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

The Tri-City Healthcare District (TCHD)

dba Tri-City Medical Center (TCMC)

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.

The Tri-City Healthcare District (TCHD) dba Tri-City Medical Center (TCMC) is a full-service community healthcare facility. Community owned and operated, TCHD has 397 beds and over 600 physicians. Our Emergency Department (ED) serves over 70,000 patients per year. Two (Oceanside and Vista) of the three cities that we serve fall under a very high community need index (1).

Physical Health: Top community health issues:

Heart Disease: The San Diego (SD) North Coastal death rate for heart disease is 93.2/100,000 people (2). Heart disease was the 2nd highest cause for hospitalization, with a total volume of 3,254 patients seen. Currently, the TCHD service area rate is below the Healthy People 2020 target of 108/100,000 individuals (3).

Cancer: Regionally, cancer is the highest cause of death with 838 deaths annually (2). Malignant neoplasms accounted for 1,501 hospital discharges in 2012, the 4th largest cause for hospitalization. Colorectal cancer was the most prevalent. Early detection of breast cancer is warranted as the North County Coastal Breast cancer death rate is 26.8/100,000 people and the Healthy People 2020 goal is a rate of 20.2/100,000 people (3).

Obesity: There are numerous consequences of obesity per the SD Community Health Assessment of 2013 (SDCHA-2013): hypertension, respiratory problems, diabetes and Coronary Heart Disease (2). Approximately 33% of adults in SD County are overweight and 26% are obese and 65% do not participate in physical activities. Nearly 30% of SD County children are overweight or obese.

Health Disparities: In 2013, the top health concerns for children and adults were obesity, culture and language, lack of insurance and mental health (5). Almost 22% of Hispanic students aged 5-19 are overweight, compared to 17.3% of their white peers. Disparities with the Medi-Cal population include –reduced access to healthy foods and education with incomes below 100% FPL. Latino adults have the lowest health literacy coupled with no insurance, transportation issues and barriers to obtaining healthcare.

Coverage and Access: TCHD served 9,000 Medi-Cal patients with 29,000 encounters in FY2015. More than 744,000 Medi-Cal enrollees exist Countywide as of December 2015 (4).

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.

TCHD is a community hospital that serves a population of approximately 382,516 (2013) people in Northern SD County (102,753 [Vista] 161,530 [Oceanside] & 118,233 [Carlsbad]) in California.

In FY 2015, TCHD provided health care services to approximately 9,000 Medi-Cal patients, for a total of approximately 29,000 encounters. The age of patients consisted of 24.6% who were 20 and younger; 70.7% who were adults ages 21-60 and 4.7% who were over the age of 61. Of these patients, 29.3% were white, 48.8% Hispanic, 5.9% Black/African American and 3.4% Asian/Pacific Islander. These data were derived from TCHD's internal records.

Income: Our community is a socioeconomically diverse population which may be due to our close proximity to the Mexican border. More than 442,000 of the 3.2 million SD County residents have income below the poverty level (2013 Census Bureau data). Approximately 14.5% of TCHD's service area lives below the poverty level. Our hospital qualifies for the 340B designation mainly because we serve a disproportionate share of low-income individuals who are not eligible for Medi-Care or Medi-Cal.

Race/Ethnicity: The demographics of TCHD's service area consist of the following: 43.5% White; 43.8% Hispanic; 6.1% Asian/Pacific Islander; 3.1% Black/African American; 3.6% other (2013).

Primary languages spoken at home: In TCHD's service area, 60.8% speak only English, 21.7% speak Spanish and 2.6% speak other languages. Approximately 12.5% of the population in our service area is bilingual.

Age: The 2011 age distribution reported for North Coastal SD County consists of the following:

	North Coastal, San Diego County	San Diego County
Years	**%**	**%**
0-14	20.1	19.2
15-24	16.4	16.0
25-44	26.0	28.0
45-64	24.7	24.6
65 and over	12.8	12.2

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.

TCHD is a full-service, acute-care, District Hospital, licensed for 397 beds and has over 600 physicians in 60 specialties. TCHD also provides outpatient Radiology and Behavioral Health Services, has a Wound Care and a PCP clinic and a medically integrated Tri-City Wellness Center.

Medical Specialties:

- Accredited by the American College of Surgeons Commission on Cancer, TCHD has a 30-bed cancer inpatient unit. In 2009-2010, TCHD averaged a 70% early diagnosis rate for breast cancer, 10% above the national average.
- The ED is a Heart Attack Receiving Center and a Joint Commission Gold Seal of Approval for Stroke. The ED has 47 multi-purpose beds.
- TCHD's Cardiovascular Health Institute provides cardiothoracic surgery, interventional radiology and other cardiological services.
- TCHD's Orthopedic and Spine Institute performs hip, knee, and shoulder replacements/laminectomies and spinal fusions.
- TCHD uses robotic systems (e.g., Da Vinci Surgical System) for procedures in in multiple specialties.
- TCHD is home to the only level 3 neonatal intensive care unit (NICU) in N. County and is the second largest in SD County.

The Inpatient payer mix for FY 15 consisted of 44% Medicare, 25% Medi-Cal, 15% HMO/PPO/Commercial, 3% Self-pay, 2% Covered CA, 5% Capitated Senior, 6%

Other.

The Outpatient payer mix for FY 15 consisted of 37% Medicare, 24% Medi-Cal, 24% HMO/PPO/Commercial, 4% Self-pay, 3% Covered CA, 4% Capitated Senior, 4% Other.

2.4 Baseline Data. *[No more than 300 words]*
Describe the current resources that your entity has in place to collect, report and monitor performance data and how these resources will support PRIME clinical quality reporting requirements. Please specify any anticipated limitations or barriers to meeting the PRIME reporting requirements and describe your proposed strategies to address these barriers.

In 2011, TCHD created a "Green Book," a quality reporting tool that includes all measures and sources for reportable data across the enterprise. This book is updated each quarter to further streamline the approach to analytics, to share data amongst hospital stakeholders and to monitor TCHD's performance. TCHD also has an established interdisciplinary Quality Assurance/Performance Improvement (QA/PI) committee where reporting of measures is presented. Hospital teams and QA/PI utilize the Focus Plan-Do-Check-Act (PDCA) performance improvement methodology. The QA/PI team provides additional guidance and recommendations to the hospital Board of Directors.

Data Collection. The Green Book consolidates the measures that we report internally and externally. The measures are organized by data source (e.g., clinical, claims, authorization, pharmacy, etc.) and identifies a subset of high-value or critical measures that are linked with either performance improvement initiatives or strategic goals. The PRIME project data will be integrated into the Green Book so it will be easy to regularly report data internally and to DHCS on PRIME outcomes.

Reporting. The Green Book is comprised of dashboards and control charts to report performance. Our utilization dashboard is reported throughout the year to a multidisciplinary clinician committee, physician stakeholders, community members on Board Committees, Sr. Leadership and the TCHD Board of Directors.

Monitoring. Our analytics team reviews data collection processes and outcomes in an ongoing manner. We have established processes to flag outliers and understand problem areas in an effort to develop targeted improvement strategies.

Potential Limitations. Once we have additional infrastructure in place we do not anticipate any limitations or barriers to meeting reporting requirements as we will be able to organize the data to meet PRIME specifications. Additional infrastructure to be implemented to address limitations includes post-discharge software and data

products targeting high risk patients. TCHD will also restructure and re-deploy existing data analysts to fulfill PRIME reporting requirements.

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.*

TCHD's overarching goal is to improve the health of the TCHD community and reduce ED use and hospital admissions/readmissions by ensuring a continuum of health care services, increasing access to a range of providers, and providing evidence-based person-centered care. The only way to improve quality of care for patients with a range of physical and healthcare needs is to move to a population health model that treats the whole person and engages patients in their self-care.

