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**

Table of Contents

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 Joaquin General Hospital (SJGH) /San Joaquin County Clinics (SJCC)

Health Care System Designation: 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.

San Joaquin General Hospital (SJGH) and its primary care clinics, San Joaquin County Clinics (SJCC), are based in French Camp, a primarily rural unincorporated area just south of Stockton (San Joaquin County's largest city). Our target community is San Joaquin County. San Joaquin County historically ranks in the bottom 20 percent of California's 58 counties in most indicators of health.

Among the most significant health issues/needs facing our community are diabetes (7th highest death rate of California's counties), heart disease and congestive heart failure, stroke, hypertension, and mental health and substance use disorders.

Health issues impact some of our county's communities far more than others. In its 2013 community health needs assessment, the Healthier Communities Coalition of San Joaquin County (composed of representatives from local hospitals, health plans, county agencies, and community-based organizations) identified ten zip codes that consistently suffered the top 20% highest rates for poor health outcomes and mortality in San Joaquin County and had socio-demographic factors that put them at increased risk for disparities in health. These communities of concern are spread throughout the county and are home to more than 257,000 county residents.

Age-adjusted rates of ED visits and hospitalizations for heart disease, diabetes, stroke, and hypertension were consistently higher for residents of the communities of concern than residents elsewhere in the county. In general, blacks and whites had the highest rates for these health conditions compared to other racial and ethnic groups. Mortality

rates for each of these health conditions in the communities of concern were consistently above county and state levels.

Coverage and Access: From 2013 to 2014, the percentage of uninsured San Joaquin County residents dropped from 17.7% to 11.5%. Residents of the ten communities of concern are more likely to be uninsured than residents of other parts of the county.

There are approximately 280,000 Medi-Cal beneficiaries residing in San Joaquin County, an enrollment increase of over 90,000 in the last two years. In spite of this increase in coverage, access to primary and specialty care remains a challenge due to ongoing provider shortages. This is also true for mental health providers.

Through the PRIME program and associated waiver initiatives, SJGH/SJCC will focus its efforts on changing our care delivery system to address the issues outlined above.

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.

SJGH/SJCC serves the population of San Joaquin County. According to California Department of Finance projections, the county is one of the fastest growing counties in the state and home to approximately 720,000 residents. Nearly 90% of the land area in San Joaquin County is rural, but almost 90 percent of the county's population lives in its urban areas.

With over 300,000 residents, Stockton is the largest of the county's four urban areas. It is California's 13th most populous city and home to approximately 40% of the county's residents. In addition to the residents of the four primary population areas, our hospital and outpatient clinics serves a large population of residents of the rural areas.

Income: The average per capita income in SJ County is $22,642 with a median household income of $53,253. These income levels are 24% and 13% below the average for California, respectively. Additionally, 42% of the population has income below 200% of the FPL with 20% living at or below the poverty level.

Age: The population is slightly younger than the state overall, with an average age of 33.2 years. The age breakdown is as follows:

- 0-17 years (28.5%)
- 18-64 years (60.5%)
- 65 and over (11%)

Race/Ethnicity and Language: San Joaquin County is more ethnically diverse than California as a whole. The County's population is 58% White, 7% Black, 1% American Indian/Alaska Native, 15% Asian, 12% some other race and 8% two or more races. 39.7% of the population is Hispanic. While the primary language spoken is English, 40% of the population speaks a language other than English at home.

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.

SJGH/SJCC is a 196-bed public hospital and clinic system. SJGH is a general acute care facility providing a full range of inpatient services including general medical/surgical care, labor and delivery, high-risk obstetrics and neonatal intensive care, pediatrics and intensive care. SJGH operates the county's only trauma center.

In addition to the hospital, the French Camp medical campus includes multiple facilities dedicated to comprehensive ambulatory services including specialty clinics in cardiology, ENT, endocrinology, gastroenterology, neurology, neurosurgery, oncology, orthopedics, rheumatology, and urology.

SJGH's primary care clinics operate under the banner of SJCC, a non-profit FQHC look-alike. On the main hospital campus, SJCC provides family medicine, internal medicine, pediatrics, and OB/GYN services. SJCC also operates a primary care clinic in downtown Stockton.

SJGH/SJCC collaborate frequently on county-wide health initiatives with San Joaquin County Health Care Services Agency (HCSA). HCSA comprises Public Health Services, Behavioral Health Services, Correctional Health Services, and the Emergency Medical Services Agency. Additionally, SJGH/SJCC frequently partner with Health Plan of San Joaquin (HPSJ) as the County's local initiative managed care Medi-Cal plan.

During the most recently ended fiscal year (2014-15), the hospital had an inpatient average daily census of approximately 107 patients and had approximately 41,000 visits to the emergency department. There were approximately 28,000 patients assigned to the SJCC clinics comprising 97,000 primary care encounters. There were an additional 52,000 patient visits to SJGH specialty clinics.

Our payer mix for the fiscal year ending June 30, 2015 was 56% Medi-Cal, 17% California Department of Corrections and Rehabilitation, 16% Medicare, 8% commercial/other, and 3% indigent.

In addition to providing direct medical services, SJGH/SJCC provides education for health professionals through post-graduate residency programs in general surgery, internal medicine and family practice. A combined total of approximately 60 residents are currently receiving training through these residency programs.

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.

In 2012, SJGH/SJCC began building an informatics department led by a physician informaticist in the newly created role of chief medical information officer. That department has grown to 11 FTEs and combined with analysts placed throughout the organization in other departments (quality, finance, clinic operations), a sizable workforce has emerged that is capable of capturing, processing, and reporting data. Most recently, SJGH/SJCC recruited a director of clinical analytics to help build an enterprise-wide clinical data strategy. One of his deliverables is to work with IT and informatics leadership to develop a data governance structure.

The organization has demonstrated success in several other projects with heavy data-reporting requirements. Among these are the previous waiver's DSRIP projects; annual UDS reporting to HRSA; the federal Meaningful Use program; HEDIS quality reporting incentive programs of health plans; and hospital-based quality reporting programs of CMS and the Joint Commission. With the PRIME programs, we intend to evolve our approach to reporting by aggregating reports in a common, easily accessible forum for all staff and providers to have ready access. We further intend to harmonize measures where possible thereby reducing duplicative or overlapping measures.

SJGH/SJCC currently relies heavily on a centralized model for reporting, with only a few users responsible for distributing periodic reports to the end-user community. We intend to move from this broadcast model to a more decentralized, self-service model of delivery. Using this approach, dashboards and other reports will be available to end-users on-demand. By 2017, we expect to be using advanced visualization tools and pre-built data models to track performance.

The most significant challenge we anticipate in meeting PRIME reporting requirements will be our conversion from multiple legacy systems to an enterprise system (Cerner) in 2017. Coalescing datasets across systems may pose some challenge following the conversion.

SJGH/SJCC recently began its enterprise-wide implementation of Cerner. Given its importance and urgency, the Cerner implementation has been carefully planned for success and timely go-live delivery. Its implementation is being jointly led by SJGH's

CIO and CMIO. Significant staff and consultant resources are being assigned to the implementation. It is scheduled to be complete by July of 2017.

