Public Hospital Redesign and Incentives in Medi-Cal (PRIME)
5-Year PRIME Project Plan

Application due: **by 5:00 p.m. on April 4, 2016**

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General Instructions

Thank you for your interest in the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program. Your response to this 5-Year PRIME Project Plan ("Plan") will enable the Department of Health Care Services (DHCS) to assess if your entity can meet the requirements specified in the waiver Special Terms and Conditions (STCs) and has the capacity to successfully participate in the PRIME program.

This 5-Year PRIME Project Plan is divided into 10 sections which are structured around the Medi-Cal 2020 Waiver's Special Terms and Conditions (STCs). Additional information about the PRIME program requirements can be found in the PRIME Projects and Metrics Protocol (Attachment Q) and Funding Mechanics (Attachment II) of the STCs.

Scoring

This Plan will be scored on a "Pass/Fail" basis. The state will evaluate the responses to each section and determine if the response is sufficient to demonstrate that the applicant will be able to effectively implement the selected PRIME Projects while simultaneously conducting the regular business of operating the hospital system.

In the event that a response to a Plan section is not sufficient and fails to meet review criteria, the applicant will have an opportunity to revise the response(s) to meet the state's satisfaction. Applicants will have three (3) days to complete the revisions upon receiving feedback from the state.

Please complete all sections in this 5-Year PRIME Project Plan, including the Appendix (the infrastructure-building process measure plan as applicable), and return to Tianna Morgan at PRIME@dhcs.ca.gov **no later than 5:00 p.m. on April 4, 2016**.

Section 1: PRIME Participating Entity Information

Health Care System/Hospital Name: Arrowhead Regional Medical Center

Health Care System Designation (DPH or DMPH): DPH

Section 2: Organizational and Community Landscape

The purpose of this section is to provide DHCS with an understanding of the demographic makeup of the community the applicant serves, the target population that will benefit from the PRIME activities, and any other relevant information that will help inform the state's review of this Plan.

2.1 Community Background. *[No more than 400 words]*

Drawing on available data (e.g., DHCS, Office of Statewide Health Planning and Development, U.S. Census Bureau), summarize the health care needs and disparities that affect the health of your local community.

ARMC is the safety-net hospital for the County of San Bernardino (largest geographic county in the United States, stretching over 20,000 square miles); and provides care for a large, underserved and disproportionately minority population. Of our patients, 75% have at least one chronic condition, 40% have multiple. An OSHPD study reported that higher than average numbers of County residents were hospitalized for manageable conditions (e.g. diabetes and congestive heart failure), as compared to other counties. This is summarized below:

Physical Health: The most prominent health issues that face our County include: diabetes, obesity, asthma, and hypertension.

- Approximately 10.6% of County adults have been diagnosed with diabetes, the highest rate among compared counties in California; 83% of these adults have

Type II diabetes. Alarmingly, the County is ranked 58th out of 58 counties for the highest rate of deaths due to diabetes.

- Obesity continues to plague County residents, triggering numerous health conditions. Fifty-eight percent of the County population is considered overweight or obese as compared to 51% statewide.
- Since 2001, the County's Central Valley population accounts for the highest portion of all asthma hospitalizations every year; 21.4 % of children and 13.8% of adults in the County have been diagnosed with asthma during their lifetime.
- Almost one-third of County adults have been diagnosed with hypertension, paving the way for increased risk of heart disease and stroke if left untreated. The County's rates are higher than California's and most counties.

Behavioral Health: Five-percent of the County's adult population has been diagnosed with a Serious Mental Illness (SMI), slightly higher than the state prevalence of 4%. This becomes more pronounced when we examine ARMC's Medi-Cal population who experience a much higher rate of SMI diagnosis at 12%. In addition, 17% of ARMC's Medi-Cal population has been diagnosed with Severe Emotional Disturbance (SED); 8% of the children in the County are diagnosed with SED.

Nine-percent of the County's population has been diagnosed with Substance Use Disorder (SUD), similar to the state prevalence.

Health Disparities: The County ranks low with respect to health outcomes compared to other California counties. Many of the disparities in care are related to the patients' socioeconomic status and access to care; with the largest county geographically, this adds to the complexity and logistics of caring for its residents. Additionally, the County has one of the lowest ratios of practitioners to patients compared to other California counties.

Many health disparities are related to race and ethnicity, with the Caucasian population faring better with diabetes, fitness levels, obesity rates and access to care.

2.2 Population Served Description. *[No more than 250 words]*

Summarize the demographic make-up of the population included in your hospital's service area, including information about per capita income, age, race, ethnicity, primary language, etc.

The County spans over 20,105 square miles and has a population of 2,112,619 residents (fifth largest population in California). Approximately 73% of the population is located within a 450 square mile area south of the San Bernardino Mountains in the San Bernardino Valley. The estimated population density of this region is approximately 2,977 persons per square mile, similar to neighboring Los Angeles and Orange counties. The

County population is expected to reach about 2.75 million by 2035, with an average annual growth rate of between one and two percent, creating a total growth of 36%.

Income: The average per capita income for the County is $21,384 with a median family income of $54,100. However, 20.47% of our County residents live below the federal poverty level, compared to 16.4% statewide.

Age: The County's population is relatively young with a median age of 31.0 years compared to 35.0 years statewide. Specifically:

- 0-17 years (27.5%)
- 18-65 years (63.8%)
- 65 and over (8.7%)

Race/Ethnicity and Language: The County is racially and ethnically diverse with half of County residents identifying themselves as Latino. Among the remaining non-Latino residents, 32% are White, 8% are Black or African American, 7% are Asian or Pacific Islander, and 3% report two or more races. Less than one percent of residents are American Indian/Alaska Native (0.6%). The primary language spoken in the County is English (58.2%). Forty-two percent of residents speak a language other than English at home, and among these 81% speak Spanish and 19% speak some other language.

2.3 Health System Description. *[No more than 250 words]*

Describe the components of your health care system, including license category, bed size, number of clinics, specialties, payer mix, etc.

ARMC includes a 456-bed teaching hospital licensed by the State of California Department of Public Health and operated by the County of San Bernardino. The medical center main campus, located on 70-acres in Colton, California, is a designated Level II trauma center. ARMC operates a regional burn center, a primary stroke center, a multispecialty outpatient care center, a behavioral health center located on the hospital campus, four primary care centers including three off-site neighborhood primary care clinics, and provides more than 40 outpatient specialty care services. In additional to primary care, the hospital and its affiliated clinics offer care in 18 specialties.

ARMC has the second busiest Emergency Department in the State of California and serves 130,000 emergency department patients, 115,000 inpatients, and 250,000 outpatients annually. In keeping with our mission to provide quality health care to the community, a variety of outreach and wellness programs are offered, including the Breathmobile (asthma education and screening), a Mobile Medical Clinic, a weekly farmers market on our main campus, cooking classes and a 5K Walk-Run event.

In fiscal year 2015 (July to June), ARMC's payer mix was 34.56% Medi-Cal Managed Care, 32.47% Medi-Cal, 18.15% Medicare, 7.24% Insurance, 3.5% Self-Pay, 3.68%

Prisoners and .40% other. The average length of stay for acute care was 5.2 days, with a 72.9% occupancy rate.

2.4 Baseline Data. *[No more than 300 words]*

Describe the current resources that your entity has in place to collect, report and monitor performance data and how these resources will support PRIME clinical quality reporting requirements. Please specify any anticipated limitations or barriers to meeting the PRIME reporting requirements and describe your proposed strategies to address these barriers.

ARMC Leadership identified Clinical and Administrative Champions to lead each of the nine PRIME projects. The Champions, along with both a PRIME Program Manager, key administrative leaders, Chief Financial Officer (CFO) and Chief Medical Information Officer (CMIO), make up the ARMC PRIME steering committee. The steering committee also includes a Database Administrator, Program Analyst, Staff Analysts (manual chart abstraction/review), and Information Technology (IT) support. This committee is working collectively towards data mining, data management, analytics and change management to support the six selected and three optional PRIME projects.

Data collection, mining and reporting will include a large volume of manual chart abstraction, developing custom electronic health record (EHR) reports and leveraging ARMC's homegrown Patient Registry. The Patient Registry was developed with dashboard capability, focusing on DSRIP reporting requirements; this will be updated for PRIME. The Patient Registry allows for real-time and retrospective data analytics.

We expect that some of our limitations will lead to barriers in regards to PRIME reporting. Collectively, we have engaged systems to work with the appropriate parties to address identified limitations/barriers in order to be successful throughout this health transformation. Initial barriers to reporting are as follows: 1) key departments, including specialty care, are not utilizing electronic clinical workflows, resulting in manual abstraction; 2) the patient registry requires numerous custom updates in order to extract data for PRIME metrics and day-to-day population health management; 3) a planned conversion to a new EHR platform which will include a transition and implementation period as well as patient information being housed on paper documents and electronically in both the current and new platforms; and 4) existing resources to implement the associated changes. As a whole we will need to continue to transform (Lean) and grow (additional funding) our infrastructure/staffing towards best possible utilization of resources.

Section 3: Executive Summary

The objective of PRIME is to accelerate participating entities' efforts (as applicable), to change care delivery, to maximize health care value and to strengthen their ability to successfully perform under risk-based Alternative Payment Methodologies (APMs). This section of the Plan will be used to present each entity's overall goals and specific aims

for PRIME. This section should also describe how these efforts will evolve over the course of the five years.

3.1 PRIME Project Abstract [No more than 600 words] *Please address the following components of the Abstract:*

1. *Describe the goals* for your 5-year PRIME Plan; Note:*
   * *Goals (generally 2-5) are general guidelines that explain what you want to achieve in your hospital or health system. They are usually medium- to longterm and represent program concepts such as "eliminate disparities." These goals may already be a part of your hospital or health system's strategic plan or similar document.*

ARMC's mission is to provide quality health care to the community, regardless of the patient's socioeconomic status; with a vision to improve the health of the community by being an innovative provider of choice for health care delivery and education.

As part of the Countywide Vision, ARMC will seek to employ a multifaceted approach to expand its capacity to provide quality healthcare services. In support of a healthy county, we value both prevention programs and superior healthcare services. Through a team based, whole person care approach, we will work to reduce chronic disease (medical and behavioral) and eliminate economic disparities through health education, promotion of healthy lifestyles, development of outcome-based health services, and increase the collaboration between and among providers and other community-based organizations.

