

Collect Data and Review Performance Indicators
Planning for SOGI

1. Best practices

2. IT infrastructure

3. Communication/training

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

Sean Cahill1, Robbie Singal3, Chris Grasso3, Dana King3, Kenneth Mayer3, Kellan Baker5, Harvey Makadon3

1 The Fenway Institute, Northeastern University Department of Political Science, Boston, MA; United States of America; 2 New York University School of Medicine, New York, NY; United States of America; 3 The Fenway Institute, Boston, MA; United States of America; 4 The Fenway Institute, Boston, MA; United States of America; 5 The Fenway Institute, New York University School of Medicine, New York, NY; United States of America; 6 The Fenway Institute, Boston, MA; United States of America

NEXTGEN

Soarian

Clinicals

Epic

Soarian

Financials

ALAMEDA HEALTH SYSTEM

A New Day In Health

Plan

Let us know if you are LGBTQ.

We Ask Because We Care

Help us personalize your care.

START TODAY!

Why We Ask

Contact Us

Alameda Health System

1831 Old Westlake Village Blvd.

Oxnard, CA 93030

(805) 487-9000

Alamedahlsystems.org

Why We Ask

SOGI Sexual Orientation and Gender Identity

Our mission is to empower you to make decisions that support your health.

We ask about who you are, where you came from, your gender and identity, to help provide care that supports your health.

We are committed to serving you.

For more information on SOGI, visit www.alamedahlsystems.org.
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></th>
<th>Pilot #1 Verbally by MAs at Intake</th>
<th>Pilot #2 Paper form at registration</th>
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<tbody>
<tr>
<td></td>
<td>Newark</td>
<td>Highland AIC</td>
</tr>
<tr>
<td>Pilot duration</td>
<td>2.5 mo</td>
<td>1.5 mo</td>
</tr>
<tr>
<td>SOGI completion rate</td>
<td>79.90%</td>
<td>87.96%</td>
</tr>
<tr>
<td>(last 30 days)</td>
<td>0.96%</td>
<td>3.16%</td>
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<tr>
<td>Refusal rate (last 30</td>
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<td>-</td>
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<tr>
<td>days)</td>
<td></td>
<td></td>
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<tr>
<td>Registration cycle time</td>
<td>0 sec</td>
<td>-</td>
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<tr>
<td>impact</td>
<td>45-60 sec</td>
<td>30 sec (mean)</td>
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<td>10 sec (min)</td>
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<td>Post-visit time impact</td>
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Real-time, online process measure

<table>
<thead>
<tr>
<th>Performance By Location</th>
<th>Percentages based on all patients seen</th>
<th>Percentages based off of patients that responded</th>
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</thead>
<tbody>
<tr>
<td><strong>All Active Patients (Past Year)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Patients</td>
<td>% Sexual Orientation Documented</td>
<td>% Gender Identity Documented</td>
</tr>
<tr>
<td>BWC - ADULT MEDICINE</td>
<td>6253</td>
<td>24.55 %</td>
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<tr>
<td>HGH - ADULT IMMUNOLOGY</td>
<td>603</td>
<td>56.06 %</td>
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<tr>
<td>HGH - ADULT MEDICINE</td>
<td>7888</td>
<td>12.07 %</td>
</tr>
<tr>
<td>HMC - ADULT IMMUNOLOGY</td>
<td>103</td>
<td>0.97 %</td>
</tr>
<tr>
<td>HMC - ADULT MEDICINE</td>
<td>5601</td>
<td>5.03 %</td>
</tr>
<tr>
<td>NWC - ADULT MEDICINE</td>
<td>5340</td>
<td>47.59 %</td>
</tr>
<tr>
<td><strong>Active Patients (Last 30 Days)</strong></td>
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<td></td>
</tr>
<tr>
<td>Total Patients</td>
<td>% Sexual Orientation Documented</td>
<td>% Gender Identity Documented</td>
</tr>
<tr>
<td>BWC - ADULT MEDICINE</td>
<td>1551</td>
<td>37.63 %</td>
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<td>HGH - ADULT IMMUNOLOGY</td>
<td>217</td>
<td>62.46 %</td>
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<tr>
<td>HGH - ADULT MEDICINE</td>
<td>2252</td>
<td>26.79 %</td>
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<tr>
<td>HMC - ADULT IMMUNOLOGY</td>
<td>27</td>
<td>3.70 %</td>
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<tr>
<td>HMC - ADULT MEDICINE</td>
<td>1487</td>
<td>16.94 %</td>
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<tr>
<td>NWC - ADULT MEDICINE</td>
<td>1299</td>
<td>81.08 %</td>
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</tbody>
</table>
SOGI implementation

