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

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

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General Instructions

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

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

Scoring

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

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

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

Section 1: PRIME Participating Entity Information

Health Care System/Hospital Name

Salinas Valley Memorial Healthcare System

Health Care System Designation (DPH or DMPH)

DMPH

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.

Low infant birth weight. Black and Asian/Pacific Islander mothers are more likely to have a low-birth weight infant. For prenatal care, Hispanic women are the least likely to enter prenatal care in the first trimester (only 71%).

Communicable diseases. Black residents have the highest rate of newly diagnosed chronic Hepatitis C infection (236.9 per 100,000). Males are also significantly more likely to be diagnosed with chronic Hepatitis C (431.0 per 100,000). Similarly to Hepatitis C, black residents are significantly more likely to be diagnosed with new HIV/AIDS cases than the average (21.3 per 100,000 vs. 8.7 per 100,000 in Monterey County). Similar disparities are seen with Chlamydia and Gonorrhea.

Chronic diseases. In 2008 to 2010, 37.1 per 100,000 Monterey County residents died from a stroke, and 137.5 per 100,000 died from heart disease. Heart disease is the leading cause of death in Monterey County. Diabetes incidence, meanwhile, has increased since 2003 (jumping from 6.8% to 9.7% in males and from 5.3% to 9.7% in females). However, the diabetes mortality rate has decreased over time and was 17.1 per 100,000 in 2010.

Cancer. Cancer is the second leading cause of death in Monterey County. White residents are significantly more likely to be diagnosed with cancer (444.6 per 100,000 in 2010) than Hispanic residents but are less likely to die of cancer. White resident mortality is 43.9 per 100,000 while Hispanic resident mortality is 48.6 per 100,000.

Behavioral health. Between 1991 and 2010, the suicide rate for females more than doubled. Suicide rates are higher among residents age 45 and older than residents age 44 and younger. Accidental poisoning/unintentional drug-related mortality is highest for white and black residents.

Health behaviors. About 10% of the adult population in Monterey County is a current smoker. Asian/Pacific Islander and white residents are significantly more likely to be a current smoker. However, that has generally been on the decline since

2003. Binge drinking continues to be an issue among certain populations, including Hispanic/Latino and white residents.

Disparities. In general, mortality rates are consistently lower for white, non-Hispanic populations than for black and Hispanic residents. All of Monterey County is designated as a primary care shortage area by the federal Health Resources and Services Administration, and most of the county is medically underserved for dental and mental health.

Data sources are listed in Appendix B.

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.

SVMHS' service area encompasses Monterey County, located south of the San Francisco Bay Area along the coastline. Monterey County is 3,771 square miles, and the largest city in Monterey County is Salinas.

As of 2012, there were 426,762 residents living in Monterey County. The population is primarily Hispanic/Latino (56%), followed by white residents (32%). This represents a significant growth in the Hispanic/Latino population since 2000, which was only 47% of the population in 2000.

The population is similar to the state in age breakdown:

- 0-19 years: 30%
- 20-64 years: 49%
- 65+ years: 11%

Nearly 40% of residents live at or below 200% of the Federal Poverty Level ($23,492 for a family of four). There is a disparity between Hispanic/Latino and black poverty rates (25% and 22%), when compared to the white, Non-Hispanic population (8%).

The education levels of the population have remained steady since 2000, with 30% of the population having less than a high school education.

For the population over 5 years of age, 47.4% speak Spanish at home, and 45.8% speak English at home. 15% of households are considered "linguistically isolated households" because no one over age 14 speaks English "very well."

Data sources are listed in Appendix B.

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.

Salinas Valley Memorial Healthcare System (SVMHS) is an integrated network of healthcare programs, services and facilities. Salinas Valley Memorial Hospital, a Public District Hospital, is the cornerstone of SVMHS. It is a 269-bed acute care hospital with a medical staff of 300 board-certified physicians across a range of specialties, and partners with affiliates to enhance and expand care throughout the region.

SVMHS has a number of distinct specializations and programs, including the Harden Memorial Heart Program, Joint Replacement Center, Regional Spine Center, a Comprehensive Community Cancer Program, Level III Neonatal Intensive Care Unit, Wound Healing Center, Sleep Medicine Center and the Ryan Ranch Center for Advanced Diagnostic Imaging. SVMHS also has the region's only Perinatal Diagnostic Center.

SVMHS operates a 1206(b) clinic to provide specialty and primary care. Salinas Valley Medical Clinic is a multi-specialty medical clinic staffed by physicians who are board-certified in cardiology, pulmonology, critical care, neurology, endocrinology and general surgery. The clinic offers services such as Health Care for Women, an Advanced Migraine Treatment Program, and a Diabetics Education Center.

In 2014, the SVMHS payer mix was: 51% Medicare, 25% Commercial and 20% Medi-Cal.

Data sources are listed in Appendix B.

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.

SVMHS has multiple data systems for inpatient, outpatient and ambulatory clinic service lines. This includes data systems that support Salinas Valley Medical Clinic and Doctors on Duty Urgent Care of which SVMHS is an 85% owner.

Current resources: Currently, there are FTEs placed in different system areas to assist with data analytics. There is a team that oversees the inpatient analytics, a team of two that manages the outpatient analytics, and a financial analyst. Additionally, Cypress Health Partners MSO provides analytic services for the medical groups, Salinas Valley Medical Clinic and Doctors on Duty. Analytic capabilities have been developed to report on standard measures such as the Physician Quality Reporting System (PQRS) and for program such as Patient-Centered Medical Homes. These resources are charged with collecting, reporting and monitoring performance. The related SVMH ambulatory clinics are all on their own EMR systems. As part of PRIME, we will be working to develop interoperability solutions for reporting and other necessary analytic capacity to meet the current and future needs of these initiatives and provide sustainability. This includes manual data analysis as well as health information technology solutions. Data will be extracted by working with the data teams to define metric specifications and running queries in each system.

Barriers and mitigation strategy: The disparate data systems are currently the most significant obstacle to streamlined baseline data reporting. Establishing the denominator requires SVMHS to identify visits across multiple systems with or without a Master Patient Index and determine who has had two visits or more per the denominator guidelines of the program. Additionally, outcomes must be pulled using a common patient identifier from all the systems and subsequently deduplicated. SVMHS is exploring both short-term and long-term solutions to the data analytics needs, including purchasing analytics software and bringing on an additional FTE to serve as the PRIME data analyst. Short-term solutions will include manual data flow and deduplication procedures. Long-term solutions include interoperability solutions and larger HIT infrastructures such as a data warehouse or real-time bidirectional data sharing.

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.*

Under PRIME, SVMHS will continue to transform care for all members and their families. Through alignment and collaboration with local healthcare providers, PRIME projects will drive improvements across the care continuum in the inpatient, ambulatory and community space settings. Our main goals can be summarized below:

1. Our customers (defined as patients, members, providers and the community at large) experience a seamless and prevention-based system of care.
2. We have developed a coordinated team approach that includes clear roles, seamless hand-offs and integration across the hospital, physician office, home, and community points of access to our integrated delivery network.
3. We are not only the top provider of choice for families and individuals irrespective of financial means and background, but their health and wellness "home."
4. Our organization, coordinating with our partners across the community, reduces duplicative services and maximizes synergies.
5. Create a "whole-person" approach to care that encompasses the mental, physical and socioeconomic aspects of care.

