District Hospital Leadership Forum

Stakeholder Advisory Committee
District/Municipal Public Hospitals and PRIME
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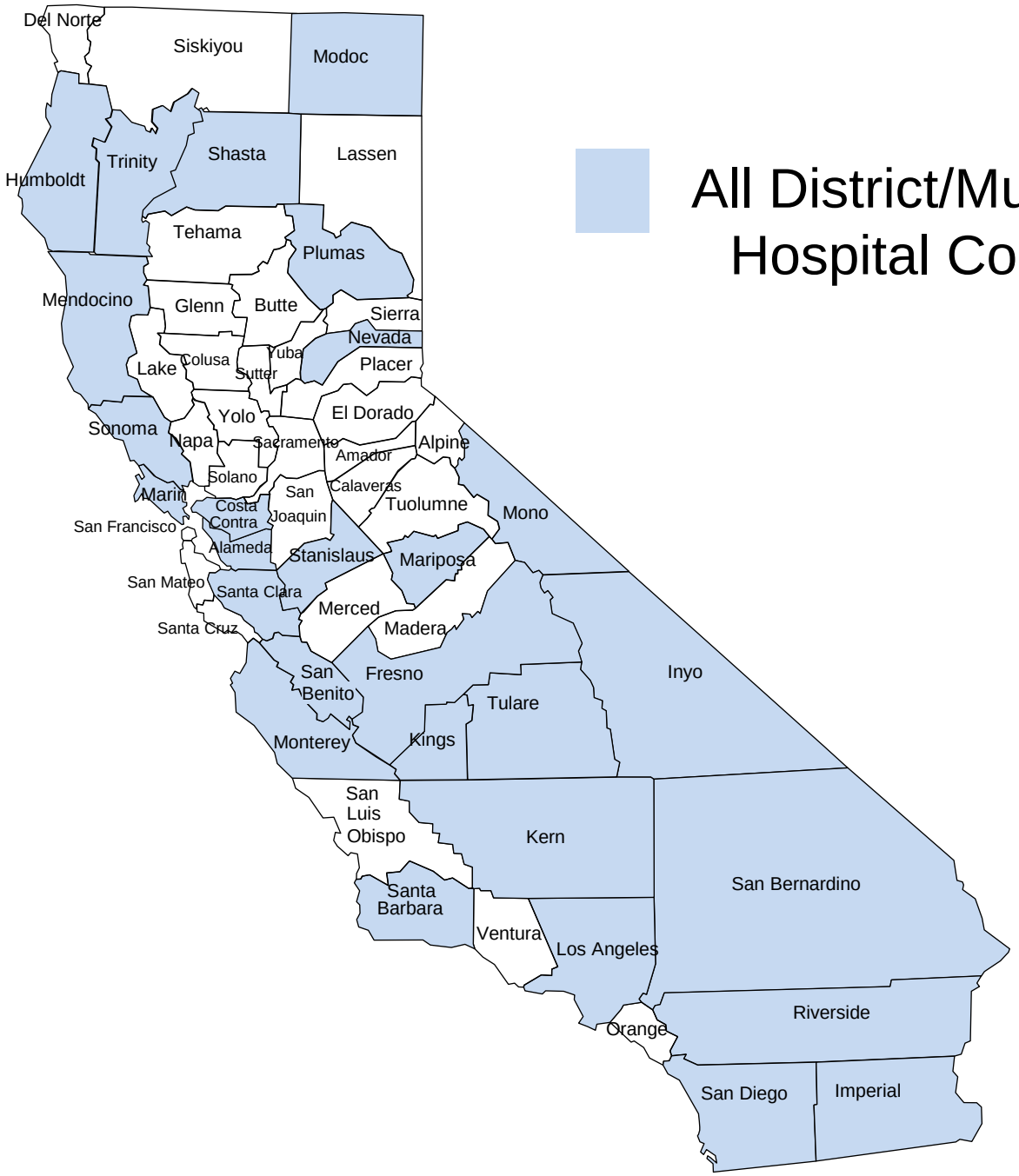
District Municipal Public Hospitals