Execution of the PRIME projects will help TCHD coordinate care for patients with a wide range of health care conditions such as mental illness, obesity, diabetes and other chronic diseases. The result will allow TCHD to transform its delivery system to an integrated, readily accessible health system which provides the right care to patients at the right time in the appropriate setting.

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.*

TCHD has 5 specific aims:

- Improve the linkage of patients to providers, including transitions from inpatient to outpatient settings, to create a strong continuum of care
- Leverage technology to streamline care and link TCHD with community providers
- Improve patient education and engagement in their own health
- Improve the health of TCHD's community.

To improve linkages of patients to providers we will expand the provider base including FQHCs and PCPs, establish workgroups with community stakeholders, assist with follow-up appointments and ensure transportation availability.

TCHD will leverage technology for real-time exchange of health information in a succinct and legible manner.

To improve patient/family education and engagement, we will create person-to-person opportunities for learning about their health and develop linguistically appropriate patient education materials about disease trajectories, how lifestyles affect their disease state and encourage patients to take ownership of their health and wellness.

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;*

TCHD selected 10 projects including Patient Safety in the Ambulatory Setting (1.4), Million Hearts Initiative (1.5), Prevention: Cancer Screening/Follow-up (1.6), Prevention: Obesity Prevention/Healthier Foods Initiative (1.7), Improvements in Perinatal Care (2.1), Care Transitions: Integration of Post-Acute Care (2.2), Complex Care Management for High Risk Medical Populations (2.3), Transition to Integrated Care: Post Incarceration (2.5), Comprehensive Advanced Illness Planning and Care (2.7) and Antibiotic Stewardship (3.1). TCHD selected these PRIME projects because they intersect with our goals and aims to transform the way we delivery care for a number of populations. Each project addresses vulnerable individuals, whether it is chronic disease, cancer, post incarceration, or newborns, with a focus on improving the linkages

between healthcare providers to provide for optimum care. The aims will support the journey to improved quality of life, longer life and accountability *for* life.

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 common link between the projects selected is they seek to improve equanimity in and coordination of patient care. For this to occur, linkages between healthcare providers and patients' must result in, delays mitigated and information efficiently transmitted to appropriate providers. Linkages are the foundation for accelerated, real-time patient care in complex disease management and a mechanism for the continuum of patient 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.*

In five years, patients served by TCHD will have received appropriate clinical and support services in the care setting optimized for their needs. Infrastructure and staff will be available to identify health needs and provide seamless connections to services across the system.

We also anticipate decreasing avoidable admissions and unnecessary ED use while increasing reliance on community-based services, including primary care, to keep people healthier and contributing members of society.

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.

Health behaviors, physical environment and social and economic factors all play a role in the health of individuals in our community. Given the extensive health care needs in our community, as demonstrated in Section 2.1, TCHD's PRIME programs address a wide range of issues dietary and health education, identifying care modalities for vulnerable patients such as those being released from prison, newborns, new moms and those afflicted with cancer or other chronic diseases. Specifically, while the TCHD service area is considered suburban, 15% of mothers did not receive early prenatal care. Infant mortality is at an approximate rate of 15% and 9% of births were to teens aged 15-17. TCHD admits a significantly higher number of preterm and low birth infants (23.2%) than other community hospitals (8-16%) as we are a Level 3 NICU. We

anticipate a lower admission rate to our NICU as a result of PRIME by encouraging breast-feeding, optimal nutrition and diabetes management.

Improving the organization and delivery of complex care management services will address local health needs, thus improving both health outcomes as well as the patient care experience. In addition, we anticipate reducing utilization of the ED and inpatient services as patients are better managed in the community and have additional resources and support services to enable self-management.

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).

TCHD will establish a PRIME Steering Committee that will design, implement, monitor and oversee all PRIME projects. This will be the governing body of PRIME and consist of hospital leaders, a PRIME Administrator and clinicians involved with the selected PRIME projects. This Committee will regularly report to the District Board on PRIME performance and/or to recommend necessary infrastructure investments. Existing workgroups responsible for individual PRIME projects will support, or be part of, the PRIME committee and will be engaged with reviewing and analyzing the monthly reported metric measurement outcomes. The monthly reporting structure will allow sufficient time to monitor and evaluate performance and identify opportunities to continue to improve the PRIME 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.

TCHD will plan community forums with agencies that offer supportive resources as well as referrals, such as FQHCs, Churches, Oceanside and Vista Boys & Girls Club. During our public board meetings, TCHD will provide an opportunity for questions and comments from the public in order to ensure that consumers have an opportunity to provide substantive input and feedback into PRIME-related planning.

As many of our patients require follow-up care from community providers, we will be supplementing our already existing stakeholder relationships with opportunities to provide feedback specifically on TCHD's PRIME project.

We already engage our community through our Community Patient Partnership Council (CPPC) that consists of members that are past patients or family members of patients. The focus of the CPPC is to guide the TCHD Team in our patient communications i.e. assisting in the revision of our patient guide and whiteboards for patient rooms. We will share all PRIME projects and their results with this Council for discussion and feedback.

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.

TCHD has a history of implementing approaches to meet our community's diverse cultural needs and to address disparities. Our providers and staff reflect the diversity of our patients. We provide signage in two languages (English and Spanish) and critical signs in four languages (English, Spanish, Tagalog and Farsi) throughout the healthcare facility. Patient education, brochures and consent forms are bilingual. TCHD also provides interpretation services in over 200 languages, to communicate with patients of Limited English Proficiencies (LEP) about their health. Planned events include health fairs and flu clinics where information is provided in both English and Spanish.

We have recently formed an employee Diversity Committee, with the goal of improving cultural competence training, communication and processes that relate to the human connection. The Committee's input will positively affect patient interactions with our staff. We intend to continue these activities as part of our commitment to providing culturally competent service and care.

With respect to disparities, TCHD accepts all patients and works closely with community clinics with the goal of improving linkages and enhanced access to providers in our area. We will also offer nutritional services for our patients and at-risk children of our community.

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.

In order to sustain the projects beyond 5-year PRIME participation, TCHD will

- Engage providers and staff in planning and implementation of patient care, follow-up, raising awareness, creation of committees, support groups and support systems,
- Continue providing specialty-based intensive education such as Skills Lab, Net Learning and education to staff in areas where gaps are identified.
- Use Focus PDCA methodologies and other evidence-based tools.
- Ensure that senior leadership is engaged in and supports all infrastructure needed to be able to manifest PRIME and meet all targeted metrics related to PRIME.
- Develop a Focus PDCA cycle plan for each PRIME project selected. Status of each project will be reported to the QA/PI committee and to the District Board.

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

TCHD selected this project because disparate communication of healthcare information typically leads to suboptimal care. For example, TCHD is disseminating information to 99 providers using 15 different electronic health records. This leads to duplication of services, delays in access to clinically indicated care, and compromised outcomes for

patients. TCHD's 30-day readmission rates for acute myocardial infarction and heart failure are 16.1% and 20.1% respectively. This project will intensify the degree of outreach efforts to manage patient care away from the high acuity settings (ED and inpatient) and improve patient safety.

The planned design and implementation approach includes:

Clinical Pathway: TCHD will develop a clinical care team to evaluate the current processes for reporting abnormal clinical results. Processes will be evaluated across settings—the ED, primary care, radiology, and laboratory. We will monitor current clinical workflows and gaps in care. The literature will be reviewed for evidence-based practices to implement. Universal protocols will be developed to inform both the patient and provider on abnormal results. Champion physicians and staff from TCHD will perform on-site training and education with collaborating providers (DY 11 and 12)**.**

Patient Identification: TCHD will implement evidenced-based outcome reporting for abnormal clinical results to identify patients who fall outside the recommended ranges for the specific testing being performed. This team will update and educate both in-hospital and community based providers on the latest research for the recommended ranges (DY 11 and 12).

