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

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

Table of Contents

General Instructions

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

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

Scoring

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

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

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

Section 1: PRIME Participating Entity Information

Health Care System/Hospital Name

San Gorgonio Memorial Hospital

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.

San Gorgonio Memorial Hospital (SGMH) is located in Banning, a rural area in the northwestern portion of Riverside County, between Riverside and Palm Springs. The health care needs and disparities of our community are summarized below.

2013 SGMH Community Needs Assessment identified "Chronic Disease with a special emphasis on Heart & Respiratory Disease as two of the primary diagnoses for admission and readmission to the hospital". The most significant health issues identified in our community are several child health issues, chronic disease (particularly heart disease), behavioral health, and access to healthcare:

- *Child Health Issues:* Children are one of our most vulnerable populations in Riverside County, the infant mortality rate ranks higher than that of California. Since 2000, the percent of low birth weight births have also steadily increased in Riverside County.

- *Chronic Disease*: In 2010, 27% of all deaths in Riverside County were attributed to coronary heart disease. Overall, heart disease and stroke are the first and third leading causes of death, respectively. In Riverside County, American Indians and African Americans are most impacted by heart disease.

- *Behavioral Health*: A person's overall mental health status is crucial to how that person views and interacts with the world. 24.30% of the Riverside County population is without adequate Social/Emotional support as compared to Healthy People 2020 target. A higher proportion of adolescents in the Inland Empire reported alcohol or other drug use in the past 30 days.

- *Access to Healthcare:* SGMH is a remote, rural acute care facility that serves a community population with a low socio-economic profile. Access to health care is crucial in the absence of regular primary care, many chronic illnesses may worsen and require preventable hospitalizations. Riverside County is considered to be a healthcare professional shortage area with the primary care

provider rate of 42.33 per 100,000 population compared to the California provider rate of 83.20 and the U.S. provider rate of 84.70.

Addressing the percent of those without health insurance is critical to community health development as lack of insurance is often a barrier to access basic healthcare.. 20.48% of Riverside County residents are uninsured, 24.70% receive Medi-Cal. While Medi-Cal enrollment has increased due to the Affordable Care Act, ongoing provider shortages limit access to appropriate primary and chronic care.

Health Disparities. Riverside County also has a higher proportion of low-income children aged 2-5 years who are considered obese (14%), as compared to Healthy people 2020 objective.

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

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

The SGMH District area is populated by approximately 90,000 year round residents. SGMH is the only acute care hospital within the District's boundaries, commonly referred to as the San Gorgonio Pass area. It includes the communities of Banning, Beaumont, Calimesa, Cabazon, Cherry Valley, and Whitewater, and is considered predominantly rural. Approximately 90% of SGMH's inpatient discharges come from the District.

Income. The average per capita income in the district is $48,500 and the median family income is $52,000. These income levels are 84% of the median for California. Additionally, 36% of the population has income 200% below the federal poverty level, with 16.2% living at or below the poverty line.

Race/Ethnicity and Language: The population of the SGMH District area is 44% White, 41% Hispanic, 7% Asian, 2.1% African American, 3.7% Native American/Alaska Native, and <1% Native Hawaiian/Pacific Islander. The diversity in race and ethnicity is reflected in the languages spoken in the area. English is the dominant language spoken, but more than 40% of the population reports speaking a language other than English at home.

The population is slightly older than the state overall with an average age of 33.7 years compared to the statewide average of 35.2 years. The age breakdown is:

- 0-18 years (21%)
- 19-64 years (67%)
- 65 and over (12%)

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.

SGMH is a full-service general acute care district hospital, providing acute inpatient, outpatient, and emergency care as well as diagnostic services on-site. SGMH has two outpatient clinics; outpatient behavioral health services in an off-site clinic as well as an outpatient cardiac rehabilitation clinic located within the hospital. SGMH is licensed for 79 inpatient beds, allocated as follows: 16 intensive care, 48 general medical/surgical, and 15 perinatal. The emergency department was recently expanded to include 23 beds and 5 rapid care bays.

