DSRIP 2.0 Concept Paper
For Designated Public Hospitals
Department of Health Care Services

Introduction

California's current 1115 waiver demonstration ends October 31, 2015. To meet the health care needs of the state, California plans to submit a new 1115 waiver proposal in February 2015. This new proposal has four primary goals:

1. Strengthen primary care delivery and access
2. Avoid unnecessary institutionalization and services by building the foundation for an integrated health care delivery system that incentivizes quality and efficiency
3. Address social determinants of health
4. Use California's sophisticated Medicaid program as an incubator to test innovative approaches to whole-person care

In the current waiver, the Delivery System Reform Incentive Program (DSRIP) has supported the stabilization of the safety net health system, built important foundations for health care transformation (e.g., chronic disease registries, expansion of health homes, chronic care management programs), advanced patient safety and clinical quality, and developed data systems to support population health.

The purpose of this paper, developed in collaboration with the California Association of Public Hospitals/Safety Net Institute, is to highlight concepts, domains, and specific projects that could be incorporated into a Delivery System Reform Incentive Program (DSRIP) 2.0 as part of the Department's 1115 waiver.

Background Concepts

Concepts for DSRIP 2.0 (to begin fall 2015) and the waiver, in general, are informed by several sources including: (1) CMS guidance; (2) experience with the current 1115 waiver; (3) health care recommendations in the report of the Governor's Let's Get Healthy California Task Force Report and the California State Innovations Model (CalSIM) plan for health system re-design; (4) consideration of the leading causes of preventable mortality and morbidity; and (5) alignment with national health targets (e.g., as identified in the National Quality Strategy and the National Prevention Strategy).

Domains

There are five domains representing important themes that drive quality improvement and population health advancement:

Domain 1: Delivery System Transformation
Domain 2: Care Coordination for High Risk, High Utilizing Populations
Domain 3: Resource Utilization Efficiency
Domain 4: Prevention

Domain 5: Patient Safety

Delivery System Transformation. As with the CalSIM plan, major health system transformation has been called for to make significant progress toward advancing the Triple Aim. In addition, the intent of the 1115 waiver, and the DSRIP program, in particular, is to transform the health care delivery system to achieve major improvements in clinical quality and population health.

Care Coordination for High Risk, High Utilizing Populations. Researchers, policymakers, and clinicians have all emphasized the need to better coordinate care within and across the sectors of physical health, behavioral health, and social aspects of health (e.g., access to food, housing, transportation, jobs, and education). This need for care coordination is particularly critical for super-utilizers and high-utilizers of health resources. The health care system has not generally addressed care across sectors. Such coordination is a goal of delivery system transformation.

Prevention. McGinnis and Foege and Mokdad and colleagues have demonstrated the importance of prevention in reducing preventable morbidity and mortality. The leading underlying causes of death (smoking, poor nutrition, physical inactivity, alcohol abuse) account for 35-50% of preventable mortality depending on the specific population. The U.S. Preventive Services Task Force and other sources have specified the evidence-based preventive services that can reduce morbidity and mortality while also reducing the financial burden of care.

Resource Utilization Efficiency. Eliminating the use of ineffective or harmful clinical services and curbing the overuse and misuse of clinical services have been championed by the Choosing Wisely Campaign (CWC). CWC was launched by the American Board of Internal Medicine and supported by the Robert Wood Johnson Foundation and Consumers Union. Thus, improved resource stewardship is an important goal for a transformed health care delivery system.

Patient Safety. Using updated methods, a recent patient safety paper projected that 200,000 to 400,000 preventable deaths occur each year in the U.S. due to medical error. There is widespread agreement that more can be done systematically to improve patient safety. However, there is also broad acknowledgement in the research and practice community that the challenges to achieving such improvement are real. One of the most serious challenges is developing data systems that can efficiently identify patient safety issues and track progress tied to corrective policies and programs.

Projects

The following pages outline a variety of projects by domain. They are meant to serve as examples demonstrating the need to address the five domains with attention to integration across domains. In addition, they have been developed to provide sufficient detail to enable a discussion of effectiveness, efficiency, and feasibility.

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Projects

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DOMAIN 1: DELIVERY SYSTEM TRANSFORMATION

Project 1.1 Ambulatory Care Redesign: Primary Care

Required Project

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

Rationale (Evidence base and reasoning behind project idea)

Patient-Centered Medical Homes (PCMHs) have the potential to improve the efficiency and effectiveness of primary care delivery (Group Health Cooperative experience; Health Affairs). However, the overall literature on PCMHs has had somewhat mixed results. This project addresses potential pitfalls by designing PCMHs based on needs assessments. By tailoring the specific PCMH model to the particular practice environment, the likelihood of success is increased substantially.

Goals/Objectives

Patients will experience timely access to high quality and efficient primary care designed to work collaboratively with patients and other care providers, in achieving and maintaining optimum patient health, and avoiding unplanned interventions.

