California’s Progress in PRIME
Years 1-4

Recording link (1 hour)

December 16, 2019
Agenda

• About
  • CAPH/SNI
  • California’s Public Health Care Systems
• PRIME
  • Background
  • Progress and Themes
• Member Perspectives
  • Los Angeles County Department of Health Services
  • UC San Diego
• Q&A
About

CAPH/SNI

California’s Public Health Care Systems
About CAPH/SNI

California Association of Public Hospitals and Health Systems (CAPH)

• Advances policy and advocacy efforts that strengthen the capacity of its members and ensures access to high-quality, culturally sensitive, comprehensive care

California Health Care Safety Net Institute (SNI)

• Informs and shapes statewide and national health care policy, provides performance measurement and reporting expertise, and accelerates decision-making and learning. Because of SNI, more people – especially the under-served – receive effective, efficient, and respectful health care regardless of their ability to pay.
21 Public Health Care Systems

Alameda County
Alameda Health System

Contra Costa County
Contra Costa Health Services:
  • Contra Costa Regional Medical Center

Kern County
Kern Medical

Los Angeles County
Los Angeles County Department of Health Services:
  • Harbor/UCLA Medical Center
  • LAC+USC Medical Center
  • Olive View / UCLA Medical Center
  • Rancho Los Amigos National Rehabilitation Center

Monterey County
Natividad Medical Center

Riverside County
Riverside University Health System

San Bernardino County
Arrowhead Regional Medical Center

San Francisco County
San Francisco Department of Public Health:
  • Zuckerberg San Francisco General Hospital
  • Laguna Honda Hospital and Rehabilitation Center

San Joaquin County
San Joaquin County Health Care Services:
  • San Joaquin General Hospital

San Mateo County
San Mateo Medical Center

Santa Clara County
Santa Clara Valley Health & Hospital System:
  • Santa Clara Valley Medical Center

Ventura County
Ventura County Health Care Agency:
  • Ventura County Medical Center

University of California (UC)
UC Health:
  • UC Davis Health
  • UCI Health
  • UC San Diego Health
  • UCSF Health
  • UCLA Health

Includes county-owned and-operated health systems and UC medical systems
The Critical Role of Public Health Care Systems

• Serve more than 2.85 million patients annually

• Just 6% of hospitals in the state, but provide 35% of all hospital care to Medi-Cal beneficiaries in the state

• Provide 10 million outpatient visits each year, and operate more than 200 outpatient clinic facilities

• Serve as the primary care provider to more than 500,000 Medi-Cal expansion enrollees

• Operate half of California’s top-level trauma and burn centers

• Train more than half of all new doctors in hospitals across the state
Background

Progress and Themes
PRIME Background

• One of four Medi-Cal 2020 Section 1115 waiver programs
• Builds on California’s first-in-the-nation DSRIP
• PRIME entities = public health care systems (designated public hospitals, or DPHs) and district & municipal hospitals
• Pay-for-performance program worth up to $3.26b in federal funds over 5 years
  • Ambitious 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 Program Timeline

PRIME Demonstration Year (DY) 14 Year-End Measurement Period:
July 1, 2018 – June 30, 2019
### 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
- Patient Safety in the Ambulatory Setting
- 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
- Transition to Integrated Care: Post Incarceration
- 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 (including at least 1 from Domain 3)
- Must report on all metrics in each required/selected project

* Includes Race Ethnicity and Language (REAL) and/or Sexual Orientation/Gender Identity (SO/GI) Disparity Reduction
DY14 PRIME Eligible Population

Individuals of all ages who either:

had least 2 encounters with the PRIME Entity Primary Care team during the measurement period,

or

are in Medi-Cal Managed Care with 12 months of continuous assignment to the PRIME Entity during the measurement period.
By DY: % Target Met