2. *List specific aims** for your work in PRIME that relate to achieving the stated goals; Note:*
   ** *Specific aims (generally 2-5) relate to the goals but provide more detail on how the goals will be achieved.*

Aims identified will assist ARMC in maximizing health care outcomes and value, further efforts towards population health management, improve patient/provider satisfaction and strengthen our system to perform under Medi-Cal 2020.

Aim 1: Improve the overall health of our population with a concerted focus on coordinated care. Specifically;

- ARMC will overhaul its referral management process. This includes procurement of a new referral management software and outreach to both ARMC and external providers during DY 16. Providers with outgoing and incoming referrals are expected to have real-time access

to the referral status. This, in turn, will be communicated to the patients, thus improving patient engagement and satisfaction.

- ARMC's Case Management team has developed relationships with step down units such as Skilled Nursing Facilities (SNFs). To improve communications with SNFs and external PCPs and providers, ARMC is working to transition discharge documentation to a fully electronic process by DY 17. ARMC has the ability to create network IDs for those providers who cannot accept such documents electronically.
- ARMC RN Care Managers utilize our Patient Registry to identify and track high-risk, high-utilization patients. We will continue to build upon this with early identification, improved care coordination and patient centered outreach both virtual and direct.
- ARMC intends to improve the medication management and adherence for its complex patients with PharmD visits. These visits are currently being piloted in three of our primary care clinics, one afternoon per week. Based on volume and success of this pilot, we plan to increase the number of visits offered.

Aim 2: Strengthen complex care management system by improving coordination between inpatient and outpatient services, and external providers/stakeholders. Specifically;

- Focus on team based care, including complex care management and coordination through the use of RN Care Managers, improved discharge planning, robust EHR, registry and eReferral systems.
- Redefine referral protocols and implement screening processes (tobacco assessment, flu vaccinations, behavioral health screenings, etc.) consistent with those in the primary care setting for continuity of care.
- Utilize health information technology (HIT) to improve coordination between ARMC's inpatient and outpatient providers as well as external providers (PCPs, SNFs, etc.).
- Pilot medication reconciliation project to reduce potential harm or adverse drug reactions and continue antibiotic stewardship efforts.
- DSRIP created a strong foundation for ARMC to start looking at quality and utilization from a reimbursement standpoint. ARMC intends to create a Clinically Integrated Network with other County entities such as the Departments of Public Health and Behavioral Health to deliver integrated care. Further, ARMC is committed to integrating its contracted physician groups into an Independent Physician Association (IPA) that would deliver and be reimbursed care based on risk (pay for performance). Legal, contractual and compliance efforts have already been started towards this

Aim 3: Identify and reduce health disparities, improving outcomes for some of our most vulnerable populations. Specifically;

- Amongst the safety-net hospitals in California, ARMC is a leader in collecting REAL and SOGI data, with collection of SOGI data beginning in early 2016. ARMC continues to make strides with accurate capture of REAL data. This includes aligning with best practices from CDS and OSHPD, staff education and accurate collection and registration and data analysis.
- Data collected will be analyzed, identifying and stratifying disparities amongst the population. With a commitment to improved patient outcomes, staff will continue to receive education on disparities, the collection of data and processes to improve disparities.

3. *Provide a statement of how the selected projects will support the identified goals and specific aims. Note that the narrative should connect the specific aims identified in Section 3.1.2 to the projects you select in Section 4. Each project does not require a specific statement. Instead, the narrative in the abstract is broadly linking projects to identified goals and specific aims;*

ARMC intends to participate in PRIME Projects 1.1, 1.2, 1.3, 1.7, 2.1, 2.2, 2.3, 2.4 and 3.1.

ARMC treats a large percentage of patients with co-occurring medical and behavioral health issues, compounded by multiple chronic health conditions. This, in combination with limited access to care in a large geographic county, contributes to lack of coordinated care and poor health outcomes. Through PRIME initiatives, ARMC seeks to improve care delivery in Primary and Specialty Care, Women's Health and Pediatrics.

4. *If more than one project is selected, describe how the projects will inter-relate to achieve system transformation (not applicable if only one project is selected); and*

It is expected that the selected projects will have significant overlap in regards to personnel, workflows, data analytics and patient population. ARMC PRIME Project Champions are coordinating meetings and discussions where the projects overlap in multiple areas; in doing so, we continue to break down silos that plague effective care coordination and in the end, improve patient outcomes.

The projects that we have selected force us to work towards a more comprehensive-coordinated approach aimed at improving outcomes for our complex population. The inter-relating between primary and behavioral care, care transitions and care management, strengthen our integration between outpatient and inpatient care. These are the building blocks necessary to

improve overall health and to reduce the disproportionate share of resources utilized by complex patients who account for a large percentage of expenditures and usage.

5. *Provide a succinct summary description of how your hospital or health system will be transformed at the end of the five years. Explain how this transformation should result in advances in clinical, population health, fiscal or other critical outcomes through PRIME.*

   With DSRIP, ARMC laid out the foundation for PRIME with transformative activities including increased access and improved care to improve our patients' population health. During the next five years ARMC expects to make significant advancements with care coordination and complex care management, thereby improving health outcomes (e.g. diabetes care, smoking cessation, mental health, vaccines, cancer screening), preparing us for risk-based alternative payment methods models and Healthy People 2020. We envision a system where our patients receive the right care at the right time; care coordination is second nature; we reduce costs by reducing high utilization; and our EHR is robust, agile and meaningful.

3.2 Meeting Community Needs. [No more than 250 words]

Describe how your organization will address health needs at a local level as described in Section 2 of the Plan. The narrative should clearly link the projects you select in Section 4 with the community needs identified in your response to Section 2.1.

Serving the County's safety-net population ARMC seeks to decrease disparities in health and improve health care outcomes, with a specific focus on our identified physical and mental health issues. PRIME projects will help to identify and address disparities among our population, bridging the gap between physical and mental health and addressing our complex care population. Specific examples to our projects:

- Through Domain 1, we will improve our ability to clearly identify our target patient population and disparities they may experience; provide appropriate screening and follow up to a vulnerable population; and expand upon our care coordination program in the primary care setting to promote achievement of self-management goals and reduce avoidable hospitalizations and Emergency Department use.

- In Domain 2, our focus will be on those patients who might be slipping through the care coordination cracks and thus not receiving optimal care. ARMC has identified interdisciplinary work groups including case management and clinicians from both sides of important patient care transitions to actively manage what happens to the patients during these vulnerable times.

- With Domain 3, our PRIME teams will focus on implementing evidence-based practices to thwart improper antibiotic use; thereby improving patient outcomes, minimize unnecessary costs and reduce antibiotic resistance.

3.3 Infrastructure and Alignment with Organizational Goals. [No more than 250 words]

Describe the organizational infrastructure that exists or will be established for purposes of implementing PRIME (e.g., current strategic plan, goals related to quality improvement, monitoring/feedback mechanisms, data-driven decisionmaking practices).

ARMC's strategic plan seeks to develop a system of care that continuously improves population health by measuring outcomes and collaborating with key providers in the Inland Empire. ARMC will focus on improving the patient's experience while driving down the cost of care on a per capita basis.

On the heels of DSRIP, we took the opportunity to set ourselves up for success by wholeheartedly embracing the implementation of PRIME. Each PRIME Project is assigned a Clinical and Administrative Champion to spearhead the project's goals and objectives. The Champions then in turn identify the necessary team members, both clinical and non-clinical; including IT support from each project's inception. Teams are conducting gap analyses to determine potential strengths and deficits so that improvement planning can begin.

ARMC's primary care clinics include three offsite Family Health Centers (FHCs), and a hospital based Internal Medicine, Pediatric, and Women's Health clinic. In addition to the primary care clinics, ARMC has 40 specialty/sub-specialty clinics located on the hospital grounds. Located in a medically underserved area, ARMC is in the midst of expanding its primary care footprint, as well as investing in new personnel, with roles formulated around population health. These include RN Care Managers, patient education specialists, quality managers, and data analysts. ARMC will continue to expand its investment in Health-IT including a registry, EHR and Data Analytics, with the intent to leverage data through reports and dashboards to improve outcomes.

On a larger scale, ARMC is collaborating with the County (Public and Behavioral Health, Sheriff's Department and other major players), managed care health plans and local providers to create a Clinically Integrated Network (CIN) to support a comprehensive approach to population health management for County residents.

3.4 Stakeholder Engagement. [No more than 200 words]

Describe plans for engaging with stakeholders and beneficiaries in the planning and implementation of PRIME projects. Describe how these activities will complement or augment existing patient engagement efforts.

Within our four walls, collaboration has already begun to break down barriers between inpatient and outpatient care. PRIME teams were designed to be comprehensive and include, Administration, inpatient and outpatient providers, nursing, case managers, RN care managers, clinic staff, bed management, case management, education, social services, and IT – all with a common goal to improve outcomes and patient and family experience.

ARMC has also had several working sessions with external stakeholders including health plans, local providers and other County departments to ensure these PRIME projects are formulated with solid footing and roots in order to allow for continued growth and development of the care delivery system.

ARMC will spread techniques developed and honed in the FHCs such as: active care coordination, complex care management, and patient engagement. This includes integration of Whole Person Care, analyzing and addressing disparities, PharmD visits and behavioral health integration. ARMC intends to expand the utilization of its electronic patient portal to give patients access to their data including reports, results and appointments, as well as expanding electronic messaging between patients and providers so that patients can be fully involved in their care.

3.5 Cultural Competence and Addressing Health Disparities. [No more than 200 words]

Describe planned efforts to ensure cultural competency in implementing PRIME projects and the strategies to reduce healthcare disparities that will be adopted. Identify the resources that the entity has available for this purpose.

ARMC and the County are fully committed to decreasing disparities related to race, ethnicity, language (REAL), sex and sexual orientation/gender identification (SO/GI). Cultural competency is an important tool that we must ingrain within our system. Prior to PRIME, ARMC provided basic education to all staff and providers regarding cultural competence and its importance for quality health care. Recently, the inclusion of SO/GI data collection at registration, required advanced education. PRIME teams worked collectively to create effective education. During initial training sessions, staff were educated on the how and why we collect the data; ensuring staff understood this was more than being a required input field at registration serves as an effective tool to assist our health care delivery system identify and address barriers and disparities amongst our population.

