DRAFT Project Descriptions – Project 1.1 Ambulatory Care Redesign: Primary Care

Required Project

Project Domain	Domain 1: Delivery System Transformation
Project Title	Ambulatory Care Redesign: Primary Care

Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)

Patients will experience barrier free access to high quality and efficient primary care designed to work collaboratively with patients in achieving and maintaining optimum health. This work entails further redesigning the ambulatory care system to be patient-centric, increase access to care, improve care coordination, expand the use of non-physician care team members and alternatives to face-to-face provider-patient modalities of care provision, employ panel and population health management strategies, and conduct continuous quality improvement.

Specific objectives include:

- Increase patient access to care
- Improve patient experience of care
- Increase the number of clinics meeting PCMH criteria
- Transform all safety net providers in primary care practices into NCQA 2014 Level Three Patient Centered Medical Homes (PCMHs)
- Increase provision of preventive health services
- Improve health indicators for patients with chronic condition(s)
- Decrease preventable acute care utilization
- Increase staff engagement

Core Components (6-10 general required steps or elements)

Systems undertaking this project will be required to complete the following components:

- Gap analysis of practice sites within the PHS system.
- Fully implement the patient-centered medical home model
- Achievement of NCQA PCMH 2014 Level Three recognition
- 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 quality improvement activities.
    - Implementation of EHR technology that meets meaningful use standards (MU)
- Support population management by implementing processes for
    - Ongoing empanelment of all patients, (including managed care patients who have been assigned but not yet seen);
    - Management of panel size, assignments, and continuity;
    - Proactive tracking, in-reach and outreach of empanelled patients by disease status, risk status, self-management status, community and family need for preventive and chronic care services.
    - Preventive care screenings including behavioral health screenings (PHQ-9, SBIRT) will be implemented for all patients to identify unmet needs.
- Clinical teams engage in team- and evidence-based care with all care team members performing key clinical service roles that match their abilities and credentials.
    - Staff training on care model including evidence based preventive and chronic disease management.

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- Patients have care plans, are engaged in their care, and are educated on self-management
- Enable prompt access to care by:
  - Implementation of open or advanced access scheduling
  - Redesigning patient encounters to be patient-centric (including alternatives to face-to-face provider/patient visits)
- Coordinate care across settings
  - Identification of care coordinators at each primary care site who are responsible for care connectivity and engagement of other staff in PCMH process as well connectivity to other care managers who provide care coordination for higher risk patients (e.g., health home care managers)
  - Processes in place for timely referral to needed medical and surgical specialty, behavioral health, acute care (urgent, emergent, inpatient), social services and supportive community based services are in place, including communication of relevant information both in advance, during and after the provision of services. Process in place for a "warm hand-off" where possible. Timely follow up with the Primary Care Team occurs as is appropriate to the level of acuity.
- Implement a system for performance feedback that includes patients, front line staff and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology
- Demonstrate engagement of patients in the design and implementation of the project.

Project Metrics (3-7 metrics; at least one metric per metric type)	
Clinical Event Outcomes	• Prevention ○ Breast Cancer Screening (NCQA, NQF 2372) ○ Cervical Cancer Screening (DMHC CCS, NCQA, NQF 0032) ○ Childhood IZ Status – Combination 3 (DMHC CIS-3, NCQA, NQF 0038) ○ Colorectal Cancer Screening (NCQA, NQF 0034) ○ Tobacco Assessment and Counseling (AMA-PCQI, NQF 0028) ○ Tobacco: Medical Assistance with Smoking Cessation (NCQA, NQF 0027) ○ Body Mass Index (BMI) Screening and Follow-Up (CMS, NQF 0421, DHCS priority) ○ Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents (NCQA, NQF 0024, DHCS priority) ○ Body Mass Index Screening and Follow-Up (CMS, NQF 0421) ○ Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI) (The Child and Adolescent Health Measurement Initiative, NQF 1349) ○ Annual Dental Visit 2-21 (if part of Medicaid benefit) (ADV) (NCQA, NQF 1388) • Chronic Care ○ Asthma Medication Ratio (NCQA, NQF 1800) ○ Medication Management for People with Asthma (NCQA 1799) ○ Controlling Blood Pressure (DMHC, NCQA, NQF 0018)

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	○ Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%), (NCQA, NQF 0059) ○ Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing (CDC-HT, DMHC, NCQA, NQF 0057) ○ Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic (NCQA, NQF 0068) ○ Prenatal and Postpartum Care – Timeliness of Prenatal Care (PPC-Pre, DMHC, NQF 1517)
Potentially Preventable Event/Value/Cost Outcomes	• Cost/member • Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) (CMS, The Joint Commission, NQF 1789) DHCS with a CA-only measure • Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year (Bridges to Excellence, NQF 0709) • Potentially Avoidable Emergency Room Visits (3M) • Potentially Avoidable Readmissions (3M)
Patient Experience	• Continuity with provider • CG-CAHPS ○ Usual source of care ▪ Is provider/clinic named the place you usually go for care?) ○ Timely Appointments, Care, and Information ▪ Getting Care Quickly (routine and urgent care appointments as soon as member thought needed) ▪ Getting Care Needed (access to specialists and getting care member thought needed) ▪ Access to Information After Hours ○ Patient would recommend provider to family and friends ○ Clerks and receptionists at provider's office ▪ Helpful; Courteous and respectful ○ Aspirin Discussion and Use • Staff Engagement scores (Gallup 12)

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DRAFT Project Description – Project 1.2 Ambulatory Care Redesign: Specialty Care

Project Domain	Domain 1: Delivery System Transformation
Project Title	Ambulatory Care Redesign: Specialty Care

Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)

Patients will experience barrier free access to high quality, effective specialty care designed to work collaboratively with patients in achieving and maintaining optimum health, and avoiding unplanned interventions. Redesign of ambulatory care system processes will include improvements to be patient centric, expand the use of non-physician care team members, implement alternatives to face-to-face patient-provider encounters, including the use of telehealth solutions, engage in population health management strategies, and improve collaboration and coordination with primary care partners.

Specific objectives include:

- Increase patient access to specialty expertise – delivered in the most effective means to meet the need.
- Partner with PCMH to improve health outcomes in chronic disease
- Improve primary care capacity to care for complex patients
- Decrease avoidable acute care utilization
- Increase specialty care staff engagement

Core Components (6-10 general required steps or elements)

Systems undertaking this project will be required to complete the following components:

- Develop a specialty care program that is broadly applied to the entire population of service.
- Conduct a gap analysis to assess target population demand need for specialty care (including 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.
    - For ideal state, consider 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.
- Engage primary care providers in development and implementation of specialty care model
    - Implement processes for primary care:specialty care co-management of patient care
    - Establish processes to enable timely follow up for specialty expertise requests
    - 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.
- Clinical teams engage in team- and evidence-based care
- 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
- Adopt and follow treatment protocols mutually agreed upon across the delivery system
- Implement technology enabled data systems to support pre-visit planning, point of care delivery, population management activities and care coordination/transitions of care. Timely, relevant and actionable data is used to support patient engagement, and drive clinical, operational and strategic decisions including continuous quality improvement activities.
    - Implement EHR technology that meets meaningful use standards (MU)
- Patients have care plans and are engaged in their care. Patients with chronic disease managed by specialty care have documented patient-driven self-management goals reviewed at each visit
- Improve medication adherence

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- Implement population management strategies for patients in need of preventive services, with chronic conditions, or with recurring long term surveillance needs
- Implement or expand use of telemedicine based on PHS capacity to address community barriers to accessing specialty expertise
    - Definition of service area for implementation including providers that will be participating with clear delineation between telemedicine hub sites versus spoke sites.
    - Service agreements in place for provision of the telemedicine service such as specialty service, participating primary care networks and nurse triage monitoring.
    - Standard protocols for the service (such as patient eligibility, appointment availability, medical record protocols, educational standards and continuing education credits) as well as to address consent and confidentiality standards meeting all federal and state requirements.
    - Coordination with local health plans to develop and ensure service authorization and payment strategies are in place to support sustainability of patient care uses.
    - Quality review process to ensure adequate use of services, appropriateness of services and quality of clinical outcomes related to use of services.
- Demonstrate engagement of patients in the design and implementation of the project
- Implement a system for performance feedback that includes patients, front line staff and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology

Project Metrics (3-7 metrics; at least one metric per metric type)	
Clinical Event Outcomes	• Access: ○ Average TNAA for new patients across Specialty Care services ○ Referral Reply Turnaround Rate – Timely Referral response rate (% within 3 business days), time to close/resolution (see Touches) ○ Specialty Care Touches: Total, # managed by primary, # co-managed, # seen in-person • Closing the referral loop: receipt of specialist report (CMS MU, CMS50v1) • Medication Management for People with Asthma (NCQA 1799) ○ *OR* Asthma Medication Ratio (NCQA, NQF 1800) • Controlling Blood Pressure (DMHC, NCQA, NQF 0018) • Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%), (NCQA, NQF 0059) • Tobacco Assessment and Counseling (AMA-PCQI, NQF 0028)
Potentially Preventable Event/Value/Cost Outcomes	• Cost/member • Potentially Avoidable Emergency Room Visits (3M) • Potentially Avoidable Readmissions (3M)
Patient Experience	• CG-CAHPS: ○ Timely Appointments, Care, and Information ○ Care Coordination ▪ PCP informed about the care from specialists

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	• Staff Engagement scores

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DRAFT Project Description – Project 1.3 Care Transitions

Project Domain	Domain 1: Delivery System Transformation
Project Title	Care Transitions: Integration of Post-Acute Care

Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)

To ensure the coordination and continuity of health care as high risk patients, particularly those with chronic health conditions, behavioral health conditions and/or housing instability, move from the hospital to the ambulatory care setting with the goal of improving patients' ability to care for themselves, successfully hand off health care responsibility to primary care and ultimately reduce readmissions. As a result, prevent the progression of chronic illness and decrease health care costs.