All of these goals are supported by the implementation of PRIME and vice versa. SVMHS' drive towards accountable, value-based care aligns with the PRIME goal of creating more ambulatory, preventive care that manages patients outside of the hospital, and reducing cost within the hospital. Many of the PRIME projects aim to treat patients as a whole person, which is a significant driver of SVMHS strategy.

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.*

   SVMHS has three aims related to PRIME participation and under which our PRIME projects fall:
   1. Increase access to preventive services to reduce the need for more costly services and prevent health complications and disease progression to more severe conditions
   2. Provide evidence-based best practice care, including care coordination and/care transition support and patient education
   3. Lower the total cost of care

   These three aims will help SVMHS achieve its larger strategic goals, stated above in Section 3.1.1. All of these strategies, if carried out effectively, will push the organization toward managing the "whole person." SVMHS will reduce the total cost of care for the system while keeping its patients healthy by pushing forward preventive care; creating care transitions and coordination support to prevent and decrease recidivism; increasing patient education/self-management; and better utilizing resources.

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;*

   Each of the projects selected was chosen because of their match with SVMHS organizational goals and project aims. When discussing project selection, strong consideration was given to how the project, when successful, will eventually transform care to be more preventive (projects 1.4, 1.5, 1.6), be a best practice (2.2, 2.3 and 2.7) and push towards a lower total cost of care (3.1, 3.4).

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*

   All the projects were selected because they work towards an integrated continuum of care, including all care settings and environments from inpatient to outpatient. We believe that all projects will positively impact the success of

the other, because patients who are treated well in any setting will have better overall health outcomes in the system. We believe that projects in Domain 1 (1.4, 1.5, 1.6), will ensure that patients receive preventive care to reduce the need for acute services and decrease the potential for additional complications. However, once they are in the hospital, projects in Domain 2 (2.2, 2.3 and 2.7), will ensure that they experience seamless care transitions to outpatient care settings, including primary care and palliative care. Projects in Domain 3 (3.1 and 3.4) will bolster the effectiveness of projects in Domain 1 and 2, as resource stewardship allows the system to allocate and manage appropriate resources to other sources of care.

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.*

SVMHS will be an integrated health and wellness system that provides comprehensive care to all members and their families. Through alignment and collaboration with local healthcare providers and other community and health care organizations, we are able to partner with our patients - our members - to support and encourage wellness. We are a valued presence in our members' lives and our exceptional team of clinicians and staff provide "whole-person", coordinated, high quality, culturally sensitive, cost effective care across the continuum. As a system that takes its stewardship of the health care dollar seriously, our alignment of financial incentives allows our providers to emphasize the importance of prevention and wellness; focusing on providing the right care, at the right place at the right time.

We anticipate that PRIME will result in 1) reduced inappropriate ED usage (clinical), 2) increased ability to take on value-based payments (finance) and 3) the development of standardized protocols for all care transitions within the system (infrastructure).

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.

The projects that SVMHS has selected were chosen because they address the health needs and disparities present in the service area, which is Monterey County. Health needs in **bold** were referenced in Section 2 of the PRIME plan.

Projects 1.4 (patient safety), 1.5 (Million Hearts) and 1.6 (cancer screening) all address the burden that **chronic diseases** have on the community's morbidity and mortality. **Cancer** and **heart disease** are notable health needs because of their leading roles in mortality in Monterey County.

Project 2.2 aims to address the **health behaviors** of patients following an inpatient stay, in order to prevent readmissions by connecting them with primary care and the appropriate resources to self-manage their conditions. This includes appropriate **behavioral health** resources that are often co-morbidities.

Project 2.3 aims to improve care management for the complex care of **chronic disease** patients by specifically addressing the **diabetes** population.

Overall, all projects (including projects 2.7, 3.1 and 3.4) are aimed at improving quality along the care continuum. This includes reducing disparities in care and ensuring that all care is evidenced-based and culturally competent, which will help reduce the **disparities** present in the health needs.

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).

SVMHS has a strong infrastructure for providing inpatient and outpatient care, and has recently expanded to include a 1206(b) clinic and partnerships with medical groups. There has been a strategic plan developed to set the organization's goals for the next five years.

SVMHS has had success in implementing several value-based care mechanisms, including Meaningful Use and the Physician Quality Reporting System. The data infrastructure is in place to track measures for these quality programs, and they will

be expanded for reporting the PRIME metrics. SVMHS will conduct a current state assessment to understand what data needs to be captured to measure PRIME progress. Improvements to the data infrastructure will include capturing data from other (ambulatory) systems and developing data sharing agreements.

SVMHS will also develop a PRIME project management office to plan, implement, and track the PRIME projects. SVMH's success with each of the projects will be dependent upon project performance effectiveness (and associated patient care improvements) as well as the documentation and timely reporting of metrics (i.e., data benchmarks). SVMH will need to strengthen relationships with partners involved in outpatient care, to ensure they are delivering appropriate clinical care as reflected in the PRIME projects. The project management office will apply process improvement methodologies and effective project management solutions to create metric improvements.

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.

SVMHS will implement PRIME in a manner that is:
Transparent: Decision-making process that is clear to participants;
Collaborative: Developing plans and making decisions through a collaborative process that reflects the needs of SVMHS communities and input of stakeholders; and
Accountable: Holding all stakeholders to common performance standards, deliverables and timelines.

Stakeholders will be engaged on a regular basis to discuss the impact of PRIME project implementation and how it impacts the continuum of care across the county. Stakeholders include: local physician partners and medical groups, community clinics, hospitals, behavioral health providers, long-term care, home health and social support services. Patients and the community will be informed on a regular basis of the impacts of PRIME and how it is improving care in the county.

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.

SVMHS leads Salinas Valley and Monterey County in convening, driving and integrating efforts to reduce health disparities and in establishing population health metrics that move us toward the vision of a model health community. We have an increased focus and attention on improving community-level population health in order to enhance the wellness of our community at large. Our efforts are focused on increasing the community's embrace of healthy habits and a healthy culture.

Each of the PRIME projects will be tailored to account for the cultural differences in the community. The SVMHS service area has a significant percentage of Hispanic residents, which continues to grow. This makes it more important to account for how cultural differences might affect what care patients choose and how they adhere to their care, as well as what social support services are available. Each PRIME intervention will be examined to see whether a specific process needs to be altered for specific populations, and what education needs to be provided for both the population and the providers.

To that end, SVMHS works to ensure that its staff are culturally competent through trainings, as well as hiring bilingual staff. All materials are translated when possible to ensure access for diverse populations. SVMHS is currently undergoing an organization wide cultural competency assessment that will drive additional improvements in community engagements.