Cultural competency education will evolve as we focus on addressing the disparities of our population. Steps have already been taken to address language barriers within our system. In 2015, ARMC contracted with a top-rated language service provider, which included installing dual handset phones in each clinic room and on the nursing and ancillary units for real time translation; video remote carts to provide effective

communication with the deaf/hard of hearing population; as well as continued access to face-to-face interpreters. Efforts such as these will be studied and implemented within our system to address the health disparities that affect our population.

3.6 Sustainability. [No more than 150 words]

Provide a high-level description of the systematic approach for quality improvement and change management that your organization plans to use. The narrative should describe the specific components you have in place, or will implement as part of PRIME, which will enable you to sustain improvements after PRIME participation has ended.

To be successful, sustain continuous quality improvement and manage change, ARMC will:

- Structure Strategic goals, including those in PRIME, around Studer's Six Pillars, which provides the foundation for achieving ARMC's organizational goals and operational excellence.

- Utilize Lean methodology to reduce waste and increase value for the patient. Presently, Lean is used to reduce patient wait times, remove bottlenecks in patient flow, and streamline patient care processes, resulting in improved throughput and reduced costs.

- During DSRIP, our clinic staff borrowed heavily from the IHI Model for Improvement became very familiar with Plan Do Study Act (PDSA) methodologies, utilizing it to develop new care delivery systems and then spread the systems once better outcomes were proven. Now, PDSAs have become an important improvement tool for our institution. We will continue to utilize IHI Improvement methods throughout PRIME, in both outpatient and inpatient settings.

- ARMC Administration has endorsed PRIME involvement throughout the institution so that it becomes the fabric of all processes and departmental workflows; working towards enhancing quality of care, optimizing utilization of resources and improving the patient experience.

- Strategically ARMC is working to collaborate intimately with County departments and local/state/federal stakeholders to enhance quality and improve health outcomes.

Section 4: Project Selection

The PRIME Projects are organized into three Domains:

- Domain 1: Outpatient Delivery System Transformation and Prevention
- Domain 2: Targeted High Risk or High Cost Populations
- Domain 3: Resource Utilization Efficiency

The PRIME program will provide incentive payments to participating entities that commit to implementing 5-year projects within the PRIME domains and as further described in *Attachment II -- PRIME Program Funding and Mechanics Protocol.* The required set of core metrics for each project is outlined in *Attachment Q: PRIME Projects and Metrics Protocol.* The purpose of this section is for applicants to indicate which projects they will implement and to describe the approaches to implementation.

Selections must comply with the requirements of the STCs and the Attachments Q and II delineating the PRIME program protocols.

Designated Public Hospitals (DPHs) are required to implement projects from all three Domains. DPHs must select at least nine projects, of which six are specifically required:

- Select at least four projects from Domain 1 (Projects 1.1, 1.2, and 1.3 are required);
- Select at least four projects from Domain 2 (Projects 2.1, 2.2, and 2.3 are required); and,
- Select at least one project from Domain 3.

District/Municipal Public Hospitals (DMPHs) are required to select at least one project to implement. DMPHs may select their project(s) from any of the three Domains.

Instructions

For Sections 4.1 - 4.3, click the box(es) that correspond to the project(s) you will undertake. In addition, click the boxes that correspond to the core components you will adhere to in order to achieve the objectives of the project. Note that core components selected are not required; they are meant to guide project execution and serve as recommendations only.

Answer all of the questions below for each selected project. Provide narrative responses in the spaces marked *"[Insert response here]":*

1. *Summarize your approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words]*
2. *Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]*

3. ***For DMPHs (as applicable),*** *indicate which project(s) your entity is selecting that will require infrastructure-building process measures and complete the supplemental document (Appendix) to identify and describe your proposed process measures.*

   For DMPHs requiring infrastructure building metrics that are approved in the Prime Project Plan, 75% of PRIME funding for DY 11 will be based on the achievement of the approved DY 11 infrastructure building metrics through the final year-end report. Up to 40% of the total PRIME funding for DY12 will be based on the achievement of the approved DY 12 infrastructure building metrics through the mid-year and final year-end report. The proposed Process Measures should meet the following criteria:

   - *Specific*
   - *Measurable: Must be able to demonstrate progress throughout the duration of the process metric measurement period.*
   - *Evidence-based: Measures should have a strong evidence-base that can linked process to outcomes.*

Section 4.1 -- Domain 1: Outpatient Delivery System Transformation and Prevention

☒ 1.1 Integration of Physical and Behavioral Health (required for DPHs)

Approximately 30% of the patients receiving care in ARMC's Primary Care Clinics (PCC) have undiagnosed mental health issues. It is known that this will affect their ability to care for their medical conditions, and has been estimated to decrease their life span by 5-10 years. These statistics paint an alarming picture of the County's mental health landscape and need to be zeroed in on in order to facilitate an improvement in health outcomes. Through PRIME, and specifically this project, ARMC's PCC are planning to provide behavioral health assessments and interventions in a collaborative medical/mental health model.

Project Development: The PCCs created a multidisciplinary PRIME workgroup to perform gap analysis of clinical pathways (EHR, staff educational needs, outcome reporting and work flow) and the PRIME core measures during DY11. Once the clinical pathways are identified, the work group will develop strategies to address the gaps in DY12.

*Behavioral Health Assessment/*Referrals: Utilizing resources from the County Behavioral Health Integration Initiative, education sessions will be developed and conducted regarding screening, referrals, and patient-self management. The PCC providers, RN Care Managers and clinical staff will screen patients aged 18 years and older using the PHQ-9 and SBIRT assessment tools. In addition, motivational interviewing and referral of appropriate patients to more intensive behavioral health services will begin in DY12. We will need to improve the current pathways to include bi-directional sharing of medical and mental health treatments, patient access and navigation through the system, patient experience, and preventive health services during and following DY13.

Behavioral Specialists: ARMC is recruiting behavioral consultants and assistants to perform SBIRT assessments on patients served by ARMC's PCCs. These behavioral health practitioners will be embedded in the PCCs to provide SBIRT, in conjunction with scheduled medical appointments during DY11. The PCCs currently have a pathway to direct appropriate patients to the County's Department of Behavioral Health for referrals of Serious Mental Issues (SMI) and Mental Health Disorders (MHD), but will need to develop a more streamlined patient-friendly process during DY 12.

Target Population/Care Delivery: PRIME initiatives give ARMC the ability to better care for our overall population. The County has a greater percentage of undiagnosed mental health disorders, SMI, and MHD than other counties in California. Building collaborative clinical pathways (routine screenings and improved access to behavioral health care) amongst the Emergency Department, inpatient, outpatient and behavioral services in our own system is an effective tool for improvement in health care outcomes for our patients.

Through these tools, we will be able to screen, refer and provide treatment options to our adult population.

We will enhance our clinical practices by integrating primary and behavioral health, which ultimately will lead to the "Triple Aim" of improved population health, improved patient experience of care, and reducing the cost of health care. Through Project 1.1 we will focus on five key areas of practice transformation, which include: assessment processes, care planning, service delivery practices, population health care management, and health promotion/patient experience. This initiative will focus on improving team based care, complex care management and coordination, health information and technology, and health promotion and self-management support, especially for those patients with mental health conditions.

Please mark the core components for this project that you intend to undertake:

Check	Core Components
Applicable	**1.1.1** Implement a behavioral health integration assessment tool (baseline and annual progress measurement).
Applicable	**1.1.2** Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration, the Collaborative Care Model, or other Integrated Behavioral Health (IBH) resources from SAMHSA)
Applicable	**1.1.3** Integrate appropriate screening tools and decision support into the emergency department (ED) to ensure timely recognition of patients with mental health and substance use disorder problems. Enhanced access to primary care and/or to behavioral health specialists will be integrated into discharge planning for these patents. Use of 24-7 care navigators (e.g., Community Physician Liaison Program) may be used to support linkages to primary care providers (PCPs), mental health (MH) and substance use disorder (SUD) specialists and behavioral health and other community services through the discharge process.
Applicable	**1.1.4** Integrate physical and behavioral health, either through implementation of a new program or an expansion of an existing program, from pilot sites to hospital and health system primary care sites or from single populations to multiple populations (e.g., obesity, diabetes, maternal, infant, and child care, end-of-life care, chronic pain management).

Applicable	**1.1.5** Patient-Centered Medical Home (PCMH) and behavioral health providers will: • Collaborate on evidence based standards of care including medication management and care engagement processes. • Implement case conferences/consults on patients with complex needs.

Check	Core Components
Applicable	**1.1.6** Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families.
Applicable	**1.1.7** Ensure systems are in place to support patient linkages to appropriate specialty physical, mental and SUD services. Preventive care screenings, including behavioral health screenings (e.g., PHQ2, PHQ-9, SBIRT), will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including the provision of brief interventions (e.g., motivational interviewing techniques) to ensure access for further evaluation and treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.
Applicable	**1.1.8** Provide cross-systems training to ensure effective engagement with patients with MH/SUD conditions. Ensure that a sufficient number of providers are trained in SBIRT and/or in other new tools used by providers to ensure effectiveness of treatment.
Not Applicable	**1.1.9** Increase access to Medication Assisted Treatment (MAT) for patients with alcohol and opioid addiction to assist in stabilizing their lives, reducing urges or cravings to use, and encourage greater adherence to treatment for co-morbid medical and behavioral health conditions. For alcohol use disorders these medications include naltrexone, acamprosate, and disulfiram. For opioid addiction, medication assisted treatment (MAT) includes maintenance treatment with methadone and buprenorphine.
Not Applicable	**1.1.10** Ensure the development of a single treatment plan that includes the patient's behavioral health issues, medical issues, substance abuse, social and cultural and linguistic needs. This includes incorporating traditional medical interventions, as well as non-traditional interventions such as gym memberships, nutrition monitoring, healthy lifestyle coaching, or access to culturally and linguistically appropriate peer-led wellness and symptom management groups.