Standard work

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

<table>
<thead>
<tr>
<th>Task #</th>
<th>Task description</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>If the PV5 alerts that the patient is missing data in the SOGI fields, ask the patient about their sexual orientation and gender identity (SOGI), using the following script: We ask every patient a few personal questions so that we can be more effective in providing individualized care. This information is confidential, and only accessible to your healthcare team. At any time you can choose not to answer: How do you identify as now (for example, male, female, transgender)? What is your sexual orientation (for example, gay, straight, bi)? Is this the same gender as on your birth certificate? (see below for translation of script in other languages)</td>
<td>Data suggests that patients expect to be asked in a healthcare setting and are unlikely to bring up SOGI unless asked. Asking about SOGI respectfully is affirming for our non-cisgender, non-heterosexual patients.</td>
</tr>
<tr>
<td>2</td>
<td>Enter the patient’s responses in the relevant fields in NC.</td>
<td></td>
</tr>
</tbody>
</table>

Spread plan – started Feb 1st!

- Spread Planning and Monitoring Tool
- Collection of SOGI data by MAs in Adult/Family Medicine andsic clinics
- PowerPoint presentation (background and overview)
- Operator standard work
- NO access sheets for data entry

What is being spread?

- Collection of SOGI data by MAs in Adult/Family Medicine and sic clinics

What are the goals?

- PowerPoint presentation (background and overview)
- Operator standard work
- NO access sheets for data entry

What tasks are available?

- Training was offered to all primary staff in October 2017. Primary Care Practice Managers and Nursing Supervisors were offered additional training in January 2018. All primary care MAs/LVNs/RNs were provided follow-up training at January 2018 downtime.

Other videos are available online as supplementary training opportunities:

1. [http://transhealth.fenway.org/vs/c/pa](http://transhealth.fenway.org/vs/c/pa)
   - Includes overview of how we ask, definitions, as well as example clinical scenarios
   - No login, registration required!

2. [http://transhealth.fenway.org/vs/c/pa](http://transhealth.fenway.org/vs/c/pa)
   - Resources from the Fenway Institute
   - Includes webinars, FAQs, medical literature on SOGI
   - Webinars can be viewed for CME or CE credit
   - Registration/log in required, but free!

How is progress monitored?

A process monitoring report is available here: [https://wiki.sogii.org/...](https://wiki.sogii.org/...)

Who is the local [site] process owner?

- Eastmont – Renee Masas
- Hayward – Bola Kafani
- Highland – Anita Roberts
- Newark – Michele Eliaza
- AIC – Heather MacDonald-Fine

Expectations of Process Owner

1. Serve as local point person
2. Ensure staff are trained and following standard work
3. Monitor site-based performance at least monthly
4. Participate on cross-site collaborations
5. Escalate challenges that can’t be resolved locally to the appropriate person/group

Where do questions or concerns get escalated?

Questions/concerns should first be brought to the attention of the site-based Process Owner. It shall engage the site-based leadership with questions/concerns. Items that cannot be addressed by the site can be escalated to the subject matter experts below. Feedback will also be sent to the Ambulatory Quality Council when both the practice managers and RN supervisors are in attendance.

