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

San Francisco Health Network

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.

In 2012, the San Francisco Department of Public Health (SFDPH) commissioned a Community Health Status Assessment which incorporated data from a comprehensive review of secondary data sources for more than 150 indicators over ten broad-based categories. [Report available at: https://www.sfdph.org/dph/files/chip/CommunityHealthStatusAssessment.pdf]

While San Francisco as a whole fares well in key health areas compared to other counties in the state and nation, there are significant disparities in morbidity and mortality by race/ethnicity, which are driven in significant part by income inequality. Among Bay Area counties, San Francisco has the highest degree of economic inequality, with a Gini coefficient of 0.51 (range 0-1, higher values indicate greater inequality, US average 0.47).

Key findings of the report include:

- The top 10 causes of death for both men and women include cardiovascular diseases – ischemic heart disease, stroke, hypertensive heart disease – lung cancer, COPD, pneumonia, Alzheimer's dementia, and colon cancer.
- Substance abuse – including drugs, alcohol and tobacco – contributes to 7 of the top 10 causes of death.
- For San Franciscans ages 15-34, homicide and suicide are the top 2 leading causes of death; drug and alcohol related mortality are among the top 10 leading causes of death.
- African Americans experience higher rates of STDs, infant mortality, homicide, and deaths due to ischemic heart disease, stroke, lung cancer, and hypertensive heart disease than other racial/ethnic groups.
- Fifty-seven percent of Latinos are obese, compared to 17% of San Franciscans overall (and 30% of Latinos statewide).
- Rates of preventable ED visits vary significantly by neighborhood; while the City-wide average is 238 per 10,000, some impoverished neighborhoods had rates as high as 452 per 10,000.

While not part of the Community Health Status Assessment, recent data from SFDPH shows that, similar to nationwide trends, unintentional death from drug overdoses are now primarily from prescription opioids. In San Francisco, these deaths are concentrated in high poverty neighborhoods and disproportionately affect African Americans.

According to 2014 Census data, approximately 18% of San Franciscans were covered by Medicaid, and 7% remained uninsured.

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 only consolidated city and county in the state, San Francisco is densely populated, with approximately 850,000 residents in a seven by seven square mile area. San Francisco is known for its culturally diverse neighborhoods. In recent years, there has been rapid change with economic development and gentrification. With this, there has been a decrease in the number of children and families with young children: only 14% of residents are under the age of 18, compared to 24% of Californians. The current racial/ethnic composition of San Francisco includes 41% Whites, 35% Asians, 15% Latinos and 6% Blacks. Over one in three residents are foreign born, with more than 40% speaking a language other than English at home. While more than 163 different languages are spoken across the City, San Francisco is the only California county where Chinese is the most frequently encountered non-English language.

Of note, over the past few decades, the African American population of San Francisco has dropped by more than half, from a high of 13% in 1970. In absolute terms, the number of African Americans living in San Francisco dropped from 88,000 in 1970 to fewer than 50,000 in 2014. The remaining Black community is one that is affected by concentrated poverty. San Francisco's median household income is approximately $73,000, but there are stark differences: White household median income is $100,000 while Black household median income is $30,000.

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.

San Francisco Health Network (SFHN) is the City and County of San Francisco's publicly funded, vertically integrated delivery system. It encompasses a network of 14 primary care clinics; full scope behavioral health services; Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG), a 284-bed acute care

hospital and level one trauma center that also provides full scope ambulatory specialty and diagnostic services; Laguna Honda Hospital (LHH), a 780-bed skilled nursing and rehabilitation facility that provides a comprehensive program of care including dementia, HIV/AIDS, traumatic brain injury, and palliative care; home health care; jail health; maternal child adolescent health; and a range of programs targeting homeless patients.

In a given year, SFHN serves over 120,000 individuals. In fiscal year 2014-2015, ZSFG had approximately 16,500 acute medical admissions, 1,800 acute psychiatric admissions, and 536,000 ambulatory visits. SFHN's patient demographic mix is significantly different from the City as a whole: overall, 17% of SFHN patients are Black, 23% Asian, 28% Latino, and 23% White. In calendar year 2015, among primary care and ZSFG patients, 54% were covered by Medi-Cal, 13% by Medicare, 18% by other (primarily public) insurance, and 15% were residually uninsured. Overall, SFHN is responsible for 42% of the City's Medicaid patients.

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.

PRIME provides the opportunity to organize our data analytic resources to improve clinical quality throughout our delivery system. SFHN has formed a PRIME technical workgroup comprised of quality improvement champions, clinical informaticists, clinical analysts, IT report developers, and EHR builders to facilitate the work of collecting, reporting, and monitoring PRIME measures.

Initially, each PRIME project team will work with representatives from the technical workgroup to identify the applicable data sources and any gaps with data collection. Project teams will work with the EHR team to establish new workflows and data collection mechanisms in the gap areas.

The PRIME technical workgroup is establishing a reporting infrastructure that encompasses data stewardship, data validation, and report construction. Clinical informaticists, along with QI champions, will work closely with clinical analysts to establish a PRIME data dictionary that will allow consistent, accurate reporting during the entire PRIME program. The initial investments into establishing reporting infrastructure will allow SFHN to leverage existing report developers, build reports tailored for quality improvement, and performance monitoring.

Each PRIME project will have a designated project manager whose responsibility includes validating data as well as monitoring PRIME measures. The project manager will assist with facilitating quality improvement as well as tracking and

communicating SFHN's improvement progress.

Although there are plans to adopt a new SFHN-wide enterprise EHR, SFHN currently operates a diverse set of clinical applications and EHRs. During the reporting baseline period, certain applications may undergo upgrades or may be replaced with other applications that will temporarily complicate reporting efforts until fully integrated.