Specific objectives include:

- Reduce readmissions
- Improve patient experience
- Increase patients capacity for self-management

Core Components (6-10 general required steps or elements)

Systems undertaking this project will be required to complete the following components:

- Conduct an assessment of all readmissions, using quantitative and qualitative information to identify the key causes of readmissions, including diagnoses, social concerns including housing, food security, substance use, transportation and health literacy barriers, and health care related concerns such as lack of engagement with a primary care provider, medication access and medication errors.
- Develop a care transitions program or expand a care transitions program to additional settings (e.g., emergency department) or to additional populations
- Utilize at least one nationally recognized care transitions program methodology (e.g., CMS Hospital Conditions of Participation, AHRQ Hospital Guide to Reducing Medicaid Readmissions, BOOST, STAAR, RED)
- Establish data analytics systems and clinical decision support to identify hospitalized patients at high risk for readmission and tiered multi-disciplinary interventions according to level of risk
- Develop standardized workflows for both discharge (inpatient) and post-discharge (outpatient) care.
    - Develop mechanisms to support patients in establish primary care for those without prior primary care affiliation.
- Involve pharmacy and palliative care team members in the care transitions program
- Optimize hospital discharge planning and medication management for all hospitalized patients.
- Support patients and family caregivers in becoming more comfortable and competent in participating in their care during care transitions through pre-discharge education and coaching and a 30-day supported transition period after a hospitalization to ensure discharge directions are understood and implemented by the patients, including:
    - Pre-discharge patient and caregiver education and coaching;
        - To ensure they are knowledgeable about red-flag indications in the patient's condition and how to respond.
        - About medication self-management
        - On how to be an active participant in hospital discharge preparation

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- Transition care plan for patient and caregiver
- Communication and coordination with receiving practitioner; and
- Community-based support for the patient and caregiver for 30-days post hospitalization focusing on patient understanding of, and capacity for, self-care and follow-up care with primary and specialty care providers

- Deliver timely access to primary and/or specialty care following a hospitalization, including
  - Assessing patient and initiating ongoing care plan, taking into account patient's unique needs and potential social determinants of health
- Develop standardized protocols for referral to and coordination with community based services: mental health, substance use, and other social services (i.e., visiting nurses and home care services)
- Use data and information technology to identify patients at high risk of readmission, support patients and care teams during the transition process, and drive performance improvement
- Engage with local health plans, as applicable, associated with the identified population to develop transition of care protocols that will ensure coordination of care will be supported, covered services including DME will be readily available and that there is a payment strategy for the transition of care services.
- Demonstrate engagement of patients in the design and implementation of the project
- Implement a system for performance feedback that includes patients, front line staff and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology

Project Metrics (3-7 metrics; at least one metric per metric type)	
Clinical Event Outcomes	• Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (AMA-PCPI, NQF 0646) • Medication Reconciliation Post-Discharge – 30 days (MRP) (NCQA, NQF 0554) • Medication Discrepancy Tool (MDT, Care Transitions Program, not endorsed but evidenced based) • *patient receives care plan at discharge* • *high risk patients have clinical encounter within 7 days of discharge (e.g, phone call, clinic visit, or home nursing visit)* • Follow-up after hospitalization for mental illness (FUH)(HEDIS, NQF 0576) • Persistence of Beta-blocker treatment after a Heart Attack (HEDIS, NQF 0071) • Heart Failure: ACE or ARB Therapy for Left Ventricular Systolic Dysfunction (Outpatient and Inpatient Setting)(AMA-PCPI, NQF 0081)
Potentially Preventable Event/Value/Cost Outcomes	• Reduction in 72-hour return rate in the Emergency Department • Potentially Avoidable Emergency Room Visits (3M) • Potentially Avoidable Readmissions (3M) • Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) (The Joint Commission, CMS, NQF 1789) • Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following heart failure hospitalization (The Joint

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	Commission, CMS, NQF 0330) • Medication Complication 30-day Readmission Rate

Patient Experience	• H-CAHPS – Care Transition Metrics (AHRQ)
	  ○ When You Left The Hospital
	  ○ Understanding Your Care When You Left The Hospital
	  ○ Care Transition Measure (CTM-3)(University of Colorado Health Sciences Center, NQF 0228)
	• CG-CAHPS
	  ○ Care Coordination (AHRQ)
	  ▪ Provider up-to-date about care received from specialists
	  ▪ Provider knew important information about patient's medical history
	  ○ Timely Appointments, Care, and Information
	  ▪ Getting Care Quickly (routine and urgent care appointments as soon as member thought needed)
	  ▪ Getting Care Needed (access to specialists and getting care member thought needed)
	  ▪ Access to Information After Hours

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DRAFT Project Description – Project 1.4 Care Coordination: High Risk Populations

Project Domain	Domain 1: Delivery System Transformation
Project Title	Care Coordination: High Risk Populations

Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)

To improve the organization of patient care activities among participants involved in a high risk patient's care in order to facilitate the appropriate delivery of health care services and to better meet the patient's needs and preferences in the delivery of high quality, high value care. Implement a comprehensive, complex care management program for high-risk patients.

Specific objectives include:

- Improve patients' functional status
- Increase patients' capacity to self-manage their condition
- Reduce avoidable acute care utilization (readmissions, admissions & ED visits)
- Improve medication management
- Improve care processes
- Improve health indicators for chronically ill patients
- Improve patient experience

Core Components (6-10 general required steps or elements)

Systems undertaking this project will be required to complete the following components:

- Conduct a qualitative assessment of higher risk patients with insufficient access to/use of primary care services.
- Develop a complex care management program, or expand an existing program from a pilot site to all sites or to additional high risk groups
- Utilize at least one nationally recognized complex care management program methodology[1]
- Develop criteria for program inclusion based on quantitative and qualitative data, such as: acute care utilization, lack of primary care utilization, number of high risk medical or behavioral conditions, polypharmacy, clinical input, functional status, patient activation, social support or other factors
- Establish data analytics systems using clinical (e.g., EHR, registries), utilization, financial and community data (e.g., health plan), 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.
- 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.
    - Provide ongoing training and mentoring opportunities to care team members.
- Evidence based practice guidelines will be implemented 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. 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.
    - Use standardized comprehensive patient assessment and evaluation tools (e.g., PHQ-9, HARMS-8, Patient Activation Measure, AHRQ Whole Person Care Assessment Tool)
- Ensure systems are in place that address patient linkage to care, ensure follow-up and

[1] see The Commonwealth Fund, California Quality Collaborative, Camden Coalition, IHI and The Center for Health Care Strategies Super Utilizer Summit and Policy Brief

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retention in care, and promote adherence to medication management, monitoring and other components of evidence based practice for management • Use data and information technology to support patients and care teams throughout the care management program (e.g., text messaging, alert programs, remote monitoring, shared data and care plans), and drive performance improvement (e.g., outcome metrics dashboard) • Demonstrate engagement of patients in the design and implementation of the project • Implement a system for performance feedback that includes patients, front line staff and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology	
Project Metrics (3-7 metrics; at least one metric per metric type)	
Clinical Event Outcomes	• General Self-Rated Health • Healthy Days Core Module (CDC HRQOL– 4) • Medication Reconciliation – 60 days (NCQA, NQF 0097) • Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%), (NCQA, NQF 0059) • Tobacco: Medical Assistance With Smoking and Tobacco Use Cessation (MSC) (NCQA, NQF 0027) • Controlling Blood Pressure (NCQA, NQF 0018, DMHC) • HIV viral load suppression (HRSA-HAB, NQF 2082)
Potentially Preventable Event/Value/Cost Outcomes	• Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) (CMS, The Joint Commission, NQF 1789) • Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year (Bridges to Excellence, NQF 0709) • Potentially Avoidable Emergency Room Visits (3M) • Potentially Avoidable Readmissions (3M)

Patient Experience	• CG-CAHPS
	  ○ Patient Loyalty, Usual Source of Care
	  ▪ Is provider/clinic named the place you usually go for care?
	  ▪ How long have you gone to this provider/clinic for care?
	  ○ Care Coordination (AHRQ)
	  ▪ Provider up-to-date about care received from specialists
	  ▪ Provider knew important information about patient's medical history
	  ○ Timely Appointments, Care, and Information
	  ▪ Getting Care Quickly (routine and urgent care appointments as soon as member thought needed)
	  ▪ Getting Care Needed (access to specialists and getting care member thought needed)
	  ▪ Access to Information After Hours
	  ▪ Wait Time (days between call for appointment and getting appoint for urgent care)

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DRAFT Project Description – Project 1.5 Integration of Physical and Behavioral Health

Project Domain	Domain 1: Delivery System Transformation
Project Title	Integration of Physical and Behavioral Health

Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)

To improve physical and behavioral health outcomes, efficiency and patient experience by establishing or expanding fully integrated care teams—primary and behavioral health care providers delivering coordinated comprehensive care for the whole patient. To integrate mental health and substance abuse with primary care services to ensure coordination of care for both services in order to: 1) identify behavioral health diagnoses early, allowing rapid treatment, 2) ensure treatments for medical and behavioral health conditions are compatible and do not cause adverse effects, and 3) de-stigmatize treatment for behavioral health diagnoses.

Specific objectives include:

- Increase use of screening tools (e.g. PHQ-9, GAD-7, AUDIT, DAST)
- Improve patient adherence to their treatment regimen
- Improve health indicators for patients with both medical and behavioral chronic conditions
- Improve care processes
- Reduce readmissions for behavioral health
- Reduce ED visits for behavioral health
- Improve patient experience
- Improve linkages to behavioral health settings
- Improve linkages to community services

Core Components (6-10 general required steps or elements)

Systems undertaking this project will be required to complete the following components:

- Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration, the IMPACT Model, or other IBH resources from SAMHSA). This may be achieved by:
    1) Integration of behavioral health specialists into primary care clinics using the collaborative care model and supporting the PCMH model, or 2) Integration of primary care services into established behavioral health sites such as clinics and Crisis Centers. When onsite coordination is not possible, then 3) Access to behavioral health specialist expertise can be incorporated into primary care coordination teams.
    2) Team Care in the ER: The model is a placement of unlicensed care navigators in the ER – 3 or 4 at a time 7 days a week, 24 hours a day. The navigators perform care coordination activities by helping certain people who show up connect to primary care providers, specialists, social workers, and behavioral health services. They use a model similar to a transitions model from a hospital and deter more costly hospital admissions. It is referred to as the, "Community Physician Liaison Program."

- Physical-behavioral health integration program may be an implementation of a new program or an expansion of an existing program, from pilot sites to all PHS 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.
- PCHM and behavioral health providers will

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

- Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families.
- Preventive care screenings including behavioral health screenings and brief interventions (PHQ-9, SBIRT) will be implemented for all patients to reduce risky behavior and to identify unmet needs. When screenings are positive, providers will take immediate steps (including brief interventions) 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.
- Provide cross-systems training to ensure effective engagement with patients with MH/SUD conditions. Ensure that sufficient number of providers is trained in SBIRT and/or in other new tools used by providers to ensure effectiveness of treatment.
- Ensure the development of a single Treatment Plan that includes the patient's behavioral health issues, medical issues, substance abuse and social 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 peer-led wellness and symptoms management groups.
- 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.
  - Outcomes are evaluated and monitored for quality and safety for each patient.
- 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 quality improvement activities.
- Demonstrate engagement of patients in the design and implementation of the project
- Ensure integration is efficient and providing value to patients by implementing a system for performance feedback that includes both front line and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology

Project Metrics (3-7 metrics; at least one metric per metric type)	
Clinical Event Outcomes	• Controlling Blood Pressure (NCQA 0018, DMHC) • Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%), (NCQA, NQF 0059) • Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD) (NCQA, NQF 1932) • Screening for Clinical Depression and follow-up (CMS, NQF 0418) • Depression Remission at 12 Months (MN Community Measurement, NQF 0710) (Remission at 6 mos: NQF 0711) • Cardiovascular Monitoring for People with CVD and Schizophrenia (NCQA, NQF 1933) • Diabetes Monitoring for people with Diabetes and Schizophrenia (NCQA, NQF 1934) • Other CQAIMH measures?