Two of the anticipated primary challenges related to the transition to Cerner and the strategies to overcome them are:

Change fatigue

SJGH/SJCC has been in a period of transformative change that will be continuing for the foreseeable future. The amount and speed of change can be challenging for physicians and staff. The Cerner implementation is an additional change adding to the fatigue.

The strategy for change management and overcoming change fatigue involves recognizing/monitoring the potential fatigue and carefully and regularly communicating through a variety of channels with all key stakeholders on issues including the reason for the change to Cerner and the outcomes that will be resulting from it. Staff and physicians at all levels are engaged and being listened to as they express concerns and solutions related to the Cerner implementation. Individual and group meetings are being held regularly. SJGH/SJCC is also currently developing a SharePoint site to serve as a central communications clearinghouse for the Cerner transformation.

Additionally, backfill labor has been planned for subject matter experts and superusers during more intense periods of Cerner project involvement. Investing in these additional resources is expected to keep our staff and providers engaged in the Cerner design/build/test/train phases while allowing for day-to-day operations to continue.

Gathering data from legacy systems

SJGH/SJCC recently contracted with a Director of Clinical Informatics to develop specific strategies for getting and storing the data in a way that is readily retrievable reportable, analyzable, and actionable. This will involve the development of a data governance infrastructure building readiness for an enterprise data warehouse. The provision of a robust reporting environment will allow us to aggregate data from source transaction systems both prior to and following the Cerner conversion.

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.*

SJGH/SJCC's primary goal is to improve the health of the residents of San Joaquin County by providing access to high quality, culturally competent, evidence-based, and well-coordinated patient-centered primary and specialty care. More specifically, SJGH/SJCC seeks to become adept at population health management and to achieve greater "systemness" across the care continuum in order to support its chances for success under value-based reimbursement models and other alternative payment methodologies. SJGH/SJCC's ability to realize the above goals relies on its ability to execute on transforming operations, evolving its staffing models, building its technology infrastructure, and maturing its analytics capabilities. In so doing, SJGH/SJCC seeks to better reach, inform, guide, and engage patients in their care.

A related goal involves achieving greater connectedness with community partners and other third-parties in order to build an ecosystem of support for its patients. Recognizing that the new imperative in healthcare delivery is collaboration, wherever possible, SJGH/SJCC endeavors to link patients to community resources to reduce disparities and to achieve the broader goals mentioned above.

Finally, we aim to improve our stewardship of resources and to focus on driving new efficiencies in our operations. We believe this will impact both access to care and the experience of care, while also driving down unnecessary utilization and extraneous cost.

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.*

In implementing the nine PRIME projects, SJGH/SJCC has a broad primary aim of building readiness for risk-based contracts and other APMs by the end of the waiver period, however, this can be broken into four key components that essentially comprise the "quadruple" variant of IHI's Triple Aim:

- Better population health: Improve access and quality; eliminate disparities
- Better patient experience: Improve patient engagement; promote patient education; honor patient choice
- Reduced per-capita cost: Protect utilization; build resource stewardship awareness
- Better provider experience: Improve morale; improve retention; increase output by adding staff/team support

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;*

All nine projects are directly aligned with and support our goal and aims. By aim, the projects tie in as follows:

- Better population health (1.1, 1.2, 1.3, 1.6, 2.1, 2.2, 2.3, 2.7, 3.2)
- Better patient experience (1.1, 1.2, 1.3, 2.1, 2.2, 2.3, 2.7)
- Reduced per-capita cost (1.1, 1.6, 2.3, 2.7, 3.2)
- Better provider experience (1.1, 1.2, 1.3, 2.7)

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*

The nine selected projects when taken together will touch all the relevant parts of the SJGH/SJCC enterprise to achieve system-wide transformation. The process improvement work taking place in the course of operationalizing each project, while profound, is expected to be no more impactful than our *approach* to waiver implementation itself. This approach places interdisciplinary staff and clinicians that have traditionally operated in their respective departmental siloes into direct contact with one another to design new workflows and new sensibilities about evidence-based practice. The end result is project execution that traverses historical siloes and that

begins to achieve true “systemness” by replacing the fragmentation of pre-waiver care delivery.

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.*

At the end of the five years, SJGH/SJCC will have much stronger linkages with community resources and our local health plans, be much more responsive and accessible to our patients, and provide our patients the appropriate coordinated services when they need them in the care setting that best meets their needs.

As a result of its mature focus on population health management, at the end of the five years SJGH/SJCC will be far more adept at reigning in costs around unnecessary imaging and managing avoidable inpatient and ED utilization. Patients will be more informed about their health status and better engaged in managing their health conditions thereby experiencing much better health outcomes and greater satisfaction. Coordinated preventive and primary care supported by community resources will assume a much larger role in keeping people healthy.

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.

SJGH/SJCC developed its PRIME plan, including its choice of optional projects and core components, to specifically address local health needs including access to and quality of care. The fifty-nine unduplicated metrics SJGH/SJCC being targeted by this PRIME plan focus on health system redesign and local health issues/needs.

As noted in Section 2, residents of San Joaquin County generally experience worse health than residents in the rest of the state on a variety of measures. Mental health issues and substance use are major challenges. Diabetes and heart disease are significant concerns. In spite of the significant recent growth in Medi-Cal coverage, access to primary and specialty care as well as behavioral health services can be problematic and there remain significant health disparities related to zip code, income, education, ethnicity, and other factors.

Our PRIME projects will complement SJGH/SJCC’s growth strategy, transforming our operational environment as we scale into broader areas of our community by adding new sites and additional providers. These sites will be located in the communities of concern identified by the community health needs assessment to improve access to

high quality care and reduce health disparities. The six required projects will redesign SJGH/SJCC core functions to address local health care needs in a variety of ways including integrating behavioral health care into primary care, improving management of diabetic patients, improving access to team-based primary care, , improving quality of care, enhancing communication between providers, ensuring loop closure for patients being seen by multiple providers, better engaging patients in managing their health conditions, and ensuring successful transitions of care from the hospital. . The three additional projects will focus on the following key areas that are aligned with the community health needs we identified in Section 2.1:

- A disproportionate share of California's cancer prevalence afflicts San Joaquin County residents. By improving our cancer screening and follow-up rates, we anticipate catching cancers earlier when treatment options are more likely to be successful.
- Our inpatient experience has revealed that a significant number of terminally-ill patients don't engage in advanced illness care planning and therefore become frequent users of the ED. They often don't take advantage of hospice and are readmitted at least a few times before dying in the hospital. We seek to address this by implementing outpatient palliative care services.
- The high cost imaging project advances SJGH's effort to improve stewardship of limited resources for an underserved community. By focusing imaging on those for whom imaging is most likely to be clinically useful, SJGH will diminish waste, reduce cost, and improve access.

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).

SJGH/SJCC is in the midst of a strategic planning effort. Practice transformation; patient-centered care; integrated inpatient, outpatient, and community systems of care; analytics, quality improvement, and investments to ensure successful implementation of PRIME are all critically important components of the strategic plan.

