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Preliminary Summative Evaluation of California's Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program

Prepared for:
California Department of Health Care Services
Prepared: August 2020
Finalized: February 2021

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Preliminary Summative Evaluation of California's Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program

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Prepared: August 2020, Finalized February 2021

This evaluation was supported by funds received from the California Department of Health Care Services (contract number 16-93440). The analyses, interpretations, and conclusions contained within this evaluation are the sole responsibility of the authors. This report contains analysis of hospital-reported metric data available up to the end of Demonstration Year (DY) 14 (July 2017 to June 2019) and survey data from early DY 15. The DHCS Chief Medical Information Officer reviewed this document for PHI and approved it for public release (CMIO-20-1017).

Acknowledgments

The authors would like to thank Maria Ditter, Denisse M. Huerta, Leigh Ann Haley, Chingyi (Ethan) Ie, Kong Xin, Dahai Yue, Isabella Agpaoa, Catly Do, Christina Read, Juan Flores, Katherine Chow, Kelly Chen, Alexandra Bryant, Callie Phillips, Sally (Hanqing) Yao, and Weihao Zhou for their hard work and support of PRIME program evaluation activities.

Suggested Citation

Pourat N, Martinez AE, Tieu L, Huynh MP, Chen X, and Needleman, J, Warrick, A. 2021. *Preliminary Summative Evaluation of California's Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program.* Los Angeles, CA: UCLA Center for Health Policy Research.

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Executive Summary

PRIME Overview

Public Hospital Redesign and Incentives in Medi-Cal (PRIME) is a program under California's Section 1115 Medicaid Waiver called "Medi-Cal 2020." PRIME goals included: (1) increased provision of patient-centered, data-driven, team-based care; (2) improved provision of point of care services, complex care management, population health management, and culturally competent care; (3) improved population health and patient experience in Medi-Cal; (4) integrated physician and behavioral health and coordinated care for vulnerable populations; and (5) transition public hospitals to value-based care (Exhibit 1 of the PRIME Evaluation Design, Appendix A. Glossary and Key Terms; Documentation from Evaluation Design).

A total of 17 designated public hospitals (DPHs) and 37 district and municipal public hospitals (DMPHs) implemented 18 projects organized under 3 domains. DPHs included 12 county-owned and operated hospitals (County) and 5 University of California (UC) hospitals. Among the DMPH hospitals, 17 were Critical Access Hospitals (CAHs), defined by having fewer general-acute care beds and located in rural areas The California Department of Health Care Services (DHCS) collaborated with stakeholders to develop core components for PRIME projects (Attachment Q). DHCS also approved metric specifications, standardized reporting instructions, and defined reimbursement methodologies for hospitals' achievements on metric performance. The PRIME implementation plan was approved by Centers for Medicare and Medicaid Services (CMS), which included a comprehensive and rigorous evaluation of PRIME in the interim and at the end of the program.

Evaluation Overview and Preliminary Summative Report Findings

The UCLA Center for Health Policy Research (UCLA) was selected to evaluate the goals of PRIME using a conceptual framework adapted from the Triple Aim: enhanced infrastructure, better care, better health, and lower costs (Exhibit 2 of the PRIME Evaluation Design, Appendix A. Glossary and Key Terms; Documentation from Evaluation Design). The evaluation questions were closely aligned with project objectives defined in Attachment Q. The evaluation findings are presented in 3 complementary reports: the Interim Evaluation Report was prepared in August 2019 and approved by CMS for release in February 2020; this Preliminary Summative Evaluation report was prepared in August 2020; and a final report is to be released in late 2021 or early 2022. A high-level summary of the Interim Evaluation Report is provided in the Introduction Section following the end of this Executive Summary.

This report, titled Preliminary Summative Evaluation Report, includes findings based on data available by April 2020, which includes both DY 15 hospital-reported survey data and changes in hospital-reported project metric performance rates and achievement values from DY11 to DY 14. The achievement rate was the hospital-reported rate for the metric; the achievement value indicated the degree to which the hospital met the target (ranged from 0-1).

This report also includes analyses of a comprehensive survey by UCLA (called "final survey" in this report) of participating PRIME hospitals completed by April 2020. This survey reflected active projects in DY 15 and examined synergies between PRIME and hospitals' mission and other ongoing initiatives, a self-assessment of achievement of PRIME goals and scope of unfinished activities, sustainability of PRIME following the end of the program, and hospitals' perceptions of the impact of PRIME on the Triple Aim. The analyses in this report are subject to limitations associated with self-reported data, such as potential biases in survey responses, or unknown or underlying variations in metric calculation by hospitals. Another potential limitation is inability to infer causal relationships from observational data.

Hospital Perspectives on PRIME

In the final survey (Appendix E: Survey Results by Hospital Type), the hospitals reported on progress in program implementation, sustainability of PRIME projects, and the overall impact of PRIME.

PRIME Implementation

UCLA examined the potential role of synergies between PRIME projects, with organizational goals and other initiatives, hospital perspectives of the progress in implementation of PRIME project goals and activities, the level of effort and difficulty in implementation, and facilitators of success.

Synergies between PRIME Projects and Organizational Goals and Other Initiatives

Quantitative survey data was collected to understand how hospital utilized the mix of projects selected to implement PRIME. PRIME implementation was measured by utilizing DY 15 survey data from hospitals, to assess synergies between PRIME projects and with other quality improvement initiatives, achievement of project goals and activities, and by reassessment of the level of staffing effort, financial investment, and difficulty of PRIME projects.

Hospitals reported on their DY 15 project selections in the survey. The survey included questions for DPHs about their 9 required and optional projects (Projects 1.1-1.3 and 2.1-2.3 were required, as well as at least 1 more project from each domain). DMPHs were not required to select any specific projects, yet many selected the more challenging DPH-required projects.

The examination of synergies between PRIME projects showed preferences for concurrent selection of specific types of projects, particularly among DMPHs. For example, the DMPH non-CAHs most frequently selected Domain 2 projects in tandem, including Projects 2.2 Care Transitions: Integration of Post-Acute Care (Care Transitions), 2.3 Complex Care Management (CCM) for High-Risk Populations, Project 2.7 Comprehensive Advanced Illness Planning and Care (Advance Care Planning), and Project 3.1 Antibiotic Stewardship from Domain 3. The smaller DMPH CAHs most frequently selected Project 2.6 Chronic Non-Malignant Pain Management (Pain Management) along with Domain 1 Projects 1.5 Million Hearts Initiative (Million Hearts) and Project 1.1 Integration of Physical and Behavioral Health (Behavioral Health Integration). While DPHs also frequently chose Project 2.6 Pain Management, they selected multiple projects from all three domains in tandem. On the survey, hospitals also rated synergies between PRIME and their organizational mission and other quality improvement initiatives highly (4.4 and 4.2 out of 5, respectively).

Progress in Achieving PRIME Project Goals and Activities

On the survey, hospital rated the extent to which they achieved the goals of PRIME projects in which they participated (from 1- Did not achieve any goals to 10- Achieved all goals).Hospitals only reported achievement scores for the projects that they implemented. The result of this hospital-reported rating varied by type of hospital and types of project. Overall, the DPHs hospital-reported scores ranged from a low of 7.0 for Project 1.7 Obesity Prevention and Healthier Foods Initiative (Healthier Foods) and a high of 9.4 for Project 3.2 Resource Stewardship: High-Cost Imaging (High-Cost Imaging). Among the projects that were required for DPHs (Project 1.1-1.3 and 2.1-2.3), the lowest achievement score was 7.7 for Project 1.3 Ambulatory Care Redesign: Specialty Care (Specialty Care Redesign) to 8.3 for Project 2.3 CCM for High-Risk Populations.

DMPH non-CAHs ratings of achievement of their selected projects ranged from a low of 6.9 for 2.2 Care Transitions to a high of 9.5 for Project 3.3 Resource Stewardship: Therapies Involving High Cost Pharmaceuticals (High-Cost Pharmaceuticals).

The DMPH CAHs achievement rates for selected projects ranged from a low of 6.0 for Project 1.5 Million Hearts to a high of 10.0 for Project 1.7 Healthier Foods.

When asked to report up to 5 specific PRIME unfinished activities, 36 hospitals reported 104 such activities, with most activities related to Projects 1.1 Behavioral Health Integration (15), 1.2 Primary Care Redesign (31), 1.3 Specialty Care Redesign (17), and 2.2 Care Transitions (13). Also, 6 hospitals noted 11 overarching unfinished activities, such as further improvements in data infrastructure and increasing their quality improvement workforce.

Unfinished activities were grouped into infrastructure and process, and data showed variations by hospital type. The majority of unfinished activities related to Project 1.1 were reported by DPHs (13), which included a mix of infrastructure (6) and process-related (7) activities. Illustrative examples of unfinished infrastructure activities included

developing registries and partnerships. Examples of unfinished process activities included increasing SBIRT and cancer screening (i.e. colonoscopy), collecting REAL/SOGI data, and expanding the use of specialty telehealth visits.

Level of Staff Effort, Financial Investment, and Difficulty of PRIME Implementation

Hospitals were asked to rate the level of effort, financial investment, and difficulty of PRIME Project (from low of 1 to high of 5). Ratings of staff effort ranged from a low of 3.5 for Project 2.5 Transition to Integrated Care: Post Incarceration (Post Incarceration) and as high as 4.8 for Project 2.4 Integrated Health Home for Foster Children (Foster Children Health Homes), with multiple projects with high scores of 4.5 such as Project 1.1 Behavioral Health Integration, Project 1.6 Cancer Screening and Follow-up, and Project 2.7 Advance Care Planning.

The examination of ratings of financial investment was somewhat lower than the level of effort, ranging from a low of 2.9 for Projects 2.6 Pain Management and Project 3.3 High-Cost Pharmaceuticals to a high of 4.0 for Project 1.1 Behavioral Health Integration and Project 2.5 Post Incarceration. The ratings of level of difficulty ranged from a low of 3.4 for Project 3.2 High-Cost Imaging and a high of 4.5 for both Project 2.4 Foster Children Health Homes and Project 2.5 Post-Incarceration Care. Hospitals noted that the most important factors to their success in implementing PRIME projects were the high prioritization of PRIME by senior leadership and the integration of PRIME into their organization's strategic mission.

Overall, the survey information regarding PRIME project implementation provided ample evidence of successful implementation as more fully described in the Conclusions and Next Steps within this Executive Summary.

Sustainability of PRIME Activities

Hospitals reported on several indicators of the sustainability of PRIME: integration of PRIME Project activities into routine standards of care; intentions to continue all or some aspects of PRIME after the end of the program; an assessment of staffing, process, and organizational factors that drove sustainability; and overall sustainability of each of the PRIME projects. The survey was completed before the COVID-19 pandemic.

The first measure of sustainability was the integration of each PRIME project's activities into routine standards of care, which was rated from a low of 1 to a high of 5. Hospitals rated the highest levels of integration for Project 3.2 High-Cost Imaging and Project 2.4 Foster Children Health Homes (4.8 and 4.5, respectively), and lowest integration for Project 2.5 Post Incarcerated Care and Project 3.3 High-Cost Pharmaceuticals (3.5 and 3.7, respectively).

The second measure of sustainability was hospitals' intentions to continue all or some aspects of PRIME projects. All hospitals intended to maintain all or certain aspects of

the vast majority of PRIME projects after the end of the program, with some differences in whether all or some aspects are continued by project. For example, 13 hospitals were planning to continue all aspects of Project 1.1 Behavioral Health Integration and 10 were planning to continue some aspects of this project. For Project 2.6 Pain Management, 10 hospitals were planning to continue all aspects, and 5 were planning to continue some aspects of the project. A few hospitals did not intend to continue specific projects such as Projects 1.5 Million Hearts and 1.7 Healthier Foods.

The third measure of sustainability was an assessment of staffing, process, and organizational factors for each project that drove sustainability. The most common factors included investment by staff in driving progress (69%); realized benefits to the organization, staff, and patients (88%); and clinical infrastructure established (80%). Fewer (37%) hospitals reported that they anticipated operational funding would be available after PRIME to support sustainability.

The fourth measure of sustainability was a rating of the overall sustainability of each of the PRIME Projects after the end of the program (ranging from 1 to 5). The lowest ratings were 3.0 and 3.3 for Projects 2.5 Transition to Integrated Care: Post Incarceration (Post-Incarceration) and 3.3 High-Cost Pharmaceuticals and the highest ratings were 4.5, 4.4, and 4.4 for Projects 1.6 Cancer Screening, 3.1 Antibiotic Stewardship, and 3.2 High-Cost Imaging. More information about specific activities are reported in Appendix D: Concurrent PRIME Project Selections by Hospital Type.

Overall, the assessment of survey data indicated that there is a high likelihood of sustainability of the majority of PRIME projects as more fully described in the Conclusions and Next Steps within this Executive Summary.

Overall Impact of PRIME

Hospitals' perceptions of the overall impact of PRIME was assessed by examining the impact on organizational capacity, managed care contracts, Triple Aim: enhanced infrastructure; better care; better health; and lower costs, promoting collaborations, and unexpected consequences. Ratings were reported on a scale of 1 (very low) to 5 (very high).

Hospitals reported the highest impact of PRIME to be on their data collection (4.1), analytics (4.0), and reporting capacity (4.0). The lowest impact was their ability to participate in risk-based contracts (2.5). To prepare hospitals to participate in value-based payment (VBP) models, DPHs were required to have assigned enrollees under one or more contracts with Medi-Cal managed care plan (MCP). All DPHs and the great majority of DMPHs reported having at least 1 contract with a Medi-Cal MCP during PRIME with assigned enrollees. The average number of contracts was highest for DMPH non-CAHs (2.5) and lowest for DPH County hospitals (1.6) and DMPH CAHs (1.6). This variation was likely influenced by the number of MCPs operating in each county. The average number of Medi-Cal MCP enrollees was highest within DPH County hospitals, totaling to over 631,000 enrollees. As a whole, DPH and DMPH hospitals reported a total of over 788,000 Medi-Cal MCP enrollees within their PRIME-eligible population (DPH: 671,000; DMPH: 127,000 (reported in the survey).

The perceived impact of PRIME on the Triple Aim was examined for each domain. Hospitals perceived that the highest impact of PRIME was on the quality of care in all 3 domains (4.3), followed by patient health outcomes (4.1 for Domains 1 and 2, and 3.8 for Domain 3), and cost containment (3.2 for Domain 1, 3.3 for Domain 2, and 3.5 for Domain 3). Methods for assessing PRIME's impact varied. Direct measurement of metrics was the most common method for assessing the quality of care (82%) and patient health outcomes (80%). But, anecdotal and other observations were most common for cost-containment and efficiency (47%).

Hospitals rated the highest impact of PRIME as 4.0 for improving internal collaboration between clinical staff and data analytics staff and 3.3 and 3.2 for improving external collaborations, such as the California Department of Health Care Services, California Association of Public Hospitals, and Safety Net Institute.

Hospitals were asked to report if there were unexpected consequences implementing PRIME. Some (20) hospitals reported unexpected adverse consequences, with the most common (10) being provider and staff resistance, burden, or burnout. In contrast, 38 hospitals reported multiple unexpected values of implementing PRIME, with the most common being driving the engagement of providers and staff in opportunities for training and leadership in quality improvement (12), and promoting data-driven quality improvement within the organization (9).

Altogether, assessing the overall impact of PRIME as perceived by hospitals further illustrated reasons for sustainability of PRIME projects and is more fully described in the Conclusions and Next Steps within this Executive Summary.

Trends in Project Metric Achievement

A total of 103 metrics across 18 projects were reported by hospitals at any time during the first 4 years of the program. The number of metrics varied by year from 96 (DY 11), 98 (DY 12), 95 (DY 13), and 89 (DY 14). These changes included retiring metrics that were no longer considered representative or recommended, and replacement or addition of metrics over time as the projects progressed and specific tasks were accomplished. Of the 103 metrics ever used, 81 measured the care processes that hospitals were expected to follow and 22 measured the outcomes of care provided by hospitals. The great majority of metrics (82%) measured hospital performance under Domain 1 (41%) and Domain 2 (41%) projects. All 96 metrics in DY 11 were pay for reporting (P4R), but the proportion of P4R metrics declined to 64% (DY 12), 36% (DY 13), and 12% (DY 14) as metrics transitioned from P4R to pay for performance P4P. All metrics were P4R during DY 11 for DPHs and DY 12 for DMPHs (except 2 DMPHs that reported data in DY 11), reflecting the different start times for data reporting for each group of hospitals.

Metric achievement was measured by meeting predefined targets that were associated with achievement values (AV) of 0 to 1. An average AV by hospital type was calculated. All metrics that were partially or fully achieved (a value greater than 0) positively contributed to the proportion of AVs partially or fully achieved. If a hospital's denominator for a metric did not have a minimum of 30 patients, that metric's AV was excluded because the metric data was considered statistically unstable (Exhibit 180). Hospitals received payments for project implementation depending on AV per metric. The average AVs for P4P Outcome metrics declined over time and was somewhat lower than P4P Process measures. P4P Outcome metrics among DPHs ranged from 0.83 in DY 12 to 0.76 in DY 14; DMPHs ranged from 0.62 in DY 12 to 0.60 in DY 14. For P4P Process metrics, DPHs were at 0.92 in all years; DMPHs ranged from 0.71 in DY 12 to 0.77 in DY 14.These findings correspond to the gradually and increasingly challenging target achievement rates that may have resulted in lower AVs in later years as well as a shift in metrics from P4R to P4P.

Trends in Project Metric Performance by DY 14

Hospitals reported metric performance rates semiannually; UCLA analyzed the year-end reports for each DY to assess the change in performance levels from DY 11 to DY 14. Additionally, this trend was assessed for improved performance as specified by the metric (i.e. readmission rates are intended to decrease over time). This trend analysis

excluded metrics that were reported for only one year (so change in performance level could not be measured), and excluded metrics without a continuous numeric value (such as attesting to having a palliative care team). In addition, if metrics were reported by hospitals as sub-rates then individual sub-metric trends could be assessed with some limitations, which is addressed in the specific metric analysis. For example, Metric 1.4.1 Abnormal Results Follow-Up: Percent of Abnormal Results with Appropriate and Timely Documentation and Follow-Up was reported by hospitals as 3 individual sub-rates, whereas Metric 1.4.2 - NQF 2371 Annual Monitoring for Patients on Persistent Medications includes analysis of multiple elements that are reported by hospitals together as one rate. Thus, an overall total of 106 (DPHs) and 88 (DMPHs) trends were included in the analysis presented in the section Trends in Project Metric Performance by DY 14.

Overall, 92% of DPH and 83% of DMPH metrics changed in the intended direction from DY 11 to DY 14. These rates varied by domain and project. A greater proportion of Domain 1 (DPH 100%, DMPH 90%) and Domain 2 (DPH 93%, DMPH 82%) than Domain 3 (DPH 75%, DMPH 67%) metrics changed in the intended direction.

Conclusions and Next Steps

The final survey data provided ample evidence of success of hospitals in implementing PRIME projects, including generally high ratings of completing specific PRIME project goals and activities, which were likely made possible due to synergies between projects and hospitals' organizational goals and mission and existing quality improvement initiatives. The 6 projects that were required for DPHs were complex, frequently requiring system-wide and comprehensive changes in infrastructure and care delivery. Several DMPHs including CAHs selected these projects and most reported high ratings (around 8 out of 10 by most hospitals) for completion of these goals. The success in implementing the goals and activities of the optional projects varied to a greater degree. The hospitals' responses regarding unfinished PRIME activities pointed to hospitals' intentions to continue many activities without additional funding. These unfinished activities were concentrated in specific projects, such as primary care (Project 1.2) and specialty care (Project 1.3) redesign. Overall, the types of activities were roughly equally divided between developing infrastructure and process of care delivery. The high rating of staffing and difficulty provide insights into challenges implementing PRIME projects.

The assessment of data indicated a high likelihood of sustainability of the majority of PRIME projects using four different measures. The data indicated that the great majority of the projects, including the required projects, were well integrated into routine standards of care; all or some aspects would continue after PRIME; staff were invested in continued progress, clinical infrastructure were established, and benefits to all stakeholders realized; and overall sustainability was high for many projects.

Assessing the overall impact of PRIME as perceived by hospitals further illustrated reasons for sustainability of PRIME projects. The high ratings of contribution of PRIME to data capacity and care processes showed that hospitals had established the basic tools for implementation of these projects. The presence of Medi-Cal managed care contracts and the significant number of these enrollees are likely to provide further motivation to continue these projects to be able to perform under capitation payment and similar or new quality improvement requirements. The ratings of perceived impact on Triple Aim was also consistent with these assumptions, highlighting the role of these projects in improving quality of care and patient health outcomes. While hospitals acknowledged that these projects had some adverse consequences, the role of PRIME in organizing internal stakeholders in systematic training and data driven quality improvements were frequently reported as unexpected high value consequences of the program.

The analyses of metric with achievement values greater than 0 indicated near perfect performance for P4R metrics, since hospitals were not required to meet targets. The data also indicated that achievement values declined once metrics transitioned to P4P. In addition, achievement values declined over time because hospitals were expected to improve their performance year by year building on their past performance. These requirements meant that performance targets became more difficult to achieve in later DYs. The lower average Achievement Values for DMPHs compared to DPHs were likely the result of three different factors. DPHs had a longer history of participating in value-based payment initiatives such as the Delivery System Reform Incentive Payment (DSRIP) program, which had led to establishment of significant health information infrastructure and metric reporting experience. In addition, DPHs began implementing projects a year earlier than DMPHs, while the latter were developing the needed infrastructure to implement PRIME projects. DMPHs were also more likely to have denominators less than 30 for reporting metrics, which led to an AV of 0 (Metrics Where PRIME Hospital Types Did Not Meet the 30 Patient Minimum Denominator Criteria).

A different assessment of hospital metric rate performance based on analysis of trends over time showed that the great majority of metrics improved from DY 11 to DY 14, with the exception of some Domain 3 project metrics. This may be because Domain 3 projects focus on reducing utilization of high cost resources, while Domain 1 and 2 projects focus on implementation of new processes of care. Domain 3 projects required changing provider behaviors such as ordering imaging for uncomplicated headaches, prescribing antibiotics for acute bronchitis, reduced transfusion of blood products, or reduced prescribing of high cost pharmaceuticals. Domain 3 projects typically had fewer metrics per project, along with some metrics with denominators under 30.

The final PRIME evaluation report will be completed approximately one year after PRIME implementation ended. The last quarter of PRIME implementation was disrupted by the COVID-19 pandemic and its consequences. Thus, the final report will include an assessment of the impact of the pandemic on PRIME using a COVID-19 specific hospital-reported survey and a quantitative assessment of metric performance

comparing DY 15 to prior performance. Additionally, the final evaluation will utilize patient-level data to compare changes in metric performance and Medi-Cal payments before and during PRIME implementation with a comparable group of Medi-Cal patients who received care from other non-PRIME providers.

Introduction

On December 30th, 2015 California received approval for an §1115 Medicaid "Medi-Cal 2020" waiver. The waiver allowed the California Department of Health Care Services (DHCS) to make specific changes to the State's Medicaid plan as approved by the Centers for Medicare and Medicaid Services (CMS). Medi-Cal 2020 included the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program. PRIME hospitals expected to improve patient outcomes and be ready to successfully function under risk-based alternative payment models (APMs) in the long term. PRIME requires hospitals to establish performance baselines, achieve established targets for improvement, and evaluate the success of quality improvement interventions on an ongoing basis. The guiding principles and specific rules of the PRIME program are specified in the Special Terms and Conditions (STCs).

PRIME Hospitals

Participating PRIME hospitals included Designated Public Hospital (DPH) systems and the District/Municipal Public Hospitals (DMPH). DPHs include 12 county-owned and operated hospital systems (DPH-county) and 5 University of California hospital systems (DPH-UC). DMPHs consist of 17 rural institutions designated as critical access hospitals (DMPH CAH) and 20 other DMPHs (non-CAH). Of these, 3 DMPHs discontinued PRIME participation. Additional information is available in Appendix B. PRIME Project Selections.

PRIME Program Goals and Design

PRIME goals included:

- Changing the care delivery to patient-centered and data-informed approaches;
- Providing specific services such as complex care management and culturally competent care;
- Improving patient outcomes and experiences;
- Physical and behavioral health integration; and
- Improvements in the ability of the hospitals to function under such alternative payment methodologies.

To achieve these goals, PRIME included 18 projects organized under 3 domains. Domain 1 projects were focused on outpatient delivery system transformation and preventive services, Domain 2 projects were focused on high-risk or high-cost populations, and Domain 3 projects were focused on resource utilization efficiency.

Funding and Payment Methodology

Up to nearly $7.5 billion in total funding was available, with $3.7 billion available from the federal government and the remaining from a combination of state contribution in

the form of administrative oversight and local funds provided by PRIME hospitals. PRIME hospitals were required to report standardized performance metrics, the majority of which were endorsed and specified by national organizations. PRIME also provided the opportunity to develop innovative metrics when standard measures did not adequately assess successful transformation in a project (Attachment Q). Metric payment started with (P4R) and transitioned to pay-for-performance (P4P) for specific metrics. Hospitals submitted their PRIME program data biannually in reports to DHCS. DHCS applied calculations specified in Attachment II to assign an Achievement Value (AV), which determined the level of payment.

PRIME Evaluation

The UCLA Center for Health Policy Research (UCLA) was selected to evaluate PRIME. UCLA developed the evaluation design and evaluation questions that were closely aligned with project objectives defined in PRIME STC Attachment Q. The overall mixed methods evaluation included analyses of quantitative and qualitative data for a comprehensive assessment of program implementation and outcomes (PRIME Evaluation Design). The evaluation findings are presented in 3 complementary reports including an Interim Evaluation Report prepared in August 2019, this report prepared in August 2020, and a final report to be released in late 2021 or early 2022.

This report, titled the Preliminary Summative Evaluation Report, includes qualitative data from two sources and available by August 2020. Data included (1) hospital-reported narrative reports and project metric performance and metric achievement values from DY11 to DY 14, and (2) a comprehensive survey by UCLA (called "final survey" in this report) of key informants such as medical directors and administrators completed by April 2020. This survey reflected active projects in DY 15 and examined synergies between PRIME and hospitals' mission and other ongoing initiatives, a self-assessment of achievement of PRIME goals and scope of unfinished activities, sustainability of PRIME following the end of the program, and hospitals' perceptions of the impact of PRIME on the Triple Aim. A detailed description of the methodology for the qualitative analyses can be found in Appendix E: Survey Results by Hospital Type.

The analyses in this report are subject to limitations associated with self-reported data such as potential biases in survey responses or unknown and underlying variations in metric calculation by hospitals. Survey data may be subject to recall bias and perceptions of respondents that may not be shared with everyone in each institution. The survey was prepared and in the field prior to the COVID-19 pandemic and did not include its impact. The hospital-reported metric data were validated by DHCS, but the underlying data used to create them were likely to vary by hospital. Another potential limitation is inability to infer causal relationships from observational data.

Summary of the Interim Evaluation

This Preliminary Summative Evaluation Report follows the Interim Evaluation Report released in August 2020. The previous report included a description of PRIME hospitals and the projects they selected under the program, the infrastructure they developed to implement the planned activities, and the processes they followed subsequently as of May 2019. The report further described the degree of achievement of metrics, which were tied to incentive payments, and the progress in metric performance from DY 11 to DY 13. The metric performance of PRIME was also examined in contrast to a group of comparable patients receiving care elsewhere, assessed with Medi-Cal and OSHPD patient-level data using a difference in difference methodology. The interim evaluation report indicated significant progress in program implementation and success in attaining pre-defined target values for the project metrics. Hospitals earned incentive payments for these achievements. The examination of hospital-reported performance metrics indicated general success in desired improvements among participating hospitals, with a few exceptions. The independent analyses of a number of metrics using Medi-Cal claims and California hospital discharge data further confirmed desired improvements under PRIME for process metrics but no evidence of success in outcome metrics as of the end of DY 13.

Preliminary Summative Evaluation Findings

Hospital Perspectives on PRIME

Shortly before PRIME was scheduled to end, hospitals were surveyed for the second time on the status of PRIME implementation, sustainability of PRIME projects, and the overall impact of PRIME. The survey was completed by key informants from 51 participating PRIME hospitals (17 DPHs, 17 DMPH non-CAHs, 17 DMPH CAHs). In administering the survey, 3 of 54 hospitals that had initiated PRIME but were no longer participating in the program in DY15 were excluded. The survey was implemented from February to April 2020. A number of survey questions asked hospitals to rate their experiences on a 1 to 5 Likert scale (1=very low, 2=low, 3=medium, 4=high, 5=very high) and one question on achievement of project goals used a 1-10 scale. Results included average rates or proportions. Responses to open-ended questions were analyzed qualitatively. The survey results were reported across all participating hospitals and by type of hospital (DPH, DMPH non-CAH, and DMPH CAH) as appropriate. Hospitals that responded to the survey are identified in Appendix C: End-of-Program Survey Questions and Respondents.

PRIME Implementation

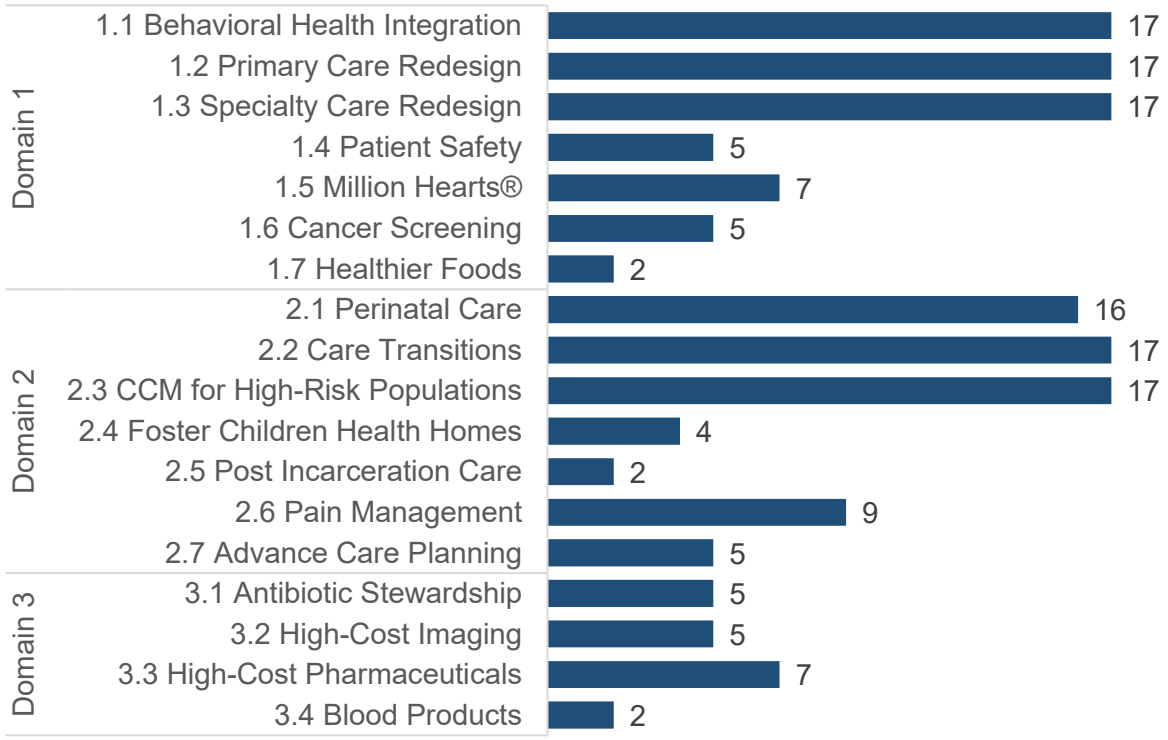
UCLA examined the potential role of synergies between PRIME projects, with organizational goals and other initiatives, hospital perspectives of the progress in implementation of PRIME project goals and activities, the level of effort and difficulty in implementation, and facilitators of success.

Synergies between PRIME Projects

UCLA highlighted synergies between optional projects selected by DPHs and DMPHs, focusing on projects that were implemented in DY 15 concurrently.

Exhibit 1 presents all the required (1.1-1.3, 2.1-2.3) and optional projects implemented by DPHs. Exhibit 1 shows the most commonly selected optional projects were Domain 2 Project 2.6 Pain Management by 9 DPHs, followed by Domain 3 Project 3.3 High-Cost Pharmaceuticals and Domain 1 Project 1.5 Million Hearts, each by 7 DPHs. The projects selected in tandem by DPHs are shown in Appendix Exhibit 168 and Exhibit 169. The data indicate the likelihood of synergies between some projects, including concurrent selection of Project 2.7 Advance Care Planning in tandem with 3.3 High-Cost Pharmaceuticals (4 DPH) and selection of Project 2.6 Pain Management in tandem with 3.2 High-Cost Imaging (3). Other optional and potentially synergistic projects selected in tandem included Project 1.6 Cancer Screening with Projects 2.7 Advance Care Planning (3) and 3.2 High-Cost Imaging (3).

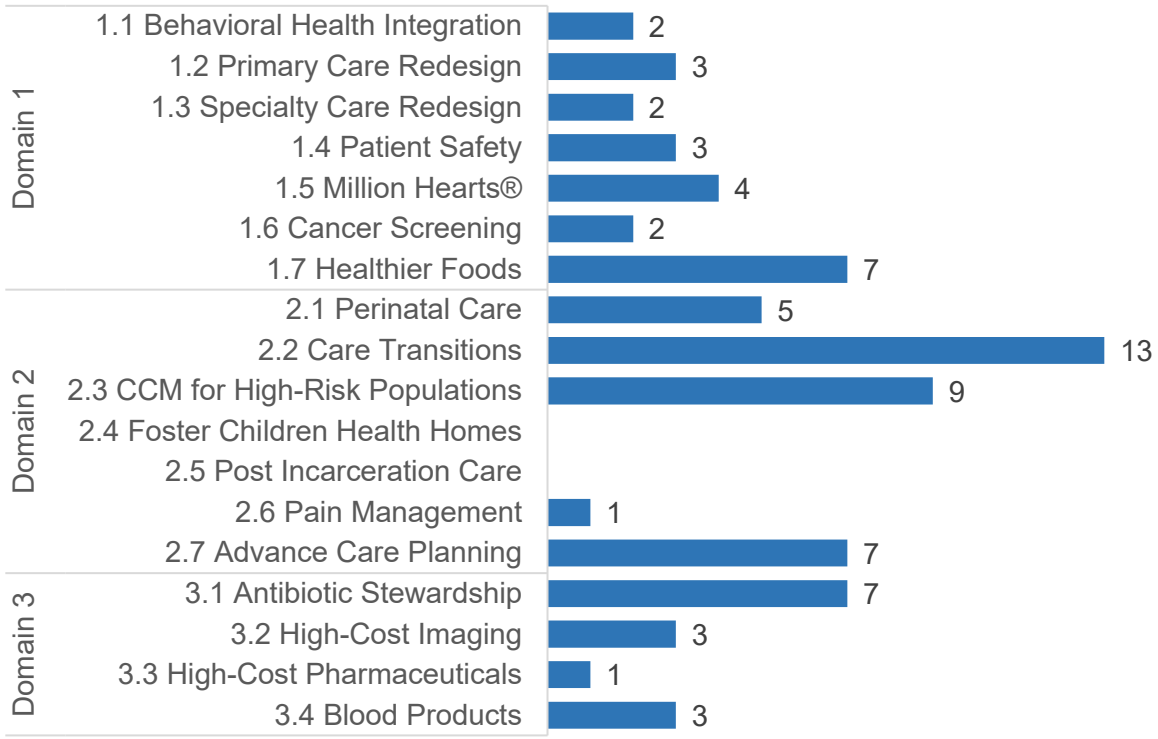
Exhibit 1: Selection of PRIME Projects by DPHs



Source: UCLA analysis of the hospital self-reports, DY15.
Notes: 17 designated public hospitals (DPHs) participated in PRIME in DY15. DPHs were required to implement Projects 1.1, 1.2, 1.3, 2.1, 2.2, and 2.3.

Among DMPH non-CAHs, Domain 2 Projects 2.2 Care Transitions and 2.3 Complex case management for High-Risk Populations were implemented by most hospitals (13 and 9, respectively; Exhibit 2). Likely synergies for these hospitals included concurrent selection of Project 2.2 Care Transitions with Projects 2.3 Complex Case Management for High-Risk Populations (8 DMPH non-CAH), 2.7 Advance Care Planning (7), and 3.1 Antibiotic Stewardship (7). DMPH-non CAH concurrent project selections are shown in Appendix Exhibit 170.

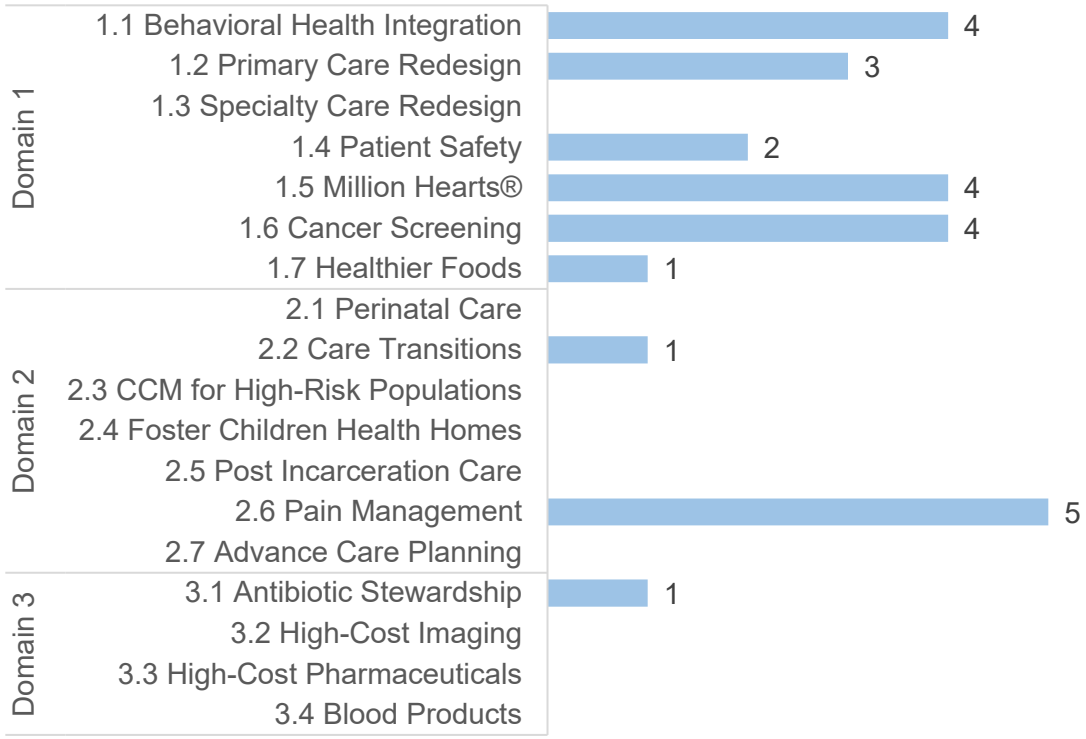
Exhibit 2: Selection of PRIME Projects by DMPH non-CAHs



Source: UCLA analysis of the hospital self-reports, DY15.
Notes: 17 district and municipal hospitals without critical access hospital designation (DMPH non-CAHs) participated in PRIME in DY15.

Among DMPH CAHs, most (5) hospitals selected Project 2.6 Pain Management; 4 hospitals selected Project 1.1 Behavioral Health Integration, 1.5 Million Hearts, and 1.6 Cancer Screening (Exhibit 3). Synergies were likely between Projects 1.1 and 2.6 selected by 3 hospitals. Synergy in DMPH CAH project selections are shown in Appendix Exhibit 171.

Exhibit 3: Selection of PRIME Projects by DMPH CAHs

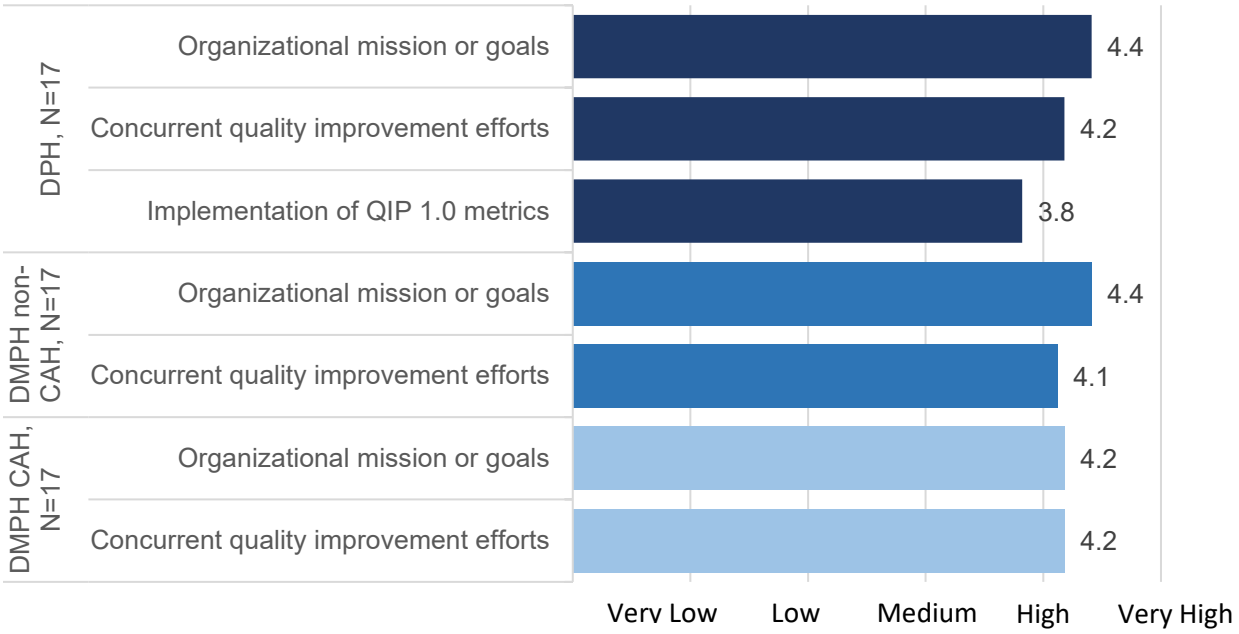


Source: UCLA analysis of the hospital self-reports, DY15.
Notes: 17 district and municipal hospitals with critical access designation (DMPH CAHs) participated in PRIME in DY15.

Synergies with Organizational Goals and Other Initiatives

In the final survey, hospitals were asked to report the synergy of PRIME with their organizational mission or goals and concurrent quality improvement efforts, on a scale from 1 (very low) to 5 (very high). In addition, DPHs rated the synergy of PRIME with their implementation of Quality Incentive Pool (QIP) 1.0 metrics. DPHs reported highest synergy (average rate of 4.4) with their organizational mission or goals. Ratings of synergy with PRIME were lowest for implementation of QIP 1.0 metrics (3.8). QIP metrics were specifically chosen to be different from PRIME metrics due to federal requirements that prohibits paying for the same metric in different programs.

Exhibit 4: Synergy of PRIME with Organizational Mission, Quality Improvement Efforts, and QIP 1.0



Source: UCLA analysis of the final survey data, implemented February to April 2020. Notes: N=51 hospitals participated in the final survey. DPH: designated public hospital; DMPH non-CAH: district and municipal public hospital without critical access hospital designation; DMPH CAH: district and municipal public hospital with critical access hospital designation, QIP: Quality Incentive Pool. Values in the exhibit represent ratings average across hospitals. QIP 1.0 metrics were only implemented by DPHs.

One hospital elaborated on the synergy of PRIME with their organizational mission or goals as follows:

> *"Driving continuous improvements in quality, safety, value and the patient experience are foundational tenets of [our] Strategic Map...These have strong synergy with PRIME initiatives and the overall goals of PRIME." (Washington Hospital Healthcare System)*

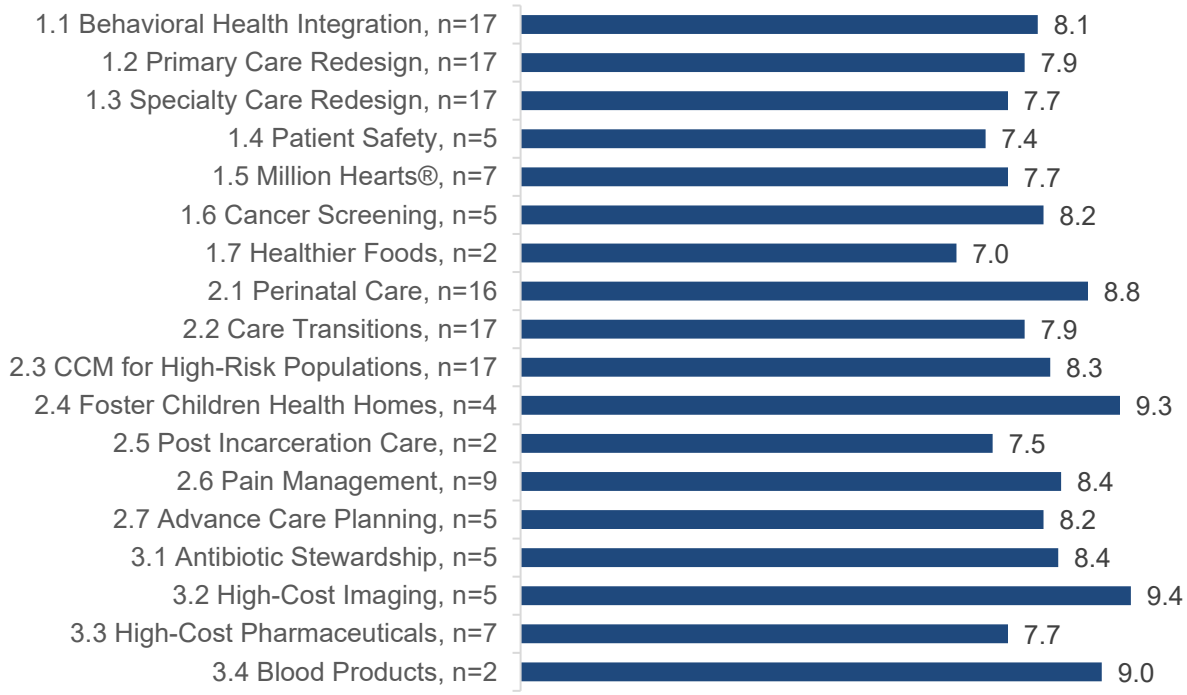
Another hospital noted the synergy of PRIME with other quality improvement programs, including QIP:

> *"Many pieces of this project are ingrained into our standard of care; reflect evidence-based clinical practices; have measurable positive outcomes for patients; and synergy with ongoing programs such as QIP [and] MACRA (Medicare Access and CHIP Reauthorization Act of 2015) … PRIME provided us with the knowledge and tools to successfully implement other quality improvement focused programs such as QIP." (Ventura County Hospital)*

Progress in Achieving PRIME Project Goals and Activities

Hospitals rated the extent to which they achieved the goals of PRIME projects in which they participated on a scale that ranged from 1 (achievement of no goals) to 10 (achievement of all goals). Exhibit 5 - Exhibit 7 present average ratings of the completion of PRIME project goals by hospital type. DPHs reported the highest rate for the achievement of goals in Project 2.4 Foster Children Health Homes (9.3), Project 3.2 High-Cost Imaging (9.4), and Project 3.4 Blood Products (9.0; Exhibit 5). The lowest ratings were for Project 1.7 Healthier Foods (7.0) and Project 1.4 Patient Safety (7.4).