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 long-term 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.*

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.*

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;*

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*

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.*

San Francisco Health Network (SFHN), the City and County of San Francisco's public delivery system, was formed in October 2013 in the context of healthcare reform. SFHN represents the reorganization of existing healthcare services – primary and specialty care, behavioral health, correctional health, acute care, trauma care and long term care – with the goal of achieving the triple aim of better care for individuals, better health for the population, and lower costs.

DSRIP laid the groundwork for much of our current work, which has only accelerated with the formation of SFHN. Investment in primary care has been central to our efforts, and includes expansion and horizontal integration of our 14 primary care clinics (4 hospital based, 10 community based), development of team-based care, primary care-behavioral health integration, improving the primary-specialty care interface, building a centralized call center to improve access to care and appointments over the phone, strengthening primary care-based population health and chronic disease management programs, ensuring smooth transitions in care post-hospitalization, and development of a primary care-based complex care management program.

Other current SFHN priorities include specialty care access and redesign, emergency department and hospital flow, improving linkages to post-acute care settings, transitions in care for correctional patients, strengthening our systems to address the needs of "high users of multiple systems," and the adoption of a lean management system.

As part of the lean process, SFHN's strategic planning identified six "True North" aspirational goals for our system:

- quality: improve the health of the people we serve
- safety: eliminate harm to patients and staff
- care experience: provide the best healthcare experience
- workforce: create an environment that values and respects our people
- fiscal stewardship: provide financially sustainable healthcare services
- equity: eliminate disparities

These six areas provide a guiding framework for our work across a diverse array of services. Two specific SFHN aims that are relevant to our PRIME work are 1) to improve patient retention by improving access to care and care experience, and 2) to create a culture of data-driven continuous improvement.

The nine PRIME projects that SFHN has committed to pursuing, namely *Integration of Physical and Behavioral Health*; *Ambulatory Care Redesign: Primary Care*; *Ambulatory Care Redesign: Specialty Care*; *Million Hearts Initiative*; *Improved Perinatal Care*; *Care Transitions: Integration of Post-Acute Care*; *Complex Care Management for High Risk Medical Populations*; *Chronic Non-Malignant Pain Management*; and *Resource Stewardship: Therapies Involving High Cost Pharmaceuticals* are squarely aligned with our ongoing transformation efforts. Most of the projects have significant synergies in reinforcing our commitment to team-based care, to centralized registries supporting proactive outreach to patients, and to using lean and quality improvement tools and methodologies (e.g., standard work) to drive and sustain change. Another common theme that cuts across most projects is the need for clinical integration across sites (e.g. inpatient and outpatient), disciplines (e.g. primary and specialty care), and existing programs (e.g. complex care management). Lastly, the outcomes driven nature of PRIME will require significant investments in data and reporting to support all projects.

Our goal is to be an accessible, patient-centered system that provides high quality, high value care, in the appropriate setting. By 2020, with the focused efforts of PRIME, an enterprise EHR in place and a more mature lean management system, we hope to be one of the best public delivery systems in the country.

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.

As San Francisco's publicly funded safety net delivery system, SFHN cares for nearly one in eight San Franciscans annually, including those most socially and medically vulnerable. As a Designated Public Hospital system, we have six required projects that together create a population approach to integrated primary, specialty, and behavioral health, with a focus on specific high risk groups of patients.

Our three optional projects were specifically selected to address the community needs outlined in section 2 above, with particular attention to disparities. While overall San Francisco has positive key health indicators compared to other counties, significant racial/ethnic disparities have been documented across a number of measures, including perinatal health, cardiovascular health, substance use disorders and overdose deaths – all ones that are targeted through PRIME.

We chose Million Hearts as one of our optional projects, as cardiovascular diseases are among the leading causes of death in San Francisco overall, as well as a

source of significant racial/ethnic disparities. Million Hearts also builds on an existing initiative, the Black/African-American Health Initiative, which includes a focus on eliminating disparities in hypertension control. Similarly, we chose Chronic Non-Malignant Pain Management because our safety net system has a high prevalence of patients who not only suffer from chronic pain, but also have a history of substance use disorders, which puts them at greater risk for opioid misuse and overdose. Lastly, we chose Therapies Involving High Cost Pharmaceuticals for fiscal stewardship purposes, due to concerns about our ability to ensure access to high cost, effective therapies for underserved patients.

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 decision-making practices).

Fortunately, because of prior DSRIP investments and the overall alignment between SFHN strategic direction and PRIME, we have basic clinical, operational, and data infrastructure already in place to support PRIME. Most of the project areas have existing champions or groups working in the area. Our greatest challenge will be building our data analytics capacity, which will require investments in data governance, stewardship and visualization, with the goal of creating timely, actionable reports that managers and care teams can use to drive daily improvement.

We have established an 1115 waiver executive team which meets on a biweekly basis. The PRIME leadership team reports to this executive team, and is comprised of our SFHN CMO, Senior Analyst for Strategic Initiatives, and team leads for each of the nine projects. We have also established a PRIME technical workgroup to address some of the data issues outlined above.

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.

Over the past few years, we have made significant investments in patient and family engagement. Each of our primary care clinics has a patient and family advisory council, with more than 80 individuals involved in identifying, implementing and evaluating improvements to healthcare services. Behavioral Health has two formal groups – the Client Council and Mental Health Board – with end user representatives. Both ZSFG and LHH have patient advisory groups as well. PRIME projects will augment the direct and ongoing engagement work across SFHN and

allow us to further embed approaches like co-design to bring together care team members, staff, patients and their families to improve the experience of care in meaningful and sustainable ways.

We also have a San Francisco mayoral fellow working in our communications department who is focused on internal patient engagement, and has conducted targeted focus groups and key informant interviews to inform select initiatives. We plan to solicit patient and client input on programmatic interventions, particularly for the primary care-based and perinatal projects.

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.