PRIME implementation is being co-led by our COO and CMIO. Individual implementation teams exist for each of the selected nine projects. Established in January 2016, these implementation teams comprise executive leadership, physician leadership, nursing leadership, analysts, and other key internal stakeholders. The COO will be the administrative lead and responsible for managing the implementation teams, and monitoring and reporting progress to DHCS. The CMIO, who is also the SJCC

CMO, will be responsible for leading implementation of the ambulatory strategies and the analytics/population health components.

PRIME implementation will be a key agenda item on SJGH's executive committee's regular meetings as frequently as needed, but no less than once per month. SJGH's CEO will be providing a written update on progress towards efforts to meet PRIME goals and performance standards to the County Board of Supervisors and the SJCC Board of Directors on a periodic basis. Additionally, a SharePoint site will be created and socialized across SJGH/SJCC to serve as a central repository and communications channel for PRIME.

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.

SJGH/SJCC will provide external stakeholders and beneficiaries multiple opportunities to engage in PRIME planning and implementation. A majority of the members of the SJCC Board of Directors receive care at SJGH/SJCC. They will continue to be informed on PRIME planning activities and their input will be sought to guide PRIME-related planning. The public will have the opportunity to ask questions and provide comments at SJCC Board meetings as well as at meetings of the County Board of Supervisors. Wherever possible/appropriate, SJGH/SJCC may choose to include patients/families on project teams for their valuable insights as consumers of health care services.

Community Medical Centers (the largest FQHC in San Joaquin County), San Joaquin County Behavioral Health Services, San Joaquin County Public Health Services, as well as several community-based organizations providing services to our patients are critically important to successful implementation of our PRIME-related projects. SJGH/SJCC will continue to seek their input in planning and work directly with them in implementation of PRIME projects. One way we will be doing this is through participation in the Healthier Communities Coalition. This Coalition provides leadership in the development and coordination of health status improvement efforts in San Joaquin County and serves as a forum for health services stakeholders to share ideas and information about projects and seek collaborative partners.

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.

SJGH/SJCC is dedicated to meeting the language and cultural needs of our diverse patient population. We seek to ensure that our providers and staff reflect the language and cultural diversity of our patients and that our patients have access to health information in their language of choice. And we reach out to underserved communities to help address disparities.

We will continue to work to recruit providers and staff reflecting the diversity of our patients. We will continue to translate educational materials into our identified threshold languages and provide real-time access to interpreter services through the Health Care Interpreter Network and other resources. SJGH will contract with El Concilio to ensure bilingual maternal advocates are available onsite 24 x 7 to educate and meet the needs of Spanish speaking women giving birth at SJGH and their families. In addition, SJGH/SJCC will develop and offer provider and staff trainings on issues related to cultural competence and health disparities.

We further seek to address healthcare disparities by providing a free transportation service for patients living in economically challenged areas of South Stockton, expanding clinic sites into some of the County's underserved communities, and initiating a series of community health fairs in underserved communities.

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.

SJGH/SJCC utilizes widely-recognized methods for quality improvement and relies heavily on data-driven analysis and iterative refinement (PDSA cycles). Change is managed through frequent communication and transparency. For example, data walls in various locations on campus display current state metrics and provide staff with information about goals and benchmarks. Each of our PRIME project-specific waiver implementation teams will continue to use these methods and principles to improve quality and to manage change.

Sustainability beyond the waiver period is expected as a result of a novel care team staffing model, a new population health management business unit, redesigned operational workflows, optimized technology, and robust analytics capabilities. SJGH/SJCC will continue to provide strong leadership support for these activities and will continue engaging providers and staff in ongoing transformation work. Staff development activities will also be provided as investments in our workforce will be required to keep up with the pace of change.

Section 4: Project Selection

The PRIME Projects are organized into three Domains:

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

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

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

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

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

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

Instructions

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

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

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

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

   For DMPHs requiring infrastructure building metrics that are approved in the Prime Project Plan, 75% of PRIME funding for DY 11 will be based on the achievement of the approved DY 11 infrastructure building metrics through the final year-end report. Up to 40% of the total PRIME funding for DY12 will be based on the achievement of the approved DY 12 infrastructure building metrics through the mid-year and final year-end report. The proposed Process Measures should meet the following criteria:
   - *Specific*
   - *Measurable: Must be able to demonstrate progress throughout the duration of the process metric measurement period.*
   - *Evidence-based: Measures should have a strong evidence-base that can linked process to outcomes.*

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

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

1. Summarize approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words]

SJGH/SJCC seeks to identify and follow an evidence-based model to address the behavioral health needs of our patients with mental health and substance use disorders through team-based care and better coordination of physical and behavioral health services.

Our planned implementation approach includes:

Co-location of behavioralists in primary care clinics: SJGH/SJCC will hire and embed behavioralists on care teams. These LCSWs will help patients deal with issues including mood disorders, anxiety, depression, substance/alcohol use, and others identified in screenings. They will take scheduled appointments, accept warm handoffs from PCPs, provide focused brief psychotherapy, and make referrals to community resources. Hiring will begin in DY11 and the program will be piloted in one clinic, expanding to others beginning in DY12.

Clinical guidelines: An interdisciplinary workgroup will develop clinical guidelines around mental health and substance abuse screening across settings (ED, inpatient, and ambulatory care) for adult and pediatric patients based on use of PHQ-2, PHQ-9 and SBIRT as well as referrals and follow-up for those with moderate and severe conditions. Workgroup will begin in DY12.

Enhanced care coordination: Nurse care coordinators will be hired as part of care teams. The first will be hired in DY11 with others being added in DY12 and DY13. Additionally, SJGH/SJCC is implementing an enterprise-wide EMR (Cerner) to ensure clinical information is available to coordinate care planning and treatment at the primary care clinics and to ensure coordination of care between the inpatient and ambulatory care settings. Implementation began in DY11. Will be complete in DY13.

Care team training: Training will be provided to care team members on ongoing basis around elements such as behavioral health screening and referral, community resources, patient self-management, and psychopharmacology. The training program will be designed in DY12 and training will begin in DY12.

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

The target population for this project and for its six associated metrics is the PRIME eligible population. This is defined as individuals with at least two encounters at SJCC or individuals continuously assigned by their Medi-Cal managed care plan to SJCC PCPs for a minimum of 12 months.

By directing staff resources, clinical guidelines, and training to identify patients with behavioral health issues and ensure integration of behavioral health services in the primary care clinics following a nationally recognized model, SJGH/SJCC expects to see improvement in behavioral and physical health of the target population including a reduction in the number of patients with HbA1c Poor Control. Many causes of mental health problems have physical consequences and can lead to worse outcomes for diabetes, heart disease, and other illnesses. As a result, people with mental illness in general have shorter life expectancies. We seek to provide necessary outreach, mental health and physical health care, and supportive services to address this disparity.

The care coordinators and behavioralists that will be critically important in this coordination and integration effort are new positions to SJGH/SJCC. The consensus clinical guidelines that will be developed will ensure consistency of screening and brief therapy in the primary care clinics, linkage to other services, and follow-up for patients with identified behavioral health conditions.

The implementation of Cerner will ensure that a single shared clinical record is accessible across the treatment team throughout SJGH/SJCC to ensure coordination of

care planning. The EMR will also be used to monitor and evaluate outcomes for every patient on an ongoing basis.