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	• % of referrals that were actually admitted to treatment
Potentially Preventable Event Outcomes	• Potentially preventable ED visits (for persons with BH diagnosis) (3M) • Behavioral Health/Substance Abuse (BH/SA) Admission Rate risk adjusted (3M) • Behavioral Health /Substance Abuse 30-day Readmission Rate risk adjusted (3M)

Patient Experience	• CG-CAHPS
	  ○ Care Coordination
	  ▪ Provider up-to-date about care received from specialists
	  ▪ Provider knew important information about patient's medical history
	  ○ Timely Appointments, Care, and Information
	  ▪ Getting Care Quickly (routine and urgent care appointments as soon as member thought needed)
	  ▪ Getting Care Needed (access to specialists and getting care member thought needed)
	  ▪ Access to Information After Hours
	  ▪ Wait Time (days between call for appointment and getting appoint for urgent care)
	• Staff Engagement (Gallup-12)

Training Evaluation	**Potential measures:** • Number of trainings conducted • Gain in knowledge • Skill attainment
	•

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DRAFT Project Worksheet – Project 2.2 Chronic Non-Malignant Pain Management

Project Domain	Domain 3: Improved Outcomes for Specific High Risk, High Utilizing Populations
Project Title	Chronic Non-Malignant Pain Management

Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)

To improve primary care physicians' and care teams' ability to identify, treat, and manage patients highly impaired by pain thereby improving patient level of function, reducing inappropriate prescribing, and reducing admissions for overdoses. Effectively managing Chronic Non-Malignant Pain while avoiding over- or under-treatment.

Specific objectives include:

- Improve the function of patients age 18 years and older with chronic pain.
- Improve the assessment and reassessment of patients age 18 years and older with chronic pain diagnosis utilizing the biopsychosocial model.
- Improve the appropriate use of Level I and Level II treatment approaches for patients age 18 years and older with chronic pain.
- Improve the effective use of non-opioid medications in the treatment of patients age 18 years and older with chronic pain.
- Improve the effective use of opioid medications in the treatment of patients age 18 years and older with chronic pain.
- Decrease the rate of opioid prescriptions for adults 18 years and older with diagnoses that do not warrant opioids (e.g., fibromyalgia, headache, sore throat, uncomplicated neck and back pain, uncomplicated musculoskeletal pain, non-traumatic tooth pain).
- Increase access to naloxone for patients with chronic opioid prescriptions

Core Components (6-10 general required steps or elements)

Systems undertaking this project will be required to complete the following components:

- Develop a Chronic Non-Malignant Pain management strategy for primary care facilities
- Use an evidence based algorithm for the assessment and management of chronic pain (such as developed by the Institute for Clinical Systems Improvement [2], The American Pain Society, or The American Society of Anesthesiologists)
- Implement protocols for primary care management of patients with chronic pain (may include)
  - 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
  - Establish standard standardized Pain Care Agreement
  - Establish standard work and policies to support safe prescribing practices
  - Establish guidelines regarding maximum acceptable dosing
- Provide culturally, linguistically and literacy level appropriate patient education on the pathology of chronic pain, rationale for rehabilitation and expected goals of treatment
- Develop a process that allows patients with chronic pain to see a dedicated care clinician who has an interest or expertise in chronic pain.

[2] Hooten WM, Timming R, Belgrade M, Gaul J, Geortz M, Hakke B, Mters C, Noonana MP, Owens J, Saeger L, Schweim K, Shteyman G, Walker N. Institute for Clinical Systems Improvement. Assessment and Management of Chronic Pain. Update November 2013.

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- Develop protocols for prescribing of short and long acting narcotics that are implemented enterprise wide (i.e., primary, specialty, ER, inpatient)
- 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 pharmacy, chemical dependency, neurology, occupational medicine, anesthesiology/pain management, behavioral health, home care, social work, physical medicine and rehabilitation, and physical therapy.
- Determine population ICD-9/ICD-10 codes for data collection that is unique to patients with chronic pain in the participating PHS (e.g., Low back pain, Headache, Neck pain, Fibromyalgia, Chronic pain)
- Employ population management and team based approaches to monitoring and management of patients with a chronic non-malignant pain diagnosis such as use of registries for pain assessments, care agreements, medication refill standing orders and urine toxicology screening
- Utilize provider activity report card provide feedback to providers on how their chronic pain management practice compares to peers and benchmarks
- Establish a policy for monitoring and maintaining opioid agreements for prescription refills with other clinics, pharmacies, dentists and specialists.
- Develop a process for scheduling follow-up patient visits to deter drug-seeking behaviors with other care clinicians, for instance, support personnel calling patients to schedule follow-up appointments with a dedicated chronic pain physician.
- Develop staff and physician training regarding the organization's process for treating patients with chronic pain that could include process of referrals to chronic pain clinician within the system, follow-up visits, prescription refills and continuity of care.
- Identify 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
    - Examples of pain assessment, functional assessment, and psychological assessment tools are, but are not limited to:
        - Brief Pain Inventory (BPI), Physical Functional Ability Questionnaire (FAQ5), Oswestry Low Back Disability Index, PHQ-9, GAD 7
    - Examples of opioid and substance abuse assessment tools are, but are not limited to:
        - CAGE and CAGE-AID, Webster's Opioid Risk Tool (ORT), DIRE Tool, Screener and Opioid Assessment for Patients in Pain (SOAPP®), Current Opioid Misuse Measure (COMMTM), Prescription Drug Use Questionnaire (PDUQ), Screening Tool for Addiction Risk (STAR), Screening Instrument for Substance Abuse Potential (SISAP), Pain Medicine Questionnaire (PMQ), Audit-C, Screening, Brief Intervention, Referral to Treatment (SBIRT)
- 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 quality improvement activities.
- Demonstrate engagement of patients in the design and implementation of the project
- Implement a system for performance feedback that includes both front line and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology

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Project Metrics (3-7 metrics; at least one metric per metric type)	
Clinical Event Outcomes	• Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (NQF) • Healthy Days Core Module (CDC HRQOL– 4) *The following measures have been developed by the Institute for Clinical Systems Improvement and others and are not NQF endorsed and are all Process Measures. It will be important that we also identify Outcome Measures.* • Patients with on long term opioid therapy co-prescribed opioid and CNS depressants (Denominator: patients with active opioid prescriptions for >90 days). (AHRQ, VA) • Patients with on long term opioid therapy checked in PDMPs (AHRQ, VA) • Assessment and management of chronic pain: percentage of chronic pain patients who are referred to diagnostic and/or therapeutic procedures if the goals for pain control or functional status have not been met. 2013 Nov. NQMC:009364 • Assessment and management of chronic pain: percentage of patients diagnosed with chronic pain who are prescribed an opioid at a dose less than 100 mg per day of morphine. 2013 Nov. NQMC:009370 ○ # of patients on high daily dose (>200mcg/d morphine) (AHRQ, VA) • Assessment and management of chronic pain: percentage of patients diagnosed with chronic pain who are prescribed an opioid who have an opioid agreement form and urine toxicology screen documented in the medical record. 2013 Nov. NQMC:009368 • Assessment and management of chronic pain: percentage of patients diagnosed with chronic pain who are receiving opioids who have documentation of the four A's assessment: 1) the degree of analgesia, 2) current opioid-related side effects, 3) current functional status and 4) existence of aberrant drug-related behaviors documented at each visit. 2013 Nov. NQMC:009367 • Assessment and management of chronic pain: percentage of patients diagnosed with chronic pain who are screened for chemical dependency before being prescribed opioid medication. 2013 Nov. NQMC:009369 • Assessment and management of chronic pain: percentage of patients diagnosed with chronic pain who have documentation of a plan of care that addresses personal goals, sleep, physical activity, stress management and pain reduction in the medical record and identifies potential barriers to patient follow-up on plan of care. 2013 Nov. NQMC:009363 • Assessment and management of chronic pain: percentage of patients diagnosed with chronic pain who have not met pain control or functional status goals who are referred to pain specialist or interdisciplinary pain team. 2013 Nov. NQMC:009365 • Assessment and management of chronic pain: percentage of patients diagnosed with chronic pain with a diagnosis of neuropathic pain who are prescribed a sedative analgesic OR anticonvulsant prior to use of opioids. 2013 Nov. NQMC:009366

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	• Assessment and management of chronic pain: percentage of patients diagnosed with chronic pain with documentation of reassessment of pain at follow-up visits using a standardized tool that addresses pain intensity, location, pattern and current functional status. 2013 Nov. NQMC:009361 • Assessment and management of chronic pain: percentage of patients diagnosed with chronic pain with documentation of receiving education regarding their diagnosis of chronic pain, medications, importance of physical activity and/or any interventional procedures in the medical record. 2013 Nov. NQMC:009359 • Assessment and management of chronic pain: percentage of patients diagnosed with chronic pain with documentation of screening for major depression and chemical dependency. 2013 Nov. NQMC:009362 • Assessment and management of chronic pain: percentage of patients diagnosed with chronic pain with functional outcome goals documented in the medical record. 2013 Nov. NQMC:009357 • Assessment and management of chronic pain: percentage of patients diagnosed with chronic pain with referral to physical rehabilitation and/or behavioral management therapy. 2013 Nov. NQMC:009358 • Assessment and management of chronic pain: percentage of patients with chronic pain diagnosis with documentation of a pain assessment completed at initial visit using a standardized tool that addresses pain intensity, location, pattern, mechanism of pain, current functional status and follow-up plan. 2013 Nov. NQMC:009360
Potentially Preventable Event/Value/Cost Outcomes	• ED visits for prescribed opiate overdose • Admissions for prescribed opiate overdose • Number of patients with a diagnosis of chronic pain prescribed short-acting narcotics • New prescriptions for short acting opiates (including ED and urgent care) (lower is better) • Proportion of patients on opioids prescribed naloxone • Proportion of patients with co-occurring pain and substance use disorder on agonist maintenance therapy • MRI Lumbar Spine for Low Back Pain without antecedent conservative therapy (CMS, NQF 0514)

Patient Experience	• CG-CAHPS
	  ○ Patient would recommend provider to family and friends
	  ○ Usual source of care
	  ▪ Is provider/clinic named the place you usually go for care?)
	  ○ Timely Appointments, Care, and Information
	  ▪ Getting Care Quickly
	  ▪ Getting Needed Care

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	▪ Access to Information After Hours ▪ Wait Times • Decreased patient calls and/or delays in refills to patients • Decreased patient complaints about pain management • Healthy Days Core Module (CDC HRQOL– 4) ○ Other measure of Increased quality of life

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DRAFT Project Description Project 2.3 Palliative Care and End of Life Planning

Project Domain	Domain 2: Care Coordination
Project Title	Palliative Care and End of Life Planning

Rationale (Evidence base and reasoning behind project idea)

Palliative care and end of life planning have the potential to increase quality of life for those most in need of sensitive, cohesive care. Though a number of initiatives have resulted in nearly two thirds of PHS offering palliative services, according to an estimate by the Berkeley Forum, only 20 percent of potentially appropriate patients have access to community-based palliative care services. Crucial to improving quality of life for patients with chronic or terminal illnesses is ensuring smooth transitions of care, and excellent care in every setting, including hospitals, skilled nursing facilities, and home-based environments.

