California Health Care Safety Net Institute

Goals and Three-Year Objectives

Approved by SNI Board
December 10, 2008

Goal I - Enhance Quality of Care Delivered at California Public Hospital Systems to Ensure Healthy Outcomes

Obj. IA – By December 31, 2011, the proportion of CAPH-member, county-operated primary care clinics fully using ***automated disease registries*** for diabetes—for population management and at the point of care—will increase from 29% to 80% (110/137 clinics); 80% of patients with diabetes will be tracked, and most clinics will use registries for one additional chronic disease.

Obj. IB – By December 31, 2011, the average ***HbA1c*** for all patients with diabetes tracked in CAPH-member clinics will improve from 7.8% to 7.5% or better, and the percentage of diabetes patients with ***well-controlled blood pressure*** will increase from 48% to 70%.[1]

Strategies (for IA & IB)

- SEED (Spreading Effective and Efficient Diabetes Care) Program, ending 12/08
- SNI 2009-2010 chronic disease management program (in development)
- Promotion/facilitation of public hospital adoption of KP PHASE/ALL cardiovascular risk reduction protocol
- Work with CAPH policy staff to support policy change, such as improved reimbursement of chronic care management

Obj. IC – By December 31, 2011, CAPH members will score in the top 10% of all hospitals nationwide on 30 (10 selected per year) publicly reported CMS ***core quality measures***. (Note: the average CAPH-member scores on the 10 improvement measures selected for 2008-2009 ranged from 40-86%, while the top 10% hospitals scored between 94-100%.)[2]

[1] Current HbA1c and BP data from Year 1 SEED Team Cohort as of July, 2008, after participation in SEED for one year.
[2] Baseline core measure data is from April 2006-March, 2007. For 2008-2009, the following measures were selected for improvement: adult smoking cessation counseling for heart attack, heart failure, and pneumonia patients; pneumococcal and influenza vaccination for pneumonia patients; discharge instructions for heart failure with particular emphasis on education/documentation for worsening symptoms, weight monitoring, and medication teaching; Surgical Care Infection Prevention (SCIP) measures including: antibiotic received 1-hr prior to incision, antibiotic selection, and antibiotic discontinued within 24 hours; and, initial antibiotics received within 6 hours for pneumonia patients.

Strategies

- Quality First Initiative
- Blue Shield of CA Foundation-funded Hospital Performance Improvement Program
- Lean Approach to Core Measures Improvement

Obj. ID – By December 31, 2011, ***public hospital systems will work with KP facilities*** and achieve measurable ***improvement in at least one major population health indicator***, and reduce disparities, within two communities where the two delivery systems have significant combined market share.

Strategies

- Encourage and support local KP-CAPH-member partnerships in support of CAPH-KP statewide partnership 5-year Goal #2
- Deepen SNI engagement in KP program to roll out PHASE/ALL to public hospital systems

Obj. IE – By December 31, 2011, three of the five existing public hospitals with ***palliative care*** programs will have been expanded and enhanced, and the total number of CAPH-member hospitals with palliative care services will have increased from five to eleven. A business case specific to public hospital operational and financial issues will have been developed and disseminated, and participating hospitals will demonstrate impact on reduced symptom distress, improved patient and family satisfaction, and decreased length-of-stay in the ICU.

Strategies

- Spreading Palliative Care in Public Hospitals Initiative, funded by CHCF

Goal II – Promote Efficient and Organized Public Hospital System Delivery Models, Enabling Easy Access to Well-Coordinated Care for the Most Patients Possible

Obj. IIA – By December 31, 2011, the number of CAPH-member clinics that have improved primary care efficiency and are regularly measuring and reporting ***cycle times of 50 minutes*** or less will increase from 26[3] to 65.

Obj. IIB – By December 31, 2011, 65 CAPH-member primary care clinics will report improvement in at least one additional ***efficiency/access*** measure, such as next available appointment or no-show rate.

Strategies (for IIA & IIB)

- Patient Visit Redesign program for 2009-2010 (in development) including access/scheduling component
- Ongoing engagement with PVR alumni clinics for data reporting and to support spread/sustainability
- Engage and request cycle time data from CAPH members who have implemented other clinic efficiency efforts outside of PVR

[3] Not all 48 clinics from the 13 CAPH-member systems that have undertaken Patient Visit Redesign are currently measuring and reporting cycle time to SNI.

Obj. IIC – By December 31, 2011, all California public hospital systems will have in place at least two of the following infrastructure components critical for improved ***specialty care access*** for patients seeking care at their facilities:

- Standardized and efficient referral process and criteria
- Bi-directional tracking and notification
- Primary care/specialty consults
- Scheduling efficiencies

Strategies:

- CAPH/SNI/KP/CPCA Specialty Care Access Initiative
- Potential specialty care initiative with CHCF

Obj. IID – By April 30, 2010, 6 public hospital systems will have a combined total of 80 managers, clinicians and staff ***trained in Lean, Six Sigma*** or other performance improvement or management engineering approaches.[4]

Strategies

- Lean Core Measures Improvement Initiative
- Promote CHCF-funded management engineering projects with public hospitals and USC School of Engineering

Obj. IIE – By December 31, 2009, SNI will have developed CAPH board-approved benchmarks for identifying a public hospital-based ***coordinated system of care***, including criteria for the "ideal clinic" or **"patient-centered medical home,"** and ***determined critical, measurable gaps*** between CAPH members' current capacity to provide coordinated care systems and the approved benchmarks.

Obj. IIF – By December 31, 2011, at least four CAPH-member systems will have ***met the majority of the criteria*** for a ***coordinated system of care***.

Strategies (for IIE & IIF)

- CAPH/SNI proposal to Blue Shield of CA Foundation, Preparing for Reform and Equipping Public Hospitals (PREP) (pending approval)
- Collaborate with CPCA on refining framework and implementing Patient-Centered Medical Home in California's safety net
- Seek funding from major California foundations to support critical components of coordinated systems of care

Obj. IIG – By December 31, 2009, four public hospital systems will be ***prescribing electronically*** from the majority of their outpatient clinics to their internal and contracted pharmacies, with demonstrated improvements in patient safety and efficiency.

Strategies

- SNI's E-Prescribing Initiative, funded by Blue Shield of CA Foundation

[4] Note: approximately 3-6 staff from 1-2 hospital systems are currently trained.

<u>Goal III</u>: Eliminate Health Care Disparities: Ensure Services Provided at Public Hospital Systems are Tailored to the Unique Needs of Each Patient, Thereby Equalizing the Opportunity for Optimal Health

<u>Obj. IIIA</u> – By December 31, 2010, at least two public hospital systems will have implemented industry-leading methods for collecting race, ethnicity and language (REAL) data and will be ***using accurate, consistent REAL data*** in all areas of the hospital system, including for service planning and identification and ***reduction of potential disparities***. By Dec. 31, 2011, at least two additional hospitals will be adopting these methods.

<u>Strategies</u>

- REAL Data Initiative (planning grant to start January, 2009, pending approval Dec. '08 from The California Endowment; funding for implementation in 2009-2010 pending successful completion of planning process)

<u>Obj. IIIB</u> – By December 31, 2011, California public hospitals will continue to demonstrate excellence and leadership in providing ***language access***, increasing the number of qualified healthcare interpreter encounters provided per month from 36,701 in 2008 to 50,000 in 2011.

<u>Strategies</u>

- Continue to collaborate with HCIN and SNI's Cultural and Linguistic Advisory Committee to spread remote technology and other improvements in interpreter services
- Work with CAPH policy staff to support policy efforts, such as Medi-Cal reimbursement of language services