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

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

Table of Contents

General Instructions

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

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

Scoring

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

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

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

Section 1: PRIME Participating Entity Information

Health Care System/ Hospital Name	
Health Care System Designation (DPH or DMPH)	

PRIMARY CONTACT

Name	
Title	
Telephone number	
Email Address	
Mailing Address	

BACKUP CONTACT

Name	
Title	
Telephone number	
Email Address	
Mailing Address	

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.

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.

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.

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.

Section 3: Executive Summary

The objective of PRIME is to accelerate participating entities' efforts (as applicable), to change care delivery, to maximize health care value and to strengthen their ability to successfully perform under risk-based Alternative Payment Methodologies (APMs). This section of the Plan will be used to present each entity's overall goals and specific aims for PRIME. This section should also describe how these efforts will evolve over the course of the five years.

3.1 PRIME Project Abstract [No more than 600 words]

Please address the following components of the Abstract:

1. *Describe the goals* for your 5-year PRIME Plan;*
   Note:
   * *Goals (generally 2-5) are general guidelines that explain what you want to achieve in your hospital or health system. They are usually medium- to long-term and represent program concepts such as "eliminate disparities." These goals may already be a part of your hospital or health system's strategic plan or similar document.*

2. *List specific aims** for your work in PRIME that relate to achieving the stated goals;*
   Note:
   ** *Specific aims (generally 2-5) relate to the goals but provide more detail on how the goals will be achieved.*

3. *Provide a statement of how the selected projects will support the identified goals and specific aims. Note that the narrative should connect the specific aims identified in Section 3.1.2 to the projects you select in Section 4. Each project does not require a specific statement. Instead, the narrative in the abstract is broadly linking projects to identified goals and specific aims;*

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

5. *Provide a succinct summary description of how your hospital or health system will be transformed at the end of the five years. Explain how this transformation should result in advances in clinical, population health, fiscal or other critical outcomes through PRIME.*

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.

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).

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.

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.

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.

Section 4: Project Selection

The PRIME Projects are organized into three Domains:

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

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

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

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

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

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

Instructions

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

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

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

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

   For DMPHs requiring infrastructure building metrics that are approved in the Prime Project Plan, 75% of PRIME funding for DY 11 will be based on the achievement of the approved DY 11 infrastructure building metrics through the final year-end report. Up to 40% of the total PRIME funding for DY12 will be based on the achievement of the approved DY 12 infrastructure building metrics through the mid-year and final year-end report. The proposed Process Measures should meet the following criteria:

   - *Specific*
   - *Measurable: Must be able to demonstrate progress throughout the duration of the process metric measurement period.*
   - *Evidence-based: Measures should have a strong evidence-base that can linked process to outcomes.*

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

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

[Insert response here]

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

☐ **1.1.1** Implement a behavioral health integration assessment tool (baseline and annual progress measurement).

☐ **1.1.2** Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration, the Collaborative Care Model, or other Integrated Behavioral Health (IBH) resources from SAMHSA)

☐ **1.1.3** Integrate appropriate screening tools and decision support into the emergency department (ED) to ensure timely recognition of patients with mental health and substance use disorder problems. Enhanced access to primary care and/or to behavioral health specialists will be integrated into discharge planning for these patents. Use of 24-7 care navigators (e.g., Community Physician Liaison Program) may be used to support linkages to primary care providers (PCPs), mental health (MH) and substance use disorder (SUD) specialists and behavioral health and other community services through the discharge process.

☐ **1.1.4** Integrate physical and behavioral health, either through implementation of a new program or an expansion of an existing program, from pilot sites to hospital and health system primary care sites or from single populations to multiple populations (e.g., obesity, diabetes, maternal, infant, and child care, end-of-life care, chronic pain management).

☐ **1.1.5** Patient-Centered Medical Home (PCMH) and behavioral health providers will:

- Collaborate on evidence based standards of care including medication management and care engagement processes.
- Implement case conferences/consults on patients with complex needs.

☐ **1.1.6** Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families.