Services provided at SGMH include a broad range of primary and secondary care including emergency services, medical and surgical care, and obstetrical services. Orthopedic, general surgery, gastro-intestinal exams and procedures, and gynecologic surgery are the primary surgical procedures performed at SGMH.

In fiscal year 2015, SGMH's payer mix was 46% Medicare, 30% Medi-Cal, 21% private insurance, and 3% other or indigent care. SGMH had 3,818 acute inpatient discharges and 50,988 ambulatory care visits. The emergency department treated 42,748 patients, most of which were outpatient visits. The average length of stay for acute care was 4.1 days. Hospital beds had a 60% occupancy rate and staffed beds as a percentage of licensed beds was 80%.

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.

DATA COLLECTION: Currently our facility uses a manual data collection process. There are a few exceptions where internal reports are generated through the Information Technology Department (i.e. readmission reports). Our facility is currently deciding on which data mining IT software program to purchase. This will provide real time data for reporting which is abstracted electronically versus our current manual process.

SGMH is in the process of converting from paper charts to an electronic medical record. Subsequently, we have a chart system which is partially electronic and partially paper.

REPORTING: Each Department and Service has selected clinical measures that are reported quarterly to the Patient Safety/Performance Improvement Committee. Our

clinical reporting requirements for regulatory agencies are met by manual chart abstraction with input by data analysts into our contracted vendor, who submits our information quarterly to CMS. Additionally, CMS also utilizes information from patient billing for other reporting requirements. All internal and regulatory data reports are reviewed and discussed at the Patient Safety/Performance Improvement Committee as well as the medical staff committees and the Governing Board.

MONITORING: Our Performance Improvement Team concurrently reviews and analyzes data collection processes and outcomes. When a problem area is identified targeted improvement strategies are implemented.

BARRIERS: A limitation to meeting the PRIME reporting requirements is the current size of the Performance Improvement Department that consists of one (1) full time clinical data abstractor, and one (1) part time clinical data abstractor. Another significant barrier to meeting the PRIME reporting requirements is a lack of current information technology software that would provide real-time data. The staff's current data abstraction responsibilities require the hours allocated for these positions, and adding additional data abstraction responsibilities would require a new FTE position being created. Additional software would need to be purchased to meet the PRIME reporting requirements.

The PRIME Operating Committee has approved an FTE who solely serves the purpose of data abstraction for the selected PRIME projects. Purchasing of IT software that is compatible with our current IT platform that will provide real time data and statistics along with adding another FTE to our Performance Improvement/Quality Department will enable SGMH to overcome our current barriers within data management and reporting.

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.*

   San Gorgonio Memorial Hospitals goal is to improve the health of our community by providing culturally sensitive and competent care which is individualized to our community health needs. As a result of our PRIME programs, we anticipate implementing community outreach as well as a much more thorough and interactive care transitions process to ultimately reduce avoidable utilization and inpatient days. This model will provide individualized, cultural specific, whole person centered care.

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.*

   San Gorgonio Memorial Hospital has three overarching specific aims:
   1) Reduction of Heart Failure and COPD Readmissions by establishing an Outpatient Cardiopulmonary Rehabilitation Program
   2) Reduction of toxicity and prevention of antimicrobial resistance illnesses such as clostridium difficile in our community through a diligent ASP

3) Reducing the adult and childhood obesity rate through education for adults and/or families with young children on healthy lifestyles, obesity prevention and referrals to county, state and federal programs

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;*

SGMH selected three projects: Obesity Prevention and Healthier Foods Initiative (4.1.7), Care Transitions (4.2.2) and Antibiotic Stewardship (4.3.1), all of which directly relate to the findings of our community health needs assessment. Our project aims correspond with these programs and will allow for our needed infrastructure growth which will integrate a strong care transitions program and community well-being resource by means of Obesity Prevention, CPP and Antibiotic Stewardship.

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

The projects we have selected will interrelate by sharing much of the same physical environment and personnel requirements within our anticipated infrastructure change.