Several concurrent statewide end of life care programs and initiatives exist with the goal to increase quality of end of life care. DSRIP hospitals should participate in these statewide initiatives as they address patient needs at the most sensitive time of life.

These statewide programs and initiatives include:

- Senate Bill 1004 (Hernandez): This legislation, enacted in September 2014 and effective January 1, 2015, directs DHCS to establish standards and provide technical assistance to Medi-Cal managed care plans to ensure delivery of palliative care services, including hospice benefits.
- Cal SIM: The Palliative Care initiative in Cal SIM is designed to better address patient preferences for individuals facing advanced illness with significant risk of death within the next year. Together with the Health Homes for Complex Patients Initiative, this effort aims to identify patients in hospitals, long-term care facilities, or the community, who may benefit from and have a desire for palliative care services, and offer them comprehensive palliative care by people who are trained in this area.
- Statewide POLST registry: The California Healthcare Foundation is coordinating an effort to establish a statewide POLST registry, and is currently planning a pilot project to test the registry. Several states have had initial success creating and maintaining a successful registry.
- Let's Get Healthy California (LGHC): There are several end of life care measures selected for LGHC, including: Terminal hospital stays that include intensive care unit days, percent of California hospitals providing in-patient palliative care, hospice enrollment rate, and advance care planning.

Goals/Objectives (Project-specific prevention goals and expected project outcomes)

Ensure access to comprehensive palliative and end of life care in alignment with patient preferences in hospital and community settings for all patients facing advanced illness with significantly lowered quality of life, and/or who are potentially at risk of death in the next year.

Specific objectives include:

- Increase access to ambulatory and inpatient palliative care services
- Introduction of Primary and/or Specialty Palliative Care services at time of diagnosis
- Relieve pain and other distressing symptoms

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- Improve quality of life for both the patient and the family
- Reduce avoidable acute care utilization

Core Components (required steps or elements)

Systems undertaking this project will be required to complete the following components:

- Establish or expand both ambulatory and inpatient palliative care programs that provide:
  - Total, active and individualized patient care
  - Support for the family
  - Interdisciplinary teamwork
  - Effective communication
- Implement or expand a Primary Care Palliative Care training program for front-line clinicians to receive basic PC training, including Advanced Care Planning, as well as certification and supervision from specialty PC clinicians.
- Develop comprehensive advance care planning and engage in provider follow-ups in order to ensure patient needs are met in every care setting and during transitions
- Establish care goals consistent with patient and family preferences, and develop protocols for management/control of pain and other symptoms among the seriously ill population, including a holistic approach that includes spiritual and emotional needs
- Enable concurrent access to hospice and curative-intent treatment, including coordination between the providing services
- Develop partnerships with community and provider resources, including Hospice, to bring the palliative care supports and services into the practice, including training and supervision of non-Palliative Care Specialists
- Identify opportunities to refer and increase access for patients to community-based palliative care services
- Engage staff in trainings to increase role-appropriate competence in palliative care skills
- Demonstrate engagement of patients and families in the design and implementation of the project
- Implement a system for performance feedback that includes patients, front line staff and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology

Project Metrics (all metrics required)

Clinical Event Outcomes	• Advance Care Plan (NCQA, NQF 0326)
	  ○ Percent of patients 65 years or older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.
	• Comfortable Dying (NHPCO, NQF 0209)
	  ○ Number of patients who report being uncomfortable because of pain at the initial assessment (after admission to hospice services) who report pain was brought to a comfortable level within 48 hours
	• Family Evaluation of Hospice Care (FEHC) (NHPCO, NQF 0208)

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	○ Composite score on the FEHC survey, which is an after-death survey administered to bereaved family caregivers of individuals who died while enrolled in hospice • Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss (Deyta, LLC, NQF 1647) • Pain Screening (UNC-Chapel Hill, NQF 1634) ○ Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation/palliative care initial encounter. • Treatment Preferences (UNC-Chapel Hill, NQF 1641) ○ Percentage of patients with chart documentation of preferences for life sustaining treatments. • Patients Treated with an Opioid who are Given a Bowel Regimen (RAND, NQF 1617) ○ Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed • Patients with Advanced Cancer Screened for Pain at Outpatient Visits (RAND, NQF 1628) ○ Adult patients with advanced cancer who are screened for pain with a standardized quantitative tool at each outpatient visit
Potentially Preventable Event/Value/Cost Outcomes	• Time in ICU during last 6 months of life • Proportion receiving chemotherapy in the last 14 days • of life (NQF 0210) • Proportion admitted to hospice for less than 3 days (NQF 0216) • Proportion with more than one emergency room visit in the last 30 days of life (NQF 0211) • Proportion with more than one hospitalization in the last 30 days of life (NQF 0212) • Proportion admitted to the ICU in the last 30 days of life (LGHC, American Society of Clinical Oncology, NQF 0213) • Proportion dying from Cancer in an acute care setting (NQF 0214) • Proportion not admitted to hospice (NQF 0215) • Proportion of patients who die in the community versus the hospital • Cost per patient for specific end of life issues (such as stage 4 cancer)
Patient Experience	• Satisfaction • Karnofsky • ECOG

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	• Palliative Performance Scale • Zarit Burden Interview (caregiver burden scale) • Location of death in place of preference

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COMPILATION of Project Descriptions – Project 2.4 Integrated Health Home for Foster Children

Project Domain	Domain 3: Improved Outcomes for Specific High Risk, High Utilizing Populations
Project Title	Integrated Health Home for Foster Children

Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)

To implement integrated health homes for children in the Department of Children Youth and Families foster system. Provide foster children with a "one-stop-shop" for fully integrated health services including physical and behavioral health, as well as needed substance abuse and social services. Improve the overall quality of care for foster children through the development and implementation of a patient centered medical home.

Specific objectives include:

- Reduce avoidable acute care utilization (ER, admissions)
- Improve care coordination for foster youth and their families
- Improve patient adherence to their treatment regimen
- Improve care processes
- Increase patient experience

Core Components (6-10 general required steps or elements)

Systems undertaking this project will be required to complete the following components:

- Develop a multi-therapeutic support model whereby PCPs working in Public Healthcare Systems receive support in the ongoing management and treatment of foster children
- Participating health homes for foster youth achieve NCQA PCMH Level 3 accreditation
- Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration)
- 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

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- Developmental assessment, identification and treatment

- 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 quality improvement activities.
- 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
- Develop liasons/linkage with school school systems
- Provide barrier free access eligibility and enrollment services to patients as part of the health home services
- 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
- Implement a system for continual performance feedback to address quality and safety of patient care, that includes patients, front line staff, and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology
- The program will demonstrate engagement of patients and families in the design and implementation of this project

Project Metrics (3-7 metrics; at least one metric per metric type)	
Clinical Event Outcomes	• Prevention ○ HPV Vaccine for Female Adolescents ○ Well Child Visits ○ Adolescent Well-Care Visit: The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year (NCQA, used by Oregon CCOs) ○ Child and Adolescent Access to Primary Care Practitioners 1-19 yo – 2 rates (1-6yo qyr, 7-19 yo q2yr) (NCQA) ○ Childhood IZ Status – Combination 3 (CIS-3, DMHC, NCQA, NQF 0038) ○ Immunization Status for Adolescents ○ Lead Screening in Children ○ Chlamydia Screening for Women (NCQA, NQF 0033) ○ Use of Appropriate Medications for Asthma (NCQA, NQF 0036) ○ Appropriate Treatment for Children with URI (NCQA, NQF 0069 ○ Appropriate Testing for Children with Pharyngitis (NCQA, NQF 0002) ○ Annual Dental Visit ○ Tobacco Assessment and Counseling (AMA-PCQI, NQF 0028) ○ Weight Assessment & Counseling for Nutrition & Physical

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	Activity for Children & Adolescents (NCQA, NQF 0024)
	• Chronic Care
	  ○ Medication Management for People with Asthma (NCQA 1799
	  ○ Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%), (NCQA, NQF 0059)
	• Behavioral Health
	  ○ Screening for Clinical Depression and follow-up (CMS, NQF 0418)
	  ○ Follow-Up Care for Children Prescribed ADHD Medication (ADD):
	  ▪ The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported- initiation and continuation phases (NCQA, NQF 0108)
	  ○ Engagement of alcohol and other drug treatment
	  ▪ The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiated AOD treatment and who had two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive) (NCQA, NQF 0004)
	• Care Coordination
	  ○ Medication Reconciliation (18yo+ w/in 60 days of discharge) (NCQA, NQF 0097)
	• Medication Adherence
	  ○ Adherence to Antipsychotic Medications for Individuals (18yo+) with Schizophrenia (CMS, NQF 1879)
	  ○ Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (18yo+) (CMS, NQF 1880)

Potentially Preventable Event/Value/Cost Outcomes	• The percent of patients who have had a visit to an Emergency Department (ED) for asthma in the past six months (HRSA) • Potentially preventable ED visits (for persons with BH diagnosis) (3M) • Behavioral Health/Substance Abuse (BH/SA) Admission Rate risk adjusted (3M) • Behavioral Health /Substance Abuse 30-day Readmission Rate risk adjusted (3M)
Patient Experience	• Continuity with provider/care team • CAHPS (AHRQ) ○ Patient Loyalty (Is doctor/clinic named the place you

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	usually go for care? ○ Timely Appointments, Care, and Information ▪ Getting Care Quickly ▪ Getting Needed Care ▪ Access to Information After Hours

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DRAFT Project Worksheet– Project 2.5 Transition to Integrated Care: Post Incarceration

Which is the focus of this project: transitions of people out of prison (State), out of jail (County) or both?

Project Domain	Domain 3: Improved Outcomes for Specific High Risk, High Utilizing Populations
Project Title	Transition to Integrated Care: Post Incarceration

Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)

To improve the transition of care for the recently incarcerated, from the criminal justice system to the public health care system. Increase rates of enrollment into coverage, successfully establish care with, and coordination between, a primary care medical home, and appropriate behavioral health, substance use and social services, reduce avoidable acute care utilization, and ultimately improve the health of the patients.