Specific objectives include:

- Increase the number of primary care practices undergoing Patient Centered Medical Home transformation
- Increase provision of preventive health services
- Improve health indicators for patients with chronic condition(s)
- Increase patient access to care
- Decrease preventable acute care utilization
- Improve patient experience of care
- Increase staff engagement

Core Components

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

1. Gap analysis of practice sites within the PHS system.
2. Primary Care practices will demonstrate advancement of their PCMH transformation through the use of a nationally recognized PCMH methodology[1]
3. Implement technology enabled data systems to support pre-visit planning, point of care delivery, population/panel management activities, care coordination, patient engagement, and operational and strategic decisions including continuous performance improvement activities.
    a. Implementation of EHR technology that meets meaningful use standards (MU)
4. Ongoing empanelment of all patients for population management (including assigned managed care lives):
    a. Manage panel size, assignments, and continuity to internal targets;
    b. Develop interventions for empanelled patients by condition, risk, and self-management status.
    c. Perform preventive care services and behavioral health screenings (e.g., PHQ-9, SBIRT).
5. Enable prompt access to care by:

[1] For example: NCQA Patient-Centered Medical Home Recognition, http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx, accessed 12/5/14; Safety Net Medical Home Initiative, http://www.safetynetmedicalhome.org/ , accessed 12/4/2014; AAFP's TransforMed, http://www.transformed.com/, accessed 12/4/2014

a. Implementing open or advanced access scheduling
b. Creating alternatives to face-to-face provider/patient visits

6. Coordinate care across settings
    a. Identification of care coordinators at each primary care site who are responsible for coordinating care within the PCMH as well as with other facilities (e.g., other care coordinators or PCMH/PHS high risk care managers)
        i. Establish onsite Care/Case managers to work with high risk patients and their care teams, or develop processes for local care coordinators to work with a central complex care management program for these patients
    b. Implement processes for timely bi-directional communication and referral to specialty care, behavioral health, acute care, social services and community based services
7. Demonstrate evidence-based preventive and chronic disease management
8. To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.
9. Improve staff engagement by:
    a. Implementing a model for team-based care in which staff performs to the best of their abilities and credentials.
    b. Providing ongoing staff training on care model
10. Engage patients using care plans, and self-management education, and through involvement in the design and implementation of this project.

Project Metrics	
Clinical Event Outcomes	• Prevention o Colorectal Cancer Screening (NCQA, NQF 0034) o Tobacco: Medical Assistance with Smoking Cessation (NCQA, NQF 0027) • Chronic Care o Controlling Blood Pressure (Medi-Cal, NCQA, NQF 0018, measure to be updated in Jan 2015 to align with JNC 8) o Screening for Clinical Depression and follow-up (CMS, NQF 0418) o Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%), (Medi-Cal, NCQA, NQF 0059) o Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic (NCQA, NQF 0068)
Potentially Preventable Events	• Potentially Avoidable ER Visits (3M)
Patient Experience	• Continuity with provider • CG-CAHPS o Timely Appointments, Care, and Information o Patient would recommend provider to family and friends o Helpful and Courteous Staff

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Project 1.2 Ambulatory Care Redesign: Specialty Care

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

Rationale (Evidence base and reasoning behind project idea)

While a strong primary care service is an essential component of an effective health system, efficient linkage to specialty care is also critical, particularly for super-utilizers and high-utilizers. The rapid increase in patients eligible for health care and other drivers necessitate system redesign that enables patients to access specialists in more efficient ways since the demand for such care is increasing while the supply is static. Use of non-physician providers, telehealth modalities, and more robust member, patient, and family engagement are some of the approaches to be employed in this project.

Goals/Objectives

Patients will experience **timely access** to high quality, effective specialty care designed to work collaboratively with patients and their PCPs, in achieving and maintaining optimum patient health, and avoiding unplanned interventions. Redesign of specialty 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, and engage in population health management strategies.

Specific objectives include:

- Partner with Patient Centered Medical Home (PCMH) to improve health outcomes in acute and chronic disease
    - Increase patient and provider access to specialty expertise – delivered in the most effective means to meet the need.
    - Provide resources to PCPs to increase their capacity to care for complex patients
- Decrease avoidable acute care utilization
- Improve Patient Experience
- Increase specialty care staff engagement
- Right size number of specialists for target population

Core Components

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

1. Develop a specialty care program that is broadly applied to the entire population of service.
2. Conduct a gap analysis to assess 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.
    a. 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.
3. Engage primary care providers in development and implementation of specialty care model
    a. Implement processes for primary care:specialty care co-management of patient care
    b. Establish processes to enable timely follow up for specialty expertise requests
    c. 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.
4. Clinical teams engage in team- and evidence-based care
5. 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
6. Adopt and follow treatment protocols mutually agreed upon across the delivery system
7. Implement technology enabled data systems to support pre-visit planning, point of care delivery,