☐ **1.1.7** Ensure systems are in place to support patient linkages to appropriate specialty physical, mental and SUD services. Preventive care screenings, including behavioral health screenings (e.g., PHQ-2, PHQ-9, SBIRT), will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including the provision of brief interventions (e.g., motivational interviewing techniques) to ensure access for further evaluation and treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.

☐ **1.1.8** Provide cross-systems training to ensure effective engagement with patients with MH/SUD conditions. Ensure that a sufficient number of providers are trained in SBIRT and/or in other new tools used by providers to ensure effectiveness of treatment.

☐ **1.1.9** Increase access to Medication Assisted Treatment (MAT) for patients with alcohol and opioid addiction to assist in stabilizing their lives, reducing urges or cravings to use, and encourage greater adherence to treatment for co-morbid medical and behavioral health conditions. For alcohol use disorders these medications include naltrexone, acamprosate, and disulfiram. For opioid addiction, medication assisted treatment (MAT) includes maintenance treatment with methadone and buprenorphine.

☐ **1.1.10** Ensure the development of a single treatment plan that includes the patient's behavioral health issues, medical issues, substance abuse, social and cultural and linguistic needs. This includes incorporating traditional medical interventions, as well as non-traditional interventions such as gym memberships, nutrition monitoring, healthy lifestyle coaching, or access to culturally and linguistically appropriate peer-led wellness and symptom management groups.

☐ **1.1.11** Ensure a culturally and linguistically appropriate treatment plan by assigning peer providers or other frontline worker to the care team to assist with care navigation, treatment plan development and adherence.

☐ **1.1.12** Ensure that the treatment plan:

- Is maintained in a single shared Electronic Health Record (EHR)/ clinical record that is accessible across the treatment team to ensure coordination of care planning.
- Outcomes are evaluated and monitored for quality and safety for each patient.

☐ **1.1.13** Implement technology enabled data systems to support pre-visit planning, point of care delivery, care plan development, population/panel management activities, coordination and patient engagement. Develop programs to implement telehealth, eReferral/eConsult to enhance access to behavioral health services.

☐ **1.1.14** Demonstrate patient engagement in the design and implementation of the project.

☐ **1.1.15** Increase team engagement by:

- Implementing a model for team-based care in which staff performs to the best of their abilities and credentials.
- Providing ongoing staff training on care model.

☐ **1.1.16** Ensure integration is efficient and providing value to patients by implementing a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

☐ 1.2 Ambulatory Care Redesign: Primary Care (required for DPHs)

[Insert response here]

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

☐ **1.2.1** Conduct a gap analysis of practice sites within the DPH/DMPH system.

☐ **1.2.2** Primary care practices will demonstrate advancement of their PCMH transformation through the use of a nationally-recognized PCMH methodology.

☐ **1.2.3** Hiring and training of frontline workforce (e.g., medical assistants, community health workers, promotoras, health navigators or other non-licensed members of the care team) to be responsible for coordination of non-clinical services and elements of the care plan.

☐ **1.2.4** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population/panel management activities, care coordination, patient engagement, and operational and strategic decisions including a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

- Implementation of EHR technology that meets meaningful use (MU) standards.

☐ **1.2.5** Ongoing identification of all patients for population management (including assigned managed care lives):

- Manage panel size, assignments, and continuity to internal targets.
- Develop interventions for targeted patients by condition, risk, and self-management status.
- Perform preventive care services including mental health and substance misuse screenings and brief interventions (e.g., PHQ-9, SBIRT).

☐ **1.2.6** Enable prompt access to care by:

- Implementing open or advanced access scheduling.
- Creating alternatives to face-to-face provider/patient visits.
- Assigning frontline workers to assist with care navigation and non-clinical elements of the care plan.

☐ **1.2.7** Coordinate care across settings:

- Identification of care coordinators at each primary care site who are responsible for coordinating care within the PCMH as well as with other facilities (e.g., other care coordinators or PCMH/DPH/DMPH high risk care managers):
  - Establish onsite care/case managers to work with high risk patients and their care teams, or develop processes for local care coordinators to work with a central complex care management program for these patients
- Implement processes for timely bi-directional communication and referral to specialty care (including mental health and substance use disorder services), acute care, social services and community-based services.