Specific objectives include:

- Increase use of primary and specialty care
- Improve health indicators for patients with chronic condition(s)
- Decrease preventable acute care utilization
- Increase enrollment into health coverage

Core Components (6-10 general required steps or elements)

Systems undertaking this project will be required to complete the following components:

- Identify patient risk factors
- Coordinate with criminal justice system to develop process for seamless transfer of patient care upon release from correctional facilities, including:
    - Identification of high risk individuals prior to time of release
    - Linkage to primary care medical home at time of release
    - Information sharing from incarcerated setting to re-entry setting, including timely transfer of complete medical records to the receiving primary care medical home by the time of release.
- Develop a system to increase rates of enrollment into coverage and assign patients to a health home
- Complete a patient needs assessment using a standardized questionnaire including assessment of social service needs. Educational materials will be utilized that are consistent with cultural and linguistic needs of the population
- Provide coordinated care that addresses co-occurring mental health, substance use and chronic physical disorders, including management of opiate utilization
- Evidence based practice guidelines will be implemented to address risk factor reduction (e.g., immunization, smoking cessation, behavioral health screening and treatment) as well as to ensure appropriate management of chronic diseases (e.g., Asthma, Cardiovascular Disease, COPD, Diabetes).
- Identify a team member (e.g., community health worker) to support system navigation and provide linkages to needed services if they are not available within the primary care home, such as social services and housing that are necessary to meet patient needs in the community.
- 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

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- Engage health plan partners to pro-actively coordinate Long Term Care services prior to release for timely placement according to need
- Use of individual and group peer support
- Establish data analytics systems using health, justice and relevant community data (e.g., health plan), to enable identification of high-risk incarcerated individuals for targeted interventions, including ability to stratify impact by race, ethnicity and language.
- 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 quality improvement activities.
- Implement a system for continual performance feedback to address quality and safety of patient care, that includes patients, front line staff, and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology
- The program will demonstrate engagement of patients and families in the design and implementation of this project

Project Metrics (3-7 metrics; at least one metric per metric type)	

Clinical Event Outcomes	• Prevention:
	  ○ Tobacco Assessment and Counseling (AMA-PCQI, NQF 0028)
	  ○ Controlling Blood Pressure (DMHC, NCQA, NQF 0018
	• Chronic Care
	  ○ Medication Management for People with Asthma (NCQA 1799
	  ○ Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%), (NCQA, NQF 0059)
	• Behavioral Health
	  ○ Screening for Clinical Depression and follow-up (CMS, NQF 0418)
	  ○ Engagement of alcohol and other drug treatment (NCQA, NQF 0004)
	  ▪ The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiated AOD treatment and who had two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive)
	• Care Coordination*: Recommend variation of both of these measure so to as apply to discharge from correctional facility*
	  ○ Medication Reconciliation – 60 days (NCQA, NQF 0097)
	  ○ Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (AMA-PCPI, NQF 0647)

Potentially Preventable	• Potentially preventable ED visits (for persons with BH diagnosis)

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Event/Value/Cost Outcomes	(3M) • Behavioral Health/Substance Abuse (BH/SA) Admission Rate risk adjusted (3M) • Behavioral Health /Substance Abuse 30-day Readmission Rate risk adjusted (3M)

Patient Experience	• CG-CAHPS Measures:
	  ○ Usual source of care
	  ▪ Is doctor/clinic named the place you usually go for care?
	  ○ Getting Care Quickly
	  ○ Getting Care Needed
	  ○ Access to Information After Hours
	  ○ Wait Time (time between requesting an appt and receipt of an appt)

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DRAFT Project Description Project 3.1 Million Hearts Initiative, Obesity Prevention, and Healthier Foods Initiative

Project Domain	Domain 3: Prevention
Project Title	Million Hearts Initiative, Obesity Prevention, and Healthier Foods Initiative

Rationale (Evidence base and reasoning behind project idea)

Million Hearts Initiative

According to the California Department of Public Health, heart disease and stroke were the first and third leading causes of death among Californians, respectively, accounting for 24.6 percent and 5.8 percent of deaths in 2010.[3] Risk factors for heart disease, such as tobacco use and hypertension, need to be reduced in order to improve cardiovascular health. The California Health Interview Survey and Behavioral Risk Factor Surveillance System indicate that 20 percent of Medi-Cal members use tobacco, compared to the State average of 12 percent.[4,5] In addition, 37 of adult Medi-Cal members have been diagnosed with hypertension at some point in their lives.[6]

In 2011, the US Department of Health and Human Services launched the Million Hearts Initiative to prevent 1 million heart attacks and strokes by 2017 through public and private commitments to:

- Improve care for people who need treatment by encouraging health systems and health professionals to focus on the "ABCS"—Aspirin when appropriate, Blood pressure control, Cholesterol management, and Smoking cessation—which address the major risk factors for cardiovascular disease and can help to prevent heart attacks and stroke.
- Empower Americans to make healthy choices, such as preventing tobacco use and reducing sodium and trans fat consumption. These efforts can reduce the number of people who need medical treatment, including blood pressure or cholesterol medications, to prevent heart attacks and stroke.[7]

DHCS is participating in the Centers for Medicare and Medicaid Services' Prevention Learning Network to advance the Million Hearts Initiative in California. As a result, Medi-Cal Managed Care Plans are participating in quality improvement learning collaboratives to improve hypertension control and reduce tobacco use prevalence. In addition, the Department is collaborating with the California Department of Public Health and Right Care Initiative to advance Million Hearts. These activities and partnerships make the designated public hospitals well positioned to meet the clinical goals of this Initiative.

Obesity Prevention and Healthier Food Initiative

Approximately two-thirds of adults and one-third of children and adolescents are overweight or obese, and the prevalence is higher among low-income populations. Evidence suggests that as weight

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[3] California Department of Public Health. Thirteen leading causes of death by race/ethnic group and sex, California, 2010. http://www.cdph.ca.gov/data/statistics/Documents/VSC-2010-0508.pdf Web site. Published October 3, 2012.
[4] California Health Interview Survey, 2009.
[5] Behavioral Risk Factor Surveillance System, 2011.
[6] AskCHIS, California Health Interview Survey, 2011-2012.
[7] Million Hearts Initiative. http://millionhearts.hhs.gov/index.html

increases to reach the levels referred to as "overweight" and "obese," the risk of several serious conditions, such as heart disease and hypertension, also increases.[8] According to the US Preventive Services Task Force, all adults and children, ages 6 and older, should be screened for obesity and referred to behavioral interventions.[9] In the broader clinical environment, the Centers for Disease Control and Prevention and Harvard School of Public Health recommend increasing the availability and affordability of healthful food and beverages in hospitals and other public venues as one key strategy to prevent obesity in the United States.[10,11]

Goals/Objectives (Project-specific prevention goals and expected project outcomes)

Implement collaboratively identified and standardized, evidence-based and population resource stewardship approaches to the use of targeted preventive services across PHS. Collaborate among CA PHS on approaches to meet clinical targets that support the Million Hearts Initiative, starting with tobacco cessation, hypertension control, and appropriate low-dose aspirin use, obesity screening and referral to treatment, and the Partnership for a Healthier America's Hospital Healthier Food Initiative.

Specific objectives include:

- Identify cost effective, evidence-based approaches to:
  - Support the Million Hearts Initiative clinical targets, starting with tobacco cessation, hypertension control, and appropriate aspirin use;
  - Implement obesity screening and referral to treatment for pediatric and adult populations
- Reduce disparities in receipt of targeted prevention services
- Reduce variation and improve performance on Million Hearts and obesity screening and referral to treatment across multiple CA PHS
- Support the provision of healthful food in clinical facilities by implementing the Partnership for a Healthier America's Hospital Healthier Food Initiative

Core Components (required steps or elements)

Systems undertaking these projects will be required to complete the following components:

- 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.
- 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.
- Improve access to quality care and decrease disparities in the delivery of preventive services.
- Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
- Adopt and use certified electronic health record systems, including clinical decision supports

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[8] U.S. Department of Health and Human Services, Overweight and Obesity Statistics. http://win.niddk.nih.gov/publications/PDFs/stat904z.pdf Updated October, 2012. Accessed October 29, 2014.
[9] U.S. Preventive Services Task Force, A and B Recommendations. http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
[10] Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. http://www.cdc.gov/mmwr/pdf/rr/rr5807.pdf Published July 24, 2009.
[11] Harvard School of Public Health, Obesity Prevention Source. http://www.hsph.harvard.edu/obesity-prevention-source/obesity-prevention/food-environment/healthy-food-environment-recommendations-for-obesity-prevention-complete-list/

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.

- 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.
- 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.
    - Provide feedback to care teams around preventive service benchmarks and incentivize quality improvement efforts.
- Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.
- Prepare for and implement the Partnership for a Healthier America's Hospital Healthier Food Initiative

Project Metrics (all metrics required)	

Clinical Event Outcomes	Million Hearts Initiative Metrics
	• Tobacco Assessment and Counseling (AMA-PCQI, NQF 0028)
	  ○ Patients screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user
	• Joint National Commission (JNC) Tobacco Measures (TOB-1, TOB-2, TOB-2a, TOB-3, TOB-3a, TOB4)
	• Controlling Blood Pressure (NCQA, NQF 0018, DMHC)
	  ○ Patients with diagnosis of HTN and whose BP was adequately controlled during the measurement year
	• Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic (NCQA, NQF 0068)
	  ○ Patients who were discharged alive for acute myocardial infarction, coronary artery bypass graft or percutaneous coronary interventions during the 12 months prior to the measurement year, or who had a diagnosis of IVD during the measurement year and the year prior to the measurement year and who used aspirin or another antithrombotic during the measurement year
	
	Obesity Metrics
	• Body Mass Index (BMI) Screening and Follow-Up (CMS, NQF 0421)
	  ○ Patients with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter
	• Weight Assessment & Counseling for Nutrition & Physical Activity

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	for Children & Adolescents (NCQA, NQF 0024) ○ Child and adolescent patients who had an outpatient visit with a PCP or an OB/GYN and who had evidence of BMI percentile documentation, and counseling for nutrition and physical activity during the measurement year Hospital Healthier Food Initiative Metrics • Partnership for a Healthier America's Hospital Healthier Food Initiative external food service verification
Potentially Preventable Event/Value/Cost Outcomes	
Patient Experience	• CG-CAHPS: Patient would recommend provider to family and friends • AI-CAHPS: Patient and Primary Doctor or Nurse (PDN) talked about how to maintain a healthy diet and healthy eating habits • AI-CAHPS: Patient and PDN talked about the exercise or physical activity the patient completes • AI-CAHPS: Patient was advised by PDN to quit smoking or stop using tobacco • AI-CAHPS: PDN recommended or discussed medication to help patient quit smoking or using tobacco • AI-CAHPS: PDN recommended or discussed methods or strategies other than medication to help patient quit smoking or using tobacco

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DRAFT Project Description—Project 3.2 Cancer Screening and Follow Up

Project Domain	Domain 3: Prevention
Project Title	Cancer Screening and Follow Up

Rationale (Evidence base and reasoning for project)

Cancer is the second leading cause of mortality in California, accounting for nearly 1 of every 4 deaths. The risk of developing cancer varies considerably by race/ethnicity. For example, African American men have the highest overall cancer rate, followed by non-Hispanic white men. Among women, non-Hispanic white women are most likely to be diagnosed with cancer, but African American women are more likely to die of the disease. The reasons for racial/ethnic differences in cancer risk and developing cancer is likely the result of a complex combination of dietary, lifestyle, environmental, occupational, and genetic factors. Higher mortality rates among some populations are due in part to poverty, which may increase the risk of developing certain cancers and limit access to and utilization of preventive measures and screening.[12]

Regular screening tests offer the ability for secondary prevention by detecting cancer early, before symptoms appear. Screening tests that allow the early detection and removal of precancerous growth are known to reduce mortality of cancers of the cervix, colon, and rectum. Early diagnosis can also save lives by identifying cancers when they require less expensive treatment and have better outcomes. Five-year relative survival rates for common cancers, such as those of the breast, colon and rectum, and cervix, are 93% to 100% if they are discovered before having spread beyond the organ where the cancer began.[1]

Goals/Objectives (Project-specific prevention goals and expected project outcomes)

Implement collaboratively identified and standardized, evidence-based and population resource stewardship approaches to the use of targeted preventive services across Public Health Systems (PHS). Collaborate among CA PHS on approaches to meet clinical targets that support cancer screening and follow up services, including breast, cervical, and colorectal cancer, that have a high clinical impact, variation in resource utilization, and have variation in performance. Increase receipt of these services by PHS patients while reducing associated PHS variation in approach, performance and disparities of receipt of services across the population.