<table>
<thead>
<tr>
<th></th>
<th>DY11</th>
<th>DY12</th>
<th>DY13</th>
<th>DY14</th>
<th>DY15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Available Funding</strong></td>
<td>$700M</td>
<td>$700M</td>
<td>$700M</td>
<td>$630M</td>
<td>$535.5M</td>
</tr>
<tr>
<td><strong>% all metrics that are P4P</strong></td>
<td>0%</td>
<td>37%</td>
<td>64%</td>
<td>89%</td>
<td>97%</td>
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<td><strong>All Metrics</strong></td>
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<td><img src="image2" alt="95%" /></td>
<td><img src="image3" alt="93%" /></td>
<td><img src="image4" alt="90%" /></td>
<td><img src="image5" alt="90%" /></td>
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<tr>
<td><strong>P4P Metrics</strong></td>
<td><img src="image1" alt="100%" /></td>
<td><img src="image2" alt="85%" /></td>
<td><img src="image3" alt="89%" /></td>
<td><img src="image4" alt="88%" /></td>
<td><img src="image5" alt="88%" /></td>
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**DY14YE data not yet approved by DHCS. Sub-rates are counted as unique metrics.**

*Metrics with denominator <30 were not counted in Target Met/Not Met*
## DY14 Additional Lives Impacted

<table>
<thead>
<tr>
<th>Additional lives impacted since DY 11</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>380,900</td>
<td>Requests for Specialty Care (SC) expertise for which an individualized response was sent to the referring provider and/or the referring provider’s care coordination team within 5 calendar days (Request for SC Expertise Turnaround Time)</td>
</tr>
<tr>
<td>371,800</td>
<td>Age 18+ with in-person primary care encounters that had sexual orientation/gender identity (SOGI) as structured data (SOGI Data Completeness)</td>
</tr>
<tr>
<td>281,000</td>
<td>Age 18+ screened for depression, &amp; if positive, follow-up plan documented (Screening for Depression &amp; FU)</td>
</tr>
<tr>
<td>102,000</td>
<td>Outpatient SC requests that were managed via non-in-person encounters (Specialty Care Touches)</td>
</tr>
<tr>
<td>92,200</td>
<td>Age 18+ who were screened for tobacco use ≥1 times within 24 months &amp; who received cessation counseling intervention if identified as a tobacco user (Tobacco Assessment &amp; Counseling)</td>
</tr>
<tr>
<td>72,500</td>
<td>Age 6 month+ seen Oct 1 - Mar 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization (Influenza Immunization)</td>
</tr>
<tr>
<td>36,300</td>
<td>Had &gt; 1 full screening, brief intervention, &amp; referral to treatment (Alcohol Drug Misuse SBIRT)</td>
</tr>
<tr>
<td>33,600</td>
<td>Age 50-75 appropriately screened for colorectal cancer (Colorectal Cancer Screening)</td>
</tr>
<tr>
<td>16,300</td>
<td>Age 18–85, with diagnosis of hypertension, whose blood pressure was controlled (Controlling Blood Pressure)</td>
</tr>
</tbody>
</table>

DY14YE data not yet approved by DHCS.
Examples of Progress: DY11→DY14

- Request for Specialty Care Expertise
  - Turnaround Time (<5 days)

- Influenza Immunization
  - (Specialty Care Project)

- Screening for Depression & Follow-Up

- Controlling Blood Pressure

- Tobacco Assessment & Counseling

- Colorectal Cancer Screening

**DY14 YE data not yet approved by DHCS.**
Disparity Focus in PRIME

By the end of Demonstration Year 14 (7/1/18 – 6/30/19)

13 out of 17 DPHs met their annual improvement target for their selected metric and disparity population.

<table>
<thead>
<tr>
<th>Selected Disparity Population</th>
<th>African Americans</th>
<th>Spanish Speakers</th>
<th>Hispanic/Latinx</th>
<th>English Speakers</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Selected PRIME measure</th>
<th>Controlling Blood Pressure</th>
<th>Diabetes: HbA1c Poor Control (&gt;9.0%)</th>
<th>Colorectal Cancer Screening</th>
<th>IVD: Use of Aspirin or Another Antithrombotic</th>
<th>Tobacco Assessment &amp; Counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

# = Number of Designated Public Hospitals focusing on this disparity
PRIME Progress Themes

1. Improve coordination & partnerships
2. Enhance patient engagement
3. Develop the workforce
4. Invest in IT & data analytics
5. Implement new processes & workflows
6. Strengthen & standardize performance improvement
PRIME Progress: Coordination & Partnerships

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

Example

Contra Costa Regional Medical Center leads a multiagency collaborative to improve care for county’s foster children by:

- Improving appointment access
- Facilitating cross-department data sharing
- Sharing commitment and resources to improve health of 1,100 youth
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 improve care transitions, Riverside University Health System redesigned their system to support patients leaving the hospital, leading to HCAHPS scores above the national average. Today, hospital patient advocates:

- Round regularly on newly admitted patients
- Offer warm welcome and orientation
- Collaborate closely with patient experience nurse
PRIME Progress: Develop the workforce

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

Example

Care teams are at the core of the preventive care outreach at San Joaquin General Hospital. Pre-visit planning is completed by team of medical assistants, working closely with primary care providers to identify and address patient care gaps.
PRIME Progress: Invest in IT & Analytics

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

Example

- **UC Davis** has expanded eConsult to 24 participating clinics for all diagnostic categories, and expanded MyChart video visits to 20 clinics
- Five DPHs have switched enterprise EHRs in the course of PRIME
Implementing new workflows and processes, some of which are tech-enabled, to enhance patient care.

Example

To improve care for mothers and babies, **Kern Medical Center** has increased the exclusive breastfeeding rate 16% in the past program year, through:

- Increasing inpatient lactation support
- Launching donor breast milk program
- Educating staff and standardizing workflows
PRIME Progress: Strengthen Performance Improvement

Utilizing improvement principles and methods, such as Lean Management or Model for Improvement, to identify areas for improvement and to test changes.

**Example**

San Francisco Health Network improved performance in PRIME’s all-cause readmission metric through QI interventions that targeted the top contributor, heart failure:

- Developed inpatient standard work to ensure consistent care
- Created a heart failure clinic and trained outpatient providers
- Improved care coordination through follow-up call or appointment within 7 days
Member Perspectives

Los Angeles County Department of Health Services
UC San Diego
Los Angeles County Department of Health Services

- 4 Hospitals
- 24 outpatient centers and clinics
- 2 Ambulatory Surgery Centers
- Jail Health Services & Juvenile Courts Health Services
- 650,000+ unique patients and 3 million + visits annually
Los Angeles County Department of Health Services

PRIME Program:
• ~ 220,000 PRIME Eligible Patients
• 13 Projects
• 66 measures
PRIME points health systems toward design changes that emphasize:

- Team-based care
- Population management
- Chronic disease management
- Prevention
- Safety
- Continuity/ownership
- “Upstream” activity (social determinants of health)
- Behavioral health integration
- Growth of new service lines (e.g. Palliative Care)
- Developing Partnerships with other County Departments (e.g. Sheriff’s)
PRIME – It takes a village (or a health system in this case)...

PRIME Leads for Project/Metric
• Accountable for improving clinical performance to meet PRIME target
• Leads a DHS-wide workgroup
• Close partnership with Primary Care Directors

Leadership Structure and Communication
• Executive Leadership
• Prioritization
• Committee integration

Data Analytics
• Report writing/troubleshooting
• Interval data for improvement
• Final reporting

DHS Quality Nursing
• Report validation
• Chart review measures
• Investigation of data capture issues

IT Team/Tools
• Build and deploy EMR-related interventions (forms, alerts, ticklers, etc.)
• Deploy Population Management Platform

Facility QI
Facility Nursing
HIM
Practice Coaches
PRIME Implications for our health system

- Primary Care is front and center
  - Ownership/Responsibility for our patients
  - Continuity/Empanelment
  - Take advantage of every touch-point
  - Use the tools
    - Health Maintenance tab in EMR
    - Population Health registries and reports
  - Document refusals/declinations
- Team approach – the provider can’t (shouldn’t) do it all
- Non-Face to Face touches
- Stay Patient – Centered (what would you want?)
Care Delivery Improvement – Example 1

Tobacco Assessment and Counseling

• Did you screen for tobacco use?

• If the screening was positive, did you do something about it?