Our social workers will assist in care transitions for those referred to the CPP as well as those with BMI who qualify them for our Obesity Prevention Programs. The dietician will be available to host seminars as well as work one on one to educate patients in both programs as well. The pharmacist on duty will be available as a resource and educator to those patients involved in any of the 3 PRIME programs we are implementing.

The department where patients will be consulted in is an area currently providing care to Cardiac Rehabilitation patients. This area will be expanded and have ample space for consults and intake of new clients to all PRIME programs. The physical environment is accommodating for the varied services we are seeking to provide within our current patient population as well as the intended target groups we have chosen.

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.*

On completion of our project period, we expect to have PRIME programs in place with an efficient referral process that allows for ease of access to the community we serve. The intense care transitions process and out-patient rehabilitation services will promote reduction of readmissions, reduced utilization and quality patient outcomes and will improve the ability of the vulnerable populations in our community to access healthcare.

We will have accomplished financial survival in a value-added construct of reimbursement and improved ED bed flow by reducing revolving door readmissions. A goal-oriented outpatient program that assists patients and caregivers with setting and achieving goals will be in place.

SGMH will be improving patient outcomes with the most cost effective therapy through stringent Antibiotic Stewardship. Our ASP will be focused on the reduction of antibiotic toxicity and preventing antimicrobial resistance illnesses such as clostridium difficile in our community.

We will be committed to reducing the rate of adult and childhood obesity with education for families with young children on healthy lifestyles, obesity prevention and referrals to county, state and federal programs. Healthy living classes and seminars will be ongoing. Obesity is implicated in multiple diseases including heart disease, diabetes, certain cancers and sleep apnea. It is estimated that $190 billion (21% of health care costs) is spent on obesity related illness. There is strong evidence that a reduction in weight can have a positive impact on health, thus reducing health care costs.

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

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

As stated, our SGMH Community Needs Assessment identified “Chronic Disease with a special emphasis on Heart & Respiratory Disease as two of the primary diagnoses for admission and readmission to the hospital”. We will expand our care management strategy to connect Cardiopulmonary patients and caregivers with needed outpatient services, with an ultimate goal of decreasing hospital admissions/readmissions.

Childhood obesity rates in Riverside County for children aged 2 to 5 is 9.6% according to Healthy People 2020. We are committed to reducing the rate of obesity in our community. We will have weight management classes for adolescents and/or adults ongoing and every six months. Participants can continue with follow up as long as they feel necessary. The healthy family seminars will be held three times a year as long as there is a desire and need in our local community. We will be active in local health fairs for adults and children so we can promote our programs.

Patient/family education will be provided by the multidisciplinary team on nutrition, physical activity and medication management to ensure patients post discharge are receiving the outpatient rehabilitation they need, receiving appropriate antibiotic regimens when prescribed and also ensuring continued support to reduce childhood obesity.

Care management services will be offered and linkage to useful resources. Collaboration on evidence-based standards of care including medication management and care engagement processes will be the standard of care. Individualized care plans that meet the patient’s needs will be implemented, engaging patients and families in the planning process.

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).

SGMH will be undergoing strategic planning in the second quarter of calendar 2016 to address current and future quality improvement and population health goals. The Community Health Needs Assessment is always a topic of discussion during strategic planning. The proposed PRIME programs will be a major focus among our Senior Leadership during this planning session as the programs we envision will meet the identified needs of our culturally diverse local communities. Our Chief Executive Officer is an active member in the PRIME Operating Committee and has been a key contributor to the selection of projects and the PRIME application process. He serves as the liaison to our governing board and champions the program.

Monitoring mechanisms and data-driven decision-making practices will be developed as part of the strategic implementation plan. These practices will be driven by a group of PRIME program champions. We have already established a separate operating committee which is focused solely on the implementation and monitoring of PRIME projects. The PRIME Operating Committee is comprised of the Chief Executive Officer, the Director of Performance Improvement, the Director of Nursing Resources and Cardiopulmonary Services, the Director of Pharmacy, the Director of Case Management, the Performance Improvement Manager and our Dietician. The committee is led by our Director of Nursing Resources and Cardiopulmonary Services and she is directly accountable to the CEO for all implementation expectations. The CEO reports the PRIME programs results and efforts to the Hospital Governing Board. This committee to date has met regularly to form alliances and set goals for the implementation model for all projects chosen by SGMH and will continue to meet to provide a solid foundation for the success of our chosen projects.