Not Applicable	**1.1.11** Ensure a culturally and linguistically appropriate treatment plan by assigning peer providers or other frontline worker to the care team to assist with care navigation, treatment plan development and adherence.
Not Applicable	**1.1.12** Ensure that the treatment plan: • Is maintained in a single shared Electronic Health Record (EHR)/ clinical record that is accessible across the treatment team to ensure coordination of care planning. Outcomes are evaluated and monitored for quality and safety for each patient.
Check	**Core Components**
Not Applicable	**1.1.13** Implement technology enabled data systems to support previsit planning, point of care delivery, care plan development, population/panel management activities, coordination and patient engagement. Develop programs to implement telehealth, eReferral/eConsult to enhance access to behavioral health services.
Not Applicable	**1.1.14** Demonstrate patient engagement in the design and implementation of the project.
Not Applicable	**1.1.15** Increase team engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. Providing ongoing staff training on care model.
Not Applicable	**1.1.16** Ensure integration is efficient and providing value to patients by implementing a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

☒ 1.2 Ambulatory Care Redesign: Primary Care (required for DPHs)

During DSRIP, ARMC's PCCs adopted the Patient Centered Medical Home (PCMH) model, implemented chronic care models, self-management goals, mammogram screening and registry tracking for diabetes and heart failure; a focus that led to improvements in our managed care population. As we continue to see our patient population grow through health care expansion, we realize the need to expand upon the PCMH, implement new technologies to expand access and quality, and identify and address disparities within our population.

PCMH Model and Access to Care: After successful implementation of the PCMH at three of our primary care clinics during DSRIP, in DY 11 we began to implement components

of the PCHM into our fourth primary care clinic, with future plans to add this model to our Pediatric and Women's Health clinics. As we set our sights on improving access to primary care, we are focused on adding additional appointment slots, scheduling timely appointments, reducing failed appointments, expanding operational hours, increasing the number of providers (especially through our residency program), clinic expansion a patient portal, appointment reminder system and referral management system.

ARMC's PCMH model includes patient empanelment, team-based care (through Podlets), patient registry with self-management goals, and staff, provider, and leadership engagement strategies. The care teams provide care via face-to-face appointments and nurse phone visits. Strategies are being designed to provide additional levels of care, including shared visits to reach multiple patients with the same disease process and technology based visits (i.e. telehealth or electronic communication). Additionally, In DY 11, we began piloting once a week medication reconciliation visits with PharmDs at three PCCs, and; added a new classification, RN Care Managers, to provide care management for our high-risk, high-utilization patients. These programs will be expanded upon as our population continues to grow.

A vital portion of our PCHM model is the use and rebuild of our patient registry. Currently our Ambulatory team is working with IM to modify and expand our patient registry, capturing additional data points, including colorectal cancer screenings, tobacco use and cessation, depression screening, blood pressure, ischemic vascular disease and alcohol and drug misuse, allowing care teams to more effectively manage population health. The scope of the registry will continue to evolve to better meet our needs and quality improvement workflows.

New Strategies: The PCCs are moving forward with a focused integration of physical and mental health, including screening and interventions for substance abuse disorder and depression. In DY 11, ARMC began collaborating with one of our managed care providers, IEHP, on a behavioral health integration initiative (BHII). The BHII is, and will be, focusing on five key areas of practice transformation, which include: assessment processes, care planning, service delivery practices, population health care management, and health promotion/patient experience.

Additionally, we will be partnering with the American Cancer Society (ACS) in an effort to improve our colorectal cancer screening rates. The ACS will be able to provide us evidence based tools to improve our rates of screening compliance for our patient population.

In DY 11, ARMC began collecting SO/GI data and an additional level of REAL data at patient registration. To begin, we reviewed literature from field experts on how to collect this data as it could be construed as very sensitive to some as well as training staff on the importance on this data and why we are collecting it. We will continue to assess the data collection make changes to the processes based on feedback from both patients and

staff. Improved accuracy of REAL and the collection of SO/GI data will be used to identify, address and reduce disparities in care. Care teams will work collaboratively to stratify the data collected and use the data in a way that we continuously aim to improve health outcomes.

Target Population/Care Delivery: The primary care redesign project provides a roadmap for ARMC to better care for its population; specifically as they seek care in the primary care setting. As we continue to grow the PCMH model in our PCCs, including expanding Podlet teams and disease registry to our fourth PCC, we align our primary care services under one umbrella.

Our patients will receive consistent services no matter which point they enter our system. PCC patients will receive routine screenings and follow up as indicated by evidencebased best practices, including regular screening for tobacco, alcohol and drug use in both our PCCs and Pediatric clinics, as well as colorectal cancer screening in our PCCs. RN Care Managers will focus efforts on patients who are identified as high service utilizers as well as those with poor outcomes in our disease registry. Disparities with race, ethnicity, sexual orientation and gender will be identified, studied and addressed to produce better outcomes for our patients.

Please mark the core components for this project that you intend to undertake:

Check, if applicable	Description of Core Components
Applicable	**1.2.1** Conduct a gap analysis of practice sites within the DPH/DMPH system.
Applicable	**1.2.2** Primary care practices will demonstrate advancement of their PCMH transformation through the use of a nationally-recognized PCMH methodology.
Applicable	**1.2.3** Hiring and training of frontline workforce (e.g., medical assistants, community health workers, promotoras, health navigators or other nonlicensed members of the care team) to be responsible for coordination of non-clinical services and elements of the care plan.
Applicable	**1.2.4** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population/panel management activities, care coordination, patient engagement, and operational and strategic decisions including a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

	• Implementation of EHR technology that meets meaningful use (MU) standards.
Applicable	**1.2.5** Ongoing identification of all patients for population management (including assigned managed care lives): • Manage panel size, assignments, and continuity to internal targets. • Develop interventions for targeted patients by condition, risk, and self-management status. • Perform preventive care services including mental health and substance misuse screenings and brief interventions (e.g., PHQ9, SBIRT).

Check, if applicable	Description of Core Components
Applicable	**1.2.6** Enable prompt access to care by: • Implementing open or advanced access scheduling. • Creating alternatives to face-to-face provider/patient visits. Assigning frontline workers to assist with care navigation and nonclinical elements of the care plan.
Applicable	**1.2.7** Coordinate care across settings: • Identification of care coordinators at each primary care site who are responsible for coordinating care within the PCMH as well as with other facilities (e.g., other care coordinators or PCMH/DPH/DMPH high risk care managers): o Establish onsite care/case managers to work with high risk patients and their care teams, or develop processes for local care coordinators to work with a central complex care management program for these patients Implement processes for timely bi-directional communication and referral to specialty care (including mental health and substance use disorder services), acute care, social services and community-based services.
Applicable	**1.2.8** Demonstrate evidence-based preventive and chronic disease management.

Check, if applicable	Description of Core Components
Applicable	**1.2.9** Improve staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the team-based care model to ensure effective and efficient provision of services (e.g., group visits, medication reconciliation, motivational interviewing, cognitive behavioral therapy and Medication-Assistance Treatment (MAT)).
Applicable	**1.2.10** Engage patients using care plans, and self-management education, and through involvement in the design and implementation of this project.
Applicable	**1.2.11** Improve the accuracy and completeness of race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI) data, and use that data to identify and reduce disparities in one or more Primary Care Redesign project metrics by: • Adding granular REAL and SO/GI data to demographic data collection processes and training front-line/registration staff to gather complete and accurate REAL/SO/GI data. • Developing capacity to track and report REAL/SO/GI data, and data field completeness. • Implementing and/or refining processes for ongoing validation of REAL/SO/GI data. • Developing capacity to stratify performance metrics by REAL/SO/GI data and use stratified performance data to identify disparities for targeted interventions. • Developing capacity to plan and implement disparity reduction interventions with input from patients and community stakeholders. • Developing dashboards to share stratified performance measures with front-line staff, providers, and senior leadership.
Applicable	**1.2.12** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

☒ 1.3 Ambulatory Care Redesign: Specialty Care (required for DPHs)

ARMC provides both primary and specialty care to our community. ARMC's specialty clinics have made immense gains in recent years focusing on processes of care coordination, collaboration, multidisciplinary team-based approaches and comanagement of care utilizing evidence-based treatment protocols.

Co-Management: ARMC's is transforming its traditional silos between "primary" and "specialty" care, taking the opportunity to ingrain the PCMH model house-wide, thus improving co-management of the patient. Specific projects within the specialty care arena include, developing a process to ensure that patients who have not received their influenza immunization in the primary care setting are given the option to receive the vaccination in the specialty setting. Through improvements in our EMR, and training of specialty staff, we can readily identify patients that are in need of the vaccination and provide that service. Additionally, specialty clinics are developing tools and protocols based on primary care services to assess and track tobacco use and corresponding cessation counseling.

To further implement the PCMH model, specialty clinics are piloting a multidisciplinary team approach including the specialty physician, nurse practitioner (NP), dietitian, social worker and clinical pharmacist when caring for patients with chronic conditions. Physicians and NP treat the patient and develop care plans, dietitians assist in the care planning and provide nutrition education, social workers address mental health issues and clinical pharmacists address medication reconciliation and adherence. Similar to primary care, patients and families are encouraged to become more engaged in their care management within specialty care.

Referral Process: ARMC recognizes a need to improve its electronic referral system to successfully implement the elements of PRIME. The redesign of the referral process will include enhancements to the way referrals are received, reviewed, processed and communicated back to the PCPs. ARMC recognizes that PRIME projects require an increased demand and sophistication in regards to the referral process, i.e. effective tracking of referrals, processing of referrals, appropriate and timely access to care and closing the referral loop with reports to referring providers. ARMC is conducting an RFP for a specialized referral management system designed to enhance bi-directional communication between primary and specialty providers thus effectuating coordination and co-management of care and removing elements of fragmented care

Non-Traditional Services: Initially ARMC will focus its efforts on a robust referral management system which will allow bi-directional communication amongst providers, care teams and the Referral Center, thereby providing the right care at the right time, optimizing health outcomes, reducing specialty utilization and streamlining specialty referrals.

Currently, ARMC specialty services are able to provide Tele-Dermatology & TeleNeurology, albeit significantly underused. This capacity provides the framework to expand telehealth technology with other specialties. As we focus on specialty expertise managed through non-face-to-face encounters, teams from both primary and specialty will meet to identify potential avenues for other non-face-to-face, or complementary encounters. Utilizing technology and clinical applications, new non-face-to-face encounters will be tested through PDSA processes, to determine effectiveness of such encounters amongst our patient population.