Training will ensure that staff understands the integrated care model and can perform to the best of their abilities to identify and address the physical and behavioral health care needs of our patients.

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

Check, if applicable	Description of Core Components
Applicable	**1.1.1** Implement a behavioral health integration assessment tool (baseline and annual progress measurement)
Applicable	**1.1.2** Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration, the Collaborative Care Model, or other Integrated Behavioral Health (IBH) resources from SAMHSA)
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).
Not 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.
Not Applicable	**1.1.6** Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients

Check, if applicable	Description of Core Components
	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 treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.
Not 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.
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

Check, if applicable	Description of Core Components
	each patient.
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.
Not Applicable	**1.1.14** Demonstrate patient engagement in the design and 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)

1. *Summarize approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words]*

Our primary care clinics will seek NCQA PCMH recognition beginning in DY12 and extending into DY13. We believe that adopting this framework aligns with the operational transformations necessary to be successful under this PRIME project. In its current form, the NCQA framework includes the following six domains:

Patient-Centered Access: We will optimize our advanced access model for patient scheduling and scale it to additional sites (currently only at 3 of 6 sites), accommodating patients' needs in a timely and convenient manner.

Team-Based Care: We will refine our staffing model to include health coaches and other team members each functioning at the top of her license to meet the various needs of patients. Particular focus will be given to engaging patients in their own care especially as regards chronic disease self-management.

Population Health Management: We will aggregate and use patient data for population based analyses and interventions. Gaps in care will be identified and appropriate management will be provided.

Care Management and Support: Standardized and evidence-based guidelines for preventive, acute, and chronic care will be in place throughout our primary care clinics.

Care Coordination and Care Transitions: Adding care coordinators will allow intensive oversight of care for those patients determined through clinical criteria and utilization patterns to be at high-risk. Special attention will be given to care around transitions from one care setting to another (as during ED/hospital discharge or specialty referrals).

Performance Measurement and Quality Improvement: Sophisticated use of analytics will inform performance improvement activities. The capabilities of existing QA/QI committees will evolve as technology sophistication improves and our dataset expands.

Many of the above goals will be enabled by new technology. Not only will our enterprise Cerner implementation (going live in DY13) drive new operational efficiencies and data transparency across our care continuum, it will also enable more robust analytics capabilities.

Supported by enhanced data and analytics, the transformation of SJGH/SJCC primary care to a recognized patient-centered medical home (PCMH) will put the resources, guidelines, personnel, and direction in place to ensure a focus on relevant project metrics including those related to patient satisfaction, health care quality, colorectal cancer screening, diabetes care, controlling blood pressure, ischemic vascular disease, screening for clinical depression and follow-up, and tobacco assessment and counseling.

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

The target population for this project and for its fourteen associated metrics is the PRIME eligible population. This is defined as individuals with at least two encounters at SJCC or individuals continuously assigned by their Medi-Cal managed care plan to SJCC PCPs for a minimum of 12 months.

We believe that the above approach will transform our transactional, inwardly-focused operations to a more patient-centric standard for conducting business. Providing on-demand, same day access is aimed at reducing unnecessary utilization of non-PCP care settings, enhancing continuity, and improving the patient experience. Further, the move from episodic care to the PCMH model will allow our delivery system to be more

effective at caring for whole populations, preventing illness in the healthy patients and helping to keep those with chronic disease under optimal control. Much of the work underlying this transformation requires strengthening relationships with health plans in order to empanel patients to PCPs appropriately, an activity which itself improves care by creating accountability between patients and care teams.

Our approach also creates opportunities for creating more convenient care, including alternatives to face-to-face visits through the use of telehealth options, patient-facing technologies, and other virtual encounters. Our planned use of eConsult in DY13 will even allow PCPs to manage conditions normally referred to specialists, an approach that will benefit patients by improving timely access to care while reducing costs.

Finally, SJGH/SJCC's commitment to evidence-based practice will also improve quality and patient outcomes. Our focus on evidence and data will allow us to refine our clinical protocols over time. Our ability to drive improvements in patient care and patient experience will be greatly enhanced by our ability to perform increasingly robust analytics. Becoming more data driven will also allow us to identify and address health disparities in our vulnerable patient population.

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

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

Check, if applicable	Description of Core Components
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).
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.
Applicable	**1.2.7** Coordinate care across settings: • Identification of care coordinators at each primary care site who are responsible for coordinating care within the PCMH as well as with other facilities (e.g., other care coordinators or PCMH/DPH/DMPH high risk care managers): o Establish onsite care/case managers to work with high risk patients and their care teams, or develop processes for local care coordinators to work with a central complex care management program for these patients Implement processes for timely bi-directional communication and referral to specialty care (including mental health and substance use disorder services), acute care, social services and community-based services.
Applicable	**1.2.8** Demonstrate evidence-based preventive and chronic disease management.
Applicable	**1.2.9** Improve staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the team-based care model to ensure effective and efficient provision of services (e.g., group visits, medication reconciliation, motivational interviewing, cognitive behavioral therapy and Medication-Assistance Treatment (MAT)).
Applicable	**1.2.10** Engage patients using care plans, and self-management education, and through involvement in the design and implementation of this project.
Applicable	**1.2.11** Improve the accuracy and completeness of race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI)

Check, if applicable	Description of Core Components
	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)**

1. Summarize approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words]

While a fair amount of process improvement and transformation work was performed in the primary care setting through previous waiver activities, little has been done to date in order to redesign the specialty care enterprise. Through this PRIME project, we endeavor to enhance specialty access, promote better communication between PCPs and specialists, and streamline operational processes around referrals, pre-authorization, and scheduling.

A key deliverable for this project will be the implementation of a centralized scheduling business unit in DY13 using Cerner's enterprise scheduling module. Led by our admitting/registration department, this business unit will draw together scheduling and authorization activities for primary care and specialty clinics, therapies, diagnostic imaging, GI lab, and other areas. This centralization will enable eReferral workflows for

timely access to specialty care as well as loop closure for PCPs once specialty consultations have been completed.

As a second key focus of this project, we've committed to exploring eConsult through a planning grant funded by Blue Shield of California Foundation (DY11/12). An early part of the feasibility analysis for eConsult involves documenting the current state of specialty care access in the community, a step that will allow us to prioritize those subspecialties where eConsult can make the greatest impact. eConsult planning will also involve achieving consensus between PCPs and specialists about criteria for referral as well as working with health plans to devise a financial sustainability model.

Finally, our enterprise Cerner implementation will include a population health management module (HealtheIntent) that will enable us to identify gaps in care across our patient population and to deliver services to those patients that are at highest risk. Our enterprise EMR provides each patient a single record across primary care and specialty clinics (as well as acute care), enabling us to deliver more integrated population-based interventions across all care settings.

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

The target population for this project and for four of its seven associated metrics is the PRIME eligible population. This is defined as individuals with at least two encounters at SJCC or individuals continuously assigned by their Medi-Cal managed care plan to SJCC PCPs for a minimum of 12 months.

For three of the seven associated metrics (DHCS All-Cause Readmission; NQF 0041 Influenza Immunization; NQF 0028 Tobacco Assessment and Counseling), the target population is the subset of the PRIME eligible population for whom PRIME Entity specialty care expertise has been requested at least once during the demonstration year.