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.

SGMH will likely use a PRIME operating committee to engage stakeholders and beneficiaries in the planning and implementation of PRIME projects. Stakeholders include primary care physicians and other healthcare-related providers in our

service area, as well as the school districts and other community service organizations. Beneficiaries will include healthcare consumers and their family/support members who will be invited to actively participate on or with the PRIME operating committee.

We intend to develop an oversight committee separate from the PRIME Operating Committee. The participants in the oversight committee will be determined through our strategic planning process, but will likely include former patients and representatives from the organizations identified above (schools, senior living communities, etc.).

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.

SGMH is surrounded by a culturally diverse population. We work diligently to meet the needs of our diverse patient population by providing language specific educational materials and discharge instructions. We have a contracted language line service to ensure we are culturally competent and efficient at communications with our patients.

In implementing our PRIME programs, we intend to translate all program educational materials, into the primary languages of those we serve. We will maintain our language line assistance service. In recruiting the multiple staff members for our PRIME program, we will seek out those who are bi-lingual or multi-lingual. Culture specific training will be ongoing with our staff and all care providers.

Based on patient need, we will identify community resources for patients and connect or refer them to community preventive resources which are culturally suitable, including those that address the social determinants of health as indicated.

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.

SGMH leaders and associates have been active participants in several patient improvement collaboratives such as CalHEN 1.0 and CalHEN 2.0, CHPSO,

CMQCC, etc. As a result of this work, along with other quality improvement strategies, SGMH will leverage its experience to sustain PRIME improvement through use of the following:

- Ensuring provided services are efficient and provide value to patients by implementing a system of continual performance feedback that includes patient feedback
- Engagement of our front-line care providers in planning and implementation of programs, utilizing program champions to promote and sustain new processes
- Up front and continual education of staff with focus on areas of need as identified through a gap analysis
- Ensuring senior leadership support for PRIME program implementation and successes
- Improved data systems and effective processes for health record maintenance
- Continued focus on partnerships with multiple post-acute providers, primary care physicians and plan carriers

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

☒ 1.7 – Obesity Prevention and Healthier Foods Initiative

Tiered Weight Management Adult Program

- SGMH will identify existing programs and best practices for weight loss encouraging healthy living for adults.
- In response to our findings, we will develop a weight loss program with the intensity and frequency of services matched to the clients' needs. A nutrition expert, health coach and physical therapist will be hired to take on this task. Both weekly group classes and individual counseling will be available to the participants for several months. Monthly follow up education on an individual basis will be used to ensure long term success along with referral to county, state and federal programs.

Child Health Education

- SGMH will identify families with young children and work with them regarding healthy lifestyles and obesity prevention. To accomplish this, SGMH will reach out to local schools and pediatricians to identify families that could benefit from these educational opportunities.

- Classes will focus on nutritional aspects such as “Rethink Your Drink”, smart snacking, eating at home, physical activity education and behavioral modification with a health coach. During these classes, SGMH will make referrals to county, state and federal programs that would assist families in meeting their health goals.

  SGMH selected this project due to the increasing rate of obesity and the critical impact obesity has on health. According to the California Health Survey of Riverside County conducted by UCLA in 2011-2012, 64.8% of African Americans, 71% of Latinos and 62% of Caucasians are defined as overweight with BMI’s greater than 25. Childhood obesity rates in Riverside County for children aged 2 to 5 is 9.6% according to Healthy People 2020. Obesity has a direct impact on health which includes increased rate of Diabetes Mellitus, Hypertension, Heart Disease, Arthritis and obesity related cancers.

1. *Target Population*

Adult Population

- Our target group will focus on Medi-Cal inpatient clientele. Additionally, we will partner with low income clinics in the area that deal with health disparities and offer this program to those showing a desire for healthier lifestyle.