☐ **1.2.8** Demonstrate evidence-based preventive and chronic disease management.

☐ **1.2.9** Improve staff engagement by:

- Implementing a model for team-based care in which staff performs to the best of their abilities and credentials.
- Providing ongoing staff training on the team-based care model to ensure effective and efficient provision of services (e.g., group visits, medication reconciliation, motivational interviewing, cognitive behavioral therapy and Medication-Assistance Treatment (MAT)).

☐ **1.2.10** Engage patients using care plans, and self-management education, and through involvement in the design and implementation of this project.

☐ **1.2.11** Improve the accuracy and completeness of race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI) data, and use that data to identify and reduce disparities in one or more Primary Care Redesign project metrics by:

- Adding granular REAL and SO/GI data to demographic data collection processes and training front-line/registration staff to gather complete and accurate REAL/SO/GI data.
- Developing capacity to track and report REAL/SO/GI data, and data field completeness.
- Implementing and/or refining processes for ongoing validation of REAL/SO/GI data.
- Developing capacity to stratify performance metrics by REAL/SO/GI data and use stratified performance data to identify disparities for targeted interventions.
- Developing capacity to plan and implement disparity reduction interventions with input from patients and community stakeholders.
- Developing dashboards to share stratified performance measures with front-line staff, providers, and senior leadership.

☐ **1.2.12** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

☐ 1.3 Ambulatory Care Redesign: Specialty Care (required for DPHs)

[Insert response here]

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

☐ **1.3.1** Develop a specialty care program that is broadly applied to the entire target population.

☐ **1.3.2** Conduct a gap analysis to assess need for specialty care including mental health and SUD services (analysis to include factors impacting ability to access specialty care), and the current and ideal state capacity to meet that need. Benchmark to other CA Public Health Care systems.

☐ **1.3.3** For ideal state analysis, include potential impact of increased primary care capacity to manage higher acuity conditions either independently, or in collaboration with, specialty care, so as to reduce the need for in-person specialty care encounters (e.g., insulin titration, IBS management, joint injections, cognitive behavioral therapy (CBT) or MAT).

☐ **1.3.4** Engage primary care providers and local public health departments in development and implementation of specialty care model.

☐ **1.3.5** Implement processes for primary care/specialty care co-management of patient care.

☐ **1.3.6** Establish processes to enable timely follow up for specialty expertise requests.

☐ **1.3.7** Develop closed loop processes to ensure all requests are addressed and if in person visits are performed, that the outcome is communicated back to the PCP.

☐ **1.3.8** Ensure that clinical teams engage in team- and evidence-based care.

☐ **1.3.9** Increase staff engagement by:

- Implementing a model for team-based care in which staff performs to the best of their abilities and credentials.
- Providing ongoing staff training on the care model.

☐ **1.3.10** Develop and implement standardized workflows for diversified care delivery strategies (e.g., shared medical visits, ancillary led services, population management, telemedicine services) to expand access and improve cost efficiency.

☐ **1.3.11** Adopt and follow treatment protocols mutually agreed upon across the delivery system.

☐ **1.3.12** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population management activities and care coordination/transitions of care. Ensure that timely, relevant, and actionable data are used to support patient engagement, PCP collaboration, and drive clinical, operational and strategic decisions including continuous quality improvement (QI) activities.

☐ **1.3.13** Implement EHR technology that meets MU standards.

☐ **1.3.14** Patients have care plans and are engaged in their care. Patients with chronic disease (including MH/SUD conditions) managed by specialty care have documented patient-driven, self-management goals reviewed at each visit.

☐ **1.3.15** Improve medication adherence.

☐ **1.3.16** Implement population management strategies for patients in need of preventive services, with chronic conditions, or with recurring long term surveillance needs.

☐ **1.3.17** Implement or expand use of telehealth based on DPH/DMPH capacity to address patient and PCP barriers to accessing specialty expertise. Implement a telehealth platform with communication modalities that connect between specialty care and primary care (e.g., eConsult/eReferral).

☐ **1.3.18** Demonstrate engagement of patients in the design and implementation of the project.