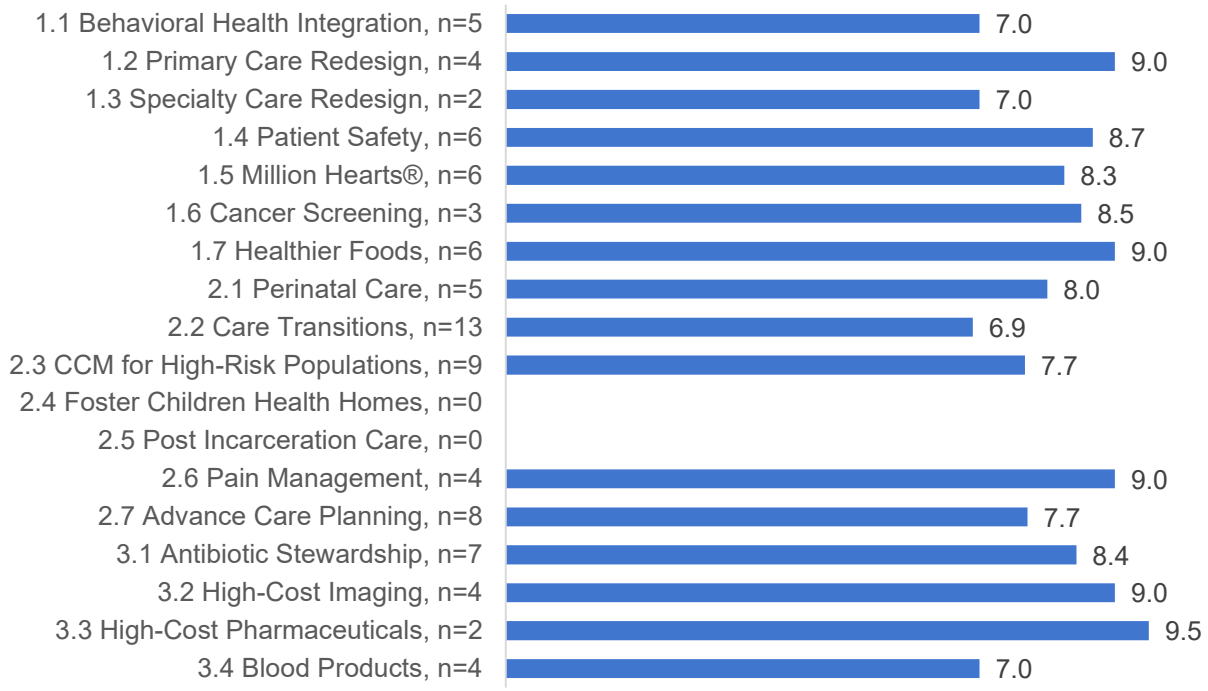
Exhibit 5: Achievement of PRIME Project Goals among Participating DPHs



Source: UCLA analysis of the final survey data, implemented February to April 2020.
*Notes: N=17 designated public hospitals (DPH) completed the final survey (*Appendix E: Survey Results by Hospital Type*). Ratings of project completion were on a scale from 1 (did not achieve any goals) to 10 (achieved all goals). Values in the exhibit represent mean ratings of achievement of goals among hospitals participating in each project. The "n" represents the number of hospitals participating in each project in DY 15 due to the timing of the survey.*

Among DMPH non-CAHs, hospitals reported high achievement of their project goals (Exhibit 6). Ratings of achievement were highest for Projects 1.2 Primary Care Redesign (9.0), 1.7 Healthier Foods (9.0), 2.6 Pain Management (9.0), 3.2 High-Cost Imaging (9.0), and 3.3 High-Cost Pharmaceuticals (9.5). DMPH non-CAHs reported lower achievement of goals for Projects 1.1 Behavioral Health Integration (7.0), 1.3 Specialty Care Redesign (7.0), 2.2 Care Transitions (6.9) and 3.4 Blood Products (7.0).

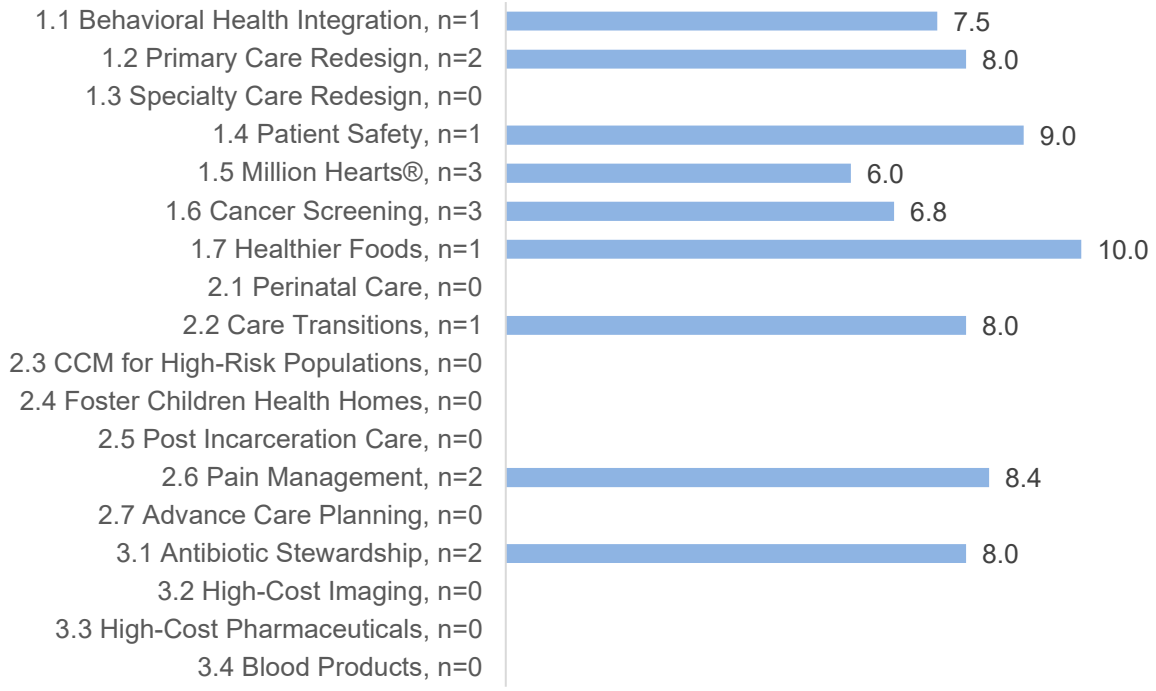
Exhibit 6: Achievement of PRIME Project Goals among Participating DMPH non-CAHs



*Source: UCLA analysis of the final survey data, implemented February to April 2020. Notes: N=17 district and municipal public hospitals without critical access hospital designation (DMPH non-CAH) who completed the final survey (*Appendix E: Survey Results by Hospital Type *). Ratings of project completion were on a scale from 1 (did not achieve any goals) to 10 (achieved all goals). Values in the exhibit represent mean ratings of achievement of goals among hospitals participating in each project. Projects without data represent projects in which no DMPH non-CAHs participated. The "n" represents the number of hospitals participating in each project in DY 15. CCM: complex case management.*

Among DMPH CAHs, ratings of achievement of project goals were highest for Projects 1.4 Patient Safety (9.0) and 1.7 Healthier Foods (10.0, Exhibit 7). In contrast, average ratings of achievement of goals for Projects 1.5 Million Hearts (6.0) and 1.6 Cancer Screening (6.8) reflected lower achievement of self-defined goals.

Exhibit 7: Achievement of PRIME Project Goals among Participating DMPH CAHs



*Source: UCLA analysis of the final survey data, implemented February to April 2020. Notes: N=17 district and municipal public hospitals with critical access hospital designation (DMPH CAH) who completed the final survey (*Appendix E: Survey Results by Hospital Type *). Ratings of project completion were on a scale from 1 (did not achieve any goals) to 10 (achieved all goals). Values in the exhibit represent mean ratings of achievement of goals among hospitals participating in each project. Projects without data represent projects in which no DMPH CAHs participated. The "n" represents the number of hospitals participating in each project in DY 15. CCM: complex case management.*

In the final survey, hospitals were asked to report, through open-ended response, up to 5 activities they intended to implement during PRIME but had not fully implemented. Responses were not restricted to activities suggested in Attachment Q and could have included other activities hospitals had planned for a project. For each activity, hospitals were asked to indicate whether they planned to implement the activity after PRIME regardless of whether external funding was secured, planned to implement the activity after PRIME only if external funding was secured, or did not plan to implement the activity after PRIME. Approximately 70% of the hospitals (36 of the 51 surveyed) reported PRIME-related activities that had not been completed during the program and

15 hospitals did not report any unfinished activities. The hospitals reported a total of 104 unfinished activities; hospitals planned to complete 68% (71) regardless of whether external funding is obtained and 26% (27) if additional external funding is secured. Hospitals reported that they did not plan to implement the remaining 5% (6) of unfinished PRIME activities (Data not shown). The 6 activities that the 5 hospitals did not plan to continue after PRIME included Baby Friendly Designation; Patient-Centered Medical Home (PCMH) recognition; and Screening, Brief Intervention, and Referral to Treatment (SBIRT).

Exhibit 8 displays examples of specific infrastructure and process related activities that hospitals reported were unfinished near the end of PRIME. For example, Project 1.1 Behavioral Health Integration unfinished activities included development of a depression registry infrastructure and increasing depression screening process. Similarly, unfinished activities for Project 2.2 Care Transitions included developing an EHR tool for identifying patients at high risk (infrastructure) and conducting home visits by health coaches (process). In addition to activities falling within specific PRIME projects, 6 hospitals noted overarching PRIME activities that they intended to implement after PRIME, such as improving data infrastructure to continue collecting, analyzing, and reporting metrics related to quality improvement and hiring additional quality improvement staff.

Exhibit 8: Examples of Unfinished Infrastructure and Process-related Activities, by PRIME Project

Project	Example(s) of Infrastructure-related Activities	Example(s) of Process-related Activities
1.1 Behavioral Health Integration, n=13	• Develop depression registries • Increase behavioral health staff • Incorporate digital platforms for behavioral health screening	• Increase depression screening • Increase SBIRT • Implement processes of communication and referral to behavioral health services
1.2 Primary Care Redesign, n=19	• Develop population health registries • Obtain PCMH Certification Increase staff for health coaching and patient outreach	• Implement REAL/SOGI data collection • Conduct outreach follow-up for patients with diabetes and hypertension
1.3 Specialty Care Redesign, n=9	• Implement e-referral or e-consult systems • Telehealth for specialty visits	• Expand use of telehealth for specialty visits
1.4 Patient Safety, n=1	N/A	• Implement point-of-care testing

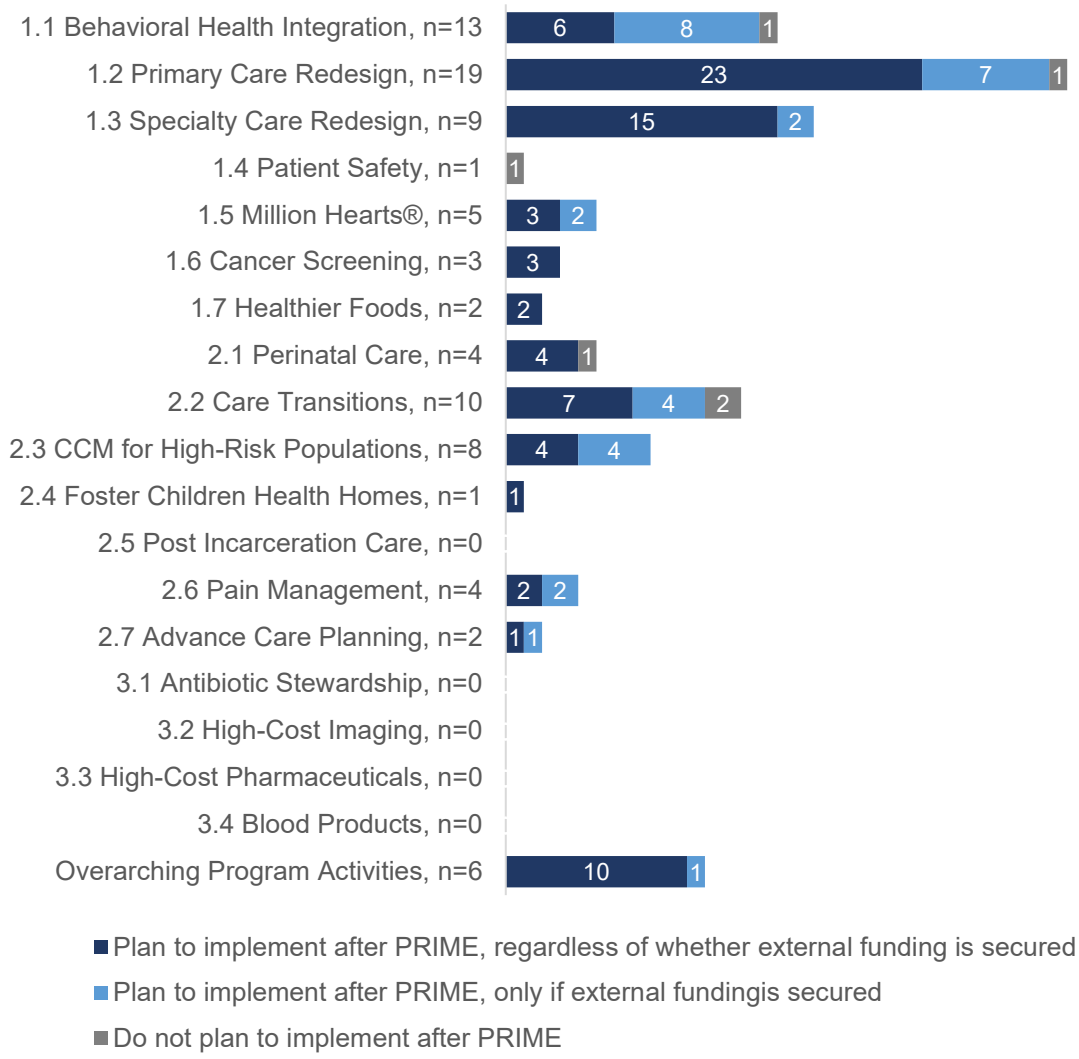
Project	Example(s) of Infrastructure-related Activities	Example(s) of Process-related Activities
1.5 Million Hearts®, n=5	• Disseminate blood pressure monitors to patients • Develop EHR workflows for monitoring for at-home blood pressure monitoring	• Improve identification of hypertension • Increase follow-up with patients with hypertension
1.6 Cancer Screening, n=3	• Develop EHR capability to retrieve colonoscopy data	• Increase cancer screening
1.7 Healthier Foods, n=2	• Implement Partnership for a Healthier America's Hospital Healthier Food Initiative	• Implement water consumption initiative
2.1 Perinatal Care, n=4	• Participate in statewide initiatives for cesarean births • Develop collaborations with prenatal diagnostic clinic	• Encourage best practices among providers to improve cesarean section rates • Develop processes for outreach to mothers with high risk
2.2 Care Transitions, n=10	• Develop EHR tool for identifying patients at high risk • Increase staff development and training for facilitating care transitions	• Provide onsite collaboration with skilled nursing facilities • Conduct home visits by health coaches • Conduct medication reconciliation on discharge
2.3 Complex Case Management for High-Risk Populations, n=8	• Develop task force for patients with high risk diabetes • Increase care coordinator staffing and outreach hours	• Implement complex care coordination for high risk patient groups
2.4 Foster Children Health Homes, n=1	• Develop foster care integrated health home	N/A
2.6 Pain Management, n=4	N/A	• Improve tracking of patients using opioids • Provide feedback to providers on chronic pain management
2.7 Advance Care Planning, n=2	• Develop physician orders for life-sustaining treatment (POLST) registry	N/A

Project	Example(s) of Infrastructure-related Activities	Example(s) of Process-related Activities
Overarching Program Activities, n=6	• Hire additional quality improvement staff • Develop enhanced tools in EHR (care management, search, bulk ordering, patient notification)	• Improve data collection and reporting

Source: UCLA analysis of the final survey data, implemented February to April 2020.
Notes: N=36 hospitals of the 51 surveyed that reported any unfinished PRIME activities. The number of hospitals reporting any unfinished activity is reported for each project. Activities could be categorized under multiple projects. SBIRT: Screening, Brief Intervention, and Referral to Treatment. PCMH: Patient-Centered Medical Home. REAL: race, ethnicity, and language. SOGI: sexual orientation and gender identify. EHR: electronic health record. POLST: Physician Orders for Life-Sustaining Treatment.

Exhibit 9 displays the number of unfinished activities by PRIME projects. Highlighting the projects with the most unfinished activities, 13 hospitals reported 16 unfinished activities relating to Projects 1.1 Behavioral Health Integration; 19 hospitals reported 31 unfinished activities for Project 1.2 Primary Care Redesign; and 9 hospitals reported 17 unfinished activities for Project 1.3 Specialty Care Redesign (Exhibit 9). However, hospitals differed in whether or not they would continue these activities after the end of PRIME by project. For example, hospitals planned to complete 7 of the 18 Project 1.1 activities regardless of funding but planned to complete 23 of the 31 Project 1.2 activities regardless of funding.

Exhibit 9: Unfinished PRIME Activities by Project and Continuation Status

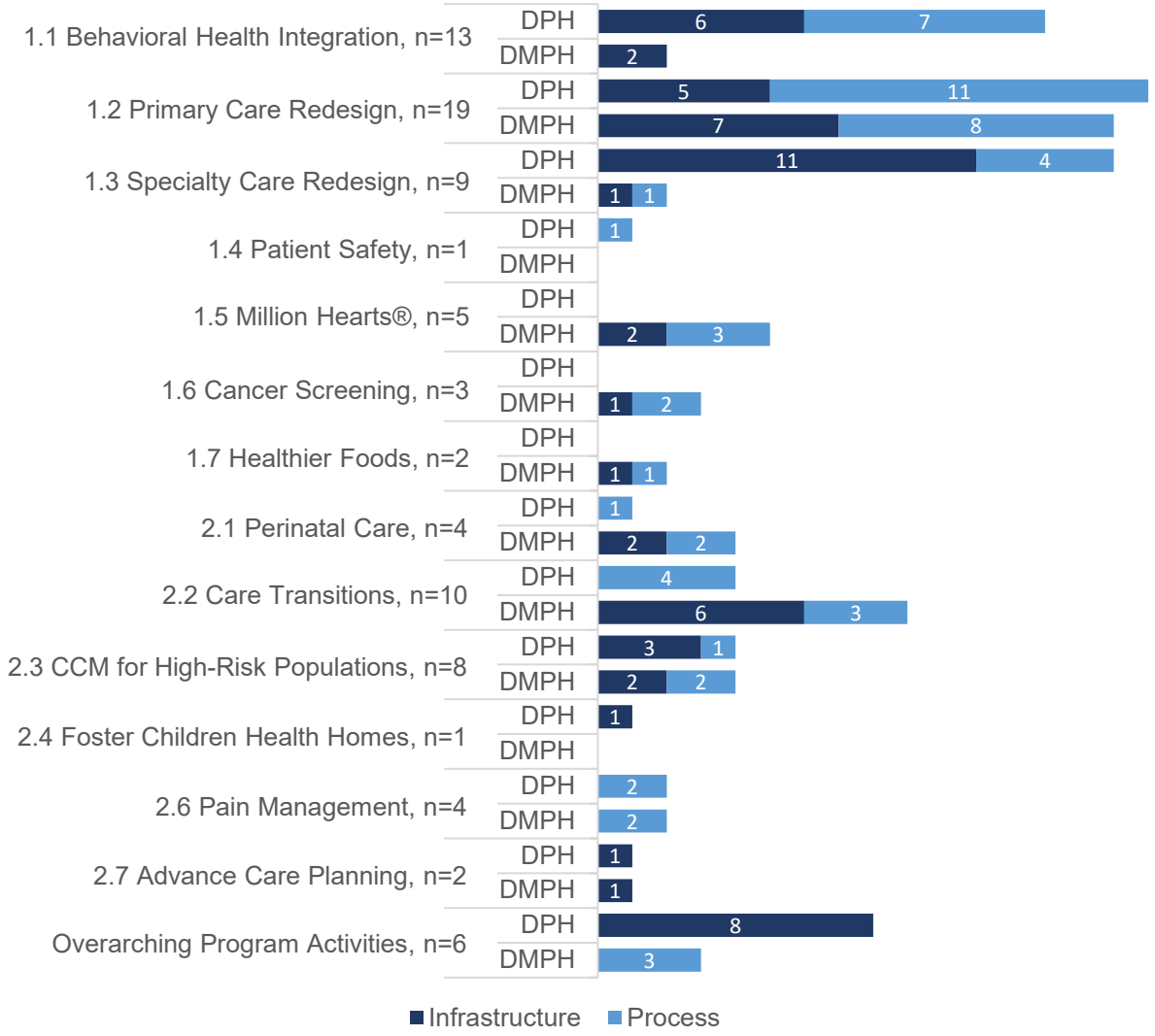


Source: UCLA analysis of the final survey data, implemented February to April 2020.
Notes: N=36 hospitals that reported any unfinished PRIME activities out of 51 hospitals surveyed. The number of hospitals reporting any unfinished activity is reported for each project. Values represent the number of activities reported. Activities could be

categorized in multiple projects. The figure excludes 1 activity related to Project 2.3 that had a missing status. CCM: complex case management.

The unfinished activities that were going to be continued with or without funding were grouped by UCLA based on whether they were infrastructure or process-related and reported by hospital type (*Exhibit 10*). The number of unfinished infrastructure activities varied by project and hospital type. For example, 6 of the 13 Project 1.1 Behavioral Health Integration unfinished activities and 11 of the 15 Project 1.3 Specialty Care Redesign unfinished activities reported by DPHs were infrastructure related. However, 2 of 2 Project 1.1 and 7 of 15 Project 1.2 Primary Care Redesign unfinished activities reported by DMPHs were infrastructure-related.

Exhibit 10: Unfinished PRIME Activities by Project and Hospital Type



Source: UCLA analysis of the final survey data, implemented February to April 2020.

Notes: N=36 hospitals of the 51 surveyed that reported any unfinished PRIME activities. The number of hospitals reporting any unfinished activity is reported for each project. Values represent the number of activities reported. Activities could be categorized in multiple projects. The figure excludes 1 activity related to Project 2.3 that had a missing status. CCM: complex case management.

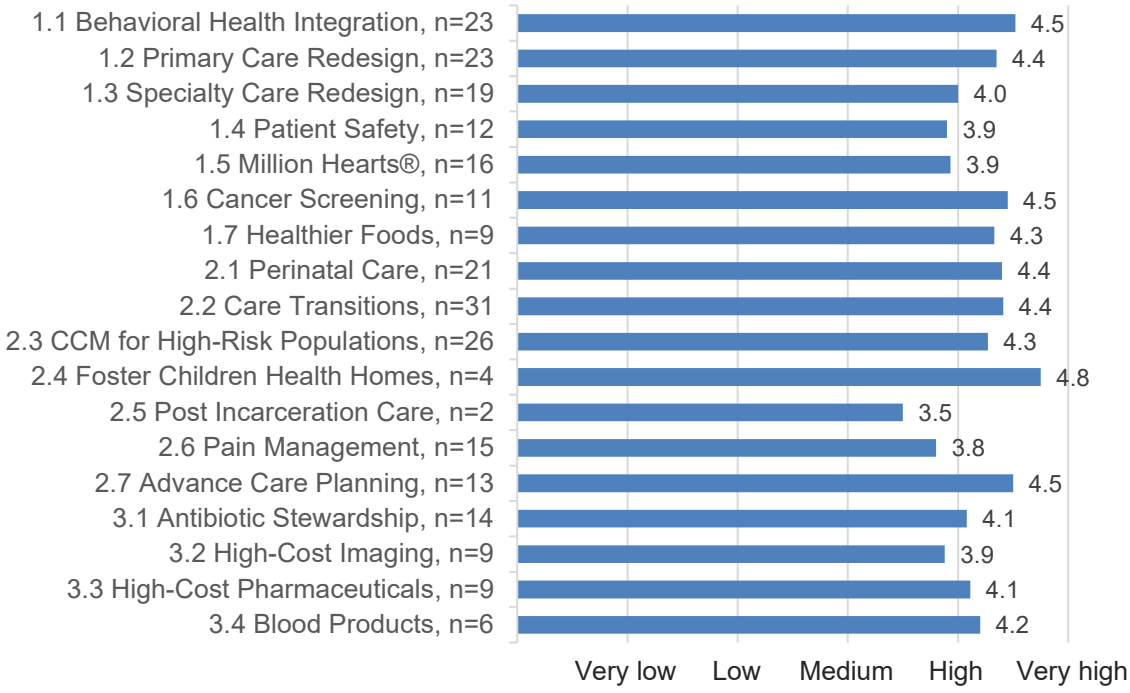
Level of Staff Effort, Financial Investment, and Difficulty of PRIME Implementation

In the final survey, hospitals were asked to rate the level of staff effort, financial investment, and overall difficulty of implementing PRIME projects in which they had participated. Ratings were assessed for all participating hospitals. For ratings by hospital type, see Appendix E: Survey Results by Hospital Type.

Level of Staff Effort

Ratings of staff effort were highest for Projects 2.4 Foster Children Health Homes (4.8), followed by Projects 1.1 Behavioral Health Integration (4.5), 1.6 Cancer Screening (4.5), and 2.7 Advance Care Planning (4.5). The lowest ratings were reported for Projects 2.5 Post Incarceration Care (3.5) and 2.6 Pain Management (3.8). As shown in Appendix E: Survey Results by Hospital Type, the ratings varied by hospital type. For example, DPH UC hospital ratings were highest for Project 2.7 (Advance Care Planning; 4.7) and lowest for Projects 1.4 Patient Safety (3.5) and 2.6 (Pain Management (3.5). Ratings of staff effort for DPH County hospitals were highest for Project 2.4 Foster Children Health Homes (4.8) and lowest for Project 1.5 Million Hearts (3.2). DMPH hospitals had similar ratings for staff effort in almost every project (from 3.7 to 5.0), with the exception to Project 1.4 Patient Safety where DMPH non-CAH reported an average rating of 3.7 and DMPH CAH a rating of 4.5.

Exhibit 11: Hospital Ratings of Level of Staff Effort Required to Implement PRIME Projects

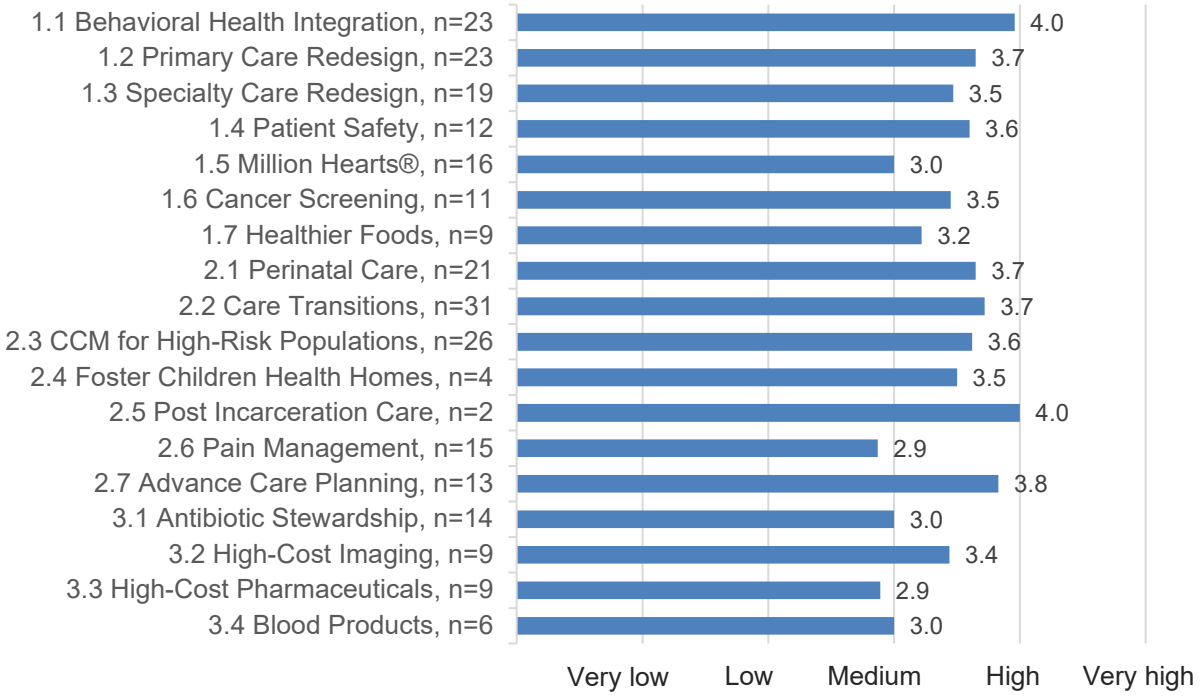


Source: UCLA analysis of the final survey data, implemented February to April 2020.
Notes: N=51 hospitals participated in the final survey. Ratings of staff effort were on a scale from 1 (very low) to 5 (very high). Values in the exhibit represent mean ratings of staff effort. The "n" reflects the number of hospitals participating in each project in DY 15. CCM: complex case management.

Financial Investment

Hospitals reported the highest levels of financial investment for Project 1.1 Behavioral Health Integration (4.0), Project 2.5 Post Incarceration Care (4.0), and Project 2.7 Advance Care Planning (3.8; Exhibit 12). Lowest ratings were reported for Projects 1.5 Million Hearts (3.0), 2.6 Pain Management (2.9), 3.1 Antibiotic Stewardship (3.0), 3.3 High-Cost Pharmaceuticals (2.9), and 3.4 Blood Products (3.0). Examining this data by hospital type showed that DPH UC hospitals, DMPH non-CAH, and DMPH CAH reported their highest levels of financial investment for Project 1.1, but other ratings of financial investment varied by hospital type, seen in Appendix E: Survey Results by Hospital Type. For example, while DMPH non-CAH reported the highest levels of financial investment for Project 1.1 Behavioral Health Integration (5.0), DMPH CAH also reported the highest levels of financial investment for Projects 1.4 Patient Safety (4.0), and 2.2 Care Transitions (4.0) in addition to Project 1.1 Behavioral Health Integration (4.0).

Exhibit 12: Hospital Ratings of Financial Investment Required to Implement PRIME Projects



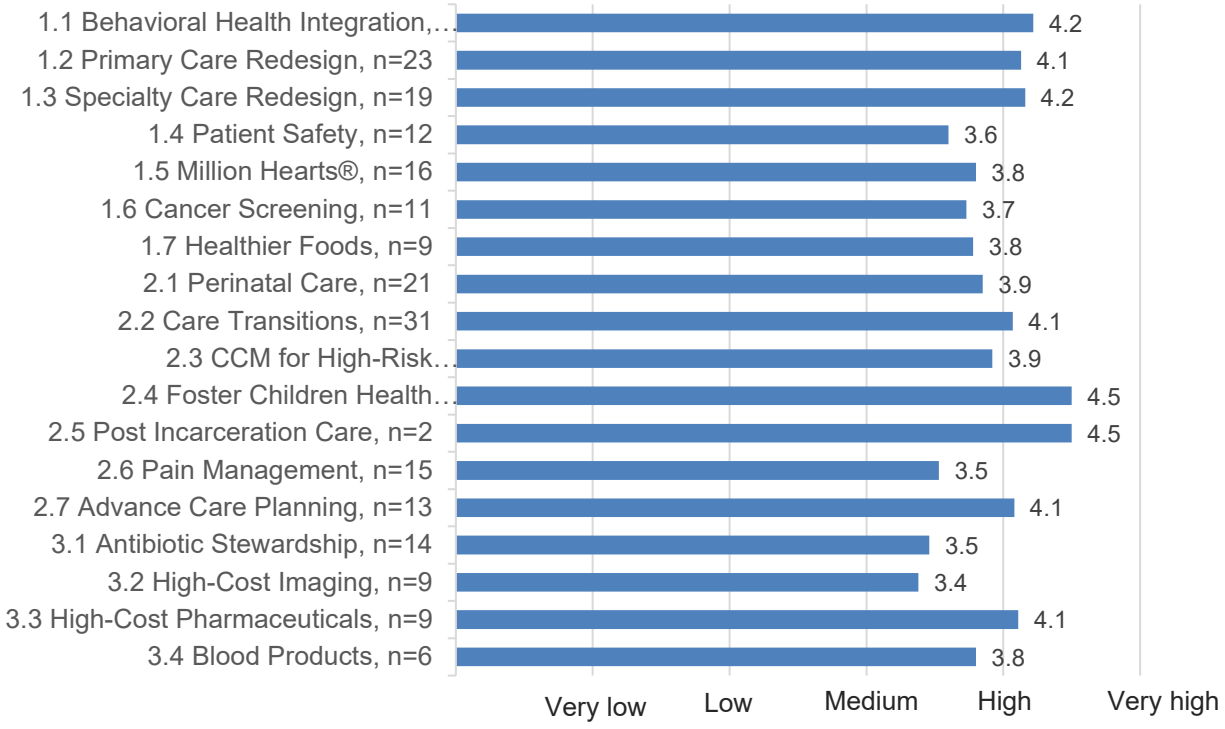
Source: UCLA analysis of the final survey data, implemented February to April 2020.
Notes: N=51 hospitals participated in the final survey. Ratings of financial investment were on a scale from 1 (very low) to 5 (very high). Values in the exhibit represent mean ratings of financial investment. The "n" represents the number of hospitals participating in each project in DY 15t. CCM: complex case management.

Level of Difficulty

Ratings of difficulty were highest for Projects 2.4 Foster Children Health Homes (4.5) and 2.5 Post Incarceration Care (4.5; Exhibit 13). Ratings of difficulty were lowest for projects focused on more specific initiatives or populations within the hospital, including Projects 2.6 Pain Management (3.5), 3.1 Antibiotic Stewardship (3.5), and 3.2 High-Cost Imaging (3.4). Examining ratings of difficulty of implementing projects by hospital type revealed numerous differences (Appendix E: Survey Results by Hospital Type). For example, DMPH non-CAH reported the highest level of difficulty for Project 1.2 Primary Care Redesign (4.7) and lowest for 3.1 Antibiotic Stewardship (3.1). DMPH CAH reported the highest level of difficulty for Projects 1.1 Behavioral Health Integration (4.3) in addition to 1.2 Primary Care Redesign (4.3) and lowest for 1.4 Patient Safety (2.0). While noting overall success implementing Project 1.4, one DMPH CAH elaborated on the difficulty of implementing the necessary data systems:

> *"It was difficult developing systems to track metrics. [We] used a hybrid of EMR generated reports and manual tracking." (Bear Valley Community Healthcare District)*

Exhibit 13: Hospital Ratings of Overall Difficulty of Implementing PRIME Projects



Source: UCLA analysis of the final survey data, implemented February to April 2020.
Notes: N=51 hospitals participated in the final survey. Ratings of overall difficulty were on a scale from 1 (very low) to 5 (very high). Values in the exhibit represent mean ratings of difficulty. The "n" represents the number of hospitals participating in each project in DY 15.

Top Facilitators of Success in Implementing PRIME

In the final survey, hospitals were asked to select the 2 most important factors that facilitated PRIME implementation and led to their success (Exhibit 14). Hospitals most often cited the integration of PRIME initiatives into their strategic mission (15, 29%), high prioritization of PRIME by senior leadership (15, 29%), and high prioritization of PRIME by clinical leadership (9, 18%) as the most important facilitators of success in implementing PRIME. Hospitals also often cited having sufficient financial resources as their most (4, 8%) or second most important factors to success (13, 25%). Fewer hospitals noted effort or staff time as the most or second most important factor to their success.

Exhibit 14: Most Important Factors to Success in Implementing PRIME

Source: UCLA analysis of the final survey data, implemented February to April 2020.
Notes: N=51 hospitals who completed the final survey. Other facilitators of success in implementing PRIME included: (1) choosing appropriate PRIME projects and metrics in the planning process, (2) standardizing workflows, and (3) building staff capacity to implement PRIME projects.

One hospital noted the importance of leadership and financial support to their implementation of PRIME:

> "Sufficient financial investment and prioritization by senior/clinical leadership allowed [hospital] to successfully put in place analytic/operational reports to drive improvement, and allowed us to hire and train new staff accountable for achieving outcomes through clinician and patient engagement." (University of California, San Francisco)

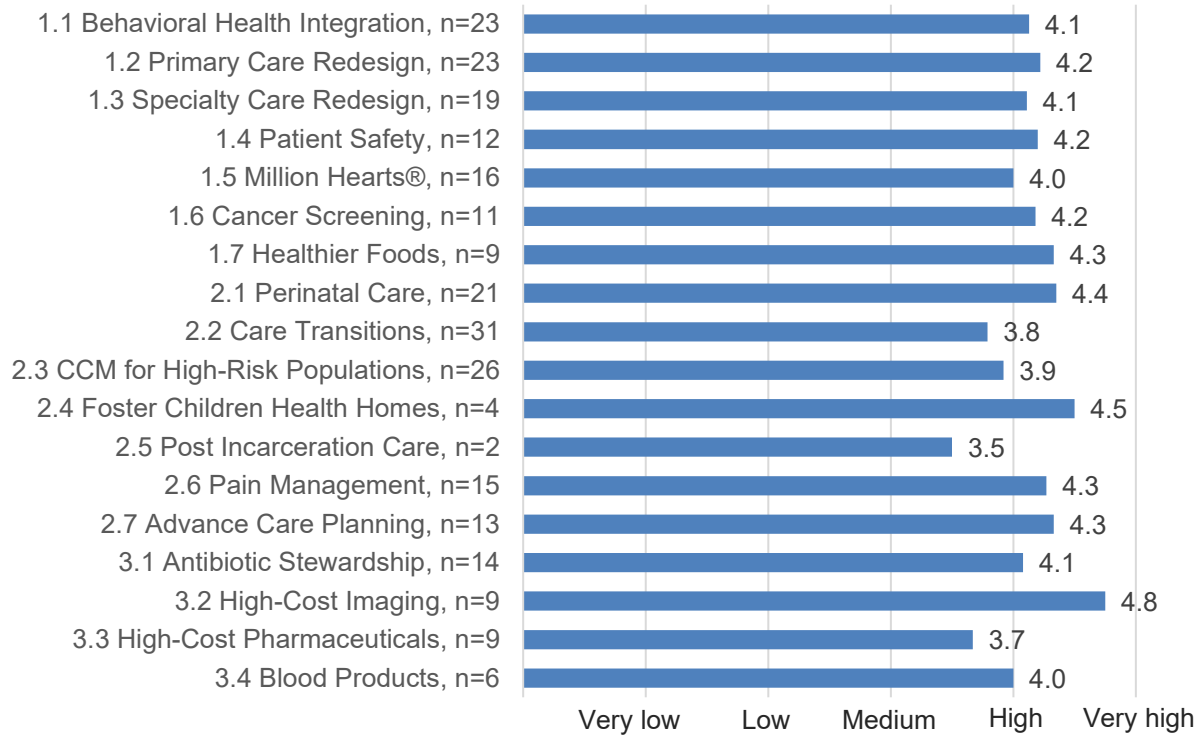
Sustainability of PRIME Activities

In the survey conducted in early 2020, hospitals were asked about sustainability of PRIME projects following the end of the program in June 2020. Most hospitals completed the survey before the COVID-19 pandemic began to impact their operations. Hospitals were asked to rate the degree of integration of PRIME activities in routine care, whether they would continue all or some aspects of PRIME projects after end of PRIME, drivers of sustainability of PRIME, and overall ratings of sustainability of each project.

Integration of PRIME Activities into Routine Standards of Care

Hospitals were asked to rate the level at which they had integrated each project's processes into their standard of care. Hospitals reported the highest level of integration of PRIME activities into routine standards of care for Project 3.2 High-Cost Imaging, (4.8) and 2.4 Foster Children Health Homes (4.5; Exhibit 15). The lowest ratings were reported for Projects 2.5 Post Incarceration Care (3.5) and 3.3 High-Cost Pharmaceuticals (3.7). As shown in Appendix E: Survey Results by Hospital Type ratings of integration varied by hospital type. For example, while Project 1.6 Cancer Screening (3.0) received one of the lowest ratings of integration into routine standards of care among DPH UCs, it received one of the highest ratings among DPH County hospitals.

Exhibit 15: Hospital Ratings of Level of Integration of PRIME Activities into Routine Standards of Care



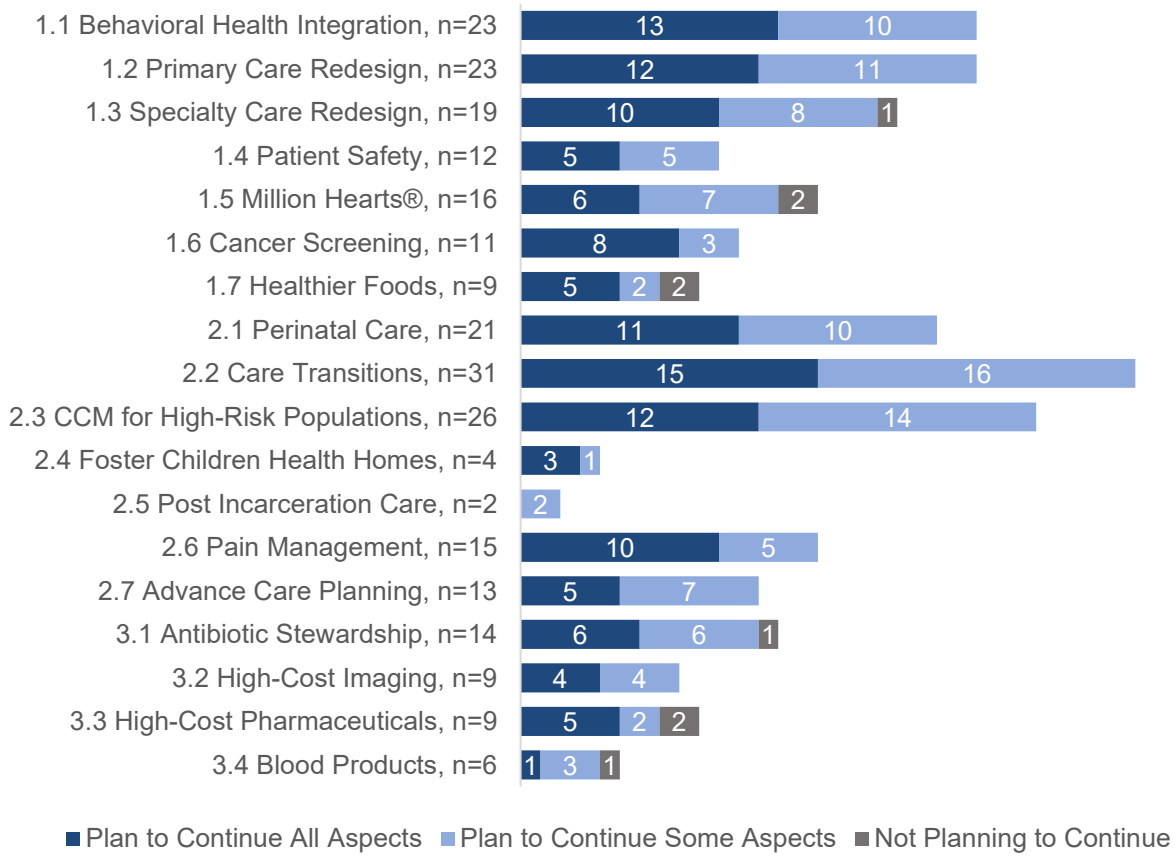
Source: UCLA analysis of the final survey data, implemented February to April 2020. Notes: N=51 hospitals participated in the final survey. Ratings of integration of PRIME project activities into standard of care were on a scale from 1 (very low) to 5 (very high). The "n" represents the number of hospitals participating in each project in DY 15. CCM: complex case management.

Plans for Complete or Partial Continuation of PRIME Projects after End of PRIME

For each project in which they participated, hospitals were asked to report their plans for continuing the project when external support for PRIME ends. More specifically, hospitals reported whether they were planning to continue the project's activities, and if so, whether they would continue all or some aspects of the project.

The majority of the participating hospitals intended to continue all aspects of 1.6 Cancer Screening, 2.4 Foster Children Health Homes, and 2.6 Pain Management. However, both participating hospitals planned to continue some aspects of Project 2.5 Post Incarceration Care. Few hospitals did not intend to continue PRIME projects.

Exhibit 16: Complete or Partial Continuation of Projects after PRIME



Source: UCLA analysis of the final survey data, implemented February to April 2020.
Notes: N=51 hospitals participated in the final survey. The "n" represents the number of hospitals participating in each project in DY 15. CCM: complex case management.

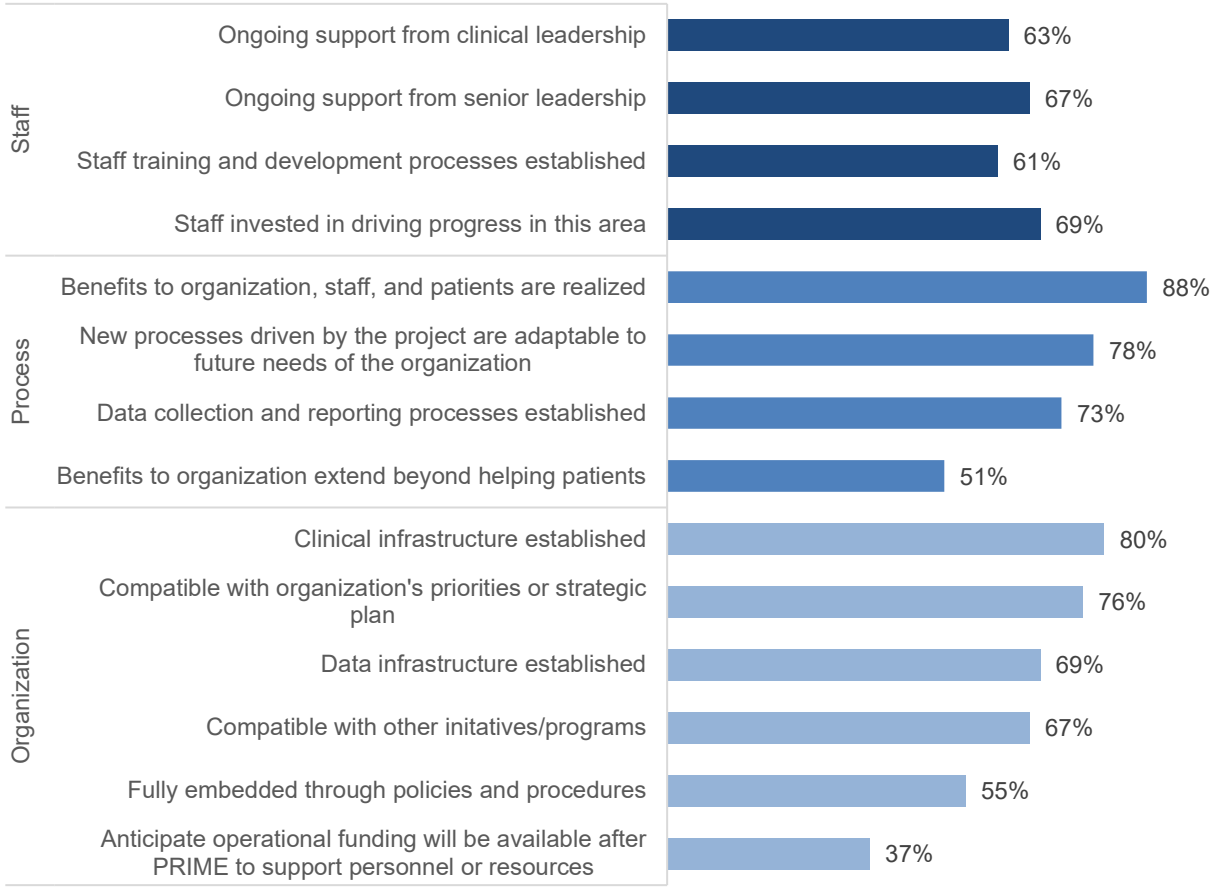
Drivers of Sustainability of PRIME Projects

To assess drivers of sustainability for the continuation of activities and initiatives started during PRIME, hospitals were asked to report the factors influencing their decision to continue their implementation of PRIME projects after the end of the program. Hospitals reported drivers of sustainability relating to the collective group of projects which they planned to continue in any capacity (fully or in part) after PRIME. The drivers of continuation of PRIME projects assessed in the final survey were adapted from a conceptual model of sustainability of health care programs covering 3 domains of sustainability: Staff, Process, and Organization (Sustainability Model, 2018).

Under the Staff domain, about two thirds of hospitals (61 to 69%) reported that support from clinical and senior leadership, establishment of processes for staff training and development, and staff investment were drivers of their continuation of PRIME projects after the end of the program (Exhibit 17). In the Process domain, hospitals most often

reported that the realization of benefits to the organization, staff, and patients (88%); the adaptability of PRIME processes to future needs (78%); and the establishment of data collection and reporting processes (74%) were drivers of the continuation of PRIME projects. Hospitals most often reported the establishment of clinical infrastructure (80%) and compatibility of PRIME with the organization's priorities or strategic plan (76%) as organizational drivers of sustainability. Fewer (37%) reported that they anticipated the availability of operational funding to support personnel or resources after PRIME.