3.6 Sustainability. [No more than 150 words]

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

As referenced in section 3.3.3, SVMHS will develop a PRIME project management office (PMO) to implement the projects and ensure long-term sustainability of the interventions. SVMH's long-term vision is to develop capacity and capabilities that will ensure success in managed care, population health management and value-based purchasing. All the work done through PRIME would not only be compatible with this long-term goal but help provide the internal culture and infrastructure to facilitate this transformation. The project management office will, among all traditional PMO competencies:

1. Develop project plans and budgets for all PRIME projects
2. Identify timelines for rolling out projects and metric improvement efforts
3. Engage stakeholders at all levels to ensure project success
4. Manage data analytics and reporting

After PRIME participation ends, the PMO will shift to carrying out similar transformational initiatives for the organization (most likely including the PRIME projects in another iteration or form).

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

☒ 1.4 – Patient Safety in the Ambulatory Setting

SVMHS has recently increased capacity for care in the ambulatory setting by expanding its 1206 (b) and (d) clinics, in addition to further development and growth of its urgent care network Doctors on Duty. Along with this expansion, SVMHS realizes the importance of keeping the same level of quality that it maintains in the inpatient setting. Physician and clinic leadership are constantly improving the care provided in the ambulatory setting through implementation of patient-centered medical homes and care protocols. This PRIME project will allow the clinics to improve monitoring for patients on persistent medications and ensure that patients with abnormal test results receive the appropriate follow-up. Through this project, SVMHS will:

1. Develop and/or improve protocols for follow-up after abnormal test results in DY12
2. Develop and/or improve protocols for annual monitoring for persistent medications in DY12
3. Identify best practices for patient safety in the ambulatory setting DY11
4. Conduct baseline studies and identify areas for process improvement in DY11
5. Train staff on standardized workflows for patient safety in DY12
6. Modify electronic medical record notifications as necessary to ensure that the proper flags are raised for patient safety in the ambulatory setting in DY12

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

Target population
The target population is all patients treated through SVMHS ambulatory clinic settings: Salinas Valley Medical Clinic, Doctors on Duty and Taylor Farms Family Health and Wellness Center. The target population is further refined by:

Patients who are on persistent medications including:

1. Angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)
2. Digoxin
3. Diuretics
4. Warfarin

And patients who have abnormal test results for:

5. Mammography
6. Cervical cancer

Vision for care delivery
SVMHS' vision for care delivery through this project is that all patients receive highest quality care through the ambulatory clinic facilities. Patients are monitored early and often for side effects and adverse medication events from long-term usage, especially in elderly patients. Dosages are corrected as necessary and the costs of annual monitoring are offset by the reduction in complications from unmonitored long-term use of persistent medications. Just as importantly, patients with abnormal test results are notified and given the proper follow-up treatment to maximize the effectiveness of early testing for cervical and breast cancer.

This PRIME project works to increase patient safety and quality of life, while preventing complicated or complex treatments from lack of timely follow-up and monitoring. In general, this moves SVMHS towards providing better care at the right time.

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.

SVMHS will perform infrastructure metrics for this project.

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

Check, if applicable	Description of Core Components
Applicable	**1.4.1** Perform a baseline studies to examine the current workflows for abnormal results follow-up and monitoring of individuals on persistent medications.

Check, if applicable	Description of Core Components
Applicable	**1.4.2** Implement a data-driven system for rapid cycle improvement and performance feedback based on the baseline study that effectively addresses all identified gaps in care and which targets clinically significant improvement in care. The improvement and performance feedback system should include patients, front line staff from testing disciplines (such as, but not limited to, radiology and laboratory medicine) and ordering disciplines (such as primary care) and senior leadership.
Applicable	**1.4.3** Develop a standardized workflow so that: • Documentation in the medical record that the targeted test results were reviewed by the ordering clinician. • Use the American College of Radiology's Actionable Findings Workgroup[1] for guidance on mammography results notification. • Evidence that every abnormal result had appropriate and timely follow-up. Documentation that all related treatment and other appropriate services were provided in a timely fashion as well as clinical outcomes documented.
Applicable	**1.4.4** In support of the standard protocols referenced in #2: • Create and disseminate guidelines for critical abnormal result levels. • Creation of protocol for provider notification, then patient notification. • Script notification to assure patient returns for follow up. Create follow-up protocols for difficult to reach patients.
Applicable	**1.4.5** Implement technology-enabled data systems to support the improvement and performance feedback system as well as engage patients and support care teams with patient identification, pre-visit planning, point of care delivery, and population/panel management activities.

☒ 1.5 – Million Hearts Initiative

In Monterey County, heart disease is the leading cause of death. Death from heart disease is preventable, if managed by the patient and their provider. SVMHS is continuing to increase its focus on preventive medicine through the ambulatory setting, which is why we selected this PRIME project. For this project, SVMHS will focus on

[1] *Actionable Findings and the Role of IT Support: Report of the ACR Actionable Reporting Work Group. Larson, Paul A. et al. Journal of the American College of Radiology, Volume 11, Issue 6, 552 – 558. http://www.jacr.org/article/S1546-1440(13)00840-5/fulltext#sec4.3, Accessed 11/16/15.*

identifying evidence-based best practices for reducing heart attacks and strokes, and working with physician and clinic leadership to implement standardized care protocols in the ambulatory setting. These protocols will be rolled out across the system to impact all patients at risk for heart disease or stroke. Our approach will include:

1. Review and incorporate USPSTF recommendations in DY12
2. Train all staff and providers on standardized care protocols in DY12
3. Identify high-risk populations for increased education and preventive care in DY11
4. Develop linkages with community resources to encourage healthy behaviors in DY12
5. Develop or enhance patient education programs to increase self-management of heart disease in DY12

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

Target population

The target population is all patients treated through SVMHS ambulatory clinic settings: Salinas Valley Medical Clinic, Doctors on Duty and Taylor Farms Family Health and Wellness Center. This population is further refined to include those at risk of heart attack and stroke, including those with hypertension, high cholesterol and heart disease (as identified by diagnosis codes).

Vision for care delivery

Similar to other PRIME projects, the vision for this intervention is to provide preventive care in the hopes of reducing hospitalizations and death. SVMHS is committed to being a provider of evidenced-based care, utilizing best practices in standardized protocols. Heart disease is one of the many diseases where adherence to evidence-based medicine can make an impact in the death rate. The Million Hearts Initiative has a wealth of resources on preventing heart attacks and strokes, which SMVHS will draw upon to craft our system-wide protocols.

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.

SVMHS will perform infrastructure metrics for this project.

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

Check, if applicable	Description of Core Components
Applicable	**1.5.1** Collect or use preexisting baseline data on receipt and use of targeted preventive services, including any associated disparities related to race, ethnicity or language need.

Check, if applicable	Description of Core Components
Applicable	**1.5.2** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to the US Preventive Services Task Force (USPSTF) A and B Recommendations.
Not Applicable	**1.5.3** Improve access to quality care and decrease disparities in the delivery of preventive services.
Not Applicable	**1.5.4** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
Not Applicable	**1.5.5** Adopt and use certified electronic health record systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population management approaches (e.g., in-reach, outreach) to reduce gaps in receipt of care.
Applicable	**1.5.6** Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.
Applicable	**1.5.7** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. • Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts.
Not Applicable	**1.5.8** Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.