Database Development: TCHD will facilitate creating a database that would include all discharged patients taking specific medications (e.g. Digoxin) or with abnormal test results. Upon development of the database, TCHD will identify and divide the patient population into 4 cohorts: high risk, establishment of primary care connection, whether they have had an abnormal result or are persistently prescribed medication (DY12).

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

Target Population: TCHD will facilitate the development of a database that would include all Medi-Cal patients who have been discharged from the ED and inpatient settings taking the following medications: Digoxin; Ace Inhibitors or Angiotensin Receptor Blockers; Diuretics; Warfarin; in addition to patients discharged with abnormal test results which include but are not limited to: Pap Smear and Mammogram. We intend to begin this work in one care setting and then move to other setting(s) (e.g., inpatient for DY12).

Vision for Care Delivery: PRIME will enable TCHD to accomplish several key objectives that are central to our ability to provide high-quality, patient centered care at the right time and in the appropriate setting. First, capturing abnormal test results and disseminating these data to patients and providers is paramount to the projects' success. This will be achieved through the development of common communication

means and clinical pathways will support providers and staff with the tools they need to better meet all aspects of achieving better health for patients. Leveraging community resources and TCHD's organic development of a communication system for hard to reach patients will increase access to necessary follow up care for vulnerable or at-risk population. This will help us connect our patients to care and services beyond the four walls of our health system. Providing education to the Care Team related to the importance of screening tools and patient engagement will contribute to improved population management and reduced fragmentation of care for patients.

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.
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.

[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.*

Check, if applicable	Description of Core Components
	• Script notification to assure patient returns for follow up. Create follow-up protocols for difficult to reach patients.
Not 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

TCHD has selected this project as an opportunity to provide enhanced care for patients at higher risk for heart disease and stroke. In the TCHD region, there are 189.4 discharges annually per 100,000 residents, or 971 per year due to coronary heart disease and stroke. By focusing on tobacco cessation, hypertension control and appropriate aspirin use, the team will help ensure that our patients have the best possible chance for mitigating their risk.

The planned design and implementation approach includes the following:

Process for Clinical Prevention Services –Convene a workgroup composed of patients and front line staff to design and implement a process for clinical prevention services and patient risk stratification while putting protocols for care, education, monitoring and reports in place. The process will include recommendations from USPSTF A and B including aspirin to prevent cardiovascular disease, blood pressure screening in adults, cholesterol abnormalities screening, and tobacco use counseling. (DY11-12).

System for Continual Feedback Performance –Design and implement a system for continual performance feedback on the effectiveness of clinical prevention services. To gather data, TCHD will hold sessions with front line staff and ask for feedback. Hold training sessions for staff and the system process will be disseminated so that expectations are clear (DY 12).

Electronic Health Record System - Implement an EMR (that supports targeted preventative services. Assess if the current EMR is satisfactory, or if add-on software needs to be installed. If add on software is installed, the team will conduct a “testing” phase to ensure the system is being efficiently utilized. Integrate the recommendations of clinical preventive services into clinical workflows and the EMR. Screening,

education and treatment will be designed and implemented and document in the EMR (DY 12).

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 will be patients between 18-85 years of age. Specific populations in this age range will be identified by those with hypertension; patients who are between 60-85 with diabetes in the presence or absence of hypertension; and patients discharged alive following for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI).
Vision for Care Delivery: PRIME will enable TCHD to provide enhanced care for patients by focusing on aspirin use, blood pressure control, cholesterol management and smoking cessation. The Million Hearts Initiative will help TCHD improve care for patients at risk for heart disease and stroke by helping us better track the patient population, so that we may adequately assess their needs and provide the best possible care.
The collection and analysis of data will enable TCHD to set an appropriate baseline. By understanding our target population, we can begin the design and implementation of a data driven system that is focused on continual improvement of patient care. By focusing on these components, TCHD can reduce disparities among the targeted population to ensure that all patients are receiving prevention services as appropriate.

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.
Applicable	**1.5.2** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to the US Preventive Services Task Force (USPSTF) A and B Recommendations.
Applicable	**1.5.3** Improve access to quality care and decrease disparities in the delivery of preventive services.
Applicable	**1.5.4** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.

Check, if applicable	Description of Core Components
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.
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

The TCHD Cancer Committee has identified the cancer-health disparities and gaps in cancer-related resources within the Tri-City community. In 2010, cancer surpassed heart disease as the leading cause of death among SD County residents. Over 30% residents older than 50 have never had a colonoscopy, sigmoidoscopy or fecal occult blood test. Nearly 70% of men over 40 have had no recent prostate cancer screening. We selected this project based on these astounding cancer and lack of cancer screening rates.

Our planned design and implementation approach includes:

Development of Cancer Task forces: Establish task forces to develop screening and follow-up protocols for each indication of breast, cervical, colon and lung cancer consisting of physicians, cancer committee members and community healthcare providers. Utilize national standards, guidelines and best practices to create clinical processes to be implemented across the system. All relevant TCHD providers will be trained on the clinical workflows and standards. Via physician coordinated electronic outreach education services, deliver instruction on cancer prevention and early detection to the community (DY11).

HPV Vaccination: The task force will promote HPV vaccinations by furthering THCD's participation in community events (e.g. education at high schools, parents and community clinics); Time between biopsy and screening results will be reduced to fewer than 14 business days for all cancers by developing, implementing and training on clinical protocols on BIRADS to Biopsy. Additional screening opportunities will be to developed, such as a low-cost lung cancer screening on a limited basis (DY12).

Screenings and Community Education: Skin cancer screenings/cancer prevention opportunities including Women's Health & Men's Health Forums, "Healthy" Lifestyle programs at the TCHD Wellness Center and various community health fairs will be held. We partner with the American Cancer Society for this program and we will explore additional community partnerships (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 will consist of the PRIME eligible Medi-Cal patients at risk for cancer, and have barriers to care. TCHD's Medi-Cal population remains much higher with an average of 9%, as compared to 6.3%. In 2015, 49 Medi-Cal patients were identified with BIRADS of 4-5. We will invite Medi-Cal individuals to participate in cancer screenings as described in Metrics Manual 1.6. Work groups for breast, cervical, and colon, will utilize the patient registries developed in the infrastructure, to identify these patients and potentially avoid undetected/untreated cancers.

Vision for Care Delivery: Through coordinated outreach and education services, we will deliver targeted education on cancer prevention education and screenings to the community. Expanding cancer education through partnerships with FQHCs will enable TCHD to focus on our target population, specific sites and cancer related diagnoses. Developing cancer screening and treatment protocols will ensure that TCHD providers are using best practices. By educating students and guardians about the HPV risks, availability of testing, and vaccination, we will manifest a reduction in HPV-related cervical cancer. As barriers to breast cancer screening are eliminated, time between suspicious mammogram to biopsy, to surgery, will be reduced. By partnering with our community physicians for colorectal cancer screenings and treatment, diagnoses and interventions such as surgery, chemotherapy, and nutritional intake monitoring can occur earlier. TCHD is developing a low-cost, low-dose CT lung cancer screening, which may enable TCHD to expand our care delivery and improve survival for patients with lung cancer. Our vision will ultimately reduce the incidence of cancer and save lives.

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.
Not Applicable	**1.6.3** Collect or use preexisting baseline data on receipt and use of targeted preventive services, including any associated disparities related to race, ethnicity or language need.
Applicable	**1.6.4** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to USPSTF A and B Recommendations.
Applicable	**1.6.5** Improve access to quality care and decrease disparities in the delivery of preventive services.
Applicable	**1.6.6** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
Applicable	**1.6.7** Adopt and use certified electronic health record systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population management approaches (e.g., in-reach, outreach) to reduce gaps in receipt of care.
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
Not 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.