Children

- SGMH will focus education through partnerships with local schools and local pediatricians for high risk families, developing materials promoting the program in school in an effort to reduce the disparities.

Vision of Care Delivery

- PRIME will enable SGMH to accomplish several key objectives central to our ability of providing sensitive and competent care. Developing a two tiered approach to education with accountability for specifically trained personnel this project will assist enrollees in sustaining their loss. These results will show a reduction of diabetes, heart disease, arthritis and debility in our community. Connecting enrollees in this project with community based services, developing individual action plans and monitoring progress over a six month period will assist the enrollee in continued success in maintaining a healthy lifestyle.

- Healthy Children and Families seminar series with be held monthly for four months. Nutrition education, exercise and behavior modification will be the focus of these seminars. An evaluation of lifestyle changes will be made to determine how this has benefited the families.

- In the hospital, we will be committed to providing a Point of Sales system that will provide nutritional data on items sold. SGMH will develop an incentive system to reward employees who are making healthy selections.

In order to assure continual Quality Improvement and success in our chosen programs, we will use the following tools/methods for evaluation:

Develop a Readiness to Change Questionnaire
Monthly weigh in for all participants
BMI screening and follow-up on all program participants
Audit percent of program participants who report an increase in physical activity

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

Check, if applicable	Description of Core Components
Not Applicable	**1.7.1** Collect or use preexisting baseline data on receipt and use of targeted preventive services, including any associated disparities related to race, ethnicity or language need.
Applicable	**1.7.2** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to USPSTF A and B Recommendations.
Applicable	**1.7.3** Improve access to quality care and decrease disparities in the delivery of preventive services.
Not Applicable	**1.7.4** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
Not Applicable	**1.7.5** Adopt and use certified electronic health record systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population management approaches (e.g., in-reach, outreach) to reduce gaps in receipt of care.
Not Applicable	**1.7.6** Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.
Not Applicable	1.7.7 Implement a system for performance management that includes ambitious targets and feedback from patients, community partners, front line staff, and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology.

Check, if applicable	Description of Core Components
Not Applicable	**1.7.8** Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts.
Applicable	**1.7.9** Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.
Applicable	**1.7.1**0 Prepare for and implement the Partnership for a Healthier America's Hospital Healthier Food Initiative.

Please complete the summary chart:

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

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

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

1. *Our Planned Approach*

Post-Acute Care

- SGMH EMR assists case managers identifying patients with readmission histories. This information then facilitates the case manager and/or social workers in collaborating with attending physicians and patients to develop post-acute care plans. Post-acute care may include participant referrals to a Cardiopulmonary Rehabilitation Program (CPP).

Patient Identification

- SGMH Policy and Procedures specify methodology identifying hospitalized patients at risk for readmission. A Participant Profile defines individuals best suited for participation with CPP. As CPP grows its IT infrastructure, additional community members at risk for readmission will be identifiable.

Care Management

- Participants guided by social work navigators will identify psycho-social barriers preventing adherence to prescribed CPP. Also exploring actions to overcome barriers of successful self-management.

Referral

- Initially, discharge planners will be the referral source. Qualified at-risk individuals may be recommended to the attending physician for program participation.

Disease Management

- CPP partners will include chronic disease management programs run by health plans. Home Care agencies may be included with initial/ongoing navigator assessments. Electronic monitoring devices will be included.

In 2015, 25% of 30 day “All-Cause” readmissions involved CHF or COPD as primary or secondary diagnosis including inpatient and observation. Readmission avoidance is significant in value-based healthcare. The CPP seeks to identify at-risk individuals with chronic cardio-pulmonary conditions and developing individualized treatment programs.

2. Target Population

Historical readmissions for individuals with cardiopulmonary conditions populating as participants in the CPP will be educated on the processes. Our target population for the Cardiopulmonary Rehabilitation Program is any patient with a history of chronic Cardiopulmonary disease who screens at risk for return ED visits or readmission to an acute care facility.Vision of Care Delivery:

PRIME will enable SGMH patients and caregivers to accomplish these objectives

- Become secure with self-management of chronic illness, readmission avoidance, embrace a healthier lifestyle, increased unity with primary care provider.