☒ 1.6 – Cancer Screening and Follow-up

Cancer is the second leading cause of death in Monterey County. Additionally, as identified in Section 2, there is a disparity in the rates of cancer diagnosis versus cancer deaths. White residents are more likely to be diagnosed with cancer but less like to die of cancer than Hispanic residents, suggesting better access to cancer screening and diagnosis resources, and better access to treatment once diagnosed. On the other hand, other populations are less likely to be screened and diagnosed, and late diagnosis can lead to worse outcomes.

For this project, SVMHS will implement standardized cancer screening guidelines for ensuring that all eligible patients get screened according to the recommended schedule. This could include:

1. Colon cancer screening for adults between 50 and 75 years old
2. Breast cancer screening for women 50-74 years on a biannual basis
3. Cervical cancer screening every three years for women age 21 to 65

SVMHS will:

1. Update all protocols to match USPSTF recommendations as is appropriate in DY12
2. Train staff on updated protocols in DY12
3. Update electronic medical records workflows to include flags for screenings in DY12

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

Target population

The target population for this project is any patient treated through the SVMHS ambulatory clinics settings (Salinas Valley Medical Clinic, Doctors on Duty and Taylor Farms Family Health and Wellness Center) who meets the eligible criteria for screening as defined above. These patients will be identified by their age and gender for the project denominator.

Vision for care delivery

Regular screening for cancer based on recommended guidelines are the key in early detection. Early diagnosis leads to better outcomes, which why it is so important that all populations in Monterey County get screened on a regular basis. SVMHS will be a leader in ensuring that patients are given the appropriate screenings based on evidence-based clinical guidelines. Additionally, screening according to the recommended schedule is important in reducing adverse side effects from unnecessary screening.

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.

SVMHS will implement infrastructure metrics for this project.

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:
	  ○ Enterprise-wide standard approach to screening (e.g., ages, frequency, diagnostic tool).
	• Follow-up for abnormal screening exams:
	  ○ Clinical risk-stratified screening process (e.g., family history, red flags).
	Timeliness (specific time benchmark for time from abnormal screening exam to diagnostic exam).

Not 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.
Not Applicable	**1.6.5** Improve access to quality care and decrease disparities in the delivery of preventive services.
Not 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.
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.

Check, if applicable	Description of Core Components
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):		**3**
Domain 1 Total # of Projects:		**3**

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

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

Recently, SVMHS began implementing a post-acute care transitions program that was aimed at reducing preventable complications after an inpatient stay or reoccurrence of health problems. This has been identified as a need because SVMHS sees many patients who are frequent ED utilizers or readmit when they do not have access to the primary care needed to manage conditions after an acute episode. Chronic disease is a noted health disparity [referenced in Section 2] and is a major contributor to repeated utilization. There will be a focus on connecting patients to the appropriate level of care during the discharge process, especially for patients with less resources or health literacy to navigate the system. This will ensure that patients have a primary care or behavioral health resource after their hospital stay to manage their condition. On the other side of the discharge process is the primary care, specialist or behavioral health provider -- this project will also work on identifying best-fit providers and networks to begin building referral patterns for this population.

We will utilize the following strategies to improve post-acute care transitions. The majority of these improvements will occur in DY12:

- Increase access to Salinas Valley Medical Clinic and Doctors on Duty Urgent Care doctors for post-discharge follow-up appointments
- Increase care manager capacity to assess all patients and arrange needed discharge resources
- Identify a designated staff member to make all post-discharge follow-ups for all patients
- Work with the ED care manager to look into programs for frequent fliers
- Increase education for patients prior to discharge
- Increase access to behavioral health services

Additionally, SVMHS will begin building the capabilities to report on all metrics for the PRIME project, which will also be used as decision support in developing care transitions interventions. This includes identifying particular patient populations, such as particular chronic diseases, to focus efforts in improving post-acute transitions.

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

Target population
The initial target population is all discharged patients including those without a primary care physician or those who need home care. The target population for this project will be further refined through review of data to identify which patient populations are most at risk for readmissions and/or in need of care post-discharge.

Vision for care delivery
SVMHS believes that this project is integral to the vision of the organization in better managing care outside of the hospital, by addressing the needs of the whole person post-discharge. The vision is that the hospital will link patients to the care system that includes primary care physicians, behavioral health providers, specialists, home health, social support services, housing, hospice and others integral to the care continuum.

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.*

SVMHS will implement infrastructure building metrics for this project.

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.

Applicable	**2.2.4** Develop standardized workflows for inpatient discharge care:
	• Optimize hospital discharge planning and medication management for all hospitalized patients.
	• Implement structure for obtaining best possible medication history and for assessing medication reconciliation accuracy.
	• Develop and use standardized process for transitioning patients to sub-acute and long term care facilities.
	• Provide tiered, multi-disciplinary interventions according to level of risk:
	  ○ Involve mental health, substance use, pharmacy and palliative care when possible.
	  ○ Involve trained, enhanced IHSS workers when possible.

Check, if applicable	Description of Core Components
	○ 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.
Not 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.
Not Applicable	**2.2.9** Demonstrate engagement of patients in the design and implementation of the project.

Check, if applicable	Description of Core Components
Not 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)

SVMHS has selected this project to further improve efforts underway to address care management for high risk populations in the community. As identified in section 2, chronic disease has a high prevalence among Monterey County residents but has potential for improved outcomes when associated with care management. The focus of this project will be on aligning **diabetes** patients with appropriate resources to better manage their care and improve symptoms. SVMH anticipates 1,569 – 3,139 new diabetes diagnoses by 2020 as one in four adults is currently at risk of being pre-diabetic.

Our planned implementation approach includes:

- Physician training program during DY11 to educate physicians of SVMHS' best practices for care management of patients with chronic disease. Training will include education regarding teaching patients to self-manage, medication reconciliation and coordinating care with outpatient services.
- Identification of high-utilizing patients throughout DY11 and DY12 as well as qualitative assessment of treatment and care management.
- Establish a point of care registry in DY12
- Expand ambulatory case management in DY12
- Incorporating focus on education and self-management of chronic conditions into treatment plans before patients are discharged, including group education classes during DY12
- Emphasis on conducting medication reconciliation during provider visits throughout demonstration and establishment of coordinated system for sharing reconciled lists between providers in DY12

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

Target Population. SVMHS has selected all admitted and emergency department patients with a primary or secondary diagnosis of diabetes in the measurement year as the target population for this project. As section 2 notes, diabetes incidence in Monterey County has consistently increased since 2003. This patient population stands to greatly benefit from PRIME through increased opportunities for education, more informed providers and improved care transitions. Development of a care management program prepared to directly address this population will improve the need of patients to utilize acute services.

Vision for Care Delivery. SVMHS envisions a comprehensive diabetes care management program will equip both patients and providers with the necessary knowledge and resources to vastly improve health outcomes. Initially, a comprehensive assessment of the patient population will identify high-utilizing diabetes patients that are most likely to benefit from education and coordinated care. Clinicians will receive training specific to this population for medication reconciliation, best practices for risk reduction, and available outpatient resources. Patients will as a result experience a more coordinated effort in their care management through the alignment of providers, outpatient partners and self-management techniques. SVMHS anticipates measurable improvements in utilization of acute care services, patient health outcomes and costly health care expenditures.