Specific objectives include:

- Identify cost effective, evidence-based approaches to breast, cervical and colorectal cancer screening and completion of follow up on abnormal screening tests
- Increase screening and completion of follow-up rates across targeted services
- Reduce disparities in receipt of targeted prevention services
- Reduce variation and improve performance on cancer screening and follow up across multiple CA PHS
- Reduce the prevalence of late presentation of targeted cancers due to lack of screening

Core Components (required steps or elements)

Systems undertaking these projects will be required to complete the following components:

[12] American Cancer Society and the California Cancer Registry of the California Department of Public Health, California Cancer Facts & Figures, 2014. http://www.ccrcal.org/pdf/Reports/ACS_2014.pdf

- 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.
- 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.
- Improve access to quality care and decrease disparities in the delivery of preventive services.
- Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
- 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.
- 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.
- 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.
    - Provide feedback to care teams around preventive service benchmarks and incentivize quality improvement efforts.
- Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.

Project Metrics (all metrics required)	

Clinical Event Outcomes	Cancer Metrics
	• Breast Cancer Screening (NCQA, NQF 2372)
	  ○ Receipt of diagnostic mammogram for an abnormal screening exam
	• Cervical Cancer Screening (DMHC CCS, NCQA, NQF 0032)
	  ○ Receipt of appropriate follow-up for abnormal screening pap smear
	• Colorectal Cancer Screening (NCQA, NQF 0034)
	  ○ Patients with positive FOBT who underwent an appropriate evaluation

Potentially Preventable Event/Value/Cost Outcomes	• *NQF 0214: Proportion dying from Cancer in an acute care setting (Measure 0214 is no longer NQF-endorsed)* • *Dx of late stage Breast Ca due to lack of screening? (the n would likely be very small)* ○ *efficient use of resources, e.g., # of screening/completions within a specific budget?*
Patient Experience	• CG-CAHPS: Patient would recommend provider to family and friends

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DRAFT Project Description Project 3.3 Prevention

Project Domain	Domain 3: Prevention
Project Title	Perinatal Care

Rationale (Evidence base and reasoning behind project idea)

Approximately 500,000 babies are born each year in California, and ensuring a healthy pregnancy, delivery, and beginnings of life are crucial to fostering a healthy population. Unfortunately, rates of maternal mortality and severe maternal morbidity in both the United States and California have doubled in the 10 years between 1999 and 2008 in California. Medical procedures during childbirth have markedly increased, including primary and repeat cesareans, labor inductions and early elective deliveries often when they are not be medically indicated; practices that result in higher costs and higher rate of complications for both women and babies. Furthermore, there are notable racial differences for key pregnancy outcomes. California data indicates that non-Hispanic, black women are more likely to have cesareans, and have 3-4 times higher rates of maternal death and morbidity. . Overall, Cesarean deliveries in California rose from 22 to 33 percent between 1998 and 2008 and now total more than 165,000 per year. While the statewide cesarean delivery rate was 33 percent in 2012, there was exceptionally large variation among hospitals with some outlier hospitals had rates as high as 80.9 percent. On the other hand 36% of California hospitals were already meeting the national HP2020 target of 23.9% for low-risk first-birth hospitals. This finding indicates that significant reduction is not only possible but already achieved by one third of our hospitals. DSRIP hospitals also have significant variation among all of these measures suggesting significant opportunities for improvement.

Several multi-disciplinary and multi-stakeholder statewide initiatives are currently in place to address perinatal care quality and safety. These programs have the goal to improve the health of women and children and to ensure these health services are delivered safely, efficiently, and equitably. DSRIP hospitals should participate in these statewide initiatives as they deliver a significant number of California births.

These statewide initiatives include:

- The California Maternal Quality Care Collaborative (CMQCC). CMQCC has engaged a wide range of stakeholders across the State to improve health outcomes of mothers and newborns through best practices. The CMQCC's California Maternal Data Center (CDMC) supports quality improvement activities by generating perinatal performance metrics.
- The Patient Safety First (PSF) initiative funded by Anthem Blue Cross has been working with over 100 California hospitals since 2009 in several patient safety areas, including obstetrics.
- The recent formation of the Hospital Quality Institute (HQI) by the California Hospital Association (CHA) is committed to improving maternity care.

  The first three of these organizations are working closely together in a unified program to support hospital-based maternity QI to reduce maternal mortality, morbidity and unneeded obstetric procedures. These initiatives are now national is scope, all being part of the National Partnership for Maternal Safety supported by ACOG, AWHONN, AHA , TJC, CMS/CMMI, and many other women's health organizations.

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- The California State Innovations Model Grant (Cal SIM) was submitted to CMS, October 2014. The Maternity Care initiative within Cal SIM was designed to promote healthy, evidence-based obstetrical care and to reduce the quality shortfalls and high costs associated with unnecessary cesarean deliveries. The aim of the initiative is to catalyze a large health system transformation through a four pronged approach: data submission for measurement/quality improvement, public reporting, payment innovation, and patient engagement. Key metrics include: Low-risk first-birth cesarean rate, vaginal birth after cesarean rate, episiotomy rate and a balancing measure of the rate of Unexpected Newborn Complications. It is anticipated that all hospitals in California will be part of the Cal-SIM project.

Goals/Objectives (Project-specific prevention goals and expected project outcomes)

- Support breastfeeding initiation, continuation, and baby-friendly practices.
- Ensure and support best practices to prevent morbidity and mortality associated with obstetrical hemorrhage.
- Decrease statewide cesarean section rate, and decrease variability in cesarean section rates in hospitals throughout California.
- Improve maternal morbidity and mortality statewide.
- Ensure women receive comprehensive, and evidenced-based, and timely prenatal and postpartum care.
- Postpartum cares should effectively address and support breastfeeding initiation and continuation, contraception, and ensure follow-up and treatment of medical co-morbidities.

Core Components (required steps or elements)

Systems undertaking these projects will be required to complete the following components:

- Public Health System engagement in best-practice learning collaborative to decrease maternal morbidity and mortality related to obstetrical hemorrhage (CMQCC/PSF/HQI combined effort).
- Achieve baby-friendly hospital designation through supporting exclusive breastfeeding prenatally, after delivery, and for 6 months after delivery and using lactation consultants after delivery
- Encourage best-practice and facilitate provider education to improve cesarean section rates, and decrease inequities among cesarean section rates. Participate, as appropriate, in state-wide QI initiatives for first-birth low-risk Cesarean births.
- Coordinate care for women in the post-partum period with co-morbid conditions including diabetes and hypertension

Project Metrics (all metrics required)

Clinical Event Outcomes	• Obstetrical hemorrhage morbidity metrics as used in the CMQCC/PSF/HQI project
	• Cesarean Section (PC-02, JNC, NQF 0471)
	  ○ Number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section
	• Healthy Term Newborn (CMQCC, NQF 0716)
	  ○ Percent of term singleton live births (excluding those with

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	diagnoses originating in the fetal period) who do not have significant complications during birth or the nursery care
	• Exclusive Breast Milk Feeding (PC-05, NQF 0480)
	  ○ Number of newborns exclusively fed breast milk during the newborn´s entire hospitalization
	• Prenatal and Postpartum Care (NCQA, NQF 1517)
	  ○ Percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization
	  ○ Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery
	• Baby Friendly Hospital designation

Potentially Preventable Event/Value/Cost Outcomes	
Patient Experience	• CG-CAHPS: Patient would recommend provider to family and friends

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DRAFT Project Worksheet – Project 4.1 Antibiotic Stewardship

Project Domain	Domain 2: Resource Utilization Efficiency
Project Title	Antibiotic Stewardship

Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)

To measure and promote the appropriate use of antimicrobials by reducing overall antibiotic use for non-bacterial diseases, and for bacterial infections, with a special emphasis on agents with broad spectrum gram negative activity, and shorten the time to initiation of therapy from the time the order is written in order to improve patient outcomes and eliminate unnecessary patient care costs.

Specific objectives include:

- Reduce overall antibiotic use
- Decrease inappropriate use of antibiotics
- Shorten time to initiation of therapy
- Improve patient experience

Core Components (6-10 general required steps or elements)

Systems undertaking this project will be required to complete the following components:

- Utilize state and/or national resources to develop an antibiotic stewardship program, such as the California Antimicrobial Stewardship Program Initiative; or IHI-CDC 2012 Update "Antibiotic Stewardship Driver Diagram and Change Package"[13]
- Develop antimicrobial stewardship policies and procedures
- 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[14]
- Create standardized protocols for ordering and obtaining cultures and other diagnostic tests prior to initiating antibiotics
- Develop a method for informing clinicians about unnecessary combinations of antibiotics
- Determine and verify antibiotic allergies and tailor therapy accordingly
- Develop processes that support prompt treatment of patients requiring antibiotics in order to shorten the time of initiation of therapy (e.g., infusion of anchor antibiotics within 1 hour of provider ordering).
- Provide standards and algorithms for recommended agents by disease type, focusing on short course regimens (e.g., 5 day therapy for community acquired pneumonia (CAP), 7 days for pyelonephritis, 5-7 days for cellulitis)
    - Incorporate evidence-based guidelines for duration of antibiotics into standard protocols and/or computerized decision support
- Develop clinical decision support and hard stop mechanisms to support stewardship. Approaches may include activities such as auto switching for specific antibiotics and doses, or restriction of specific antibiotics at the point of ordering (e.g., broad spectrum agents)

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[13] 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).

[14] Launched in February 2010, this statewide antimicrobial stewardship program expands use of evidenced-based guidelines to prevent and control infections and improve patient outcomes: http://www.cdph.ca.gov/programs/hai/Pages/AntimicrobialStewardshipProgramInitiative.aspx.