Exhibit 17: The Role of Internal Support in Continuation of PRIME Projects



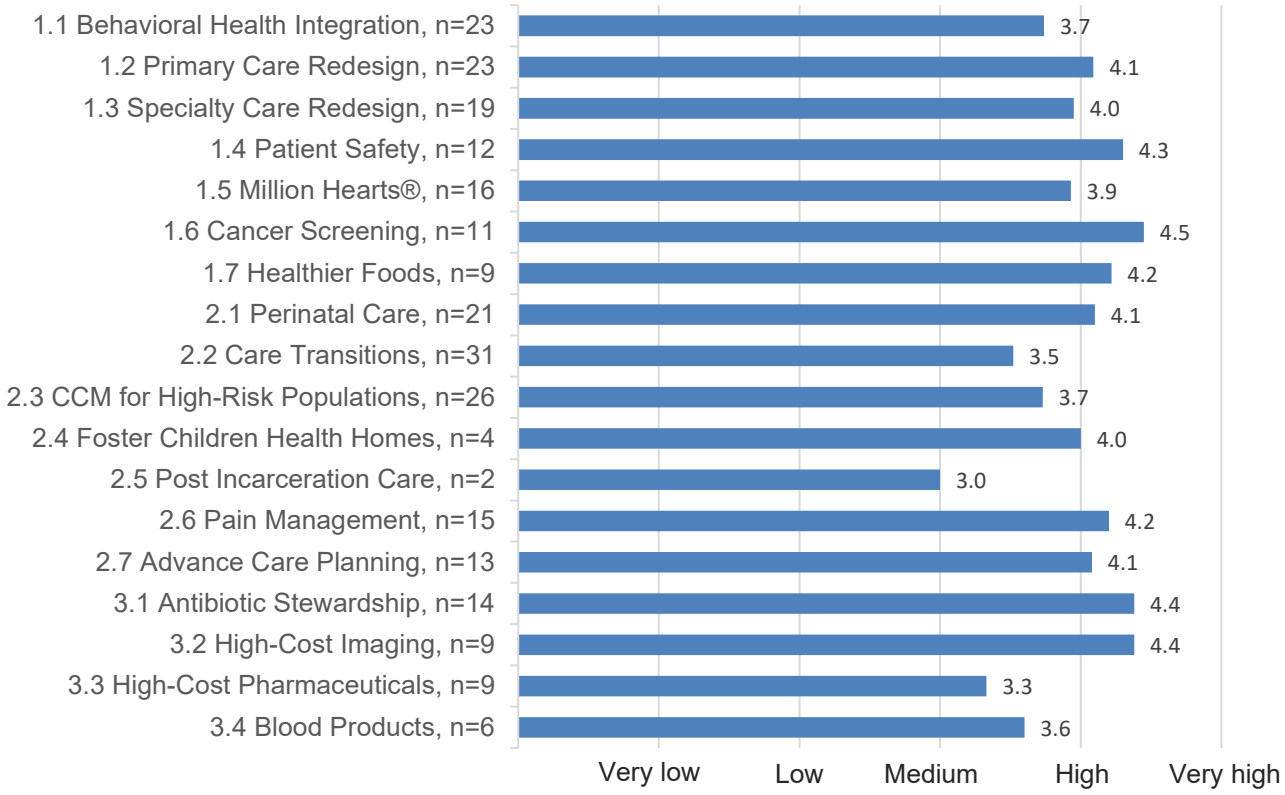
Source: UCLA analysis of the final survey data, implemented February to April 2020.
Notes: N=51 hospitals participated in the final survey. Percentages reflect the proportion of hospitals reporting that the factor is a reason for continuing PRIME projects after external support for PRIME ends.

Ratings of Overall Sustainability of PRIME Projects

Hospitals were asked to rate the general sustainability of each PRIME project when PRIME ends. Hospitals reported the highest ratings for sustainability of Projects 1.6

Cancer Screening, 3.1 Antibiotic Stewardship, and 3.2 High-Cost Imaging (Exhibit 18). In contrast, ratings of sustainability were lowest for Projects 2.5 Post Incarceration Care and 3.3 High-Cost Pharmaceuticals. As shown in Appendix E: Survey Results by Hospital Type, ratings of sustainability of PRIME projects varied by hospital type. For example, DPH UC hospitals reported the highest ratings for Projects 1.5 Million Hearts (5.0), 1.6 Cancer Screening (5.0), and 3.2 High-Cost Imagery (5.0) and lowest for Project 3.3 High-Cost Pharmaceuticals (3.0). DPH County hospitals reported the highest sustainability ratings for Project 3.1 Antibiotic Stewardship (4.7) and lowest for Project 3.4 Blood Products (2.5).

Exhibit 18: Sustainability of PRIME Projects after the End of the Program



Source: UCLA analysis of the final survey data, implemented February to April 2020.
Notes: N=51 hospitals participated in the final survey. Ratings of PRIME project sustainability were on a scale from 1 (very low) to 5 (very high). The "n" represents the number of hospitals participating in each project in DY 15. CCM: complex case management.

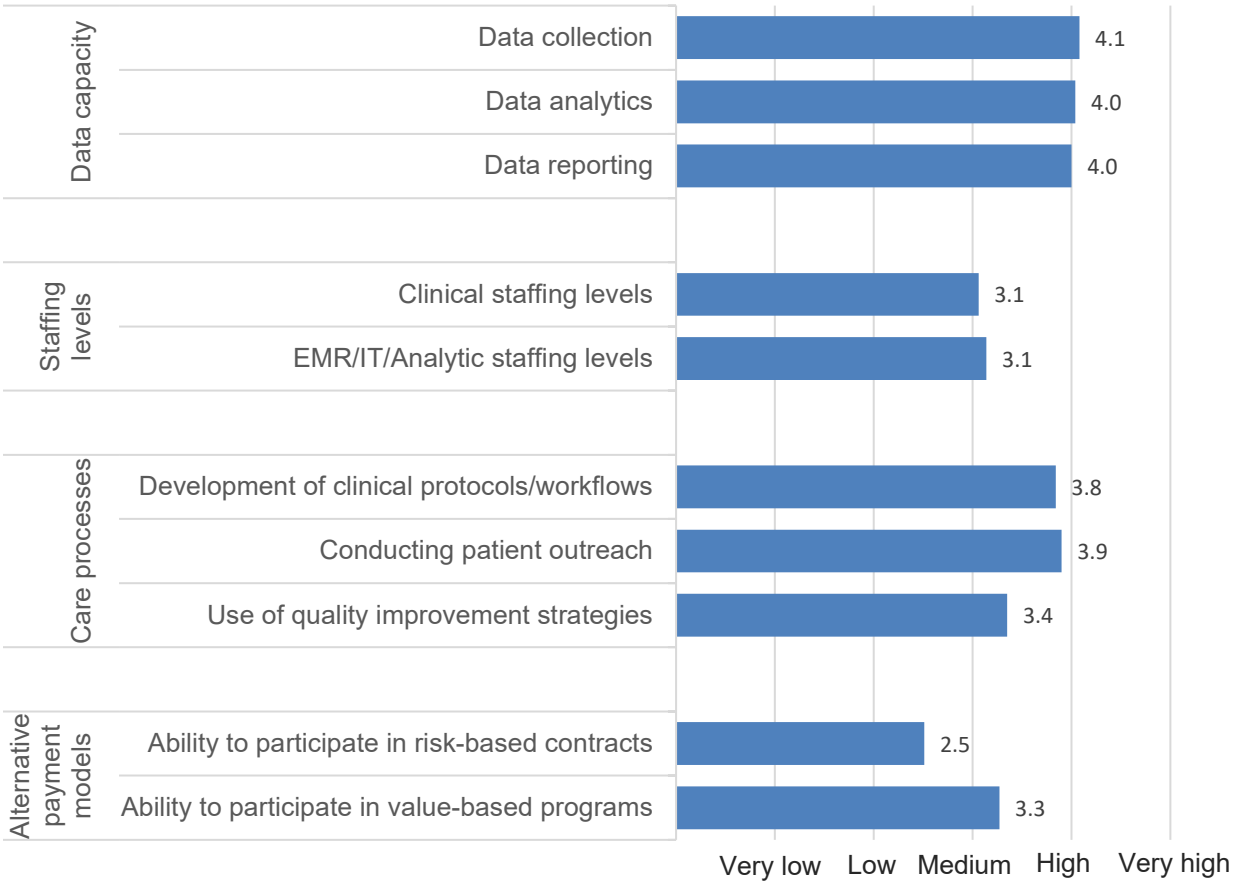
Overall PRIME Impact

Hospitals were asked to report on impact of PRIME on organizational capacity, participation in risk-based arrangements, the Triple Aim, and internal and external collaborations, as well as unexpected PRIME impacts.

Impact of PRIME on Organizational Capacity

Hospitals rated the impact of PRIME on data capacity, staffing levels, development of care processes, and ability to use alternative payment models (Exhibit 19). Hospitals rated impact of PRIME on promoting capacity for data collection, analytics, and reporting to be the highest (4.1, 4.0, and 4.0, respectively). The impact on ability to use alternative payment models was rated lowest, particularly for ability to participate in risk-based contracts (average rating 2.5). As shown in Appendix E: Survey Results by Hospital Type ratings of the impact of PRIME by hospital type differed in a few instances. Ratings of the impact of PRIME on the ability to participate in risk-based contracts was rated lowest among DPH UC (2.2), DPH County (2.7), DMPH non-CAH (2.8), and DMPH CAH (2.2). However, DPH UC hospitals found PRIME to promote the most capacity in conducting patient outreach (3.8) while DPH County hospitals found PRIME to promote the most capacity in data collection, analytics, and reporting (4.3). DMPH non-CAH found PRIME to promote the most capacity in data reporting (4.1) and development of clinical workflows (4.0). DMPH CAH found PRIME to promote the most capacity in data collection (average rating 4.3).

Exhibit 19: Hospital Ratings of Impact of PRIME on Organizational Capacity



Source: UCLA analysis of the final survey data, implemented February to April 2020.
Notes: N=51 hospitals participated in the final survey. Ratings of PRIME impact were on a scale from 1 (very low) to 5 (very high). Values in the exhibit represent mean ratings.

Impact on Risk-based Medi-Cal Managed Care Contracts

In the final survey, hospitals were asked to report the number of primary care Medi-Cal managed care organization (MCO) contracts they had, and the number of patients who were assigned to the PRIME hospital as the primary care provider among their PRIME-eligible population. All DPHs and almost all DMPHs reported at least 1 managed care contract during PRIME (Exhibit 20). Hospitals reported a total over 788,000 PRIME patients enrolled in a Medi-Cal managed care plan for their primary care assignment, including 631,000 in DMPH County hospitals, 40,000 in DPH UC hospitals, 101,000 in DMPH non-CAHs, and 16,000 in DMPH CAHs.

Exhibit 20: Medi-Cal Managed Care Enrollment for Primary Care by Hospital Type

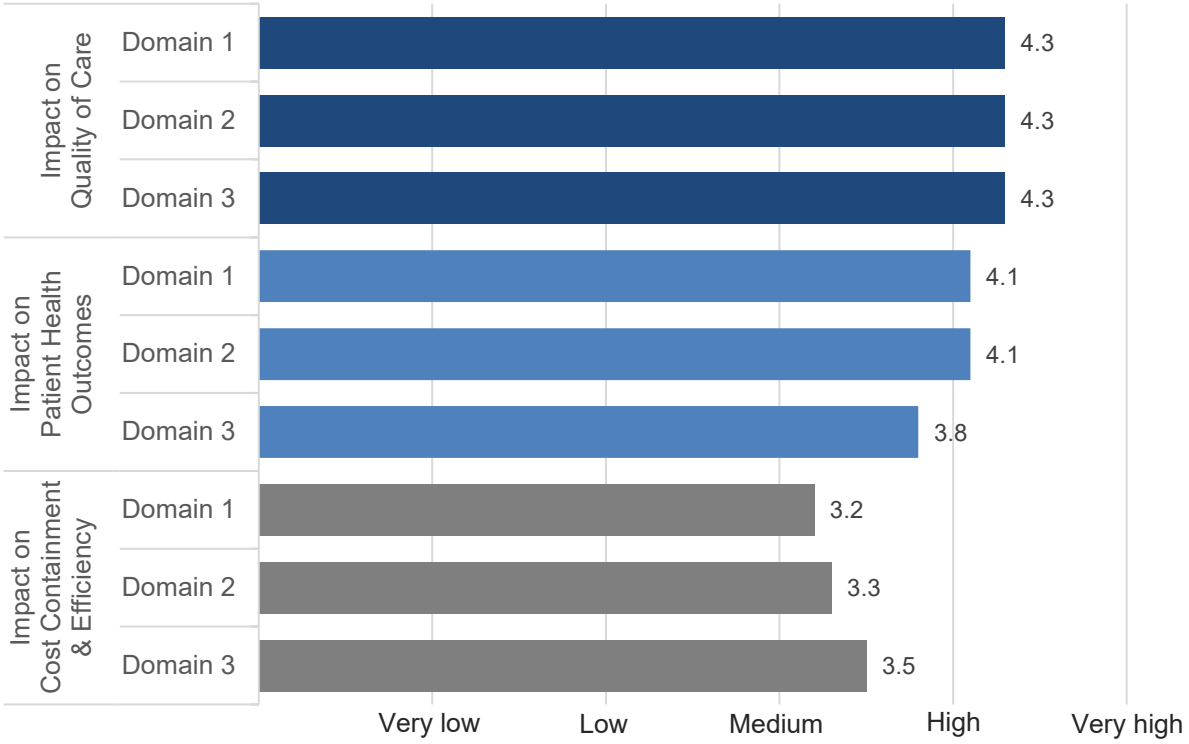
Medi-Cal Managed Care Enrollment	All Hospitals	DPH UC	DPH County	DMPH non-CAH	DMPH CAH
Proportion of Hospitals with at Least 1 Medi-Cal MCO Contract	94%	100%	100%	88%	94%
Average Number of Medi-Cal MCO Contracts [a]	1.9	1.8	1.6	2.5	1.6
Total Estimated Number of Medi-Cal MCO Primary Care Enrollees in PRIME Hospitals who are PRIME Eligible (in thousands) [b]	788	40	631	101	16

Source: UCLA analysis of the final survey data, implemented February to April 2020.
Notes: N=51 hospitals participated in the final survey. Values noting number of patients have been rounded to the nearest 1000. MCO: managed care organization.
[a] Average calculated among hospitals with any MCO primary care enrollment.
[b] Represents the number of the total DY14 PRIME eligible population that was enrolled in Medi-Cal MCO (managed care organization) for their primary care assignment. Values represent totals of all hospitals of each type. Data reported by 4 hospitals (1 DPH, 1 DMPH non-CAH, and 2 DMPH CAHs) was excluded after a check of validity. Analysis of Medi-Cal MCO population excludes managed care population for specialty care services.

Hospital Perceptions of Impact of PRIME on Triple Aim

In the final survey, hospitals were asked to rate the impact of PRIME on the Triple Aim of quality of care, patient outcomes, and cost containment for each domain in which they participated. On average, hospitals reported the highest impact of PRIME domains on quality of care (4.3) and patient health outcomes (range 3.8 to 4.1), and lower ratings for the impact of PRIME on cost containment (range 3.2 to 3.5; *Exhibit 21*).

Exhibit 21: Hospital Perceptions of Impact of PRIME on the Triple Aim by Domain

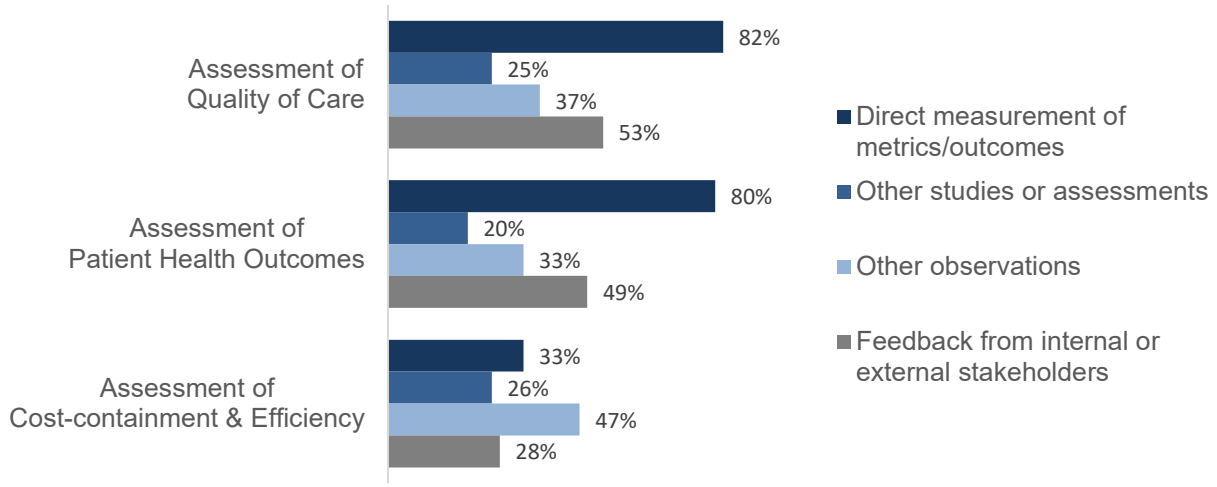


Source: UCLA analysis of the final survey data, implemented February to April 2020.
Notes: N=51 hospitals participated in the final survey. Ratings of PRIME domain impact on the Triple Aim were on a scale from 1 (very low) to 5 (very high). Values in the exhibit represent mean ratings.

Hospitals were asked to report how they assessed the impact of PRIME on Triple Aim, categorized as direct measurement of PRIME metrics or outcomes, other studies or assessments (e.g., readmission rates), other observations (e.g., anecdotal observations), and feedback from internal or external stakeholders (e.g., patient satisfaction, hospital recognition).

Exhibit 22 shows that hospitals perceptions of impact of PRIME on quality of care were most frequently (82%) based on direct measurement of metrics or outcomes and least frequently (25 to 53%) based on other more general indicators such as readmission rates, patient satisfaction, and feedback from stakeholders. A similar pattern was observed for perceptions of impact on health outcomes. However, the perceived impact on efficiency was based most frequently on observations that may have been anecdotal (47%) followed by direct measurement (33%).

Exhibit 22: Methods of Assessing PRIME's Impact on Triple Aim



Source: UCLA analysis of the final survey data, implemented February to April 2020.
Notes: N=51 hospitals participated in the final survey.

Hospitals provided description of how they formed perceptions of PRIME's impact on the Triple Aim and examples of types of information they used to form these perceptions (Exhibit 23). Examples of direct measurement of metrics/outcomes included measurement of blood pressure and diabetes control. Examples of other studies or assessments were examination of utilization rates (e.g., readmissions, care visits) and pilot studies. Examples of other observations were examination of clinical workflows and anecdotal observations. Feedback from patients, staff, providers, and health plans, or external recognition of their quality improvement work were other examples of how hospitals formed perceptions of impact.

Exhibit 23: Methods of Assessment of PRIME's Impact on the Triple Aim

Method of Assessment	Examples
Direct Measurement of metrics/outcomes	• "Blood pressure in control, IVD monitoring patients for appropriate aspirin/anti-thrombotic use, lower C-section rates, and higher rates for exclusively breast milk fed babies, higher adherence to high cost pharmaceutical medications." • "Comprehensive Diabetes poor control greater than 9... patients are being referred to Diabetes Education program to learn on how to decrease their A1c, this, in turn, is creating better outcomes for patient keeping them out of the ER or inpatient due to Diabetes complications and other chronic conditions that are a direct reflection of previously being poor controlled."

Method of Assessment	Examples
	• "Reducing the postpartum hemorrhage, c/section, uncontrolled diabetes and hypertension, hospital readmission rates have an impact on cost containment."
Other studies or assessments	• "We have reduced our readmissions rate from 24% to 17% and…C-sections from 27% to 22% preventing unnecessary readmission and procedures." • "Recurring daily tracking of…several engagement and care pilot studies have all highlighted improvement in the overall quality of patient care delivered, or improved outcomes by patients." • "The data for calculating cost savings, such as internal measures of costs per visit across the system as compared to external benchmarks for cost, such as those provided by CMS for MACRA MIPS Cost Category."
Other observations	• "The project further improved the clinic workflow and office efficiency with huddles, nurse protocols for orders, and pre-visit preparation." • "Anecdotal observations"
Feedback from internal or external stakeholders	• "The collaboration with our Health Plans provide additional support of improved quality of care. Patient experience scores have improved. Patient and Family Advisory Team provide input on the patient experience, as well as providing recommendations to improve the patient experience." • "Feedback from the clinic staff has shown us they appreciate the standardization that has occurred over the last few years as a direct result of PRIME." • "Provider and health plan feedback indicates patient care has improved." • "[We] received a quality leadership award for performance excellence for redesigning heart failure clinic to improve access, ensure supportive transitions of care, and address social needs."

Source: UCLA analysis of the final survey data, implemented February to April 2020.
Notes: N=51 hospitals participated in the final survey.

Impact of PRIME on Promoting Internal and External Collaborations

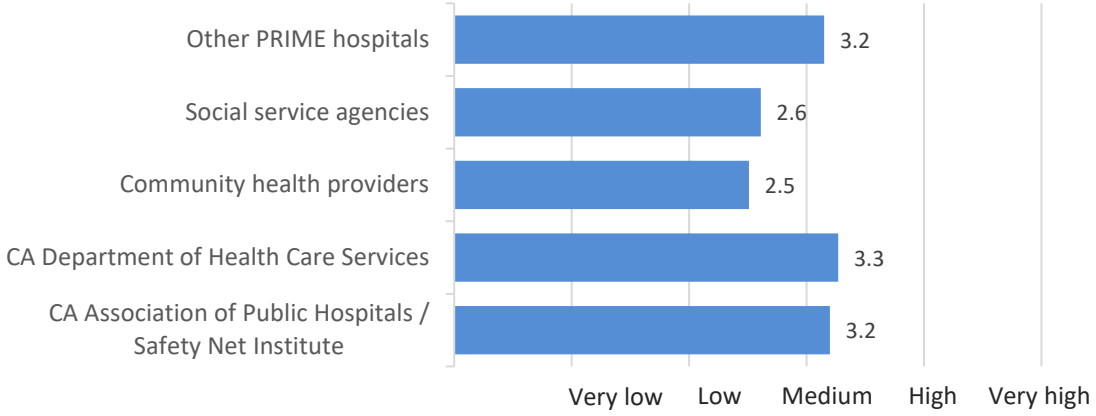
In the final survey, hospitals were asked to rate the impact of PRIME on promoting collaboration between leadership, clinicians, and staff within of the hospital. The impact of PRIME on collaboration was rated highest between clinical and EMR/analytics staff, senior leadership and clinical staff, and administrative staff and frontline providers (4.0) and lowest for primary care and specialty care providers (3.5; Exhibit 24).

Exhibit 24: PRIME Impact on Collaboration within Hospital, Average Rating among Participating Hospitals

Source: UCLA analysis of the final survey data, implemented February to April 2020.
Notes: N=51 hospitals participated in the final survey.

Hospitals were asked to rate the impact of PRIME on promoting collaboration between various stakeholders outside of the hospital. In rating PRIME's impact on collaboration with entities outside of the hospital, hospitals reported higher impact on collaboration with the California Department of Health Care Services (3.3), other PRIME hospitals (3.2), and California Association of Public Hospitals and Safety Net Institute (3.2) (Exhibit 25). Ratings of the impact of PRIME on promoting collaboration were lower for social service agencies (2.6) and community health providers (2.5).

Exhibit 25: PRIME Impact on Collaboration Outside Hospital, Average Rating Among Participating Hospitals



Source: UCLA analysis of the final survey data, implemented February to April 2020.
Notes: N=51 hospitals participated in the final survey.

Unexpected Impacts of PRIME

Overall, 20 hospitals (39%) reported that there were unintended adverse consequences of implementing PRIME (Data not shown). For example, 10 hospitals described an increase in administrative and clinical burden placed on providers and staff associated with implementing PRIME, which in some cases contributed to resistance or burnout (Exhibit 26). In addition, some hospitals noted that investment of resources in PRIME led to lower prioritization of competing demands (5). In some hospitals, PRIME highlighted limitations in the ability to address the full spectrum of patient needs (4), such as social determinants of health or an increased demand for behavioral health services, which would require further investment. Finally, a few hospitals discussed the difficulties associated with implementing the data infrastructure necessary for PRIME (3) and implementing metrics that were not always aligned with organizational priorities or clinical experiences (3).

Exhibit 26: Hospitals Reports on Unexpected Adverse Consequences of Implementing PRIME

Unintended Adverse Consequences	Hospitals	Illustrative Example
Provider/staff resistance, burden, or burnout	10	"[There was] additional administrative burden on clinicians to document activity that was being performed but not captured in a discreet field in the EHR (and able to be pulled automatically)."

Unintended Adverse Consequences	Hospitals	Illustrative Example
High cost or use of resources	5	"Other operational needs were placed at a lower priority due to the amount of resources required by PRIME."
Limited ability of hospital to address patient needs	4	"One unintended negative consequence was due to screening all patients for behavioral health needs is the overall community need for even more outpatient mental health services for this community...we continue to increase the time with providers and will soon be at capacity."
Difficulty/complexity of building capacity for data infrastructure and processes	3	"Changing Electronic Health Records in the middle of PRIME and having to rebuild metric queries...this proved challenging especially in helping to improve metrics."
Metrics not aligned with priorities or clinical experience	3	"Some metrics just didn't age well, so we put a lot of resources to meet them even though they either 1) added little clinical value, 2) represented outdated clinical guidance, or 3) didn't reflect local leaders' priorities."

Source: UCLA analysis of the final survey data, implemented February to April 2020.
Notes: N=51 hospitals participated in the final survey.

The majority of hospitals (38, 75%) reported that implementing PRIME brought unexpected value (Data not shown). Most commonly, 12 hospitals described an unexpected value of PRIME in driving engagement among providers and staff in training, leadership, and quality improvement activities (Exhibit 27).

In addition, hospitals commonly described the positive impact of PRIME on promoting data-driven processes (9), standardizing care processes (6), and promoting a focus on population health and quality improvement at the organizational level (6). Hospitals also noted unexpected effects of implementing PRIME on driving collaboration within the hospital (7; e.g., breaking down silos), with DHCS and other PRIME hospitals (6; e.g., to share best practices), and with community partners and patients (8). A few hospitals noted the positive effect of PRIME on specific patient outcomes (4, e.g., reducing hospitalizations), the ability to obtain additional funding (3), and in supporting care improvements for populations that lacked a previous focus (3).

Exhibit 27: Unexpected Value of Implementing PRIME

Unexpected Values	Hospitals	Example
Engaged providers and staff in training and leadership in quality improvement	12	"We knew that there would be staff involvement however, their level of engagement exceeded expectations and added unexpected value."
Promotion of data-driven quality improvement	9	"Data systems and analytics, and interoperability have become "mainstream" to clinicians."
Collaboration and engagement with community partners and patients	8	"Positive patient engagement and feedback Improved community collaboration that includes chronic disease self-management programs, monthly community outreach events such as project mana food distribution, affordable labs, Family Resource centers, etc."
Collaboration within hospital	7	"We were able to discover the disconnect between the clinical side of our hospital and the administration side, and work together."
Collaboration with DHCS and other PRIME hospitals	6	"We didn't anticipate the degree to which other hospitals would openly share best practices, lessons learned, policies, and materials."
Standardization of care processes	6	"PRIME also drove standardization of processes and clinical documentation across the agency."
Organizational focus and priority on quality improvement and population health	6	"…this was the first "population health" project of its kind for our hospital, and it really moved the needle on our ability to conceptualize the relationship of the hospital to the overall community health."
Improved patient outcomes	4	"[PRIME] raised awareness and changes in patient care to focus on outcomes rather than volume."
Set stage for obtaining additional funding or containing costs	3	"[PRIME] "fast tracked" [the] implementation of [medication-assisted treatment] MAT program due to the awareness in need and additional funding related to grants because of this."
Supported a focus on specific conditions or populations	3	"[PRIME] reduced stigma for behavioral health concerns."

Unexpected Values	Hospitals	Example
(e.g., behavioral health, palliative care)		

Source: UCLA analysis of the final survey data, implemented February to April 2020.
Notes: N=51 hospitals participated in the final survey.

Summary of Hospital Perspectives on PRIME Key Findings

Hospitals reported on progress in program implementation including synergies between projects and with other initiatives, sustainability of PRIME projects, and their perspectives on the overall impact of PRIME.

Hospitals appeared to select some optional projects due to implicit synergies. For example, DPHs may have concurrently selected optional Projects 2.6 Pain Management, 3.2 High-Cost Imaging, and 3.3 High-Cost Pharmaceuticals due to synergies in management of pain with reduction in use of specific medications or imaging. Among DMPH non-CAHs, synergies were likely related to concurrent selection of Project 2.2 with Projects 2.3 Complex Case Management for High-Risk Populations, 2.7 Advance Care Planning, 3.1 Antibiotic Stewardship, and 3.2 High Cost Imaging. Among DMPH CAHs, synergies were most likely between Projects 1.1 and 2.6 concurrently selected. In addition, hospitals reported high ratings of the synergy of PRIME Projects collectively with their organizational mission or goals and concurrent quality improvement efforts, and with QIP 1.0 among DPHs.

Hospital ratings indicated that they had achieved the majority of their project goals to date. Among DPHs, ratings of achievement of goals were highest for Projects 2.4 Foster Children Health Homes, 3.2 High-Cost Imaging, and 3.4 Blood Products. DMPH non-CAHs noted highest ratings for Projects 1.7 Healthier Foods, 3.2 High-Cost Imaging and 3.3 High-Cost Pharmaceuticals, while DMPH CAHs noted highest ratings for Projects 1.4 Patient Safety, 1.7 Healthier Foods, and 2.6 Pain Management.

Despite their efforts, hospitals reported not finishing some planned activities. Overall, 36 of the 51 surveyed hospitals reported 104 unfinished PRIME activities that were planned, with most activities related to Projects 1.1 Behavioral Health Integration (15), 1.2 Primary Care Redesign (31), 1.3 Specialty Care Redesign (17), and 2.2 Care Transitions (13). In addition, 6 hospitals noted 11 overarching unfinished activities, such as further improvements in data infrastructure and increasing their quality improvement workforce. Illustrative examples of unfinished activities included developing registries and partnerships, increasing SBIRT and cancer screening, collecting REAL/SOGI data, and expanding use of specialty telehealth visits.

Hospitals rated staff effort, financial investment, and overall difficulty of implementation and these ratings varied by PRIME project. Ratings of staff effort were the highest for Project 2.4 Foster Children Health Home. Ratings of financial investment were highest

for Projects 1.1 Behavioral Health Integration and 2.5 Post Incarceration. Ratings of highest levels of difficulty were reported for Projects 2.4 Foster Children Health Homes and 2.5 Post-Incarceration Care. Hospitals noted that the most important factors to their success in implementing PRIME were the high prioritization of PRIME by senior leadership and the integration of PRIME into their organization's strategic mission.

Sustainability of PRIME projects appeared likely given hospital reports on several indicators of sustainability. Data showed a high level of integration of PRIME activities into routine standards of care for the majority of PRIME projects. Hospitals rated the highest levels of integration for Project 3.2 High-Cost Imaging and Project 2.4 Foster Children Health Homes (4.8 and 4.5, respectively), and lowest integration for Project 2.5 Post Incarcerated Care and Project 3.3 High-Cost Pharmaceuticals (3.5 and 3.7, respectively).

Hospitals reported that they intended to implement the vast majority of PRIME projects, either fully or in part, after the end of the program. Few hospitals noted that they did not intend to continue PRIME projects in which they had participated. The majority of hospitals noted that numerous sources of internal support at the staff, process, and organization level were drivers of the sustainability of PRIME projects which they intended to continue. These drivers included the realized benefits of the program to internal stakeholders, the establishment of clinical infrastructure, and the adaptability of PRIME processes to the future needs of the organization. Fewer hospitals reported that they anticipated that operational funding would be available after PRIME to support personnel or resources. Ratings of overall sustainability of PRIME projects after the end of the program were variable, with Projects 1.6 Cancer Screening, 3.1 Antibiotic Stewardship, and 3.2 High-Cost Imaging receiving the highest ratings, and Projects 2.5 Post-Incarceration and 3.3 High-Cost Pharmaceuticals receiving the lowest ratings of sustainability beyond PRIME.

Hospitals reported higher impact of PRIME on their data capacity (i.e., collection, analytics, reporting), and lower impact on their ability to participate in risk-based contracts. All DPHs and almost all DMPHs reported having at least 1 contract with a managed care organization. As a whole, hospitals reported approximately 788,000 Medi-Cal managed care enrollees within their PRIME-eligible population. Hospitals perceived that the highest impact of PRIME was on quality of care, followed by patient health outcomes, and cost containment. Hospitals noted the highest impact of PRIME on improving internal collaboration between clinical staff and data analytics staff, as well as their external collaborations with the CA Department of Health Care Services, and California Association of Public Hospitals and Safety Net Institute. Hospitals reported on common but unintended adverse consequences of implementing PRIME such as provider and staff resistance, burden, or burnout. They also reported multiple unexpected values of implementing PRIME such as driving the engagement of providers and staff in opportunities for training and leadership in quality improvement, and promoting data-driven quality improvement within the organization.

Trends in Metric Achievement Values by DY 14

During PRIME implementation, hospitals reported on their progress in mid-year and year-end reports, which included a self-reported rate for metrics (achievement rates). Hospitals earned an achievement value (AV) as an indication of their progress toward the target (see Interim Report Payment Methodology for more information) and DHCS issued payments to hospitals by using the achievement value to calculate an eligible payment amount. These achievement values ranged from 0 (not achieved) to 1 (full achievement). Thus, achievement values are one of the indicators of PRIME hospitals' success in improving or maintaining care processes and outcomes of care. UCLA identified the average achievement value in each demonstration year by hospital type, financial incentive, and process vs. outcome metrics.

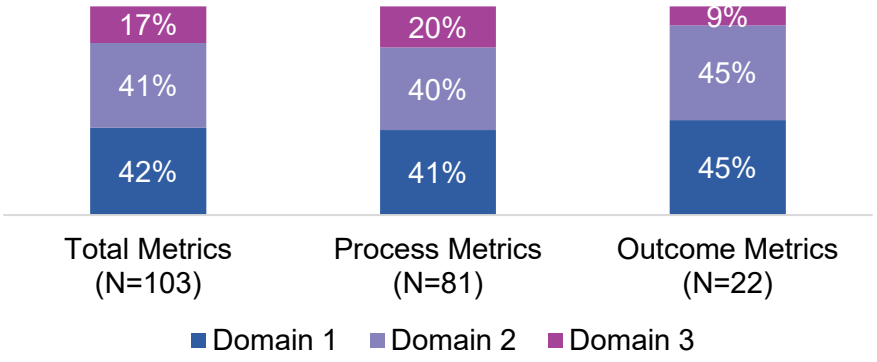
Metrics were categorized as pay-for-reporting (P4R) for the hospitals' first reporting year, then many metrics transition in later years to be pay-for-performance (P4P). For the first 2 years of PRIME, P4R or P4P metric status varied depending on whether a hospital was a DPH or DMPH. In DY 11 all metrics began as P4R for DPHs; most DMPHs were working on Infrastructure Building Milestones and did not report metric data. Subsequently, in DY 12, some metrics were a mix of P4R or P4P, depending on whether the hospital had reported in DY 11. Most DMPHs started reporting in DY 12, so their metrics were categorized as P4R. By DY 13, the P4R or P4P metric status was consistent across all hospital types. In addition to the DHCS classification of the specific financial incentive (P4R or P4P), the UCLA evaluation assessed metrics as either a process or outcome metric. Process metrics indicated better care or successful changes in implementing project objectives. Outcome metrics indicated better health or improvements in population health indicators.

All metrics that were partially or fully achieved (a value greater than 0) contributed to the achievement calculations within this section. Detailed methods are described in Interim Report Achievement Value Analysis: Methodology and Metric-Specific Averages, by Hospital Type.

PRIME Metric Descriptions

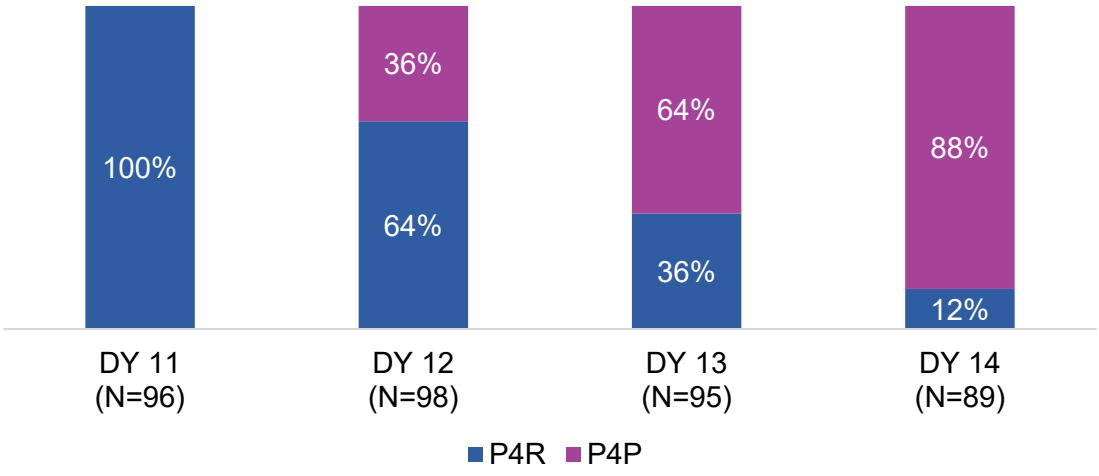
Overall, a total of 103 metrics across 18 projects were implemented by hospitals during PRIME (Exhibit 28). Of the 103 PRIME metrics, 81 (79%) were classified as process metrics, and 22 (21%) were classified as outcome metrics. Across the three domains, the proportion of outcome and process metrics was similar, except for fewer outcome metrics than process metrics in Domain 3.

Exhibit 28: PRIME Metrics by Metric Type and Domain



The exact number of implemented metrics varied by demonstration year, ranging from 98 metrics in DY 12 to 89 in DY 14 (Exhibit 29).

Exhibit 29: PRIME Metrics by Payment Type and Demonstration Year



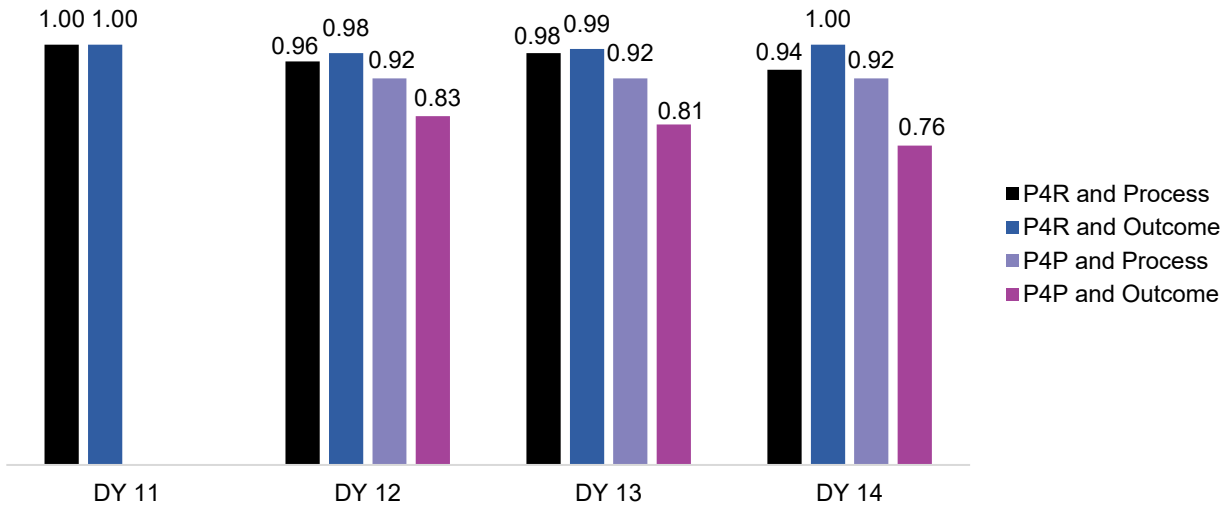
Notes: DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance.

DPH Performance by Average Achievement Values

DPHs were required to participate in Projects 1.1, 1.2, 1.3, 2.1, 2.2, and 2.3. In DY 11, all metrics were classified as P4R, and DPHs fully achieved all metrics for all projects, resulting in an average achievement value of 1 for both process and outcome metrics in that year (Exhibit 30). From DY 12 to DY 14, achievement values for these metrics remained high, particularly for those designated as outcome metrics.

In DY 12 and later, some metrics transitioned from P4R to P4P, and achievement values declined for some of these metrics. One possible explanation for these declines may be that the P4P metric targets were typically reset annually to be more challenging, based on the prior year's performance rates and the applicable benchmarks (Interim Report PRIME Funding and Payment Methodology).

Exhibit 30: Average Achievement Value for DPHs by Metric Type



Source: UCLA Analysis of the hospital-reported data, April to June 2020.

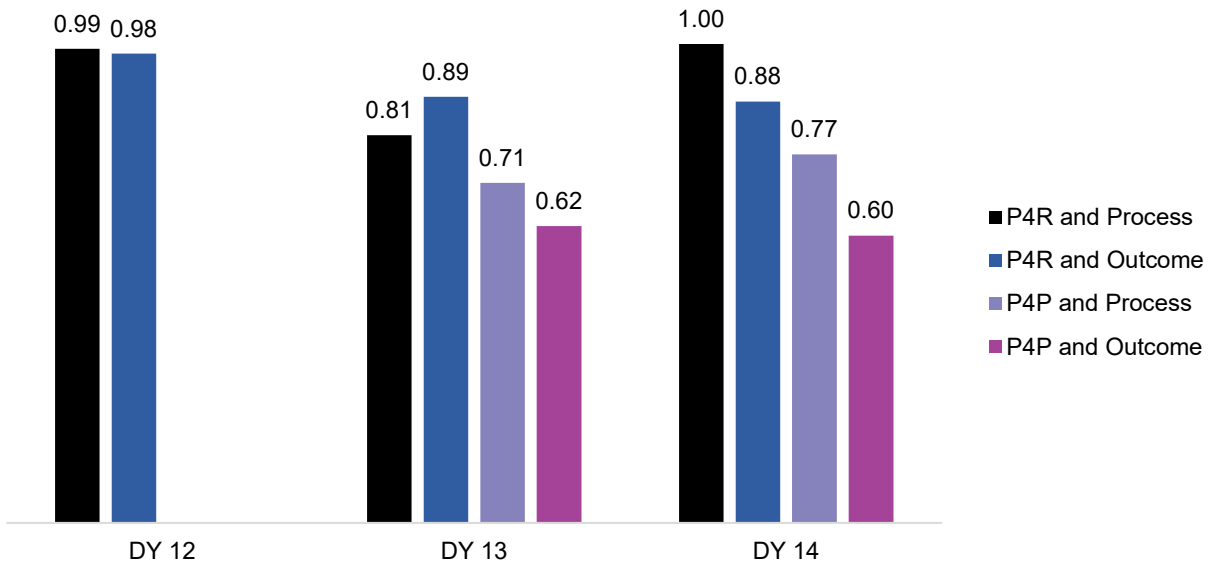
Notes: P4R: pay-for-reporting, P4P: pay-for-performance. See Interim Report Achievement Value Analysis: Methodology and Metric-Specific Averages, by Hospital Type for further information.

DMPH Performance by Average Achievement Values

Metric achievement pattern analysis for DMPHs was based on DY 12 (P4R for all but 2 hospitals who reported in DY 11) through DY 14; most DMPHs did not report metric data in DY 11, as they were reporting on PRIME infrastructure building milestones. In DY 12, almost all DMPHs fully achieved the P4R metrics for their projects (Exhibit 31). The average achievement value was close to 1 for both process and outcome metrics (0.99 and 0.98). However, there was a decline in the P4R achievement values in DY 13, with outcome metrics (0.89) outperforming process metrics (0.81). By DY 14, the average achievement value for process P4R metrics increased to 1, while the value for outcome metrics remained at 0.88. The drop in P4R metrics in DY 13 may be explained by exclusion of data from hospitals that did not reach the minimum denominator of 30 for certain metrics in different years.

In DY 13 and later, some metrics transitioned from P4R to P4P, and achievement values declined for these metrics. By DY 14, the average achievement value for process P4P metrics was 0.77 and for outcome P4P metrics was 0.60.

Exhibit 31: Average Achievement Value for DMPHs by Metric Type



Source: UCLA Analysis of the hospital-reported data, April to June 2020.

Notes: P4R: pay-for-reporting, P4P: pay-for-performance. See Interim Report Achievement Value Analysis: Methodology and Metric-Specific Averages, by Hospital Type for further information.

Summary of Key Findings for Trends in Metric Achievement Value by DY 14

A total of 103 metrics across 18 projects were implemented by hospitals during PRIME. The majority of these, 81 were process and 22 were outcome metrics. The distribution of metrics was even for Domain 1 (41%) and Domain 2 (41%) metrics. All 96 metrics in DY 11 were P4R, but the proportion of P4R metrics declines in DY 12 (64%), DY 13 (36%), and DY 14 (12%). For DMPHs, all metrics were P4R during DY 12 without the 30-patient minimum criteria (except for 2 hospitals that reported in DY 11).

Hospitals received payments depending on achievement values (0 to 1). The examination of the average achievement values for metrics with values greater than 0 showed perfect or very high average achievement values for P4R metrics over time. However, the average achievement values for P4P outcome metrics was somewhat lower (e.g., 0.83 in DY 12 and 0.76 in DY 14). A similar pattern was observed for DMPHs (e.g., 0.62 in DY 13 and 0.60 in DY 14 for P4P outcome metrics).

Trends in Project Metric Performance by DY 14

UCLA used the hospitals-reported performance levels for each metric at the end of each demonstration year (DY) to assess the amount of change in performance levels from DY 11 to DY 14 and whether this change was in the intended direction. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 11 and DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, all metrics had the same P4R or P4P designation for both DPHs and DMPHs. UCLA further categorized the metrics as indicators of process or outcome.

Hospital PRIME reports included the achievement rate and the numerator and denominator used to calculate that rate for each metric, for each DY. UCLA calculated the weighted average for each metric and excluded metrics with a denominator of less than 30 in these calculations following PRIME's criteria. PRIME followed the National Committee for Quality Assurance (NCQA) guidance that considered such rates to be too small to be valid (PPL 17-002; PPL-19-001). DMPHs may not have reported data if they were working on Infrastructure Building Milestones or had other constraints on data availability. Most DMPHs did not report data in DY 11.

A total of 103 metrics across 18 projects were ever reported by hospitals during PRIME. The number of metrics changed over time, reflecting the addition of sub-rates to better measure progress, retiring metrics that were no longer considered representative or recommended, and replacement of metrics over time as the projects progressed and specific tasks were accomplished. For example, 1.2.6 Documented REAL and/or SOGI disparity reduction plan and 1.2.9 Primary Care Redesign metrics stratified by REAL categories and SOGI were reported only in DY 12. After that, 1.2.10 REAL and/or SO/GI disparity reduction began in DY 13 and continued to the end of PRIME.

UCLA analyzed the year-end hospital-reported metric reports for each DY to assess the change in performance levels from DY 11 to DY 14. Additionally, this trend was assessed for improved performance as specified by the metric (i.e. readmission rates are intended to decrease over time). This trend analysis excluded metrics that were reported for only one year (so change in performance level could not be measured), and excluded metrics without a continuous numeric value (such as attesting to having a palliative care team). In addition, if metrics were reported by hospitals as sub-rates then individual sub-metric trends could be assessed with some limitations, which is addressed in the specific metric analysis. For example, Metric 1.4.1 Abnormal Results Follow-Up: Percent of Abnormal Results with Appropriate and Timely Documentation and Follow-Up was reported by hospitals as 3 individual sub-rates, whereas Metric 1.4.2 - NQF 2371 Annual Monitoring for Patients on Persistent Medications includes analysis of multiple elements that are reported by hospitals together as one rate. Thus, an overall total of 106 (DPHs) and 88 (DMPHs) trends were included in metric performance

analyses. The time periods varied by metric and hospital type. Most DMPH hospitals began reporting metric data in DY 12, whereas DPHs started reporting in DY 11. Trend breaks were issued in DY 12 (PPL 17-007) and DY 14 (PPL 19-002 and PPL 19-003). In DY 12, 4 metrics were impacted, thus, a trend was not calculated for these metrics. In DY 14, metrics 4 metrics had trending breaks that did not impact the present analysis. Each trend was then assessed on whether it had changed in the intended direction. Detailed methods are included in the Interim Report.

Project 1.1 – Integration of Behavioral Health & Primary Care

Project Overview and Summary of Key Findings

Project 1.1 was designed to promote behavioral health and primary care integration in order to improve outcomes of care for patients with behavioral health conditions. Main goals of the project included: 1) early identification of behavioral health conditions; 2) comprehensive and appropriate treatment of behavioral health conditions; and 3) improvement of outcomes for patients with chronic medical and behavioral health conditions. Specific objectives can be found in Attachment Q.