Patients often wait weeks for appointments to certain specialty clinics. The benefits to the target population in this project are clear: improved access and reduced waits and delays for specialty care. Furthermore, by utilizing eConsult, PCPs are better able to manage conditions that would otherwise require specialty referral, a practice that improves patient experience and reduces fragmentation of care. That eConsult implementation requires PCPs and specialists to arrive at consensus around clinical guidelines also ensures that care is evidence-based and sensitive to cost, quality, and outcomes.

Any intervention that enhances communication between care teams also has clear benefits to patients. Having a centralized business unit allows both patients and

referring providers a single point of contact for scheduling care. Centralizing and digitizing referrals also improves loop closure so that PCPs reliably receive expert guidance from subspecialists and other consultants. In the present state, PCPs bemoan the reliability of internal referrals which creates referral leakage outside the network, a condition which also produces greater care fragmentation.

Another way in which this project will impact the target population is through the intensive workflow mapping and redesign efforts that will accompany the implementation of the Cerner EMR and its population health management platform, HealtheIntent. By careful workflow design and expert execution in SJGH/SJCC's novel population health management business unit, patients stand to benefit from insights gleaned from the robust datasets being produced throughout the hospital and clinics. Patients determined to be at high risk will be assigned care coordinators that can perform targeted outreach, navigation, and health coaching.

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

Check, if applicable	Description of Core Components
Applicable	**1.3.1** Develop a specialty care program that is broadly applied to the entire target population.
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.
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).
Not Applicable	**1.3.4** Engage primary care providers and local public health departments in development and implementation of specialty care model.
Applicable	**1.3.5** Implement processes for primary care/specialty care co-management of patient care.
Applicable	**1.3.6** Establish processes to enable timely follow up for specialty expertise requests.
Applicable	**1.3.7** Develop closed loop processes to ensure all requests are

Check, if applicable	Description of Core Components
	addressed and if in person visits are performed, that the outcome is communicated back to the PCP.
Applicable	**1.3.8** Ensure that clinical teams engage in team- and evidence-based care.
Applicable	**1.3.9** Increase staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the care model.
Applicable	**1.3.10** Develop and implement standardized workflows for diversified care delivery strategies (e.g., shared medical visits, ancillary led services, population management, telemedicine services) to expand access and improve cost efficiency.
Applicable	**1.3.11** Adopt and follow treatment protocols mutually agreed upon across the delivery system.
Applicable	**1.3.12** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population management activities and care coordination/transitions of care. Ensure that timely, relevant, and actionable data are used to support patient engagement, PCP collaboration, and drive clinical, operational and strategic decisions including continuous quality improvement (QI) activities.
Applicable	**1.3.13** Implement EHR technology that meets MU standards.
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.
Applicable	**1.3.16** Implement population management strategies for patients in need of preventive services, with chronic conditions, or with recurring long term surveillance needs.
Applicable	**1.3.17** Implement or expand use of telehealth based on DPH/DMPH capacity to address patient and PCP barriers to accessing specialty expertise. Implement a telehealth platform with communication modalities that connect between specialty care and primary care (e.g.,

Check, if applicable	Description of Core Components
	eConsult/eReferral).
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.
Not Applicable	**1.3.20** Test use of novel performance metrics for redesigned specialty care models.

☒ 1.6 – Cancer Screening and Follow-up

1. Summarize approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words]

San Joaquin County suffers from higher death rates from cancers than most other California counties. Providing preventive services including cancer screenings and follow-up is of major importance to our patients and for SJGH/SJCC. We have also chosen this project because it enables us to build on the lessons and methodologies we employed in DSRIP during the Big Aims campaign where we improved mammography rates.

Project leadership: SJGH/SJCC has formed a multidisciplinary team targeting cancer screening and follow-up. Its first task is to finalize the plan for implementing this project and anticipate the current and additional resources needed to implement the core components of the project to ensure success.

Patient Identification and outreach: During DY11 and DY12, SJGH will use eCW along with the i2iTracks disease registry and help from our health plan partners to identify the appropriate patients for screening and follow-up. Beginning in DY13, eCW and i2iTracks will be replaced by Cerner and its HealtheIntent platform. Patients identified in need of screening will have their medical records flagged so the providers/care teams are aware of the need to order appropriate tests when the patients come to their appointments. Outreach to patients needing appointments will be conducted by phone, email, and via the patient portal. As in all other projects, given the diversity of the community, language appropriate and culturally sensitive information and education will be provided.

Staff engagement and training: Targeted education related to the importance of these tests and follow-up will be provided to all clinic staff. Clinic staff will receive compliance scores regularly.

Continual improvement: SJGH/SJCC will regularly poll its patients to garner their feedback on how SJGH/SJCC can eliminate barriers and improve its processes. We will adapt our services based on data and feedback from our patients, providers, and health plan partners.

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

The target population for this project and for its five associated metrics is the PRIME eligible population. This is defined as individuals with at least two encounters at SJCC or individuals continuously assigned by their Medi-Cal managed care plan to SJCC PCPs for a minimum of 12 months.

By ensuring patients in the target population receive appropriate and timely cancer screenings and appropriate follow-up, SJGH/SJCC will be able to detect cancers early, giving its patients the best chances for better outcomes. Most cancer screening guidelines carry strong levels of evidence for improving mortality and morbidity benefit to patients. Screening at appropriate intervals and following evidence-based guidelines will undoubtedly save lives. This is especially true in our target population; as mentioned above, San Joaquin County's mortality rate from cancers exceeds the mortality rates in all but a few of California's counties.
Beyond the obvious benefits of early detection, the target population will also experience a greater sense of emphasis by their health system on prevention and wellness rather than disease treatment. This is an important change in focus for our health system and as patients grow to understand and embrace it, they will hopefully become more engaged in other parts of their own care (nutrition, exercise, heart health, diabetes prevention and control).

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

Check, if applicable	Description of Core Components
Applicable	**1.6.1** Develop a multi-disciplinary cross-participating PRIME entity task force to identify principle-based expected practices for screening and follow-up for the targeted services including, but not limited to: • Standard approach to screening and follow-up within each DPH/DMPH. • Screening: o Enterprise-wide standard approach to screening (e.g., ages, frequency, diagnostic tool). • Follow-up for abnormal screening exams:

Check, if applicable	Description of Core Components
	o Clinical risk-stratified screening process (e.g., family history, red flags). Timeliness (specific time benchmark for time from abnormal screening exam to diagnostic exam).
Applicable	**1.6.2** Demonstrate patient engagement in the design and implementation of programs.
Applicable	**1.6.3** 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.
Applicable	**1.6.4** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to USPSTF A and B Recommendations.
Applicable	**1.6.5** Improve access to quality care and decrease disparities in the delivery of preventive services.
Applicable	**1.6.6** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
Applicable	**1.6.7** 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	**1.6.8** 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.
Applicable	**1.6.9** Implement a system for continual performance management and rapid cycle improvement that includes feedback from patients, community partners, front line staff, and senior leadership.