☐ **1.3.19** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

☐ **1.3.20** Test use of novel performance metrics for redesigned specialty care models.

☐ 1.4 – Patient Safety in the Ambulatory Setting

[Insert response here]

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

☐ **1.4.1** Perform a baseline studies to examine the current workflows for abnormal results follow-up and monitoring of individuals on persistent medications.

☐ **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.

☐ **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.

---

[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.*

☐ **1.4.4** In support of the standard protocols referenced in #2:
- Create and disseminate guidelines for critical abnormal result levels.
- Creation of protocol for provider notification, then patient notification.
- Script notification to assure patient returns for follow up.
- Create follow-up protocols for difficult to reach patients.

☐ **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

[Insert response here]

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

☐ **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.

☐ **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.

☐ **1.5.3** Improve access to quality care and decrease disparities in the delivery of preventive services.

☐ **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.

☐ **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.

☐ **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.

☐ **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.

☐ **1.5.8** Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.

☐ 1.6 – Cancer Screening and Follow-up

[Insert response here]

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

☐ **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).

☐ **1.6.2** Demonstrate patient engagement in the design and implementation of programs.

☐ **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.

☐ **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.

☐ **1.6.5** Improve access to quality care and decrease disparities in the delivery of preventive services.

☐ **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.

☐ **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.

☐ **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.

☐ **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

[Insert response here]

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

☐ **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.

☐ **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.

☐ **1.7.3** Improve access to quality care and decrease disparities in the delivery of preventive services.

☐ **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.

☐ **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.

☐ **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.

☐ **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.

☐ **1.7.8** Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts.

☐ **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):		
Domain 1 Total # of Projects:		

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

☐ 2.1 – Improved Perinatal Care (required for DPHs)

[Insert response here]

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

☐ **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).

☐ **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.

☐ **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.

☐ **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)

[Insert response here]

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

☐ **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.

☐ **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.

☐ **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.

☐ **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.

☐ **2.2.5** Inpatient and outpatient teams will collaboratively develop standardized transition workflows:

- Develop mechanisms to support patients in establishing primary care for those without prior primary care affiliation.
- Develop process for warm hand-off from hospital to outpatient provider, including assignment of responsibility for follow-up of labs or studies still pending at the time of discharge.

☐ **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.

☐ **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.

☐ **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.

☐ **2.2.9** Demonstrate engagement of patients in the design and implementation of the project.

☐ **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.

☐ **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)

[Insert response here]

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

☐ **2.3.1** Develop a complex care management program at one site or with one defined cohort, or expand an existing program from a pilot site to all sites or to additional high-risk groups and demonstrate engagement of patients in the design and implementation of the project.

☐ **2.3.2** Utilize at least one nationally recognized complex care management program methodology.

☐ **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.

☐ **2.3.4** Conduct a qualitative assessment of high-risk, high-utilizing patients.

☐ **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.

☐ **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.

☐ **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.

☐ **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.

☐ 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.

☐ **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.

☐ **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.

☐ 2.4 – Integrated Health Home for Foster Children

[Insert response here]

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

☐ **2.4.1** Healthcare systems receive support in the ongoing management and treatment of foster children:

- Demonstrate engagement of patients and families in the design and implementation of this project.

☐ **2.4.2** Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration).

☐ **2.4.3** Multi-therapeutic care team will:

- Identify patient risk factors using a combination of qualitative and quantitative information.
- Complete a patient needs assessment using a standardized questionnaire.
- Collaborate on evidence-based standards of care including medication management, care coordination and care engagement process.
- Implement multi-disciplinary case conferences/consults on patients with complex needs.
- Ensure the development of a single Treatment Plan that includes the patient's behavioral health issues, medical issues, substance abuse and social needs:
  - Use of individual and group peer support.
- Develop processes for maintaining care coordination and "system continuity" for foster youth who have one or more changes in their foster home.
- Ensure that the Treatment Plan is maintained in a single shared EHR/clinical record that is accessible across the treatment team to ensure coordination of care planning.
- Assess and provide care for all routine pediatric issues with a specific focus on:
  - Mental health/toxic stress
  - Obesity
  - Chronic disease management
  - Medication/care plan adherence which are vulnerable when kids transition care givers frequently
  - Substance abuse issues
  - Developmental assessment, identification and treatment

☐ **2.4.4** Implement technology-enabled data systems to support pre-visit planning, point-of-care delivery, population/panel management activities and care coordination. Timely, relevant and actionable data is used to support patient engagement, and drive clinical, operational and strategic decisions including continuous QI activities.