SFHN has a longstanding commitment to cultural competency and eliminating disparities. Cultural competency is a topic that is included in all new employee orientations, and we have two major staff training initiatives underway on racial humility and trauma informed systems of care.
We have been collecting race, ethnicity, and language data for many years now. In the past few years, we have stratified our primary care quality measures by race/ethnicity and implemented specific interventions to reduce disparities. One of SFHN's programmatic priorities is the Black/African-American Health Initiative, which is focused on reducing disparities in heart disease, alcohol misuse, breast cancer, and STD rates.

Given that one third of San Franciscans are immigrants, language access has been a key area of investment. We have one of the most robust healthcare interpreter services in the country, with two internal call centers staffed with approximately 30 full time interpreters. Internal interpreter encounters can be by videoconference, by phone, or in person. These services are supplemented by a contracted telephonic interpreter vendor that provides backup for staff interpreters as well as access to interpreters for less commonly encountered languages.

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

As mentioned previously, at a high level PRIME is aligned with SFHN's strategic direction. We have basic clinical, operational, and data infrastructure already in place to support PRIME, and most of the project areas have existing champions or groups working in the area. Our main approach to sustainability is to adopt as many of the PRIME measures into core quality improvement initiatives as possible, and to incorporate key measures into our True North framework. The main barriers to this are the proliferation of measures required for external reporting, and, for some of the measures, lack of a clear relation between improvement in the measure and improvements in patient outcomes. In addition, PRIME mandates including enrolled patients who have not yet accessed care in our quality improvement efforts; this broadening of scope presents challenges while also giving us an opportunity to more effectively improve the health of our population. .

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 <u>each</u> selected project. Provide narrative responses in the spaces marked *"<u>[Insert response here]</u>":*

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. ***<u>For DMPHs (as applicable)</u>,** 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)

SFHN has done considerable work in physical and behavioral health integration, including developing primary care-based behavioral health teams, piloting telepsychiatry, establishing a consultative service to guide psychiatrists in the basic management of medical conditions arising from psychiatric medication treatment, and establishing Behavioral Health Homes, led by primary care nurse practitioners, in mental health clinics. While we now have behavioral health teams integrated into all primary care clinics, many of the

other initiatives targeting patients with serious mental illness remain in a pilot phase or have been unevenly implemented across sites.

For PRIME, we will be examining our range of physical-behavioral health integration efforts to determine which ones to further scale. We will start with the primary care-based behavioral health teams, which are comprised of a part time psychiatrist, a Behavioral Health Clinician (LCSW, MSW, PhD, and/or PsyD) and a Behavioral Assistant whose role is to assist patients in accessing social services. We will focus on achieving consistent staffing across primary care clinics, clarifying team roles and expectations, and standardizing trainings of behavioral assistants.

We will work with primary care leadership to review current clinic workflow for mental health, smoking, and substance abuse screening with a specific focus on PHQ-2, tobacco, and SBIRT screenings and interventions. We will develop standard workflows for both screening and referrals, with a focus on ensuring referral completion. As part of this process we will review and update our central database of mental health, smoking, and substance use disorder treatment programs.

1. *Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]*

   Our main focus will be on implementing effective screening and referral protocols for depression, specifically targeting patients in subpopulations at highest risk for disease (e.g. multiple comorbidities, homeless). In addition, given the high prevalence of tobacco use among our primary care patients is 17% (compared to 12% in San Francisco), with rates that range between 11% and 51% depending on the clinic and neighborhood, we will also strengthen our referral protocols for patients who smoke. Patients who screen positive will be referred to the primary care-based behavioral health team. Patients who are assessed as having more severe mental illness or substance use disorders will be referred out to a community based specialty program.

   Standardized, universal screenings will provide better data as to the actual prevalence of mental health, smoking, and substance use disorders in our primary care population, which will in turn identify potential resource gaps. Warm handoffs for onsite counseling will improve patient engagement in cessation support, treatment, and specialty mental health. Staff training will reduce unwarranted variation in care. Through these efforts we hope to improve our population management of depression, smoking, and substance use disorders.

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

Check, if applicable	Description of Core Components
Not Applicable	**1.1.1** Implement a behavioral health integration assessment tool (baseline and annual progress measurement)
Not 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)
Not 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.
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., PHQ-2, 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

Check, if applicable	Description of Core Components
	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.
Not Applicable	**1.1.13** Implement technology enabled data systems to support pre-visit 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.
Applicable	**1.1.14** Demonstrate patient engagement in the design and

Check, if applicable	Description of Core Components
	implementation of the project.
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.
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)

SFHN has designed its vertically integrated delivery system with a foundation of primary care. Our network of 14 primary care clinics uses QI methodology to achieve improvements in chronic disease management, preventive care and access measures. Currently, QI champions at each of our clinics attend monthly meetings to learn and apply QI methodology. Our care teams also use centralized population registries for both in-reach and outreach panel management.

As we adopt tools of Lean management, we are shifting from a QI champion model to a daily management system that integrates continuous performance improvement into daily work for sustainability purposes. Our biggest challenge will be building our data analytics capacity which will require improvements in data governance, stewardship, and visualization. The goal is to develop timely actionable reports that managers and care teams can use to drive daily improvement.

- Explore efficient and cost-effective options for centralized outreach by leveraging our existing call center specifically to address our enrolled in Medi-Cal patients that have not yet been screened for blood pressure and/or colorectal cancer.
- Explore the complementary use of patient generated data technologies (kiosks, tablets) to assist with our point-of-care screenings.
- Develop dashboards for clinic staff and providers involving medications, alcohol screening, and preventable admissions.

- The other major area of work will be in strengthening the care team, and encouraging everyone to "work to the top of their license." Specifically for the hypertension, ischemic vascular disease, and diabetes management we're working on developing protocols and training to the following:
    - Nurses and pharmacists titrating medications
    - Medical assistance and navigators supporting in home BP monitoring
    - Developing non-licensed staff to screen for adverse health behaviors such as alcohol and tobacco use.