☒ 1.7 – Obesity Prevention and Healthier Foods Initiative

TCHD selected this project because of the significant need to provide preventive and therapeutic nutritional counseling/treatment to our community. The present obesity rate for adults in SD County is 26% and 30% of children are overweight/obese. In SD County 29.2% of hospitalizations are patients with diabetes which costs approximately $120,000,000 (5). As mentioned in other PRIME Projects (e.g.1.6), outpatient nutritional counseling can significantly improve health outcomes for a variety of patients afflicted with cancer, diabetes/gestational diabetes and newborns.

Our planned design and implementation approach includes:

Referral Processes: TCHD will contact PCP offices about the availability of nutritional counseling under Medi-Cal's Nutritional Therapy. Community outreach will be performed to encourage referrals while identifying gaps in services. TCHD Dietitians will address the gaps discovered by performing community outreach in DY 11 and after. A minimum of 30 patients will be counseled in DY 11, to be increased by at least 10% each year.

Clinical Pathways: BMI measurements will be obtained at Screening and Follow-up encounters, in a space within the hospital. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents will be provided through partnering with community organizations. Counseling will be available for adults at risk for diabetes, obesity and mal-nutrition. We will continue with The Partnership for a Healthier America's Hospital Healthy Food Initiative (PHA's HHFI) to provide food choices for hospital guests and pursue external food service verification by partnering with after school programs (DY 11).

Care Team Training: TCHD will assess knowledge levels across the care team regarding BMI screening, weight assessment and counseling for nutrition/ physical activity for children/adolescents, the PHA's HHFI, and dietary self-management. A training program for each element will be developed. This work will start in DY 11 with a needs assessment. In DY 12 the design and implementation of the training program will be achieved.

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

Target Population: Because of the potential range of interventions throughout this project, we have identified several target populations. For BMI Screenings and Follow-up, Medi-Cal adults with BMIs over 30 are potential patients; often, this population will include the diabetic and/or gestational diabetic patients. With the Weight Assessment and Counseling for nutrition and physical activity for children and adolescents, all Medi-Cal children or adolescents at the 85th or above percentile are potential patients. For PHA's HHFI, we will target options in the hospital cafeteria that will allow individuals to meet their weight loss goals from our available selections. The target population for referral would be all Medi-Cal patients needing weight and/or blood sugar control.

Vision for Care Delivery: PRIME will enable TCHD to accomplish several key objectives that are central to our ability to provide high-quality, patent centered care. Routine BMI screenings will enable us to initiate weight control and/or blood glucose monitoring at an earlier stage, thereby possibly preventing metabolic syndrome and/or diabetes as well as other health risks such as cardiovascular disease and cancer. Using clinical preventive services in line with national standards, including but not limited to USPSTF A and B Recommendations we will support providers and staff with the tools they need to better meet all aspects of their patients' needs. Providing education/ training to the entire care team will contribute to improved population management and reduced fragmentation of care for patients.

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

Check, if applicable	Description of Core Components
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.
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.

Check, if applicable	Description of Core Components
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.
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.
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.
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.
☒	**1.7.10** 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):		**4**
Domain 1 Total # of Projects:		**4**

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

☒ 2.1 – Improved Perinatal Care (required for DPHs)

TCHD has chosen this project because the facility has a high-risk perinatal population, the highest Medicaid population in SD County according to vital statistics and is the only Level III for neonatal care in North SD County. According to vital statistic data on Nulliparous Women with a Term Singleton baby in a Vertex position (NTSV) delivered by cesarean, in 2014, our facility was at 31.3% which is higher than both California (26.1%), and the national target (23.9%). The project will decrease maternal and unexpected newborn complications and ensure that the mother and infant transition as a family unit with resources for care during the prenatal and post-partum period.

Our planned design and implementation approach includes:

Quality Improvement: The team will establish multidisciplinary committees to oversee the metrics posed in this project DY11.

Policies and Procedures: Breastfeeding policies and procedures will be established, staff will be trained on evidence-based research and a work plan developed to achieve a “Baby-Friendly Hospital” designation (DY12).

Evidence Based Practices: For NQF# 0471, we will encourage best practice and facilitate provider education to reduce in cesarean section rates and decrease inequities among cesarean section rates. The task force will review current practices that influence delivery by cesarean section in DY11.

Perinatal Diabetes Program: To address NQF#716, SMM and OB Hemorrhage metrics, the focus will be on improving the health of the pregnant mothers at higher risk of pregnancy complications by implementing a perinatal diabetes program. Women at risk will be referred to our Tri-City Wellness center to participate in Miracle Babies Healthy Women Healthy Children program (DY11).

Training: Evidence-based training to all staff members who provide direct care to mothers and infants to safely and effectively implement all of the afore mentioned care practices (DY11 and ongoing).

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

Target Populations: Maternal and Newborn patients to include prenatal, antepartum, and intrapartum at the appropriate gestational age per indicator, and postpartum.

Medi-Cal Women with a Term Singleton baby in a Vertex position (NTSV) delivered by cesarean birth because lowering this rate decreases the risk factors for complications with this pregnancy and subsequent pregnancies.

Vision for Care Delivery: Overwhelming evidence-based research shows improved health of both mother and baby, spanning the course of their lifetime when breast-fed. Breast-feeding has the potential to address many neurological deficiencies, metabolic diseases seen in infants and the single most powerful means to reduce infant mortality. Mothers will be supported to breastfeed in the community exclusively for the first six months of life as this has the potential to improve infant health and save in healthcare costs. Baby-Friendly will help TCHD create the most optimal level of care for breastfeeding.

Participation in the Miracle Babies program will promote regular exercise throughout pregnancy, which in turn reduces the risk of excessive gestational weight gain, prenatal depression, gestational diabetes and post-partum weight retention in moms and also directly benefits the health of the offspring.

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

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

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

TCHD selected this project in order to expand our complex care management infrastructure to Medi-Cal patients, in order to assist the transition from the hospital to

the ambulatory care setting, reduce avoidable all-cause 30-day readmissions averaging 14.3% (June 2011-2014), optimize patients' course of chronic illness, and improve care for those patients across the continuum.

Our planned design and implementation approach includes:

Identification of interventions to improve readmission rates and reduce overutilization: Identify the factors which influence acute care utilization and 30-day readmissions. Should our rates exceed national benchmark levels, we will implement rapid cycle improvement in patient-centered care (DY11-DY12).

Care Team Connectivity: TCHD to determine best practices to decrease admissions/readmissions for the responsible diagnoses, per ACSC. We will improve communication between the IP/OP care teams through collaboration where, for example, the EHR systems of both TCHD and Tri-City Home Health are linked (DY12).

Evidence-based Practices: Evidence-based readmission reduction efforts will be based on Dr. Eric Coleman's Care Transitions Intervention (CTI) program (6, 7). These interventions have reduced readmissions and acute care utilization in our Medicare/Medicare HMO patient population. This will be implemented through identifying care enhancement coordinators who can then connect Medi-Cal patients with the necessary resources post-discharge (DY12).

Clinical Strategy: Modify current, or develop new interventions to reduce avoidable 30-day readmissions. Develop a tiered approach to service delivery so that intensity and frequency of services is matched with patient need. One current intervention is to remotely monitor patient health status and progression toward improved self-management. This may include the hiring, education, or retraining of staff as needed to meet the demands of the modified or new interventions. Improvements to TCHD's EHR system will facilitate stratification of patients in order to better reduce avoidable readmissions and provide seamless coordination of the transition of care between acute and post-acute (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 will be Medi-Cal patients who are determined by diagnoses per ACSC, and frequency of visits to both hospital and ED, and all-cause readmissions in the past 6 months. The ACSC diagnoses include: Grand mal status and other epileptic convulsions, Chronic Obstructive Pulmonary disease, Asthma, Heart failure and pulmonary edema, Hypertension, Angina, and Diabetes. We will also look at lack of primary care utilization, functional status, and social support.