Target Population/Care Delivery: ARMC specialty clinic care transformation will be critical to meeting the needs of our specialty population. ARMC is located in a region that has one of the highest burdens of advanced chronic disease in the nation and, remarkably in the world. This is a consequence of the degree of poverty, high concentration of immigrants, and historically poor access to health care — allowing chronic disease to take deep root.

With DSRIP, ARMC began setting the ground work towards primary and specialty care redesign, including reducing wait times and coordinating care. With PRIME, ARMC will focus on evolving the co-management of the patient between primary and specialty, a renovation of the referral process, including electronic referrals and the exploration and implementation of non-traditional visits, through the use of technology in DY 12 and 13.

Redesign of specialty care will ensure coordinated, seamless and effective patient care that breaches the gap patients often fall into when straddling both primary and specialty care arenas.

Specialty referred patients can expect improved care outcomes, including improved dialog and care coordination between primary and specialty care, specialty protocols and reduced wait times through improved technology; all improving patient experience.

Please mark the core components for this project that you intend to undertake:

Check	Core Components
Not Applicable	1.3.1 Develop a specialty care program that is broadly applied to the entire target population.
Not Applicable	**1.3.2** Conduct a gap analysis to assess need for specialty care including mental health and SUD services (analysis to include factors impacting ability to access specialty care), and the current and ideal state capacity to meet that need. Benchmark to other CA Public Health Care systems.
Not Applicable	**1.3.3** For ideal state analysis, include potential impact of increased primary care capacity to manage higher acuity conditions either independently, or in collaboration with, specialty care, so as to reduce the

need for in-person specialty care encounters (e.g., insulin titration, IBS management, joint injections, cognitive behavioral therapy (CBT) or MAT).

Applicable 1.3.4 Engage primary care providers and local public health departments in development and implementation of specialty care model.

Applicable 1.3.5 Implement processes for primary care/specialty care comanagement of patient care.

Applicable 1.3.6 Establish processes to enable timely follow up for specialty expertise requests.

Applicable 1.3.7 Develop closed loop processes to ensure all requests are addressed and if in person visits are performed, that the outcome is communicated back to the PCP.

Applicable 1.3.8 Ensure that clinical teams engage in team- and evidence-based care.

Applicable 1.3.9 Increase staff engagement by:

- Implementing a model for team-based care in which staff performs to the best of their abilities and credentials.
- Providing ongoing staff training on the care model.

Applicable 1.3.10 Develop and implement standardized workflows for diversified care delivery strategies (e.g., shared medical visits, ancillary led services, population management, telemedicine services) to expand access and improve cost efficiency.

Applicable 1.3.11 Adopt and follow treatment protocols mutually agreed upon across the delivery system.

Not Applicable **1.3.12** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population management activities and care coordination/transitions of care. Ensure that timely, relevant, and actionable data are used to support patient engagement, PCP collaboration, and drive clinical, operational and strategic decisions including continuous quality improvement (QI) activities.

Applicable 1.3.13 Implement EHR technology that meets MU standards.

Not Applicable **1.3.14** Patients have care plans and are engaged in their care. Patients with chronic disease (including MH/SUD conditions) managed by specialty care have documented patient-driven, self-management goals reviewed at each visit.

Applicable 1.3.15 Improve medication adherence.

Not Applicable **1.3.16** Implement population management strategies for patients in need of preventive services, with chronic conditions, or with recurring long term surveillance needs.

Applicable **1.3.17** Implement or expand use of telehealth based on DPH/DMPH capacity to address patient and PCP barriers to accessing specialty expertise. Implement a telehealth platform with communication modalities that connect between specialty care and primary care (e.g., eConsult/eReferral).

Not Applicable **1.3.18** Demonstrate engagement of patients in the design and implementation of the project.

Not Applicable **1.3.19** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

Not Applicable **1.3.20** Test use of novel performance metrics for redesigned specialty care models.

☒ 1.7 – Obesity Prevention and Healthier Foods Initiative

The development of a comprehensive program for overweight and obese adults and children alike is long overdue for ARMC. Local groups, health plans, insurance companies, schools and medical providers have started many programs that target this population. However, ARMC is poised to implement a multi-pronged approach, including co-morbid condition management, dietary/nutrition education, family engagement and buy-in, preventative care coordination, specific EHR documentation, improved community access, and specialty/primary care provider attention.

Program Development: In DY 11, a random sampling detailing the quality and quantity of weight education and intervention will be performed. With this data, a comprehensive pilot program will be developed and implemented initially with our primary care population (DY 12). A yearlong program with routine checks and benchmarks will assess effectiveness. These checks will include: weight and height measurements, blood pressure readings, BMI calculations, dietary/exercise documentation and any necessary interventions by specialists or individual consultations for patients who haven't met goals. Surveys will determine family/patient participation as well as mark improvements or setbacks. The program will be aided by care coordination, reminder calls and EHR alerts. Once proven successful, this model will be rolled out to our outreach programs.

Outreach: Innovatively, once off the ground (DY 14), ARMC will pilot the program with its Breathmobile clinics. Many asthmatics from far-flung communities who receive free asthma care through mobile clinics are also overweight and/or obese. Adding an obesity educational offering to a motivated population of families will benefit both disease conditions and increase access. Health disparities will be addressed as these mobile clinics provide services throughout the community where specialty services are

nonexistent and at no cost whatsoever. Further, the obesity program will take advantage of existing collaborative relationships with school partners that funnel at-risk students for care in the Breathmobiles. A similar approach will be undertaken with ARMC's Mobile Medical clinic, which serves the more remote regions of the County and cares for a higher proportion than normal of undocumented patients.

Nutrition: In DY 12, ARMC will begin to offer meals according to the guidelines set in the Partnership for Healthier America commitment, including food presentation, pricing and calorie counts. We will continue to focus on implementing different components of this Partnership with a goal of delivering nutritious options to our patients, visitors and staff.

Target Population/Care Delivery: Fifty-eight percent of the County population is considered overweight or obese as compared to 51% statewide. With the implementation of an obesity identification and follow up program we believe that these programs will have positive effect in reducing the rates of obesity as well as conditions associated with obesity such as diabetes and hypertension. Screening and follow up will include both adult and pediatric patients in the primary care setting; the initial pilot and PDSAs will begin in early DY 12, with a strong focus on care coordination with PCPs and RN Care Managers and self-management tool. The nutritional component will be rolled out in phases house-wide with a goal to reach all eight criteria by DY 15.

The challenges of managing a large database, providing individualized care for complex patients will be difficult. Incremental improvements and frequent, attainable goals are keys to program sustainment and success. Utilization of hospital and clinic specialists as well as other community resources will be important to permeate the family unit and to begin to change culture. Through these efforts, we expect to see steady improvements in BMI levels of our patient population, lowering risks for future serious health conditions.

Please mark the core components for this project that you intend to undertake:

Check	**Core Components**
☒	1.7.1 Collect or use preexisting baseline data on receipt and use of targeted preventive services, including any associated disparities related to race, ethnicity or language need.
☐	**1.7.2** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to USPSTF A and B Recommendations.
☐	**1.7.3** Improve access to quality care and decrease disparities in the delivery of preventive services.

☒ **1.7.4** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.

☒ **1.7.5** Adopt and use certified electronic health record systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population management approaches (e.g., in-reach, outreach) to reduce gaps in receipt of care.

☒ **1.7.6** Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.

Check Core Components

☐ **1.7.7** Implement a system for performance management that includes ambitious targets and feedback from patients, community partners, front line staff, and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology.

☐ **1.7.8** Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts.

☐ **1.7.9** Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.

☒ **1.7.10** Prepare for and implement the Partnership for a Healthier America's Hospital Healthier Food Initiative.

Please complete the summary chart:

Domain 1	For DPHs	For DMPHs
Domain 1 Subtotal # of DPH-Projects:	**3 Required**	**0**
Domain 1 Subtotal # of Optional Projects (Select At Least 1):	**1**	
Domain 1 Total # of Projects:	**4**	

Section 4.2 -- Domain 2: Targeted High-Risk or High-Cost Populations

☒ 2.1 – Improved Perinatal Care (required for DPHs)

ARMC performs approximately 3,000 live births per year in a service area that has one of the highest litigation and paid settlement rates in the State, with our patient population often experiencing limited to no prenatal care. Data supports the unfortunate trends toward increasing maternal mortality and morbidity among our population. Recent trends including rising rates of maternal injury, death and increased numbers of deliveries by cesarean section suggest a need for system overhaul. The increasing rise in maternal morbidity and mortality since 1999 is cause for alarm and action. Complications from preeclampsia and obstetric hemorrhage are preventable, yet are the leading causes of maternal morbidity.

Project Development: The scope of this project begins with prenatal education; further encompassing preventable complications of pregnancy and continues through postpartum follow-up. The Labor and Delivery/Postpartum units will need to work closer with the hospital's Women's Health Clinic, as well as other outsider providers and stakeholders, to improve rates of compliance with pre and postnatal visits leading to healthier deliveries and improved outcomes. This will involve a concerted effort to bring providers, care teams and stakeholders together to integrate and coordinate the care provided. In DY 12, we will begin the process to move towards this goal.

Perinatal Care and Collaboration: Recently we adopted the California Quality Maternal Care Collaborative toolkits for the prevention/management of obstetric hemorrhage and preeclampsia, promoting readiness, recognition and response. Utilizing these tools, in DY 11, we educated our nursing staff on managing an obstetric hemorrhage through simulation drills. Additionally, we created a preeclampsia bag for rapid respond to the crisis and then educated our nursing and attending physicians on care of the patient with preeclampsia through simulation drills. As we move forward with improved perinatal care, we plan to adopt and implement the toolkit for cesarean sections from CMQCC.

As part of our current ongoing department safety and educational initiatives, we conduct annual education on fetal monitoring and plan to continue multidisciplinary simulation drills to include shoulder dystocia and crash C-sections.

ARMC will begin to collaborate and refer patients to the County's LIFT and BONUS programs; two programs focused on improved health outcomes. The LIFT program seeks to improve the health and well-being for first time mothers by providing weekly in-home comprehensive educational programs, by registered nurses, designed to promote mothers' effective physical and emotional care for their new child. The nurses will link the mother (family) with needed health, mental health and other human services. The BONUS program, funded by First 5, provides breastfeeding support to all mothers, regardless of income. The program focuses on increasing the number and length of exclusive breastfeeding babies, by providing a 24-hour breastfeeding support via 211 for families and working with medical providers and hospitals to provide support and education to encourage exclusive breastfeeding for at least 6 months.