<table>
<thead>
<tr>
<th>PRIME Year</th>
<th>Performance</th>
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<tbody>
<tr>
<td>Baseline</td>
<td>70%</td>
</tr>
<tr>
<td>DY 12</td>
<td>87%</td>
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<tr>
<td>DY 13</td>
<td>91%</td>
</tr>
<tr>
<td>DY 14</td>
<td>95%</td>
</tr>
</tbody>
</table>
Tobacco Assessment and Counseling – system-wide redesign

**Clinic Practice Changes**
- Nicotine Replacement
- Oral medications
- Counseling
- Referral

**New Services Available Onsite**
- Psychologists
- Social Workers

**Practice Coaching**
- Elbow Support for providers
- Data support for Clinic Directors

**Data / Validation**
- Data team re-designed reports to capture new activity
- Validated by quality nurses

**Partnerships**
- California Smokers’ Helpline (1-800-NO-BUTTS)
- eConsult

**IT Solutions**
- New forms (better data capture, organized approach)
- Health Maintenance Alerts
- Direct requests to Smoking Cessation Services
- Pop Health Platform Reports

**Process Changes**
- Standardization of intake process to more consistently include tobacco screening and discussion with patients.

Better Care - Measure Success!
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

- Does the patient have acute bronchitis? (usually viral)
- Did you NOT give antibiotics?

<table>
<thead>
<tr>
<th>PRIME Year</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>25.67%</td>
</tr>
<tr>
<td>DY 12</td>
<td>29.93%</td>
</tr>
<tr>
<td>DY 13</td>
<td>51.26%</td>
</tr>
<tr>
<td>DY 14</td>
<td>55.46%</td>
</tr>
</tbody>
</table>
Antibiotics and Bronchitis

• **Initial Plans (before data)**
  • Massive DHS-wide effort
  • All providers
  • Signage - (aimed at both providers and patients)
  • Screen-savers
  • Workgroups/meetings
  • “Viral Illness” prescription pads in clinical settings

• **What the initial data revealed:**
  • Total possible prescribers ~ 500
  • Prescribers who gave antibiotics for bronchitis = 143
    • Only 27% of possible prescribers failed the measure.
  • Prescriptions written = 532 (some providers saw multiple patients with bronchitis)
  • “High Volume” Prescribers with ten or more prescriptions = 16
  • Prescriptions written by High Volume Prescribers = 244
    • (46% of all prescriptions were written by 16 providers!)
Antibiotics and Bronchitis — targeted interventions

- **Revised Plans (after data)**
  - Congratulate and reinforce optimal behavior by most providers!
  - Focused effort to coach High Volume prescribers locally.
    - Some were not aware of the evidence against antibiotics for bronchitis
    - Some were responding to perceived patient expectations for antibiotics
    - Some had just fallen into a “habit” of antibiotic prescribing.
  - Antibiotic stewardship programs continued their usual work
  - Expected Practice (EP) published on the DHS Clinical Care Library to clarify when to use (or not use) antibiotics in common conditions (including acute bronchitis).
    - This has been downloaded over 300 times in the past year.
  - Practice “coaches” kept an eye on prescribing habits and flagged outliers for their local medical directors.

![Measure Compliance Graph](image-url)
**Tobacco Use**

- The entire system is now designed to ask about and offer multiple interventions to quit smoking.
- By staying connected to community partners, like the California Smokers’ Helpline, patients get a more coordinated effort to help them.
- By successfully quitting smoking, patients reduce their risk of a large number of health complications.

**Antibiotics and bronchitis**

- More informed use of antibiotics decreases resistance and increases the potential for antibiotics to work more effectively when patients really need them.
- Patients learn more about what illnesses do not need antibiotics.
Continuous Performance Improvement requires improving capability in multiple domains.

- Data and Reporting
- Population Management solutions – registries, etc.
- Practice Coaching
- EMR-based forms/alerts/dropdowns
- Team-based care / Collaboration
- Standardization across locations and service lines
- Communication – rolling out new ideas/solutions
- Culture change – challenging long held assumptions/preferences

- Not every “tool” is needed for each measure
- The application of a given “tool” may look different from measure to measure.

* Innovation / creativity is usually a more powerful improvement strategy than trying to wring more efficiency out of an already maxed-out process.