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*

SVMHS will implement infrastructure building metrics for this project.

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.
Not 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).

Check, if applicable	Description of Core Components
	Include patient factors associated with a higher probability of being impacted by complex care management.
Not Applicable	**2.3.4** Conduct a qualitative assessment of high-risk, high-utilizing patients.
Not 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.
Not Applicable	**2.3.6** Develop a multi-disciplinary care team, to which each participant is assigned, that is tailored to the target population and whose interventions are tiered according to patient level of risk.
Applicable	**2.3.7** Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets.
Not Applicable	**2.3.8** Implement evidence-based practice guidelines to address risk factor reduction (smoking cessation/immunization/substance abuse identification and referral to treatment/depression and other behavioral health screening, etc.) as well as to ensure appropriate management of chronic diseases: • Use standardized patient assessment and evaluation tools (may be developed locally, or adopted/adapted from nationally recognized sources). Use educational materials that are consistent with cultural, linguistic and health literacy needs of the target population.
Not Applicable	**2.3.9** Ensure systems and culturally appropriate team members (e.g. community health worker, health navigator or promotora) are in place to support system navigation and provide patient linkage to appropriate physical health, mental health, SUD and social services. Ensure follow-up and retention in care to those services, which are under DPH/DMPH authority, and promote adherence to medications.
Not Applicable	**2.3.10** Implement technology-enabled data systems to support patients and care teams throughout the care management program including patient identification, pre-visit planning, point-of-care delivery, care plan development and population/panel management activities.
Applicable	**2.3.11** Implement a data-driven system for rapid cycle improvement and performance feedback to address quality and safety of patient care, which includes patients, front line staff and senior leadership.

☒ 2.7 – Comprehensive Advanced Illness Planning and Care

SVMHS currently has one physician who is charged with leading efforts to expand appropriate use of palliative care. The team includes a social worker and a nurse, whose aims are to increase knowledge of palliative care options to staff, physicians and patients. They round in the ICU to identify patients who should consider palliative care, based on a set of "trigger criteria." Through this PRIME project, the palliative care team will expand staff and improve the effectiveness of the palliative care services through:

1. Identifying accredited standards and revising protocols to meet standards
2. Revising the trigger criteria tool for palliative care
3. Increase the use of advanced directives and POLST tools
4. Improve adherence to existing advanced directives and the POLST
5. Identify staffing needs and hire staff to manage and deliver palliative care services
6. Increase education for family and caregivers on palliative care and care transitions
7. Develop referral workflows for hospice

SVMHS selected this project because increasing the effectiveness of palliative care services has long been a goal of the organization. A significant percentage of patients in the SVMHS service area are aging with chronic diseases. As an acute care hospital, SVMHS understands the need to incorporate all aspects of care in cases of serious and advanced illness, including identifying cultural differences. The purpose of providing palliative care is to provide the best quality of life for patients and their families while aiming to reduce suffering.

The core components selected below will be modified as such:

1) 2.7.1 will establish only an inpatient palliative care program

In the outpatient setting, SVMH will continue to implement a palliative care program in the oncology program. We plan to hire a palliative care physician for the outpatient setting in DY12. Additionally, SVMH recognizes the importance of ensuring that patients select treatment preferences early in the care planning process, during the initial assessment regardless of the setting – inpatient, outpatient, subacute or other care and treatment facilities. Our program currently includes assessments covering all care settings that support and encourage conversations about end-of-life planning, palliative care and advanced directives. As part of this project, we will expand the outpatient efforts to ensure that patients have treatment preferences.

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

Target population
The target population for this project is admitted patients who are eligible for palliative care or end of life planning, criteria to be defined but which could include (from the National Consensus Project for Quality Palliative Care):

- Children and adults with congenital injuries or conditions leading to dependence on life-sustaining treatments and/or long-term care with support by others with the activities of daily living.
- People of any age with acute, serious, and life-threatening illnesses where cure or reversibility is a realistic goal, but the conditions themselves and their treatments pose significant burdens and result in poor quality of life.
- People living with progressive chronic conditions
- People living with chronic and life-limiting injuries from accidents or other forms of trauma.
- Seriously and terminally ill patients who are unlikely to recover or stabilize and for whom intensive palliative care is the predominant focus and goal of care for the remainder of their lives.

Vision for care delivery
Palliative care involves integration of multiple care team members to best manage symptoms and reduce suffering and pain while considering the psychosocial, cultural and spiritual factors that may influence treatment. The vision for the SVMHS palliative care program is to be able to anticipate the needs of patients and their families in these situations and provide all options such as hospice and pain management. In this way, SVMHS will work to be responsible stewards of care and focus on quality of life in treatment.

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.*

SVMHS will implement infrastructure building metrics for this project.

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.

Check, if applicable	Description of Core Components
	• Engagement of patients and families in the design and implementation of the program.
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.
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.
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.
Not 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

Check, if applicable	Description of Core Components
	facilities and care partners who do not have access to the health system's medical record.
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):		**3**
Domain 2 Total # of Projects:		**3**

Section 4.3 – Domain 3: Resource Utilization Efficiency

☒ 3.1 – Antibiotic Stewardship

SVMHS has recently identified antibiotic stewardship as an area of improvement for the hospital. An antibiotic stewardship program was implemented recently, and this PRIME project was selected to expand the scope and impact of the new program. Through this project, the antibiotic stewardship physician leaders will add to the metrics to measure success, identify best practices, improve protocols and train staff in clinical best practices. Antibiotic stewardship is a best care practice because it reduces unnecessary antibiotic use, which can lead to increase resistance or simply unnecessary use of resources that contributes to the total cost of care. Through this project, SVMHS will:

1. Identify best practices for antibiotic stewardship by reviewing literature and choosing methodologies in DY11
2. Revise or implement protocols for selected antibiotic processes in DY12
3. Train staff and physicians on antibiotic stewardship protocols in DY12
4. Create and update an antibiotic stewardship dashboard with relevant metrics and PRIME metrics in DY12

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

Target population
The target population for this project is all SVMHS admitted patients, and those ambulatory clinic (Salinas Valley Medical Clinic, Doctors on Duty and Taylor Farms Family Health and Wellness Center) patients who present with acute bronchitis or a urinary tract infection.

Vision for care delivery
For the admitted patients, the goal will be to identify how to most effectively prescribe the right treatment and dosage of medications to reduce antibiotic overuse. While they are in the hospital, the antibiotic stewardship program will reduce their chances of C. Diff. infection through best practice use of equipment and cleaning beds. The processes around prophylactic use of antibiotics will be revised to ensure that minimal prophylactic antibiotics are used at the time of surgical closure. For patients presenting with acute bronchitis or a urinary tract infection, physicians will adhere to procedures that indicate when antibiotics are necessary or when the patient can be effectively treated without them. SVMHS will become a leader in the industry for antibiotic resource stewardship while simultaneously improving care for their patients.