Finally, SFHN will develop data entry workflows and frontline staff training to gather accurate REAL and SOGI data to enable identification and analysis of disparities for specific populations.

2. *Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]*

For many years now, our primary care clinics have empaneled patients to enable team-based panel management, focusing on patients who have been seen in primary care. PRIME provides the impetus for us to provide care to a broader population, in a more proactive manner. Specifically, we will be reaching out to patients who are assigned to SFHN primary care clinics through managed care but have not yet come in for a visit. We will attempt to engage these patients in primary care in order to offer both preventive and chronic care services.
Many of our past initiatives have focused on redesign of chronic care for diabetes, which affects approximately 8,000 of our active patients. PRIME will support the application of the chronic care model – including team-based care delivery, registries, clinical decision support and self-management support – to our more than 18,000 patients with hypertension and ischemic vascular disease. Importantly, PRIME will also provide additional impetus to our work addressing racial disparities in both preventive services such as colorectal cancer screening and chronic conditions such as hypertension.

With the improved data and systems that we build through this program, we also hope to better understand the causes of preventable ED visits and readmissions, with the goal of safely shifting utilization from acute care to primary care.

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

Check, if applicable	Description of Core Components
Not	**1.2.1** Conduct a gap analysis of practice sites within the DPH/DMPH

Check, if applicable	Description of Core Components
Applicable	system.
Not 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 non-licensed members of the care team) to be responsible for coordination of non-clinical services and elements of the care plan.
Not 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., PHQ-9, SBIRT).
Not 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 non-clinical elements of the care plan.
Not 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

Check, if applicable	Description of Core Components
	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.
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)).
Not 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)**

Under DSRIP we focused on expanding specialty clinic capacity through both traditional means (increasing the number of specialty visits) and telehealth. We have also developed monthly dashboards across 28 specialty clinics to provide timely data on a variety of operational and quality measures. We plan to build on this work through three areas.

First, we will focus on the development and implementation of team based care models in specialty care clinics. Activities will include conducting a staffing analysis of all specialty clinics to determine the optimal sizing of each clinic ("right sizing of the clinics"); implementing a standard staff satisfaction survey across all specialty care clinics; creating standard work for specialty care team members (from check-in to check-out process) including pre- and post-clinic work; and developing and sustaining a curriculum for the specialty care management teams to learn and spread quality improvement in their respective areas.

Second, we will continue to work on expanding patient access to specialty care clinics through operational improvements and further expansion of telehealth. Activities will include reducing no shows (and improving patient experience) through the expansion of our centralized call center to include specialty clinics; adopting lean tools for rapid improvement work focused on patient flow; and performing an analysis on the utility of expanding telehealth to other specialty care areas beyond tele-dermatology, tele-retinopathy, and tele-spirometry.

Third, we will focus on "closing the loop" between specialty care and primary care for those patients who are seen by a specialist. Activities will include conducting a needs assessment of the current communication between primary and specialty care; partnering with primary care clinicians to establish discharge criteria for common specialty care diagnoses/conditions; and establishing an automated, electronic method for sending specialty care reports/clinic visit notes to referring providers, particularly affiliated providers who are not on our ambulatory EHR.

2. *Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]*

Our goal is to implement the proposed projects across all forty-five of our specialty care clinics (including ambulatory, procedural, and diagnostic services) that provide specialty care to over 90,000 patients in our network.

PRIME will allow SFHN specialty care services to accomplish a number of important objectives that are critical to providing high quality, timely and patient-

centered care. First, learning from our experience in primary care, we aim to establish a team-based care model in specialty care clinics. Each clinic will not only have dedicated teams, but we will develop clear roles and responsibilities for each team member. Several studies have shown that such a model not only improves clinic efficiency but enhances staff and patient satisfaction.
Second, by performing a thorough analysis of current barriers to specialty care access with a focus on rapid operational improvement, along with judicious application of telehealth, we aim to achieve a third next available appointment of 15 business days or less for all specialty clinics.

Finally, we plan to ensure that a seamless and clear pathway of communicating specialty care reports/clinic visit notes to referring providers is established and implemented. In doing so, our goal is to ensure that high quality and timely information is communicated to referring providers with the goal of improving patient care and minimizing adverse events/harm to patients as a result of miscommunication.

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

Check, if applicable	Description of Core Components
☒	**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).
☒	**1.3.4** Engage primary care providers and local public health departments in development and implementation of specialty care model.
☒	**1.3.5** Implement processes for primary care/specialty care co-management of patient care.
Applicable	**1.3.6** Establish processes to enable timely follow up for specialty

Check, if applicable	Description of Core Components
	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.
Not 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.
Not 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.
Not 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.
Not Applicable	**1.3.17** Implement or expand use of telehealth based on DPH/DMPH capacity to address patient and PCP barriers to accessing specialty

Check, if applicable	Description of Core Components
	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.
Applicable	**1.3.19** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.
Applicable	**1.3.20** Test use of novel performance metrics for redesigned specialty care models.

☒ 1.5 – Million Hearts Initiative

SFHN chooses the Million Hearts project as our optional project in Domain 1.

As mentioned previously in our Community Background, cardiovascular diseases – including ischemic heart disease, stroke, and hypertensive heart disease – are not only among the leading causes of mortality for both men and women, but also a significant source of racial and ethnic disparities in San Francisco.

Building on our work in primary care-based population management of diabetes, we hope to leverage both our infrastructure and knowledge to improve the care of our more than 18,000 patients with hypertension, tobacco use, and ischemic vascular disease. Specifically, we will use a multipronged strategy of team-based care delivery, patient registries, clinical decision support and self-management support. We will also augment our existing efforts around addressing racial disparities in cardiovascular disease prevention.