☐ **2.4.5** Provide linkages to needed services that at a minimum includes child welfare agency, mental health, substance abuse and public health nursing as well as any other social services that are necessary to meet patient needs in the community.

☐ **2.4.6** Develop liaisons/linkage with school systems.

☐ **2.4.7** Provide timely access to eligibility and enrollment services as part of the health home services.

☐ **2.4.8** Evidence-based practice guidelines will be implemented to address risk factor reduction (e.g., immunization, smoking cessation, behavioral health screening) as well as to ensure appropriate management of chronic diseases (e.g., asthma, diabetes). Assessment of social service needs will be integral to these activities. Educational materials will be utilized that are consistent with cultural and linguistic needs of the population.

☐ **2.4.9** 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.

☐ 2.5 – Transition to Integrated Care: Post Incarceration

[Insert response here]

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

☐ **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.

☐ **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.
- 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.

☐ **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.

☐ **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.

☐ **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.

☐ **2.5.6** Provide coordinated care that addresses co-occurring mental health, substance use and chronic physical disorders, including management of chronic pain.

☐ **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.

☐ **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).

☐ **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.

☐ **2.5.10** Engage health plan partners to pro-actively coordinate long-term care services prior to release for timely placement according to need.

☐ **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.

☐ **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.

☐ **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.

☐ **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.

☐ **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.

☐ **2.5.16** Participate in the testing of novel metrics for this population.

☐ 2.6 – Chronic Non-Malignant Pain Management

[Insert response here]

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

☐ **2.6.1** Develop an enterprise-wide chronic non-malignant pain management strategy.

☐ **2.6.2** Demonstrate engagement of patients in the design and implementation of the project.

☐ **2.6.3** Implement or adapt a state or nationally recognized methodology for the assessment and management of chronic pain.

☐ **2.6.4** Implement protocols for primary care management of patients with chronic pain including:

- A standard standardized Pain Care Agreement.
- Standard work and policies to support safe prescribing practices.
- Comprehensive pain history including psycho/social evaluation, functional evaluations, care plan, pain medication risk/benefit informed consents, ongoing monitoring of plan/outcomes (e.g., use of standardized monitoring template for follow-up visits for CNP), aberrant behavior screening and management protocols.

- Guidelines regarding maximum acceptable dosing.

☐ **2.6.5** Provide culturally, linguistically and literacy level-appropriate patient education on the pathology of chronic pain, rationale for rehabilitation and expected goals of treatment.

☐ **2.6.6** Coordinate a chronic pain care team that minimally consists of a physician champion and medical support staff. Suggestions for care clinicians from other disciplines include occupational and physical therapy, behavioral health, pharmacy, substance use disorder specialists, neurology, occupational medicine, anesthesiology/pain management, home care, social work, and physical medicine and rehabilitation.

☐ **2.6.7** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, and team based population/panel management and care coordination.

☐ **2.6.8** Determine population ICD-9/ICD-10 codes for data collection that is unique to patients with chronic pain on opioids and develop a registry for pain assessments, care agreements, medication refill standing orders and urine toxicology screening.

☐ **2.6.9** Utilize provider activity report card to provide feedback to providers on how their chronic pain management practice compares to peers and benchmarks.

☐ **2.6.10** Establish a policy for monitoring and maintaining opioid agreements for prescription refills with other clinics, pharmacies, dentists and specialists.

☐ **2.6.11** Develop a process for scheduling pain focused follow-up patient visits to ensure that patients receive refills in a timely manner while also receiving recommended monitoring for signs of diversion or misuse.