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.

SVMHS will be implementing infrastructure metrics for this project.

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

Check, if applicable	Description of Core Components
Not Applicable	**3.1.1** Utilize state and/or national resources to develop and implement an antibiotic stewardship program, such as the California Antimicrobial Stewardship Program Initiative, or the IHI-CDC 2012 Update "Antibiotic Stewardship Driver Diagram and Change Package.[2] • Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**3.1.2** Develop antimicrobial stewardship policies and procedures.
Not Applicable	**3.1.3** Participate in a learning collaborative or other program to share learnings, such as the "Spotlight on Antimicrobial Stewardship" programs offered by the California Antimicrobial Stewardship Program Initiative.[3]
Applicable	**3.1.4** Create standardized protocols for ordering and obtaining cultures and other diagnostic tests prior to initiating antibiotics.
Applicable	**3.1.5** Develop a method for informing clinicians about unnecessary combinations of antibiotics.
Not Applicable	**3.1.6** Based on published evidence, reduce total antimicrobial Days of Therapy (DOT) by providing standards and algorithms for recommended agents by disease type, focusing on short course regimens (e.g., 3-5 days of therapy for uncomplicated cystitis, 7 days for uncomplicated pyelonephritis, 5-7 days for uncomplicated non-diabetic cellulitis, 5-day therapy for community acquired pneumonia (CAP), 7-8 days for therapy for VAP or hospital acquired pneumonia).
Applicable	**3.1.7** Develop evidence-based computerized provider order entry (CPOE) algorithms and associated clinician training, to support antibiotic stewardship choices during order entry. These could include approaches such as guidelines for duration of antibiotics, within drug class auto-

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

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

Check, if applicable	Description of Core Components
	switching for specific antibiotics and doses, or restriction of specific antibiotics at the point of ordering (e.g., broad spectrum agents).
Applicable	**3.1.8** Implement stewardship rounds focusing on high yield drugs to promote de-escalation after the drugs are started, such as regular antibiotic rounds in the ICU.
Applicable	**3.1.9** Improve diagnostic and de-escalation processes to reduce unnecessary antibiotic use based upon length of therapy or antibiotic spectrum, such as: • Procalcitonin as an antibiotic decision aid. • Timely step-down to oral antibiotic therapy to support early discharge from the hospital for acute infections. • Use of oral antibiotics for osteomyelitis to reduce prolonged IV exposures.
Not Applicable	**3.1.10** Evaluate the use of new diagnostic technologies for rapid delineation between viral and bacterial causes of common infections.
Not Applicable	**3.1.11** Adopt the recently described "public commitment" strategy in outpatient clinics to encourage providers not to prescribe antibiotics for upper respiratory tract infections (URIs).
Not Applicable	**3.1.12** Publish organization-wide provider level antibiotic prescribing dashboards with comparison to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.
Applicable	**3.1.13** Implement a system a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

☒ 3.4 – Resource Stewardship: Blood Products

SVMHS currently has a transfusion committee who manages the utilization of blood products for the hospital. The committee consists of physicians and staff who are tasked with establishing standard transfusion practices. It is crucial that hospitals have strong blood products management policies and procedures to ensure appropriate use of transfusions and safety for patients. SVMHS recently recognized the need to have a transfusion committee in order to meet best practices standards, reduce errors and prevent adverse outcomes. Transfusions are common but not all are necessary, and they can be costly (in terms of staffing and potentially preventable complications). To that end, the committee has begun creating policies and measuring outcome metrics. The focus of the committee includes:

- ordering practices
- patient identification
- sample collection and labeling
- infectious and non-infectious adverse events
- near-miss events
- usage and discard
- appropriateness of use
- blood administration policies
- the ability of services to meet patient needs
- compliance with peer-review recommendations

Through this project, Resource Stewardship: Blood Products, the committee will guide the improvement of SVMHS' blood products policies and protocols by identifying best practices and implementing process improvement.

This will include:

1. Identify blood products management best practice methodologies DY11
2. Identifying metrics prior to transfusion, including PRIME required metrics in DY11
3. Creating a policy for one unit ordering in DY12
4. Identifying process improvement opportunities in DY12
5. Improving the use of reports such as physician crossmatches and transfusions to create a culture of accountability and transparency in DY12
6. Revising workflows as necessary to meet the transfusion committee standards in DY12
7. Creating a review process of blood products utilization in DY12

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

Target population. The target population is all patients who are treated at SVMHS who are the recipient of a blood product or a potential recipient. Every patient represents an opportunity to maintain quality and positive patient outcomes. Somewhere between 10 and 20 percent of every admitted patient will receive a blood product, according to a 2011 survey by AHRQ.

Vision for care delivery. The purpose of implementing an expanded blood products management policy is to reinforce the health care reform idea of "right care, right patient at the right time." Blood products management ensures that the right patients are given transfusions according to clinical best practices, overall improving patient safety in the hospital and reducing unnecessary complications. Studies have shown that unnecessary blood products usage can increase complications and length of stay. SVMHS strives to be a best practice facility for providing care and managing resources.

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.
SVMS will implement infrastructure metrics for this project.

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

Check, if applicable	Description of Core Components
Not Applicable	**3.4.1** Implement or expand a patient blood products management (PBM) program.
Applicable	**3.4.2** Implement or expand a Transfusion Committee consisting of key stakeholder physicians and medical support services, and hospital administration.
Applicable	**3.4.3** Utilize at least one nationally recognized patient blood management program methodology (e.g., The Joint Commission, AABB).
Applicable	**3.4.4** Develop processes for evaluating impact of blood product use including appropriateness of use, adequacy of documentation, safety implications, cost, and departmental budget impact. Develop a data analytics process to track these and other program metrics.
Applicable	**3.4.5** Establish standards of care regarding use of blood products, including: Use of decision support/CPOE, evidence based guidelines and medical criteria to support and/or establish standards.
Applicable	**3.4.6** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

Check, if applicable	Description of Core Components
Applicable	**3.4.7** Develop organization-wide dashboards to track provider level blood use patterns. Dashboard to include comparisons to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.
Not Applicable	**3.4.8** Participate in the testing of novel metrics for PBM programs.