Care team development may include creating protocols and training modules for 1) nurses and pharmacists to titrate medications and promote medication adherence in hypertension and ischemic vascular disease, 2) medical assistants or navigators to support patients in home BP monitoring and basic pharmacy navigation, 3) non-licensed staff to screen patients for adverse health behaviors such as alcohol and tobacco use, possibly with supporting technology such as patient portals or waiting room kiosks and 4) behavioral health staff to provide tobacco cessation counseling.

We plan to continue care team use of population registries for both in-reach and outreach. We will explore methods for centralized outreach that will allow us to expand blood pressure screenings to managed care patients who are assigned to SFHN primary care clinics but have not yet come in for care; we anticipate doing this through partnerships with local health plans and community based organizations.

Lastly we will need to build our data analytics capacity to develop new reports for medication adherence, depression screening and referrals, tobacco cessation counseling and disparities stratification.

1. *Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]*

Among adult patients who have been seen over the last two years in our primary care system, 25% (approximately 18,000) have been diagnosed with

hypertension. While 65% of all SFHN patients with hypertension have controlled blood pressures, only 56% of our African-American patients with hypertension have controlled blood pressures. Overall, 17% of our adult active patients are current smokers, with rates that vary between 11% to 51% across clinic sites and neighborhoods. Focusing on cardiovascular disease prevention and tobacco cessation should have significant population health benefits for SFHN.
Success with the Million Hearts project will require the engagement of a diverse group of stakeholders in addressing disparities, variations in care and social determinants of health. We plan to create a primary care Equity Workgroup that allows clinical QI champions to partner with patient advisors and public health program leaders in shaping interventions, particularly around hypertension control and tobacco cessation.

The Million Hearts project is also synergistic with both the primary care redesign and integration of physical and behavioral health projects.

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

Check, if applicable	Description of Core Components
Applicable	**1.5.1** 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.
Not Applicable	**1.5.2** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to the US Preventive Services Task Force (USPSTF) A and B Recommendations.
Applicable	**1.5.3** Improve access to quality care and decrease disparities in the delivery of preventive services.
Applicable	**1.5.4** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
Not Applicable	**1.5.5** 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.
Not Applicable	**1.5.6** 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, if applicable	Description of Core Components
Applicable	**1.5.7** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. • Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts.
Applicable	**1.5.8** Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.

Please complete the summary chart:

	For DPHs	For DMPHs
Domain 1 Subtotal # of DPH-Required Projects:	**3**	**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)

SFHN has several ongoing efforts in perinatal care that will be leveraged in service of this project. The leadership team that will be designing and implementing this project is a standing interdisciplinary team focused on obstetric quality improvement. This team is comprised of physicians, nurses, midwives, pharmacists, medical assistants, health educators, and lactation consultants. This leadership group will work closely with the SFHN's existing Perinatal Linkage Committee, which serves as a forum for inpatient and outpatient stakeholders to work on the delivery of quality perinatal care.

The first stage of the project will be a thorough review of the defined patient population, metrics, and baseline data. Specific interventions will be selected based on this analysis, and will help us identify gaps, and set improvement targets. Data collection and analysis will likely be a combination of internal data and use of CMQCC Maternity Data Center analytics tools.

Preliminary interventions under consideration for implementation and testing include:

- Strengthening and re-commitment of resources to Baby Friendly practices already proven and working within our organization
- Broadening of the criteria for review of cesarean section cases based on an analysis of the drivers of the cesarean section rate
- Publishing cesarean section rates by provider to encourage dialogue and data driven behavior change
- Switching from a 2-week postpartum visit to a 1-week visit focusing on depression screening and breastfeeding and 6-week visit focusing on family planning and linkage to primary care
- Updating system-wide pregnancy test workflows in both specialty and primary care clinics based on successful tests of change at several clinics
- Standardize management of postpartum hemorrhage, incorporating new technologies and therapies, and revising existing guidelines through iterative simulation testing
- Review of drivers for newborn complications/interventions and applying standardized management tools to minimize unwarranted variation (e.g. adoption of the Kaiser sepsis algorithm)

1. *Describe how the project will enable your entity to improve care for the specified population* ***[No more than 250 words]***

Participation in PRIME will highlight perinatal care as an important contributor to community wellness. This is an area where we know health disparities exist, so a deeper understanding of our perinatal population and their differential outcomes is valuable in meeting our commitment to care for vulnerable populations. PRIME, with its imperative to engage people from the time of enrollment in a managed care plan, will synergize well with our participation in a San Francisco-wide project to reduce preterm births. Creating stronger linkage between primary care and prenatal care and removing barriers for pregnant women to enter care will lead to overall improvement in pregnancy outcomes, including reducing preterm birth.

The ZSFG inpatient obstetrics service has a long tradition of cutting edge quality improvement in perinatal care. Based on participation in other publically reported data sets, we anticipate performing well on many of the PRIME metrics. However, we see this as an opportunity to use appreciative inquiry to strengthen existing systems and reduce variation across our Network.

Historically the connection between inpatient and outpatient services has been challenging. We are invested in creating a seamless service line from primary care to prenatal care/labor and delivery and on to primary care for the newborn, postpartum woman, and whole family. Our health care system is often needlessly complex, for both providers and patients. Focusing on key quality indicators will create the unified focus necessary to align the system for the patients' benefit.

Activities for perinatal quality improvement will be selected through a multistep process. Working groups for specific perinatal quality areas have been created and tasked with generating proposals for activities specific to each area; final plans will emerge out of discussions among all perinatal working groups.

Although patient experience is not explicit in the perinatal PRIME metrics, we plan to include a strong patient experience component, involving patients in both the setting of priorities and in testing and refining of our interventions.
Finally, we are hoping that participating in PRIME can help create learning laboratories where innovations in maternity care can be developed, tested, disseminated, and ultimately valued as important contributors to public health.