☐ **2.6.12** Develop staff and clinician training regarding the organization's process for managing patients with chronic non-malignant pain.

☐ **2.6.13** Train providers to identify signs of prescription opioid use disorders and provide treatment options for patients diagnosed with opioid use disorders, including suboxone treatment, referral to methadone maintenance, referral to inpatient and outpatient substance use disorder treatment facilities, and referral to needle exchanges.

☐ **2.6.14** Develop and implement protocols for prescribing naloxone to patients receiving opioids for chronic pain.

☐ **2.6.15** Identify standardized multidimensional pain assessment, functional assessment, psychological assessment, and opioid assessment tools that meet the needs of the care clinicians and are appropriate for the patient populations.

☐ **2.6.16** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. Timely, relevant and actionable data is used to support patient.

☐ 2.7 – Comprehensive Advanced Illness Planning and Care

[Insert response here]

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

☐ **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.

☐ **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.

☐ **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.

☐ **2.7.4** Develop comprehensive advance care planning processes and improve implementation of advance care planning with advanced illness patients.

☐ **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.

☐ **2.7.6** Improve completion of Physician Orders for Life-Sustaining Treatment (POLST) with eligible patients and participate in the state-wide POLST registry.

☐ **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.

☐ **2.7.8** Enable concurrent access to hospice and curative-intent treatment, including coordination between the providing services.

☐ **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.

☐ **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.

☐ **2.7.11** Engage staff in trainings to increase role-appropriate competence in palliative care skills, with an emphasis on communication skills.

☐ **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 table below:

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

Section 4.3 – Domain 3: Resource Utilization Efficiency

☐ 3.1 – Antibiotic Stewardship

[Insert response here]

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

☐ **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.

☐ **3.1.2** Develop antimicrobial stewardship policies and procedures.

☐ **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]

☐ **3.1.4** Create standardized protocols for ordering and obtaining cultures and other diagnostic tests prior to initiating antibiotics.

☐ **3.1.5** Develop a method for informing clinicians about unnecessary combinations of antibiotics.

☐ **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.

☐ **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).

☐ **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.

☐ **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.

☐ **3.1.10** Evaluate the use of new diagnostic technologies for rapid delineation between viral and bacterial causes of common infections.

☐ **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).

☐ **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.

☐ **3.1.13** Implement a system a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

☐ 3.2 – Resource Stewardship: High Cost Imaging

[Insert response here]

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

☐ **3.2.1** Implement an imaging management program, demonstrating engagement of patients in the design and implementation of components of the project.

☐ **3.2.2** Program should include identification of top imaging tests whose necessity should be assessed for possible overuse. Criteria for assessment could include:

- Frequency and cost of inappropriate/unnecessary imaging:
  - Appropriate Use: Beginning with state- or nationally-recognized models or guidelines (e.g., American College of Radiology Appropriateness Criteria, American College of Cardiology Appropriate Use Criteria) and incorporating pertinent local factors, programs will set out definitions for appropriateness.
  - Cost: Programs will identify imaging studies associated with high costs due to high cost per study or high volume across the system.
- Unwarranted practice variation within the participating DPHs/DMPHs. Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed.
- Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed.
- Whether there are established, tested and available evidence-based clinical pathways to guide cost-effective imaging choices.

☐ **3.2.3** Establish standards of care regarding use of imaging, including:

- Costs are high and evidence for clinical effectiveness is highly variable or low.
- The imaging service is overused compared to evidence-based appropriateness criteria.
- Lack of evidence of additional value (benefits to cost) compared to other imaging options available to answer the clinical question.

☐ **3.2.4** Incorporate cost information into decision making processes:

- Develop recommendations as guidelines for provider-patient shared decision conversations in determining an appropriate treatment plan.
- Implementation of decision support, evidence-based guidelines and medical criteria to recommend best course of action.

☐ **3.2.5** Provide staff training on project components including implementation of recommendations, and methods for engaging patients in shared decision making as regards to appropriate use of imaging.

☐ **3.2.6** Implement a system for continual rapid cycle improvement and performance feedback that includes patients, front line staff and senior leadership.