Please complete the summary chart:

	For DPHs	For DMPHs
Domain 3 Subtotal # of Selected Projects (Select At Least 1):		**2**
Domain 3 Total # of Projects:	**2**	

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 $ 10,180,000
- DY 12 $ 10,180,000
- DY 13 $ 10,180,000
- DY 14 $ 9,162,000
- DY 15 $ 7,787,700

Total 5-year prime plan incentive amount: $ 47,489,700

Section 9: Health Plan Contract (DPHs Only)

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

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

Section 10: Certification

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

Appendix A - Infrastructure Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date

1.	Develop a Foundation of Tools and Information for Data Collection and Metric Reporting	• Review all SVMHS hospital metric specifications with hospital data team and perform a data collection analysis per Project Metric, document for each: data sources, disparate systems, questions, and concerns.
		• Create a task list with identified next steps for data collection in DY12, including timelines and assignments.
		• Develop a SVMHS specific reporting toolkit in Word or Excel that captures all of the applicable PRIME metric specifications, with notes on SVMH-specific guidelines/data sources
		  ○ Build in a Plan-Do-Study-Act reporting timeline that project leads must update. The PDSA content will be driven by monthly data pulls and project meetings and will track accountability and performance improvement initiatives for each measure.
		  ○ Build in data request table which outlines inclusions and exclusions for the numerator and denominator that are
			All	April 4, 2016- June 30, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		specific to each measure. These data points and parameters are defined within the measure specifications, tailored to SVMH and are to be utilized by the data team to pull accurate reporting values. ○ Build in a Measure Calculation and monthly tracking graph to monitor progress of PRIME metrics		
2.	Identify gaps in data sources and map out reporting workflows	• Create and execute a data collection methodology & plan: ○ Create a basic diagram for each Project Metric to show the flow of information ○ Once baselines are established, confirm adherence to measure specifications through quality review and provide notes/minutes from process • Create a final report summarizing the data collection process and reporting process with sign-off from the PRIME Project Lead ○ In the report, include an assessment report on Project Metrics identifying where there are gaps in data collection	All	July 1, 2016 – June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		○ In the report, outline data solutions to fill gaps through partnerships or system solutions/workflow changes.		
3.	Develop Strategies to Improve Adherence to Recommended Clinical Protocols within the Ambulatory Projects.	• Gather data on specified populations per project in the ambulatory setting: patients who are eligible for cancer screening recommendations (1.6), patients who are eligible for heart disease interventions (1.5) and patients who receive abnormal test results (1.4) • Conduct analysis of patients and their adherence to recommended clinical protocols for each project. Use analysis of age, location, gender, provider, socioeconomic status, or other factors to identify which patients are least likely or more likely to be given the recommended standard of care • Using analysis results, develop recommendation list of three strategies to implement in DY12 and DY13 to improve adherence to recommended care guidelines (9 strategies listed total). One recommendation list for each project.	1.4, 1.5, 1.6	July 1, 2016 – June 30, 2017
4.	Assess Current State Clinical Protocols for Cancer Screening with Appropriate	• Develop a report of best practices, educational resources, and/or accreditations for cancer screening, in specific target populations if possible.	1.6	April 4, 2016- June 30, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date

	Stakeholders and Compare to Best Practices	• Distribute best practices literature to staff
		• Create a "PRIME Change Team" for the project that is tasked with participating in updating, and leading the implementation of clinical protocols.
		  ○ Identify a group of four clinic and/or hospital staff stakeholders as members of the PRIME Change Team
		  ○ Create a charter for the PRIME Change Team over the course of DY12
		• For project 1.6, do a gap analysis report, highlighting where current protocols do not exist or differ from best practices created by PRIME Change Team
		• For project 1.6, identify five short term action items, to initiate change before clinical protocols are formally changed		

5.	Assess Current State Clinical Protocols for Abnormal Results Follow-up & Million Hearts Initiative with Appropriate Stakeholders and Compare to Best Practices	• For project 1.6, document lessons learned from this process in a retrospective document for use on projects 1.4 and 1.5 in DY12 • Based on lessons learned from 1.6 conduct literature review and develop a report of best practices, educational resources, and/or accreditations for abnormal results follow-up (1.4) and the Million Hearts	1.4, 1.5, 1.6	July 1, 2016 – June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date

		Initiative (1.5), in specific target populations if possible.
		• For 1.4 and 1.5, distribute best practices literature to staff in each relevant clinic
		• For 1.4 and 1.5, create a "PRIME Change Team" for each project that is tasked with participating in updating, and leading the implementation of clinical protocols.
		  ○ Identify a group of four clinic and/or hospital staff stakeholders as members of the PRIME Change Team, per project (8 staff total for the two projects)
		  ○ Create and implement a charter for each PRIME Change Team over the course of DY12
		• For 1.4 and 1.5, gap analysis report, highlighting where current protocols do not exist or differ from best practices created by PRIME Change Team (1 per project)
		• For 1.4 and 1.5, implement five short term action items (per project), to initiate change before clinical protocols are formally changed, are developed and implemented		

6.	Update, and Train Staff on Clinical Protocols for	• The PRIME Change Team for each project will update cancer screening, heart failure care and abnormal results follow-up clinical protocols through a	1.4, 1.5, 1.6	July 1, 2016 – June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
	Ambulatory Projects	series of 2-3 meetings for each project (6-9 meetings total) • Sign-off of updated protocols from CMO • Distributed updated protocols to appropriate clinic staff for each project (at least one department per project) through email or other avenue • Conduct three trainings for at least 10 staff members each on updated protocols and/or project topic (one training for each project, total of three trainings, 30 staff trained) on clinical protocols or abnormal follow-up/cancer screening/heart failure treatment education • Conduct analysis of adherence to updated protocols for each project through observation, surveys or data analysis– – create three reports and review with CMO		
7.	Develop a transitional care management team with four roles and outlined responsibilities	• Hold meeting to review current care transitions process and identify responsibilities that are needed to carry out process • Refine position descriptions (if necessary) for four care transitions team roles based on expectations for PRIME project implementation and workflows • Finalize four role descriptions for the transitional care team and review with each assigned team member, get sign off from each team member acknowledging understanding of roles	2.2	January 1, 2016 – June 30, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
8.	Assess Care Transitions Current State Workflow & Partnerships	• Conduct a current state assessment on care transitions post-discharge through three interviews with staff members to understand how care transitions process currently works. Provide one report with three areas for improvement identified. • Reach out to 5 community partners on resource brochure created by SVMHS in 2015. Confirm their current state information and survey their awareness of their referral relationship with SVMHS. Develop a short report for the care transitions team.	2.2	April 4, 2016 – June 30, 2016
9.	Develop Care Transitions Community Partnerships, Project Workflow, and Implementation Plan.	• Create a formalized partnership with 3 of the community resources (in the form of a letter of engagement or MOU) identified in the resource brochure and develop a standardized protocol for referral coordination. Report on any outcomes from this partnership that take place by the end of DY12. • Fully integrate risk stratification into clinical decision-making protocols for care transitions team. Identify recommendations for use after reviewing the effectiveness of integrating the intended process into workflows. Create a report on the SVMHS Risk	2.2	July 1, 2016 – June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		Stratification Methodology for identifying priority admitted patients for care transition outreach. • Develop a report on nationally recognized care transitions program methodology. • Stakeholder workgroup of hospital staff and/or post-acute care community partner staff will meet to update post-acute care transitions clinical protocols, aligned with nationally recognized standards, through a series of 2-3 meetings. • Sign-off of updated protocols from CMO • Distributed updated protocols to all care transitions-related staff through email or other avenue • Conduct two trainings for at least 5-10 relevant staff members each on updated protocols on care transitions principles, identifying patients for transitions and linking with the discharge team.		
10.	Identify and Analyze the SVMHS patient population; all high-utilizing/ high-cost diabetes patients.	• Extract a list of SVMH Medi-Cal patients who have utilized the emergency department or inpatient services who have diabetes. The list will include stratifying factors such as age, gender, address, provider, or other diagnosis codes. The data will	2.3	April 4, 2016 – June 30, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		be pulled for the last five calendar years. • Using data, create a hot spot map of the patients based on address to identify locations or service areas that are seeing highest utilization. • Report on data findings including 3-5 short-term action items to address specific populations that are seeing high utilization. • Review report with CMO and get sign off.		
11.	Assess, Update, and Train Staff on Clinical Protocols for Complex Care Management for High Risk Medical Populations.	• Develop a report of best practices, and educational resources for complex care management of diabetes patients • Create a "PRIME Change Team" for the Complex Care Management Project that is tasked with participating in updating and leading the implementation of clinical protocols. o Identify a group of four clinic and/or hospital staff stakeholders as members of the PRIME Change Team o Create and implement a charter for the PRIME Change Team over the course of DY12 • Distribute best practices literature to PRIME Change team staff	2.3	July 1, 2016 – June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Document where current protocols do not exist or differ from best practices (gap analysis) • Five short term action items, to initiate change before clinical protocols are formally changed, are developed and implemented • Workgroup of clinic staff/hospital staff, led by the PRIME Change Team will update clinical protocols for Complex Care Management of High Risk Medical Populations through a series of 2-3 meetings • Sign-off of updated protocols from CMO • Distribute updated protocols to all relevant staff through email or other avenue • Conduct two trainings for at least 5 staff members each on accessing updated protocols and/or diabetes management principles • Conduct analysis of adherence to updated protocols for project through observation, surveys and data analysis– create a report and review with CMO • Develop two community partnerships to engage in care management for this population. Hold one meeting with each community partner and develop a partnership plan. Measure and report outcomes of partnership within DY12.		