Baby Friendly and Exclusive Breastfeeding: ARMC was designated as a Baby Friendly facility in 2009 and currently meets the 10-Steps required for re-designation. To improve success with this initiative, we require our nursing staff to attend a 16-hour breastfeeding class and spend 3 hours performing hand-on training with our lactation staff. In addition, medical students rotating though Labor and Delivery/Postpartum are required to attend an hour and a half breastfeeding class.

As of April 2015, our current exclusive breastfeeding rate was 52% and we struggle with this metric. Some of our identified challenges include the lack of prenatal care or lack of continuous prenatal care and therefore, lack of education. Once admitted, we have a small window of opportunity to educate the mother on the benefits and importance of breastfeeding. While we have a Women's Health clinic on-site, many of our patients are referred from surrounding clinics. We would like to focus more of our efforts on prenatal education and community outreach.

We currently do not follow our patients post-discharge in regards to continuous breastfeeding. In DY 12, will be piloting a program with additional lactation consultants who will contact mothers, post-discharge, to provide education, and referrals for breastfeeding and well-child care. This process will continue 6-months post-delivery. We will continue to encourage our lactation consultants and health educators review and implement best practices to further improve our rates of compliance with exclusive breastfeeding.

Target Population/Care Delivery: As a County provider, our population often experiences limited to no prenatal care. Further aligning our inpatient and outpatient practices, adopting best practices and policies and collaborating with CMQCC we can make monumental improvements to our high-risk maternal population. Through a combined effort of California Department of Health Care Services (DHCS) recommended initiatives/core components and our internal initiatives, we feel confident that we can continue to sway the pendulum in a more positive direction and reduce the risks to our population while increasing the quality of care.

Throughout PRIME we will continue our work with CMQCC and CMPS on implementing the obstetric hemorrhage and pre-eclampsia toolkit. With early identification and treatment, evidence demonstrates that the risk of maternal mortality and morbidity can be decreased by almost 50%. Through consistent efforts, ARMC will improve its clinical practices, connect with other community providers and recognized organizations, educate and engage women of childbearing age on the importance of prenatal and perinatal care as well as improve rates of breastfeeding compliance.

Please mark the core components for this project that you intend to undertake:

Check	Core Components
Applicable	2.1.1 DPHs/DMPHs engagement in best practice learning collaborative to decrease maternal morbidity and mortality related to obstetrical hemorrhage (CMQCC/PSF/HQI combined effort).
Applicable	**2.1.2** Achieve baby-friendly hospital designation through supporting exclusive breastfeeding prenatally, after delivery, and for 6 months after delivery and using lactation consultants after delivery.
Applicable	**2.1.3** Encourage best practice and facilitate provider education to improve cesarean section rates, and decrease inequities among cesarean section rates. Participate, as appropriate, in statewide QI initiatives for first-birth low-risk cesarean births.
Applicable	**2.1.4** Coordinate care for women in the post-partum period with co-morbid conditions including diabetes and hypertension.

☒ 2.2 – Care Transitions: Integration of Post-Acute Care (required for DPHs)

As a safety-net hospital, we have identified numerous factors that have a direct impact on our readmission rate. Our population is complex; many patients have multiple comorbidities, lack of access to resources, are non-compliant with care plans, and suffer from poly-substance abuse with little recourse to rehabilitation assistance and limited means for to access medical follow up in general. ARMC has been piloting several programs aimed at reducing complications and improving compliance during care transitions. Our focus is to improve the transition of our patient population from the inpatient hospital setting to other care settings; improve quality of care, reduce avoidable readmissions, and document measureable savings.

Care Transition: A multi-faceted team, including physicians, nurses, pharmacists and case managers are developing processes to ensure multiple layers of patient contingencies are in place before the patient leaves the facility. This includes providing the patient with a discharge summary that is useful, informative and written in a manner in which they can comprehend, including follow-up instructions, required labs and imaging exams, comprehensible medication reconciliation, primary care provider assignments, specialty follow-up appointments and any other information germane to ensuring a safe and effective discharge. These tools are currently being developed with the assistance of our IT team and expect to be fully implemented in DY 12.

Health Literacy: A high proportion of our patient population has limited health literacy or very rudimentary understanding of the information being conveyed. Individuals with limited health literacy often lack or misunderstand information about the body or disease process, as such, care transitions can go south once discharged from the hospital. In DY 11/12, we will educate and equip our staff with the tools to provide timely, culturally and linguistically competent post-discharge education to patients.

Community Involvement: In DY 11/12 we will initiate a dialog and improve communication with area hospitals, health plans, skilled facilities, and community based facilities as they relate to our patient population. This includes working with local care facilities to establish bi-directional communication for discharged patients; sending and receiving discharge summaries, medication reconciliation and PCP assignments. This will allow us to better coordinate care for our patients as they transition through their recovery process.

Target Population/Care Delivery: Our target population will include all patients discharged from ARMC. We will seek to improve health outcomes for these patients by developing a robust care transition program, focusing on empowering our patients with the tools they need, in a manner in which they can understand, making community connections and participating in bi-directional communication to ensure coordinated care transitions. We will engage our patients with self-management tools and enhanced system navigation. Through the use of medication reconciliation, self-management, PCMHs, PCP and specialist follow-up, an understanding of "red flag" indicators for worsening conditions and appropriate next steps; our patients will be empowered with the tools they need to succeed after discharge as they transition to another setting.

Please mark the core components for this project that you intend to undertake:

Check	Core Components
Applicable	**2.2.1** Develop a care transitions program or expand a care transitions program to additional settings (e.g., emergency department), or to additional populations, using or adapting at least one nationally recognized care transitions program methodology.
Applicable	**2.2.2** Establish or expand on a system to track and report readmission rates, timeliness of discharge summaries, and other transition processes, and investigate system-specific root causes/risk factors for readmission, using quantitative and qualitative information to identify the key causes of readmissions, including physical, behavioral and social factors.
Applicable	**2.2.3** Develop and implement a process, including utilization of data and information technology, to reliably identify hospitalized patients at high-risk for readmission.

Check	Core Components

Applicable 2.2.4 Develop standardized workflows for inpatient discharge care:

- Optimize hospital discharge planning and medication management for all hospitalized patients.
- Implement structure for obtaining best possible medication history and for assessing medication reconciliation accuracy.
- Develop and use standardized process for transitioning patients to sub-acute and long term care facilities.
- Provide tiered, multi-disciplinary interventions according to level of risk:
  - Involve mental health, substance use, pharmacy and palliative care when possible.
  - Involve trained, enhanced IHSS workers when possible.
  - Develop standardized protocols for referral to and coordination with community behavioral health and social services (e.g., visiting nurses, home care services, housing, food, clothing and social support). ○ Identify and train personnel to function as care navigators for carrying out these functions.

Applicable 2.2.5 Inpatient and outpatient teams will collaboratively develop standardized transition workflows:

- Develop mechanisms to support patients in establishing primary care for those without prior primary care affiliation.
- Develop process for warm hand-off from hospital to outpatient provider, including assignment of responsibility for follow-up of labs or studies still pending at the time of discharge.

Not Applicable 2.2.6 Develop standardized workflows for post-discharge (outpatient) care:

- Deliver timely access to primary and/or specialty care following a hospitalization.
- Standardize post-hospital visits and include outpatient medication reconciliation.

Not Applicable 2.2.7 Support patients and family caregivers in becoming more comfortable, competent and confident in self-management skills required after an acute hospitalization by providing:

- Engagement of patients in the care planning process.
- Pre-discharge patient and caregiver education and coaching.
- Written transition care plan for patient and caregiver.
- Timely communication and coordination with receiving practitioner. Community-based support for the patient and caregiver post hospitalization focusing on self-care requirements and follow-up care with primary and specialty care providers.

Check **Core Components**

Applicable 2.2.8 Engage with local health plans to develop transition of care protocols that ensure: coordination of care across physical health, substance use disorder and mental health spectrum will be supported; identification of and follow-up engagement with PCP is established; covered services including durable medical equipment (DME) will be readily available; and, a payment strategy for the transition of care services is in place.

Applicable 2.2.9 Demonstrate engagement of patients in the design and implementation of the project.

Applicable 2.2.10 Increase multidisciplinary team engagement by:

- Implementing a model for team-based care in which staff performs to the best of their abilities and credentials.
- Providing ongoing staff training on care model.

Applicable 2.2.11 Implement a system for continual performance feedback and rapid cycle improvement that uses standard process improvement methodology and that includes patients, front line staff and senior leadership.

☒ 2.3 – Complex Care Management for High Risk Medical Populations (required for DPHs)

ARMC continues to focus on those patients who utilize the Emergency Department (ED) as a means of primary care and/or those with recurrent inpatient admissions due to lack of coordinated care. The majority of these patients are identified as complex; with multiple medical and behavioral conditions. These patients put strains on our already saturated ED, over utilize inpatient services, increase costs, and in the end are no healthier because of it.

High Utilization Patient Care Outreach (HUPCO): In DY 11, the HUPCO Program was developed, using embedded RN Care Managers (RNCM) in the PCCs, to coordinate more effective care for this complex/high risk population. The program aim is to improve the patients' health status and significantly reduce ED visits and preventable hospitalizations. The RNCM program has been integrated in three of the four PCCs in DY 11. Plans for DY 12 include expanding the number of embedded RNCM at existing sites, from three to six RNCMs, and incorporating RNCMs at the fourth PCC and Pediatric Clinic. The workforce plan will include innovative recruitment lists to fill positions and a streamlined hiring process to help mitigate inherent inefficiencies in the County hiring process.

A combination of in-person clinic visits, coordinated with the patient's PCP; face to face visits with the patient's RNCM; and telephonic/electronic communications will be utilized to best serve our targeted population. Evidence based means to better risk stratify potential patients will be developed in DY 11 with "go-live" implementation of the tool in DY 12. Improved integration with existing community resources, as well as piloting new services and expanding the RNCM's "tool box" will be undertaken to improve the health indicators for our chronically ill members including those with medical, behavioral and substance use disorders.