Vision for Care Delivery: A care transitions program will improve TCHD's ability to support patients with multiple chronic conditions who could be at risk of unnecessary ED use or avoidable readmissions in the absence of additional support. Our program will improve care transitions through several activities: developing an action plan;

identifying post-acute or post-ED discharge needs; connecting patients with TCHD clinical, and/or non-clinical services; and monitoring progress. Care coordinators will also work to engage patients in self-management support, including supporting the adoption of healthy behaviors.

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.
	  ○ 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:

Check, if applicable	Description of Core Components
	• 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.
Not Applicable	**2.2.7** Support patients and family caregivers in becoming more comfortable, competent and confident in self-management skills required after an acute hospitalization by providing: • Engagement of patients in the care planning process. • Pre-discharge patient and caregiver education and coaching. • Written transition care plan for patient and caregiver. • Timely communication and coordination with receiving practitioner. Community-based support for the patient and caregiver post hospitalization focusing on self-care requirements and follow-up care with primary and specialty care providers.
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.
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)

TCHD has selected this project due to the current state of disparate sources of information, data, and resources available to effectively identify, define, and assess standards of improvement within the high risk Medi-Cal populations. The coordinated expansion of a complex care management infrastructure to Medi-Cal patients will result in a reduction in all cause 30-day readmissions currently at the following levels by condition: AMI 5.1%; Diabetes 14.5%; COPD 6.8%, PNA 9.2% and Heart Failure 15.3%.

Our planned design and implementation approach includes:

Identify Problem: Internally calculated rates of readmissions and length of stay (LOS) for the Medi-Cal patient population will be used and opportunities for improvement identified, which will provide insights on how to manifest improvements (DY 11-12).

Data Analytics – TCHD will establish data analytics systems using data sources (EHR, registries, utilization), financial, and health plan to identify high risk patients for targeted complex care management interventions, including the ability to stratify impact based on race, ethnicity, and language (DY 12).

Clinical Strategy: Modify current, or develop new, interventions to reduce avoidable 30-day readmissions. TCHD will implement best practices to decrease admissions/readmissions for the responsible diagnoses, per ACSC (DY 12).

Form a Multidisciplinary Care Team –Develop a multi-disciplinary care team that is educated for the assigned target population and whose interventions are tiered according to the patient level of risk. The team will conduct a qualitative assessment of the identified high risk, high utilizing patients. Patients will be engaged to self-manage their health conditions by supporting the adoption of healthy behaviors (DY12).

Support Services: Investigate and develop a robust database/catalogue of community resources and a process to link patients. Develop processes that ensure patients are linked to the available community services (DY12).

Incorporate Technology –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 management activities (DY 12).

Employ Evidence-Based Practices: Apply current evidence-based readmission reduction efforts to the Medi-Cal and potential Medi-Cal patient population (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 will be Medi-Cal patients who are determined by diagnoses per ACSC, and frequency of visits to both hospital and ED in the past 6 months. The ACSC diagnoses include: Grand mal status and other epileptic convulsions, Chronic Obstructive Pulmonary disease, Asthma, Heart failure and pulmonary edema, Hypertension, Angina, and Diabetes. We will also look at lack of primary care utilization, functional status, and social support.

Vision for Care Delivery: This project will be designed to work collaboratively with patients and their PCPs in achieving and maintaining optimum patient health and avoiding unplanned interventions. Patients will experience timely access to high quality, focused interventions. By developing a tiered approach to service delivery so that intensity and frequency of services is matched with patient need, patients with multiple chronic conditions who could be at risk for unnecessary ED use or avoidable readmissions in the absence of additional support, will receive the support needed. Our program will improve care transitions through several activities: developing an action plan; identifying post-acute or post-ED discharge needs; connecting patients with TCHD clinical, and/or non-clinical services; and monitoring progress. Care coordinators will also work to engage patients in self-management support, including supporting the adoption of healthy behaviors. TCHD will utilize care management services such as remote patient monitoring technology, telephonic follow up, collaborating with the County's San Diego Care Transitions Partnership (SDCTP) and Tri-City Home Health, community based organizations, and/or other entities, i.e. non-medical home care agencies. Lastly, as a culturally and linguistically sensitive complex care management program, TCHD will provide access to education, care coordination, monitoring and supportive services that will empower this vulnerable population with the necessary tools/ services/information to take control of their health thus decreasing the likelihood of disease progression and/or complications resulting in readmissions or emergency room visits.

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

Check, if applicable	Description of Core Components
	engagement of patients in the design and implementation of the project.
Applicable	**2.3.2** Utilize at least one nationally recognized complex care management program methodology.
Applicable	**2.3.3** Identify target population(s) and develop program inclusion criteria based on quantitative and qualitative data (e.g., acute care utilization, lack of primary care utilization, number of high-risk medical mental or SUD conditions, polypharmacy, primary care input, functional status, patient activation, social support or other factors). Include patient factors associated with a higher probability of being impacted by complex care management.
Applicable	**2.3.4** Conduct a qualitative assessment of high-risk, high-utilizing patients.
Applicable	**2.3.5** Establish data analytics systems using clinical data sources (e.g., EHR, registries), utilization and other available data (e.g., financial, health plan, zip codes), to enable identification of high-risk/rising risk patients for targeted complex care management interventions, including ability to stratify impact by race, ethnicity and language.
Applicable	**2.3.6** Develop a multi-disciplinary care team, to which each participant is assigned, that is tailored to the target population and whose interventions are tiered according to patient level of risk.
Applicable	**2.3.7** Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets.
Applicable	**2.3.8** Implement evidence-based practice guidelines to address risk factor reduction (smoking cessation/immunization/substance abuse identification and referral to treatment/depression and other behavioral health screening, etc.) as well as to ensure appropriate management of chronic diseases: • Use standardized patient assessment and evaluation tools (may be developed locally, or adopted/adapted from nationally recognized sources). Use educational materials that are consistent with cultural, linguistic and health literacy needs of the target population.
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.

Check, if applicable	Description of Core Components
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.

☒ 2.5 – Transition to Integrated Care: Post Incarceration

Our medical center is uniquely positioned to foster an optimal environment to facilitate care transition for individuals post incarceration. The Vista Detention Facility lies within the TCHD and has the capacity for 825 inmates. The program, once initiated, can be scaled to numerous other local detention facilities within SD County whose inmates' specialty medical care is currently being provided by providers affiliated with TCHD. Access to a pharmacy, knowing which pharmacy to go to and having the prescription called in are significant hurdles former inmates face. A 2014 report by the SD Reentry Roundtable notes that any health gains that are made for inmates are lost in the absence of infrastructure to access prescription medications and follow up care (8). TCHD estimates that the volume of ED visits for post incarcerated patients is 300 per year.

TCHD's planned design and implementation approach includes:

Infrastructure development: Identify the optimal location, times of service and hard asset resources needed located within the healthcare district (DY 11-12).

Resource development: Recruit providers to support the needs of the patients of the clinic. Identify post incarcerated individual(s) who can act as the liaison between the releasing facility and the clinic. Engage with local resources for the post incarcerated population that includes access to housing and employment services (DY12).

Program development: Create resources accessible to patients of the clinic that include – referrals to local specialists for treatment chronic conditions, behavioral health and substance abuse services, social services and access to prescription medications and teaching (DY12).

Care Transition Clinic: By developing a post incarceration care transition clinic, associated training for clinical staff to manage the unique needs of the specific

population and assigning the patients to a healthcare clinical liaison, the service needs can be met to reduce unnecessary healthcare costs (DY12).

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

Target Population: We have identified specific target populations for this project. Current inmates with anticipated release dates who will be eligible for Medi-Cal upon release and who have a chronic health condition: cancer, diabetes, heart disease, COPD, asthma and substance abuse. The inclusion criteria will be any of the following: those individuals that have one chronic condition of any age; or any persons > 50 years with or without a chronic condition. TCHD will coordinate with the Vista Detention facility the identification mechanism of this population in order to link to community based care and resources.