- Demonstrated ability to adapt to new barriers interfering with their prescribed medical regimen, need limited support and use available community resources supporting self-management of chronic cardio-pulmonary conditions.

- Develop tele-health monitoring that supports primary care providers efforts to treat in the outpatient setting. A telehealth monitoring program has been purchased and occurs through an established vendor. The data collected will be integrated into our current EHR and is retrievable by physicians inhouse and remotely. The program allows for remote monitoring of patients who have been screened and meet the criteria for outpatient monitoring. The system alerts designated healthcare providers for determination of follow up need. The system is integral in the self management of chronic disease which in turn will decrease ED visits and ultimately readmissions.

  Provide seed financing for infrastructure needs including social work staff, dietitian support, respiratory practitioner availability, physical and occupational therapists, pharmacist support, and enhancements to the EHR, in sharing information including telehealth alerts with primary care and focused specialist clinics

- ***Correlation between objective of care delivery and implementation approach:***
  - Early Intervention: Telehealth monitor alerts provide early warning of changes in health status. With timely intervention by a HCP or the primary care provider, patients will be identified for integration into the Cardiopulmonary Program.
  - Primary Care Connectedness: There is an existing and ever progressing EHR functionality for information sharing between partners. During discharge planning, social work navigators make patient access to primary care a priority.
  - Learning Self-Management: Patients (or their caregivers) will be taught and monitored for effective management of chronic Cardiopulmonary Disease. Central to development of policies and procedures is the goal of self-management of chronic disease.

- Social Worker Navigators: In large part, the success of the program revolves around this role. Refinement of the role, provisioning, assessment tools, decision algorithms and metrics of success are crucial in the implementation of our outpatient program.

- In order to assure continual Quality Improvement and success in our chosen programs, we will use the following tools/methods for evaluation:

  Self- assessment questionnaire
  Audit of patient's compliance with medication regimen.
  Audit of patient's improvement in functional ability
  Audit of reduction of ED visits per patient as well as readmissions

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

Check, if applicable	Description of Core Components
Not 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: o Involve mental health, substance use, pharmacy and palliative care when possible. o Involve trained, enhanced IHSS workers when possible. o Develop standardized protocols for referral to and coordination with community behavioral health and social

Check, if applicable	Description of Core Components
	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.
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.
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.

Check, if applicable	Description of Core Components
Not 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.

Please complete the summary chart:

	For DPHs	For DMPHs
Domain 2 Subtotal # of DPH-Required Projects:	**3**	**0**
Domain 2 Subtotal # of Optional Projects (Select At Least 1):		**1**
Domain 2 Total # of Projects:		**1**

Section 4.3 – Domain 3: Resource Utilization Efficiency

☒ 3.1 – Antibiotic Stewardship

1. *Our Planned Approach*

Utilizing State Resources/CDPH

- Use the CDPH Antibiotic Stewardship Program (ASP) Toolkit 2015 as a guideline for development of SGMH's own ASP. CDPH ASP Toolkit has established 11 elements of basic, intermediate and advanced ASP. This will assist in identifying gaps in our current ASP offering strategies to improve our current program.

Developing Protocols/Training

- ASP committee will develop policies and procedures promoting appropriate use of antibiotics. Published guidelines will assist in determining appropriate antimicrobial agents for suspected infections. In addition, employ an indication for antibiotic treatment with prescribers CPOE orders.

Reporting System/Process Measures

- SGMH will use antibiotic stewardship surveillance software to monitor potential clinical events through alerts/reports. Surveillance software will collect metrics in to evaluate our ASP progress. Metrics will be reported to hospital committees and compared to other PRIME participating entities.

SGMH selected Antibiotic Stewardship to improve appropriate use of antibiotics. Inappropriate use of antibiotics contributes to resistant infections and adverse drug events putting patient's health at risk and increasing healthcare costs. The large number of broad spectrum antibiotics used at SGMH puts patients at risk for resistance and adverse drug events linked to inappropriate antimicrobial use. Improving antibiotic stewardship practices will help optimize proper antibiotic use and improve clinical outcomes while minimizing unintended consequences.