Case Management/Care Transition: In DY 11/12, a multi-faceted team, including physicians, nurses, pharmacists and case managers are developing processes to ensure multiple layers of patient contingencies are in place before the patient leaves the facility. This includes coordination with community organizations to improve care transitions and reduce avoidable readmissions.

Target Population/Care Delivery: Our target population will be piloted to the HUPCO patients. High utilizers of inpatient and ED services are identified utilizing billing, admission and patient registry sources. Our regional Medicaid managed care entities, and other payers have begun to provide a Behavioral Health target population lists for the RNCM program to identify, assess for risk and engage. A multidisciplinary team including medical providers, clinical pharmacists, case managers and education specialists will develop an integrated model utilizing a shared EHR for the targeted population. This team will provide support and navigation for vulnerable patients throughout the healthcare system. Further expansion of services will include dietary education and maintenance, social service assistance and community health workers to sponsorship in demonstration years 12 through 14.

With various factors impeding reduction of our readmission rates, ARMC will continue to address each population though collaborative care teams led by Case Management. In DY 11 a pilot program commenced, aimed at reducing readmissions for heart failure to below 10%; our average was 15.6% with a national average of 22%. Through concerted efforts with internal and external players, in February 2016, we were able to reduce heart failure readmits to 2 patients, versus the average 6-7 patients per month. Providing patients with tools from community organizations (scales, cookbooks, Mrs. Dash, 211 flyers, education booklets, diet regime information, weight logs, etc.), and ARMC care management follow up allowed us to experience successes with pilot implementation. These types of focused programs will be expanded to address readmission for other factors, i.e. uncontrolled diabetes, COPD, etc.

Please mark the core components for this project that you intend to undertake:

Check	Core Components

Applicable	**2.3.1** Develop a complex care management program at one site or with one defined cohort, or expand an existing program from a pilot site to all sites or to additional high-risk groups and demonstrate engagement of patients in the design and implementation of the project.
Applicable	**2.3.2** Utilize at least one nationally recognized complex care management program methodology.
Applicable	**2.3.3** Identify target population(s) and develop program inclusion criteria based on quantitative and qualitative data (e.g., acute care utilization, lack of primary care utilization, number of high-risk medical mental or SUD conditions, polypharmacy, primary care input, functional status, patient activation, social support or other factors). Include patient factors associated with a higher probability of being impacted by complex care management.
Applicable	**2.3.4** Conduct a qualitative assessment of high-risk, high-utilizing patients.
Applicable	**2.3.5** Establish data analytics systems using clinical data sources (e.g., EHR, registries), utilization and other available data (e.g., financial, health plan, zip codes), to enable identification of high-risk/rising risk patients for targeted complex care management interventions, including ability to stratify impact by race, ethnicity and language.
Applicable	**2.3.6** Develop a multi-disciplinary care team, to which each participant is assigned, that is tailored to the target population and whose interventions are tiered according to patient level of risk.
Applicable	**2.3.7** Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets.
Applicable	**2.3.8** Implement evidence-based practice guidelines to address risk factor reduction (smoking cessation/immunization/substance abuse identification and referral to treatment/depression and other behavioral health screening, etc.) as well as to ensure appropriate management of chronic diseases: • Use standardized patient assessment and evaluation tools (may be developed locally or adopted/adapted from nationally recognized sources). • Use educational materials that are consistent with cultural, linguistic and health literacy needs of the target population.
Check	**Core Components**
Not Applicable	**2.3.9** Ensure systems and culturally appropriate team members (e.g. community health worker, health navigator or promotora) are in place to support system navigation and provide patient linkage to appropriate physical health, mental health, SUD and social services. Ensure followup and retention in care to those

services, which are under DPH/DMPH authority, and promote adherence to medications.

Applicable 2.3.10 Implement technology-enabled data systems to support patients and care teams throughout the care management program including patient identification, pre-visit planning, point-of-care delivery, care plan development and population/panel management activities.

Applicable 2.3.11 Implement a data-driven system for rapid cycle improvement and performance feedback to address quality and safety of patient care, which includes patients, front line staff and senior leadership.

☒ 2.4 – Integrated Health Home for Foster Children

The approach to improved care for foster children requires collaboration, service development and care coordination that has not been available in an organized manner in the County. Foster children have not been able to benefit from a specific process to address questions of continuity of care, chronic disease management and County resource implementation of services. Presently, the County bestows open access MediCal coverage to foster children; allowing for easy access to care but not encouraging establishing a relationship with a PCP. Consequently, foster children access medical care sporadically; "physician shop" based on convenience, and must continually reestablish relationships with medical professionals. Easily, these patients get substandard care as a result of a system that requires household stability in order to keep patients and parents "plugged in".

Identification/Communication: Foster population data analysis is needed to identify patients who utilize the health system on a regular basis. Several methods will be utilized in DY 11 to accurately capture ARMC's foster population, including understanding the enrollment and eligibility processes through collaborative efforts with Children and Family Services. In-system attempts to acknowledge these patients through registration alerts, physician communication and medical record extraction will augment efforts. An in-depth look at medical care, chart documentation and conversations with foster families will gauge the present state of the quality of care these patients have. Once the patient has been identified, the RN Care Manager will be responsible for continued engagement and follow up with the foster child and their family.

Care Coordination/Psychiatric Screening: In DY 12 psychiatric/depression questionnaire and tobacco screening and follow up will be included in well visits for patients between ages 12 to 18. By early identification of at-risk patients, pediatricians can better organize mental health needs. An RN Care Manager will be tasked to follow these patients individually, where the patients will benefit from a personalized care coordinator who will maximize educational opportunities, plan referral/authorization/specialty needs, and

monitor indicators that impact conditions such as diabetes, asthma, obesity, hypertension, vaccinations, etc. Relationship building leading to trust will root patients to the medical home instead of sampling physicians. Continued data management on outcomes and regular surveys will determine the effectiveness of the program.

The RN Care Manager position is not new to ARMC as the position was created and implemented in our primary care clinics to manage patients with complex health care needs. The RN Care Manager assigned to the Pediatric Clinic, will build upon our current care manager model, focusing on our foster population, tailoring duties to improve the health and well-being of this vulnerable population.

The RN Care Manager will play a vital role with our foster population, serving as the point person for care coordination and management; coordinating specialty referrals, additional studies, including labs and imaging, treatment plans and follow-up care. When necessary, the RN Care Manager will coordinate efforts to obtain pertinent (past) medical records including immunization records, making sure that all necessary documentation is captured appropriately in the EMR for continuity of care purposes. The RN Care Manager will onboard new foster children and their families to the Pediatric Clinic, encouraging engagement in the child's health and social needs. They will coordinate efforts for an integrated health home approach: assisting foster families with resources, internal and external, for mental health, drug addiction, nutrition, dental resources, social and legal services and more.

For those foster children with chronic conditions, the RN Care Manager, under direction of the provider, will develop care plans and interventions, monitor progress, provide education and refine care plans as necessary. This individual will perform medication management based on standing orders and protocols, encouraging adherence to and appropriate medication refills. Through a team effort, foster children and their families will find support and stability through this care model.

Community Involvement: Collaborative efforts will be expanded in DY 12/13 to include other organizations that touch this population segment. School liaisons, inter County agency communication, and mental health professional involvement are examples of further embellishing the health home for foster children.

Target Population/Care Delivery: While all children can benefit from a coordinated health home approach, the greatest returns offered by health homes with primary care being the corner stone, are those who are marked with complex health needs and unsettled living conditions, such of that of a foster child. Our targeted population is small, compared to most of the PRIME initiatives allowing our teams to align care with the health home model, which will be piloted in our Pediatric clinic. Children will receive care coordination, including well-visit checks, mental health and tobacco screening and follow up.

With an integrated health home, led by the primary care team, foster children will no longer need to navigate through a fragmented system, plagued with inappropriate psychotropic medications, higher rates of behavioral issues and acute or chronic health conditions. Our approach of identification and coordinated care management will have markedly improved health outcome results for our foster population.

Please mark the core components for this project that you intend to undertake:

Check	Core Components
Applicable	**2.4.1** Healthcare systems receive support in the ongoing management and treatment of foster children: • Demonstrate engagement of patients and families in the design and implementation of this project.
Not Applicable	**2.4.2** Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration).
Applicable	**2.4.3** Multi-therapeutic care team will: • Identify patient risk factors using a combination of qualitative and quantitative information. • Complete a patient needs assessment using a standardized questionnaire. • Collaborate on evidence-based standards of care including medication management, care coordination and care engagement process. • Implement multi-disciplinary case conferences/consults on patients with complex needs. • Ensure the development of a single Treatment Plan that includes the patient's behavioral health issues, medical issues, substance abuse and social needs: ○ Use of individual and group peer support. • Develop processes for maintaining care coordination and "system continuity" for foster youth who have one or more changes in their foster home. • Ensure that the Treatment Plan is maintained in a single shared EHR/clinical record that is accessible across the treatment team to ensure coordination of care planning.

Check	Core Components
	• Assess and provide care for all routine pediatric issues with a specific focus on: ○ Mental health/toxic stress ○ Obesity ○ Chronic disease management ○ Medication/care plan adherence which are vulnerable when kids transition care givers frequently

- Substance abuse issues
- Developmental assessment, identification and treatment

Not Applicable **2.4.4** Implement technology-enabled data systems to support pre-visit planning, point-of-care delivery, population/panel management activities and care coordination. Timely, relevant and actionable data is used to support patient engagement, and drive clinical, operational and strategic decisions including continuous QI activities.

Applicable **2.4.5** Provide linkages to needed services that at a minimum includes child welfare agency, mental health, substance abuse and public health nursing as well as any other social services that are necessary to meet patient needs in the community.

Not Applicable **2.4.6** Develop liaisons/linkage with school systems.

Applicable **2.4.7** Provide timely access to eligibility and enrollment services as part of the health home services.

Applicable **2.4.8** Evidence-based practice guidelines will be implemented to address risk factor reduction (e.g., immunization, smoking cessation, behavioral health screening) as well as to ensure appropriate management of chronic diseases (e.g., asthma, diabetes). Assessment of social service needs will be integral to these activities. Educational materials will be utilized that are consistent with cultural and linguistic needs of the population.

Not Applicable **2.4.9** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement, which includes patients, front line staff, and senior leadership.