Vision for Care Delivery: PRIME will enable TCHD to execute a scalable strategy in which patient-centered care is the focal point. The initial identification of the patient target population will take place in collaboration with the SD Sheriff's Department. TCHD will execute a strategy to link these patients with the appropriate clinical setting where medical and social resources can be provided in a timely manner post release. By engaging a community health worker functioning as the liaison between the clinic and the detention facility, seamless care and transition services/resources will be provided.

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

Check, if applicable	Description of Core Components
Applicable	**2.5.1** Develop a care transitions program for those individuals who have been individuals sentenced to prison and/or jail that are soon-to-be released/or released in the prior 6 months who have at least one chronic health condition and/or over the age of 50.
Applicable	**2.5.2** Develop processes for seamless transfer of patient care upon release from correctional facilities, including: • Identification of high-risk individuals (e.g., medical, behavioral health, recidivism risk) prior to time of release. • Ongoing coordination between health care and correctional entities (e.g., parole/probation departments). • Linkage to primary care medical home at time of release. • Ensuring primary care medical home has adequate notification to schedule initial post-release intake appointment and has appropriate medical records prior to that appointment, including key elements for effective transition of care.

Check, if applicable	Description of Core Components
	• Establishing processes for follow-up and outreach to individuals who do not successfully establish primary care following release. • Establishing a clear point of contact within the health system for prison discharges.
Applicable	**2.5.3** Develop a system to increase rates of enrollment into coverage and assign patients to a health home, preferably prior to first medical home appointment.
Applicable	**2.5.4** Health System ensures completion of a patient medical and behavioral health needs assessment by the second primary care visit, using a standardized questionnaire including assessment of social service needs. Educational materials will be utilized that are consistent with the cultural and linguistic needs of the population.
Applicable	**2.5.5** Identify specific patient risk factors which contribute to high medical utilization Develop risk factor-specific interventions to reduce avoidable acute care utilization.
Applicable	**2.5.6** Provide coordinated care that addresses co-occurring mental health, substance use and chronic physical disorders, including management of chronic pain.
Applicable	**2.5.7** Identify a team member with a history of incarceration (e.g., community health worker) to support system navigation and provide linkages to needed services if the services are not available within the primary care home (e.g., social services and housing) and are necessary to meet patient needs in the community.
Not Applicable	**2.5.8** Evidence-based practice guidelines will be implemented to address risk factor reduction (e.g., immunization, smoking cessation, screening for HCV, trauma, safety, and overdose risk, behavioral health screening and treatment, individual and group peer support) as well as to ensure appropriate management of chronic diseases (e.g., asthma, cardiovascular disease, COPD, diabetes).
Applicable	**2.5.9** Develop processes to ensure access to needed medications, DME or other therapeutic services (dialysis, chemotherapy) immediately post-incarceration to prevent interruption of care and subsequent avoidable use of acute services to meet those needs.
Not Applicable	**2.5.10** Engage health plan partners to pro-actively coordinate long-term care services prior to release for timely placement according to need.

Check, if applicable	Description of Core Components
Applicable	**2.5.11** Establish or enhance existing data analytics systems using health, justice and relevant community data (e.g., health plan data), to enable identification of high-risk incarcerated individuals for targeted interventions, including ability to stratify impact by race, ethnicity and language.
Not Applicable	**2.5.12** Implement technology-enabled data systems to support pre-visit planning, point-of-care delivery, population/panel management activities, care coordination, and patient engagement, and to drive operational and strategic decisions including continuous QI activities.
Not Applicable	**2.5.13** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff, and senior leadership.
Applicable	**2.5.14** Improve staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on care model. • Involving staff in the design and implementation of this project.
Not Applicable	**2.5.15** Engage patients and families using care plans, and self-management education, including individual and group peer support, and through involvement in the design and implementation of this project.
Applicable	**2.5.16** Participate in the testing of novel metrics for this population.

☒ 2.7 – Comprehensive Advanced Illness Planning and Care

TCHD selected this project because establishing an integrated, outcome driven, community based palliative care program will enable us to create culturally and linguistically appropriate multi-disciplinary teams around realistic goal setting, patient symptom management, family-caregiver support, practical support, psychosocial support and spiritual support in the hospital and as a patient-family transitions to the community. Although 53% of California Medicare patients ages ≥ 65 years use hospice, only 32% of Medi-Cal patients ages 21 to 64 years enrolled in hospice after a diagnosis of stage IV lung cancer, Mack et.al reports (9). In 2013, TCHD performed a gap analysis to assess the need for comfort care, determining that ~260 patients per year were referred out for palliative care measures, of which ~20% were on Medi-Cal.

Our planned design and implementation approach includes:

- *Hospital Based Palliative Care:* Create a multi-disciplinary, hospital based palliative care program capable of following patients in the community after discharge. (DY11)

- *Care Coordination*: Partner with a local palliative care program. In conjunction with our Home Health team, combined resources will allow the patient-family to have round the clock access to coordinated care including psychosocial, as well as, pain and symptom management (DY12).

- *Patient Engagement*: Engage and inform patients and families about their health care options, removing barriers and implementing appropriate care goals. Palliative care removes futile treatments that do not change medical outcomes (DY12).

- *Readmission Reduction Program:* The completion of the CCTP program will allow Tri-City the opportunity to partner with County based readmission reduction resources (DY12).

- *POLST*: Improve care by having crucial conversations and decisions made before the patient is in a health crisis. Using POLST as a tool to identify patient wishes and consider all needs. Train Tri-City Physicians, Nurses and Social Workers on effective use of POLST (DY12).

- *Education:* Establish a partnership with the Institute of Palliative Care in order to educate Tri-City Physicians, Nurses and Social Workers on timely referrals to palliative care and/or hospice services (DY11).

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 will include all our adult Medi-Cal and Medi-Cal managed care patients with chronic and/or end-of-life diagnosis. Palliative Care consults will be available in the acute care setting and the community in conjunction with a local hospice and Tri-City Home Health.

Vision for Care Delivery: PRIME will enable Tri-City to not only implement palliative care in the acute care setting, but also extend the service to the comforts of the patient's own home via home/ambulatory setting thus preventing patients from having to return to the hospital to make end-of-life care decisions. Patient care will be improved by introducing patients to a wider range of care options consistent with their wishes and desires. Through the coordinated efforts of the palliative team and provision of care in the home, hospital admissions will be decreased. By adopting POLST for this program the patients will have choice in selecting the intensity and

setting of their treatment. The integration of an inpatient to outpatient supportive care system will allow patient and families to make decisions early on in their diagnosis regarding comfort care and desirable interventions.

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

Check, if applicable	Description of Core Components
Applicable	**2.7.1** Establish or expand both ambulatory and inpatient palliative care (PC) programs that provide: • Total, active and individualized patient care, including comprehensive assessment, inter-professional care planning and care delivery. • Support for the family. • Interdisciplinary teamwork. • Effective communication (culturally and linguistically appropriate). • Effective coordination. • Attention to quality of life and reduction of symptom burden. • Engagement of patients and families in the design and implementation of the program.
Applicable	**2.7.2** Develop criteria for program inclusion based on quantitative and qualitative data: • Establish data analytics systems to capture program inclusion criteria data elements.
Not Applicable	**2.7.3** Implement, expand, or link with, a Primary Palliative Care training program for front-line clinicians to receive basic PC training, including advanced care planning, as well as supervision from specialty PC clinicians. Assure key palliative care competencies for primary care providers by mandating a minimum of 8 hours of training for front line clinicians in communication skills and symptom management.
Applicable	**2.7.4** Develop comprehensive advance care planning processes and improve implementation of advance care planning with advanced illness patients.
Applicable	**2.7.5** Establish care goals consistent with patient and family preferences, and develop protocols for management/control of pain and other symptoms in patients with advanced illness, including a holistic approach that includes spiritual and emotional needs.
Not 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.