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

Check, if applicable	Description of Core Components
Not Applicable	**2.1.1** DPHs/DMPHs engagement in best practice learning collaborative to decrease maternal morbidity and mortality related to obstetrical

Check, if applicable	Description of Core Components
	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)

Over the past few years, SFHN has been developing and refining its approach to post-acute care transitions. We have a multidisciplinary, cross-continuum Care Transitions Taskforce that includes representatives from inpatient and primary care, high user case management programs, hospital nursing and pharmacy, home health care, and utilization management. This Taskforce will provide broad oversight to the project and lead the improvement work.

Interventions under consideration for testing and implementation span the continuum of care. Physician and nursing champions from the inpatient services, skilled nursing facilities, and primary care will be called upon to facilitate broad testing and uptake of effective interventions. Ideas for testing include:

- Care Transitions “Always Events” for all patients, including systems to ensure communication with primary care providers upon admission and prior to discharge, universal assessment for and referral to home-based services when appropriate, and post-acute follow-up within seven days of discharge
- A standardized approach to “warm hand-offs” to outpatient or post-acute care providers, including clearly defined accountability for tests and studies pending at discharge, post-acute follow up, and medication reconciliation
- A process or tool to identify patients at high risk for readmission which includes both clinical markers (high risk diagnoses), markers of function

(ADL and IADL dependencies, cognitive impairment), behavioral health markers (mental illness and substance use), and demographic markers (housing instability/homelessness, social isolation)

- A standardized multidisciplinary approach to enhanced discharge planning for high-risk patients which includes optimization of an existing transitional care nursing program based on the Project RED model
- Enhanced medication education and pharmacy coordination for patients on high-risk medications or with polypharmacy
- Specialized approaches to patients with frequent acute care utilization, including network-wide complex care planning
- Ideas will be tested through Plan-Do-Study-Act cycles with an eye toward spreading those that demonstrate efficacy, promote staff and patient satisfaction, and minimally impact work-flows and productivity.

Approaches to collecting qualitative and quantitative data to identify root causes of readmissions will be ongoing. We will be developing data dashboards that track key process and outcome measures for hospital and ambulatory/primary care executive leadership as well as front-line staff, and promote rapid cycle improvement.

2. *Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]*

This project will support SFHN's efforts to develop and consistently apply a standardized, evidence-based approach to care transitions for medically and socially vulnerable hospitalized patients. Our goal is for all patients to receive high quality transitions in care, with timely communication and transfer of discharge paperwork to the receiving provider.

Patients found to be at high risk for readmission will receive enhanced services tailored to particular risk domains and deployed in a standardized way by a multidisciplinary team. These patients will be tracked carefully and surveyed, when possible, to determine if the interventions improved their outcomes and experience. The immediate feedback will allow medical providers and other members of the care team to continuously adjust and improve as part of a learning health system.

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

Check, if applicable	Description of 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

Check, if applicable	Description of Core Components
	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.
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: o Involve mental health, substance use, pharmacy and palliative care when possible. o Involve trained, enhanced IHSS workers when possible. o 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.
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.

Check, if applicable	Description of Core Components
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.
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)

1. SFHN has long recognized the importance of being able to identify and provide alternative care models for patients who are at high risk for frequent ED visits and hospitalizations. The San Francisco Department of Public Health has developed a centralized data repository that tracks utilization across traditional physical and behavioral health venues as well as shelter,

respite, sobering center, and EMS use. Over the years we have developed a number of interventions focused on different populations, including ED case management, primary care-based complex care management, and a program targeting “high users of multiple systems” with the goal of providing more “upstream” care and management to reduce unplanned care and improve outcomes. However, these programs historically been developed with little coordination or alignment. Our goal would be to better coordinate and streamline care for our patients within the current network of complex care management programs.

The overall approach to this project will be threefold. First, we will convene the various complex care management programs across SFHN to develop streamlined, transparent processes for patient recruitment, ensure cross-programmatic communication, and develop shared metrics. Our goal is to develop processes so that our “high risk” patients are assigned a single care coordinator who can serve as the primary point of contact for the patient and system across housing, healthcare, and behavioral health.

Second, we will implement key elements of complex care management models across all primary care clinics. This includes the systematic identification of patients with multiple chronic health conditions, the assignment of a small panel of patients to a nurse within the medical home, establishing a care plan with the patient, and proactive outreach and follow-up with assigned patients. We will partner with primary care nursing leadership in this spread, with a focus on chronic disease management. Third we will continue to work with the central data repository team to refine its analytic capabilities and point-of-service user interface to support the identification and utilization tracking of high-risk patients.

2. Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]

By aligning all the complex care management programs across SFHN, we hope to both eliminate redundancies (where a given patient may be followed by more than one program) and identify gaps, thereby using our resources more effectively. Establishing common metrics and outcomes will allow the complex care management network to identify gaps in care, consider new strategies to reach our population, and provide much-needed data to demonstrate cost-savings to the broader medical community.

The vast majority of the existing complex care management programs target “high-utilizing” populations – generally those with significant numbers of hospitalizations and ED visits and/or who are homeless. However, we recognize that there are many patients with multiple chronic conditions who

could benefit from better management of their chronic medical conditions. We hope that embedding components of complex care management in primary care will prevent hospitalizations and ED visits even in patients who might not otherwise be the target population of existing programs.

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

Check, if applicable	Description of 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.
Not 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.
Not 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).

Check, if applicable	Description of Core Components
	Use educational materials that are consistent with cultural, linguistic and health literacy needs of the target population.
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 follow-up 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.
Not 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.

☒ 2.6 – Chronic Non-Malignant Pain Management

SFHN chooses the Chronic Non-Malignant Pain Management project as our optional project in Domain 2.