Please complete the summary table below:

Domain 2	For DPHs	For DMPHs
Domain 2 Subtotal # Of DPHRequired Projects:	**3**	**0**
Domain 2 Subtotal # Of Optional Projects (Select At Least 1):	**1**	
Domain 2 Total # Of Projects:	**4**	

Section 4.3 – Domain 3: Resource Utilization Efficiency

☒ 3.1 – Antibiotic Stewardship

Antimicrobial resistance can be attributed, in part, to inappropriate use of antibiotics. Resistant strains can cause an increase in the length of hospitalization, as well as suboptimal clinical outcomes. ARMC selected this project in response to the increasing incidence of bacterial resistance to multiple antimicrobial agents. In conjunction with the California Antimicrobial Stewardship Program Initiative, ARMC will be able to ensure appropriate and cost-effective antimicrobial therapy, which will result in a decrease in the development of resistant bacterial strains.

Antibiotic Stewardship Program (ASP): ARMC will expand upon its ASP in DY 11/12 in an effort to achieve optimal clinical outcomes related to antimicrobial use. The ASP members meet quarterly (and ad hoc) to review current utilization of antimicrobials and formulate initiatives to pilot and implement. Through this program, teams educate staff and licensed independent practitioners involved in antimicrobial ordering, dispensing, and administration, develop reports that will analyze the outcomes (clinical and financial) of the antimicrobial stewardship activities, and participate in the reporting system developed by the Centers of Disease Control and Prevention.

Antimicrobial Review: Throughout PRIME, the ASP will review the antimicrobial formulary and, in conjunction with the Pharmacy and Therapeutics Committee, determine which agents should be removed from the formulary or restricted to specific category of provider. Education tools and protocols will be created and implemented to ensure information regarding the formulary is implemented house-wide.

Antimicrobial Stewardship Pharmacists: In DY 11, we designated antimicrobial stewardship pharmacists who directs and oversees the activities of our pharmacy residents, including daily review of antimicrobials, interventions, and documentation. Each day, these teams review a microbiology report, which identifies all patients receiving antibiotics, and culture and sensitivity results. The team identifies opportunities for deescalation of antibiotics to a narrower spectrum regimen, using the latest guidelines published by the Infectious Disease Society of America. The clinical pharmacist then contacts the prescriber of the current antibiotics and recommends the new therapy, thereby decreasing inappropriate use of antibiotics. When there are questions, our Infectious Disease specialist is readily available to discuss the recommended regimen with the primary team.

Target Population/Care Delivery: Though PRIME projects are targeted to a specific "eligible population", our efforts will have a direct impact on all patients who are admitted with an infection, and those who might have developed an infection while hospitalized.

As result of current and expanded ASP efforts, we expect to achieve an earlier resolution of infectious processes, leading to shorter hospital stays, improved outcomes and significant cost savings. Additionally, we expect appropriate antimicrobial use and education, particularly at discharge, will decrease the rate of 30-day readmissions.

Success from the ASP has already begun to surface. During this time period, Linezolid IV drug monthly purchases decreased from $30,124 to $6,866. Current efforts are being focused toward appropriate use of Meropenem where rates have improved from 28% (12/43) in October 2015 to 67% (35/52) in January 2016. These types of improvement efforts are important to improve our patient outcomes, reduce future resistance to antimicrobial resistance and reduce costs.

Please mark the core components for this project that you intend to undertake:

Check	Core Components
Applicable	**3.1.1** Utilize state and/or national resources to develop and implement an antibiotic stewardship program, such as the California Antimicrobial Stewardship Program Initiative, or the IHI-CDC 2012 Update "Antibiotic Stewardship Driver Diagram and Change Package.[1] • Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**3.1.2** Develop antimicrobial stewardship policies and procedures.
Applicable	**3.1.3** Participate in a learning collaborative or other program to share learnings, such as the "Spotlight on Antimicrobial Stewardship" programs offered by the California Antimicrobial Stewardship Program Initiative.[2]
Applicable	**3.1.4** Create standardized protocols for ordering and obtaining cultures and other diagnostic tests prior to initiating antibiotics.
Applicable	**3.1.5** Develop a method for informing clinicians about unnecessary combinations of antibiotics.

[1] The Change Package notes: "We do not recommend that any facility attempt to implement all of the interventions at once. There are a large number of interventions outlined in the Change Package, and attempting to implement too many at one time will likely create huge challenges. Rather, the Change Package is meant to serve as a menu of options from which facilities can select specific interventions to improve antibiotic use." (p. 1, Introduction).

[2] Launched in February 2010, this statewide antimicrobial stewardship program expands use of evidenced-based guidelines to prevent and control infections and improve patient outcomes: Click here to see this statistic's source webpage.

Check **Core Components**

Applicable 3.1.6 Based on published evidence, reduce total antimicrobial Days of Therapy (DOT) by providing standards and algorithms for recommended agents by disease type, focusing on short course regimens (e.g., 3-5 days of therapy for uncomplicated cystitis, 7 days for uncomplicated pyelonephritis, 5-7 days for uncomplicated non-diabetic cellulitis, 5-day therapy for community acquired pneumonia (CAP), 7-8 days for therapy for VAP or hospital acquired pneumonia).

Applicable 3.1.7 Develop evidence-based computerized provider order entry (CPOE) algorithms and associated clinician training, to support antibiotic stewardship choices during order entry. These could include approaches such as guidelines for duration of antibiotics, within drug class autoswitching for specific antibiotics and doses, or restriction of specific antibiotics at the point of ordering (e.g., broad spectrum agents).

Applicable 3.1.8 Implement stewardship rounds focusing on high yield drugs to promote de-escalation after the drugs are started, such as regular antibiotic rounds in the ICU.

Applicable 3.1.9 Improve diagnostic and de-escalation processes to reduce unnecessary antibiotic use based upon length of therapy or antibiotic spectrum, such as:

- Procalcitonin as an antibiotic decision aid.
- Timely step-down to oral antibiotic therapy to support early discharge from the hospital for acute infections.
- Use of oral antibiotics for osteomyelitis to reduce prolonged IV exposures.

Applicable 3.1.10 Evaluate the use of new diagnostic technologies for rapid delineation between viral and bacterial causes of common infections.

Applicable 3.1.11 Adopt the recently described "public commitment" strategy in outpatient clinics to encourage providers not to prescribe antibiotics for upper respiratory tract infections (URIs).

Applicable 3.1.12 Publish organization-wide provider level antibiotic prescribing dashboards with comparison to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.

☒ **3.1.13** Implement a system a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

Please complete the summary table below:

Domain 3	For DPHs	For DMPHs
Domain 3 Subtotal # of Selected Projects (Select At Least 1):	**1**	
Domain 3 Total # of Projects:	**1**	

Section 5: Project Metrics and Reporting Requirements

Each project includes a required set of metrics, as specified in Attachment Q: PRIME Project and Metrics Protocol. All of the metrics for the required and selected projects must be reported each demonstration year (DY) in compliance with Attachment Q.

Participating entities must report and include baseline data for all relevant project metrics and will identify data sources, consolidating data from multiple inpatient and ambulatory systems, and including data on assigned lives reported from health plans reporting on this data semi-annually. Report submissions must include the numerator and denominator data for each of the metrics for which the entity is seeking payment under PRIME. A PRIME participating entity may provide estimates or reasonable projections if particular data is unavailable due to circumstances beyond the PRIME entity's control, including data that is collected and maintained by an external entity, such as an MCP, which has not been provided to the participating PRIME entity in a timely and accurate manner.

DPHs are required to strengthen data and information sharing with MCPs under the PRIME. To support this requirement, DHCS will establish data and information sharing guidelines and/or mechanisms, which DPHs and DMPHs must follow, consistent with applicable state and federal data privacy and security law, to provide for timely sharing of beneficiary data, assessment, and treatment information, for purposes of identifying and treating the beneficiary for PRIME and Whole-Person Care (WPC). DPHs must demonstrate establishment of new and/or strengthened data and information sharing with MCPs during the demonstration. In particular, the following must occur: reporting of complete, accurate, reasonable and timely reporting of encounter data; sharing of treatment and assessment data for care coordination purposes; and, establishment of processes and infrastructure to support MCP achievement of quality improvement efforts when aligned with PRIME projects.

☒ I understand and accept the responsibilities and requirements for reporting on all metrics for required and selected projects

Section 6: Data Integrity

Each PRIME participating entity must establish and adhere to a data integrity policy throughout the execution of the PRIME Program. Participating entities must be able to verify that all fiscal, clinical, and quality improvement work for which a metric claim is reported. State and federal officials reserve the right to require additional substantiation or verification of any data claim or related documentation and may conduct periodic audits when indicated.

☒ I understand and accept the responsibilities and requirements for establishing and adhering to a data integrity policy.

Section 7: Learning Collaborative Participation

All PRIME participating entities are encouraged to actively participate in learning collaboratives that will be launched by DHCS or their designees for purposes of providing technical assistance and information exchange opportunities as PRIME implementation gets underway. At a minimum, each PRIME participating entity is required to participate in at least one face-to-face statewide learning collaborative per PRIME year. Please acknowledge your understanding and acceptance of this responsibility below.

☒ I understand and accept the responsibility to participate in-person at the annual statewide collaborative.

Section 8: Program Incentive Payment Amount

Please indicate the total computable PRIME incentive payment amount for this 5-year plan, consistent with the PRIME Funding and Mechanics Attachment:

Total computable 5-year PRIME plan incentive payment amount for:

- DY 11 $ 86,128,000
- DY 12 $ 86,128,000
- DY 13 $ 86,128,000
- DY 14 $ 77,515,200
- DY 15 $ 65,887,920

Total 5-year prime plan incentive amount: $ 401,787,120

Section 9: Health Plan Contract (DPHs Only)

DPHs are required to commit to contracting with at least one Medi-Cal managed care health plan (MCP) in the MCP service area that they operate using alternative payment methodologies (APMs) by January 1, 2018.

☒ I understand and accept the responsibility to contract with at least one MCP in the service area that my DPH operates no later than January 1, 2018 using an APM.

Section 10: Certification

☒ I hereby certify that all information provided in this Plan is true and accurate to the best of my knowledge, and that this plan has been completed based on a thorough understanding of program participation requirements as specified in Attachment Q and Attachment II of the Waiver STCs.