Check, if applicable	Description of Core Components
Not Applicable	**2.7.7** Provide access to clinical psychologist on the palliative care team to address psychological needs of patient and the family members during the advanced illness and provide grief counseling and support to the family after death of their loved ones.
Applicable	**2.7.8** Enable concurrent access to hospice and curative-intent treatment, including coordination between the providing services.
Applicable	**2.7.9** Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice, including linkage with PC training program.
Not Applicable	**2.7.10** For advanced illness patients transitioning between primary care, hospital, skilled nursing facilities (SNFs), and/or home-based environments, ensure that the advance care plan is clearly documented in the medical record and transmitted in a timely manner to the receiving facilities and care partners who do not have access to the health system's medical record.
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):		**5**
Domain 2 Total # of Projects:		**5**

Section 4.3 – Domain 3: Resource Utilization Efficiency

☒ 3.1 – Antibiotic Stewardship

TCHD has selected project 3.1 Antibiotic Stewardship to not only be in line with mandatory state legislation but also to promote the appropriate use of antibiotics in order to improve patient outcomes, reduce the emergence of resistance, reduce costs while minimizing adverse events including toxicity. This can be achieved by promoting and measuring the use of the appropriate agent, dose, duration and route of administration of antimicrobial agents. At our hospital, we strive to keep hospital acquired infections at a minimum. However, because we still see *Clostridium difficile* (~3 cases/month), Methicillin-resistant *Staphylococcus aureus* (4.5 cases/month), Vancomycin-resistant enterococci (< 1/month) and infections caused by Extended Spectrum β-Lactamase producing bacteria (1/month) we think it's beneficial to maintain an Antibiotic Stewardship program.

Our planned design and implementation approach includes:

Antibiotic Stewardship Program: A broader-based Antibiotic Stewardship committee will be established. The overall goal of this committee will be to promote the judicial use of antimicrobials. This committee will review and update our antimicrobial stewardship policies and procedures to include the required metrics. We will work on this in DY11.

Monitoring Performance: In DY11 infrastructure building will be required for tracking and reporting some of the metric data in the form of additional surveillance tools. We will work closely with our Information Technology department to create reports which will enable TCHD to establish baseline metric data (DY11).

Policies and Procedures: The Antibiotic Stewardship committee will include an infectious disease (ID) MD, an ID pharmacist, an infection control specialist and additional clinical members such as an RN or NP. The California Antimicrobial Stewardship Program Initiative guidelines will be used for implementation of this program. Program interventions will include prospective audit and feedback, antimicrobial formulary restrictions, and the creation of hospital-specific evidence based treatment guidelines (DY11).

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

Target Population: We expect the target population for interventions by the antimicrobial stewardship program will include Medi-Cal adult patients started on antimicrobials in the acute care inpatient setting, surgery, and the ED.

Vision for Care Delivery: Promoting appropriate antibiotic use in acute bronchitis, low colony urinary cultures, and in the surgical setting will allow us to reduce unnecessary

antimicrobial exposure. Reducing the inappropriate use of antimicrobials in the hospital will lead to improved patient outcomes by reducing the risk of adverse events resulting from antimicrobial exposure (i.e. *Clostridium difficile* infections) and reducing the emergence of bacterial resistance. Monitoring antimicrobial use via the National Healthcare Safety Network Antimicrobial Use Option, will allow us to keep track and regulate use of broad-spectrum antibiotics within the hospital.

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.[2] • Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**3.1.2** Develop antimicrobial stewardship policies and procedures.
Applicable	**3.1.3** Participate in a learning collaborative or other program to share learnings, such as the "Spotlight on Antimicrobial Stewardship" programs offered by the California Antimicrobial Stewardship Program Initiative.[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.
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).

[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
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).
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 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.
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 $ 14,040,000
- DY 12 $ 14,040,000
- DY 13 $ 14,040,000
- DY 14 $ 12,636,000
- DY 15 $ 10,740,600

Total 5-year prime plan incentive amount: $ 65,496,600

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.

Section 11: References

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Appendix- Infrastructure Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
1.	Integrate TCHD's EHR with the County of San Diego's HIE system.	• Identify the required Directed Exchange service • Propose HIE system modules/systems • Seek TCHD Board of Directors approval for an HIE improvement.	1.4, 1.5, 1.6, 1.7, 2.1, 2.2, 2.3, 2.5, 2.7, 3.1	4/2016/-6/2016
2.	Create and convene PRIME project implementation committee/workgroup	• Develop list of appropriate hospital staff to participate in workgroup • Develop a workgroup • Develop a charter • Develop list of stakeholders to engage • Identify patient populations affected by the initiatives chosen. • Convene PRIME project implementation workgroup	1.4, 1.5, 1.6, 1.7, 2.1, 2.2, 2.3, 2.5, 2.7, 3.1	1/2016-6/2016
3.	Assess data systems capabilities and needs to pull data for reporting on all PRIME required metrics	• Assess current IT data and reporting systems • Identify data and reporting needs under PRIME • Develop a plan for IT and data reporting improvements that need to be made • Identify project leader associated with initiative • Educate data manager on the metrics	1.4, 1.5, 1.6, 1.7, 2.1, 2.2, 2.3, 2.5, 2.7, 3.1	1/2016-11/2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
4.	Develop Rapid Cycle Improvement process	• Assess technology based platform to increase access to preventative care services • Assess current state of capability to utilize preventative care on the technology platform • Determine stakeholder focus group to assess effectiveness of technology and implement any recommended changes	1.4, 1.5, 1.6, 1.7, 2.1, 2.2, 2.3, 2.5, 2.7, 3.1	4/2016-6/2016
5.	Conduct workforce GAP analysis	• Evaluate the need to deploy resources for each project • If necessary, develop a job description for the extra resources	1.4, 1.5, 1.6, 1.7, 2.1, 2.2, 2.3, 2.5, 2.7, 3.1	4/2016-6/2016
6.	Proposed physician clinical decision support modules for secure use via texting and system log on.	• Research secure texting options • Select secure texting system • Seek TCHD Board of Directors approval for system • Propose secure texting system for future implementation.	1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 2.7	4/2016-6/2016
7.	Establish nutrition and weight control program for MNT and hospital staff.	• Identify space in hospital for Nutritional counseling • Educate RDNs where needed re: MNT for Obesity, diabetes, Cancer , Gestational diabetes	1.6,1.7, 2.1, and 2.2	1/2016 - 6/2016
8.	Plan community outreach with information about	• Create an education plan. • Identify content with Marketing for new	1.6,1.7, 2.1, and 2.2	4/2016 - 12/2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
	nutrition and weight management programs for MNT	outpatient brochures to be distributed to discharged patients and community members. • Determine which outreach methods work in recruiting clients. • Initiate meeting with community organizations about the availability of TCHD programs. • Prepare announcement of program at public District Board meetings		
9.	Develop a tool to track client visits and progress towards a nutritionally sound diet and weight loss	• Convene a workgroup to provide expertise on tool development • Research best practices on nutritional diet and weight loss standards • Train providers and patients on use of tool • Integrate tool into EMR	1.6,1.7, 2.1, and 2.2	1/2016 - 12/2016
10.	Assess modalities of transmitting information about nutrition after securing feedback from stakeholders.	• Engage clients to provide feedback on what works and what doesn't. • Make programmatic adjustments according to feedback. • Determine best method to provide feedback to engaged stakeholders.	1.6,1.7, 2.1, and 2.2	1/1/2016 -12/2016
11.	Identify high –risk patients	• Create IT infrastructure to identify patient population with 4 or more chronic conditions • Capture baseline data to evaluate disparities	2.2, 2.3	6/2016-12/2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Form multi-disciplinary team to assess current processes of care for high risk post discharge from ED vs. best practice evaluation • Design process at ED registration to ensure patient is linked to a community primary care provider for post discharge follow up		
12.	Retain and educate clinical personnel	• Identify physician and care coordinator champions for training team of providers both in-house and in the community • Develop educational materials • Educate staff	2.2, 2.3	6/2016-12/2016
13.	Assess Real-Time Data reporting and reports generation from Cerner (EHR) for Pharmacy and Infection Control. Combines real-time clinical intelligence with actionable business intelligence and predictive analytics.	• Propose system to the TCHD Board of Directors. • Prepare capital requisition for purchase.	2.2, 2.3, 3.1	1/2016-12/2016
14.	Research upgrades to EHR for needed add-ons such as Readmission Software	• Propose system to the TCHD Board of Directors. • Prepare capital requisition for purchase.	1.4, 2.2, 2.3	1/2016-6/2016
15.	Assess current capture of abnormal test results and create pathway on follow up	• Review literature on capturing results best practices	1.4	6/2016 – 12/2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
	of abnormal laboratory results	• Educate staff on timely and accurate reporting • Identify personnel designated to evaluate laboratory process improvement in results reporting • Review literature on appropriate clinical follow up if abnormal results identified. • Identify a common reporting methodology/mechanism between hospital and ambulatory providers • Educate hospital and community provider staff on best practices • Recommend an infrastructure/system to reach target population		
16.	Develop Utilization Review process	• Assess gaps in current utilization review process • Develop process that address gaps in existing process • Engage providers and front line staff in review of process	1.4	4/2016-6/2016
17.	Assess disparities and patient need for preventative services	• Establish baseline report • Develop front-line multi-disciplinary team to extrapolate data for next steps in project • Create a tool to do a gap analysis of infrastructure not meeting preventative healthcare needs of population	1.5	05/2016-6/2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
18.	Develop education program for Providers on Preventative Services	• Develop an education plan for care providers in ambulatory settings on best practices for preventative services • Develop education plan to educate local providers on best practices.	1.5	4/2016-12/2016
19.	Develop database of Community resources	• Assess community for available resources to vulnerable population. • Create a method to assist in the development of a database to store community resources	1.5	4/2016-12/2016
20.	Develop strategy to improve breast cancer screening rates	• Establish committee to review criteria, and determine feasibility of measure. • Appoint individual(s) to be responsible for data tracking and reporting to the PRIME committee as determined. • Create a report template using PRIME criteria to document and report.	1.6	4/2016-6/2016
21.	Develop strategy to track data and report on PRIME metrics (e.g. cervical cancer screening)	• Identify a committee to review criteria and feasibility of data collection. • Appoint individual(s) to guide, facilitate, track data, and report to the PRIME committee. • Develop a job description for a staff member to facilitate this project. *JD to be broad enough to encompass other areas of	1.6	1/2016-6//2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		the PRIME project (i.e. colorectal measures).		
22.	Identify gaps in TCHD community education regarding nutrition and food choices	• Document potential evidence-based methods to reduce gaps • Identify local healthy food solutions for gaps. • Determine availability of RDN	1.6,1.7, 2.1, and 2.2	4/2016-12/2016
23.	Develop strategy to address current performance of the measures	• Develop audit tool to capture breast-feeding, NTSV-C-Section, and Newborn infection statistics, • Establish baseline on statistics from above. • Set targets for breast feeding rates, NTSV C Section rates, and newborn infection rates • Collect data •	2.1	