Who are the subject:

1. Heather MacDonald-Fine

Title: SOGI Screening - Intake

Date: 1/19/2018

Departments who must adopt: Adult Primary Care
Operators who must adopt: MAs, LVNs, RNs

<table>
<thead>
<tr>
<th>Task #</th>
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<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>This is an addition to the existing intake standard workflow. These questions should be integrated after review of the standing orders and at the beginning of the section entitled “Screening Summary Tab”</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Enter the patient’s responses in the relevant fields in NC.</td>
<td></td>
</tr>
</tbody>
</table>
After…

• We have SOGI data on \(~17,000\) patients
  – \(~5\%\) identify as homosexual or bisexual
  – \(~0.3\%\) identify as transgender or genderqueer
  – Less than 5% decline to answer
Timely Prenatal Care
Before…

AHS below 25th percentile for timely prenatal care

PRIME Prenatal Care Rate, November 2016

56% 74% 91%

...And some skepticism and resistance to change

“That data can’t be right”

“We are already doing everything we can do”

“That 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>Location (Outside/Inside)</th>
<th>Activity Type</th>
<th>Number of Slots</th>
<th>Other Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 - 9:00</td>
<td>5</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>9:00 - 10:00</td>
<td>5</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>10:00 - 11:00</td>
<td>5</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>11:00 - 12:00</td>
<td>5</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>12:00 - 1:00</td>
<td>5</td>
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<td>1</td>
<td></td>
</tr>
<tr>
<td>1:00 - 2:00</td>
<td>5</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2:00 - 3:00</td>
<td>5</td>
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<td></td>
</tr>
<tr>
<td>3:00 - 4:00</td>
<td>5</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>4:00 - 5:00</td>
<td>5</td>
<td></td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

2. Building capacity with non-traditional visits

Ambulatory Care Services

<table>
<thead>
<tr>
<th>Task</th>
<th>Task Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Patient calls the Call Center regarding prenatal care</td>
</tr>
<tr>
<td>2</td>
<td>Call Center staff verifies insurance. If suspect/insurance, redirect patient to assigned provider (or facilitate immediate change of provider)</td>
</tr>
<tr>
<td>3</td>
<td>If patient has not done a pregnancy test, schedule patient for a Nurse Visit at the time of the appointment. If pregnancy is confirmed, schedule this appointment to occur within 4 weeks.</td>
</tr>
</tbody>
</table>

Ambulatory Project Summary

Clinic Cancellation Policy
Transformation Activities: Eliminating Waste

Streamlining entry to prenatal care

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

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

Transformation Activities:
- Eliminating Waste

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

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

After: Two steps between a patient calling and seeing a provider
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</td>
<td>10/20/2016</td>
<td>1/14/2016</td>
<td>4/27/2016</td>
<td>NULL</td>
</tr>
</tbody>
</table>

Pt had early prenatal care with AHS, then transferred to CHCN site (Tibucio 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 specifics have a Denominator exclusion for Continuous Accountability cases where we can provide evidence that the patient is no longer with us for Primary Care.

| x     | Ok    | 20020171003 | 10/24/2016 | 1/26/2016             | 5/9/2016            | NULL                 |
| x     | Ok    | 20020129074 | 10/30/2016 | 1/21/2016             | 5/4/2016            | NULL                 |
| x     | Ok    | 20020782551 | 11/28/2016 | 2/28/2016             | 6/15/2016           | NULL                 |
| x     | Ok    | 20020797435 | 12/17/2016 | 3/12/2016             | 6/24/2016           | NULL                 |

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>x</th>
<th>DelEnc</th>
<th>WorkingEDD</th>
<th>FirstTrimesterStartDT</th>
<th>FirstTrimesterEndDT</th>
<th>FirstTrimesterVisitDT</th>
</tr>
</thead>
<tbody>
<tr>
<td>x</td>
<td>20016919605</td>
<td>NULL</td>
<td>8/12/2015</td>
<td>11/24/2015</td>
<td>10/29/2015</td>
</tr>
<tr>
<td>x</td>
<td>20017683880</td>
<td>NULL</td>
<td>8/20/2015</td>
<td>12/2/2015</td>
<td>NULL</td>
</tr>
</tbody>
</table>
After

90th percentile: 91%

Data integrity issues resolved

Improvement activities improve performance by 8%... 6 times the gap closure needed for PRIME
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 $\rightarrow$ 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
Care Delivery Improvements: Patient Impact

**PROVIDER AND CARE TEAM DRIVEN CHANGES**

**IMPACT:** DY11 to DY13 $\rightarrow$ 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

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