- In 28 California counties
- Two-thirds are rural
- 20 have a critical access hospital (CAH) designation
  - Fewer than 25 beds
  - Less than 96 hour acute inpatient stays
  - More than 35 miles from nearest hospital (generally)
- 29 are in health personnel shortage area
- Very diverse
  - Licensed acute beds range from 3 to more than 400
  - Services range from emergency coupled with a medical unit and distinct part nursing facility to tertiary/trauma
  - Many rural (and some urban) DMPHs have rural health clinics

District Municipal Public Hospitals

- 37 district hospitals and 1 municipal hospital
- Also known as non-designated public hospitals (NDPH)
  - Publicly-elected Boards of Directors
  - Local governments responsible for providing for the healthcare needs of their communities
    - Ability to use funds – CPEs/IGTs – as non-federal share



All District/Municipal Hospital Counties

PRIME

- All but 1 DMPH is participating in PRIME
- Minimum of 1 project (11 DMPHs doing one project)
  - Primarily CAHs
- Large DMPHs doing as many as 11

Differ from County/UC

- Inability to hire physicians (some recent exceptions)
- Time needed to ready projects for measuring (P4P)
  - Address physician issues via clinics or arrangements with other providers
  - IT system needs
  - Hiring and training staff
- Infrastructure measures included in DMPH plans for DY 11 and DY 12, if needed
  - Most took advantage of this opportunity

PRIME Projects

- 110 projects among 37 hospitals/system
- Projects chosen to 1) meet communities' needs/gaps in services
  - Primary and specialty care
  - Behavioral health
  - Preventative programs
  - Post acute transitions (most popular project)

PRIME Projects (cont)

- 2) Remain viable in the future especially with some DMPHs' challenges related to volume and size
  - More focus on outpatient services
  - More focus on primary care
  - Partnerships with community providers

Top DMPH PRIME Projects

- 13 – care transitions: integration of post-acute care
- 10 – million hearts initiative
- 9 – cancer screening and follow-up
- 9 – complex care management for high-risk medical populations
- 9 – patient safety in the ambulatory setting
- 9 – antibiotic stewardship
- 8 – comprehensive advanced illness planning and care
- 7 – Integration of behavioral health and primary care
- 7 – ambulatory care redesign: primary care

Top DMPH *Rural* PRIME Projects

- Million hearts
- Integration of behavioral health and primary care
- Ambulatory care redesign: primary care
- Chronic non-malignant pain management

DMPH Prime Projects to Bring Services to a Community

- Palliative care (inpatient and outpatient) (8 DMPHs)
- Non-malignant pain management (5 DMPHs)
- Expanding other services

Funding

- Intergovernmental transfers (IGTs) used to draw down federal funds
  - Aggregate federal funds:
    - $100 million annually (DY 11, 12 and 13)
    - $ 90 million (DY 14)
    - $ 76 million (DY 15)
- Distribution formula primarily based on Medi-Cal volumes with a small factor for number of projects
- Funding floor for small and rural DMPHs in recognition of infrastructure all PRIME entities require

Coordination with health plans

- Varying degrees of coordination
- Source of data
- Coordination of projects

DMPHs

- *Much enthusiasm!*
- Grateful for opportunities provided (not discounting challenges)
- Benefit all patients in the DMPH communities by implementing projects that meet the Triple Aim

Infrastructure Challenges

- Diversity among DMPHs
  - Some with a system of rural health clinics provide primary care and have lives assigned to them by health plans
  - Others are still transitioning from a stand-alone hospital providing primarily acute inpatient and outpatient services

Infrastructure Challenges (cont.)

- Requirement that the denominator for most primary care projects is two encounters; identifying patient population on which to focus is initially challenging
  - Initially requirement could be interpreted to be ALL patients (out-of-area; assigned to other facilities, etc.) * working with DHCS to clarify.
  - Putting in place MOUs/arrangements with community providers has been difficult in some instances due to competition, etc.
  - Challenges with some medical groups due to payer

Infrastructure Challenges (cont.)