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
24.	Develop Risk stratification process	• Conduct a literature search on the use of the Bishop Score • Evaluate readiness for induction using Bishop Score before Pitocin is started.	2.1	
25.	Develop Sweet Success Program	• Create a work group to develop the Sweet Success Program • Assess enrollment/referral to Sweet Success Perinatal Diabetic Program for potential patients from participating clinics. • Assess staffing needs for Sweet Success Program • Develop policies and procedures • Develop educational materials	2.1	
26.	Acquire process improvement system that can provide quality-based skilled nursing facility ratings for improved informed decision making for patients.	• Acquire system • Set up system • Test system • Train users on system •	2.2	2/2016-6/2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
27.	Acquire and implement remote care management platform solution	• Acquire system • Set up system • Test system • Train users on system	2.2	1/2016-6/2016
28.	Develop process to improve communication between inpatient and outpatient care teams	• Assess current gaps in communication between inpatient and outpatient teams • Develop policies and procedures to address gaps in communication • Train staff on new policies and procedures • Monitor and track timeliness of DC summaries and transition processes • Develop, pilot, and implement process to involve and engage Pt/family/CG in transitional process	2.2	1/2016-12/2016
29.	Develop process to increase patients' capacity to self-manage their condition	• Enter into contract for services with SD County for SDCTP program • Establish Scope of Work for Home Instead Senior Care Diabetes program • Create educational plan for patients • Develop, pilot, and implement pre-DC patient and caregiver education and coaching materials •	2.2	6/2016-12/2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
30.	Develop process to improve medication management and reconciliation	• Determine feasibility of Pharmacist intern for medication reconciliation • Develop, pilot, and implement system to reconcile, track and report medications upon arrival, discharge and 30 days post discharge. •	2.2	4/2016-6/2016
31.	Develop process to reduce avoidable acute care utilization	• Internally calculate readmission rate and acute care utilization for Medi-Cal population • Explore potential expansion of a care transitions program to additional settings, or to additional populations, in line with Coleman CTI • Prepare options for community-based resources for the patient and caregiver post hospitalization focusing on self-care	2.2	3/2016-6/2016
32.	Define the scope of Project 2.5 in collaboration with SD Sheriff Department at the Vista Detention Facility	• Identify current system of patient identification • Determine barriers to enrollment for health insurance • Establish front line care team and coordinator of care from detention facility to clinic	2.5	4/2016-6/2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
33.	Retain Clinical resources: staff, space	• Identify space for clinical evaluation and assessment • Provide staff education on population processes • Identify post-incarcerated community health worker to be liaison for care • Retain medical service provider and ambulatory clinic space with public transportation access • Educate front line staff on specific needs of post-incarcerated patient population	2.5	6/2016-12/2016
34.	Develop process to link post incarcerated patients to community resources	• Develop resource guide for clinical staff and liaison • Validate community resource services by meeting in person • Assess affordable housing in the area • Build partnerships with community social services for patients seen at the post-incarceration clinic	2.5	6/2016-12/2016
35.	Develop, educate and retain clinical and IT resources	• Engage multidisciplinary team for both inpatient and outpatient settings for program inclusion • Develop IT data analytics to capture appropriate patient base for the program based on selection criteria	2.7	05/2016-12/2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Educate caregivers on initial program rollout and care path for patients		
36.	Develop a Comprehensive resource plan needed to care for patients in the program at the appropriate stage of their condition.	• Engage providers of services including social, spiritual, familial, and psychological to integrate with medical providers in the program • Test integration of program, and make changes to process where necessary	2.7	6/2016-12/2016
37.	Establish Care Pathway	• Educate all direct service providers (medical, social, other) on appropriate care pathways based on the stage of the patients' condition • Form care continuum with Hospice services through collaborative efforts in education and training for service providers to meet the needs of patients and families.	2.7	6/2016-12/2016

38.	Develop an Antibiotic Stewardship committee	• Convene a committee of the following provider types
		  ○ Infectious disease (ID) MD,
		  ○ An ID pharmacist,
		  ○ An infection control specialist and
		  ○ Additional clinical members such as an RN or NP
		• Develop mission and goals
			3.1	1/2016-6/2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Develop roles and responsibilities for committee members		
39.	Develop protocol to reduce antimicrobial Days of Therapy	• Review best practices to reduce antimicrobial Days of Therapy • Assess gaps in existing process to reduce antimicrobial Days of Therapy • Based on gaps identified, develop protocol to reduce antimicrobial Days of Therapy • Train staff on to reduction of antimicrobial Days of Therapy protocol • Pilot reduction of antimicrobial Days of Therapy protocol and make changes if necessary.	3.1	1/2016-6/2016