Like most healthcare organizations, the San Francisco Department of Public Health struggles to treat people with chronic nonmalignant pain appropriately and compassionately using an evidence-based and consistent approach. Working with our local Medi-Cal managed care plan, most clinics have adopted clinic-wide pain management guidelines which include annual pain assessments, treatment agreements, peer consultation committees, and monitoring for concerning behavior. Using a chronic disease registry which has been a valuable tool in our other population health improvement work, we have had only modest success in capturing all relevant clinical data for our active patients with chronic pain treated with opiate pain medications.

Our intention with PRIME is to create standard work which enables us to capture all patients with chronic pain on opiate pain medications and to create population-level and provider-level reports to monitor adherence to clinic policies and state guidelines. Importantly, we are in the process of developing alternative management strategies and programs for patients who

are interested in exploring non-pharmacologic treatment modalities. The second focus of our PRIME improvement project will be to use patient-centered assessments of the new programs to guide spread with the goal of being able to offer alternatives to opiates to all patients with chronic pain.

We're choosing this as an alternative project because, while we have the building blocks to systematically reduce the use of opiates to treat chronic non-malignant pain in primary care, we have not put these together into a consistent and coherent system-wide, population-based strategy for this vexing clinical issue. Through improved monitoring, creating standard work (for example, prescribing of naloxone for people on opiates, and establishing standards before dose limits can be exceeded), we have the opportunity to reduce prescription opiate overdoses, misuse, and diversion. With alternative treatment options, we also can offer our patients more effective and safe pain management.

1. *Describe how the project will enable your entity to improve care for the specified population* ***[No more than 250 words]***

In using a registry to support a population health management approach to chronic pain, we will be able to more appropriately monitor our patients for diversion, misuse, and other risky behaviors. More importantly, however, we will have a platform for ensuring appropriate management strategies such as routine prescribing of naloxone, culturally appropriate patient education materials for people with limited health literacy and English proficiency, dose limits, and access to non-pharmacologic treatment modalities are available to all patients. Our goal is to systematically expand options for providers and patients who have historically had very limited safe alternatives to powerful and risky opiate medications.

As we have started to develop an Integrative Pain Management Program for our highest risk patients with chronic pain, we have benefited from our strong foundation of Patient Advisors who work with us on quality improvement programs throughout our Primary Care clinics. Patient Advisors have given input on written education materials addressing chronic pain management included in new patient welcome packets and the treatment model for the Integrative Pain Management Program. Using our patients' experience will promote development of team-based, culturally appropriate systems to ensure safe and effective opiate prescribing.

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

Check, if applicable	Description of Core Components

Check, if applicable	Description of Core Components
Applicable	**2.6.1** Develop an enterprise-wide chronic non-malignant pain management strategy.
Applicable	**2.6.2** Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**2.6.3** Implement or adapt a state or nationally recognized methodology for the assessment and management of chronic pain.
Applicable	**2.6.4** Implement protocols for primary care management of patients with chronic pain including: • A standard standardized Pain Care Agreement. • Standard work and policies to support safe prescribing practices. • Comprehensive pain history including psycho/social evaluation, functional evaluations, care plan, pain medication risk/benefit informed consents, ongoing monitoring of plan/outcomes (e.g., use of standardized monitoring template for follow-up visits for CNP), aberrant behavior screening and management protocols. • Guidelines regarding maximum acceptable dosing.
Applicable	**2.6.5** Provide culturally, linguistically and literacy level-appropriate patient education on the pathology of chronic pain, rationale for rehabilitation and expected goals of treatment.
Not Applicable	**2.6.6** Coordinate a chronic pain care team that minimally consists of a physician champion and medical support staff. Suggestions for care clinicians from other disciplines include occupational and physical therapy, behavioral health, pharmacy, substance use disorder specialists, neurology, occupational medicine, anesthesiology/pain management, home care, social work, and physical medicine and rehabilitation.
Not Applicable	**2.6.7** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, and team based population/panel management and care coordination.
Applicable	**2.6.8** Determine population ICD-9/ICD-10 codes for data collection that is unique to patients with chronic pain on opioids and develop a registry for pain assessments, care agreements, medication refill standing orders and urine toxicology screening.
Applicable	**2.6.9** Utilize provider activity report card to provide feedback to providers on how their chronic pain management practice compares to peers and benchmarks.
Not Applicable	**2.6.10** Establish a policy for monitoring and maintaining opioid agreements for prescription refills with other clinics, pharmacies, dentists and specialists.

Check, if applicable	Description of Core Components
Not Applicable	**2.6.11** Develop a process for scheduling pain focused follow-up patient visits to ensure that patients receive refills in a timely manner while also receiving recommended monitoring for signs of diversion or misuse.
Applicable	**2.6.12** Develop staff and clinician training regarding the organization's process for managing patients with chronic non-malignant pain.
Applicable	**2.6.13** Train providers to identify signs of prescription opioid use disorders and provide treatment options for patients diagnosed with opioid use disorders, including suboxone treatment, referral to methadone maintenance, referral to inpatient and outpatient substance use disorder treatment facilities, and referral to needle exchanges.
Applicable	**2.6.14** Develop and implement protocols for prescribing naloxone to patients receiving opioids for chronic pain.
Not Applicable	**2.6.15** Identify standardized multidimensional pain assessment, functional assessment, psychological assessment, and opioid assessment tools that meet the needs of the care clinicians and are appropriate for the patient populations.
Applicable	**2.6.16** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. Timely, relevant and actionable data is used to support patient.

Please complete the summary chart:

	For DPHs	For DMPHs
Domain 2 Subtotal # of DPH-Required 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

☒ 3.3 – Resource Stewardship: Therapies Involving High Cost Pharmaceuticals

SFHN chooses the Therapies Involving High Cost Pharmaceuticals as our optional project in Domain 3.