By the end of DY 14, a total of 22 hospitals continued to participate and report metric performance for Project 1.1. This project was required for all 17 DPHs, and was an optional project for DMPHs, of which 5 participated through DY 14 and 2 dropped in DY 12. Detailed information on DPH and DPMH participation can be found in Appendix B. PRIME Project Selections.

Performance of the hospitals in Project 1.1 was measured by the following 7 metrics. Metrics 1.1.1a and 1.1.7 included sub-rates.

Exhibit **32***: PRIME Project 1.1 Metric Details*

Metric Name	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcome of Care
Alcohol and Drug Misuse Sub-rate #1: Brief Annual Screen	1.1.1.a	Increase	Process
Alcohol and Drug Misuse Sub-rate #2: Full Screen, Brief Intervention, and Referral to Treatment (SBIRT)	1.1.1.a	Increase	Process
Care Coordinator Assignment (deactivated after DY 12)	1.1.2*	Increase	Process
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	1.1.3.d	Decrease	Outcome
Depression Remission at 12 Months (deactivated after DY 12)	1.1.4	Increase	Outcome
Screening for Clinical Depression and Follow-Up	1.1.5.f	Increase	Process
Tobacco Use – Screening and Cessation Intervention	1.1.6.t	Increase	Process

Metric Name	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcome of Care
Depression Remission or Response for Adolescents and Adults (DRR): Follow-Up (added in DY 13)	1.1.7	Increase	Process
Depression Remission or Response for Adolescents and Adults (DRR): Depression Response (added for DY 13)	1.1.7	Increase	Outcome
Depression Remission or Response for Adolescents and Adults (DRR): Depression Remission (added for DY 13)	1.1.7	Increase	Outcome

Source: PRIME Metrics Specs, DY 14YE

*Notes: SBIRT: screening, brief intervention, and referral to treatment, DY: Demonstration Year * Denotes innovative metric.*

Both DPHs and DMPHs showed an overall improvement over time in 4 metrics (1.1.1.a, 1.1.5.f, 1.1.6.t, and 1.1.7). DPH Counties did not show improvement for Metric 1.1.2. DPH UCs did not show improvement for Metric 1.1.4. DMPH Non-CAHs did not show improvement for Metric 1.1.3.d. DMPH reporting for 2 metrics (1.1.2, 1.1.4) did not have a trend, as the metrics were only in effect for 1 demonstration year.

Metric 1.1.1.a – Alcohol and Drug Misuse Screening, Brief Intervention, and Referral to Treatment (SBIRT) and Brief Annual Screening

Metric 1.1.1.a measured the rates of screening for alcohol or drug misuse and appropriate intervention and referral to treatmen. Hospitals were intended to decrease future risks and complications by improving the detection of alcohol-related disorders and intervention. The original SBIRT metric became sub-rate #2 (full screening), thus the change over time could be calculated and the metric was P4P in DY 14. The new sub-rate #1 is for a brief annual screening and was P4R in DY 14. The denominator includes individuals in the PRIME Project 1.1 Target Population ages 12 years or older who had a qualifying outpatient service. SBIRT rates increased as intended for all hospital types.

*Exhibit **33**: PRIME Hospital-Reported Alcohol and Drug Misuse Screening, Brief Intervention, and Referral to Treatment (SBIRT) Rates for Metric 1.1.1.a (Sub-rate #2)*

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	3.29%	2.59%	5.24%	9.45%	6.16%	Yes
UC	2.31%	1.44%	2.20%	6.88%	4.57%	Yes
County	4.16%	3.71%	7.95%	11.80%	7.64%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	6.67%	11.90%	19.04%	12.37%	Yes
Non-CAH	---	0.50%	0.97%	2.61%	2.11%	Yes
CAH	---	14.23%	22.24%	41.81%	27.57%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11.

Exhibit 34: PRIME Hospital-Reported Alcohol and Drug Misuse Brief Screening Rates for Metric 1.1.1.a (Sub-rate #1)

DPH	DY 14 P4R
Total	39.12%
UC	22.58%
County	54.22%
DMPH	**DY 14 P4R**
Total	58.11%
Non-CAH	66.45%
CAH	46.56%

Source: UCLA analysis of the hospital-reported data, February to June 2020.

Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. This separate brief annual screening sub-rate came into effect for DY 14 and was applicable for the remainder of PRIME.

Metric 1.1.2 – Care Coordinator Assignment

Metric 2.3.1 measured the percentage of clients with an assigned care coordinator. Hospitals were intended to leverage care coordinators to more reliably ensure appropriate and timely delivery of care while also improving patient experience. This metric was retired after DY 12, so no data was reported for DY 13 or DY 14 and results for this metric are available in the Interim Report.

Metric 1.1.3.d –NQF 0059: Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)

Metric 1.1.3.d measured the rate of poor control (>9.0), missing, or incomplete HbA1c tests among diabetic patients (NQF 0059). Hospitals were intended to reduce the risk of microvascular complications, such as eye, kidney, and nerve diseases by maintaining control of HbA1c blood levels for individuals 18-75 years old. These rates declined as intended for all hospital types except Non-CAH DMPHs.

Exhibit **35***: PRIME Hospital-Reported Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) Rates for Metric 1.1.3.d*

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Decreased as Intended
Total	28.52%	26.41%	25.12%	24.80%	-3.71%	Yes
UC	19.52%	19.51%	20.47%	17.39%	-2.13%	Yes
County	31.04%	27.76%	26.07%	26.99%	-4.05%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Decreased as Intended**
Total	---	13.83%	18.54%	25.29%	11.46%	No
Non-CAH	---	10.34%	15.55%	24.48%	14.14%	No
CAH	---	35.34%	29.09%	27.55%	-7.79%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH.
---: DMPHs did not report data in DY 11.

Metric 1.1.4 – Depression Remission at 12 Months

Metric 1.1.4 measured the rate of adult patients with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrated remission at 12 months (NQF 0710). Hospitals were intended to increase remissions by improving patient care and behavioral health. Data is not reported because this metric was removed after DY 12 and replaced by Metric 1.1.7. Results for Metric 1.1.4 are available in the Interim Report.

Metric 1.1.5.f – Screening for Clinical Depression and Follow-Up

Metric 1.1.5.f measured the rate of adults ages 18 and older who received a standardized clinical depression screening, and if positive, received a follow-up plan (NQF 0418). Hospitals were intended to combat depression by improving proactive measures and ensuring patients received a thorough diagnosis and follow-up plan. Screening and follow-up rates increased as intended for all hospital types.

Exhibit **36***: PRIME Hospital-Reported Screening for Clinical Depression and Follow-Up Rates for Metric 1.1.5.f*

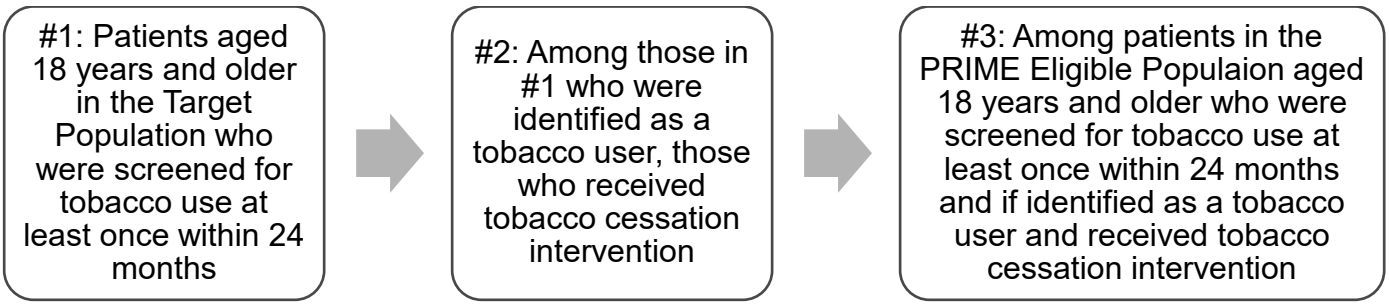
DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	17.77%	34.66%	54.81%	73.07%	55.30%	Yes
UC	14.71%	15.14%	38.92%	70.05%	55.35%	Yes
County	20.37%	48.44%	65.02%	75.14%	54.77%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	35.10%	63.05%	77.27%	42.17%	Yes
Non-CAH	---	51.00%	91.61%	87.35%	36.35%	Yes
CAH	---	17.79%	27.48%	58.12%	40.33%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11.

Metric 1.1.6.t –Tobacco Use – Screening and Cessation Intervention

Metric 1.1.6.t measured the rate at which patients aged 18 years and older were screened for tobacco use and received cessation intervention if identified as a tobacco user. Hospitals were intended to promote screening and intervention for tobacco users. There is good evidence to suggest such actions are successful in helping tobacco users quit. Tobacco Use – Screening and Cessation Intervention was revised with additional instructions in DY 14 to include 3 criteria, of which entities reported the 3rd (Exhibit 37). Tobacco use screening and cessation intervention rates increased as intended for all hospital types.

Exhibit 37: Criteria for reporting Tobacco Use-Screening and Cessation in DY 14



Source: PRIME Reporting Manual, DY 14.

Exhibit **38***: PRIME Hospital-Reported Tobacco Use: Screening and Cessation Intervention Rates for Metric 1.1.6.t*

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	81.64%	93.20%	95.94%	97.07%	15.43%	Yes
UC	92.58%	96.39%	96.87%	97.50%	4.92%	Yes
County	74.53%	90.63%	95.19%	96.74%	22.21%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	44.89%	83.74%	89.88%	44.99%	Yes
Non-CAH	---	52.88%	86.52%	91.88%	39.00%	Yes
CAH	---	31.66%	79.64%	87.01%	55.35%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH.
---: DMPHs did not report data in DY 11.

Metric 1.1.7 – Depression Remission or Response for Adolescents and Adults (DRR)

Metric 1.1.7 measured the number of patients aged 18 years and older who had an initial elevated PHQ-9 score who received a follow-up PHQ-9 screening that demonstrated depression response or remission within 4 to 8 months. Hospitals were intended to improve care for patients aged 12 or older with depression by thorough diagnosis and comprehensive treatment. This metric replaced Metric 1.1.4 – Depression Remission at 12 Months. Depression remission or response rates increased as intended for all hospital types.

Depression Follow-Up

Exhibit **39***: PRIME Hospital-Reported Depression Follow-Up Rates for Metric 1.1.7*

DPH	DY 13 P4R	DY 14 P4P	Change from DY 13 to DY 14	Increased as Intended
Total	24.42%	32.84%	8.43%	Yes
UC	25.14%	36.76%	11.61%	Yes
County	24.11%	30.44%	6.33%	Yes
DMPH	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 13 to DY 14**	**Increased as Intended**
Total	41.80%	59.79%	17.99%	Yes
Non-CAH	43.61%	55.98%	12.37%	Yes
CAH	34.91%	67.93%	33.02%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.

Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. This metric was added and designated as P4R in DY 13.

Depression Response

*Exhibit **40**: PRIME Hospital-Reported Depression Response Rates for Metric 1.1.7*

DPH	DY 13 P4R	DY 14 P4P	Change from DY 13 to DY 14	Increased as Intended
Total	7.36%	10.90%	3.54%	Yes
UC	8.49%	13.84%	5.35%	Yes
County	6.89%	9.10%	2.21%	Yes
DMPH	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 13 to DY 14**	**Increased as Intended**
Total	5.55%	25.30%	19.75%	Yes
Non-CAH	3.89%	29.52%	25.62%	Yes
CAH	11.83%	16.30%	4.47%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.

Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. This metric was added and designated as P4R in DY 13.

Depression Remission

Exhibit **41***: PRIME Hospital-Reported Depression Remission for Metric 1.1.7*

DPH	DY 13 P4R	DY 14 P4P	Change from DY 13 to DY 14	Increased as Intended
Total	4.09%	6.39%	2.30%	Yes
UC	5.18%	8.89%	3.70%	Yes
County	3.63%	4.86%	1.23%	Yes
DMPH	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 13 to DY 14**	**Increased as Intended**
Total	4.07%	23.57%	19.50%	Yes
Non-CAH	3.12%	30.53%	27.42%	Yes
CAH	7.69%	8.70%	1.00%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.

Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. This metric was added and designated as P4R in DY 13.

Project 1.2 – Ambulatory Care Redesign: Primary Care

Project Overview and Summary of Key Findings

Project 1.2 focused on promoting system integration and improving efficiency in primary care delivery to ultimately improve access to care. These goals were to be achieved by transforming primary care practice into the patient-centered medical home (PCMH) care delivery model. Hospitals were encouraged to implement the PCMH principles including team-based care, care coordination across settings, population health management using EHR technologies and other approaches, promoting evidence-based care delivery including monitoring of provider performance, and promoting access through open-access scheduling. Specific objectives can be found in Attachment Q.

By the end of DY 14, a total of 23 hospitals continued to participate and report metric performance for Project 1.2. This project was required for all 17 DPHs and was an optional project for DMPHs, of which 6 participated through DY 14 and 1 dropped in DY 12. Detailed information on DPH and DMPH participation can be found in Appendix B. PRIME Project Selections.

Performance of hospitals in Project 1.2 was measured by the following 14 metrics (Exhibit 42). Detailed Race/Ethnicity/and Preferred Language (REAL) and Sexual Orientation/Gender Identity (SO/GI) data were collected and reported in 5 metrics, which are presented together for this analysis.

Exhibit 42: PRIME Project 1.2 Metric Details

Metric Name	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcome of Care
Alcohol and Drug Misuse Sub-rate #1: Brief Annual Screen	1.2.1.a	Increase	Process
Alcohol and Drug Misuse Sub-rate #2: Full Screen, Brief Intervention, and Referral to Treatment (SBIRT)	1.2.1.a	Increase	Process
CG-CAHPS: Provider Rating	1.2.2	Increase	Outcome
Colorectal Cancer Screening	1.2.3.c	Increase	Process
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	1.2.4.d	Decrease	Outcome
Controlling Blood Pressure	1.2.5.b	Increase	Outcome
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	1.2.7.i@	Increase	Process

Metric Name	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcome of Care
Prevention Quality Overall Composite (PQI) #90	1.2.8	Decrease	Outcome
Screening for Clinical Depression and Follow-Up	1.2.12.f	Increase	Process
Tobacco Use – Screening and Cessation Intervention	1.2.14.t	Increase	Process
REAL and SO/GI Metrics			
Documented REAL and/or SOGI Disparity Reduction Plan (DY 12 only)	1.2.6*^	Increase	Process
Primary Care Redesign Metrics Stratified by REAL Categories and SOGI (DY 12 only)	1.2.9*^	Increase	Process
REAL and/or SO/GI Disparity Reduction (begins in DY 13)	1.2.10*#	Increase	Outcome
REAL Data Completeness	1.2.11	Increase	Process
SO/GI Data Completeness (begins in DY 12)	1.2.13	Increase	Process

Source: PRIME Metrics Specs, DY 14YE
*Notes: REAL: Detailed Race, Ethnicity, and Language, SO/GI: Sexual Orientation/ Gender Identity, * Denotes innovative metric. ^ Attestation reported for DY 12 only, # reported for DY 13 to DY 15; baseline is DY 12. @ A trend break was issued for this metric in DY 12; thus, a trend was not calculated for this metric; a higher rate indicates better performance. The metrics pertaining to race, ethnicity, and language (REAL) and sexual orientation and gender identity (SO/GI) were organized so that 2 were reported only in DY 12 (1.2.6 and 1.2.9), 1 began in DY 12 (1.2.13), and another began in DY 13 (1.2.10). Metrics in Project 1.2 related to REAL: Detailed Ethnicity/Race and Language SO/GI: Sexual Orientation/Gender Identity are presented together.*

Both DPHs and DMPHs showed overall improvement over time in 10 metrics (1.2.1.a, 1.2.2, 1.2.3.c, 1.2.4.d, 1.2.5.b, 1.2.8, 1.2.10, 1.2.12.f, 1.2.13, 1.2.14.t). CAH DMPHs did not show improvement for 1 metric (1.2.10), and UC DPHs did not show improvement for 1 metric (1.2.11). The 2 metrics 1.2.6 and 1.2.9 did not have a trend, as they were only in effect for 1 demonstration year, and metric 1.2.7.i had a trend break issued in DY 12, therefore a trend was not calculated for this metric. Of note, many of these metrics were stratified by demographics and hospitals selected specific populations for disparities reductions.

Metric 1.2.1.a – Alcohol and Drug Misuse Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Metric 1.2.1.a measured the rates of screening for alcohol or drug misuse and appropriate intervention and referral to treatment. Hospitals were intended to provide accurate diagnosis and comprehensive treatment procedures to support patients with alcohol or drug misuse. Hospitals were intended to decrease future risks and complications by improving the detection of alcohol-related disorders and intervention. The original SBIRT metric became sub-rate #2 (full screening), thus the change over time could be calculated and the metric was P4P in DY 14. The new sub-rate #1 is for a brief annual screening, was P4R in DY 14, and a trend was not calculated because there was 1 year of data. The denominator includes individuals in the PRIME Project 1.2 Target Population ages 12 years or older who had a qualifying outpatient service. SBIRT rates increased as intended for all hospital types.

Exhibit 43: PRIME Hospital-Reported Alcohol and Drug Misuse Screening, Brief Intervention, and Referral to Treatment (SBIRT) Rates for Metric 1.2.1.a (Sub-rate #2)

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	3.29%	2.59%	5.24%	9.45%	6.16%	Yes
UC	2.31%	1.44%	2.20%	6.88%	4.57%	Yes
County	4.16%	3.71%	7.95%	11.80%	7.64%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	0.81%	15.33%	8.66%	7.85%	Yes
Non-CAH	---	0.86%	15.80%	9.34%	8.48%	Yes
CAH	---	0.31%	12.32%	2.69%	2.39%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance, ---: DMPHs did not report data in DY 11.

Exhibit 44: PRIME Hospital-Reported Alcohol and Drug Misuse Brief Annual Screening Rates for Metric 1.2.1.a (Sub-rate #1)

DPH	DY 14 P4R
Total	39.12%
UC	22.58%
County	54.22%
DMPH	**DY 14 P4R**
Total	60.59%
Non-CAH	58.30%
CAH	80.71%

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting. A separate brief annual screening metric came into effect for DY 14 and was applicable for the remainder of PRIME.

Metric 1.2.2 – CG-CAHPS: Provider Rating

Metric 1.2.2 measured the number of individuals that rated their provider as 9 or 10, with 10 indicating "Best Provider Possible" (NQF 0005 AHRQ). Hospitals were intended to assess and surpass patient expectations by ensuring providers were cognizant, accurate, and empathetic. The PRIME Eligible Population and Project Target Population do not apply to the denominator for this metric. Instead, the target populations for the surveys are patients who have had at least one visit to the selected provider in the target time frame and hospitals report only primary care CG CAHPS results. Rates increased as intended for all hospital types.

Exhibit 45: PRIME Hospital-Reported Provider Rating Rates for Metric 1.2.2

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	78.07%	80.84%	80.61%	82.71%	4.64%	Yes
UC	83.11%	84.73%	85.89%	87.19%	4.08%	Yes
County	71.90%	77.75%	77.24%	77.56%	5.66%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	74.55%	67.13%	82.51%	7.96%	Yes
Non-CAH	---	74.53%	72.17%	82.77%	8.24%	Yes
CAH	---	75.00%	33.99%	80.44%	5.44%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance, ---: DMPHs did not report data in DY 11. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH.

Metric 1.2.3.c – Colorectal Cancer Screening

Metric 1.2.3.c measured the number of patients 50 to 75 years old in the Project 1.2 Target Population that received an appropriate screening for colorectal cancer (NQF 0034, QPP #113 spec). Hospitals were intended to increase screenings for colorectal cancer in order to catch the disease in its earliest stages and increase 5-year survival rate. Rates increased as intended for all hospital types.

Exhibit 46: PRIME Hospital-Reported Colorectal Cancer Screening Rates for Metric 1.2.3.c

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	58.52%	64.61%	67.39%	69.79%	11.27%	Yes
UC	62.62%	66.53%	69.19%	71.22%	8.60%	Yes
County	55.98%	63.35%	66.23%	68.82%	12.84%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	19.38%	34.23%	44.99%	25.61%	Yes
Non-CAH	---	18.67%	33.63%	45.77%	27.09%	Yes
CAH	---	23.12%	37.29%	40.73%	17.61%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance, ---: DMPHs did not report data in DY 11. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH.

Metric 1.2.4.d – Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)

Metric 1.2.4.d measured the number of individuals with Type 1 diabetes or Type 2 diabetes aged 18-75 years old who had hemoglobin A1c in poor control (>9.0) or was missing a result (NQF 0059). Hospitals were intended to reduce microvascular complications in patients with diabetes through improving management of hemoglobin A1c levels. Rates decreased as intended for all hospital types.

Exhibit 47: PRIME Hospital-Reported Diabetes Poor Control (>9.0) Rates for Metric 1.2.4.d

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Decreased as Intended
Total	28.52%	26.46%	25.11%	24.80%	-3.71%	Yes
UC	19.52%	19.51%	20.47%	17.39%	-2.13%	Yes
County	31.04%	27.82%	26.04%	26.99%	-4.05%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Decreased as Intended**
Total	---	38.42%	34.21%	28.10%	-10.32%	Yes
Non-CAH	---	38.46%	32.39%	28.62%	-9.85%	Yes
CAH	---	37.58%	49.25%	23.04%	-14.54%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance, ---: DMPHs did not report data in DY 11. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH.

Metric 1.2.5.b – Controlling Blood Pressure

Metric 1.2.5.b measured the proportion of patients between the ages of 18 and 85 that had at least 1 outpatient encounter with a diagnosis of hypertension and had their blood pressure (BP) adequately controlled. For all patients aged 18 to 59, and patients aged 60 to 85 with a diagnosis of diabetes, adequately controlled BP was defined as <140/90 mmHg. For patients between the ages of 60 and 85 without a diagnosis of diabetes, adequately controlled BP was <150/90 mmHg. In DY14, the definition of adequate control was changed to be the same for all groups (<140/90). Hospitals were intended to increase early detection of hypertension so that patients could start interventions earlier. Rates increased as intended for all hospital types.

Exhibit 48: PRIME Hospital-Reported Blood Pressure Control Rates for Metric 1.2.5.b

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	66.78%	71.54%	73.59%	75.20%	8.42%	Yes
UC	69.81%	74.51%	74.71%	76.66%	6.85%	Yes
County	64.90%	69.77%	72.90%	74.37%	9.47%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	61.93%	63.84%	70.35%	8.42%	Yes
Non-CAH	---	63.11%	68.44%	70.25%	7.14%	Yes
CAH	---	53.85%	46.75%	70.63%	16.78%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance, ---: DMPHs did not report data in DY 11. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH.

Metric 1.2.7.i – Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

Metric 1.2.7.i measured the number of patients who had an active medication of aspirin or another antiplatelet among patients in the Project 1.2 Target Population aged 18 and over with a visit during the measurement period who had an acute myocardial infarction (AMI), coronary artery bypass grafting (CABG) or percutaneous coronary intervention (PCI) during the 12 months prior to the measurement period or who had a diagnosis of IVD overlapping the measurement period. Hospitals were intended to reduce the risk of serious vascular events, such as myocardial infarction or stroke, by tracking the proportion of patients with an active antiplatelet medication. Note that a trend-break notice was issued for this metric in DY 12 (PPL-17-007 DY 12) to clarify that the numerator includes active medications for patients and to add details to the time periods for events in the denominator inclusion criteria. Thus, a trend was not calculated for this metric, although achievement was measured by an increasing rate. Use of aspirin or another antithrombotic/antiplatelet are measured in Metrics 1.2.7.i and 1.5.2.i.

Exhibit 49: PRIME Hospital-Reported Ischemic Vascular Disease -Aspirin or Another Antithrombotic Use Rates for Metric 1.2.7.i

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P
Total	79.41%	84.80%	88.94%	87.03%
UC	82.57%	84.78%	88.41%	82.95%
County	76.45%	84.82%	89.30%	91.59%
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**
Total	---	88.06%	75.00%	85.62%
Non-CAH	---	88.99%	82.26%	87.41%
CAH	---	75.68%	49.30%	75.27%

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance, ---: DMPHs did not report data in DY 11. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 11 and DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH. A trend-break notice was issued for this metric in DY 12 (PPL-17-007 DY 12) to clarify that the numerator includes active medications for patients and added details to the time periods for events in the denominator inclusion criteria. Thus, a trend was not calculated for this metric.

Metric 1.2.8 – AHRQ Prevention Quality Indicators (PQI #90)

Metric 1.2.8 measured the proportion of patients 18 years of age or older who were discharged and met the inclusion and exclusion rules for the numerator in following PQIs: #1, 3, 5, 7, 8, 10-12, and 14-16 (Exhibit 181). Rates decreased as intended for all hospital types.

Exhibit 50: PRIME Hospital-Reported Prevention Quality Indicator- Overall Composite Rates for Metric 1.2.8

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14	Decreased as Intended
Total	1.64%	2.31%	0.90%	0.93%	-0.72%	Yes
UC	1.44%	1.26%	0.84%	0.75%	-0.69%	Yes
County	1.72%	2.73%	0.92%	1.01%	-0.71%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Decreased as Intended**
Total	---	3.33%	3.09%	2.17%	-1.16%	Yes
Non-CAH	---	3.14%	3.04%	2.06%	-1.08%	Yes
CAH	---	7.93%	4.14%	4.63%	-3.29%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance, ---: DMPHs did not report data in DY 11. PQI is an overall composite score in which a lower rate indicates better performance.

Metric 1.2.12.f – Screening for Clinical Depression and Follow-Up

Metric 1.2.12.f measured the number of patients age 18 or older who were screened for clinical depression in an eligible encounter and, if applicable, provided a follow-up plan. Hospitals were intended to identify and treat depression in its early stages in order to reduce risks of the negative outcomes associated with depression by increasing routine screenings for depression as a part of primary care. Rates increased as intended for all hospital types.

Exhibit 51: PRIME Hospital-Reported Depression Screening and Follow-Up Rates for Metric 1.2.12.f

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	17.77%	35.74%	54.81%	73.07%	55.30%	Yes
UC	14.70%	15.14%	38.92%	70.05%	55.35%	Yes
County	20.37%	49.67%	65.02%	75.14%	54.77%	Yes
DMPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 12 to DY 14	Increased as Intended
Total	---	17.95%	52.73%	69.86%	51.91%	Yes
Non-CAH	---	18.37%	57.07%	70.73%	52.36%	Yes
CAH	---	10.86%	27.52%	64.50%	53.64%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance, ---: DMPHs did not report data in DY 11.

Metric 1.2.14.t – Tobacco Use – Screening and Cessation Intervention

Metric 1.2.14.t measured the number of who patients received tobacco screening and, if identified as a tobacco user, received tobacco cessation intervention. Hospitals were intended to promote screening and intervention for tobacco users. There is good evidence to suggest such actions are successful in helping users quit. Tobacco Use – Screening and Cessation Intervention was revised with additional instructions in DY 14 to include 3 criteria, of which entities reported the 3rd (Exhibit 37). Tobacco use screening and cessation intervention rates increased as intended for all hospital types.

Exhibit 52: PRIME Hospital-Reported Tobacco Assessment and Counseling Rates for Metric 1.2.14.t

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	81.64%	93.20%	95.94%	97.07%	15.43%	Yes
UC	92.58%	96.39%	96.88%	97.50%	4.92%	Yes
County	74.53%	90.63%	95.19%	96.74%	22.21%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	52.08%	81.22%	83.84%	31.76%	Yes
Non-CAH	---	51.01%	82.26%	83.84%	32.82%	Yes
CAH	---	65.91%	75.59%	83.90%	17.99%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance, ---: DMPHs did not report data in DY 11. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 11 and DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH.

Metric 1.2.6 – Documented REAL and/or SO/GI Disparity Reduction Plan

Metric 1.2.6 measured the number of hospitals that attested to completing a race, ethnicity, language, (REAL) and/or sexual orientation or gender identity (SO/GI) disparity reduction plan targeting 1 or more disparities. Hospitals were intended to reduce primary care health disparities that exist on the lines of REAL and SO/GI to provide equal opportunity and fair treatment to all. This was reported only in DY 12 and the analysis can be found in the Interim Report.

Metric 1.2.9 – Primary Care Redesign Metrics Stratified by REAL Categories and SO/GI

Metric 1.2.9 measured the number of metrics stratified by the following sub-populations of the PRIME Eligible Population: Ethnicity Group (Detailed Ethnicity); Race Category; Detailed Race; Preferred Language; Sexual Orientation; Gender Identity. This was reported only in DY 12 and the analysis can be found in the Interim Report.

Metric 1.2.10 – REAL and/or SO/GI Disparity Reduction

Metric 1.2.10 measured the number of PRIME Primary Care Redesign project metrics targeted for disparity reduction in the PRIME hospital's DY 12 REAL and/or SO/GI Disparity Reduction Plan. Hospitals were intended to decrease disparities in health, health outcomes, or health care delivery amongst sub-populations of the PRIME Eligible Population. Rates increased as intended for the majority of hospital types.

Exhibit 53: PRIME Hospital-Reported Disparity Reduction Rates for Metric 1.2.10*

DPH	DY 13 P4P	DY 14 P4P	Change from DY 13 to DY 14	Increased as Intended
Total	58.70%	60.93%	2.23%	Yes
UC	63.40%	67.27%	3.86%	Yes
County	57.04%	58.69%	1.65%	Yes
DMPH	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 13 to DY 14**	**Increased as intended**
Total	30.69%	54.42%	23.73%	Yes
Non-CAH	28.74%	56.27%	27.53%	Yes
CAH	53.70%	25.00%	-28.70%	No

Source: UCLA analysis of the hospital-reported data, February to June 2020.
*Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4P: pay-for-performance. Metric 1.2.10 came into effect for DY 13. * Denotes innovative metric. Metric 1.2.10 came into effect for DY 13 and was applicable for the remainder of PRIME.*

Metric 1.2.11 – REAL Data Completeness

Metric 1.2.11 measured the number of patients who have complete race, ethnicity, and preferred language (REAL) data available on file. Hospitals were intended to improve and maintain data completeness to support cohesive patient care and reduce health disparities by race, ethnicity, and language. Rates increased as intended for the majority of hospital types.

Exhibit 54: PRIME Hospital-Reported Race, Ethnicity, and Preferred Language (REAL) Data Completeness Rates for Metric 1.2.11

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	35.77%	57.71%	78.04%	80.74%	44.97%	Yes
UC	64.38%	39.37%	57.79%	58.64%	-5.75%	No
County	18.70%	68.76%	90.27%	93.98%	75.28%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	21.90%	82.74%	92.90%	71.00%	Yes
Non-CAH	---	21.23%	84.20%	92.45%	71.22%	Yes
CAH	---	34.55%	65.44%	98.61%	64.05%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance, ---: DMPHs did not report data in DY 11. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 11 and DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH.

Metric 1.2.13 – SO/GI Data Completeness

Metric 1.2.13 measured the number of patients with both sexual orientation and gender identity (SO/GI) available on file. Hospitals were intended to reduce primary care health disparities that exist on the lines of sexual orientation or gender identity. This metric began in DY 12. Rates increased as intended for all hospital types.

Exhibit 55: PRIME Hospital-Reported Sexual Orientation and Gender Identity (SO/GI) Data Completeness Rates for Metric 1.2.13

DPH	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 12 to DY 14	Increased as Intended
Total	8.89%	43.54%	66.18%	57.28%	Yes
UC	1.28%	14.88%	38.79%	37.52%	Yes
County	14.10%	63.48%	85.17%	71.07%	Yes
DMPH	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	21.91%	57.91%	66.19%	44.28%	Yes
Non-CAH	23.29%	56.49%	65.88%	42.59%	Yes
CAH	0.00%	72.47%	70.16%	70.16%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. This metric was implemented starting in DY 12.

Project 1.3 – Ambulatory Care Redesign: Specialty Care

Project Overview and Summary of Key Findings

Project 1.3 was designed to integrate specialty and primary care and thus improve timely access to high quality and effective specialty care by transformation of specialty care practice, including mental health and substance abuse treatment. This goal was to be achieved by establishing needed infrastructure such as specialty care support tools for primary care providers (PCPs) and implementing processes that promote delivery of integrated care including team-based care, technology-assisted expanded access to specialty care, and improved management of patients. Specific objectives can be found in Attachment Q.

Project 1.3 was required for all 17 DPHs. Additionally, 2 DMPHs participated in this project. Detailed information on DPH and DPMH participation can be found in v

Performance in Project 1.3 was measured by the following 7 metrics (Exhibit 56).

Exhibit 56: PRIME Project 1.3 Metric Details

Metric Name	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcome of Care
Closing the Referral Loop: Receipt of Specialist Report	1.3.1	Increase	Process
DHCS All-Cause Readmissions	1.3.2	Decrease	Outcome
Influenza Immunization	1.3.3	Increase	Process
Post Procedure ED Visits	1.3.4*	Decrease	Outcome
Request for Specialty Care Expertise Turnaround Time	1.3.5*	Increase	Process
Specialty Care Touches: Specialty Expertise Requests Managed via Non-Face to Face Specialty Encounters	1.3.6*	Increase	Process
Tobacco Use: Screening and Cessation Intervention	1.3.7	Increase	Process

Source: PRIME Metrics Specs, DY 14YE
Notes: SBIRT: screening, brief intervention, and referral to treatment, Denotes innovative metric.*

Overall, hospitals showed improved performance from DY 11 to DY 14. Both DPH and DMPHs showed progress over time in 5 metrics (1.3.1, 1.3.3, 1.3.5, 1.3.6, 1.3.7). DPHs also showed progress in the remaining 2 metrics (1.3.2 and 1.3.4).

Metric 1.3.1 – Closing the Referral Loop: Receipt of Specialist Report

Metric 1.3.1 measured the proportion of all patients regardless of age, for which the provider both gave a referral and received a report back from the specialty care provider to whom the patient was referred. Hospitals were intended to close the loop on the receipt of referrals, since physicians did not always receive a report from specialists. Rates of closing the specialist referral loop increased as intended for all hospital types (Exhibit 57).

Exhibit 57: PRIME Hospital-Reported Rate of Closing the Specialist Referral Loop for Metric 1.3.1

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	67.42%	70.57%	81.29%	84.48%	17.06%	Yes
UC	49.64%	80.70%	85.91%	85.30%	35.66%	Yes
County	75.84%	64.09%	78.32%	83.97%	8.13%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	53.11%	52.13%	57.15%	4.05%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11.

Metric 1.3.2 – DHCS All-Cause Readmissions – Statewide Collaborative QIP Measure

Metric 1.3.2 measured the proportion of patients that were readmitted within 30 days of the Index Hospital Stays (IHS) for individuals 21 years of age and older from the Project 1.3 Target Population . Hospitals were intended to reduce readmissions as a result of improved transition of patients to post-hospital care. All-cause 30-day readmission rates declined as intended for all hospital types except Non-CAH DMPHs (Exhibit 58).

Exhibit 58: PRIME Hospital-Reported All-Cause Readmission Rates for Metric 1.3.2

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Decreased as Intended
Total	13.94%	13.40%	13.40%	13.54%	-0.40%	Yes
UC	14.43%	15.11%	13.71%	13.68%	-0.74%	Yes
County	13.52%	11.98%	13.20%	13.45%	-0.07%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Decreased as Intended**
Non-CAH	---	5.52%	13.10%	16.27%	10.75%	No

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH. ---: DMPHs did not report data in DY 11.

Metric 1.3.3 – NQF #0041 Influenza Immunization

Metric 1.3.3 measured the proportion of patients who received an influenza immunization or had a previous receipt of an influenza immunization in the Project 1.3 Target Population aged 6 months and older . Hospitals were intended to promote influenza vaccinations to reduce contraction rates and risks of disease. Influenza immunization rates increased as intended for all hospital types (Exhibit 59).

Exhibit 59: PRIME Hospital-Reported Influenza Immunization Rates for Metric 1.3.3

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	49.49%	55.48%	68.47%	75.83%	26.34%	Yes
UC	55.58%	51.35%	67.75%	73.23%	17.64%	Yes
County	45.20%	60.32%	69.22%	79.08%	33.88%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	16.18%	25.63%	40.96%	24.78%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11. The Target Population are those in the PRIME Eligible Population who had an in-person PRIME Entity Specialty Care visit at least once during the Measurement Period.

Metric 1.3.4 – Post Procedure Emergency Department (ED) Visits

Metric 1.3.4 determined the proportion of PRIME hospital emergency department (ED) visits that occurred within 7 calendar days of the denominator outpatient specialty care encounters during surgeries and procedures being completed on the same individuals; all ages were included in this metric. Hospitals were intended to reduce unplanned admissions to emergency rooms for outpatient procedures and surgeries in order to lower the development of adverse events associated with these procedures. No data was reported for DY 14 because this metric was retired after DY 13. Results for this metric are available in the Interim Report.

Metric 1.3.5 – Request for Specialty Care Expertise Turnaround Time

Metric 1.3.5 measured the proportion of requests in which an individualized response was returned to the requester within 5 calendar days over the total number of requests sent to the PRIME Hospital specialists. The rationale of this metric was to promote timely responses from the specialists to ultimately provide the well-informed, best care possible to patients. Specialty care request rates increased as intended for all hospital types except Non-CAH DMPH's .

Exhibit 60: PRIME Hospital-Reported Specialty Care Request Rates for Metric 1.3.5*

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	33.23%	51.37%	59.93%	66.67%	33.44%	Yes
UC	23.55%	45.27%	62.62%	62.87%	39.32%	Yes
County	47.46%	57.63%	57.67%	69.93%	22.47%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	35.99%	41.88%	81.87%	45.88%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
*Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11. * Denotes innovative metric.*

Metric 1.3.6 – Specialty Care Touches: Specialty Expertise Requests Managed via Non-Face to Face Specialty Encounters

Metric 1.3.6 measured the rate of outpatient specialty care requests that were managed via non-in person face to face encounters within 6 months of the date of request for specialty care expertise. Hospitals were intended to increase the number of specialist requests that could be managed via telephone, email, or video encounters for electronic correspondence without the need for patients to be admitted to a hospital. These rates increased as intended for all hospital types.

Exhibit 61: PRIME Hospital-Reported Specialty Care Touches: Specialty Expertise Requests Managed via Non-Face to Face Specialty Encounters Rates for Metric 1.3.6*

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	6.02%	5.27%	6.81%	13.93%	7.91%	Yes
UC	0.72%	1.36%	1.74%	13.69%	12.97%	Yes
County	10.04%	8.81%	11.03%	14.25%	4.21%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	0.00%	8.02%	4.31%	4.31%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
*Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11. * Denotes innovative metric.*

Metric 1.3.7 – Tobacco Use: Screening and Cessation Intervention

Metric 1.3.7 measured the proportion of adults (ages 18 and over) who were screened for tobacco use at an in-person specialty care visit and who received cessation counseling intervention if identified as a tobacco user. Hospitals were intended to promote screening and intervention for tobacco users. There is good evidence to suggest such actions are successful in helping tobacco users quit. Tobacco Use – Screening and Cessation Intervention was revised with additional instructions in DY 14 to include 3 criteria, of which entities reported the 3rd (Exhibit 37). Tobacco use screening and cessation intervention rates increased as intended for all hospital types.

Exhibit 62: PRIME Hospital-Reported Tobacco Use: Screening and Cessation Intervention Rates for Metric 1.3.7

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	83.47%	94.57%	97.14%	97.76%	14.29%	Yes
UC	93.65%	97.41%	97.87%	98.44%	4.79%	Yes
County	76.73%	91.85%	96.41%	97.14%	20.41%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	73.39%	86.09%	91.33%	17.94%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH. ---: DMPHs did not report data in DY 11.

Project 1.4 – Patient Safety in the Ambulatory Setting

Project Overview and Summary of Key Findings

Project 1.4 was designed to improve quality of care in the outpatient setting by reducing medication errors and delays in delivery of preventive services, particularly for patients with chronic conditions who may be at risk for adverse events related to missed diagnoses, medication side-effects, or other potential problems related to chronic disease management. These goals were to be achieved by examining the existing infrastructure and care delivery processes such as gap analyses, establishing needed infrastructure such as data systems, and improving processes such as insuring abnormal results follow-up for common laboratory tests and for monitoring patients on persistent medications (Attachment Q).

By the end of DY 14, a total of 10 hospitals continued to participate and report metric performance for Project 1.4. Detailed information on DPH and DPMH participation can be found in Appendix B. PRIME Project Selections.

Performance in Project 1.4 was measured by the following 3 metrics. Metric 1.4.1 consisted of 3 sub-rates including abnormal BIRADS follow-up, abnormal INR follow-up, and abnormal potassium follow-up. (Exhibit 63).

Exhibit 63: PRIME Project 1.4 Metric Details

Metric Name	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcome of Care
Abnormal Results Follow-Up: Abnormal Potassium Follow-up	1.4.1*	Increase	Process
Abnormal Results Follow-Up: Abnormal INR Follow-Up	1.4.1*	Increase	Process
Abnormal Results Follow-Up: Abnormal BIRADS Follow-Up	1.4.1*	Increase	Process
Annual Monitoring for Patients on Persistent Medications	1.4.2	Increase	Process
INR Monitoring for Individuals on Warfarin	1.4.3	Increase	Process

Source: PRIME Metrics Specs, DY 14YE
*Notes: * Denotes innovative metric.*

Both DPHs and DMPHs improved in 2 of the sub-rates for metric 1.4.1, Abnormal Potassium Follow-Up and Abnormal International Normalized Ratio (INR) Follow-Up.

Only DPHs improved in the Abnormal BIRADS Follow-Up sub-rate. Both DPHs and DMPHs showed improvement in metrics 1.4.2 and 1.4.3 over time.

Metric 1.4.1 – Abnormal Results Follow-Up: Potassium Follow-Up

Metric 1.4.1 measured the percentage of ambulatory care serum potassium tests performed on patients 18 years of age and older who received at least 180 treatment days of angiotensin converting enzyme (ACE), angiotensin receptor blockers (ARB), or diuretic therapy, at least 1 potassium monitoring event, and follow-up appropriate to the results Hospitals were intended to increase the number of appropriate results and timely documentation. All hospitals reported an increase in abnormal potassium follow-up rates as intended.

Exhibit 64: PRIME Hospital-Reported Abnormal Potassium Follow-Up Rates for Metric 1.4.1*

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	90.76%	93.22%	93.58%	93.73%	2.97%	Yes
UC	92.63%	92.05%	92.07%	92.81%	0.19%	Yes
County	90.12%	94.09%	94.54%	94.44%	4.32%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	84.79%	90.75%	92.44%	7.65%	Yes
Non-CAH	---	84.58%	89.59%	91.83%	7.25%	Yes
CAH	---	86.00%	96.06%	95.52%	9.52%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
*Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11. * Denotes innovative metric.*

Metric 1.4.1 – Abnormal Results Follow-Up: Abnormal INR Follow-Up

Metric 1.4.1 measured the percentage of ambulatory care International Normalized Ratio Tests (INR) performed on patients 18 years of age and older who received warfarin therapy for at least 56 days, at least 1 INR monitoring test during each 56-day interval with active warfarin therapy, and follow-up appropriate to the results. Hospitals were intended to increase the number of appropriate results and timely documentation. All hospital types reported an increasing trend in abnormal INR follow-up rates as intended.

Exhibit 65: PRIME Hospital-Reported Abnormal INR Follow-Up Rates for Metric 1.4.1*

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	92.67%	93.48%	94.43%	94.66%	1.98%	Yes
UC	91.05%	93.06%	94.98%	95.73%	4.68%	Yes
County	93.46%	93.75%	94.20%	94.12%	0.66%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	84.66%	90.48%	96.27%	11.61%	Yes
Non-CAH	---	84.87%	89.59%	96.44%	11.57%	Yes
CAH	---	81.77%	94.64%	94.37%	12.60%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
*Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11. * Denotes innovative metric.*

Metric 1.4.1 – Abnormal Results Follow-Up: Abnormal BIRADS Follow-Up

Metric 1.4.1 measured the percentage of ambulatory care Breast Imaging Reporting and Data System (BIRADS) performed on patients of any age with a mammogram and received follow-up appropriate to the resultant BIRADS assessment). County DPHs and CAH DMPHs reported an increasing trend in abnormal BIRADS follow-up as intended.

Exhibit 66: PRIME Hospital-Reported BIRADS Follow-Up Rates for Metric 1.4.1*

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	60.74%	62.82%	60.84%	65.67%	4.93%	Yes
UC	77.67%	73.74%	71.03%	71.86%	-5.81%	No
County	53.33%	56.05%	55.79%	62.81%	9.48%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	85.80%	84.68%	84.07%	-1.73%	No
Non-CAH	---	88.93%	84.79%	84.02%	-4.91%	No
CAH	---	47.60%	83.39%	84.79%	37.19%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
*Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ^ Achievement was measured by an increase in rates. ---: DMPHs did not report data in DY 11. * Denotes innovative metric.*

Metric 1.4.2 – Annual Monitoring for Patients on Persistent Medications

Metric 1.4.2 measured the percentage of individuals 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and at least 1 therapeutic monitoring agent in the measurement period Hospitals were intended to improve the annual monitoring for patients on ACE, ARB, digoxin, or diuretics. All hospital types reported an increasing trend in annual monitoring for patients on persistent medications as intended.

Exhibit 67: PRIME Hospital-Reported Annual Monitoring for Patients on Persistent Medication Rates for Metric 1.4.2

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	84.89%	91.14%	91.80%	92.76%	7.88%	Yes
UC	88.23%	89.34%	89.49%	91.69%	3.46%	Yes
County	83.50%	92.20%	93.13%	93.56%	10.06%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	57.78%	84.38%	90.56%	32.78%	Yes
Non-CAH	---	55.56%	84.15%	90.15%	34.59%	Yes
CAH	---	79.13%	86.12%	94.53%	15.40%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH. ---: DMPHs did not report data in DY 11.

Metric 1.4.3 – INR Monitoring for Individuals on Warfarin

Metric 1.4.3 measured the percentage of individuals 18 years of age and older with at least 56 days of warfarin therapy who receive an International Normalized Ratio (INR) test during each 56-day interval with active warfarin therapy Hospitals were intended to improve the monitoring for patients who receive an INR test during each 56-day interval with warfarin. All hospital types reported an increasing trend in INR monitoring for individuals on warfarin as intended.

Exhibit 68: PRIME Hospital-Reported INR Monitoring for Individuals on Warfarin Rates for Metric 1.4.3

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	55.85%	67.70%	79.51%	81.54%	25.68%	Yes
UC	45.51%	49.43%	69.95%	66.73%	21.23%	Yes
County	66.60%	84.94%	87.85%	90.24%	23.64%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	69.11%	77.00%	80.42%	11.30%	Yes
Non-CAH	---	53.68%	76.12%	79.69%	26.02%	Yes
CAH	---	80.10%	82.93%	85.23%	5.12%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11.

Project 1.5 – Million Hearts Initiative

Project Overview and Summary of Key Findings

Project 1.5 was designed to support participation in the Million Hearts® initiative, a national initiative aimed at promoting evidence-based practices for the prevention and treatment of cardiovascular disease and empowering patients to make healthy choices. These activities were expected to reduce disparities in receipt of preventive services and reduce variations in performance. These goals were to be achieved by developing needed infrastructure such as registries and protocols for delivery of guideline-concordant care, as well as implementing changes in care delivery processes such as assessment of existing disparities and clinical management of patients (Attachment Q). Specific objectives can be found in Attachment Q.

By the end of DY 14, a total of 14 hospitals participated and reported metric performance for Project 1.5. Detailed information on DPH and DMPH participation can be found in Appendix B. PRIME Project Selections.

Project 1.5 was measured by the following 4 metrics (Exhibit 69).

Exhibit 69 : PRIME Project 1.5 Metric Details

Metric Name	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcome of Care
Controlling Blood Pressure	1.5.1.b	Increase	Outcome
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	1.5.2.i @	Increase	Process
PQRS # 317 Preventative Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	1.5.3	Increase	Process
Tobacco Use – Screening and Cessation Intervention	1.5.4.t	Increase	Process

Source: PRIME Metrics Specs, DY 14YE

Notes: PQRS: Physician Quality Reporting System. @ A trend- break was issued for this metric in DY 12; thus, a trend was not calculated for this metric; a higher rate indicates better performance.

Both DPHs and DMPHs reported increased rates as intended across all metrics.