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)

1. Summarize approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words]

SJGH/SJCC designed and will be implementing this project to build upon a transformation in perinatal care services that has been underway at SJGH for the last decade. The core project components are well aligned with existing transformation priorities and efforts around maternal morbidity and mortality, cesarean section rates, and post-partum care coordination, and exclusive breastfeeding education and support. Since submitting its PRIME plan, SJGH received designation as a Baby-Friendly hospital.
The SJGH/SJCC team responsible for overseeing the design and implementation of this project will monitor, coordinate, and build on existing efforts underway to improve performance on each of the perinatal care project performance metrics using evidence-based best practices. As an example of an effort already underway, through the Joint Commission Core Measures program, the hospital has been collecting data on elective delivery, Cesarean section rates, exclusive breast milk feeding and other indicators and implementing efforts to improve performance. SJGH/SJCC also recently received funding from HPSJ to begin an effort to improve timeliness of prenatal and postpartum care starting in DY11.

SJGH/SJCC has joined the California Maternal Quality Care Collaborative (CMQCC) (DY11) to learn and use best practice tools and resources to monitor and prevent perinatal complications and reduce leading causes of maternal morbidity and mortality including obstetrical hemorrhage.

To address disparities and expand the benefits of this project, SJGH/SJCC will continue to provide care within the broader community. OB/GYN providers will be seeing maternity patients at Community Medical Centers (CMC, the local private FQHC) clinic sites throughout the County. This relationship helps bring access to OB/GYN care for patients in the communities served by CMC and allows SJGH/SJCC to track patients delivering babies in other hospitals. In addition, we will be partnering with El Concilio in DY11 to provide for bilingual/bicultural support to help our Spanish speaking patients overcome communication challenges and to provide a transportation service to enable our patients with transportation barriers to access needed care.

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

The target population for this project and for its nine associated metrics is the PRIME eligible population or any woman with two prenatal visits with the PRIME Entity during the measurement period. The PRIME eligible population is defined as individuals with

at least two encounters at SJCC or individuals continuously assigned by their Medi-Cal managed care plan to SJCC PCPs for a minimum of 12 months.

Building on past efforts to identify and implement evidence-based best practice by our OB/GYN physicians and other staff, the project will enable SJGH/SJCC to improve perinatal care for the target population by addressing such issues as Caesarean section rates, unexpected newborn complications, timely prenatal and postpartum care, obstetrical hemorrhage, and exclusive breastfeeding. Work on each of these areas confers the following benefits to mothers and to their babies:

- Timely access to prenatal care has been shown to improve health outcomes of pregnancy for mothers and infants including improved birth weight and decreased risk of preterm delivery
- Exclusive breastfeeding has been shown to reduce the number and seriousness of childhood illnesses, improve the health of mothers, and save money for families
- Judicious C-section use reduces risks of complications and death for women.

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

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

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

1. Summarize approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words]

The SJGH/SJCC waiver implementation team responsible for this project will convene a multidisciplinary care transitions workgroup to develop and operationalize a care transitions program. The workgroup will be composed of hospitalists, discharge planners, clinic operations leadership, physician leadership representation from clinical informatics, representation from San Joaquin County Behavioral Health Services, and representation from Medisas – a technology vendor whose software platform underlies our care transitions process.

This group will address a variety of components in developing the care transitions program including:

- developing an algorithmic protocol for risk stratification to target individuals by level of risk
- standardizing discharge care, plans and summaries
- standardizing workflows for peri- and post-discharge care including hand-off from hospital to primary care
- updating patient education protocol to enhance patient engagement
- engaging with HPSJ to ensure that payment for transition of care services will be available and that a system can be put in place for SJGH/SJCC to receive alerts if a discharged patient has been admitted to another hospital
- ongoing monitoring and quality improvement

SJGH/SJCC is looking to support and enhance its care transitions with use of technology in at least a couple ways. First is to stratify discharged patients by risk of poor outcomes/readmission to assign level of post discharge intervention needed. Second is to facilitate standardized workflow including discharge planning, hand-offs to primary care providers, medication reconciliation, scheduling of follow-up appointments with primary care providers, etc. SJGH currently uses the Medisas platform to help with handoffs of hospitalized patients between SJGH hospitalists and will be adopting Medisas for transitions of care to SJCC primary care physicians during DY11 and DY12. Upon implementing Cerner as an enterprise-wide EHR in DY13, the organization will begin using that platform's I-PASS framework for patient transitions.

All staff involved in transitions of care will be trained on the care transitions model.

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

The target population for this project and for its five associated metrics is the subset of the PRIME eligible population having experienced at least one inpatient discharge from any acute care facility during the measurement year. The PRIME eligible population is defined as individuals with at least two encounters at SJCC or individuals continuously assigned by their Medi-Cal managed care plan to SJCC PCPs for a minimum of 12 months.

Developing and implementing a care transitions program based on a nationally recognized model will result in significant improvements in care for the target population in several ways including the following:

- It will optimize discharge planning for all hospitalized patients and maximize the likelihood of successful transition from the hospital.
- It will ensure that discharged patients and family caregivers have been engaged in the care planning, have received education and coaching, and have a written transition care plan.
- It will ensure improved medication reconciliation at admission and discharge with reliable transmission of discharge medication lists to PCPs via technology-enabled workflows.
- It will enable better linkage to behavioral health, palliative care, medical respite, skilled nursing facilities, and/or community support services as needed.
- It will enable improved hand-off to SJCC primary care providers including scheduling of follow-up appointments.
- It will ensure that durable medical equipment and other support is ready for the discharged patient.
- It will reduce likelihood of hospital readmission and all the risks and hassles involved with admission to a hospital.

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

Check, if applicable	Description of Core Components
Applicable	**2.2.4** Develop standardized workflows for inpatient discharge care: • Optimize hospital discharge planning and medication management for all hospitalized patients. • Implement structure for obtaining best possible medication history and for assessing medication reconciliation accuracy. • Develop and use standardized process for transitioning patients to sub-acute and long term care facilities. • Provide tiered, multi-disciplinary interventions according to level of risk: 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.
Applicable	**2.2.7** Support patients and family caregivers in becoming more comfortable, competent and confident in self-management skills required after an acute hospitalization by providing: • Engagement of patients in the care planning process. • Pre-discharge patient and caregiver education and coaching. • Written transition care plan for patient and caregiver. • Timely communication and coordination with receiving practitioner. Community-based support for the patient and caregiver post hospitalization focusing on self-care requirements and follow-up care with primary and specialty care providers.

Check, if applicable	Description of Core Components
Applicable	**2.2.8** Engage with local health plans to develop transition of care protocols that ensure: coordination of care across physical health, substance use disorder and mental health spectrum will be supported; identification of and follow-up engagement with PCP is established; covered services including durable medical equipment (DME) will be readily available; and, a payment strategy for the transition of care services is in place.
Applicable	**2.2.9** Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**2.2.10** Increase multidisciplinary team engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on care model.
Applicable	**2.2.11** Implement a system for continual performance feedback and rapid cycle improvement that uses standard process improvement methodology and that includes patients, front line staff and senior leadership.