- Data systems not talking to one another (even within the hospital); cost challenges associated with a potential fix; many (especially small) resorted to a manual process
- Clinic licensing
- Recruiting staff especially in rural areas
- Much turnover (staff and senior management)
- Minimum of 30 patients in a metric
- Teaching old dogs new tricks
  - Physician engagement
- Still many silos in healthcare

Challenges (cont.)

- Keeping many balls in the air (PRIME metrics; initiatives from Medi-Cal managed care plans, etc.) for resource-challenged facilities
- Natural disasters
  - Hospital closures
  - Construction/renovation delays
  - Impact on planned community partners

Infrastructure Successes

- Hospitals chose projects that the community needed or that the hospital knew it needed to implement to remain viable
- All hospitals (even the small ones) have invested (staff/other resources) in making PRIME successful
- Especially since this is new for DMPHs, they have engaged physicians, staff, community and others in the planning/development phases
  - Report improved communications beyond PRIME; also resulted in improved patient/community service
  - Increased awareness in community of services available

Successes (cont)

- PRIME projects benefit all patients
- Chief patient complaints left little time for discussions/plans regarding prevention; PRIME allowed for population health staff, software and workflows
  - Implementing population health and care planning analytics platforms support data driven decision making for clinical improvement initiatives and metric reporting

Successes (cont)

- Consistently reported data serves as catalyst for clinical quality change
  - Previous quality initiatives often were reactive
  - With data review, hospitals better understand systems and function in the way providers see patients and identify areas for improvement
  - Gaps discovered in infrastructure phase (short-term challenge) related to documentation
  - Hospitals report some surprises in data review
- Ambulatory care redesign – hospitals became active participants
  - To prevent readmissions, working with other community providers (long-term care)

Specific improvements

- Increased the number of primary care clinicians within RHC sites (ambulatory care redesign)
- Begun farmers' markets at hospitals and cooking programs in coordination with schools (obesity prevention/healthier foods initiative)
- Portola district hospital providing behavioral health services and screening primary care patients to allow for early intervention
  - This CAH hired three behavioral health staff where there were none previously (Eastern Plumas)

Specific Improvements (cont.)

- Integrating behavioral health with primary care has highlighted the need in communities
  - Exploring implementation of a behavioral adult day program to offer additional support to those identified in need
    - Potentially acquiring and licensing a nearby building to meet additional behavioral health and substance abuse needs
    - Working with community to further identify behavioral health, diabetic, smoking cessation and substance abuse needs (Kern Valley)

Specific Improvements (cont)

- Even for projects not implemented, the consideration of projects has brought change
  - Behavioral health and antibiotic stewardship at CAH while focusing on another project (Mountains Community)
  - Opening needed primary care clinic (Mayers)

Specific Improvements (cont)

- Diabetic patient unable to get A1C under control
  - Determined refrigeration lacking for insulin. Once a refrigerator provided, disease managed more effectively. (Kaweah – complex care management)
- Patient engagement: Chronic care survey (Kaweah)
  - 88% learn more about condition; 100% care plan; 65% attend appointments; 88% transportation assist; 71% assist with other services
  - Incorporating needs into care plan

Specific Improvements (cont.)

- Developed three clinics in rural coastal community to ensure care can be provided in local community without travel to urban area (Lompoc)
  - Oncology; Orthopedics; ENT
- Hiring of primary care providers (i.e., medical director at RHCs) has been the most impactful of infrastructure measures
  - Reduce use of temporary doctors at RHCs to strengthen doctor-patient relationships (El Centro)

Summary

- Beginning July 1, DMPHs began P4P portion of PRIME
- Continue to work collaboratively with each other and in communities
- Projects are improving care and patient health and decreasing costs
- Looking forward to subsequent reports regarding performance

Appreciation

- It is clear that all involved want PRIME to be successful:
  - DHCS PRIME staff work with the hospitals to find solutions when problems encountered
  - County/UC hospitals being ahead of DMPHs provide lessons learned and pitfalls to avoid

Questions?