Metric 1.5.1.b – NQF 0018: Controlling Blood Pressure (HEDIS 2019)

Metric 1.5.1.b measured the proportion of patients between the ages of 18 and 85 that had at least 1 outpatient encounter with a diagnosis of hypertension and had their blood pressure (BP) adequately controlled. For all patients aged 18 to 59, and patients aged 60 to 85 with a diagnosis of diabetes, adequately controlled BP was defined as <140/90 mmHg. For patients between the ages of 60 and 85 without a diagnosis of diabetes, adequately controlled BP was <150/90 mmHg. In DY14, the definition of adequate control was changed to be the same for all groups (<140/90). Hospitals were intended to increase early detection of hypertension so that patients could start interventions earlier. Blood pressure control rates increased as intended for all hospital types (Exhibit 70).

Exhibit 70: PRIME Hospital-Reported Blood Pressure Control Rates for Metric 1.5.1.b

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	69.91%	74.80%	76.41%	78.14%	8.23%	Yes
UC	70.30%	78.38%	79.26%	80.73%	10.44%	Yes
County	69.31%	71.30%	74.10%	76.08%	6.77%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R***	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	13.11%	60.49%	58.23%	45.12%	Yes
Non-CAH	---	13.14%	59.61%	57.59%	44.45%	Yes
CAH	---	12.98%	71.99%	68.53%	55.54%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.

*Notes: DPH: designated public hospital, UC: University of California, DMPH: district and municipal public hospital, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 12, P4R or P4P metric status mainly varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH. * Since one DMPH reported in DY 11, their DY 12 rate was P4P, but the other DMPHs were newly reporting and were P4R.*

Metric 1.5.2.i –Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic (QPP spec, eCQM spec)

Metric 1.5.2.i measured the number of patients who had an active medication of aspirin or another antiplatelet among patients in the Project 1.5 Target Population aged 18 and over with a visit during the measurement period who had an acute myocardial infarction (AMI), coronary artery bypass grafting (CABG) or percutaneous coronary intervention (PCI) during the 12 months prior to the measurement period or who had a diagnosis of IVD overlapping the measurement period. Hospitals were intended to reduce the risk of serious vascular events, such as myocardial infarction or stroke, by tracking the proportion of patients with an active antiplatelet medication. Note that a trend-break notice was issued for this metric (PPL-17-007, DY 12) to clarify that the numerator includes active medications for patients and to add details to the time periods for events in the denominator inclusion criteria. Thus, a trend was not calculated for this metric, although achievement was measured by an increasing rate (Exhibit 71). Use of aspirin or another antithrombotic/antiplatelet are measured in Metrics 1.2.7.i and 1.5.2.i.

Exhibit 71: PRIME Hospital-Reported Ischemic Vascular Disease -Aspirin or Another Antithrombotic Use Rates for Metric 1.5.2.i

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P
Total	83.72%	87.92%	92.21%	92.40%
UC	87.41%	90.30%	92.90%	92.36%
County	75.58%	84.23%	91.29%	92.48%
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**
Total	---	77.20%	80.97%	84.03%
Non-CAH	---	77.50%	81.19%	83.85%
CAH	---	N/A	78.87%	87.00%

Source: UCLA analysis of the hospital-reported data, February to June 2020.

Notes: DPH: designated public hospital, UC: University of California, DMPH: district and municipal public hospital, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: Most DMPHs did not report data in DY 11. N/A: analyses not conducted due to a denominator less than 30. ⁺ Denotes change from DY 13 to DY 14. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH. A trend-

break was issued for this metric in DY 12; thus, a trend was not calculated for this metric; a higher rate indicates better performance.

Metric 1.5.3 –QPP #317 Preventative Care and Screening: Screening for High Blood Pressure and Follow-Up Documented (QPP spec, eCQM spec)

Metric 1.5.3 measured the proportion of patients who were screened for high blood pressure *and* had a recommended follow-up plan if the blood pressure is pre-hypertensive or hypertensive among the Project 1.5 Target Population aged 18 and over (PQRS # 317). Hospitals were intended to increase follow-up protocols after blood pressure measurement to prevent the progression of hypertension and the development of heart disease. These rates increased as intended for all hospital types (Exhibit 72).

Exhibit 72: PRIME Hospital-Reported Screening for High Blood Pressure and Follow-Up Documented Rates for Metric 1.5.3

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	42.46%	68.81%	76.90%	83.92%	41.46%	Yes
UC	50.70%	71.83%	81.84%	86.16%	35.47%	Yes
County	31.08%	66.04%	73.15%	82.42%	51.34%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	38.90%	64.80%	72.04%	33.13%	Yes
Non-CAH	---	40.80%	67.26%	72.31%	31.52%	Yes
CAH	---	3.99%	40.40%	66.30%	62.31%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.

Notes: DPH: designated public hospital, UC: University of California, DMPH: district and municipal public hospital, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: Most DMPHs did not report data in DY 11.

Metric 1.5.4.t – Tobacco Use – Screening and Cessation Intervention

Metric 1.5.4.t measured the proportion of patients in the Project 1.5 Target Population aged 18 and over seen for at least 2 visits or at least 1 preventive visit who received tobacco screening and, if identified as a tobacco user, received tobacco cessation intervention. Hospitals were intended to promote screening and intervention for tobacco users. There is good evidence to suggest such actions are successful in helping tobacco users quit. Tobacco Use – Screening and Cessation Intervention was revised with additional instructions in DY 14 to include 3 criteria, of which entities reported the 3rd (Exhibit 37). Tobacco use screening and cessation intervention rates increased as intended for all hospital types.

Exhibit 73: PRIME Hospital-Reported Tobacco Use – Screening and Cessation Intervention Rates for Metric 1.5.4.t

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	80.60%	95.06%	97.35%	97.90%	17.30%	Yes
UC	90.84%	96.70%	97.86%	98.22%	7.39%	Yes
County	70.43%	93.48%	96.93%	97.65%	27.22%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	79.51%	90.55%	96.24%	16.74%	Yes
Non-CAH	---	83.71%	95.69%	96.30%	12.59%	Yes
CAH	---	62.98%	55.47%	95.50%	32.51%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.

Notes: DPH: designated public hospital, UC: University of California, DMPH: district and municipal public hospital, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: Most DMPHs did not report data in DY 11. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 12, P4R or P4P metric status varied, but by DY 13, the P4R or P4P status of metrics was identical.

Project 1.6 – Cancer Screening and Follow-Up

Project Overview and Summary of Key Findings

Project 1.6 was designed to improve early diagnosis and timely treatment of cancer by promoting evidence-based and coordinated processes for prevention, screening, and follow-up. These goals were to be achieved by developing needed infrastructure such as development of health information technology and data, a multidisciplinary taskforce, and protocols for guideline concordant care delivery; as well as following processes such as addressing disparities and linking patients to community-based services (Attachment Q).

By the end of DY 14, a total of 11 hospitals continued to participate and report metric performance for Project 1.6, which was not required for DPHs. Project 1.6 was selected by 6 DPHs and 9 DMPHs, of which 5 DPHs and 6 DMPHs continued through DY 14. Detailed information on DPH and DMPH participation can be found in Appendix B. PRIME Project Selections.

Performance of hospitals in Project 1.6 was measured by the following 5 metrics (Exhibit 74).

Exhibit 74: PRIME Project 1.6 Metric Details

Metric Name	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcome of Care
BIRADS to Biopsy	1.6.1*	Increase	Process
Breast Cancer Screening	1.6.2	Increase	Process
Cervical Cancer Screening	1.6.3	Increase	Process
Colorectal Cancer Screening	1.6.4.c	Increase	Process
Receipt of Appropriate Follow-Up for Abnormal CRC Screening	1.6.5*	Increase	Process

Source: PRIME Metrics Specs, DY 14YE.
*Notes: * Denotes innovative metric.*

Both DPH and DMPHs showed progress over time in all metrics (1.6.1, 1.6.2, 1.6.3, 1.6.4.c, and 1.6.5). UC DPHs did not show an increase in rates as intended for 1 metric (1.6.2). DMPHs struggled with the 30-patient minimum denominator in some metrics, and analysis was not conducted for CAH DMPHs for 2 metrics (1.6.1 and 1.6.5) and Non-CAH DMPHs for 1 metric (1.6.5). Overall, hospitals reported improvements in the majority of metrics.

Metric 1.6.1 – BIRADS to Biopsy

Metric 1.6.1 measured the proportion of individuals for whom a breast biopsy was performed or outsourced within 14 business days in the Project 1.6 Target Population who received either a screening or diagnostic mammogram by the PRIME Hospital during the measurement period that was assessed as BIRADs 4 or 5. Hospitals were intended to encourage timely follow up procedures for individuals that tested as suspicious or suggestive for malignancies in order to diagnose and treat patients as early as possible. Biopsy rates increased as intended for all hospital types (Exhibit 75).

Exhibit 75: PRIME Hospital-Reported BIRADS to Biopsy Rates for Metric 1.6.1*

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	44.52%	50.16%	47.27%	57.06%	12.54%	Yes
UC	40.87%	60.27%	52.09%	62.39%	21.52%	Yes
County	45.16%	48.01%	45.88%	56.51%	11.35%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	84.15%	82.61%	88.29%	4.14%	Yes
Non-CAH	---	85.53%	85.54%	90.38%	4.85%	Yes
CAH	---	N/A	N/A	N/A	N/A	N/A

Source: UCLA analysis of the hospital-reported data, February to June 2020.
*Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance, ---: DMPHs did not report data in DY 11, N/A: analyses not conducted due to a denominator less than 30, * Denotes innovative metric.*

Metric 1.6.2 – Breast Cancer Screening

Metric 1.6.2 measured the proportion of women who had a mammogram to screen for breast cancer in the Project 1.6 Target Population ages 50 to 74. Hospitals were intended to diagnose and treat breast cancer early, especially as it ranks as the second leading cause of cancer-related mortality in women. Breast cancer screening rates increased as intended for all hospital types except UC DPHs (Exhibit 76).

Exhibit 76: PRIME Hospital-Reported Breast Cancer Screening Rates for Metric 1.6.2

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	64.10%	70.55%	72.79%	76.66%	12.56%	Yes
UC	80.61%	81.14%	79.01%	78.62%	-1.99%	No
County	62.52%	69.34%	72.06%	76.42%	13.91%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	38.47%	53.18%	64.62%	26.15%	Yes
Non-CAH	---	44.81%	62.28%	66.20%	21.39%	Yes
CAH	---	29.51%	40.52%	59.98%	30.47%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance, ---: DMPHs did not report data in DY 11, N/A: analyses not conducted due to a denominator less than 30. In DY 12 the P4R and P4P differed, but were synchronized in DY 13.

Metric 1.6.3 – Cervical Cancer Screening

Metric 1.6.3 measured the proportion of women who were screened for cervical cancer either through cervical cytology or human papillomavirus co-testing in the Project 1.6 Target Population ages 24 to 64 (NQF 2372, HEDIS, eQCM). Hospitals were intended to diagnose and treat women with cervical cancer early; if pre-cancerous lesions are detected early, the likelihood of survival is nearly 100 percent. Cervical cancer screening rates increased as intended for all hospital types (Exhibit 77).

Exhibit 77: PRIME Hospital-Reported Cervical Cancer Screening Rates for Metric 1.6.3

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	40.89%	53.73%	56.99%	59.44%	18.55%	Yes
UC	72.98%	75.49%	76.24%	75.34%	2.36%	Yes
County	38.37%	51.29%	54.98%	57.77%	19.39%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	20.89%	45.48%	59.12%	38.23%	Yes
Non-CAH	---	22.68%	55.89%	61.62%	38.94%	Yes
CAH	---	16.72%	26.66%	49.71%	32.99%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance, ---: DMPHs did not report data in DY 11. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH.

Metric 1.6.4.c – Colorectal Cancer Screening

Metric 1.6.4.c measured the number of patients 50 to 75 years old in the Project 1.6 Target Population that received an appropriate screening for colorectal cancer (NQF 0034, QPP spec, eCQM). Hospitals were intended to increase screenings for colorectal cancer in order to catch the disease in its earliest stages and increase 5-year survival rate. Colorectal cancer screening rates increased as intended for all hospital types (Exhibit 78).

Exhibit 78: PRIME Hospital-Reported Colorectal Cancer Screening Rates for Metric 1.6.4.c

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	61.82%	67.19%	70.59%	73.16%	11.34%	Yes
UC	76.07%	76.18%	76.78%	76.24%	0.17%	Yes
County	60.07%	65.87%	69.66%	72.67%	12.60%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	22.57%	39.18%	50.89%	28.31%	Yes
Non-CAH	---	19.99%	40.49%	50.29%	30.30%	Yes
CAH	---	25.82%	38.11%	52.52%	26.69%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, CAH: critical access hospital, P4R: pay-for-reporting, P4P: pay-for-performance, ---: DMPHs did not report data in DY 11. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH.

Metric 1.6.5 – Receipt of Appropriate Follow-Up for Abnormal CRC Screening

Metric 1.6.5 measured the number of patients receiving a colonoscopy within 6 months of the date of the positive stool test among patients in the Project 1.6 Target Population ages 51 to 75 with a positive FIT/FOBT during the first 6 months of the measurement period. Critical to a FIT screening strategy is colonoscopy completion after an abnormal screening test. Organized approaches between primary care practice, gastroenterology, and patients are needed to improve care coordination. Colonoscopy follow-up rates increased as intended for all hospital types (Exhibit 79).

Exhibit 79: PRIME Hospital-Reported Abnormal Colorectal Cancer Screening Follow-Up Rates for Metric 1.6.5*

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	37.86%	19.37%	19.61%	48.45%	10.59%	Yes
UC	48.94%	36.11%	40.43%	53.57%	4.63%	Yes
County	37.57%	19.20%	19.38%	48.30%	10.73%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 12 to DY 13**	**Increased as Intended**
Total	---	5.26%	25.00%	N/A	19.74%	Yes
Non-CAH	---	N/A	N/A	N/A	N/A	N/A
CAH	---	3.33%	N/A	N/A	N/A	N/A

Source: UCLA analysis of the hospital-reported data, February to June 2020.
*Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, CAH: critical access hospital, P4R: pay-for-reporting, P4P: pay-for-performance, ---: DMPHs did not report data in DY 11, N/A: analysis not conducted due to a denominator less than 30, * Denotes innovative metric.*

Project 1.7 – Obesity Prevention and Healthier Foods Initiative

Project Overview and Summary of Key Findings

Project 1.7 was designed to reduce obesity by using evidence-based approaches to guide systematic delivery of related services by providers and promoting the availability of healthier foods in public settings such as hospitals. These goals were to be achieved by developing the needed infrastructure such as availability of data and development of protocols for obesity screening, referral, and treatment; as well as following care processes that promote population health such as providing healthier food options at hospital facilities and linking patients to community-based resources (Attachment Q).

Project 1.7 was not a required project for DPHs. 2 DPHs selected this project and both continued through DY 14; 7 DMPHs selected the project with 6 continuing through DY 14. Detailed information on DPH and DMPH participation can be found in Appendix B. PRIME Project Selections.

Performance of hospitals in Project 1.7 was measured by the following 3 metrics (Exhibit 80).

Exhibit 80: PRIME Project 1.7 Metric Details

Metric Name	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcome of Care
Body Mass Index (BMI) Screening and Follow-Up	1.7.1@	Increase	Process
Partnership for a Healthier America's Hospital Health Food Initiative External Food Service Verification	1.7.2	Increase	Process
Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents	1.7.3	Increase	Process

Source: PRIME Metrics Specs, DY 14YE
Notes: @: A trend break was issued for this metric in DY 12; thus, a trend was not calculated for this metric.

Overall, hospitals made significant progress in implementing Project 1.7, as both DPHs and DMPHs improved their performance in the 2 standard process metrics where a trend was calculated. Because only 1 CAH participated, some CAH DMPH rates were not calculated due to denominators under 30.

Metric 1.7.1 – Body Mass Index (BMI) Screening and Follow-Up

Metric 1.7.1 measured the number of patients in the Project 1.7 Target Population aged 18 years and older with a documented BMI and a documented follow-up if BMI was outside the normal parameter. The normal parameter for patients aged 18 years and older was a BMI between 18.5 and 25 kg/m^2. Hospitals were intended to increase earlier detection of chronic disease and other health complications, particularly for patients who are obese or underweight. Note that a trend-break notice was issued for this metric in DY 12 (PPL-17-007 DY 12) to expand the time period for the numerator. Therefore, a trend was not calculated for this metric, although a higher rate indicates better performance.

Exhibit 81: PRIME Hospital-Reported BMI Screening and Follow-Up Rates for Metric 1.7.1

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P
County	32.48%	52.64%	88.10%	89.80%
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**
Total	---	30.49%	29.04%	68.40%
Non-CAH	---	30.49%	29.05%	68.41%
CAH	---	---	N/A	N/A

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, CAH: critical access hospital, P4R: pay-for-reporting, P4P: pay-for-performance, DY: demonstration year. ---: DMPHs did not report data in DY 11; the CAH joined the project later and began reporting for DY 13, Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH. A trend-break notice was issued for this metric in DY 12 (PPL-17-007 DY 12) to expand the time period for the numerator. Therefore, a trend was not calculated for this metric.

Metric 1.7.2 – Partnership for a Healthier America's Hospital health Food Initiative External Food Service Verification

Metric 1.7.2 measured the number of Hospital Healthier Food Initiative Criteria met by hospital cafeterias (Exhibit 183). Hospitals were intended to promote full-service healthier hospital food operations. The numerator for Metric 1.7.2 was the total number of criteria that each hospital met relative to the denominator of 8 total criteria per facility. For example, a hospital with 1 facility that implemented 5 of the criteria would be 5/8. Some hospitals had more than 1 facility in their system, so the denominator was calculated as the total number of criteria (8) times the total number of hospitals in that system. For example, Los Angeles reported for 5 facilities, resulting in a denominator of 40 (8 metrics*5 facilities). UCLA created a weighted average of the numerators and denominators. Rates increased as intended for all hospital types (Exhibit 82).

Exhibit 82: PRIME Hospital-Reported Partnership for a Healthier America's Hospital Health Food Initiative Rates for Metric 1.7.2

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
County	43.75%	66.67%	85.42%	100.00%	56.25%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	28.57%	57.81%	95.31%	66.74%	Yes
Non-CAH	---	28.57%	57.14%	94.64%	66.07%	Yes
CAH	---	---	N/A	N/A	N/A	N/A

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, CAH: critical access hospital, P4R: pay-for-reporting, P4P: pay-for-performance, DY: demonstration year. DMPHs did not report data in DY 11; the CAH joined the project later and began reporting for DY 13, but had fewer than 30 in the denominator (N/A). Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH.

Metric 1.7.3 – Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents

Metric 1.7.3 measured the proportion of patients in the Project 1.7 Target Population between the ages of 3 and 17 who had received counseling for nutrition or physical activity or had their height, weight, and BMI recorded during the measurement period. Hospitals were intended to track BMI monitoring and counseling rates among pediatric patients.

Rates increased as intended for all hospital types (Exhibit 83). The increase from the first to second year of data reporting was frequently noted as a result of data quality improvements, for example Los Angeles County reported in their hospital-reported data that "our quality improvement efforts focused on two areas: improving data extraction and optimizing workflow for documentation." Likewise, Arrowhead reported "our challenge with this metric is appropriate and consistent documentation in the medical record. In our Pediatric Clinic our Information Management department has built templates in the EHR…; this data is then easily mined from the system with programming...we have been working closely with our RN Care Manager to ensure that staff and providers are trained on the importance of completing these fields."

Exhibit 83: PRIME Hospital-Reported Weight Assessment & Counseling for Nutrition and Physical Activity Rates for Metric 1.7.3

DPH (County)	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Counseling for Nutrition	5.45%	68.27%	80.53%	81.68%	76.22%	Yes
Counseling for Physical Activity	8.24%	66.35%	76.71%	80.46%	72.22%	Yes
Weight Assessment (BMI)	45.98%	95.70%	94.46%	95.60%	49.62%	Yes
DMPH (Non-CAH)	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Counseling for Nutrition	---	35.55%	46.45%	69.06%	33.51%	Yes
Counseling for Physical Activity	---	35.30%	45.19%	69.03%	33.73%	Yes

DPH (County)	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Weight Assessment (BMI)	---	97.90%	97.69%	98.27%	0.37%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, CAH: critical access hospital, P4R: pay-for-reporting, P4P: pay-for-performance, DY: demonstration year. Only County and Non-CAH hospitals reported data for this metric, ---: DMPHs did not report data in DY 11. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH

Project 2.1 – Improved Perinatal Care

Project Overview and Summary of Key Findings

Project 2.1 was designed to promote quality improvement and use of best practices to deliver safe, efficient, and equitable care and subsequently improve maternal and child health. These goals were to be achieved by participating in statewide and national initiatives focused on improved perinatal and postpartum care, including care coordination to address co-morbidities, decreased unnecessary cesarean section (C-section) rates, reduced morbidity and mortality associated with maternal hemorrhage, and increased breastfeeding rates. Specific objectives can be found in Attachment Q.

By the end of DY 14, 20 hospitals participated and reported metric performance data. This project was required for DPHs; however, 16 DPHs implemented this required project. It was optional for DMPHs, of which 4 participated in this project. Detailed information on DPH and DPMH participation can be found in Appendix B. PRIME Project Selections.

Performance of hospitals in Project 2.1 was measured by the following 9 metrics, including Metric 2.1.6 which had two sub-rates (Exhibit 84).

Exhibit 84: PRIME Project 2.1 Metric Details

Metric Name	Metric ID Number	Achievement by Increase or Decrease	Care Delivery Process vs. Outcome of Care
Baby-Friendly Hospital Designation*	2.1.1	Increase	Process
Exclusive Breast Milk Feeding	2.1.2	Increase	Process
Obstetric (OB) Hemorrhage: Massive Transfusion	2.1.3	Decrease	Outcome
Obstetric (OB) Hemorrhage: Total Products Transfused	2.1.4	Decrease	Outcome
Cesarean Section	2.1.5	Decrease	Outcome
Prenatal Care	2.1.6	Increase	Process
Postpartum Care	2.1.6	Increase	Process
Severe Maternal Morbidity (SMM) per 100 Women with Obstetric Hemorrhage	2.1.7	Decrease	Outcome

Metric Name	Metric ID Number	Achievement by Increase or Decrease	Care Delivery Process vs. Outcome of Care
Unexpected Newborn Complications	2.1.8	Decrease: Balancing ^	Outcome
OB Hemorrhage Safety Bundle*	2.1.9	Increase	Process

Source: PRIME Metrics Specs, DY 14 YE
Notes: ∗The target population for 2.1.1 and 2.1.9 are the PRIME Entity hospital(s). ^This metric was a balancing measure, with the rationale that a low chance of unexpected newborn complications would be valued more than low-medium rates of obstetric procedures.

DPHs made progress in the intended direction in 8 of the metrics (2.1.1-2.1.6, 2.1.8 and 2.1.9). DMPHs made progress in 4 metrics (2.1.6-2.1.9). In Metric 2.1.9, all 4 DMPHs reported implementation of the Post-Event Debriefs in DY 13, however, in DY 14 only 3 DMPHs reported implementation. DMPHs reported an increase in number of hospitals implementing 3 OB Safety Drills Each Quarter from DY 13 to DY 14.

Overall, DPHs generally had improvement in the majority of metrics, however, DMPHs had varying levels of success in the metrics for this project.

Metric 2.1.1 – Baby-Friendly Hospital Designation

Metric 2.1.1 measured the total number of hospitals that met the criteria of the Baby-Friendly Hospital Designation (BFUSA). Hospitals were intended to promote infant and mother bonding, breastfeeding, and beginnings of life without breastmilk substitutes or breastfeeding barriers. In DY 14 1 County, 2 UCs, and 1 Non-CAH DMPH did not have this designation; 2 County DPHs added it, and 1 non-CAH did not sustain it from DY 13 to DY 14. Baby-friendly hospital designation rates increased as intended for DPHs, and did not increase for DMPHs.

Exhibit 85: PRIME Hospital-Reported Certification Phase Completion for Baby-Friendly Hospital Designation Rates for Metric 2.1.1

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	56.25%	56.25%	68.75%	81.25%	25.00%	Yes
UC	20.00%	20.00%	60.00%	60.00%	40.00%	Yes
County	72.73%	72.73%	72.73%	90.91%	18.18%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	75.00%	75.00%	50.00%	-25.00%	No

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH. ---: DMPHs did not report data in DY 11.

Metric 2.1.2 – Exclusive Breast Milk Feeding

Metric 2.1.2 measured the number of single term newborns that were discharged alive from the hospital who had only been fed breast milk since birth. Hospitals were intended to increase the prevalence of exclusive breastfeeding for the first 6 months of neonatal life. These rates increased as intended for DPHs, and did not increase for DMPHs.

Exhibit 86: PRIME Hospital-Reported Exclusive Breast Milk Feeding Rates for Metric 2.1.2

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	59.29%	65.01%	67.17%	71.62%	12.32%	Yes
UC	70.91%	70.66%	70.83%	75.56%	4.65%	Yes
County	55.33%	62.00%	65.33%	69.54%	14.21%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	58.91%	57.18%	58.80%	-0.12%	No

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, UC: University of California, DMPH: district and municipal public hospital, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance, Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH. ---: DMPHs did not report data in DY 11.

Metric 2.1.3 – Obstetric (OB) Hemorrhage: Massive Transfusion

Metric 2.1.3 measured the proportion of maternal cases during which the patient received ≥4 units of Packed Red Blood Cells. Hospitals were intended to promote healthier pregnancies and deliveries and to reduce maternal mortality and morbidity. These rates decreased as intended for DPHs, and did not decrease for DMPHs.

Exhibit 87: PRIME Hospital-Reported Obstetric (OB) Hemorrhage: Massive Transfusion Rates for Metric 2.1.3

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4R	Change from DY 11 to DY 14	Decreased as Intended
Total	0.37%	0.46%	0.28%	0.28%	-0.09%	Yes
UC	0.41%	0.49%	0.40%	0.40%	-0.01%	Yes
County	0.35%	0.44%	0.21%	0.20%	-0.15%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4R**	**Change from DY 12 to DY 14**	**Decreased as Intended**
Non-CAH	---	0.18%	0.16%	0.20%	0.02%	No

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, UC: University of California, DMPH: district and municipal public hospital, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting. Achievement was measured by a decrease in rates. ---: DMPHs did not report data in DY 11.

Metric 2.1.4 – Obstetric (OB) Hemorrhage: Total Products Transfused

Metric 2.1.4 measured the proportion of maternal cases during which packed Red Blood Cells (PRBC) and Fresh Frozen Plasma (FFP) units transfused. Hospitals were intended to promote healthier pregnancies and deliveries and to reduce mortality and morbidity. These rates decreased as intended for DPHs, and did not decrease for DMPHs.

Exhibit 88: PRIME Hospital-Reported Obstetric (OB) Hemorrhage: Total Products Transfused Rates for Metric 2.1.4

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4R	Change from DY 11 to DY 14	Decreased as Intended
Total	7.91%	8.81%	8.25%	7.42%	-0.49%	Yes
UC	9.59%	9.97%	11.80%	9.50%	-0.09%	Yes
County	6.89%	8.10%	5.85%	6.05%	-0.84%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4R**	**Change from DY 12 to DY 14**	**Decreased as Intended**
Non-CAH	---	3.45%	3.34%	3.65%	0.20%	No

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, UC: University of California, DMPH: district and municipal public hospital, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting,. ---: DMPHs did not report data in DY 11.

Metric 2.1.5 – Cesarean Section

Metric 2.1.5 measured the proportion of nulliparous patients who delivered a live term singleton newborn in vertex presentation that were cesarean births. Hospitals were intended to reduce the prevalence of unnecessary cesarean birth among nulliparous patients. These rates decreased as intended for DPHs, and did not decrease for DMPHs.

Exhibit 89: PRIME Hospital-Reported Cesarean Section Rates for Metric 2.1.5

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Decreased as Intended
Total	22.62%	22.14%	21.11%	20.97%	-1.64%	Yes
UC	23.71%	22.31%	21.87%	22.66%	-1.05%	Yes
County	21.38%	22.01%	20.40%	19.45%	-1.93%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Decreased as Intended**
Non-CAH	---	22.75%	25.32%	25.13%	2.37%	No

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, UC: University of California, DMPH: district and municipal public hospital, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH. ---: DMPHs did not report data in DY 11.

Metric 2.1.6 – Prenatal Care

Metric 2.1.6 measured the proportion of live births that had a prenatal visit during the first trimester or within 42 days of enrollment or continuous accountability out of all live births. Hospitals were intended to increase prenatal care visits for pregnant women to improve maternal and infant health. These rates increased as intended for all hospital types.

Exhibit 90: PRIME Hospital-Reported Prenatal Care Rates for Metric 2.1.6

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	68.49%	81.11%	90.10%	92.52%	24.03%	Yes
UC	75.32%	88.51%	95.33%	94.91%	19.59%	Yes
County	62.25%	74.28%	85.91%	90.56%	28.31%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	19.90%	27.09%	23.69%	3.79%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, UC: University of California, DMPH: district and municipal public hospital, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11.

Metric 2.1.6 – Postpartum Care

Metric 2.1.6 measured the proportion of women who received postpartum visits for a pelvic exam or postpartum care on or between 21 and 56 days after delivery out of all women who gave birth. Hospitals were intended to increase postpartum care visits for mothers to improve maternal and infant health. These rates increased as intended for all hospital types.

Exhibit 91: PRIME Hospital-Reported Postpartum Care Rates for Metric 2.1.6

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	61.69%	66.43%	72.74%	76.28%	14.59%	Yes
UC	71.45%	70.75%	74.37%	78.80%	7.35%	Yes
County	53.22%	62.44%	71.43%	74.20%	20.98%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	20.24%	28.68%	28.48%	8.24%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, UC: University of California, DMPH: district and municipal public hospital, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance, Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. ---: DMPHs did not report data in DY 11.

Metric 2.1.7 – Severe Maternal Morbidity (SMM) per 100 Women with Obstetric (OB) Hemorrhage

Metric 2.1.7 measured the proportion of women who experienced severe maternal morbidity out of all women with a birth admission (>20 weeks of gestation) and who were discharged with an obstetric hemorrhage diagnosis. Hospitals were intended to lower the incidence of morbidity (i.e., severe injury, including but not limited to death) among women who experience obstetric hemorrhage. These rates decreased as intended for DPMHs, and did not decrease for DPHs.

Exhibit 92: Hospital Self-Reported Severe Maternal Morbidity (SMM) per 100 Women with Obstetric (OB) Hemorrhage Rates for Metric 2.1.7

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4R	Change from DY 11 to DY 14	Decreased as Intended
Total	20.96%	24.77%	22.07%	25.38%	4.41%	No
UC	18.09%	22.03%	22.30%	27.43%	9.34%	No
County	23.35%	26.64%	21.90%	23.86%	0.51%	No
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4R**	**Change from DY 12 to DY 14**	**Decreased as Intended**
Non-CAH	---	26.16%	32.30%	24.87%	-1.29%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, UC: University of California, DMPH: district and municipal public hospital, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting. ---: DMPHs did not report data in DY 11.

Metric 2.1.8 – Unexpected Newborn Complications

Metric 2.1.8 measured the proportion of newborns with severe or moderate complications out of all singleton, live-born babies without preexisting conditions, who are normally grown and were not exposed to maternal drug use. Hospitals were intended to decrease the prevalence of babies with unexpected newborn complications. These rates decreased as intended for all hospital types.

Exhibit 93: PRIME Hospital-Reported Unexpected Newborn Complications Rates for Metric 2.1.8

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4R	Change from DY 11 to DY 14	Decreased as Intended
Total	6.28%	6.39%	4.82%	4.71%	-1.57%	Yes
UC	5.79%	5.49%	4.61%	4.70%	-1.08%	Yes
County	6.64%	6.88%	4.95%	4.71%	-1.93%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 12 P4R**	**DY 14 P4R**	**Change from DY 12 to DY 14**	**Decreased as Intended**
Non-CAH	---	5.82%	3.72%	3.99%	-1.83%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, UC: University of California, DMPH: district and municipal public hospital, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting. ---: DMPHs did not report data in DY 11.

Metric 2.1.9 – Obstetric (OB) Hemorrhage Safety Bundle

Metric 2.1.9 measured the number of required CMQCC OB Hemorrhage Safety Bundle components (out of 16) that hospitals adopted to reduce childbirth-related hemorrhages. It is reported at the facility level. Additional detail about this metric is described in Obstetric Hemorrhage Bundle, Project 2.1. These rates increased as intended for all hospital types.

Exhibit 94: PRIME Hospital-Reported Obstetric (OB) Hemorrhage Safety Bundle Implementation for Metric 2.1.9; Proportion of the 16 Elements that Were Met

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	63.44%	72.81%	100.00%	100.00%	36.56%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	70.00%	100.00%	100.00%	30.00%	Yes

Source and notes below.

Exhibit 95: Number of PRIME Hospitals that Reported Obstetric (OB) Hemorrhage Safety Bundle Implementation for Metric 2.1.9 Quarterly Activities

DPH Number of hospitals=16	DY 13	DY 14	Change from DY 13 to DY 14	Increased as Intended
10 Post-Event Debriefs Each Quarter (fewer if less than 10 cases)	15/16	16/16	1/16	Yes
3 OB Safety Drills Each Quarter	14/16	16/16	2/16	Yes
DMPH Number of hospitals=4	**DY 13**	**DY 14**	**Change from DY 13 to DY 14**	**Increased as Intended**
10 Post-Event Debriefs Each Quarter (fewer if less than 10 cases)	4/4	3/4	-1/4	No
3 OB Safety Drills Each Quarter	2/4	3/4	1/4	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, DY: Demonstration Year, P4R: pay-for-reporting, P4P: pay-for-performance. DMPHs did not report data in DY 11. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 12, P4R or P4P metric status

varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH. The metric is calculated per Entity. Quarterly activities were reported in DY 13 onward.

Project 2.2 - Care Transitions: Integration of Post-Acute Care

Project Overview and Summary of Key Findings

The primary goal of Project 2.2 was to reduce avoidable readmissions by linking patients to ambulatory care following inpatient discharge. Successful transition to outpatient settings post-discharge is of particular relevance for public hospitals that have a higher than average readmission rate, potentially because they provide care to patients who are high-risk and have chronic conditions, behavioral health conditions, and unstable housing. This goal was achieved by 1) developing the needed infrastructure for successful care transition including using evidence-based models; 2) identifying high-risk patients; 3) developing standardized workflows and protocols; 4) establishing care transition activities including training staff, teaching patients' self-care, use of multidisciplinary teams, warm handoffs, and monitoring provider performance. Specific objectives can be found in Attachment Q.

At the end of DY 14, 29 hospitals participated in Project 2.2 and reported metric performance data, including all 17 DPHs as required by PRIME, along with 12 DMPHs.

Performance of hospitals in Project 2.2 was measured by 5 metrics (Exhibit 96: *PRIME Project 2.2 Metric Details*).

*Exhi*bit 96: *PRIME Project 2.2 Metric Details*

Metric Name	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcomes of Care
DHCS All-Cause Readmissions	2.2.1	Decrease	Outcome
H-CAHPS-Care Transition Metrics	2.2.2	Increase	Outcome
Medication Reconciliation – 30 Days	2.2.3	Increase	Process
Reconciled Medication List Received by Discharged Patients	2.2.4	Increase	Process
Timely Transmission of Transition Record	2.2.5	Increase	Process

Source: PRIME Metrics Specs, DY 14YE
Notes: Hospital Consumer Assessment of Healthcare Providers and Systems (H-CAHPS)

DMPHs reported improvements across the metrics with increases from DY 12 to DY 14. DPHs reported improvements in the intended direction for results across 4 metrics (2.2.1, 2.2.3, 2.2.4, and 2.2.5). Both hospital types had the largest change (20% to 60%) from the start of PRIME to DY 14 for metrics 2.2.3, 2.2.4, and 2.2.5. Metrics 2.2.1 and 2.2.2 had smaller improvements, with changes of less than 5% in the intended direction.

Overall, DMPHs improved in all metrics and DPHs improved in 4 of the 5 metrics for this project.

Metric 2.2.1 – DHCS All-Cause Readmissions – Statewide Collaborative QIP Measure

Metric 2.2.1 measured the proportion of patients that were readmitted within 30 days of the Index Hospital Stays (IHS) for individuals 21 years of age and older. Hospitals were intended to reduce readmissions as a result of improved transition of patients to post-hospital care. All-cause 30-day readmission rates declined as intended for all hospital types except County DPHs.

Exhibit 97: PRIME Hospital-Reported All-Cause Readmission Rates for Metric 2.2.1

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Decreased as Intended
Total	13.64%	12.91%	13.03%	13.35%	-0.29%	Yes
UC	14.47%	14.84%	13.47%	13.69%	-0.78%	Yes
County	12.86%	11.45%	12.78%	13.17%	0.31%	No
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Decreased as Intended**
Total	---	12.07%	10.45%	10.83%	-1.24%	Yes
Non-CAH	---	12.10%	10.45%	10.87%	-1.23%	Yes
CAH	---	8.03%	10.40%	4.69%	-3.34%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, UC: University of California, DMPH: district and municipal public hospital, CAH: critical access hospital, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY. In DY 11 and DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH.

Metric 2.2.2 – H-CAHPS: Care Transition Metrics

Based on H-CAHPS, Metric 2.2.2 measured patients' assessment of whether hospital staff addressed their health care needs and if patients clearly understood how to manage their health after leaving the hospital. Hospitals were intended to be responsive to patients' needs during hospitalization and to improve their understanding of how to manage their care after discharge. H-CAHPS rates increased as intended for DMPHs and County DPHs. Additional detail is available in Metric 2.2.2 – H-CAHPS: Care Transition Metric Methodology.

Exhibit 98: PRIME Hospital-Reported Care Transition (H-CAHPS) Rates for Metric 2.2.2

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	54.21%	54.20%	51.86%	53.61%	-0.60%	No
UC	67.73%	67.07%	60.40%	61.59%	-6.14%	No
County	47.31%	48.34%	46.76%	49.34%	2.03%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	44.59%	49.79%	48.82%	4.23%	Yes
Non-CAH	---	48.75%	50.62%	50.46%	1.71%	Yes
CAH	---	25.81%	45.58%	39.00%	13.19%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, P4R: pay-for-reporting, P4P: pay-for-performance, Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY. In DY 11 and DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH. ---: DMPHs did not report data in DY 11. PRIME Eligible Population and Project Target Population do not apply to this metric, so achievement rates for this metric were the averages of the hospital-wide rates.

Metric 2.2.3 – Medication Reconciliation – 30 Days

Metric 2.2.3 measured whether discharge medication reconciliation was conducted in an outpatient visit following an inpatient stay. The denominator for this measure is all discharges from any PRIME inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years of age and older in the PRIME Project 2.2 Target Population seen within 30 days following discharge in the office. Patients may appear in the denominator more than once if there was more than one discharge followed by an office visit in the performance period. Hospitals were intended to improve continuity between inpatient and ongoing care, since medications are often changed while a patient is hospitalized. All hospital types reported an increasing trend in medication reconciliation rates as intended.

Exhibit 99: PRIME Hospital-Reported Medication Reconciliation Rates for Metric 2.2.3

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	71.89%	71.02%	80.46%	91.22%	19.33%	Yes
UC	81.98%	84.24%	90.21%	96.14%	14.16%	Yes
County	60.79%	64.65%	74.28%	88.41%	27.62%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	14.66%	65.09%	73.04%	58.38%	Yes
Non-CAH	---	12.10%	64.40%	72.54%	60.44%	Yes
CAH	---	66.34%	100.00%	93.59%	27.25%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, P4R: pay-for-reporting, P4P: pay-for-performance, ---: DMPHs did not report data in DY 11. The denominator is based on discharges with a timely office visit, not patients. Patients may appear in the denominator more than once if there was more than one discharge followed by an office visit in the performance period.

Metric 2.2.4 – Reconciled Medication List Received by Discharged Patients

Metric 2.2.4 measured the proportion of patients, regardless of age, discharged from inpatient care who received a reconciled medication list at the time of discharge. Hospitals were intended to ensure that prescriptions are explained in a clear and structured manner during times of transition for patients. All hospital types reported an increasing trend in medication list reconciliation as intended.

Exhibit 100: PRIME Hospital-Reported Reconciled Medication List Rates for Metric 2.2.4

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	55.91%	82.70%	90.38%	96.41%	40.50%	Yes
UC	74.25%	93.32%	97.40%	98.47%	24.22%	Yes
County	42.15%	72.94%	83.66%	92.03%	49.88%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	67.70%	88.58%	92.65%	24.95%	Yes
Non-CAH	---	67.98%	88.76%	92.79%	24.81%	Yes
CAH	---	19.72%	49.60%	60.32%	40.60%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, P4R: pay-for-reporting, P4P: pay-for-performance, ---: DMPHs did not report data in DY 11.

Metric 2.2.5 – Timely Transmission of Transition Record

Metric 2.2.5 measured the proportion of discharges from inpatient care to home care for which a transition record was transmitted to the facility or primary physician or healthcare professional designated for follow-up within 24 hours of discharge. Hospitals were intended to improve the continuity of care and decrease the risk of re-hospitalization by providing vital information to outpatient providers about their patients' recent hospital admissions. All hospital types reported an increasing trend in timely transition record rates as intended.

Exhibit 101: PRIME Hospital-Reported Care Timely Transition Record Rates for Metric 2.2.5

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	51.18%	56.80%	76.01%	86.60%	35.42%	Yes
UC	92.58%	93.80%	94.55%	97.44%	4.86%	Yes
County	20.79%	32.75%	65.65%	80.17%	59.38%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	39.02%	46.64%	66.55%	27.53%	Yes
Non-CAH	---	38.88%	46.50%	66.44%	27.56%	Yes
CAH	---	71.13%	98.06%	99.01%	27.88%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, P4R: pay-for-reporting, P4P: pay-for-performance, ---: DMPHs did not report data in DY 11.

Project 2.3 – Complex Care Management for High Risk Medical Populations

Project Overview and Summary of Key Findings

Project 2.3 was designed to improve the health of patients with complex conditions and reduce use of preventable emergency department (ED) visits by improving care coordination for better management of complex and high-risk patients. These goals were achieved by 1) using guideline concordant frameworks and staffing models; 2) training care teams on managing complex patients; and 3) systematic identification and coordination for these patients. The framework and staffing models are described in the Interim Report; for example, care models included: the Geriatric Resources for Assessment and Care of Elders (GRACE) Team Care Model, Embedded Care Manager Model, Complex Care Management Program, Chronic Care Model, and Camden Coalition Care Management Model. Staffing model examples included having a care coordinator embedded in the primary care teams or having a centralized care coordination team. Care team members included a mix of clinical support staff, care manager, care coordinator, primary care provider, patient navigator, mental health professional, nutritionist, intensivist, and substance use treatment provider. Common criteria that hospitals utilized to identify the target population for complex care management using criteria such as the number of high-risk medical conditions, ED or inpatient stays, and lack of support. The project's goals were to be achieved by managing the care of complex patients using established protocols and delivery of needed care. Specific objectives can be found in Attachment Q.

By the end of DY 14, 26 hospitals participated and reported metric performance data. All DPHs participated in this project as required by PRIME. Additionally, 9 DMPHs participated in this project. Detailed information on DPH and DPMH participation can be found in Appendix B. PRIME Project Selections.

Performance of hospitals in Project 2.3 was measured by the following 4 metrics (**Exhibit *102***).

Exhibit 102: PRIME Project 2.3 Metric Details

Metric Name and Years Reported	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcome of Care
Care Coordinator Assignment (DY 11 and DY 12) #	2.3.1*	Increase	Process

Metric Name and Years Reported	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcome of Care
Medication Reconciliation – 30 Days (All years)	2.3.2	Increase	Process
Prevention Quality Overall Composite #90 (DY 11-DY 13) ^	2.3.3	Decrease	Outcome
Timely Transmission of Transition Record (All years)	2.3.4	Increase	Process

Source: PRIME Metrics Specs, DY 14YE
*Notes: DY: demonstration year. * Denotes innovative metric. # The metric was retired after DY 12. ^This metric was retired after DY 13.*

Overall, hospitals made progress in implementing Project 2.3, as both DPHs and DMPHs improved in 3 metrics (2.3.2, 2.3.3, 2.3.4). Metric 2.3.1 was discontinued after DY 12; DPHs showed an improvement and no trend was assessed for DMPHs, since the metric was only in effect for 1 demonstration year for those hospitals.

Metric 2.3.1 – Care Coordinator Assignment

Metric 2.3.1 measured the percentage of clients with an assigned care coordinator. Hospitals were intended to leverage care coordinators to more reliably ensure appropriate and timely delivery of care while also improving patient experience. This metric was retired after DY 12, so no data was reported for DY 13 or DY 14 and results for this metric are available in the Interim Report.

Metric 2.3.2 – Medication Reconciliation – 30 Days

Metric 2.3.2 measured whether discharge medication reconciliation was conducted in an outpatient visit following an inpatient stay. The medical reconciliation must have been conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge.. The denominator for this measure is all discharges from any PRIME inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years of age and older in the PRIME Project 2.3 Target Population seen within 30 days following discharge in the office. Patients may appear in the denominator more than once if there was more than one discharge followed by an office visit in the performance period. Hospitals were intended to improve continuity between inpatient and ongoing care, since medications are often changed while a patient is hospitalized. Medical reconciliation rates increased as intended for all hospital types (Exhibit 103).

Exhibit 103: PRIME Hospital-Reported Medical Reconciliation Rates for Metric 2.3.2

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	78.63%	72.14%	81.61%	91.39%	12.77%	Yes
UC	91.89%	92.15%	94.21%	97.23%	5.34%	Yes
County	59.00%	65.34%	74.60%	88.54%	29.53%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	7.41%	51.39%	78.89%	71.47%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11.

Metric 2.3.3 – Prevention Quality Overall Composite #90

Metric 2.3.3 measured the number of discharges that met the inclusion and exclusion rules for the numerator for the Prevention Quality Indicators (PQI). PQI is an overall composite score in which a lower rate indicates better performance. This metric was retired after DY 13, so no data were reported for DY 14 and results for this metric are available in the Interim Report.

Metric 2.3.4 – Timely Transmission of Transition Record

Metric 2.3.4 measured the percentage of discharges from inpatient care for which a transition record was transmitted to the facility, primary physician, or other health care professional designated for follow-up care within 24 hours of discharge. Hospitals were intended to improve the continuity of care and decrease the risk of re-hospitalization by providing vital information to outpatient providers about their patients' recent hospital admissions. The timely transmission of transition record rates increased as intended for all hospital types (Exhibit 104). This metric applies to the Project 2.3 Target Population age 18 and older. The denominator is all applicable discharges for qualifying patients, including if the same patient had multiple discharges during the reporting period.

Exhibit 104: PRIME Hospital-Reported Timely Transmission of Transition Record Rates for Metric 2.3.4

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	51.30%	51.78%	77.00%	85.84%	34.53%	Yes
UC	95.49%	96.21%	95.78%	96.34%	0.84%	Yes
County	17.96%	26.70%	68.11%	80.13%	62.17%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	2.93%	13.04%	36.29%	33.35%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11.

Project 2.4 - Integrated Health Home for Foster Children

Project Overview and Summary of Key Findings

Project 2.4 was designed to implement integrated health homes for children in the foster system, providing foster children with a "one-stop-shop" for fully integrated health services including physical and behavioral health, as well as needed substance abuse and social services. Specific objectives included: improved patient adherence to their treatment regimen; improved communication and documentation of communication and coordination with child welfare services; reduced avoidable acute care utilization (ED, inpatient admissions); and improved patient experience. Specific objectives can be found in Attachment Q.

This project was not required for DPHs, and 4 County DPHs implemented this project and reported data through the end of DY 14. No DMPHs selected Project 2.4. Detailed information on DPH participation can be found in Appendix B. PRIME Project Selections.

Performance of hospitals in Project 2.4 was measured by 8 metrics (Exhibit 105).

Exhibit 105: PRIME Project 2.4 Metric Details

Metric Name and Reporting Period	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcome of Care
Adolescent Well-Care Visit	2.4.1	Increase	Process
Developmental Screening in the First Three Years of Life	2.4.2	Increase	Process
Documentation of Current Medications in the Medical Record (0-18 y.o.)	2.4.3	Increase	Process
Screening for Clinical Depression and Follow Up	2.4.4	Increase	Process
Tobacco Use – Screening and Cessation Intervention (13 y.o. and older)	2.4.5	Increase	Process
Well Child Visits- First 15 months of Life (reported DY 11-DY 12)	2.4.6	Increase	Process
Well Child Visits-Third, Fourth, Fifth, Sixth Years of Life	2.4.7	Increase	Process
Comprehensive Medical Evaluation Following Foster Youth Placement in Foster Care (began in DY 13)	2.4.8*	Increase	Process

Source: PRIME Metrics Specs, DY14YE
*Notes: y.o.: years old, DY: Demonstration Year, * Denotes innovative metric.*

Overall, DPHs reported an increase in rates between DY 11 and DY 14, denoting movement in the intended direction, in all metrics. Metrics 2.4.1 and 2.4.7 both showed small increases in rates of less than 5%. Metrics 2.4.2, 2.4.3, 2.4.4, 2.4.5 reported the largest increases in rates of around 20% to 50% from DY 11 to DY 14.