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

1. *Summarize approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words]*

SJGH/SJCC's implementation of this project will include the following key activities and components:

Patient identification and risk stratification*:* Following best practices from other organizations, SJGH/SJCC clinical informatics staff will apply predictive analytics to develop an algorithm for identifying candidates for high-risk management and stratifying high-risk, medium-risk, and low-risk patients. Factors to be considered will include demographics, diagnoses, co-morbidities including behavioral health and/or substance use, functional assessment, medications, and utilization patterns. SJGH/SJCC will work with HPSJ and its claims and other data in refining our risk stratification algorithm over time.

Complex care management model development: SJGH/SJCC's recently established population health unit will be responsible for developing and implementing the complex care management program following Medicare CCM methodology. The program will involve care coordinators, primary care providers, quality nurses, and clinical analysts. The complex care management care program will be piloted at one primary care site in DY13 and expanded to all primary care clinics by the end of DY14.

Staffing: SJGH/SJCC will be adding nurse care coordinators in its population health unit. Specific responsibilities for complex care management for entire care team including the care coordinators will be developed. Care coordinators are being assigned to the clinics in DY12. All staff will be trained on the complex care management program with training over time for new and existing care coordinators and other team members.

Technology: SJGH/SJCC plans to use its enterprise-wide Cerner EHR to support patients and care teams throughout the care management program.

Patient engagement and education: Care coordinators will work with physicians and patients to engage identified patients in the program. SJGH/SJCC will explore chronic disease self-management programs and partnering with third party content providers in ensuring that educational materials are available to meet the cultural, linguistic, and health literacy needs of the target population.

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

The target population for this project and for its four associated metrics is the subset of the PRIME eligible population at least age 18 with four or more chronic medical conditions during the preceding demonstration year. The PRIME eligible population is defined as individuals with at least two encounters at SJCC or individuals continuously assigned by their Medi-Cal managed care plan to SJCC PCPs for a minimum of 12 months. We may further refine the target population for this project based on algorithmic risk stratification analyses that we undertake in the early part of the project surrounding implementation of core component 2.3.3.

This project will enable SJGH/SJCC to transform its practices to directly improve care for high-risk and rising risk patient populations through the following:

- Development and implementation of an evidence-based complex care management program based on Medicare CCM methodology
- Patient identification through risk stratification enabling provision of focused services based on risk
- Trained care coordinators embedded in engaged and well trained care teams

- Patient engagement and education with a focus on self-care and self-management

Patients identified at high or rising risk will have a central point of contact for their care team. The care coordinator will work with a patient's PCP to design a care plan addressing clinical and non-clinical issues and coordinate with the rest of the care team. The care coordinator will establish positive, trusting connections with patients to help engage them in their care and ensure that they have their health care needs met. They will track patient activity, provide education, manage referrals, and support patient self-management of their chronic conditions.

These care coordinators will also identify and help patients address non-clinical barriers to care such as lack of transportation or unstable housing. They will also develop strong linkages with community resources and work with HPSJ's case managers to assist patients to access community resources as needed.

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.
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.

Check, if applicable	Description of Core Components
Applicable	**2.3.6** Develop a multi-disciplinary care team, to which each participant is assigned, that is tailored to the target population and whose interventions are tiered according to patient level of risk.
Applicable	**2.3.7** Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets.
Applicable	**2.3.8** Implement evidence-based practice guidelines to address risk factor reduction (smoking cessation/immunization/substance abuse identification and referral to treatment/depression and other behavioral health screening, etc.) as well as to ensure appropriate management of chronic diseases: • Use standardized patient assessment and evaluation tools (may be developed locally, or adopted/adapted from nationally recognized sources). Use educational materials that are consistent with cultural, linguistic and health literacy needs of the target population.
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.

☒ 2.7 – Comprehensive Advanced Illness Planning and Care

1. *Summarize approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words]*

Advanced illness planning/care is directly aligned with SJGH/SJCC's strategic priorities of improving access to patient and family-centered care, improving quality of care and patient satisfaction with a focus on high-risk/high cost-populations, and reducing cost of care.

SJGH has operated an inpatient palliative care program since 2013 and recently sought and received funding from California Healthcare Foundation (CHCF) to establish an ambulatory palliative care program. Using lessons learned from the inpatient program and technical assistance from CHCF, SJGH/SJCC seeks to significantly enhance advanced illness planning/care for its patients and make it available as soon as possible after diagnosis in the ambulatory setting.

Our approach will include:

Program eligibility criteria: While the inpatient program is available for all patients diagnosed with terminal illness, the ambulatory program will initially focus on HPSJ members. This will ensure availability of data to document program outcomes and agree on plans for sustaining the program beyond HPSJ members in DY13.

Finalizing ambulatory program components and care team: The interdisciplinary palliative care workgroup led by board-certified palliative care physicians will finalize program components, formalize program relationships with local hospices, and prepare for ambulatory program to begin in DY12. SJGH/SJCC will be hiring a social worker and program coordinator. Physician education on palliative care and advanced illness planning, program eligibility, etc. will be ongoing.

POLST completion improvement efforts: SJGH/SJCC will develop and implement a physician and patient outreach/education campaign. We will work with HPSJ to help them educate their members.

Ongoing program evaluation and continuous improvement efforts: With SJGH/SJCC's data; claims, lab, and pharmacy data from HPSJ; and technical assistance from CHCF's consultants, we will model and track program outcomes and fiscal impact for both SJGH/SJCC and HPSJ that will derive from offering earlier access to palliative care. We will identify and make improvements as needed.

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

The target population for this project and for its six associated metrics is the subset of the PRIME eligible population with a stage 4 cancer diagnosis or with advanced end-organ failure. The PRIME eligible population is defined as individuals with at least two encounters at SJCC or individuals continuously assigned by their Medi-Cal managed care plan to SJCC PCPs for a minimum of 12 months.

Through the initiation of advanced illness planning and care in the ambulatory care setting, data-driven enhancements to the inpatient and ambulatory care palliative care services, outreach to encourage the completion of POLST forms, and physician training on advanced illness planning, this project seeks to improve health outcomes and satisfaction for patients in the target population.

Through this project, SJGH/SJCC will help patients and their families understand, plan for, and guide their treatment for terminal illnesses. Inpatient and outpatient palliative care services will be provided by an interdisciplinary team of physicians, nurses, and social workers with linkage to hospice and other community resources as needed. The ambulatory palliative care team will assess and address pain, assess and address psychosocial emotional and spiritual issues, discuss and document goals of care, and link with hospice and other community resources.

The project will result in improved advanced care planning, significant increase in number of patients with completed POLST forms, improved pain management, improved patient and family satisfaction with care, improved health outcomes, earlier connection to hospice, reduction in unnecessary emergency room visits, reduction in time in the hospital, and a decrease in hospital deaths.

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

Check, if applicable	Description of Core Components
Applicable	**2.7.1** Establish or expand both ambulatory and inpatient palliative care (PC) programs that provide: • Total, active and individualized patient care, including comprehensive assessment, inter-professional care planning and care delivery. • Support for the family. • Interdisciplinary teamwork. • Effective communication (culturally and linguistically appropriate). • Effective coordination. • Attention to quality of life and reduction of symptom burden. • Engagement of patients and families in the design and implementation of the program.