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date

12.	Assess Current State Care Protocols for Palliative Care and Compare to Best Practices	• Develop a report of best practices, and educational resources for Palliative & End of Life care.
		• Distribute best practices literature to identified staff.
		• Create a "PRIME Change Team" for the Palliative Care project that is tasked with participating in updating and leading the implementation of best practices.
		  ○ Identify a group of four clinic and/or hospital staff stakeholders as members of the PRIME Change Team
		  ○ Create a charter for the PRIME Change Team over the course of DY12
		• Gap analysis Report, highlighting where current protocols do not exist or differ from best practices created by PRIME Change Team
		• Identify five short term action items, to initiate change before protocols are formally changed
			2.7	April 4, 2016 – June 30, 2016

13.	Expand Existing Palliative Care Program Through Adopting Best Practices, Expanding Staff and Developing Project	• Hire a palliative care coordinator: Draft position description and ensure that it matches PRIME project needs. Hire palliative care coordinator and train in PRIME project expectations. • Workgroup of clinic staff/hospital staff, led by the PRIME Change	2.7	July 1, 2016 – June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
	Workflows and Implementation Plans.	Team will update Palliative Care protocols through a series of 2-3 meetings. • Sign-off of updated protocols from CMO • Distributed updated protocols to appropriate staff (such as social services, nursing) through email or other avenue • Conduct two trainings for at least 10 staff members each (20 total) on palliative care concepts, identifying patients, and accessing palliative care team. • Conduct analysis of adherence to updated protocols through observation, surveys and data analysis– create report and review with CMO • Create map of current state workflow for discussing advanced directives and POLST in the inpatient setting and outpatient oncology clinic. • Conduct a rapid process improvement session to identify areas of improvement and map out a future state workflow. • Develop a one-year project plan to move to future state workflow.		
14.	Assess Current State Care Protocols for Antibiotic Stewardship and Compare to Best Practices	• Create a “PRIME Change Team” for the Antibiotic Stewardship project that is tasked with participating in updating and leading the implementation of best practices.	3.1	April 4, 2016 – June 30, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		○ Identify a group of four clinic and/or hospital staff stakeholders as members of the PRIME Change Team ○ Create a charter for the PRIME Change Team over the course of DY12 • Develop a report of best practices, and educational resources for Antibiotic Stewardship. Distribute best practices literature to identified staff • Gap analysis Report, highlighting where current protocols do not exist or differ from best practices created by PRIME Change Team • Identify five short term action items, to initiate change before protocols are formally changed		
15.	Expand Antibiotic Stewardship Program Through Adopting Best Practices and Developing an Antibiotic Stewardship Dashboard.	• Workgroup of hospital staff, led by the PRIME Change Team will update clinical protocols for Antibiotic Stewardship through a series of 2-3 meetings • Sign-off of updated protocols from CMO • Distribute updated protocols to all staff through email or other avenue • Conduct two trainings for at least 5 staff members each on updated protocols and/or antibiotic stewardship best practices	3.1	July 1, 2016 – June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Conduct analysis of adherence to updated protocols for project through observation, surveys and data analysis– create a report and review with CMO • Create an excel or web-based dashboard on antibiotic stewardship measures, with PRIME metrics and targets built into the dashboard. Ensure that the dashboard is reviewed at least quarterly through a meeting (four meeting minutes minimum)		

6	Assess Current State Protocols for Blood Products Resource Stewardship and Compare to Best Practices	• Create a "PRIME Change Team" for the Blood Products Resource Stewardship project that is tasked with participating in updating and leading the implementation of best practices.
		  ○ Identify a group of four clinic and/or hospital staff stakeholders as members of the PRIME Change Team
		  ○ Create a charter for the PRIME Change Team over the course of DY12
		• Develop a report of best practices, and educational resources for resource stewardship: blood products.
		• Distribute best practices literature to identified staff
		• Gap analysis Report, highlighting where current
			3.4	April 4, 2016 – June 30, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		protocols do not exist or differ from best practices created by PRIME Change Team • Identify five short term action items, to initiate change before protocols are formally changed		
17.	Develop a Dashboard for Implementation, Tracking and Training on Resource Stewardship: Blood Products Management Best Practices	• Create an excel dashboard of at least five metrics for blood products management and create policies and procedures for updating and reviewing dashboard. • Create a quarterly meeting for dashboard review and updates with key stakeholders • Workgroup of hospital staff, led by the PRIME Change Team will update clinical protocols for blood products resource stewardship through a series of 2-3 meetings • Sign-off of updated protocols from CMO • Distribute updated protocols to appropriate staff through email or other avenue • Conduct two trainings for at least 5 staff members each on updated protocols	3.4	July 1, 2016 – June 30, 2017

Appendix B - Citations

Section 2.1

- Monterey County 2013 Community Health Assessment
- Monterey County Health Department, Communicable Disease Unit; June 15, 2012; statistical analyses performed by Monterey County Health Department, Surveillance and Epidemiology Unit
- California Department of Public Health, Health Information and Research Section, Birth Statistical Master File 1999- 2010; statistical analyses performed by Monterey County Health Department, Surveillance and Epidemiology Unit.

Section 2.2

- US Census Bureau, American Community Survey, multiple years

Section 2.2

- Office of Statewide Health Planning and Development, 2014

Project 3.4

- Agency for Healthcare Research and Quality, 2013. *Most Frequent Procedures Performed in U.S. Hospitals, 2011*