Metric 2.4.1 – Adolescent Well-Care Visits (HEDIS)

Metric 2.4.1 measured the percentage of adolescents ages 12 to 18 who had at least 1 comprehensive well-care visit with a primary care physician (PCP) or an obstetric/gynecologic (OB/GYN) practitioner. Hospitals were intended to increase well child visits in order to assess physical, emotional, and social development. Adolescent well-care visit rates increased as intended for county hospitals (Exhibit 106).

Exhibit 106: PRIME Hospital-Reported Adolescent Well-Care Visit Rates for Metric 2.4.1

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
County	76.65%	83.84%	83.53%	80.34%	3.69%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. Project 2.4-Specific PRIME Target Population: 1) Individuals with at least 1 encounter with the PRIME Entity Primary Care team during the first half of the measurement period) AND 2) Child, 0 to less than 18 years old, in out of home placement under the jurisdiction of the local children's dependency system (as identified by the PRIME entity) at any point during the measurement period AND 3) If the child had more than one removal in the measurement period, for the purpose of this measure, use the earliest removal date that meets the Project 2.4 Tenure Criteria. Tenure Criteria: the child must continue to remain in protective custody under the jurisdiction of the local children's dependency system for a minimum of 30 consecutive days after the date of removal.

Metric 2.4.2 – Developmental Screening in the First Three Years of Life (CMS Core Set)

Metric 2.4.2 measured the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday. Hospitals were intended to increase developmental surveillance as a component of every preventative care visit to identify concerns about a child's development and implement proper management when a child has a positive screening result for a developmental problem. Developmental screening rates increased as intended for county hospitals (Exhibit 107).

Exhibit 107: PRIME Hospital-Reported Developmental Screening Rates for Metric 2.4.2

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
County	15.38%	15.68%	36.58%	51.21%	35.83%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. Project 2.4-Specific PRIME Target Population: 1) Individuals with at least 1 encounter with the PRIME Entity Primary Care team during the first half of the measurement period) AND 2) Child, 0 to less than 18 years old, in out of home placement under the jurisdiction of the local children's dependency system (as identified by the PRIME entity) at any point during the measurement period AND 3) If the child had more than one removal in the measurement period, for the purpose of this measure, use the earliest removal date that meets the Project 2.4 Tenure Criteria. Tenure Criteria: the child must continue to remain in protective custody under the jurisdiction of the local children's dependency system for a minimum of 30 consecutive days after the date of removal.

Metric 2.4.3 – Documentation of Current Medications in the Medical Record (0-18 y.o.)

Metric 2.4.3 measured the percentage of visits for patients aged 0 to less than 18 years old for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. Hospitals were intended to increase accurate and complete medication lists in order to ensure patients are taking the correct medication regimen and decrease the likeliness of serious adverse drug events (ADE) occurring. Documentation of current medication rates increased as intended for county hospitals (Exhibit 108).

Exhibit 108: PRIME Hospital-Reported Documentation of Current Medication in the Medical Record Rates for Metric 2.4.3

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
County	68.89%	80.94%	85.36%	88.26%	19.38%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. Project 2.4-Specific PRIME Target Population: 1) Individuals with at least 1 encounter with the PRIME Entity Primary Care team during the first half of the measurement period) AND 2) Child, 0 to less than 18 years old, in out of home placement under the jurisdiction of the local children's dependency system (as identified by the PRIME entity) at any point during the measurement period AND 3) If the child had more than one removal in the measurement period, for the purpose of this measure, use the earliest removal date that meets the Project 2.4 Tenure Criteria. Tenure Criteria: the child must continue to remain in protective custody under the jurisdiction of the local children's dependency system for a minimum of 30 consecutive days after the date of removal.

Metric 2.4.4 – Screening for Clinical Depression and Follow-Up

Metric 2.4.4 measured the percentage of individuals age 12 and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen. Hospitals were intended to improve identification and treatment of depression in its early stages in order to reduce risks of the negative outcomes associated with depression by increasing routine screenings for depression as a part of primary care for those age 12 and older until DY 14, when this was categorized for those aged 12 to 17. Depression screening rates increased as intended for County hospitals (Exhibit 109).

Exhibit 109: PRIME Hospital-Reported Clinical Depression Screening Rates for Metric 2.4.4

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
County	20.00%	26.86%	57.86%	71.43%	51.43%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. Project 2.4-Specific PRIME Target Population: 1) Individuals with at least 1 encounter with the PRIME Entity Primary Care team during the first half of the measurement period) AND 2) Child, 0 to less than 18 years old, in out of home placement under the jurisdiction of the local children's dependency system (as identified by the PRIME entity) at any point during the measurement period AND 3) If the child had more than one removal in the measurement period, for the purpose of this measure, use the earliest removal date that meets the Project 2.4 Tenure Criteria. Tenure Criteria: the child must continue to remain in protective custody under the jurisdiction of the local children's dependency system for a minimum of 30 consecutive days after the date of removal.

Metric 2.4.5 – Tobacco Use – Screening and Cessation Intervention

Metric 2.4.5 measured the percentage of patients aged 13 years and older who were screened for tobacco use 1 or more times within 24 months and who received cessation counseling intervention if identified as a tobacco user. Hospitals were intended to promote screening and cessation interventions for those who use tobacco products. There is good evidence to suggest such actions are successful in helping tobacco users quit. Metric 1.2.14.t was revised with additional instructions in DY 14 to include 3 criteria, of which entities reported the 3rd (Exhibit 37). Tobacco assessment and counseling rates increased as intended for county hospitals (Exhibit 110).

Exhibit 110: PRIME Hospital-Reported Tobacco Use – Screening and Cessation Intervention Rates for Metric 2.4.5

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
County	64.24%	88.46%	94.87%	96.51%	32.26%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. Project 2.4-Specific PRIME Target Population: 1) Individuals with at least 1 encounter with the PRIME Entity Primary Care team during the first half of the measurement period) AND 2) Child, 0 to less than 18 years old, in out of home placement under the jurisdiction of the local children's dependency system (as identified by the PRIME entity) at any point during the measurement period AND 3) If the child had more than one removal in the measurement period, for the purpose of this measure, use the earliest removal date that meets the Project 2.4 Tenure Criteria. Tenure Criteria: the child must continue to remain in protective custody under the jurisdiction of the local children's dependency system for a minimum of 30 consecutive days after the date of removal.

Metric 2.4.6 – Well Child Visits – First 15 Months of Life

Metric 2.4.6 measured the percentage of children who turned 15 months old during the measurement year and had 6 or more well child visits with a primary care physician (PCP) during their first 15 months of life. Hospitals were intended to increase well child visits at age-appropriate times because early interventions increase overall wellness and reduce medical costs. This metric was removed and replaced by Metric 2.4.8 in the PRIME Project 2.4 measure set after DY 12 (and results for this metric are available in the Interim Report.

Metric 2.4.7 – Well Child Visits – Third, Fourth, Fifth, and Sixth Years of Life

Metric 2.4.7 measured the percentage of children ages 3 to 6 who had 1 or more well-child visits with a primary care physician (PCP) during the measurement period. Hospitals were intended to increase well child visits in order to assess physical, emotional, and social development There is evidence these actions would ultimately influence health and development as the child progresses towards adulthood. Well child visit rates increased as intended for county hospitals (Exhibit 111).

Exhibit 111: PRIME Hospital-Reported Well Child Visit Rates for Metric 2.4.7

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
County	88.37%	87.16%	92.74%	88.60%	0.23%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. Project 2.4-Specific PRIME Target Population: 1) Individuals with at least 1 encounter with the PRIME Entity Primary Care team during the first half of the measurement period) AND 2) Child, 0 to less than 18 years old, in out of home placement under the jurisdiction of the local children's dependency system (as identified by the PRIME entity) at any point during the measurement period AND 3) If the child had more than one removal in the measurement period, for the purpose of this measure, use the earliest removal date that meets the Project 2.4 Tenure Criteria. Tenure Criteria: the child must continue to remain in protective custody under the jurisdiction of the local children's dependency system for a minimum of 30 consecutive days after the date of removal.

Metric 2.4.8 – Comprehensive Medical Evaluation Following Foster Youth Placement in Foster Care

Metric 2.4.8 measured the number of patients with an encounter with a primary care provider within 30 days of their Date of Removal. Hospitals were intended to increase the rate of medical evaluations for foster children to ensure foster children have timely access to appropriate medical care.

This metric was added in DY 13 to replace Metric 2.4.6 in the PRIME Project 2.4 measure set.

Exhibit 112: PRIME Hospital-Reported for Comprehensive Medical Evaluation Rates for Metric 2.4.8*

DPH	DY 13 P4R	DY 14 P4R	Change from DY 13 to DY 14	Increased as Intended
County	68.95%	79.67%	10.72%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.

*Notes: DPH: designated public hospital, DY: demonstration year, P4R: pay-for-reporting. * Denotes innovative metric. Project 2.4-Specific PRIME Target Population: 1) Individuals with at least 1 encounter with the PRIME Entity Primary Care team during the first half of the measurement period) AND 2) Child, 0 to less than 18 years old, in out of home placement under the jurisdiction of the local children's dependency system (as identified by the PRIME entity) at any point during the measurement period AND 3) If the child had more than one removal in the measurement period, for the purpose of this measure, use the earliest removal date that meets the Project 2.4 Tenure Criteria. Tenure Criteria: the child must continue to remain in protective custody under the jurisdiction of the local children's dependency system for a minimum of 30 consecutive days after the date of removal.*

Project 2.5 – Transition to Integrated Care: Post Incarceration

Project Overview and Summary of Key Findings

Project 2.5 was designed to improve the transition of care for those recently incarcerated from the criminal justice system into the public health care system. The main goals of the project were to enroll post-incarcerated patients in health coverage; establish them with primary care; and coordinate their care between medical, behavioral health, and social services. Specific objectives can be found in Attachment Q.

This was an optional project for DPHs, of which 2 participated through DY 14; previously, 2 DMPHs ended participation in DY 12. Detailed information on DPH and DPMH participation can be found in Appendix B. PRIME Project Selections.

Performance of hospitals in Project 2.5 was measured by the following 5 metrics (Exhibit 113**: PRIME Project 2.5 Metric Details**).

Exhibit **113***: PRIME Project 2.5 Metric Details*

Metric Name	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcome of Care
Alcohol and Drug Misuse Sub-rate #1: Brief Annual Screen	2.5.1	Increase	Process
Alcohol and Drug Misuse Screening, Brief Intervention, and Referral to Treatment (SBIRT) Sub-rate #2: Full Screen	2.5.1	Increase	Process
Controlling Blood Pressure	2.5.2	Increase	Outcome
Prevention Quality Overall Composite #90	2.5.3	Decrease	Outcome
Screening for Clinical Depression and Follow-Up	2.5.4	Increase	Process
Tobacco Use: Screening and Cessation Intervention	2.5.5	Increase	Process

Source: PRIME Metrics Specs, DY 14YE
Notes: A sub-rate was added to 2.5.1 in DY 14.

Overall, DPHs generally had improvements in the majority of metrics. DPHs reported continuous improved performance in 2 metrics (2.5.3, 2.5.4). Performance in the other 3 metrics (2.5.1, 2.5.2, and 2.5.5) also improved, but inconsistently over time.

Metric 2.5.1 – Alcohol and Drug Misuse Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Metric 2.5.1 measured the rates of screening for alcohol or drug misuse and appropriate intervention and referral to treatment. Hospitals were intended to decrease future risks and complications by improving the detection of alcohol-related disorders and intervention. The original SBIRT metric became sub-rate #2 (full screening), thus the change over time could be calculated and the metric was P4P in DY 14. The new sub-rate #1 is for a brief annual screening and was P4R in DY 14. The denominator includes individuals in the PRIME Project 2.5 Target Population ages 12 years or older who had a qualifying outpatient service. The SBIRT rate increased as intended for County DPHs.

Exhibit 114: PRIME Hospital-Reported Alcohol and Drug Misuse Screening, Brief Intervention, and Referral to Treatment (SBIRT) Rates for Metric 2.5.1 (Sub-rate #2)

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
County	21.10%	19.91%	41.82%	42.94%	21.84%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, P4R: pay-for-reporting, P4P: pay-for-performance, DY: demonstration year. The Target Population are those in the PRIME Eligible Population who are incarcerated in prison and/or jail that are soon-to-be released, or released during the 6 months prior to the start of the measurement period and have at least one chronic health condition or are greater than 50 years old.

Exhibit 115: PRIME Hospital-Reported Alcohol and Drug Misuse Brief Annual Screening Rates for Metric 2.5.1 (Sub-rate #1)

DPH	DY 14 P4R
County	72.14%

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, P4R: pay-for-reporting, DY: demonstration year. The Target Population are those in the PRIME Eligible Population who are incarcerated in prison and/or jail that are soon-to-be released, or released during the 6 months prior to the start of the measurement period and have at least one chronic health condition or are greater than 50 years old. A separate brief annual screening sub-rate came into effect for DY 14 and was applicable for the remainder of PRIME.

Metric 2.5.2 – Controlling Blood Pressure

Metric 2.5.2 measured the proportion of patients between the ages of 18 and 85 that had at least 1 outpatient encounter with a diagnosis of hypertension and had their blood pressure (BP) adequately controlled. For all patients aged 18 to 59, and patients aged 60 to 85 with a diagnosis of diabetes, adequately controlled BP was defined as <140/90 mmHg. For patients between the ages of 60 and 85 without a diagnosis of diabetes, adequately controlled BP was <150/90 mmHg. In DY14, the definition of adequate control was changed to be the same for all groups (<140/90). Hospitals were intended to increase early detection of hypertension so that patients could start interventions earlier. Overall, controlling blood pressure rates increased as intended for county hospitals (Exhibit 116).

Exhibit 116: PRIME Hospital-Reported Controlling Blood Pressure Rates for Metric 2.5.2

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
County	43.97%	63.24%	61.63%	74.42%	30.45%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, P4R: pay-for-reporting, P4P: pay-for-performance, DY: demonstration year. The Target Population are those in the PRIME Eligible Population who are incarcerated in prison and/or jail that are soon-to-be released, or released during the 6 months prior to the start of the measurement period and have at least one chronic health condition or are greater than 50 years old.

Metric 2.5.3 – Prevention Quality Overall Composite #90

Metric 2.5.3 measured the proportion of patients 18 years of age or older who were discharged and met the inclusion and exclusion rules for the numerator in following PQIs: #1, 3, 5, 7, 8, 10-12, and 14-16. PQI was also Metric 1.2.8 and 2.3.3 (Exhibit 181). This metric was retired after DY 13, so no data was reported for DY 14 and results for this metric are available in the Interim Report.

Metric 2.5.4 – Screening for Clinical Depression and Follow-Up

Metric 2.5.4 measured the percentage of individuals age 18 and older screened for clinical depression in an eligible encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen. Hospitals were intended to improve identification and treatment of depression in its early stages in order to reduce risks of the negative outcomes associated with depression by increasing routine screenings for depression as a part of primary care. Overall, screening for clinical depression and follow-up rates increased as intended for county hospitals.

Exhibit 117: PRIME Hospital-Reported Screening for Clinical Depression and Follow-Up Rates for Metric 2.5.4

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
County	14.32%	61.67%	65.02%	62.74%	48.42%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, P4R: pay-for-reporting, P4P: pay-for-performance, DY: demonstration year. The Target Population are those in the PRIME Eligible Population who are incarcerated in prison and/or jail that are soon-to-be released, or released during the 6 months prior to the start of the measurement period and have at least one chronic health condition or are greater than 50 years old.

Metric 2.5.5 – Tobacco Use – Screening and Cessation Intervention

Metric 2.5.5 measured the proportion of patients 18 and older who were screened for tobacco use at least once within 24 months and who received tobacco cessation intervention if identified as a tobacco user. Hospitals were intended to promote screening and intervention for tobacco users. There is good evidence to suggest such actions are successful in helping tobacco users quit. Tobacco Use – Screening and Cessation Intervention was revised with additional instructions in DY 14 to include 3 criteria, of which entities reported the 3rd (Exhibit 37). Tobacco use screening and cessation intervention rates increased as intended.

Exhibit 118: PRIME Hospital-Reported Tobacco Use- Screening and Cessation Intervention Rates for Metric 2.5.5

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
County	58.15%	81.19%	75.26%	91.74%	33.59%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, P4R: pay-for-reporting, P4P: pay-for-performance, DY: demonstration year. The Target Population are those in the PRIME Eligible Population who are incarcerated in prison and/or jail that are soon-to-be released, or released during the 6 months prior to the start of the measurement period and have at least one chronic health condition or are greater than 50 years old.

Project 2.6 – Chronic Non-Malignant Pain Management

Project Overview and Summary of Key Findings

Project 2.6 was intended to promote identification and management of chronic pain using evidence-based models that are designed to improve outcomes. These goals were achieved by developing infrastructure, such as developing protocols and training providers about multimodal approaches to pain, and implementation activities, including monitoring adherence to policies and utilizing screening tools. Specific objectives can be found in Attachment Q.

By the end of DY 14, a total of 14 hospitals continued to participate and report metric performance. This project was optional, and 9 DPHs participated with 1 adding the project in DY 12 and 5 DMPHs participated through DY 14. Detailed information on DPH and DPMH participation can be found in Appendix B. PRIME Project Selections.

Performance of hospitals in Project 2.6 was measured by the following 5 metrics, including 2.6.1 which had two sub-rates (Exhibit 42).

Exhibit 119: PRIME Project 2.6 Metric Details

Metric Name	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcome of Care
Alcohol and Drug Misuse Sub-rate #1: Brief Annual Screen	2.6.1	Increase	Process
Alcohol and Drug Misuse Sub-rate #2: Full Screen, Brief Intervention, and Referral to Treatment (SBIRT)	2.6.1	Increase	Process
Assessment and Management of Chronic Pain: Patients Diagnosed with Chronic Pain Who Are Prescribed an Opioid Who Have an Opioid Agreement Form and an Annual Urine Toxicology Screen	2.6.2	Increase	Process
Patients with Chronic Pain on Long Term Opioid Therapy Checked in PDMPs	2.6.3*	Increase	Process
Screening for Depression and Follow-Up	2.6.4	Increase	Process
Treatment of Chronic Non-Malignant Pain with Multi-Modal Therapy	2.6.5*	Increase	Process

Source: PRIME Metrics Specs, DY 14YE
*Notes: * Denotes innovative metric.*

Overall, DPHs showed progress in 3 metrics (2.6.2, 2.6.3, 2.6.4) and had an inconsistent pattern over time but overall improved results in 2 metrics (2.6.1, 2.6.5). DMPHs showed progress in all 5 metrics (2.6.1, 2.6.2, 2.6.3, 2.6.4, 2.6.5).

Metric 2.6.1 – Alcohol and Drug Misuse Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Metric 2.6.1 measured the rates of screening for alcohol or drug misuse and appropriate intervention and referral to treatment. Hospitals were intended to decrease future risks and complications by improving the detection of alcohol-related disorders and intervention. The original SBIRT metric became sub-rate #2 (full screening), thus the change over time could be calculated and the metric was P4P in DY 14. The new sub-rate #1 is for a brief annual screening and was P4R in DY 14. The denominator includes individuals in the PRIME Project 2.6 Target Population ages 12 years or older who had a qualifying outpatient service. SBIRT rates increased as intended for all hospital types (Exhibit 120).

Exhibit 120: PRIME Hospital-Reported Alcohol and Drug Misuse Screening, Brief Intervention, and Referral to Treatment (SBIRT) Rates for Metric 2.6.1 (Full screening, Sub-rate #2)

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	3.77%	3.17%	4.46%	8.22%	4.45%	Yes
UC	0.15%	0.12%	1.74%	9.95%	9.80%	Yes
County	4.18%	4.56%	5.37%	3.52%	3.52%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	1.92%	15.92%	29.77%	27.85%	Yes
Non-CAH	---	0.00%	47.97%	35.79%	35.79%	Yes
CAH	---	2.09%	10.79%	28.08%	25.99%	Yes

Source and notes below.

Exhibit 121: PRIME Hospital-Reported Alcohol and Drug Misuse Brief Screening Rates for Metric 2.6.1 (Brief Annual Screening, Sub-rate #1)

DPH	DY 14 P4R
Total	54.57%
UC	3.09%
County	70.24%
DMPH	**DY 14 P4R**
Total	57.65%
Non-CAH	58.99%
CAH	57.27%

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital,

CAH: critical access hospital, P4R: pay-for-reporting. The brief annual screening came into effect for DY 14 and was applicable for the remainder of PRIME. Target Population is the PRIME Eligible Population with a moderate to severe chronic pain diagnosis and without cancer nor enrolled in hospice.

Metric 2.6.2 – Assessment and Management of Chronic Pain: Patients Diagnosed with Chronic Pain Who Are Prescribed an Opioid Who Have an Opioid Agreement Form and an Annual Urine Toxicology Screen

Metric 2.6.2 measured the number of patients with documentation of patient provider agreement and toxicology testing at least once during the measurement period among the Project 2.6 Target Population on long-term opioid therapy (patients with active prescriptions of opioid-containing medication for greater than 90 consecutive days. Hospitals were intended to enhance appropriate opioid therapy management for patients with chronic pain. In DY 13, this metric was modified to be an innovative metric. This included the following changes: standardizing the definition of “toxicology testing,” and modifying criteria for Pain Agreement and Toxicology testing so that both include time criteria as specified by "at least once during the measurement period.” Additionally, the metric added that "urine drug testing is the preferred method for toxicology testing. However, there may be extenuating circumstances in which serum or salivary testing may be more appropriate and will qualify as numerator compliant.” Codes were updated to align with these changes. The denominator language was changed to match 2.6.3 and added: "Data for 'long-term opioid therapy' may be sourced from any of the following: Medication Lists in the medical chart, Pharmacy claims/fill data, and ICD-10 code: Z79.891." Denominator exclusion criteria removed “Patients with Migraines.” The definition specifies that "'Opioid Therapy is Active' Prescription for Opioid therapy includes sufficient doses to last until or past the last day of the measurement period or dispensing of opioid therapy continues through the last day of the measurement period.". All reported assessment and management of chronic pain rates increased as intended for all hospital types (Exhibit 122).

Exhibit 122: PRIME Hospital-Reported Assessment and Management of Chronic Pain Rates for Metric 2.6.2

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	28.54%	28.85%	36.25%	61.26%	32.72%	Yes
UC	13.07%	23.91%	42.74%	61.63%	48.56%	Yes
County	34.39%	30.76%	31.06%	60.73%	26.34%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	22.85%	34.80%	69.16%	46.31%	Yes
Non-CAH	---	11.11%	27.48%	63.27%	52.16%	Yes
CAH	---	26.85%	38.31%	72.38%	45.53%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. DMPHs did not report data in DY 11.

Metric 2.6.3 – Patients with Chronic Pain on Long Term Opioid Therapy Checked in PDMPs

Metric 2.6.3 measured the proportion of patients on long-term opioid therapy who had annual checks for prescription drug monitoring programs (PDMPs) among the Project 2.6 Target Population (patients with active prescriptions opioid-containing medication for greater than 90 consecutive days). Hospitals were intended to minimize the risk of opioid prescribing by multiple prescribers. All prescription drug monitoring program (PDMP) review rates increased as intended for all hospital types (Exhibit 123).

Exhibit 123: PRIME Hospital-Reported Prescription Drug Monitoring Program (PDMP) Review Rates for Metric 2.6.3*

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	28.22%	28.65%	56.95%	92.48%	64.26%	Yes
UC	15.56%	17.57%	65.75%	96.71%	81.15%	Yes
County	29.49%	29.19%	49.87%	86.34%	56.85%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	27.26%	41.81%	82.71%	55.45%	Yes
Non-CAH	---	0.00%	31.53%	82.04%	82.04%	Yes
CAH	---	37.33%	46.75%	83.07%	45.74%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
*Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. DMPHs did not report data in DY 11. * Denotes innovative metric.*

Metric 2.6.4 – Screening for Depression and Follow-up

Metric 2.6.4 measured the percentage of individuals age 18 and older screened for clinical depression in an eligible encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen. Hospitals were intended to improve identification and treatment of depression in its early stages in order to reduce risks of the negative outcomes associated with depression by increasing routine screenings for depression as a part of primary care. All reported screening for depression and follow-up rates increased as intended for all hospital types (Exhibit 124).

Exhibit 124: PRIME Hospital-Reported Screening for Depression and Follow-Up Rates for Metric 2.6.4

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	24.02%	31.45%	70.81%	81.42%	57.40%	Yes
UC	2.95%	7.26%	63.60%	77.68%	74.73%	Yes
County	34.26%	43.74%	72.69%	82.40%	48.14%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	39.29%	56.66%	82.65%	43.36%	Yes
Non-CAH	---	4.21%	72.46%	87.94%	83.73%	Yes
CAH	---	44.09%	53.06%	81.13%	37.04%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. DMPHs did not report data in DY 11.

Metric 2.6.5 – Treatment of Chronic Non-Malignant Pain with Multi-Modal Therapy

Metric 2.6.5 measured the proportion of patients who received a recommendation, education about, prescription for, or referral to non-opioid pain management in the outpatient setting among the Project 2.6 Target Population. The hospitals were intended to track the possible overprescribing of opioids by healthcare providers. A multi-modal, multidisciplinary approach to pain management could help increase utilization of non-opioid treatment modalities. All reported treatment of chronic nonmalignant pain with multi-model therapy rates increased as intended for all hospital types (Exhibit 125).

Exhibit 125: PRIME Hospital-Reported Treatment of Chronic Non-Malignant Pain with Multi-Modal Therapy Rates for Metric 2.6.5*

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	82.44%	81.54%	85.12%	88.45%	6.01%	Yes
UC	87.33%	88.21%	84.43%	87.49%	0.16%	Yes
County	79.97%	79.08%	85.35%	88.72%	8.75%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Total	---	58.65%	73.72%	88.61%	29.96%	Yes
Non-CAH	---	0.00%	34.68%	80.69%	80.69%	Yes
CAH	---	81.58%	93.78%	95.07%	13.49%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
*Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. DMPHs did not report data in DY 11. * Denotes innovative metric.*

Project 2.7 – Comprehensive Advanced Illness Planning and Care

Project Overview and Summary of Key Findings

Project 2.7 was designed to improve the quality of end of life care by ensuring access to comprehensive palliative care that is aligned with patient preferences in hospital and community settings. Hospitals were to accomplish these goals by establishing the infrastructure for delivering palliative care, such as multidisciplinary care teams that are located in outpatient and inpatient settings and are trained to deliver this care; as well as following appropriate care processes, such as providing the needed care and linking patients to community-based providers. Specific objectives include: increase timely access to ambulatory and inpatient palliative care services, introduce Primary and/or Specialty Palliative Care services at the time of diagnosis of serious illness, relieve pain and other distressing symptoms, improve quality of life for both the patient and the family, improve concordance between patient/family preference and provision of care, and reduce avoidable acute care utilization.

By the end of DY 14, a total of 12 hospitals continued to participate and report metric performance for Project 2.7. Detailed information on DPH and DPMH participation can be found in Appendix B. PRIME Project Selections. Performance of hospitals in Project 2.7 was measured by the following 6 metrics (Exhibit 126).

Exhibit 126: PRIME Project 2.7 Metric Details

Metric Name	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcome of Care
Advance Care Plan	2.7.1	Increase	Process
Ambulatory Palliative Team Established (DY 11-DY 13)	2.7.2*	Increase	Process
MWM #8 - Treatment Preferences (Inpatient)	2.7.3	Increase	Process
MWM #8 - Treatment Preferences (Outpatient)	2.7.4*	Increase	Process
Palliative Care Service Offered to Patients with Advanced Illness	2.7.5*	Increase	Reporting
Proportion Admitted to Hospice for Less than 3 Days	2.7.6	Decrease	Process

Source: PRIME Metrics Specs, DY 14YE
Notes: Denotes innovative metric.*

Hospitals showed improvement in 5 metrics (2.7.1, 2.7.2, 2.7.3, 2.7.4, and 2.7.6). While results were mixed for DPHs in 1 metric (2.7.5), DMPHs showed progress in this metric.

Metric 2.7.1 – Advance Care Plan

Metric 2.7.1 measured the percentage of patients in the PRIME Project 2.7 target population, aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan (NQF 0326, QPP). Hospitals were intended to better establish and clarify patient wishes regarding their medical treatment. All care plan rates increased as intended for all hospital types.

Exhibit 127: PRIME Hospital-Reported Advance Care Plan Rates for Metric 2.7.1

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	42.96%	51.31%	59.17%	63.96%	21.00%	Yes
UC	40.34%	38.11%	47.83%	55.20%	14.86%	Yes
County	56.47%	96.89%	97.90%	97.07%	40.59%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	36.45%	53.90%	85.49%	49.04%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11.

Metric 2.7.2 – Ambulatory Palliative Team Established

Metric 2.7.2 was an innovative metric that determined whether PRIME entities had a multidisciplinary care team available, defined by the presence of an outpatient or home-based interdisciplinary palliative care service that includes care provided by a physician, nurse, social worker, and availability of a spiritual care professional, at least one of whom has evidence of training in palliative care. Metrics 2.7.2 and Metric 2.7.5 were linked, so if the hospital had a care team (meaning they reported "yes" to 2.7.2), then they reported data for 2.7.5. The data for this metric was primarily narrative. Metric 2.7.2 was retired following DY 13, so results for this metric are available in the Interim Report.

Metric 2.7.3 – Treatment Preferences (Inpatient)

Metric 2.7.3 measured the number of patients *18 years of age and older from the Project Target Population receiving specialty palliative care (except for those with exclusions)* in an acute hospital setting in which the patient or responsible party was asked about preferences regarding use of life-sustaining treatments. Hospitals were intended to improve patient and family satisfaction outcomes by ensuring patients nearing the end of their life have an opportunity to express their preferences *that guide the use of life-sustaining forms of* treatment in the inpatient setting. All inpatient treatment preference rates increased as intended for all hospital types.

Exhibit 128: PRIME Hospital-Reported Inpatient Treatment Preference Rates for Metric 2.7.3

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	52.76%	78.84%	89.52%	92.94%	40.17%	Yes
UC	56.52%	80.46%	92.69%	95.65%	39.12%	Yes
County	44.26%	74.59%	76.83%	85.16%	40.89%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	53.13%	95.97%	86.29%	33.16%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11.

Metric 2.7.4 – Treatment Preferences (Outpatient)

Metric 2.7.4 measured the number of patients 18 or older who are receiving specialty palliative care in an ambulatory setting with documented or confirmed preferences about life-sustaining treatments or hospitalization (MWM#8). Hospitals were intended to focus on appropriate care by explicitly integrating the outpatient palliative care patients' preferences for life-sustaining treatments. All hospital-reported outpatient treatment preferences rates increased as intended for all hospital types.

Exhibit 129: PRIME Hospital-Reported Outpatient Treatment Preferences Rates for Metric 2.7.4*

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14+	Increased as Intended
Total	78.43%	77.36%	87.87%	96.06%	17.63%	Yes
UC	78.43%	80.41%	86.59%	96.48%	18.04%	Yes
County	N/A	74.01%	91.67%	94.29%	20.27%+	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	17.68%	54.42%	78.21%	60.54%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. + Change was measured from DY 12 to DY 14 for County hospitals. N/A: analyses not conducted due to a denominator less than 30. Denotes innovative metric.*

Metric 2.7.5 – Palliative Care Service Offered to Patients with Advanced Illness

Metric 2.7.5 measured the rate of palliative care services/referrals offered during the measurement period to patients aged 18 and older with advanced illness. Hospitals were intended to increase palliative care services to patient who may benefit from them. Metrics 2.7.2 and Metric 2.7.5 were linked, so if the hospital had a palliative care team (meaning they reported "yes" to 2.7.2), then they reported data for Metric 2.7.5. Of all participating hospital types, only Non-CAH DMPH hospitals reported increased rates as intended of palliative care services offered to patients with advanced illnesses.

Exhibit 130: PRIME Hospital-Reported Palliative Care Services Offered to Patients with Advanced Illness Rates for Metric 2.7.5*

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4R	Change from DY 11 to DY 14	Increased as Intended
Total	16.22%	14.09%	18.01%	5.85%	-10.37%	No
UC	14.62%	7.61%	15.45%	7.41%	-7.21%	No
County	19.20%	25.57%	21.59%	4.00%	-15.20%	No
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4R**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	8.98%	23.02%	17.01%	8.03%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11.

Metric 2.7.6 – Proportion Admitted to Hospice for Less than 3 Days

Metric 2.7.6 measured the percentage of patients in the Project 2.7 Target Population who were admitted to hospice fewer than 3 days before they died; the denominator are all patients who died (NQF 0216). Hospitals were intended to ensure patients receive earlier referrals and admissions to hospice. All hospital types reported decreases in the intended direction for rates of hospice admission less than 3 days before death.

Exhibit 131: PRIME Hospital-Reported Hospice Admission Less than 3 Days Rates for Metric 2.7.6

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Decreased as Intended
Total	29.34%	13.93%	10.51%	9.89%	-19.45%	Yes
UC	34.81%	11.42%	9.15%	10.65%	-24.15%	Yes
County	16.67%	15.29%	13.48%	7.23%	-9.44%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Decreased as Intended**
Non-CAH	---	21.68%	19.78%	13.78%	-7.90%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11.

Project 3.1 Antibiotic Stewardship

Project Overview and Summary of Key Findings

Project 3.1 was designed to reduce the resistance of infections to antimicrobials by implementing an antibiotic stewardship program that reduces antibiotic use for non-bacterial diseases and optimizes antibiotic use for bacterial infections. These goals were to be achieved by developing the necessary infrastructure such as a multidisciplinary team and clinical protocols for appropriate antibiotic use; as well as implementing the project broadly through stewardship rounds and monitoring provider performance. Specific objectives can be found in Attachment Q.

A total of 12 hospitals chose to participate and reported metric performance data through DY 14 for Project 3.1, which was not required for DPHs. The total included 5 DPHs and 7 DMPHs that participated through DY 14, with 1 additional DPMH dropping halfway through DY 12. Detailed information on DPH and DPMH participation can be found in Appendix B. PRIME Project Selections.

Performance of hospitals in Project 3.1 was measured by the following 5 metrics (Exhibit 132). Among these, 4 were standard metrics and 1 was an innovative metric.

Exhibit 132: PRIME Project 3.1 Metric Details

Metric Name	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcome of Care
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis#	3.1.1	Increase	Process
Avoidance of Antibiotic Treatment with Low Colony Urinary Cultures (retired after DY 11)	3.1.2*	Decrease	Process
National Healthcare Safety Network (NHSN) Antimicrobial Use Measure	3.1.3	Decrease	Process
Peri-Operative Prophylactic Antibiotics Administered After Surgical Closure^	3.1.4	Decrease	Process
Reduction in Hospital Acquired Clostridium Difficile Infections	3.1.5	Decrease	Outcome

Source: PRIME Metrics Specs, DY 14YE
Notes: Denotes innovative metric. # Metric in DY 11 was reported as "Patients who were dispensed antibiotic medication on or 3 days after the index episode start date (a higher rate is better). The measure is reported as an inverted rate (i.e. 1- numerator/ denominator) to reflect the number of people not dispensed an antibiotic." In DY 12, the metric changed "prescribed" to "not prescribed or dispensed" and removed the inverted rate. ^ Metric name in DY 11 was "Prophylactic antibiotics discontinued at time of surgical closure."*

DPHs improved in all metrics where a trend could be calculated, except for 3.1.4, where a large increase in rates for DPH County hospitals led the overall DPH rates in the unintended direction. DMPHs showed the appropriate decreasing trends for all metrics (3.1.2, 3.1.3, 3.1.4, 3.1.5). However, DMPH CAHs had issues with denominator size, which was a challenge to reporting performance, as several hospitals did not meet the 30-patient denominator threshold for Metric 3.1.4.

Metric 3.1.1 – Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

Metric 3.1.1 measured the proportion of patients age 18 – 64 years of age in the PRIME 3.1 Target Population with an outpatient or emergency department (ED) visit with a diagnosis of acute bronchitis who were not prescribed antibiotics (NQF 0058). Hospitals were intended to reduce misuse and overuse of antibiotics; this metric aimed to help raise awareness among healthcare providers about inappropriate antibiotic use. DHCS issued a trend-break notice for this metric in DY 12 (PPL-17-007) because the Target Population was changed to those with a diagnosis of acute bronchitis who *were* prescribed antibiotics to instead be those who were *not* prescribed antibiotics, and instructions were removed to report an inverted rate. Thus, a trend was not calculated for this metric; a higher rate indicates better performance.

Exhibit 133: PRIME Hospital-Reported Avoidance of Antibiotic Treatment Rates for Acute Bronchitis for Metric 3.1.1

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P
Total	39.31%	46.59%	53.58%	53.66%
UC	66.34%	53.35%	55.67%	54.90%
County	32.67%	44.58%	53.03%	53.02%
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**
Total	---	56.56%	79.11%	86.41%
Non-CAH	---	56.23%	79.08%	86.49%
CAH	---	N/A	N/A	N/A

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance, N/A: analyses not conducted due to a denominator less than 30. ---: DMPHs did not report data in DY 11. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH. Metric 3.1.1 in DY 11 was reported as "Patients who were dispensed antibiotic medication on or 3 days after the index episode start date (a higher rate is better). The measure is reported as an inverted rate (i.e. 1-numerator/denominator) to reflect the number of people not dispensed an antibiotic." In DY 12, the metric changed "prescribed" to "not prescribed or dispensed" and removed the inverted rate.

Metric 3.1.2 – Avoidance of Antibiotic Treatment for Low Colony Urinary Cultures

Metric 3.1.2 measured the number of new systemic antibiotics administered to PRIME hospital patients with predetermined levels of colony counts of specified pathogens. Hospitals were intended to decrease unnecessary use of antibiotics by only treating patients who show bacterial levels consistent with infection (>100,000 colony forming units/ml). Only DY 11 data was reported, so this analysis can be found in the Interim Report.

Metric 3.1.3 – National Healthcare Safety Network Antimicrobial Use Measure

Metric 3.1.3 measured the proportion of aggregate sum of days for which any specific antimicrobial agent was administered to individual patients (NQF 2720). Hospitals were intended to evaluate their antimicrobial usage trends and determine and reduce unnecessary antimicrobial usage in order to decrease antibiotic resistance. County DPHs and Non-CAH DMPHs reported a decreasing trend in unnecessary antimicrobial usage.

Exhibit 134: PRIME Hospital-Reported Antimicrobial Use Rates for Metric 3.1.3

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14	Decreased as Intended
Total	18.88%	21.99%	15.41%	15.59%	-3.29%	Yes
UC	19.22%	30.21%	25.76%	26.05%	6.83%	No
County	18.58%	17.73%	12.04%	10.51%	-8.07%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 11 to DY 14**	**Decreased as Intended**
Total	---	25.55%	25.13%	21.34%	-4.21%	Yes
Non-CAH	---	25.58%	25.14%	21.33%	-4.25%	Yes
CAH	---	9.36%	10.07%	44.20%	34.84%	No

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting. ---: DMPHs did not report data in DY 11.

Metric 3.1.4 – Peri-Operative Prophylactic Antibiotics Administered After Surgical Closure

Metric 3.1.4 measured the number of surgical cases in which peri-operative antibiotics are administered after surgery unnecessarily. The rationale for this metric was to discourage providers from administering antimicrobial agent doses after the surgical incision is closed in the operating room. County DPHs and Non-CAH DMPHs reported a decreasing trend for unnecessary peri-operative antibiotics.

Exhibit 135: PRIME Hospital-Reported Peri-Operative Antibiotic Administration Rates for Metric 3.1.4

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14	Decreased as Intended
Total	16.65%	53.42%	43.91%	25.51%	8.86%	No
UC	15.95%	47.86%	38.55%	32.01%	16.06%	No
County	19.87%	67.08%	58.46%	10.65%	-9.22%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Decreased as Intended**
Total	---	38.81%	46.57%	23.68%	-15.13%	Yes
Non-CAH	---	38.76%	46.58%	23.68%	-15.08%	Yes
CAH	---	N/A	N/A	N/A	N/A	N/A

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting. N/A: analyses not conducted due to a denominator less than 30. ---: DMPHs did not report data in DY 11.

Metric 3.1.5 – Reduction in Hospital Acquired Clostridium Difficile Infections (CDI)

Metric 3.1.5 measured the ratio of total number of observed hospital-onset CDI laboratory-identified events (LabID) over the total number of expected hospital- onset CDI LabID events. Hospitals were intended to reduce hospital-onset CDI LabID occurrences by improving hospital management of infection and sanitation. UC DPHs and Non-CAH DMPHs reported a decreasing trend in hospital-onset CDI LabID occurrences.

Exhibit 136: PRIME Hospital-Reported Observed to Expected Hospital-Onset Clostridium Difficile Event Ratios for Metric 3.1.5

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Decreased as Intended
Total	0.91	0.84	0.58	0.69	-0.22	Yes
UC	1.27	0.92	0.65	0.70	-0.58	Yes
County	0.67	0.78	0.52	0.68	0.01	No
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Decreased as Intended**
Non-CAH	---	1.01	0.90	0.60	-0.40	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11. The achievement rate was not a weighted average because the underlying data was reported as a standardized infection ratio (SIR), and hospitals used the CDC National Healthcare Safety Network (NHSN) website to calculate the expected cases data.

Project 3.2 Resource Stewardship: High-Cost Imaging

Project Overview and Summary of Key Findings

Project 3.2 was designed to reduce inappropriate utilization of high-cost imaging studies. This goal was to be achieved by developing evidence-based models and methods on the appropriate use of imaging; establishing processes and protocols, such as monitoring imaging use; and making decision support tools available to providers. Specific objectives can be found in Attachment Q.

By the end of DY 14, 8 hospitals reported metric performance data. This project was optional for DPHs and 5 participated in DY 14, as well as 3 DMPHs. Detailed information on DPH and DPMH participation can be found in Appendix B. PRIME Project Selections.

Performance of hospitals in Project 3.2 was measured by 4 metrics (Exhibit 137).

Exhibit 137: PRIME Project 3.2 Metric Details

Metric Name	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcome of Care
Don't Do Imaging for Uncomplicated Headaches (Choosing Wisely)	3.2.1*	Decrease	Process
Appropriate Emergency Department Utilization of CT for Pulmonary Embolism	3.2.2	Increase	Process
Use of Imaging Studies for Low Back Pain	3.2.3	Increase	Process
Appropriate Use of Imaging Studies for Low Back Pain (Anytime)	3.2.4*	Increase	Process
Inappropriate Use of Imaging Studies for Low Back Pain	3.2.4*	Decrease	Process

Source: PRIME Metrics Specs, DY 14YE
*Notes: CT: Computed Tomography, * Denotes innovative metric.*

Metric performance for DPHs included progress in the intended direction for 2 metrics (3.2.2 and 3.2.4) and movement in the unintended direction for 2 metrics, but by a small percentage – less than 5% (3.2.1 and 3.2.3). DMPHs reported progress in the intended direction for all metrics. For metric 3.2.2, both DPHs and DMPHs reported a steady increase in rates in the intended direction, around 35% and 60% respectively. Metric 3.2.4 had 2 sub-rates (appropriate and inappropriate imaging) and was revised after DY

11. For DY 12 and beyond, DPHs showed an intended increase of 33% in appropriate imaging, and a matching intended 33% decrease in inappropriate imaging. Similarly, DMPHs showed an increase of 24% in appropriate imaging and a 24% decrease in inappropriate imaging. Overall, DPHs had varying success in the metrics within Project 3.2, whereas DMPHs reported movement in the intended direction for all metrics.

Metric 3.2.1 – Don't Do Imaging for Uncomplicated Headaches

Metric 3.2.1 measured the proportion of patients in the Metric 3.1 population with an outpatient diagnosis of headache that received a Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) related procedure within 30 days of the index case diagnosis. Hospitals were expected to apply the Choosing Wisely recommendations, developed by a national initiative of the American Board of Internal Medicine Foundation (ABIM) to reduce unnecessary and inappropriate ordering of tests. In DY 14 the metric was renamed to clarify that lower rates indicate potentially more appropriate treatment (*don't do* imaging for *uncomplicated* headaches). These rates decreased as intended for all hospital types except for UC DPHs.

Exhibit 138: PRIME Hospital-Reported Don't Do Imaging Rates for Uncomplicated Headaches Rates for Metric 3.2.1*

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Decreased as Intended
Total	13.86%	14.15%	12.94%	14.70%	0.85%	No
UC	13.61%	16.58%	15.47%	17.31%	3.70%	No
County	13.97%	13.47%	11.67%	12.31%	-1.66%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Decreased as Intended**
Non-CAH	---	34.06%	43.16%	22.59%	-11.47%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
*Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11. * Denotes innovative metric. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH.*

Metric 3.2.2 – Appropriate Emergency Department Utilization of CT for Pulmonary Embolism

Metric 3.2.2 measured the percentage of emergency department visits of patients with either 1) a CT pulmonary angiogram who had either moderate or high clinical probability for pulmonary embolism, or 2) a positive result or elevated D-dimer result. This metric was designed to promote appropriate ordering of CT pulmonary angiography based on pre-test conditions. The denominator includes patients in the Project 3.2 target population for all emergency department visits during which patients aged 18 or older had a CT pulmonary angiogram (CTPA) ordered by an emergency care provider, regardless of discharge disposition. All hospital types reported an increase in this rate as intended.

Exhibit 139: PRIME Hospital-Reported Appropriate Emergency Department Utilization of CT for Pulmonary Embolism Rates for Metric 3.2.2

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	60.25%	71.98%	91.28%	95.84%	35.59%	Yes
UC	96.76%	84.08%	93.01%	97.99%	1.22%	Yes
County	40.42%	56.10%	88.98%	93.00%	52.58%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	23.38%	55.50%	81.37%	57.99%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11.

Metric 3.2.3 – Use of Imaging Studies for Low Back Pain

Metric 3.2.3 measured the proportion of patients in the Project 3.2 Target Population 18-50 years of age with a diagnosis of uncomplicated lower back pain during either an outpatient or emergency department visit that did not have an imaging study conducted within 28 days of the diagnosis. Hospitals were intended to reduce unnecessary imaging for lower back pain. This metric was reported as an inverted rate with higher rates indicating improved performance. Non-CAH DPMHs were the only hospital type to report an increase in rates as intended.

Exhibit 140: PRIME Hospital-Reported Imaging Studies for Low Back Pain Rates for Metric 3.2.3

DPH	DY 11 P4R	DY 12 P4P	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
Total	86.63%	88.35%	90.32%	82.22%	-4.41%	No
UC	88.72%	90.28%	87.93%	69.71%	-19.01%	No
County	86.15%	87.81%	90.91%	84.66%	-1.49%	No
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	39.58%	75.45%	80.95%	41.37%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 11 and DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH.

Metric 3.2.4 – Use of Imaging Studies for Low Back Pain (Anytime): Appropriate and Inappropriate Imaging

Metric 3.2.4 measured the proportion of patients who received an imaging study with a principal diagnosis of low back pain (LBP), either appropriately (with clinical red flags present at any time in the patient's medical history) or inappropriately (with no documentation of clinical red flags). Hospitals were intended to reduce inappropriate imaging and promote appropriate imaging for lower back pain by applying clinically appropriate indications for imaging. This is an innovative metric which includes a definition of "red flags", while 3.2.3 (a HEDIS metric) does not.

In DY 11 the metric had 3 stratified levels which can be found in the Interim Report. From DY 12 to DY 14 the metric had 2 levels with the following sub-rates; Rate #1: Appropriate Imaging for LBP and Rate #2: Inappropriate Imaging for LBP. PRIME policy letters (PPL 19-002 and PPL-19-003) were issued regarding the trend-break, and hospitals reported the DY 13 and DY 14 version of the rates in the mid-year reporting.

The DY 14 version of the metrics is utilized in this analysis. All hospital types reported an increase in appropriate imaging and a decrease in inappropriate imaging as intended.

Exhibit 141: PRIME Hospital-Reported Appropriate Imaging for Low Back Pain Rates for Metric 3.2.4*

DPH	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 12 to DY 14	Increased as Intended
Total	27.40%	56.27%	60.57%	33.17%	Yes
UC	8.24%	53.92%	51.87%	43.63%	Yes
County	43.05%	59.22%	68.46%	25.41%	Yes
DMPH	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	22.69%	20.21%	46.78%	24.09%	Yes

Source and notes below.