Market dynamics over the past few years have been shifting in a manner that has caused the prices of certain pharmaceuticals to rise at an extraordinary rate, resulting in a sharp increase in both drug spend and inventory costs. One driver of this trend is the development of new, very expensive treatments for conditions that previously had limited medication therapy options but have now migrated to short-term, curative drug therapy. Oversight of treatment options requires continuous vigilance to ensure we are prescribing and using medications in the most effective and efficient ways possible.

The Resource Stewardship project to evaluate therapies involving high cost pharmaceuticals will allow us to build a strategic approach for medication management across SFHN.

Pharmaceutical expenses can no longer be measured solely in financial terms (i.e., cost and reimbursement), but must be evaluated in relation to the overall value medications bring to patient outcomes. Our approach will be to develop a systematic process to identify which high cost pharmaceuticals to target. Using an interdisciplinary team approach, the team will identify the top medications and medication classes whose efficacy is significantly greater than available lower cost medications. The group will develop processes for proactively evaluating the impact of high cost, high efficacy drugs in the safety net population. Medications will be evaluated in relation to the overall value they bring to patient outcomes such as improved health, improved function and the reduction of health care services. Systems for tracking high cost medication use and prescribing patterns will be developed. Where appropriate, we will establish prescribing standards and work with providers whose prescribing patterns are outside these established standards.

We will also use this program to maximize the use of 340B drug programs and to share tools for monitoring 340B program compliance and fostering integrity in the program.

2. Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]

Although the long term plan is to create effective high cost pharmaceutical therapies for all of our patients, the initial target population will involve our Medical managed-care patients where we have access to drug claims that will allow us to effectively calculate the Proportion of Days Covered (PDC) as specified in the projects. We also plan to explore how we can include our uninsured patients that have received therapies pending our ability to effectively calculate their medication adherence.

Pharmaceutical expenses must be evaluated in relation to the overall value that medications bring to patient outcomes. The metrics in this Resource Stewardship project are aligned with optimizing care while most appropriately utilizing resources. Developing processes to evaluate patient adherence to high cost medication therapies is a good example of this alignment. Barriers to medication adherence in the target population will be identified during the course of this project. With the processes that will be developed to monitor and measure adherence, new approaches that may improve adherence – and ultimately patient outcomes – can be rapidly tested and evaluated.

Medication histories are important in preventing prescription errors and consequent risks to patients. Accurate documentation of concomitant over-the-counter, herbal, and vitamin/nutritional supplements is rare, despite the importance they may have in causing adverse effects or drug-drug interactions.

This project will allow the team to identify barriers for collecting this information and to develop systems and educational programs that will improve patient safety. The team will also be developing and implementing new ordering protocols for high cost medications. The protocols will be based upon the most recent evidence from the literature. Mechanisms for educating staff about best practices and for providing timely feedback on prescribing patterns will need to be developed and will result in new systems and methods to rapidly and successfully foster change.

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

Check, if applicable	Description of Core Components
Applicable	**3.3.1** Implement or expand a high-cost pharmaceuticals management program.
Applicable	**3.3.2** Implement a multidisciplinary pharmaceuticals stewardship team.
Applicable	**3.3.3** Develop a data analytics process to identify the participating PRIME entity highest cost pharmaceuticals (high-cost medications or moderate-cost meds with high prescribing volume). Identify high-cost medications

Check, if applicable	Description of Core Components
	whose efficacy is significantly greater than available lower cost medications. • Using purchase price data, identify the top 20 medications and medication classes, focusing on the following: Analgesics, Anesthetics, Anticoagulants, Anti-Neoplastics, Diabetes, Hepatitis C, Immunoglobulins, Mental Health (Anti-Depressants/Sedatives/ Anti-Psychotics), Respiratory (COPD/Asthma), Rheumatoid Arthritis. o Exclude Anti-Infectives and Blood Products (addressed in separate PRIME Projects).
Applicable	**3.3.4** Develop processes for evaluating impact of high-cost, high-efficacy drugs, particularly drugs to treat conditions (e.g., HCV) or to address circumstances (e.g., oral anticoagulants for patients without transportation for blood checks) more prevalent in safety net populations: • Consider criteria that include ability of identified medications to improve patient health, improve patient function and reduce use of health care services.
Not Applicable	**3.3.5** Develop processes to impact prescribing by providers by establishing standards of care regarding prescribing of high cost pharmaceuticals, including: • Use of decision support/CPOE, evidence-based guidelines and medical criteria to support established standards. • Develop processes to improve the appropriate setting for medication delivery including, transitioning pharmaceutical treatment to the outpatient setting wherever possible. • Promote standards for generic prescribing. • Promote standards for utilizing therapeutic interchange.
Not Applicable	**3.3.6** Improve the process for proper billing of medications, through clinician education and decision support processes.
Applicable	**3.3.7** Develop formulary alignment with local health plans.
Not Applicable	**3.3.8** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership rapid cycle improvement using standard process improvement methodology.
Not Applicable	**3.3.9** Develop organization-wide provider level dashboards to track prescribing patterns for targeted high cost pharmaceuticals. Dashboard to include comparisons to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.

Check, if applicable	Description of Core Components
Not Applicable	**3.3.10** Develop processes for working with providers with prescribing patterns outside established standards, to identify and reduce barriers to meeting prescribing standards: • Develop guidelines and provide staff training on methods for engaging patients in shared decision making for developing treatment plans within the context of the established standards.
Applicable	**3.3.11** Maximize access to 340b pricing: • Share templates for contracting with external pharmacies. To improve program integrity, share tools for monitoring of 340b contract compliance.

Please complete the summary chart:

	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 $ 68,432,000
- DY 12 $ 68,432,000
- DY 13 $ 68,432,000
- DY 14 $ 61,588,800
- DY 15 $ 52,350,480

Total 5-year prime plan incentive amount: $ 319,235,280

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.'

Appendix- Infrastructure Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
1.				
2.				
3.				
4.				
5.				