2. *Target Population*

SGMH target populations are adults admitted to the Intensive Care Unit (ICU) and Medical Surgical Unit (MSU). SGMH will work with ICU patients who are likely to be treated with multiple antibiotics and broad spectrum regimens. SGMH will transition its focus to MSU patients. SGMH will also target Emergency Department adult patients and develop areas of focus during ASP quarterly meetings.

Vision for Care Delivery

- An intermediate ASP will improve appropriate use of antibiotics. ASP will focus on multidisciplinary collaborative rounds to improve patient outcomes. Reducing broad spectrum antibiotic use and focusing on de-escalation will be a priority of ASP. SGMH will incorporate antibiotic stewardship practices into ICU rounds. Process measures will be used to determine whether ASP interventions had an impact on utilization of antibiotics; reducing hospital acquired C. difficile infections. ASP outcomes will be reported to hospital leadership committees and compared to neighboring facilities that have similar patient demographics.

In order to assure continual Quality Improvement and success in our chosen programs, we will use the following tools/methods for evaluation:

Use CDPH ASP toolkit
Audit current literature for evidence based practices
Measure reduction in HAI C. Diff infections
Audit reduction in physician prescribing of broad spectrum antibiotics

Audit to reduce unnecessary antibiotic treatment based on contaminated blood cultures

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

Check, if applicable	Description of Core Components
Applicable	**3.1.1** Utilize state and/or national resources to develop and implement an antibiotic stewardship program, such as the California Antimicrobial Stewardship Program Initiative, or the IHI-CDC 2012 Update "Antibiotic Stewardship Driver Diagram and Change Package.[1] • Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**3.1.2** Develop antimicrobial stewardship policies and procedures.

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

Check, if applicable	Description of Core Components
Applicable	**3.1.3** Participate in a learning collaborative or other program to share learnings, such as the “Spotlight on Antimicrobial Stewardship" programs offered by the California Antimicrobial Stewardship Program Initiative.[2]
Applicable	**3.1.4** Create standardized protocols for ordering and obtaining cultures and other diagnostic tests prior to initiating antibiotics.
Applicable	**3.1.5** Develop a method for informing clinicians about unnecessary combinations of antibiotics.
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).
Not 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-switching for specific antibiotics and doses, or restriction of specific antibiotics at the point of ordering (e.g., broad spectrum agents).
Not 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.
Not 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	**3.1.10** Evaluate the use of new diagnostic technologies for rapid

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

Check, if applicable	Description of Core Components
Applicable	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.
Not 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.

Please complete the summary chart:

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

Section 5: Project Metrics and Reporting Requirements

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

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

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

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

Section 6: Data Integrity

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

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

Section 7: Learning Collaborative Participation

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

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

Section 8: Program Incentive Payment Amount

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

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

- DY 11 $ 3,501,188
- DY 12 $ 3,501,188
- DY 13 $ 3,501,188
- DY 14 $ 3,151,069
- DY 15 $ 2,678,409

Total 5-year prime plan incentive amount: $ $16,327,500

Section 9: Health Plan Contract (DPHs Only)