- Develop and implement global training/education for clinicians (including physicians, NPs, PAs, and pharmacists), in accordance with computer physician order entry (CPOE), where possible
- 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
- Develop processes to promote:
    - Use of procalcitonin as an antibiotic decision aid for respiratory infection
    - Early 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
- Evaluate the use of new diagnostic technologies for rapid delineation between viral and bacterial causes of common infections
- Adopt the recently described "public commitment" strategy in outpatient clinics to encourage providers not to prescribe antibiotics for URIs
- 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
- Demonstrate engagement of patients in the design and implementation of the project
- Implement a system for performance feedback that includes patients, front line staff and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology

Project Metrics (3-7 metrics; at least one metric per metric type)	

Clinical Event Outcomes	• Appropriate Testing for Children With Pharyngitis (CWP) (NCQA, NQF 0002)
	• Antibiotics for respiratory tract infections in outpatient settings
	  ○ Appropriate treatment for children with upper respiratory infection (URI) (NCQA, NQF 0069)
	  ○ Avoidance of antibiotic treatment in adults with acute bronchitis: (NCQA, NQF 0058)
	  ○ Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Appropriate Use) (AMA)
	  ○ Community-Acquired Bacterial Pneumonia (CAP): Empiric Antibiotic (AMA-PCPI, NQF 0096)
	  ○ Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients (CMS, NQF 0147)
	• # Antibiotic prescriptions for asymptomatic bacteriuria and funguria, including in the presence of urinary catheters
	• # patients discharged on antibiotics who received antibiotics during hospitalization)
	• Prophylactic antibiotics discontinued within 24 hours after surgery end time (CMS, NQF 0529)
	• # Prescriptions for agents with activity against Pseudomonas aeruginosa used to treat infections commonly caused by Staphylococcus or Streptococcal species (e.g., skin infections, CAP).
	• % compliance with short course therapies for common infections,

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	including: ○ 5-7 days of therapy for cellulitis ○ 7 days of therapy for pyelonephritis ○ 5-7 days of therapy for community acquired pneumonia ○ 7-8 days for therapy for VP or hospital acquired pneumonia.
Potentially Preventable Event/Value/Cost Outcomes	• Total antibiotic use and expenditures ○ Antimicrobial Defined Daily Doses (DDDs) per 1000 Patient Days (Inpatient and Outpatient) ○ Costs associated with DDD/1000 pt days ○ Antimicrobial expenditures per admission
Patient Experience	• HCAHPS? • CG-CAHPS?

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DRAFT Project Worksheet– DSRIP Project 4.2 Resource Stewardship: High Cost Imaging

Project Domain	Domain 2: Resource Utilization Efficiency
Project Title	Resource Stewardship: High Cost Imaging

Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)

To implement evidence based and population resource stewardship approaches to the use of high cost imaging services. Reduce use of high cost imaging in situations where evidence shows outcomes are not be impacted by the use of such imaging. Improve use of clinically effective, lower cost, lower radiation dose imaging modalities where imaging is warranted. Increase the use of decision support mechanisms for provider ordering of high cost imaging.

Specific objectives include:

- Decrease inappropriate use of high cost imaging
- Reduce the number of unnecessary/inappropriate scans
- Minimize radiation exposure
- Improve patient experience

Core Components (6-10 general required steps or elements)

Systems undertaking this project will be required to complete the following components:

- Implement an imaging management program, including Identification of top tests whose necessity should be assessed. Criteria for assessment could include:
  - Relative risk of the imaging study to patient-safety;
  - Frequency and cost of inappropriate/unnecessary use
  - Data completeness and ability to report the extent of the problem;
  - Practice variation within the participating PHS; and
  - Whether there are established, tested and available evidence-based clinical pathways
- Establish standards of care regarding use of imaging
  - Costs are high and evidence for clinical effectiveness is highly variable or low, or the clinical intervention (product or service) is overused compared to evidence-based appropriateness criteria.
  - Evidence of additional value (benefits to cost) compared to other treatments for the same condition is low.
- Incorporating both cost and radiation dose information:
  - Develop recommendations as guidelines for provider-patient conversations in determining an appropriate treatment plan.
  - Use of decision support, evidence based guidelines and medical criteria to recommend best course of action
- Demonstrate engagement of patients in the design and implementation of the project
- Implement a system for performance feedback that includes patients, front line staff and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology
- 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

Project Metrics (3-7 metrics; at least one metric per metric type)

Clinical Event Outcomes	• Use of Imaging Studies for Low Back Pain: percentage of members 18-50 with a primary diagnosis of low back pain with and

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	outpatient or ED encounter who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis (NCQA, NQF 0052) • Thorax CT: Use of Contrast Material (CMS, NQF 0513) • MRI Lumbar Spine for Low Back Pain without antecedent conservative therapy (CMS, NQF 0514) • Radiation Dose of Computed Tomography (CT) (UCSF, NQF 0739) ○ Radiology: percentage of final reports for CT examinations performed with documentation of use of appropriate radiation dose reduction devices OR manual techniques for appropriate moderation of exposure • Inappropriate Pulmonary CT Imaging for Patients at Low Risk for Pulmonary Embolism (ACEP, NQF 0667) • Appropriate Head CT Imaging in Adults with Mild Traumatic Brain Injury (ACEP, NQF 0668) • Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery (CMS, NQF 0669) • Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients (AMA-PCPI, NQF 0389) • Use of neuroimaging in children and adolescents with defined clinical headache syndrome diagnoses whose neurological examinations are normal (Headache. 2000 Sep;40(8):629-32) • Use of neuroimaging studies in patients with stable headaches that meet criteria for migraine. • Use of imaging studies for routine evaluation of abdominal pain in children[15].
Potentially Preventable Event/Value/Cost Outcomes	• Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI): (PQRS, ACCF, NQF 0671) • Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients (PQRS, ACCF, NQF 0672) • Total medical expenses for imaging services
Patient Experience	• ? • Total Radiation dose per facility?

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[15] A study revealed that use of CT scans increased from 1 percent in 1998 to 15 percent in 2008 with no change in use of other technology, diagnosis of appendicitis or hospital admission. Therefore, we recommend using the rate of occurrence from 1998. Jahan F et al. "Computed tomography use among children presenting to emergency departments with abdominal pain." *Pediatrics* October, 2012.

DRAFT Project Worksheet – DSRIP Project 4.3 Resource Stewardship: High Cost Pharmaceuticals

Project Domain	Domain 2: Resource Utilization Efficiency
Project Title	Resource Stewardship: High Cost Pharmaceuticals

Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)

To implement evidence based and population resource stewardship approaches to the use of high cost pharmaceuticals. To guide clinician use of targeted medications, develop decision analyses that include the impact of such treatments on the participating PHS population in terms of health outcomes and the efficient use of available resources. Increase the use of decision support mechanisms for provider ordering of high cost pharmaceuticals.

Specific objectives include:

- Increase appropriate use of high cost pharmaceuticals
- Decrease inappropriate use of high cost pharmaceuticals
- Improve outcomes
- Improve use of shared decision making with patients

Core Components (6-10 general required steps or elements)

Systems undertaking this project will be required to complete the following components:

- Implement or expand a high cost pharmaceuticals management program
- Develop a data analytics process to identify the PHS' 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.
- Develop processes for evaluating value 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
- Establish standards of care regarding prescribing of high cost pharmaceuticals, including
    - Use of decision support/CPOE, evidence based guidelines and medical criteria to support establish standards
    - Transition pharmaceutical treatment to the outpatient setting wherever possible
    - Promote standards for generic prescribing
- Implement a system for performance feedback that includes patients, front line staff and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology
- 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.
- 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

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Project Metrics (3-7 metrics; at least one metric per metric type)	
Clinical Event Outcomes	•
Potentially Preventable Event/Value/Cost Outcomes	• Reduce the number of unnecessary/inappropriate high cost pharmaceutical prescriptions • Pharmaceuticals expenditures per patient, per patient days • Prescribed high cost pharmaceutical per patient, per days
Patient Experience	• CAHPS ○ Shared decision making

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COMPILATION of Project Descriptions – Project 4.4 Resource Stewardship: Blood Products

Project Domain	Domain 2: Resource Utilization Efficiency
Project Title	Resource Stewardship: Blood Products

Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)

To implement evidence based approaches to the use of blood products. Increase use of decision support mechanisms for provider ordering of blood products to improve the safety and appropriateness of their use, with resultant improvements in health quality and resource utilization.

Specific objectives include:

- To identify, develop and promote the implementation of measures that reduce wastage through improved health provider inventory management of blood and blood products
- To identify, develop and promote the implementation of patient blood management (PBM) to improve appropriate use of blood and blood products by health providers.
- Improve patient experience

Core Components (6-10 general required steps or elements)

Systems undertaking this project will be required to complete the following components:

- Implement or expand a blood products management program.
- Utilize at least one nationally recognized blood management program methodology (e.g., The Joint Commission[16], AABB)
- Develop processes for evaluating impact of blood product use including appropriateness of use, adequacy of documentation, safety implications and cost. Develop a data analytics process to track these and other program metrics.
- Establish standards of care regarding use of blood products, including
    - Use of decision support/CPOE, evidence based guidelines and medical criteria to support establish standards
- Implement a system for performance feedback that includes patients, front line staff and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology
- 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.
- Develop processes for working with providers with blood use patterns outside established standards, to identify and reduce barriers to meeting 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

Project Metrics (3-7 metrics; at least one metric per metric type)

Clinical Event Outcomes	• PBM-01 Transfusion Consent • PBM-02 RBC Transfusion Indication • PBM-03 Plasma Transfusion Indication • PBM-04 Platelet Transfusion Indication • PBM-05 Blood Administration Documentation • PBM-06 Preoperative Anemia Screening

[16] The Joint Commission. Implementation Guide for The Joint Commission Patient Blood Management Performance Measures 2011. http://www.jointcommission.org/assets/1/6/pbm_implementation_guide_20110624.pdf.

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	• PBM-07 Preoperative Blood Type Testing and Antibody Screening
Potentially Preventable Event/Value/Cost Outcomes	• Medical expenditures for blood products (per patient days) • Total transfusions per patient days
Patient Experience	• *What patient experience measures would be applicable here?*

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DRAFT Project – Project 4.5 Right Place Care: Rebalancing of Primary Care Capacity in the Health Care System

Project Domain	Domain 2: Resource Utilization Efficiency
Project Title	Right Place Care: Rebalancing of Primary Care Capacity in the Health Care System

Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)

To improve patients' access to robust primary care by developing a Public Health Care System (PHS) Patient Centered Medical Neighborhood with a Primary Care hub whose capacity is matched to the health care needs of the population cared for by the PHS. A robust primary care infrastructure that is seamlessly integrated to the spokes of needed specialty, ancillary, and acute care services will result in improved prevention and control of chronic diseases, and thus eventual lowered demand for acute care resources.

Specific objectives include:

- Increase patient access to care
- Improve patient experience of care
- Newly established clinics will meet PCMH criteria
- Increase provision of preventive health services
- Improve health indicators for patients with chronic illness(es)
- Reduce avoidable specialty care utilization
- Decrease preventable acute care utilization
- Increase staff engagement (retention?)