Check, if applicable	Description of Core Components
Applicable	**2.7.2** Develop criteria for program inclusion based on quantitative and qualitative data: • Establish data analytics systems to capture program inclusion criteria data elements.
Not Applicable	**2.7.3** Implement, expand, or link with, a Primary Palliative Care training program for front-line clinicians to receive basic PC training, including advanced care planning, as well as supervision from specialty PC clinicians. Assure key palliative care competencies for primary care providers by mandating a minimum of 8 hours of training for front line clinicians in communication skills and symptom management.
Applicable	**2.7.4** Develop comprehensive advance care planning processes and improve implementation of advance care planning with advanced illness patients.
Applicable	**2.7.5** Establish care goals consistent with patient and family preferences, and develop protocols for management/control of pain and other symptoms in patients with advanced illness, including a holistic approach that includes spiritual and emotional needs.
Applicable	**2.7.6** Improve completion of Physician Orders for Life-Sustaining Treatment (POLST) with eligible patients and participate in the state-wide POLST registry.
Not Applicable	**2.7.7** Provide access to clinical psychologist on the palliative care team to address psychological needs of patient and the family members during the advanced illness and provide grief counseling and support to the family after death of their loved ones.
Applicable	**2.7.8** Enable concurrent access to hospice and curative-intent treatment, including coordination between the providing services.
Applicable	**2.7.9** Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice, including linkage with PC training program.
Applicable	**2.7.10** For advanced illness patients transitioning between primary care, hospital, skilled nursing facilities (SNFs), and/or home-based environments, ensure that the advance care plan is clearly documented in the medical record and transmitted in a timely manner to the receiving facilities and care partners who do not have access to the health system's medical record.

Check, if applicable	Description of Core Components
Applicable	**2.7.11** Engage staff in trainings to increase role-appropriate competence in palliative care skills, with an emphasis on communication skills.
Applicable	**2.7.12** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

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

☒ 3.2 – Resource Stewardship: High Cost Imaging

1. Summarize approach to designing and implementing the project. Include a rationale for selecting the project and planned approach to implementation. [No more than 300 words]

This project was selected due to difficulties our patients experience in accessing diagnostic and other ancillary services. Seeing an important opportunity to improve access, the waiver implementation team working on this project devised the following two broad deliverables:

Achieve clinical consensus: A multispecialty team of primary care physicians, medical and surgical subspecialists, and radiologists will curate existing evidence-based guidelines from a variety of sources. ACR Appropriateness Criteria and Choosing Wisely are two key sources, but the team will pull from the existing literature on the three entities we aim to impact (low back pain, headache, and pulmonary embolism). While clinical focus will be on best practices and evidence-based indications for imaging, comprehensive guidance on diagnostic and therapeutic management for these three entities will also be provided. This activity is expected to be completed in DY12, but the clinical group will be convened periodically throughout the waiver period.to refine the clinical protocols as the body of literature/evidence evolves.

Protocols will be socialized among medical staff through medical staff committees, departmental meetings, email/web/intranet communications, and peer review activities.

Use technology to influence provider behavior: In addition to educational activities aimed at standardizing provider practice, we intend to build clinical decision support alerts in our EMR to reinforce and sustain evidence-based practices. Particular attention will be given to determining our costs for the various imaging studies included in our protocols and attempts will be made to include cost-related feedback to our providers at the time of ordering via CPOE. In addition, we plan to use analytical tools within the EMR to examine and monitor adherence to our evidence-based order sets, measuring the reason for alert overrides and using that information to further refine our protocols. The activities described here can only be achieved once our enterprise Cerner EMR is implemented and optimized for such use (DY13 and beyond).

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

The target population for this project and for its four associated metrics is the PRIME eligible population or any individual with any acute care utilization at the PRIME Entity

during the measurement period. The PRIME eligible population is defined as individuals with at least two encounters at SJCC or individuals continuously assigned by their Medi-Cal managed care plan to SJCC PCPs for a minimum of 12 months.

The reduction of inappropriate and/or unnecessary high cost imaging will help SJGH/SJCC improve care for the target population in several ways:

- Reducing unnecessary demand for diagnostic services allows patients that do require imaging more timely access to services. At the present time, waits and delays for outpatient imaging appointments of several days up to a few weeks are not uncommon. For emergency department and inpatient imaging, there is often backlog in the CT scanner that negatively impacts patient throughput in the ED and hospital.
- For those patients that have a share of cost for their appointments and diagnostic services, there are net reductions in out-of-pocket costs. Several of our patients pay for diagnostic services in cash so this project could ease their financial burden.
- Following evidence-based imaging protocols has the effect of decreasing unnecessary radiation exposure.
- Deferring non-evidence based imaging allows clinicians to make more timely interventions rather than waiting for imaging results before treating symptoms or making other management choices. Additionally, patients need not make an extra office visit for results.
- Reducing the number of inappropriate imaging tests improves patient experience for the reasons mentioned above but also by reducing the anxiety of waiting for imaging results. When clinicians are confident that they are following evidence-based protocols that have been developed by experts and vetted by peers, they also inspire confidence in their patients.
- Unnecessary imaging can yield false positive or incidental results that require additional work-up. This adds avoidable cost, patient anxiety, and delay.

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

Check, if applicable	Description of Core Components
Not Applicable	**3.2.1** Implement an imaging management program, demonstrating engagement of patients in the design and implementation of components of the project.
Applicable	**3.2.2** Program should include identification of top imaging tests whose necessity should be assessed for possible overuse. Criteria for assessment could include: • Frequency and cost of inappropriate/unnecessary imaging:

Check, if applicable	Description of Core Components
	○ Appropriate Use: Beginning with state- or nationally-recognized models or guidelines (e.g., American College of Radiology Appropriateness Criteria, American College of Cardiology Appropriate Use Criteria) and incorporating pertinent local factors, programs will set out definitions for appropriateness. ○ Cost: Programs will identify imaging studies associated with high costs due to high cost per study or high volume across the system. • Unwarranted practice variation within the participating DPHs/DMPHs. Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed. • Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed. • Whether there are established, tested and available evidence-based clinical pathways to guide cost-effective imaging choices.
Applicable	**3.2.3** Establish standards of care regarding use of imaging, including: • Costs are high and evidence for clinical effectiveness is highly variable or low. • The imaging service is overused compared to evidence-based appropriateness criteria. Lack of evidence of additional value (benefits to cost) compared to other imaging options available to answer the clinical question.
Applicable	**3.2.4** Incorporate cost information into decision making processes: • Develop recommendations as guidelines for provider-patient shared decision conversations in determining an appropriate treatment plan. • Implementation of decision support, evidence-based guidelines and medical criteria to recommend best course of action.
Applicable	**3.2.5** Provide staff training on project components including implementation of recommendations, and methods for engaging patients in shared decision making as regards to appropriate use of imaging.
Not Applicable	**3.2.6** Implement a system for continual rapid cycle improvement and performance feedback that includes patients, front line staff and senior leadership.

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 $ 40,133,800
- DY 12 $ 40,133,800
- DY 13 $ 40,133,800
- DY 14 $ 36,120,420
- DY 15 $ 30,702,357

Total 5-year prime plan incentive amount: $ 187,224,177

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.