☐ 3.3 – Resource Stewardship: Therapies Involving High Cost Pharmaceuticals

[Insert response here]

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

☐ **3.3.1** Implement or expand a high-cost pharmaceuticals management program.

☐ **3.3.2** Implement a multidisciplinary pharmaceuticals stewardship team.

☐ **3.3.3** Develop a data analytics process to identify the participating PRIME entity highest cost pharmaceuticals (high-cost medications or moderate-cost meds with high prescribing volume). Identify high-cost medications whose efficacy is significantly greater than available lower cost medications.

- Using purchase price data, identify the top 20 medications and medication classes, focusing on the following: Analgesics, Anesthetics, Anticoagulants, Anti-Neoplastics, Diabetes, Hepatitis C, Immunoglobulins, Mental Health (Anti-Depressants/Sedatives/ Anti-Psychotics), Respiratory (COPD/Asthma), Rheumatoid Arthritis.
  - Exclude Anti-Infectives and Blood Products (addressed in separate PRIME Projects).

☐ **3.3.4** Develop processes for evaluating impact of high-cost, high-efficacy drugs, particularly drugs to treat conditions (e.g., HCV) or to address circumstances (e.g., oral anticoagulants for patients without transportation for blood checks) more prevalent in safety net populations:

- Consider criteria that include ability of identified medications to improve patient health, improve patient function and reduce use of health care services.

☐ **3.3.5** Develop processes to impact prescribing by providers by establishing standards of care regarding prescribing of high cost pharmaceuticals, including:

- Use of decision support/CPOE, evidence-based guidelines and medical criteria to support established standards.
- Develop processes to improve the appropriate setting for medication delivery including, transitioning pharmaceutical treatment to the outpatient setting wherever possible.
- Promote standards for generic prescribing.
- Promote standards for utilizing therapeutic interchange.

☐ **3.3.6** Improve the process for proper billing of medications, through clinician education and decision support processes.

☐ **3.3.7** Develop formulary alignment with local health plans.

☐ **3.3.8** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership rapid cycle improvement using standard process improvement methodology.

☐ **3.3.9** Develop organization-wide provider level dashboards to track prescribing patterns for targeted high cost pharmaceuticals. Dashboard to include comparisons to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.

☐ **3.3.10** Develop processes for working with providers with prescribing patterns outside established standards, to identify and reduce barriers to meeting prescribing standards:

- Develop guidelines and provide staff training on methods for engaging patients in shared decision making for developing treatment plans within the context of the established standards.

☐ **3.3.11** Maximize access to 340b pricing:

- Share templates for contracting with external pharmacies.
- To improve program integrity, share tools for monitoring of 340b contract compliance.

☐ 3.4 – Resource Stewardship: Blood Products

[Insert response here]

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

☐ **3.4.1** Implement or expand a patient blood products management (PBM) program.

☐ **3.4.2** Implement or expand a Transfusion Committee consisting of key stakeholder physicians and medical support services, and hospital administration.

☐ **3.4.3** Utilize at least one nationally recognized patient blood management program methodology (e.g., The Joint Commission, AABB).

☐ **3.4.4** Develop processes for evaluating impact of blood product use including appropriateness of use, adequacy of documentation, safety implications, cost, and departmental budget impact. Develop a data analytics process to track these and other program metrics.

☐ **3.4.5** Establish standards of care regarding use of blood products, including:
- Use of decision support/CPOE, evidence based guidelines and medical criteria to support and/or establish standards.

☐ **3.4.6** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

☐ **3.4.7** Develop organization-wide dashboards to track provider level blood use patterns. Dashboard to include comparisons to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.

☐ **3.4.8** Participate in the testing of novel metrics for PBM programs.

Please complete the summary table below:

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

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 $ payment amount
- DY 12 $ payment amount
- DY 13 $ payment amount
- DY 14 $ payment amount
- DY 15 $ payment amount

Total 5-year prime plan incentive amount: $ payment amount

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.

Click or tap here to enter your digital signature.	Click here to enter today's date.
CHIEF EXECUTIVE OFFICER	**DATE**

Appendix- Infrastructure Building Process Measures

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