Exhibit 142: PRIME Hospital-Reported Inappropriate Imaging for Low Back Pain Rates for Metric 3.2.4*

DPH	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 12 to DY 14	Decreased as Intended
Total	72.60%	43.73%	39.43%	-33.17%	Yes

DPH	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 12 to DY 14	Decreased as Intended
UC	91.76%	46.08%	48.13%	-43.63%	Yes
County	56.95%	40.78%	31.54%	-25.41%	Yes
DMPH	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Decreased as Intended**
Non-CAH	77.31%	79.79%	53.22%	-24.09%	Yes

Source: UCLA analysis of the hospital-reported data, February to June 2020.
*Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11. * Denotes innovative metric. UCLA analyzed this metric using the DY 14 definition in which the denominator consisted of patients who received a diagnosis of lower back pain and received an imaging study.*

Project 3.3 – Resource Stewardship: Therapies Involving High-Cost Pharmaceuticals

Project Overview and Summary of Key Findings

Project 3.3 was designed to promote resource stewardship to reduce costs and move toward efficient use of high-cost medications or moderate-cost medications with high prescribing volume. Participating PRIME hospitals strove to develop robust resource stewardship programs. This was to be accomplished through decision analysis and increased use of decision support mechanisms that provide the impact of high-cost pharmaceuticals on the hospital population in terms of both outcomes and efficient use of available resources to guide clinician use of targeted therapies involving high-cost medications. By establishing multidisciplinary teams of experts with committed time to monitor and contain pharmaceuticals costs and investing in resource stewardship, the project aimed at yielding significant savings. Specific objectives included increasing the appropriate use of high-cost pharmaceutical therapies, decreasing inappropriate use of high-cost pharmaceutical therapies, improving use of shared decision making with patients, driving down health-care costs through improved use of targeted mediations and prescribing behaviors, and optimizing 340B discounts, if eligible. Section 340B of the Public Health Service Act requires the discounted sale of outpatient drugs to specific types of health care organizations, such as HRSA-supported health centers and look-alikes, Medicare/Medicaid Disproportionate Share Hospitals, children's hospitals, and other safety net providers. Specific objectives can be found in Attachment Q.

By the end of DY 14, a total of 8 hospitals (7 DPHs and 1 DMPH) continued to participate and report metric performance. This project was not required. Detailed information on DPH and DPMH participation can be found in Appendix B. PRIME Project Selections.

Performance of hospitals in Project 3.3 was measured by 4 metrics (Exhibit 143), although in DY 12, the metric that measured documentation of current medication in the medical record in DY 11 was replaced with a more specific metric that measured documentation of medication reconciliation. All metrics reported in DY 14 are innovative, denoted with an asterisk.

Exhibit 143: PRIME Metrics for Project 3.3

Metric Name	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcomes of Care
Adherence to Medications	3.3.1*	Increase	Process

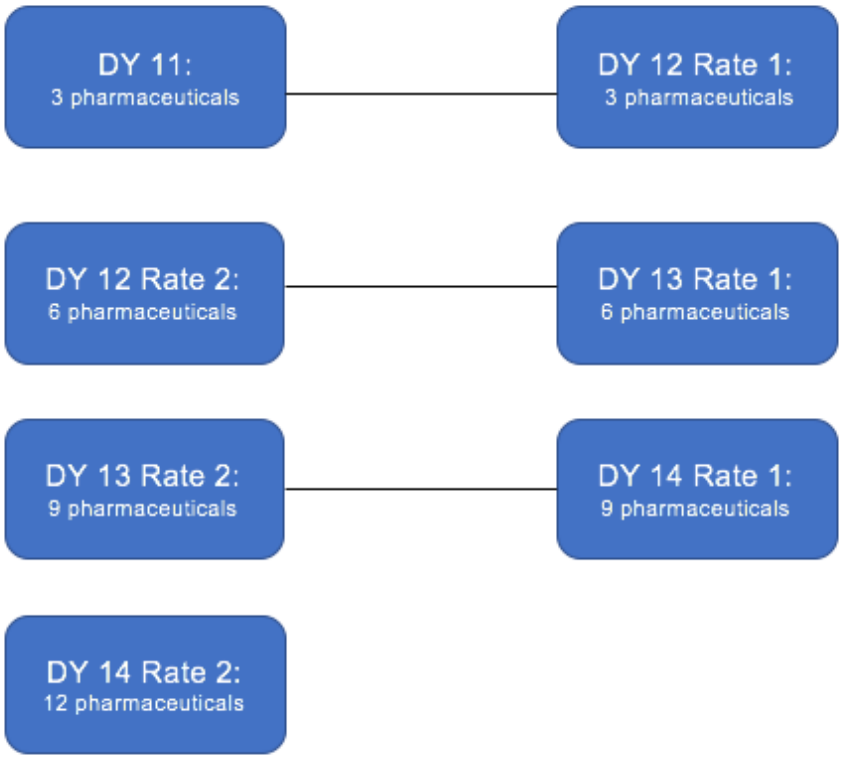
Metric Name	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcomes of Care
Documentation of Current Medications in the Medical Record (metric discontinued after DY 11)	3.3.2	Increase	Process
High-Cost Pharmaceutical Ordering Protocols	3.3.3*	Increase	Process
Documentation of Medication Reconciliation in the Medical Record for Patients on High-Cost Pharmaceuticals (added in DY 12)	3.3.4*	Increase	Process

Source: PRIME Metrics Specs, DY 14YE
*Notes: * Denotes innovative metric.*

Hospitals were required to target, at minimum, 3 new medications each DY and the same selection applied to all relevant metrics (Exhibit 144).Both DPHs and DMPHs reported a decrease in rates of patient adherence to high-cost pharmaceuticals for 6 medications, but an increase in rates for 9 medications from DY 13 to DY 14. No trend was observed for Metric 3.3.2, which was discontinued and replaced with Metric 3.3.4. In Metric 3.3.3, all hospitals reported an increase in rates throughout all demonstration years for high-cost pharmaceutical ordering protocols. Similarly, DPHs reported steady increases in rates for all DYs in Metric 3.3.4, but DMPHs experienced a decrease in rates from DY 13 Rate 2 to DY 14 Rate 1.

Overall, both DPHs and DMPHs had improvements for a majority of the metrics.

Exhibit 144: PRIME Project 3.3 Reporting of Cumulative and Dual Pharmaceutical Performance Rates



Notes: DY: demonstration year. Rate 1: Metric performance was based on the high-cost pharmaceuticals targeted for management in the prior DY, Rate 2: Metric performance was based on the high-cost pharmaceuticals targeted for management in the current DY. Rate 2 of the current DY was evaluated with Rate 1 in the next DY due to comparable pharmaceutical counts between these rates.

Metric 3.3.1 – Adherence to Medications

This metric was designed to measure the percentage of patients at least 18 years of age prescribed high cost pharmaceuticals who had at least two drug claims or fills for the specified pharmaceuticals and had a Proportion of Days Covered (PDC) of at least 0.8 for the specified pharmaceuticals during the treatment period. Rate #1 was for medications targeted in the prior DY and Rate #2 was for all medications in the current DY. In DY 12, 3 medications were added for a total of 6, DY 13 included 9, and DY 14 included 12.Metric 3.3.1 was P4R from DY 11- DY 13, then transitioned to P4P in DY 14. This was an innovative metric, noted with an asterisk below.

Exhibit 145: PRIME Hospital-Reported Rate of Patient Adherence to High-Cost Pharmaceuticals for Three Medications in DY 11 and DY 12 for Metric 3.3.1*

DPH	DY 11	DY 12 Rate 1	Change	Increased as Intended
Total	29.64%	75.68%	46.04%	Yes
UC	34.18%	65.26%	31.08%	Yes
County	28.65%	84.35%	55.69%	Yes
DMPH	**DY 11**	**DY 12 Rate 1**	**Change**	**Increased as Intended**
Non-CAH	---	67.86%	---	---

Source and notes below. Metrics are P4R.

Exhibit 146: PRIME Hospital-Reported Rate of Patient Adherence to High-Cost Pharmaceuticals for Six Medications in DY 12 and DY 13 for Metric 3.3.1*

DPH	DY 12 Rate 2	DY 13 Rate 1	Change	Increased as Intended
Total	69.21%	58.30%	-10.91%	No
UC	69.96%	66.60%	-3.35%	No
County	68.12%	55.66%	-12.45%	No
DMPH	**DY 12 Rate 2**	**DY 13 Rate 1**	**Change**	**Increased as Intended**
Non-CAH	59.41%	31.82%	-27.59%	No

Source and notes below. Metrics are P4R.

Exhibit 147: PRIME Hospital-Reported Rate of Patient Adherence to High-Cost Pharmaceuticals for Nine Medications in DY 13 and DY 14 for Metric 3.3.1*

DPH	DY 13 Rate 2	DY 14 Rate 1	Change	Increased as Intended
Total	58.96%	61.58%	2.62%	Yes

DPH	DY 13 Rate 2	DY 14 Rate 1	Change	Increased as Intended
UC	64.54%	75.79%	11.25%	Yes
County	54.26%	52.03%	-2.23%	No
DMPH	**DY 13 Rate 2**	**DY 14 Rate 1**	**Change**	**Increased as Intended**
Non-CAH	32.63%	49.71%	17.08%	Yes

Source and notes below. DY 13 is P4R, DY 14 is P4P.

Exhibit 148: PRIME Hospital-Reported Rate of Patient Adherence to High-Cost Pharmaceuticals for Nine Medications in DY 13 and DY 14 for Metric 3.3.1*

DPH	DY 14 P4P Rate 2
Total	63.55%
UC	76.03%
County	55.12%
DMPH	**DY 14 P4P Rate 2**
Non-CAH	51.78%

Source: UCLA analysis of the hospital-reported data, February to June 2020.
*Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4P: pay-for-performance. *Denotes innovative metric.*

Metric 3.3.2 – Documentation of Current Medications in the Medical Record

This metric measured how frequently providers recorded all current medications and supplements, including names, dosages, frequency, and administration route, at each visit in the medical records of adult patients. This measure was intended to promote providers' monitoring of use of pharmaceuticals to reduce the risk of adverse drug events. No trend was observed because the metric was inactivated and replaced by Metric 3.3.4 following DY 11. Analysis can be found in the Interim Report.

Metric 3.3.3 – High-Cost Pharmaceutical Ordering Protocols

This metric measured and tracked the percent of newly prescribed pharmaceuticals in which a specified ordering protocol was used, relative to the number of newly prescribed targeted pharmaceuticals. Ordering protocols needed to list lower cost alternatives and appropriateness of therapy for identified/newly prescribed high-cost pharmaceuticals. Rate #1 was for medications targeted in the prior DY and Rate #2 was for all medications in the current DY. In DY 12, 3 medications were added for a total of 6, DY 13 included 9, and DY 14 included 12. Metric 3.3.1 was P4R from DY 11- DY 13, then transitioned to P4P in DY 14. This metric was a variation on a NQF metric. This is an innovative metric, noted with an asterisk.

*Exhibit 149: PRIME Hospital-Reported High-Cost Pharmaceutical Ordering Protocols for Three Pharmaceuticals in DY 11 and DY 12 for Metric 3.3.3**

DPH	DY 11	DY 12 Rate 1	Change	Increased as Intended
Total	1.31%	33.55%	32.24%	Yes
UC	0.00%	1.81%	1.81%	Yes
County	2.54%	42.16%	39.62%	Yes
DMPH	**DY 11**	**DY 12 Rate 1**	**Change**	**Increased as Intended**
Non-CAH	---	0.00%	---	---

Source and notes below. DY 11 and DY 12 are P4R.

*Exhibit 150: PRIME Hospital-Reported High-Cost Pharmaceutical Ordering Protocols for Six Pharmaceuticals in DY 12 and DY 13 for Metric 3.3.3**

DPH	DY 12 Rate 2	DY 13 Rate 1	Change	Increased as Intended
Total	16.23%	47.44%	31.21%	Yes
UC	0.53%	5.25%	4.72%	Yes
County	34.94%	52.32%	17.38%	Yes
DMPH	**DY 12 Rate 2**	**DY 13 Rate 1**	**Change**	**Increased as Intended**
Non-CAH	0.00%	2.78%	2.78%	Yes

Source and notes below. DY 12 and DY 13 are P4R.

*Exhibit 151: PRIME Hospital-Reported High-Cost Pharmaceutical Ordering Protocols for Nine Pharmaceuticals in DY 13 and DY 14 for Metric 3.3.3**

DPH	DY 13 Rate 2	DY 14 Rate 1	Change	Increased as Intended
Total	28.84%	52.68%	23.84%	Yes
UC	3.32%	16.53%	13.21%	Yes
County	37.58%	63.87%	26.29%	Yes
DMPH	**DY 13 Rate 2**	**DY 14 Rate 1**	**Change**	**Increased as Intended**
Non-CAH	2.44%	74.24%	71.80%	Yes

Source and notes below. DY 13 is P4R and DY 14 is P4P.

*Exhibit 152: PRIME Hospital-Reported High-Cost Pharmaceutical Ordering Protocols for Twelve Pharmaceuticals in DY 14 for Metric 3.3.3**

DPH	DY 14 P4P Rate 2
Total	50.68%
UC	15.44%
County	62.37%
DMPH	**DY 14 P4P Rate 2**
Non-CAH	71.79%

Source: UCLA analysis of the hospital-reported data, February to June 2020.
*Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, UC: University of California, CAH: critical access hospital, DY: demonstration year, P4P: pay-for-performance. * Denotes innovative metric.*

Metric 3.3.4 – Documentation of Medication Reconciliation in the Medical Record for Patients on High-Cost Pharmaceuticals

Starting in DY 12, a new metric was used to measure the percentage of primary care and relevant specialty care visits that had an associated medication reconciliation documented in the medical record for patients 18 years of age or older who were prescribed high cost pharmaceuticals and had at least two prescription drug claims or fills for specified high cost pharmaceuticals. Hospitals were intended to increase efficiency of use of high-cost pharmaceuticals. This metric replaced Metric 3.3.2 in DY 12. It is P4R from DY 12 to DY 14. This is an innovative metric, noted with an asterisk.

*Exhibit 153: PRIME Hospital-Reported Documentation of Medication Reconciliation for Six Pharmaceuticals in DY 12 and DY 13 for Metric 3.3.4**

DPH	DY 12 Rate 2	DY 13 Rate 1	Change	Increased as Intended
Total	69.59%	77.96%	8.37%	Yes
UC	80.54%	89.35%	8.81%	Yes
County	42.19%	70.07%	27.88%	Yes
DMPH	**DY 12 Rate 2**	**DY 13 Rate 1**	**Change**	**Increased as Intended**
Non-CAH	N/A	71.06%	N/A	N/A

*Source and notes below. DY 12 and DY 13 are P4R. N/A: analyses not conducted due to a denominator less than 30. * Denotes innovative metric.*

*Exhibit 154: PRIME Hospital-Reported Documentation of Medication Reconciliation for Nine Pharmaceuticals in DY 13 and DY 14 for Metric 3.3.4**

DPH	DY 13 Rate 2	DY 14 Rate 1	Change	Increased as Intended
Total	82.29%	85.10%	2.81%	Yes
UC	90.36%	92.56%	2.20%	Yes
County	68.28%	75.34%	7.06%	Yes
DMPH	**DY 13 Rate 2**	**DY 14 Rate 1**	**Change**	**Increased as Intended**
Non-CAH	71.33%	69.62%	-1.72%	No

Source and notes below.

*Exhibit 155: PRIME Hospital-Reported Documentation of Medication Reconciliation for Twelve Pharmaceuticals in DY 13 and DY 14 for Metric 3.3.4**

DPH	DY 14 P4R Rate 2
Total	83.42%
UC	92.32%
County	72.63%
DMPH	**DY 14 P4R Rate 2**
Non-CAH	69.30%

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital,

*UC: University of California, CAH: critical access hospital, DY: Demonstration Year. DY 12 to DY 14 are P4R. * Denotes innovative metric.*

Project 3.4 – Resource Stewardship: Blood Products

Project Overview and Summary of Key Findings

Project 3.4 was designed to promote efficiency in management of blood products and transfusion, which are common and costly procedures. This goal was to be achieved by using evidence-based guidelines and decision support tools, developing and streamlining clinical processes, and tracking clinical outcomes to better manage blood products. Further detail on objectives and suggested core components of this project can be found in Attachment Q.

By the end of DY 14, a total of 5 hospitals continued to participate and report metric performance for this optional project. Detailed information on DPH and DPMH participation can be found in Appendix B. PRIME Project Selections.

Performance of the hospitals in Project 3.4 was measured by the following 5 metrics. UCLA categorized 4 as process metrics and 1 as an outcome metric.

Exhibit 156: PRIME Project 3.4 Metric Details

Metric Name	Metric ID Number	Achievement Measured by Increase or Decrease	Care Delivery Process vs. Outcome of Care
ePBM-01 Pre-Op Anemia Screening, Selected Elective Surgical Patients	3.4.1	Increase	Process
ePBM-02 Pre-Op Hemoglobin Level, Selected Elective Surgical Patients	3.4.2^#	Increase	Process
ePBM-03 Pre-Op Type and Cross-match, Type and Screen, Selected Elective Surgical Patients	3.4.3	Increase	Process
ePBM-04 Initial Transfusion Threshold	3.4.4^	Increase	Process
ePBM-05 Outcome of Patient Blood Management, Selected Elective Surgical Patients	3.4.5#	Decrease	Outcome

Source: PRIME Metrics Specs, DY 14YENotes: ePBM: Electronic Patient Blood Management. ^ Metric included a stratification that was not available in the hospital-reported data analyzed by UCLA. # Metric retired after DY 13.

All hospitals were above 90% for 3.4.2 and 3.4.4; however, UCLA was not able to assess whether there was an improvement, due to the absence of consistent stratified hospital-reported data and a large enough sample size. DPHs improved in 2 metrics (3.4.1, 3.4.3)

and reported steady results at 100% in 1 metric (3.4.4) and mixed results in 2 metrics (3.4.2 and 3.4.5). DMPHs reported no change in rates for 1 metric (3.4.4) and inconsistent or declining results for 4 metrics (3.4.1, 3.4.2, 3.4.3, and 3.4.5). The size of the denominator was a challenge to reporting performance, and multiple hospitals did not meet the 30-patient volume threshold for Metrics 3.4.2 and 3.4.5.

Overall, DPHs generally had improvements in the majority of metrics, but DMPHs had limited success in the metrics for this project.

Metric 3.4.1 – Pre-Op Anemia Screening, Selected Elective Surgical Patients

Metric 3.4.1 measured the proportion of selected elective surgical patients in the Project 3.4 Target Population aged 18 years and over with documentation of preoperative anemia screening between 14-45 days before their surgery start date (ePBM-01). Hospitals were intended to increase earlier detection of anemia in order to intervene with effective blood resource management by applying the most appropriate transfusion-sparing strategy and avoid subsequent risks of potential postsurgical complications. DPHs increased their pre-op anemia screening rates as intended while DMPHs did not.

Exhibit 157: PRIME Hospital-Reported Pre-Op Anemia Screening Rates for Metric 3.4.1

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
County	26.05%	25.88%	47.63%	53.55%	27.50%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	33.33%	32.75%	28.49%	-4.85%	No

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11.

Metric 3.4.2 – Pre-Op Hemoglobin Level, Selected Elective Surgical Patients

Metric 3.4.2 measured the number of patients who received a preoperative hemoglobin level laboratory test within 45 days prior to the start of their elective surgical procedure among patients in the Project 3.4 Target Population aged 18 and over who received a whole blood or packed red blood cell transfusion (ePBM-02). Hospitals were intended to increase testing for hemoglobin levels to identify patients with suboptimal hemoglobin levels. Through early detection, hospitals would have the opportunity to implement the most appropriate transfusion-sparing blood management strategies and reduce blood transfusions and adverse surgical procedure outcomes. Achievement in this metric would be measured by increasing the pre-operative testing, decreasing the number of transfusions that fall outside of the hemoglobin level criteria, and shifting the stratified rates over time. However, hospital-reported data about the hemoglobin level stratification was not consistently available to assess whether there was a shift in the metric. Analysis of this metric can be found in the Interim Report.

Metric 3.4.3 – Pre-Op Type and Cross-match, Type and Screen, Selected Elective Surgical Patients

Metric 3.4.3 measured the proportion of selected elective surgical patients in the Project 3.4 Target Population aged 18 and over who received a preoperative blood type status screening or cross-match within 45 days prior to the start of their surgical procedure (ePBM-03). This metric was intended to encourage hospitals to improve protocols for earlier identification of patients' blood type and subsequently assure availability of safe blood products and reduce the likelihood of an adverse transfusion reaction. DPHs increased their blood type screening and cross-match rates as intended, while DMPHs did not (Exhibit 158).

Exhibit 158: PRIME Hospital-Reported Pre-Op Cross-match and Screening Rates for Metric 3.4.3

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4P	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
County	77.42%	82.44%	87.06%	88.77%	11.35%	Yes
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4P**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	70.73%	53.42%	31.26%	-39.46%	No

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11.

Metric 3.4.4 – Initial Transfusion Threshold

Metric 3.4.4 measured the proportion of patients in the Project 3.4 Target Population aged 18 and over receiving their first unit of a whole blood or packed red blood cell transfusion who also received a laboratory test that assessed preoperative hemoglobin levels within 45 days prior to the start of their blood transfusion during an inpatient encounter (ePBM-04). Hospitals were intended to administer transfusions after assessing proper hemoglobin levels in order to reduce transfusion-associated complications, including mortality and infection.

The purpose of this measure is to utilize initial transfusion hemoglobin thresholds to shift the proportion of initial units infused for patients with the higher hemoglobin values to those with lower hemoglobin values. Stratified results by hemoglobin level prior to the first transfusion were not available due to the small population size and limited number of hospitals that reported such data each year. All participating hospital types maintained their initial transfusion rates at 100% as intended (Exhibit 159).

Exhibit 159: PRIME Hospital-Reported Initial Transfusion Rates for Metric 3.4.4

DPH	DY 11 P4R	DY 12 P4R	DY 13 P4R	DY 14 P4P	Change from DY 11 to DY 14	Increased as Intended
County	100.00%	99.59%	99.50%	100.00%	0.00%	Yes (maintained as intended)
DMPH	**DY 11 P4R**	**DY 12 P4R**	**DY 13 P4R**	**DY 14 P4P**	**Change from DY 12 to DY 14**	**Increased as Intended**
Non-CAH	---	100.00%	99.86%	100.00%	0.00%	Yes (maintained as intended)

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, CAH: critical access hospital, DY: demonstration year, P4R: pay-for-reporting, P4P: pay-for-performance. ---: DMPHs did not report data in DY 11.

Metric 3.4.5 – Outcome of Patient Blood Management, Selected Elective Surgical Patients

Metric 3.4.5 was designed to determine which patients received a red blood cell transfusion among elective surgical patients in the Project 3.4 Target Population aged 18 years and older who had a preoperative anemia screening (ePBM-05). This metric was intended to encourage hospitals to reduce rates of transfusions of elective surgical patients receiving allogenic or directed donation red blood cell transfusions. No data was reported for DY 14 because this metric was retired after DY 13. Results for this metric are available in the Interim Report.

Conclusions

This evaluation report includes data on the progress of PRIME implementation in DY 14. The interim evaluation of PRIME prepared in August 2019 and approved by CMS in early 2020 provided extensive data on the infrastructure developed and the processes followed in implementing each PRIME project as of May 2018, as well as descriptive and rigorous assessment of metric performance through DY 13. The interim evaluation report provides evidence that hospitals developed and enhanced needed infrastructure, instigated changes in care delivery processes, and attained pre-defined improvements in performance metrics and achievement values. Analyses of claims data indicated success in process metrics but lack of evidence of success in outcome metrics.

The data in this evaluation report showed synergies between PRIME projects with other initiatives and provided evidence of sustainability of PRIME near the end of the program. Data also indicated high rates of achievement of metrics and changes in the intended direction. The final evaluation report will examine the impact of the COVID-19 pandemic on PRIME, further changes in metric performance in DY 15, and comparison of changes in metric performance and Medi-Cal payments before and during PRIME implementation with a comparable group of patients who received care from other providers.

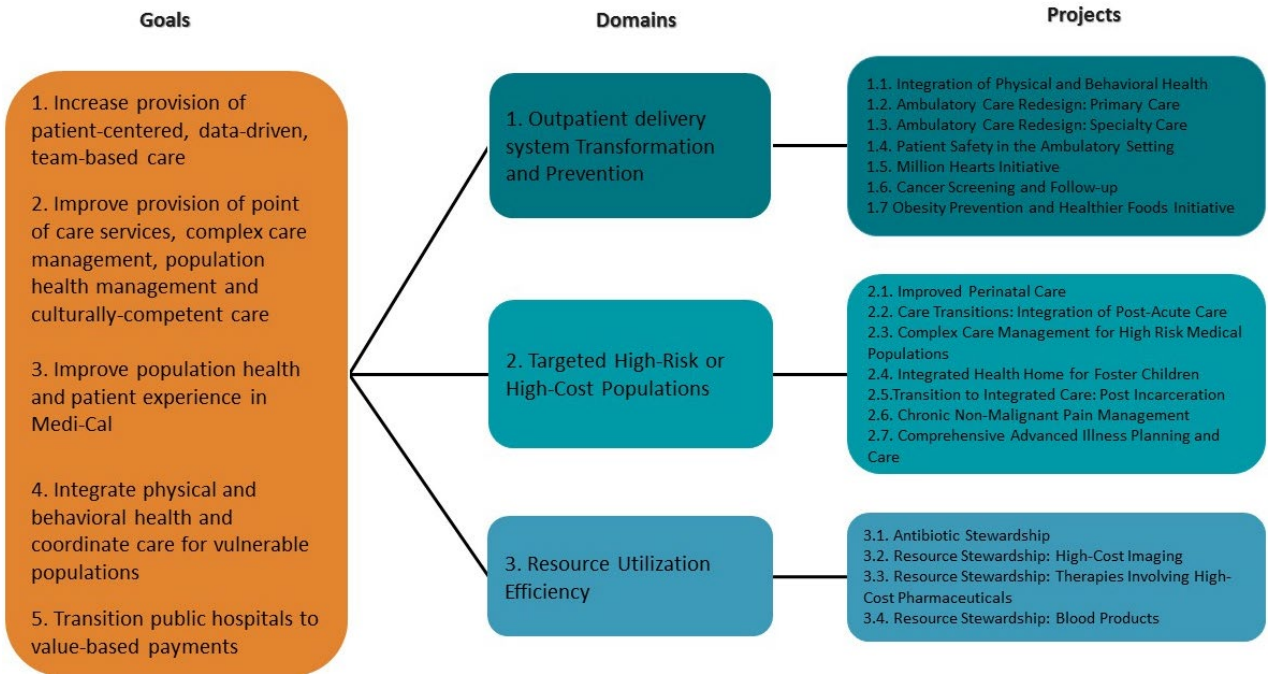
Appendices

Appendix A. Glossary and Key Terms; Documentation from Evaluation Design

Exhibit 160: Glossary and Key Terms

TERM	ACRONYM
10th revision of the International Statistical Classification of Diseases and Related Health Problems	ICD-10
Agency for Healthcare Research and Quality	AHRQ
Alcohol and Drug Misuse	SBIRT
Behavioral Health	BH
California Maternal Quality Care Collaborative	CMQCC
Centers for Medicare & Medicaid Services	CMS
Consumer Assessment of Healthcare Providers and Systems	CAHPS or H-CAHPS
Critical Access Hospitals	CAH
Demonstration Year	DY
Department of Health Care Services	DHCS
Designated Public Hospitals	DPHs
District/Municipal Public Hospitals	DMPHs
Electronic health record	EHR
Emergency Department	ED
Healthcare Effectiveness Data and Information Set	HEDIS
National Committee for Quality Assurance	NCQA
Pay for Performance	P4P
Pay for Reporting	P4R
Prevention Quality Indicators	PQIs
PRIME Funding Mechanics	Attachment II
PRIME Projects and Metrics Protocol	Attachment Q
Public Hospital Redesign and Incentives in Medi-Cal	PRIME
Screening, Brief Intervention and Referral to Treatment for Alcohol and Drug Misuse	SBIRT
Special Terms & Conditions	STC
UCLA Center for Health Policy Research	UCLA
University of California	UC

Exhibit 161: PRIME Program Goals and Projects (from the PRIME Evaluation Design)



Source: Special Terms and Conditions (STC); image from PRIME Final Evaluation Design

Exhibit 162. PRIME Domain 1 Project Names-Outpatient Delivery System Transformation & Prevention

Number	Name	Abbreviated Name	Required for DPHs
1.1	Integration of Behavioral Health & Primary Care	Behavioral Health Integration	Yes
1.2	Ambulatory Care Redesign: Primary Care	Primary Care Redesign	Yes
1.3	Ambulatory Care Redesign: Specialty Care	Specialty Care Redesign	Yes
1.4	Patient Safety in the Ambulatory Setting	Patient Safety	No
1.5	Million Hearts® Initiative	Million Hearts	No
1.6	Cancer Screening & Follow-Up	Cancer Screening	No
1.7	Obesity Prevention & Healthier Foods Initiative	Healthier Foods	No

Exhibit 163. PRIME Domain 2 Project Names- Targeted High Risk Or High Cost Populations

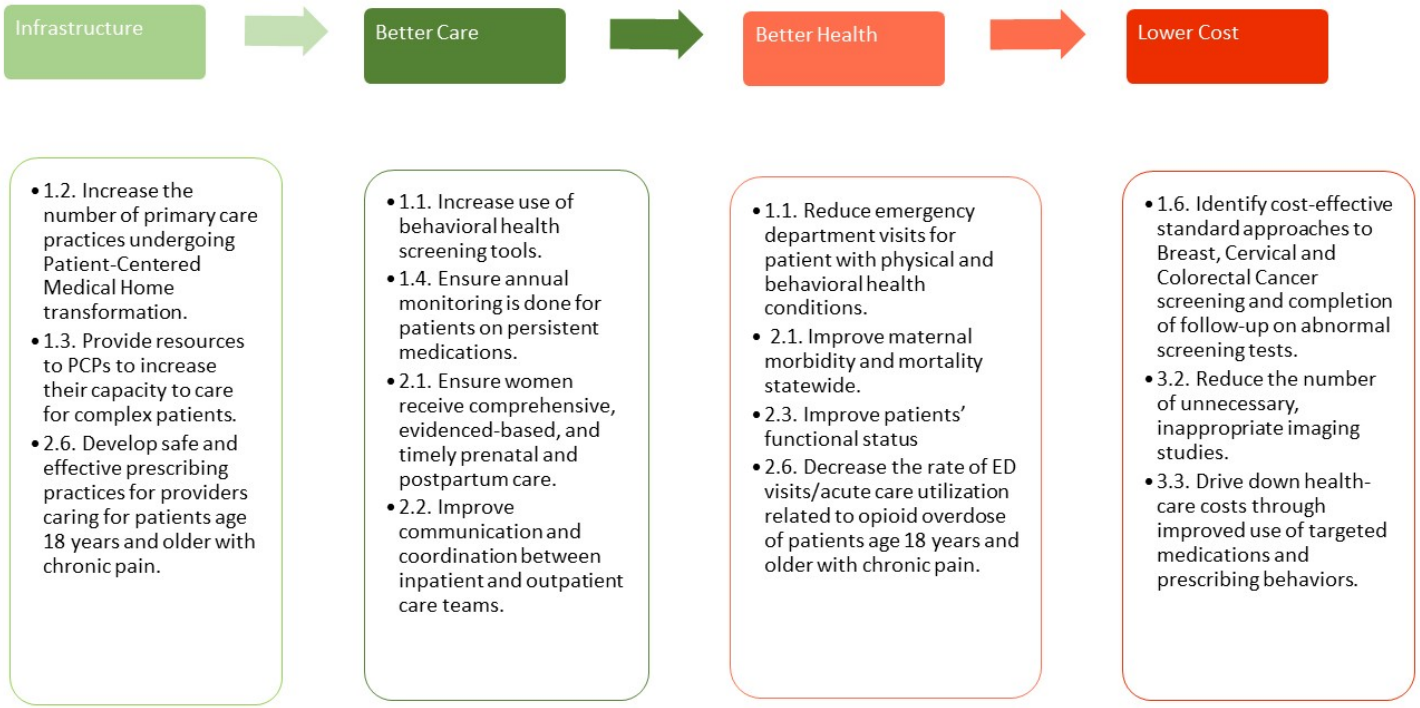
2.1	Improvements in Perinatal Care	Perinatal Care	Yes
2.2	Care Transitions: Integration of Post-Acute Care	Care Transitions	Yes
2.3	Complete Care Management for High-Risk Medical Populations	CCM for High Risk Populations	Yes
2.4	Integrated Health Home for Foster Children	Foster Children	No
2.5	Transition to Integrated Care: Post Incarceration	Post Incarceration	No
2.6	Chronic Non-Malignant Pain Management	Pain Management	No
2.7	Comprehensive Advanced Illness Planning & Care	Advance Care Planning	No

Exhibit 164. PRIME Domain 3 Project Names- Resource Utilization Efficiencies

3.1	Antibiotic Stewardship	Antibiotic Stewardship	No
3.2	Resource Stewardship: High-Cost Imaging	High Cost Imaging	No

3.1	**Antibiotic Stewardship**	**Antibiotic Stewardship**	**No**
3.3	Resource Stewardship: Therapies Inv. High-Cost Pharmaceuticals	High Cost Pharmaceuticals	No
3.4	Resource Stewardship: Blood Products	Blood Products	No

Exhibit 165. PRIME Evaluation Conceptual Framework, Selected Elements of PRIME Interventions



Note: PRIME projects include infrastructure, better care, better health, and lower cost elements. The elements identified in the framework are illustrative examples of aspect of a given project that pertains to infrastructure development, delivery of better care, anticipated improvements in population health, and potential reduction in costs.

Appendix B. PRIME Project Selections

No projects were dropped in DY15 (as of January 2020). No projects were dropped or added between DY13 and DY14. In April 2018, DHCS updated the plan modification policy to align with the language in the STCs (PRIME Plan Modification Guidelines 4-23-18), clarifying that dropped projects would mean that the entity would forfeit any further funding for that project. If they added a project, the entity *may* be able to gain additional funds (subject to funding availability) for the added project. Funds were available for DMPHs, so several DMPHs added projects for DY15.

A total of 17 DPHs participated in PRIME. Projects 1.1-1.3, 2.1-2.3 were required for DPHs, however San Mateo was not able to implement 2.1 due to not having maternity services. Alameda participated in Projects 1.4 and 1.6 for DY11, but discontinued these projects and added Project 1.5 in DY12YE. Arrowhead discontinued Project 2.4 and added Project 2.6 in DY12YE.

Exhibit 166: DPH Project Selections

Project:	1.1	1.2	1.3	1.4	1.5	1.6	1.7	2.1	2.2	2.3	2.4	2.5	2.6	2.7	3.1	3.2	3.3	3.4	N
Number of DPHs that ever selected the Project	17	17	17	6	7	6	2	16	17	17	5	2	9	5	5	5	7	2	--
Alameda	X	X	X	D[12]	X[12]	D[12]		X	X	X			X		X				11
Arrowhead	X	X	X				X	X	X	X	D[12]		X[12]		X				9
Contra Costa	X	X	X			X		X	X	X	X		X			X			10
Kern Medical	X	X	X	X				X	X	X		X				X			9
Los Angeles	X	X	X	X		X	X	X	X	X		X		X	X		X		13
Natividad	X	X	X		X			X	X	X			X					X	9
Riverside	X	X	X		X			X	X	X			X				X		9
San Francisco	X	X	X		X			X	X	X			X				X		9
San Joaquin	X	X	X			X		X	X	X				X		X			9
San Mateo	X	X	X	X				X	X	X	X						X		9
Santa Clara	X	X	X			X			X	X	X		X			X			9
UC Davis	X	X	X		X			X	X	X			X			X			9
UC Irvine	X	X	X	X				X	X	X			X		X				9
UC Los Angeles	X	X	X	X				X	X	X				X			X		9
UC San Diego	X	X	X		X			X	X	X				X	X		X		10
UC San Francisco	X	X	X			X		X	X	X				X			X		9
Ventura	X	X	X		X			X	X	X	X							X	9

Source: DHCS. Data available from January 2020.
Notes: X- Project implemented; D- Project discontinued from year prior; Number (i.e.11) Year Project discontinued or added

A total of 20 DMPH Non-CAHs participated in PRIME. Coalinga, Sonoma West, and Tulare stopped PRIME participation, and a total of 17 DMPH CAHs participated in PRIME.

Exhibit 167: DMPH Non-CAH Project Selections

Project	Type	1.1	1.2	1.3	1.4	1.5	1.6	1.7	2.1	2.2	2.3	2.4	2.5	2.6	2.7	3.1	3.2	3.3	3.4	N
Name	Count	4	4	2	6	7	4	7	4	12	9	0	1	1	8	6	4	1	4	--
Antelope Valley	Non-CAH						D[12]		X	X	X				X	X	X		X	8
Coalinga	Non-CAH					D[12]		D[12]												2
El Camino	Non-CAH	X							X										X	3
El Centro	Non-CAH		X					X15									X			3
Hazel Hawkins	Non-CAH										X									1
Kaweah Delta	Non-CAH		X	X		X				X	X			X	X					7
Lompoc Valley	Non-CAH			X		X		X		X										4
Marin	Non-CAH										X				X					2
Oak Valley	Non-CAH		X		X															2
Palo Verde	Non-CAH	X								X	X									3
Palomar	Non-CAH				D[13]	D[13]		X		X	X				X	X	X	X	D[11]	10

Project	Type	1.1	1.2	1.3	1.4	1.5	1.6	1.7	2.1	2.2	2.3	2.4	2.5	2.6	2.7	3.1	3.2	3.3	3.4	N
Pioneers	Non-CAH				X		X			X						X				4
Salinas Valley	Non-CAH				X	X	X			X	X				X	X			X	8
San Gorgonio	Non-CAH							X		X						X				3
Sierra View	Non-CAH	X15						X		X	X				X					4
Sonoma Valley	Non-CAH									X										1
Sonoma West	Non-CAH									X										1
Tri-City	Non-CAH	D[12]			D[13]	X		X	X	X	X		D[12]		D[13]	X				10
Tulare	Non-CAH	D	D		D	D	D													5
Washington	Non-CAH								X	X15					X		D[12]			3

Exhibit 168: DMPH CAH Project Selections

Project	Type	1.1	1.2	1.3	1.4	1.5	1.6	1.7	2.1	2.2	2.3	2.4	2.5	2.6	2.7	3.1	3.2	3.3	3.4	N
Name	**Count**	**4**	**4**	**1**	**3**	**5**	**4**	**1**	**2**	**2**	**1**	**1**	**1**	**6**	**1**	**3**	**1**	**1**	**1**	**-**
Bear Valley	CAH													X						1
Eastern Plumas	CAH	X																		1
Healdsburg	CAH					X	X							X15						3
Jerold Phelps	CAH					X														1
John C. Fremont	CAH		X																	1
Kern Valley	CAH	X																		1

Project	Type	1.1	1.2	1.3	1.4	1.5	1.6	1.7	2.1	2.2	2.3	2.4	2.5	2.6	2.7	3.1	3.2	3.3	3.4	N
Mammoth	CAH	X												X						2
Mayers	CAH					D[13]		X[13]												17
Mendocino	CAH						X													1
Modoc	CAH		X																	1
Northern Inyo	CAH															X				1
Plumas	CAH													X		X15				2
San Bernardino	CAH				X	X15														2
Seneca	CAH								X15	X15										2
Southern Inyo	CAH		X				X													2
Tahoe	CAH					X								X						2
Trinity	CAH				X		X													2

Source: DHCS. Data available from January 2020.

Notes: X- Project implemented; D- Project discontinued from year prior; Number (i.e.11) Year Project discontinued or added

Appendix C: End-of-Program Survey Questions and Respondents

Organization Background:

1) **Please indicate your entity's name.**

2) **Please indicate your entity's type.**
   a. Designated Public Hospital (DPH) system
   b. District-Municipal Public Hospital (DMPH)
   c. DMPH that is also a Critical Access Hospital (CAH)

3) **Please enter your name and contact information.**
   a. Name
   b. Email Address
   c. Phone Number

4) **Which of the following Domains did your hospital participate in, at any point during the PRIME program? (This question is necessary for the skip pattern of the survey. For subsequent questions below asking you to assess specific PRIME domains, only domains you select in this question will appear.)**
   a. Domain 1: Outpatient Delivery System Transformation and Prevention
   b. Domain 2: Targeted High-Risk or High-Cost Populations
   c. Domain 3: Resource Utilization Efficiency

5) **Which of the following projects did your hospital participate in, at any point during the PRIME program? (This question is necessary for the skip pattern of the survey. For subsequent questions below asking you to assess specific PRIME projects, only projects you select in this question will appear.)**
   - 1.1 Integrating Behavioral Health & Primary Care
   - 1.2 Redesign of Ambulatory Primary Care
   - 1.3 Redesign of Ambulatory Specialty Care
   - 1.4 Promoting Patient Safety in the Ambulatory Setting
   - 1.5 Implementing the Million Hearts® Initiative
   - 1.6 Increasing Cancer Screening & Follow-Up
   - 1.7 Preventing Obesity & promoting Healthier Foods
   - 2.1 Improving Delivery of Perinatal Care
   - 2.2 Improving Transition of Patients from Acute to Post-Acute Care
   - 2.3 Management of Care for High-Risk Medical Populations
   - 2.4 Integrating Health Home for Foster Children
   - 2.5 Transitioning of Post Incarceration Patients into Primary Care
   - 2.6 Managing Chronic Non-Malignant Pain
   - 2.7 Comprehensive Planning for Advanced Illness and Care Delivery
   - 3.1 Stewardship of Antibiotics

- 3.2 Stewardship of High-Cost Imaging
- 3.3 Stewardship of Therapies for High-Cost Pharmaceuticals
- 3.4 Stewardship of Blood Products

6) **PRIME Denominator:**
   How many unique patients were in the PRIME denominator in DY14?
   Please provide one value that includes both patients who were in the PRIME denominator due to their utilization or managed care assignment.

Managed Care Programs:

7) **How many Medi-Cal Managed Care plans is your hospital contracted with? If your hospital does not have any managed care contracts in place, please list "0".**
   a. Free response

8) **Please list the name(s) of the Medi-Cal Managed Care plan(s) with which your hospital has contracted. If your hospital does not have any managed care contracts in place, please list "N/A".**
   a. Free response

9) **How many patients within your hospital's PRIME eligible population are enrolled in a Medi-Cal Managed Care plan? Please provide your best estimate. If your hospital does not have any managed care contracts in place, please list "0".**
   Note: This question refers to PRIME patients who receive their primary care through a Medicaid Managed Care plan (e.g., assigned PCP in managed care plan).
   a. Free response

Synergies

10) On a scale from 1 (very low) to 5 (very high):
How would you rate the <u>synergy</u> of PRIME with the following within your organization?

Options 1 (Very Low) 2 (Low) 3 (Medium) 4 (High) 5 (Very High) N/A

- Organizational mission or goals
- Concurrent quality improvement efforts
- **(DPH Only)**
- Implementation of QIP 1.0 metrics
- Comments:

11) Thinking <u>collectively</u> about the PRIME projects in which your hospital was successful, please select the most important and second most important factors that facilitated your hospital's success.

Category	Most Important	Second Most Important
Integration of PRIME initiatives into the organization's strategic mission	☐	☐
High priority to senior leadership	☐	☐
High priority to clinical leadership	☐	☐
Sufficient financial resources to ensure successful implementation	☐	☐
Existing data analytic capacity	☐	☐
Adequate leadership effort	☐	☐
Adequate clinical staff time	☐	☐
Adequate administrative staff time	☐	☐
Other, please specify factor and ranking in comments:	☐	☐
Other, please specify factor and ranking in comments:	☐	☐

Comments:

Progress toward Planned Activities and Goals:

12) On a scale from 1 to 10:

For each project, please indicate the degree to which your hospital has succeeded in achieving the goals of the project. If your hospital did not participate in a project long enough to evaluate this, please select "N/A."

Score options: 1 (Did not achieve any goals) to 10 (Achieved all goals) 1 -10, N/A

Project

- 1.1 Integrating Behavioral Health & Primary Care
- 1.2 Redesign of Ambulatory Primary Care
- 1.3 Redesign of Ambulatory Specialty Care
- 1.4 Promoting patient Safety in the Ambulatory Setting
- 1.5 Implementing the Million Hearts® Initiative
- 1.6 Increasing Cancer Screening & Follow-Up
- 1.7 Preventing Obesity & promoting Healthier Foods
- 2.1 Improving delivery of Perinatal Care
- 2.2 Improving Transition of Patients from Acute to Post-Acute Care
- 2.3 Management of Care of High-Risk Medical Populations
- 2.4 Integrating Health Home for Foster Children
- 2.5 Transitioning of Post Incarceration Patients into Primary Care
- 2.6 Managing Chronic Non-Malignant Pain
- 2.7 Comprehensive planning for Advanced Illness and care delivery
- 3.1 Stewardship of Antibiotics
- 3.2 Stewardship of High-Cost Imaging
- 3.3 Stewardship of Therapies for High-Cost Pharmaceuticals
- 3.4 Stewardship of Blood Products
- Comments:

Project Implementation

13) On a scale of 1 (very low) to 5 (very high):
For each project, please rate the level of <u>staff effort</u> required to implement the project. If your hospital did not participate in a project long enough to evaluate this, please select "N/A."

Categories 1 (Very Low) 2 (Low) 3 (Medium) 4 (High) 5 (Very High) N/A

- 1.1 Integrating Behavioral Health & Primary Care
- 1.2 Redesign of Ambulatory Primary Care
- 1.3 Redesign of Ambulatory Specialty Care
- 1.4 Promoting patient Safety in the Ambulatory Setting
- 1.5 Implementing the Million Hearts® Initiative
- 1.6 Increasing Cancer Screening & Follow-Up
- 1.7 Preventing Obesity & promoting Healthier Foods
- 2.1 Improving delivery of Perinatal Care
- 2.2 Increasing transition of patients from acute to post-acute care
- 2.3 Management of care of High-Risk Medical Populations
- 2.4 Integrating Health Home for Foster Children
- 2.5 Transitioning of Post Incarceration patients into primary care
- 2.6 Managing Chronic Non-Malignant Pain
- 2.7 Comprehensive planning for Advanced Illness and care delivery
- 3.1 Stewardship of Antibiotics
- 3.2 Stewardship of High-Cost Imaging
- 3.3 Stewardship of Therapies for High-Cost Pharmaceuticals
- 3.4 Stewardship of Blood Products
- Comments:

14) On a scale of 1 (very low) to 5 (very high):
For each project, please rate the level of <u>financial investment</u> required to implement the project. If your hospital did not participate in a project long enough to evaluate this, please select "N/A."

Categories ☐ 1 (Very Low),☐ 2 (Low) ☐ 3 (Medium) ☐ 4 (High) ☐ 5 (Very High) ☐ N/A

- 1.1 Integrating Behavioral Health & Primary Care
- 1.2 Redesign of Ambulatory Primary Care
- 1.3 Redesign of Ambulatory Specialty Care
- 1.4 Promoting patient Safety in the Ambulatory Setting
- 1.5 Implementing the Million Hearts® Initiative
- 1.6 Increasing Cancer Screening & Follow-Up
- 1.7 Preventing Obesity & promoting Healthier Foods
- 2.1 Improving delivery of Perinatal Care

- 2.2 Increasing transition of patients from acute to post-acute care
- 2.3 Management of care of High-Risk Medical Populations
- 2.4 Integrating Health Home for Foster Children
- 2.5 Transitioning of Post Incarceration patients into primary care
- 2.6 Managing Chronic Non-Malignant Pain
- 2.7 Comprehensive planning for Advanced Illness and care delivery
- 3.1 Stewardship of Antibiotics
- 3.2 Stewardship of High-Cost Imaging
- 3.3 Stewardship of Therapies for High-Cost Pharmaceuticals
- 3.4 Stewardship of Blood Products
- Comments:

15) On a scale of 1 (very low) to 5 (very high):
For each project, please rate the level of <u>overall difficulty</u> of implementing the project. If your hospital did not participate in a project long enough to evaluate this, please select "N/A."