Core Components (6-10 general required steps or elements)

Systems undertaking this project will be required to complete the following components:

- A clear strategy document that includes current assessment of community health care needs, and facility service capabilities, expertise and gaps, and addresses avoidable hospital use. This document must include evidence of community involvement in the development and the specific activities that will be undertaken during the project term.
- Based on the community health care needs assessment, current patient volumes, volume of assigned managed care patients who have not yet seen, and historical attrition rates, identify appropriate primary care to specialty care, and primary care to inpatient care capacity ratios.
- Based on the calculated demand and capacity ratios, build primary care capacity to meet these local supply/demand calculations, including identification of appropriate primary care panel sizes and team based care staffing ratios to accommodate current and anticipated demand for primary care.
- Newly established primary care clinics will fully implement the patient-centered medical home model and achieve NCQA 2014 Level Three Patient Centered Medical Home Recognition.
- Implement a system for performance feedback that includes patients, front line staff and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology
- Demonstration of engagement Medicaid members in the design and implementation of system transformation.

Project Metrics (3-7 metrics: at least one metric per metric type)

Clinical Event Outcomes	• Prevention ○ Breast Cancer Screening (NCQA, NQF 2372)

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	○ Cervical Cancer Screening (DMHC CCS, NCQA, NQF 0032) ○ Childhood IZ Status – Combination 3 (CIS-3, DMHC, NCQA, NQF 0038) ○ Colorectal Cancer Screening (NCQA, NQF 0034) ○ Tobacco Assessment and Counseling (AMA-PCQI, NQF 0028) ○ Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents (NCQA, NQF 0024, DHCS priority) ○ Body Mass Index Screening and Follow-Up (CMS, NQF 0421) ○ Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI) (The Child and Adolescent Health Measurement Initiative, NQF 1349) ○ Annual Dental Visit 2-21 (if part of Medicaid benefit) (ADV) (NCQA, NQF 1388) • Chronic Care ○ Medication Management for People with Asthma (NCQA 1799) ▪ OR Asthma Medication Ratio (NCQA, NQF 1800) ○ Controlling Blood Pressure (DMHC, NCQA, NQF 0018) ○ Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%), (NCQA, NQF 0059) ○ Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing (CDC-HT, DMHC, NCQA, NQF 0057) ○ Prenatal and Postpartum Care – Timeliness of Prenatal Care (PPC-Pre, DMHC, NQF 1517) ○ Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic (NCQA, NQF 0068)
Potentially Preventable Event/Value/Cost Reduction Outcomes	• Cost/member • Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) (CMS, The Joint Commission, NQF 1789) DHCS with a CA-only measure • Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year (Bridges to Excellence, NQF 0709) • Potentially Avoidable Emergency Room Visits (3M) • Potentially Avoidable Readmissions (3M)
Patient Experience	• Continuity with provider • CG-CAHPS ○ Usual source of care ▪ Is provider/clinic named the place you usually go for care?) ○ Timely Appointments, Care, and Information ▪ Getting Care Quickly ▪ Getting Needed Care ▪ Access to Information After Hours ○ Patient would recommend provider to family and friends ○ Clerks and receptionists at provider's office ▪ Helpful; Courteous and respectful

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	• Staff Engagement scores (Gallup 12) ○ OR Staff Retention

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DRAFT Project Descriptions – Project 5.1 Patient Safety Culture

Project Domain	Domain 5: Patient Safety
Project Title	Promoting a Culture of Patient Safety
Goals/Objectives (Substantially Reduce Adverse Events through Safety Protocols)	
A large effort has been focused on improving patient safety in the first DSRIP program, yet more work remains to be done. The objective of this project is for health systems to think globally about their patient safety culture. A global focus on culture makes it appropriate to measure improvement with a composite patient safety measure that includes multiple domains such as surgical procedures, pressure ulcers, and infections. Specific objectives include: • Implementation of robust process improvement (e.g., Lean, Six Sigma) • Critical assessment of current formal safety protocols • Critical assessment of informal safety culture (e.g., attitudes, leadership beliefs, disrespectful behavior, cover-up of errors) • Based on ongoing analyses, improve organizational safety formal and informal culture	
Core Components (1) Make safety a priority, (2) Analyze problems with rigorous methods, (3) There are no one-size fits all approaches; DPHs should develop approaches to optimize safety across care delivery	
Health care organizations are complex systems that have evolved different strategies, rules, and attitude (culture) to address problems such as patient safety. Thus, different institutions should carefully analyze their own policies, procedures, behaviors, and attitudes toward patient safety, and work to improve areas that are lacking.	
Project Metrics	
CMS Hospital-Acquired Condition (HAC) Reduction Program	A more global measure such as the CMS HAC Reduction Composite (HAC) could facilitate the development of a hospital-wide patient safety culture—there are opportunities to think about how the measure scoring could be modified for appropriate health care comparisons. <u>Hospital-Acquired Condition (HAC) Measure</u>

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The measure includes two domains[17]:

"Domain 1: Agency for Health Care Research and Quality (AHRQ) composite PSI #90. This measure includes the following indicators: Pressure ulcer rate (PSI 3); Iatrogenic pneumothorax rate (PSI 6); Central venous catheter-related blood stream infection rate (PSI 7); Postoperative hip fracture rate (PSI 8); Postoperative pulmonary embolism (PE) or deep vein thrombosis rate (DVT) (PSI 12); Postoperative sepsis rate (PSI 13); Wound dehiscence rate (PSI 14); and Accidental puncture and laceration rate (PSI 15)."

"Domain 2: Two healthcare-associated infection measures developed by the Centers for Disease Control and Prevention's (CDC) National Health Safety Network: Central Line-Associated Blood Stream Infection and Catheter-Associated Urinary Tract Infection."

"Hospitals will be given a score for each measure within the two domains. A domain score will be calculated—with Domain 1 weighted at 35 percent and Domain 2 weighted at 65 percent—to determine a total score under the program. Risk factors such as the patient's age, gender, and comorbidities will be considered in the calculation of the measure rates so that hospitals serving a large proportion of sicker patients will not be penalized unfairly. Hospitals will be able to review and correct their information."

Advantages and Disadvantages of the HAC Measure

Advantages:

1. All software necessary for estimation is in the public domain.
2. Components except for the weighting system are all endorsed by NQF.
3. Hospitals are familiar with the Medicare HAC Reduction program.
4. Includes more measures than PSI 90 alone.

Disadvantages:

- Some researchers believe that some hospitals are actively trying to game the measure by reviewing all numerator codes with clinicians before finalizing the abstract/claim.
- The measure may disadvantage teaching/safety net hospitals because certain types of events are more likely to be documented by resident physicians versus attending physicians.
- The measure is based entirely on administrative data.

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[17] http://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2013-fact-sheets-items/2013-08-02-3.html

- The weighting scheme may be changed significantly in 2015 due to #2 above (to maintain NQF endorsement).

Implementing the HAC Measure for DSRIP

Data

The OSHPD Patient Discharge Dataset (PDD) is the most complete and validated dataset to produce the PSI 90 composite part of the measure. Unlike Medi-Cal claims and encounter data that currently only have fields for two diagnoses on each claim or encounter, the OSHPD PDD has fields for 25 diagnoses. If a DSRIP project focusses on Medi-Cal members, it would be possible to use the PDD "expected payer" field. This field, however, has been shown to be somewhat inaccurate so it might be advisable to focus on all hospital patients regardless of their expected payer.

The California Department of Public Health collects data and reports information related to Central Line-Associated Bloodstream Infections (CLABSI). Although we need to confirm with CDPH, it appears that they also collect data for catheter-associated urinary tract infections (at least for Medi-Cal fee-for-service members).

Preliminary Analyses

DHCS staff has calculated PSI 90 rates using the 2012 OSHPD PDD. They found significant variation among the DSRIP hospitals. It is also possible to review the preliminary HAC scores for DSRIP hospitals that are published by CMS. The DHCS and CAPH/SNI teams could look at the preliminary data when thinking about how to best structure a project related to patient safety.

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DRAFT Project Descriptions – Project 5.2 Reducing Inappropriate Surgeries

Project Domain	Domain 5: Patient Safety
Project Title	Reducing Inappropriate Surgeries
Goals/Objectives	
Clinical practice varies across regions of the United States. The variation is not always explained by patient illness or preferences; the supply (or oversupply) of medical treatments impacts quality (or failure) of our health system. The United States has focused on medical errors and associated performance measures to reduce practice variation. Although important, it is misleading to solely measure the quality of how medicine is administered without also considering if medical treatments should have been administered in the first place. Although there is far less research concerning overutilization in healthcare as compared to other areas such patient safety and underutilization, researchers illustrated that many surgical procedures are overutilizated. Possible the best example is the overutilization of cesarean deliveries among many US hospitals. There are numerous mechanisms to reduce overutilization such as treatment reviews and approvals or complex finance agreements between payers and providers. An additional mechanism encouraged physicians to used evidence-based shared decision making aids to more clearly illustrate the benefits and risks associated with procedures. There is growing evidence that shared decision aids can reduce inappropriate surgeries and improve patient satisfaction. For example a May 2013 Cochrane review of 86 randomized control trails illustrates that patients have more accurate expectations of potential benefits and risks and often opt for more conservative approaches.[18] Specific objectives include: • Promote the use of shared decision making tools for procedures associated with overutilization	
Core Components Promote shared decision making (SDM)	
The rapidly developing literature around shared decision making suggests that giving patients a much clearer understanding of the risks associated with procedures often leads to lower utilization. For example, when women have more information about the complications that can be associated with cesarean deliveries, they might be less likely to choose their child's birthday. Given the substantial risks associated with many surgeries, reducing the number of inappropriate or unnecessary procedures has important implications for patient safety.	

[18] http://www.commonwealthfund.org/publications/newsletters/quality-matters/2012/october-november/in-focus

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The following procedures might be a good area of focus:

- Cesarean delivery
- Coronary artery bypass grafting (CABG)
- Percutaneous coronary artery angioplasty (PCI)
- Back surgery
- Cholecystectomy
- Hip replacement surgery
- Carotid artery surgery
- Lower extremity arterial bypass surgery
- Radical prostatectomy

Project Metrics (more research required)

The Affordable Care Act also authorizes a Shared Decision Making (SDM)Program to help beneficiaries collaborate with their health care providers to make more informed treatment decisions based on an understanding of available options, and each patient's circumstances, beliefs and preferences. There are not yet, however, any specific NQF measures (that we can identify) to measure share decision making.

Many professional organizations and academics are actively researching SDM and numerous metrics have been proposed and tested.

One proposal is for a simple question or set of questions given to all patients considering an elective surgery that addresses the degree to which options were provided[19]:

"Did any of your doctors explain that you could choose whether or not to (HAVE NTERVENTION)? An alternative we often have used: "Did any of your health care providers explain that there were choices in what you could do to treat your [condition]?" As worded, these only work after an intervention has been done."

[19] http://www.informedmedicaldecisions.org/wp-content/uploads/2014/04/Measuring_DQ_Sepucha_Fowler_Final.pdf

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