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

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

Section 10: Certification

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

Appendix- Infrastructure Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
1.	Develop and Initiate A Tiered Weight Management Program for Adults	• Identify existing programs and best practices • Develop program • Designate and design consultation area • Design marketing material • Purchase equipment needed to consult and manage patients (ie. scales, BMI measurement tools) • Purchase food models • Create educational materials for distribution • Hire per diem Health Coach, Physical Therapist, Registered Dietitian and Social Worker • Initiate program	1.7	July 2016- July 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
2.	Develop and Initiate A Healthy Children and Families Program	• Identify existing programs and best practices • Develop program • Designate and design consultation area • Develop marketing materials • Identify at risk children and/or families • Partner with schools and local pediatricians for collaboration on program and target population • Create educational materials for distribution • Hire per diem Health Coach, Physical Therapist, Registered Dietitian and Social Worker • Initiate program	1.7	July 2016- July 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
3.	Establish A Care Transitions Team	• Conduct a workforce gap analysis to determine staffing needs for the Weight Management Program for Adults • Conduct a workforce gap analysis to determine staffing needs for the Healthy Children and Families Program • Conduct a workforce gap analysis to determine staffing needs for the Cardiopulmonary Program (CPP) • Develop a staffing plan based on findings of gap analysis to include shared staff of Obesity Prevention/Healthy Food Initiative and CPP • Perform cost analysis of recruitment and hiring • Develop job descriptions for: 1. Case Management Navigator 2. Social Work Navigator 3. Respiratory Therapist 4. Physical Therapist	1.7 2.2	July 2016- July 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		5. Pharmacist 6. Dietician 7. Clinical Licensed Nurse 8. Health Information Clerk • Determine and delegate duties of each member of the Care Transitions Team as related to developed job descriptions • Recruit and hire staff for Care Transitions Team staff positions • Establish partnership with Post-Acute Facilities and Home Health Care Providers		

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
4.	Analyze Non-Human Resource Infrastructure Needs	• Perform assessment of existing Cardiac Rehabilitation Program software and equipment • Analyze need for, and cost of, hardware and software enhancements to existing system • Perform cost analysis of any IT needs specific to program implementation • Identify Primary Care access to our EMR and address any HIPAA compliance issues • Finalize implementation timeline	1.7 2.2 3.1	July 2016-January 2017
5.	Develop Workflows and applicable Policies and Procedures	• Analyze health records needs specific to outpatient Cardiopulmonary Program • Define criteria for selection of patients to enroll in Cardiopulmonary Program • Write Policies and Procedures to outline patient referral process to Cardiopulmonary Program • Select and train case	2.2	July 2016-January 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		management navigators to identify potential patients for the Cardiopulmonary Program • Integrate the social work navigator into the discharge planning process for individuals at high risk for recurrence/readmission and begin referral process to the Cardiopulmonary Program • Partner with referral sources from within the community		

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
6.	Conduct Referral Source Training	• Identify Case management navigators and social work navigators that will implement referral process for Cardiopulmonary Program • Train current case managers and social workers on making appropriate referrals to the case management and/or social work navigator • Design marketing materials to present program to community referral sources	2.2	August 2016-December 2016
7.	Implement a Chronic Disease Self-Management Model	• Convene development workgroup • Literature review of evidenced base practices • Design the Model • Initiate pilot to begin on approval of PRIME program, through a discharge planning process initiated by social workers on high risk patients who are	2.2	August 2016-January 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		determined to be potential readmissions. This will occur via inpatient setting discharge planning. • Analyze effectiveness with participant involvement • Set timeline for change implantation • Refined CPP rollout		
8.	Development of Antibiotic Stewardship Program	• Develop a multidisciplinary work group • Use CDPH ASP Toolkit to draft Policies and Procedures consistent with state and national standards for ASP • Conduct a needs assessment • Recruit and hire an Infectious Disease consultant • Identify areas of focus; i.e. reducing HAI C. diff	3.1	July 2016-January 2017
9.	Evaluating Antibiotic Prescription Practices	• Develop a job description for the pharmacist who will champion ASP program and have direct oversight to include ASP data	3.1	July 2016-January 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		collection • Appoint pharmacist to assist in the antibiotic stewardship assignments • Evaluate current data collection capabilities of our current electronic medical record system • Purchase and implement data surveillance software and interfaces that will efficiently identify inappropriate antibiotic use through our current electronic medication administration record • Collect metrics based on requirements from Prime Metric Specification Manual		

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
10.	Education of hospital staff on Antibiotic Stewardship	• Using metrics collected: educate prescribers on current prescribing trends • Develop a process to reach out to all hospital staff and educate on ASP; newsletters • Develop a process for accessing our current program and identifying ways to improve	3.1	July 2016-January 2017
11.	Data sharing and telehealth monitoring systems implementation	• Hardware and software enhancements to existing systems assessment • Initiate pilot program of remote monitoring of Cardiopulmonary or other select patients who have been screened as appropriate	2.2	July 2016 – December 2016