Categories ☐ 1 (Very Low) ☐ 2 (Low) ☐ 3 (Medium) ☐ 4 (High) ☐ 5 (Very High) ☐ N/A

- 1.1 Integrating Behavioral Health & Primary Care
- 1.2 Redesign of Ambulatory Primary Care
- 1.3 Redesign of Ambulatory Specialty Care
- 1.4 Promoting patient Safety in the Ambulatory Setting
- 1.5 Implementing the Million Hearts® Initiative
- 1.6 Increasing Cancer Screening & Follow-Up
- 1.7 Preventing Obesity & promoting Healthier Foods
- 2.1 Improving delivery of Perinatal Care
- 2.2 Increasing transition of patients from acute to post-acute care
- 2.3 Management of care of High-Risk Medical Populations
- 2.4 Integrating Health Home for Foster Children
- 2.5 Transitioning of Post Incarceration patients into primary care
- 2.6 Managing Chronic Non-Malignant Pain
- 2.7 Comprehensive planning for Advanced Illness and care delivery
- 3.1 Stewardship of Antibiotics
- 3.2 Stewardship of High-Cost Imaging
- 3.3 Stewardship of Therapies for High-Cost Pharmaceuticals
- 3.4 Stewardship of Blood Products
- Comments:

Sustainability:

16) On a scale from 1 (very low) to 5 (very high):

How much did PRIME promote capacity (e.g., infrastructure, knowledge, resources) in the following domains within your organization?

Categories ☐ 1 (Very Low) ☐ 2 (Low) ☐ 3 (Medium) ☐ 4 (High) ☐ 5 (Very High) ☐ N/A

- Data collection
- Data analytics
- Data reporting
- Clinical staffing levels
- EMR/IT/Analytic staffing levels
- Development of clinical protocols/ workflows
- Conducting patient outreach
- Use of frameworks, methods, or tools for continuous quality improvement (e.g., LEAN, rapid cycle improvement, PDSAs)
- Ability to participate in risk-based contracts (e.g., managed care)
- Ability to participate in value-based programs (e.g., pay-for-performance)

Comments:

17) On a scale of 1 (very low) to 5 (very high):
For each project, please rate the level at which your hospital has integrated the project's processes into standard of care. If your hospital did not participate in a project long enough to evaluate this, please select "N/A."

Categories ☐ 1 (Very Low) ☐ 2 (Low) ☐ 3 (Medium) ☐ 4 (High) ☐ 5 (Very High) ☐ N/A

- 1.1 Integrating Behavioral Health & Primary Care
- 1.2 Redesign of Ambulatory Primary Care
- 1.3 Redesign of Ambulatory Specialty Care
- 1.4 Promoting patient Safety in the Ambulatory Setting
- 1.5 Implementing the Million Hearts® Initiative
- 1.6 Increasing Cancer Screening & Follow-Up
- 1.7 Preventing Obesity & promoting Healthier Foods
- 2.1 Improving delivery of Perinatal Care
- 2.2 Increasing transition of patients from acute to post-acute care
- 2.3 Management of care of High-Risk Medical Populations
- 2.4 Integrating Health Home for Foster Children
- 2.5 Transitioning of Post Incarceration patients into primary care
- 2.6 Managing Chronic Non-Malignant Pain
- 2.7 Comprehensive planning for Advanced Illness and care delivery
- 3.1 Stewardship of Antibiotics
- 3.2 Stewardship of High-Cost Imaging
- 3.3 Stewardship of Therapies for High-Cost Pharmaceuticals
- 3.4 Stewardship of Blood Products

Comments:

18) On a scale of 1 (very low) to 5 (very high):
For each project, please rate the <u>sustainability of the project's activities</u> when external support for the PRIME project ends. If your hospital did not participate in a project long enough to evaluate this, please select "N/A."

Categories ☐ 1 (Very Low) ☐ 2 (Low) ☐ 3 (Medium) ☐ 4 (High) ☐ 5 (Very High) ☐ N/A

- 1.1 Integrating Behavioral Health & Primary Care
- 1.2 Redesign of Ambulatory Primary Care
- 1.3 Redesign of Ambulatory Specialty Care
- 1.4 Promoting patient Safety in the Ambulatory Setting
- 1.5 Implementing the Million Hearts® Initiative
- 1.6 Increasing Cancer Screening & Follow-Up
- 1.7 Preventing Obesity & promoting Healthier Foods
- 2.1 Improving delivery of Perinatal Care
- 2.2 Increasing transition of patients from acute to post-acute care
- 2.3 Management of care of High-Risk Medical Populations
- 2.4 Integrating Health Home for Foster Children
- 2.5 Transitioning of Post Incarceration patients into primary care
- 2.6 Managing Chronic Non-Malignant Pain
- 2.7 Comprehensive planning for Advanced Illness and care delivery
- 3.1 Stewardship of Antibiotics
- 3.2 Stewardship of High-Cost Imaging
- 3.3 Stewardship of Therapies for High-Cost Pharmaceuticals
- 3.4 Stewardship of Blood Products

Comments:

19) For each project, please indicate if your organization plans to continue the project <u>when external support for the PRIME project ends</u>. If your organization will continue the project, please identify the reasons for continuation.

Project X.X

- ☐ Already discontinued project
- ☐ Do <u>not</u> plan to continue the project
- ☐ Plan to continue <u>some</u> aspects of the project
- ☐ Plan to continue <u>all</u> aspects of the project
- Reasons for continuation: (free response)

20) Thinking collectively about the projects your hospital plans to continue (fully or in part) when external support for PRIME ends, please indicate the reasons for continuing the projects' activities (check all that apply)

- ☐ Data collection and reporting processes established
- ☐ New processes driven by the project are adaptable to future needs of the organization
- ☐ Benefits to organization, staff, and patients are realized
- ☐ Benefits to organization extend beyond helping patients (e.g., processes run more smoothly, reduce waste, improve daily working lives of staff members)
- ☐ Staff training and development processes established
- ☐ Staff invested in driving progress in this area
- ☐ Ongoing support from senior leadership
- ☐ Ongoing support from clinical leadership
- ☐ Data infrastructure established
- ☐ Clinical infrastructure established
- ☐ Fully embedded through policies and procedures
- ☐ Anticipate operational funding will be available after PRIME to support personnel or resources
- ☐ Compatible with organization's priorities or strategic plan
- ☐ Compatible with other initiatives/programs
- ☐ Not planning to continue any PRIME projects
- ☐ Other, please specify: _____

21) This question asks you to identify unfinished activities for PRIME.

Step 1: In the fields indicated by an asterisk (*) below, please describe up to five PRIME project components or initiatives you intended to implement during PRIME, but have not fully implemented.

Step 2: For each activity, please indicate whether you intend to continue the activity when external support for PRIME ends.

If you intend to implement the activity after PRIME, please indicate whether it will be necessary to secure external funding (e.g., grants, other quality programs linked to funding) to continue the project.

Categories

- ☐ Do **not** plan to implement after PRIME
- ☐ Plan to implement after PRIME, **regardless of whether external funding is secured**
- ☐ Plan to implement after PRIME, **only if external funding is secured**
- ☐ N/A

- **Activity 1** ** Please describe the project component or initiative:* _____
- **Activity 2** ** Please describe the project component or initiative:* _____

- **Activity 3** ** Please describe the project component or initiative: _____*
- **Activity 4** ** Please describe the project component or initiative: _____*
- **Activity 5** ** Please describe the project component or initiative: _____*

Appendix D: Concurrent PRIME Project Selections by Hospital Type

Exhibit 169. Selection of Required and Optional PRIME Projects by DPHs

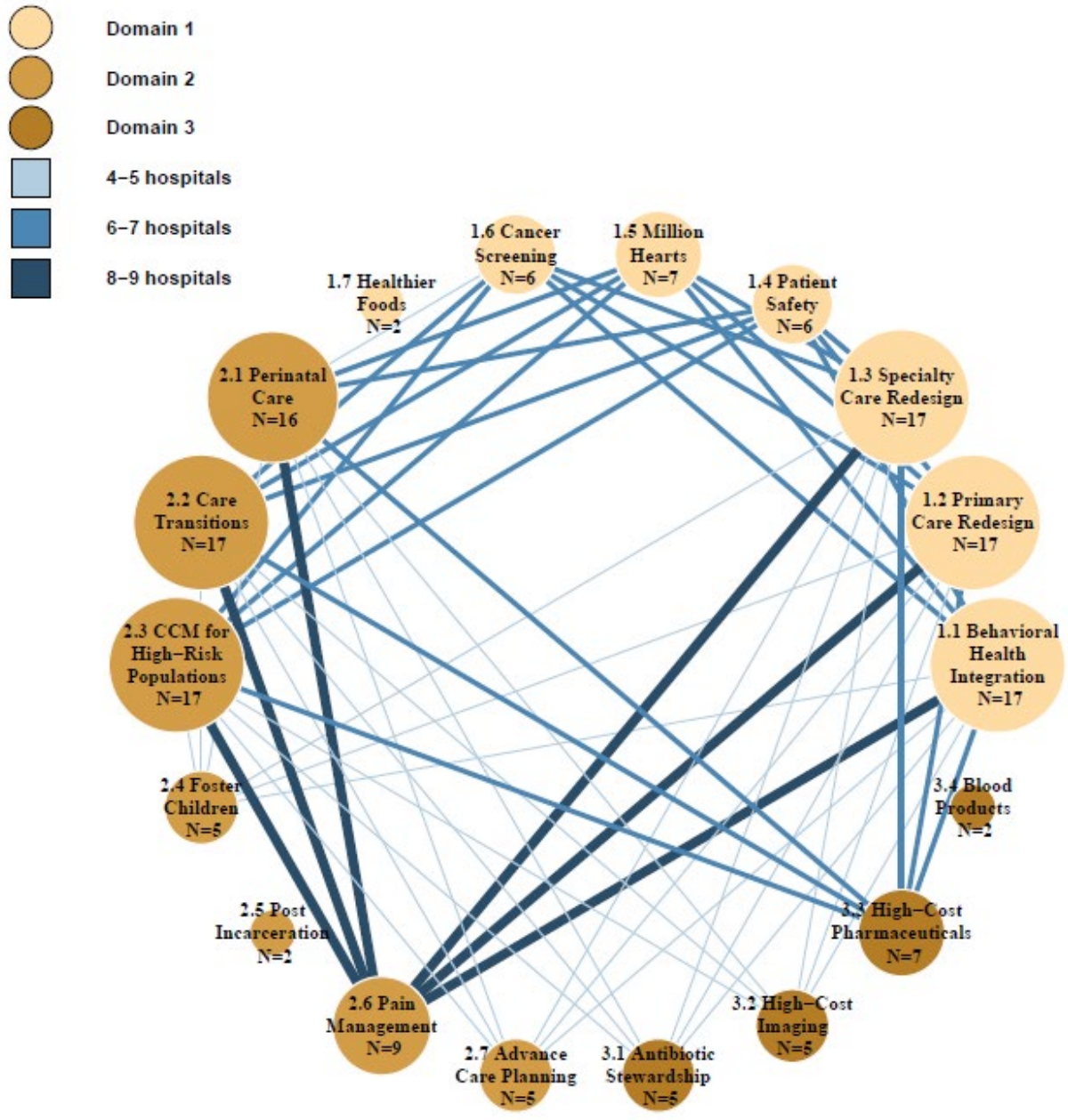


Exhibit 170. Selection of Optional Projects by DPHs

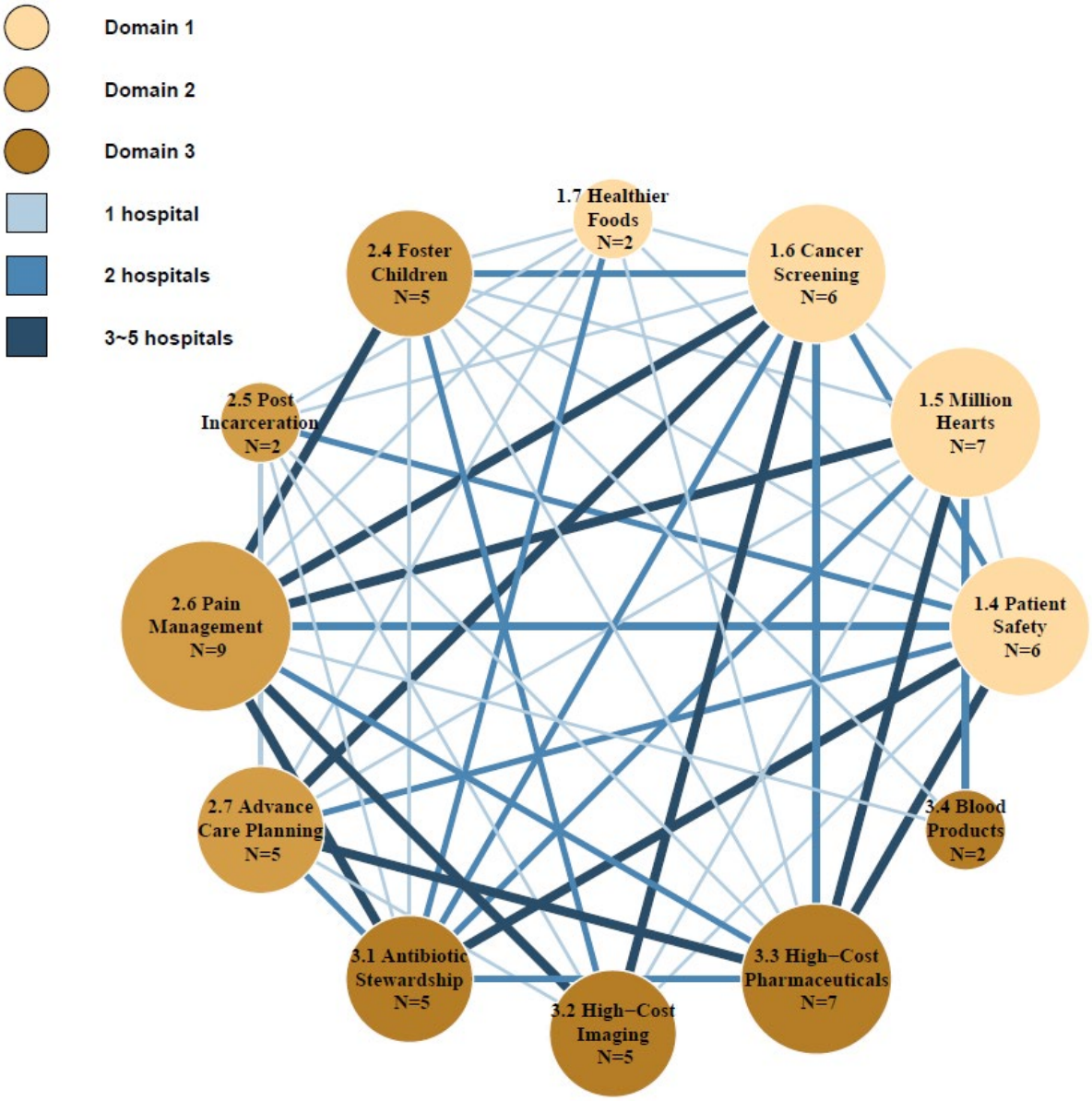


Exhibit 171. Concurrent PRIME Projects Selected by DMPH non-CAHs

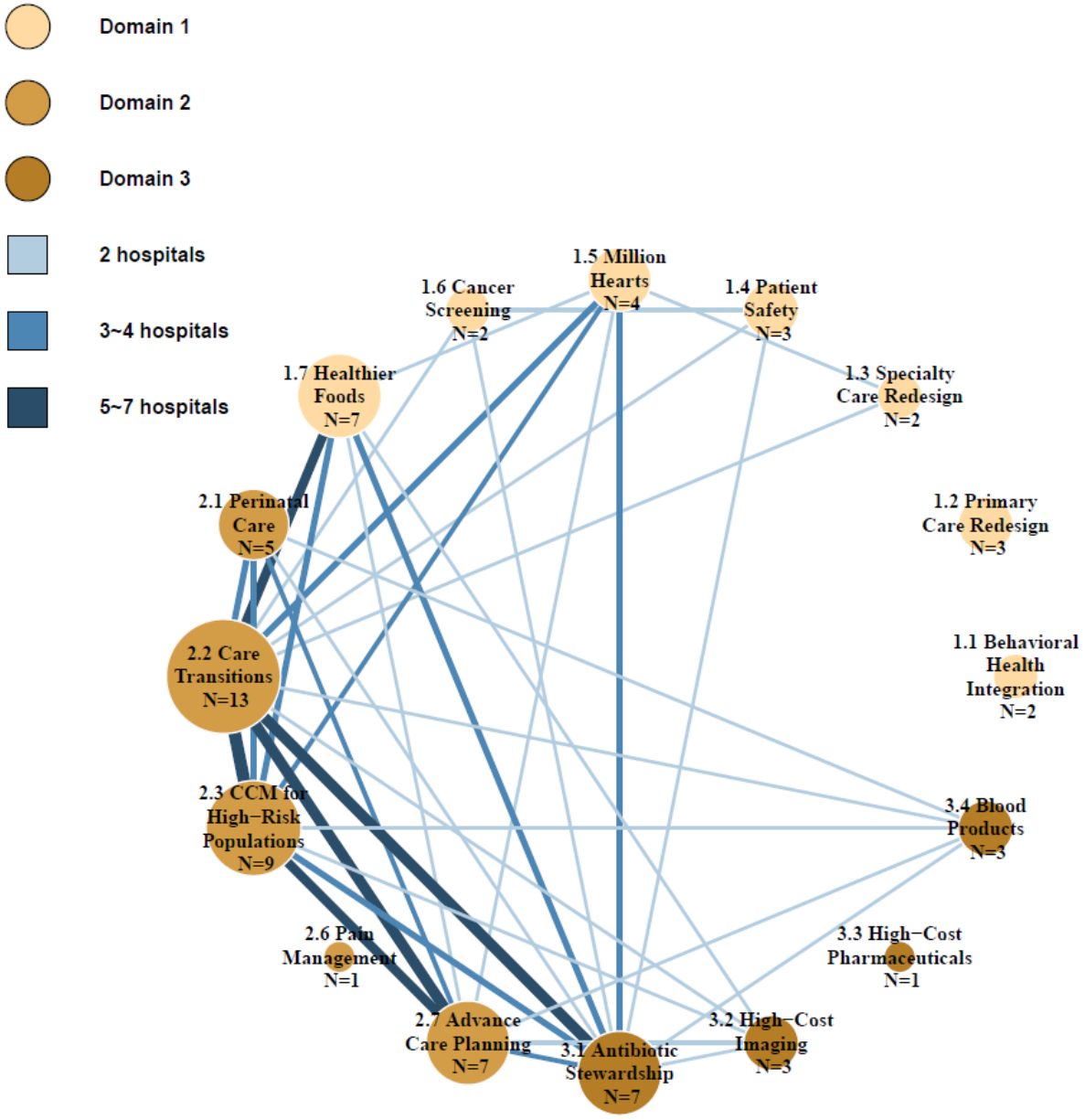
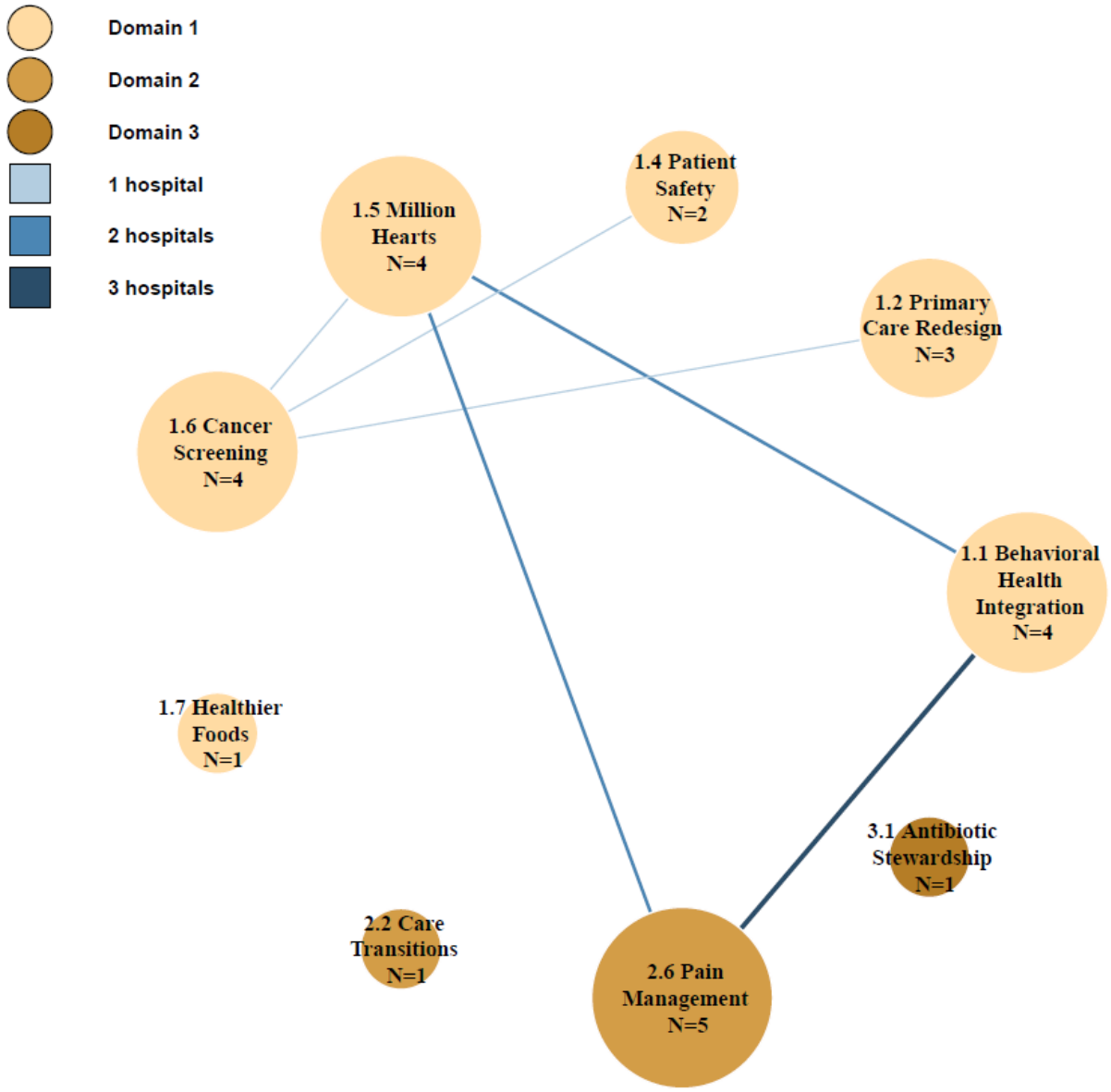


Exhibit 172. Concurrent PRIME Projects Selected by DMPH CAHs



Appendix E: Survey Results by Hospital Type

Exhibit 173: Hospital Ratings of Staff Effort Required to Implement PRIME Projects by Hospital Type

PRIME Project	DPH UC n=5	DPH County n=12	DMPH non-CAH n=18	DMPH CAH n=16
1.1 Behavioral Health Integration, n=23	4.4	4.4	5.0	4.8
1.2 Primary Care Redesign, n=23	4.2	4.3	4.7	4.7
1.3 Specialty Care Redesign, n=19	3.8	3.9	5.0	N/A
1.4 Patient Safety, n=12	3.5	4.0	3.7	4.5
1.5 Million Hearts®, n=16	4.0	3.2	4.8	4.0
1.6 Cancer Screening, n=11	4.0	4.5	4.0	4.8
1.7 Healthier Foods, n=9	N/A	3.5	4.5	5.0
2.1 Perinatal Care, n=21	4.4	4.5	4.3	N/A
2.2 Care Transitions, n=31	4.2	4.5	4.5	4.0
2.3 CCM for High-Risk Populations, n=26	4.0	4.3	4.4	N/A
2.4 Foster Children Health Homes, n=4	N/A	4.8	N/A	N/A
2.5 Post Incarceration Care, n=2	N/A	3.5	N/A	N/A
2.6 Pain Management, n=15	3.5	3.4	5.0	4.2
2.7 Advance Care Planning, n=13	4.7	4.0	4.6	N/A
3.1 Antibiotic Stewardship, n=14	4.5	3.7	4.1	4.0
3.2 High-Cost Imaging, n=9	3.0	3.5	4.7	N/A
3.3 High-Cost Pharmaceuticals, n=9	4.0	3.8	5.0	N/A
3.4 Blood Products, n=6	N/A	4.0	4.3	N/A

Source: UCLA analysis of the final survey, data received February to April 2020.
Notes: N=51 hospitals participated in the final survey. DPH UC: designated public hospital with University of California affiliation; DPH County: County-operated designated public hospital; DMPH non-CAH: district and municipal public hospital without critical access hospital designation; DMPH CAH: district and municipal public hospital with critical access hospital designation. CCM: complex case management. Ratings of staff effort were on a scale from 1 (very low) to 5 (very high). Values in the exhibit represent mean ratings. The number of hospitals participating in each project in DY 15 is included for each project.

Exhibit 174: Hospital Ratings of Financial Investment Required to Implement PRIME Projects by Hospital Type

PRIME Project	DPH UC n=5	DPH County n=12	DMPH non-CAH n=18	DMPH CAH n=16
1.1 Behavioral Health Integration, n=23	4.0	3.8	5.0	4.0
1.2 Primary Care Redesign, n=23	3.4	3.8	4.3	3.0
1.3 Specialty Care Redesign, n=19	3.4	3.4	4.0	N/A
1.4 Patient Safety, n=12	3.5	3.7	3.3	4.0
1.5 Million Hearts®, n=16	3.5	2.6	3.5	2.8
1.6 Cancer Screening, n=11	3.0	3.8	3.0	3.5
1.7 Healthier Foods, n=9	N/A	2.5	3.5	3.0
2.1 Perinatal Care, n=21	3.8	3.6	3.5	N/A
2.2 Care Transitions, n=31	3.4	3.8	3.8	4.0
2.3 CCM for High-Risk Populations, n=26	3.6	3.6	3.7	N/A
2.4 Foster Children Health Homes, n=4	N/A	3.5	N/A	N/A
2.5 Post Incarceration Care, n=2	N/A	4.0	N/A	N/A
2.6 Pain Management, n=15	2.5	2.7	4.0	3.0
2.7 Advance Care Planning, n=13	3.7	3.5	4.0	N/A
3.1 Antibiotic Stewardship, n=14	3.0	3.0	3.1	2.0
3.2 High-Cost Imaging, n=9	2.0	3.5	3.8	N/A
3.3 High-Cost Pharmaceuticals, n=9	3.3	2.3	3.5	N/A
3.4 Blood Products, n=6	N/A	3.5	2.7	N/A

Notes: N=51 hospitals participated in the final survey. DPH UC: designated public hospital with University of California affiliation; DPH County: County-operated designated public hospital; DMPH non-CAH: district and municipal public hospital without critical access hospital designation; DMPH CAH: district and municipal public hospital with critical access hospital designation. CCM: complex case management. Ratings of financial investment were on a scale from 1 (very low) to 5 (very high). Values in the exhibit represent mean ratings. The number of hospitals participating in each project in DY 15 is included for each project.

Exhibit 175: Hospital Ratings of Overall Difficulty of Implementing PRIME Projects by Hospital Type

PRIME Project	DPH UC n=5	DPH County n=12	DMPH non-CAH n=18	DMPH CAH n=16
1.1 Behavioral Health Integration, n=23	4.2	4.2	4.5	4.3
1.2 Primary Care Redesign, n=23	3.8	4.1	4.7	4.3
1.3 Specialty Care Redesign, n=19	4.2	4.2	4.0	N/A
1.4 Patient Safety, n=12	4.0	4.3	3.7	2.0
1.5 Million Hearts®, n=16	3.5	3.4	4.5	3.8
1.6 Cancer Screening, n=11	3.0	4.3	3.5	3.5
1.7 Healthier Foods, n=9	N/A	2.5	4.3	3.0
2.1 Perinatal Care, n=21	4.0	3.7	4.0	N/A
2.2 Care Transitions, n=31	4.4	4.2	3.8	4.0
2.3 CCM for High-Risk Populations, n=26	3.8	4.0	3.9	N/A
2.4 Foster Children Health Homes, n=4	N/A	4.5	N/A	N/A
2.5 Post Incarceration Care, n=2	N/A	4.5	N/A	N/A
2.6 Pain Management, n=15	2.5	3.6	4.0	3.8
2.7 Advance Care Planning, n=13	4.0	3.5	4.3	N/A
3.1 Antibiotic Stewardship, n=14	4.5	3.3	3.1	4.0
3.2 High-Cost Imaging, n=9	3.0	3.3	3.7	N/A
3.3 High-Cost Pharmaceuticals, n=9	4.7	3.8	4.0	N/A
3.4 Blood Products, n=6	N/A	3.5	4.0	N/A

Notes: N=51 hospitals participated in the final survey. DPH UC: designated public hospital with University of California affiliation; DPH County: County-operated designated public hospital; DMPH non-CAH: district and municipal public hospital without critical access hospital designation; DMPH CAH: district and municipal public hospital with critical access hospital designation. CCM: complex case management. Ratings of overall difficulty were on a scale from 1 (very low) to 5 (very high). Values in the exhibit represent mean ratings. The number of hospitals participating in each project in DY 15 is included for each project.

Exhibit 176: Hospital Ratings of Level of Integration of PRIME Activities into Routine Standards of Care by Hospital Type

PRIME Project	DPH UC n=5	DPH County n=12	DMPH non-CAH n=18	DMPH CAH n=16
1.1 Behavioral Health Integration, n=23	4.2	4.0	3.5	4.8
1.2 Primary Care Redesign, n=23	4.2	4.3	4.7	3.7
1.3 Specialty Care Redesign, n=19	4.2	4.1	4.0	N/A
1.4 Patient Safety, n=12	4.0	4.3	4.0	4.5
1.5 Million Hearts®, n=16	4.5	3.8	4.0	4.0
1.6 Cancer Screening, n=11	3.0	4.5	4.0	4.3
1.7 Healthier Foods, n=9	N/A	4.5	4.2	5.0
2.1 Perinatal Care, n=21	4.4	4.4	4.3	N/A
2.2 Care Transitions, n=31	3.6	3.8	3.9	4.0
2.3 CCM for High-Risk Populations, n=26	3.8	3.8	4.2	N/A
2.4 Foster Children Health Homes, n=4	N/A	4.5	N/A	N/A
2.5 Post Incarceration Care, n=2	N/A	3.5	N/A	N/A
2.6 Pain Management, n=15	4.0	4.3	4.0	4.4
2.7 Advance Care Planning, n=13	4.3	3.5	4.6	N/A
3.1 Antibiotic Stewardship, n=14	4.5	4.3	3.9	4.0
3.2 High-Cost Imaging, n=9	5.0	4.5	5.0	N/A
3.3 High-Cost Pharmaceuticals, n=9	3.0	3.8	4.5	N/A
3.4 Blood Products, n=6	N/A	3.5	4.3	N/A

Notes: N=51 hospitals participated in the final survey. DPH UC: designated public hospital with University of California affiliation; DPH County: County-operated designated public hospital; DMPH non-CAH: district and municipal public hospital without critical access hospital designation; DMPH CAH: district and municipal public hospital with critical access hospital designation. CCM: complex case management. The number of hospitals participating in each project in DY 15 is included for each project.

Exhibit 177: Sustainability of PRIME Projects by Hospital Type

PRIME Project	DPH UC n=5	DPH County n=12	DMPH non-CAH n=18	DMPH CAH n=16
1.1 Behavioral Health Integration, n=23	4.0	3.8	3.0	3.5
1.2 Primary Care Redesign, n=23	4.2	3.8	4.7	4.3
1.3 Specialty Care Redesign, n=19	4.2	3.8	4.0	N/A
1.4 Patient Safety, n=12	3.5	4.0	4.7	5.0
1.5 Million Hearts®, n=16	5.0	3.8	4.0	3.3
1.6 Cancer Screening, n=11	5.0	4.0	4.5	4.8
1.7 Healthier Foods, n=9	N/A	4.5	4.0	5.0
2.1 Perinatal Care, n=21	4.8	3.7	4.3	N/A
2.2 Care Transitions, n=31	4.0	3.4	3.6	4.0
2.3 CCM for High-Risk Populations, n=26	4.2	3.7	3.6	N/A
2.4 Foster Children Health Homes, n=4	N/A	4.0	N/A	N/A
2.5 Post Incarceration Care, n=2	N/A	3.0	N/A	N/A
2.6 Pain Management, n=15	4.5	4.0	4.0	4.4
2.7 Advance Care Planning, n=13	4.7	3.0	4.1	N/A
3.1 Antibiotic Stewardship, n=14	4.5	4.7	4.1	5.0
3.2 High-Cost Imaging, n=9	5.0	4.0	4.7	N/A
3.3 High-Cost Pharmaceuticals, n=9	3.0	3.8	3.0	N/A
3.4 Blood Products, n=6	N/A	2.5	4.3	N/A

Notes: N=51 hospitals participated in the final survey. DPH UC: designated public hospital with University of California affiliation; DPH County: County-operated designated public hospital; DMPH non-CAH: district and municipal public hospital without critical access hospital designation; DMPH CAH: district and municipal public hospital with critical access hospital designation. CCM: complex case management. The number of hospitals participating in each project in DY 15 is included for each project.

Exhibit 178: Hospital Ratings of Impact of PRIME on Organizational Capacity by Hospital Type

	DPH UC n=5	DPH County n=12	DMPH non-CAH n=18	DMPH CAH n=16
Data collection	3.2	4.3	3.9	4.3
Data analytics	3.6	4.3	3.9	4.1
Data reporting	3.4	4.3	4.1	3.9
Clinical staffing levels	2.6	2.9	3.1	3.3
EMR/IT/Analytic staffing levels	2.8	3.7	2.9	3.1
Development of clinical protocols/workflows	3.2	3.8	4.0	3.9
Conducting patient outreach	3.8	3.9	3.7	4.1
Use of quality improvement strategies	3.4	3.7	3.1	3.4
Ability to participate in risk-based contracts	2.2	2.7	2.8	2.2
Ability to participate in value-based programs	3.2	3.9	3.3	2.8

Notes: N=51 hospitals participated in the final survey. DPH UC: designated public hospital with University of California affiliation; DPH County: County-operated designated public hospital; DMPH non-CAH: district and municipal public hospital without critical access hospital designation; DMPH CAH: district and municipal public hospital with critical access hospital designation. Ratings of PRIME impact were on a scale from 1 (very low) to 5 (very high). Values in the exhibit represent mean ratings.

Appendix F. Self-Reported Metrics Payment Methodology Progression, Achievement Value Methodology, and Results

Metric Progression

Metrics were designated as either pay-for-reporting (P4R) or pay-for-performance (P4P) in a given DY, and they progressively transitioned from P4R to P4P over the five demonstration years of PRIME. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH (Attachment Q). Hospitals may not have reported data if they were working on Infrastructure Building Milestones or had other constraints on data availability. In general, DMPHs did not report data in DY 11. Blanks after the letter indicate that a project was dropped; blanks before the letter indicate that a project was added.

Participating PRIME healthcare organizations were assessed and reimbursed based on their performance on their PRIME projects. In addition to classifying the specific financial incentive (P4R or P4P), based on the project and DY, hospitals were assessed using either a process or outcome metric. Process metrics indicated better care or changes in successful implementation of project objectives. Outcome metrics indicated better health or improvements in population health indicators.

Achievement Value Analysis: Methodology and Metric-Specific Averages, by Hospital Type

During PRIME implementation, participating hospitals were required to submit progress reports twice a year—mid-year and year-end. Reports included a self-reported rate for metrics (achievement rates). An achievement value (AV) s assigned per the STC Attachment II as an indication of the achievement rate progress toward the target. UCLA identified the proportion of metrics achieved per project in each demonstration year by DPHs and DMPHs. As described in the prior section, Metric Progression, metrics were designated as either pay-for-reporting (P4R) or pay-for-performance (P4P) in a given DY. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH or DMPH. All metrics that were partially or fully achieved (a value greater than 0) contributed to the achievement calculation.

Exhibit 179: Steps Used to Analyze the AVs

Steps	Steps used to analyze metric AV values
1.	Excluded any rows that indicated metrics that were not implemented for all consecutive years during DY 11 and DY 14. Excluded the following metrics: 1.1.2, 1.2.6, 1.2.9, 1.2.10, 1.2.13, 1.3.4, 2.3.1. 2.3.3, 2.5.3, 2.7.2, 3.1.2, 3.4.2, 3.4.5
2.	Excluded the Rate 2 rows from Project 3.3 for DY 12 to DY 14
3.	Manually calculated and verified AVs for Metrics 1.7.2, 2.1.1, and 2.1.9 for DY 12 to DY 14 based on the PRIME metric manual specifications, due to multiple rows that influence achievement
4.	Adjusted AV values based on metric names and numerator/denominator values for Metric 2.1.1 for DY 13
5.	BFUSA Designation Yes and Development Phase Complete Yes metrics were set to have AV = 1 and AV = 0 otherwise
6.	Development Plans Submitted metrics were set to have AV = 0.75 if denominator is larger than or equal to 5 and numerator/denominator is larger than or equal to 0.8 AV = 0.5 if denominator is larger than or equal to 5 and numerator/denominator is larger than or equal to 0.6 AV = 0 otherwise
7.	To assign the final AV values AV = 1 if either BFUSA Designation or Development Phase Complete has AV = 1 AV = 0.75 if Development Plans Submitted has AV = 0.75 AV = 0.5 if Development Plans Submitted has AV = 0.5
8.	Adjusted AV values based on metric names and numerator/denominator values for 2.1.9 for DY 13
9.	Structure Elements metrics were set to have AV = 1 if numerator/denominator = 1
10.	OB Safety Drills Each Quarter Yes and fewer if less than 10 cases) Yes metrics were set to have AV =1
11.	To assign the final AV values AV = 1 if all three metrics has AV =1 AV = 0.75 if Structure Elements metrics has AV =1, and either OB Safety Drills Each Quarter and fewer if less than 10 cases) has AV = 1 AV = 0.5 if only Structure Elements metrics has AV = 1 AV = 0 otherwise
12.	Adjusted AV values by taking the average for multi-part metrics: 1.1.1.a, 1.2.1.a, 1.1.7, 1.4.1, 1.7.3, 2.1.6, 2.5.1, 2.6.1, and 3.2.4
13.	Adjusted reporting and process/outcome categorization for specific metrics
14.	Adjusted all DMPH reporting type in DY 12 to be P4R

A total of 87 metrics was assessed from DY 11 to DY 14 (Exhibit 179). 70 process metrics (80%) and 17 outcome metrics (20%) were included in this total. In DY 11, all metrics were P4R. Starting in DY 12, DPHs had 34 P4P metrics, while all metrics for the DMPHs were categorized as P4R during that year. With each continuing demonstration year, there were more P4P metrics. During DY 13, 67% of the total metrics were P4P compared to 33% being P4R. Additionally, during DY 14, 92% of the total metrics were P4P compared to 8% being P4R, demonstrating an increase in P4P metrics.

Exhibit 180: Metric Comparisons Across Demonstration Years (DY) for Achievement Value Analysis

Metric Type	DY 11	DY 12	DY 13	DY 14
P4R & Process	70	46	23	3
P4R & Outcome	17	7	6	4
P4P & Process	0	24	47	67
P4P & Outcome	0	10	11	13

Notes: P4R: pay-for-reporting; P4P: pay-for-performance.

Metrics Where PRIME Hospital Types Did Not Meet the 30 Patient Minimum Denominator Criteria

Denominators of the achievement rates represented the patients that fell within the eligible population for a metric. According to the PRIME Projects and Metrics Protocol (Attachment Q and the PRIME Policy Letter (PPL 17-002), PRIME entities must have a minimum of 30 individuals or cases in a metric denominator in order to be eligible to report on that metric, as determined by DHCS. If a participating PRIME entity meets this minimum, then the participating PRIME entity must report the metric. If a participating PRIME entity has fewer than 30 cases, the participating PRIME entity is not eligible to report on the metric for the reporting period (Attachment Q(V)(J)). Baseline reports <30 were allowed in DY 11 for DPHs and in DY 12 for the majority of DMPHs.

Furthermore, PPL 17-002 specifies that the basis for a denominator of 30 or more is derived from the National Committee for Quality Assurance (NCQA) definition, because a denominator of less than 30 is too small to report a valid rate. Therefore, the UCLA analysis applied the criteria of a denominator of 30 or more when reporting on the hospital sub-types. If a denominator total was less than 30 for the total of all hospitals within a sub-type, the data was not statistically stable enough to make PRIME inferences. There were metrics where a hospital sub-type's total denominator was greater than 0 but less than 30; Exhibit 180 shows these 10 metrics and the corresponding sub-types and years for which data could not be analyzed.

Exhibit 181: Metrics with Denominators Greater Than 0 and Less Than 30 Within PRIME Hospital Sub-Types

Metric	Hospital Type	Hospital Sub-Type	DY 11	DY 12	DY 13	DY 14
1.5.2.i	DMPH	CAH		X		
1.5.2.i	DMPH	Non-CAH	X			
1.6.1	DMPH	CAH		X	X	X
1.6.5	DMPH	CAH			X	X
1.6.5	DMPH	Non-CAH		X	X	X
1.7.1	DMPH	CAH			X	X
1.7.2	DMPH	CAH			X	X
2.1.1	DMPH	Non-CAH			X	X
2.1.1	DPH	County			X	X
2.1.1	DPH	UC				X
2.7.4	DPH	County	X			
3.1.1	DMPH	CAH		X	X	X
3.1.4	DMPH	CAH		X	X	X
3.4.2	DPH	County	X		X	

Notes: CAH: critical access hospital.

Appendix G. Metric Details

Prevention Quality Indicators (PQI) (1.2.8, 2.3.3, 2.5.3)

Exhibit 182: PRIME Prevention Quality Indicators

PQIs	Description
#1	Diabetes Short-Term Complications Admission Rate
#3	Diabetes Long-Term Complications Admission Rate
#5	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
#7	Hypertension Admission Rate
#8	Heart Failure Admission Rate
#10	Dehydration Admission Rate
#11	Community-Acquired Pneumonia Admission Rate
#12	Urinary Tract Infection Admission Rate
#14	Uncontrolled Diabetes Admission Rate
#15	Asthma in Younger Adults Admission Rate
#16	Lower-Extremity Amputation among Patients with Diabetes Rate

Source: PRIME Metrics Specs, DY 14YE.

Race/Ethnicity, Language (REAL)/Sexual Identity, Gender Orientation (SO/GI)

Hospitals were intended to identify significant disparities in health, health outcomes, or health care delivery amongst sub-populations of the PRIME Eligible Population and determine target disparities for future intervention. For Metric 1.2.9, the achievement rate was not a weighted average because the underlying data was reported as "yes" or "no" to the metric. Even when hospitals indicated that they did not have a plan, they achieved 1 for reporting (P4R metric).

Exhibit 183: PRIME Target Disparities Using REAL/SOGI Data for Metric 1.2.9 and 1.2.10, Reported in DY 12

Hospital	Type	Target Patient Populations	Targeted Condition
Alameda Health System	DPH	African Americans	Diabetes
Arrowhead Regional Medical Center	DPH	Latino Men	Colorectal Cancer
Contra Costa Regional Medical Center	DPH	African Americans	Hypertension
Kern Medical Center	DPH	Spanish-language	Ischemic Vascular Disease
Los Angeles County Health System	DPH	African Americans	Colorectal Cancer
Natividad Medical Center	DPH	English-language	Colorectal Cancer

Hospital	Type	Target Patient Populations	Targeted Condition
Riverside University Health System	DPH	Spanish-language Latinos (ages 18-39)	Diabetes
San Francisco General Hospital	DPH	African Americans (ages 18-85)	Hypertension
San Joaquin General Hospital	DPH	African Americans	Hypertension
San Mateo Medical Center	DPH	African Americans	Hypertension
Santa Clara Valley Medical Center	DPH	Latinos (ages 19-60)	Diabetes
UC Davis Medical Center	DPH	African Americans	Diabetes
UC Irvine Medical Center	DPH	Latinos	Colorectal Cancer
UC Los Angeles Medical Center	DPH	African Americans	Hypertension
UC San Diego Medical Center	DPH	African Americans	Tobacco Use
UC San Francisco Medical Center	DPH	African Americans (ages 18-85)	Hypertension
Ventura County Medical Center	DPH	Latinos (ages 18-64)	Hypertension
El Centro Regional Medical Center, El Centro	DMPH	Latino Men (ages 50-75)	Colorectal Cancer
John C. Fremont Healthcare District, Mariposa	DMPH	Women	Diabetes
Kaweah Delta Health Care District, Visalia	DMPH	English-language	Hypertension
Modoc Medical Center, Alturas	DMPH	Latinos	Hypertension
Oak Valley Hospital District	DMPH	Latina Women	Diabetes

Source: Hospital reports for DY 12 and survey data; data received May 2019.

Healthier Food Initiative Criteria

Exhibit 184: Summary of Hospital Healthier Food Initiative Criteria for Metric 1.7.2

Healthier Foods Initiative Criteria
Label all items in the cafeteria with their calorie information
Only show healthier options in pictures/advertisements at the cafeteria and on patient menus
Only display healthier foods at check out and within 5 feet of cafeteria cash registers
Offer at least 1 daily Children's Wellness Meal
Offer daily Wellness Meals, starting with 1 and annually add another, for a minimum of 3
Offer health-promoting entrees and side dishes in the cafeteria and on patient menus
Fruit and vegetable sales are 10% of food dollar purchases
Healthier beverage sales are 80% of beverage dollar purchases, tap water is included as a credit
Optional: remove fryers and deep-fat fried products from the cafeteria and patient menus

Obstetric Hemorrhage Bundle, Project 2.1

Metric 2.1.9 includes 16 required elements designed to target obstetric hemorrhage. In DY 11, hospitals reported the number of elements that had been implemented in each of the facilities for an achievement value of 1; all DPHs qualified and DMPHs did not report data. In DY 12, hospitals must have implemented 8 elements to qualify for an achievement value of 1, which all hospitals did (data not shown). In DY 13 onwards, hospitals had to have implemented all 16 requirements, as well as performing quarterly activities: at least 3 obstetric safety drills (including at least 1 about hemorrhage), and performing at least 10 post-event debriefs on cases of obstetric hemorrhage.

In Exhibit 184, the numerator is the sum of requirements that the hospital completed. For health care systems with multiple labor and delivery facilities, each was counted separately. The denominator is the number of requirements (16) multiplied by the total number of maternity facilities within the PRIME hospital system. For example, if a hospital with 1 maternity facility completed 11 requirements, their performance would be 11/16. If a hospital with 2 maternity facilities completed 11 requirements each, their performance would be 22/32 (Exhibit 184).

Exhibit 185: PRIME Hospital-Reported Obstetric (OB) Hemorrhage Safety Bundle Implementation for Metric 2.1.9

Year	Number of Elements Met among All DPH (n=16) Facilities	Number of DPH Facilities Multiplied by Total Elements	Proportion of Elements Met
DY 11 P4R	203	320	63.44%
DY 12 P4P	233	320	72.81%

Year	Number of Elements Met among All DPH (n=16) Facilities	Number of DPH Facilities Multiplied by Total Elements	Proportion of Elements Met
DY 13 P4P	352	352	100.00%
DY 14 P4P	320	320	100.00%
Year	**Number of Elements Met among All DMPH (n=4) Facilities**	**Number of DMPH Facilities Multiplied by Total Elements**	**Proportion of Elements Met**
DY 12 P4R	56	80	70.00%
DY 13 P4P	80	80	100.00%
DY 14 P4P	80	80	100.00%

Source: UCLA analysis of the hospital-reported data, February to June 2020.
Notes: DPH: designated public hospital, DMPH: district and municipal public hospital, DY: Demonstration Year, P4R: pay-for-reporting, P4P: pay-for-performance. DMPHs did not report data in DY 11. Metrics were designated as either pay for reporting (P4R) or pay for performance (P4P) in a given DY and they progressively transitioned from P4R to P4P over the 5 demonstration years of PRIME. In DY 12, P4R or P4P metric status varied depending on whether the hospital was a DPH and DMPH. By DY 13, the P4R or P4P status of metrics was identical whether a hospital was a DPH or DMPH. The metric is calculated per hospital facility.

Care Transitions, Project 2.2

Metric 2.2.2 – H-CAHPS: Care Transition Metric Methodology

Hospitals reported a top-box composite score combining 3 questions in the category of Understanding Your Care When You Left the Hospital:

- Question #23: During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.
- Question #24: When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
- Question #25: When I left the hospital, I clearly understood the purpose for taking each of my medications.

This metric is not specific to the PRIME Eligible Population or Project Target Population and is based on H-CAHPS data targeting the entire population served by a hospital. Therefore, the achievement rates calculated for this metric were the averages of the rates reported by hospitals.

References

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