What DHS has been learning
PRIME – THE IMPACT
UC San Diego Health – One of Five Medical Centers within the UC System

10-campus University of California system

Five medical centers and 18 professional schools, collectively UC Health

UC San Diego

UC San Diego Health Sciences, includes teaching, research and clinical enterprises

UC San Diego Health, refers to the branded patient care enterprise
Organizational Structure

UC San Diego Health Sciences

ACADEMIC ENTERPRISE

UC San Diego School of Medicine
Skaggs School of Pharmacy and Pharmaceutical Sciences
School of Public Health

CLINICAL ENTERPRISE

UC San Diego Health
UC San Diego Medical Center
Jacobs Medical Center
Sulpizio Cardiovascular Center
Moores Cancer Center
Shiley Eye Institute
Koman Family Outpatient Pavilion
Student Health
UC San Diego Health Sciences – Mission

Committed to achieving national excellence in each area
UC San Diego Health – World-Class Care

- **9,161** Employees
- **808** Licensed Beds
- **31,715** Annual Hospital Admissions
- **943,856** Outpatient Visits & Surgeries
- **$1.85B** Operating Budget

- Magnet Recognized
- NCI Designated Comprehensive Cancer Center
- Healthcare Equality Leader
- CHIME HealthCare's most wired 2019
PRIME Facts:

✓ ~ 42K PRIME Eligible Patients
✓ 55 Measures
    49 P4P
✓ 38 Metrics in DY14 were above Nation 90th%ile or 2x State target

Our focus is to improve patient health outcomes, integrate physical and behavioral health, and increase access to healthcare services, particularly for our complex care population.
PRIME Governance

PRIME Leads

PRIME Executive Sponsors

PRIME Executive Committee

PRIME Steering Committee

Members on PRIME Executive & Steering
A New Standard of PI Approach

Metric Improvement Teams
Each area of patient care has an improvement team, an executive owner in leadership and reports progress to the PRIME and QIP Steering and Executive committees.

Quality Improvement Collaboration
Quality improvement teams collaborate between the UC systems as well as with systems in the PRIMEd collaborative.

Interactive Data through Tableau
For PRIME and QIP metrics reporting Epic EMR data Tableau dashboards were built to provide updated rates on a daily basis. Drilldown is possible at a clinic and provider level.

Quarterly Training and Updates for Teams
Lean Six Sigma training and tools provided to teams and Quality team is available to help develop charters, A3s, root cause analysis and other project improvement tools.
A New Way to Visualize Data

1.1.5 - Screening for Clinical Depression and follow-up

<table>
<thead>
<tr>
<th>Score</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>77.18%</td>
<td>21,848</td>
<td>28,307</td>
</tr>
</tbody>
</table>

Score Over Time - Score over time for this group
The Impact – Our Patients

Exclusive Breast Milk Feeding
118 more babies were exclusive breast milk fed in DY14 compared to the prior year.
68% to 72%

How?
✓ Passionate and committed clinical lead
✓ 2 year journey for Milk Bank
✓ Fully committed and aligned clinical teams and leadership
Anticoagulants for IVD
94% of eligible PRIME patients were placed on the appropriate anticoagulant.
84% to 94%

How?
✓ Passionate and committed clinical leads
✓ Heavy investment in outreach and data validation
✓ Committed team with 90 min weekly meetings and PI cycles
✓ Link to other collaboratives
The Impact – Our Patients

Depression Screening
7340 more patients were screened for clinical depression and follow-up.
40% to 72%

How?
✓ Passionate and committed clinical leads
✓ Investment in care integration model
✓ Significant workflow design and optimization
THANK YOU

- health.ucsd.edu
- 858-657-7000
- facebook.com/UCSDHealth
- twitter.com/UCSDHealth
- youtube.com/UCSDMedicalCenter
- ucsdhealthsciences.tumblr.com
- linkedin.com/company/ucsdhealth
PRIME Takeaways & Looking Ahead

• Continued demonstrated improvement in patient outcomes, quality, and clinical care
  • Several systems above national Medicaid 90\textsuperscript{th} percentile performance benchmarks

• Data analytics and population management are core health system capabilities

• Continues to promotes system integration and coordination
  • Inpatient, outpatient, and specialty care

• Focus on hard-wiring improvements & spreading successes

• Looking ahead
  • Alignment with DHCS priorities
  • Leveraging PRIME lessons learned
Q&A

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More Information

Webinar deck and & recording to be posted
https://safetynetinstitute.org/membersupport/primesupport/

CAPH/SNI Publications
Reducing Health Disparities through PRIME
Improving Quality of Care Through PRIME

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