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population management activities and care coordination/transitions of care. Timely, relevant and actionable data is used to support patient engagement, PCP collaboration, and drive clinical, operational and strategic decisions including continuous quality improvement activities.
   a. Implement EHR technology that meets meaningful use standards (MU)
8. 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
9. Improve medication adherence
10. Implement population management strategies for patients in need of preventive services, with chronic conditions, or with recurring long term surveillance needs
11. Implement or expand use of telehealth based on PHS capacity to address patient and PCP barriers to accessing specialty expertise. Implementse of telehealth platform for communication modalities that connect between specialty care and primary care (e.g., eConsult/eReferral)
12. Demonstrate engagement of patients in the design and implementation of the project
13. Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.
14. Test use of novel performance metrics for redesigned specialty care models

Project Metrics (all metrics required)	
Clinical Event Outcomes	Prevention: • Tobacco Assessment and Counseling (AMA-PCQI, CMS 226, NQF 0028) • Flu, Pneumo for IBD, CHF, ESRD (NQF 227) • Flu - broad and/or specific

Potentially Preventable Event/ Value/Cost Outcomes	• All-Cause Readmissions (Medi-Cal)
	• Potentially Avoidable Emergency Room Visits (3M)
	• Potentially Avoidable Readmissions (3M)
	• Post procedure ED visits/admissions
	• Safe Surgery Checklist (CMS OP-25)
	Specialty Care Benchmarking (P4R) reported across all specialties
	• # specialty requests/1000 primary care patients
	• # given specialists/100,000 primary care patients
	Access (P4R):
	• Referral Reply Turnaround Rate
	  o Timely Referral response rate (% within 3 business days)
	  o Time to close/resolution (see Touches)
	• Specialty Care Touches (total, # managed by primary care, # co- managed by specialty and primary care, # seen in-person by specialty care, same day touches for emergencies)
	Communication
	• Closing the referral loop: receipt of specialist report (CMS MU, CMS50v1)

Patient Experience	• CG-CAHPS:
	  o Timely Appointments, Care, and Information
	  ▪ Getting Care Quickly (routine and urgent care appts)
	  ▪ Access to Information After Hours
	  o Care Coordination
	  ▪ PCP informed about the care from specialists
	  ▪ Provider knew important information about patient's medical history

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	• Staff Engagement scores (P4R)
	  o Staff turnover
	  o Staff satisfaction or QOL

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Project 1.3 Care Transitions: Integration of Post-Acute Care

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

Rationale (Evidence base and reasoning behind project idea)

Transitions from in-patient and emergency department settings have been identified in the literature (refs) as a critical intervention point to prevent avoidable readmissions and to advance the trajectory toward optimal health and function. This project will use data and analysis to identify system-specific gaps in care transition. In addition, it will take a multi-disciplinary approach toward system re-design incorporating physical, behavioral, and social health needs and perspectives.

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

To ensure the coordination and continuity of health care as high risk patients, with chronic health conditions, behavioral health conditions and/or housing instability, move from the hospital to the ambulatory care setting. To improve patients' ability to care for themselves, effectively hand off health care responsibility to the appropriate ambulatory care provider, optimize patients' course of chronic illness and ultimately reduce avoidable acute utilization.

Specific objectives include:

- Improve communication and coordination between inpatient and outpatient care teams
- Increase patients capacity for self-management
- Improve patient experience
- Reduce avoidable acute care utilization

Core Components (required steps or elements)

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

1. Develop a care transitions program or expand a care transitions program to additional settings (e.g., emergency department), or to additional populations, using or adapting at least one nationally recognized care transitions program methodology[2].
2. Establish or expand on a system to track and report readmission rates, timeliness of discharge summaries, and other transition processes, and investigate PHS specific root causes / risk factors for readmission, using quantitative and qualitative information to identify the key causes of readmissions, including physical, behavioral and social factors.
3. Develop and implement a process, including utilization of data and information technology, to reliably identify hospitalized patients at high risk for readmission
4. Develop standardized workflows for inpatient discharge care.
   a. Optimize hospital discharge planning and medication management for all hospitalized patients.
   b. Implement structure for obtaining best possible medication history and for assessing medication reconciliation accuracy.
   c. Develop and use standardized process for transitioning patients to sub-acute and long term care facilities
   d. Provide tiered multi-disciplinary interventions according to level of risk
      i) Involve pharmacy and palliative care when possible
      ii) Develop standardized protocols for referral to and coordination with community behavioral health and social services (e.g., visiting nurses, home care services, housing, food, clothing and social support). Identify and train personnel to function as care

[2] E.g., CMS Discharge Planning Hospital Conditions of Participation, AHRQ Hospital Guide to Reducing Medicaid Readmissions, Coleman Care Transitions Intervention-CTI, Project BOOST, STAAR, Project RED

navigators for carrying out these functions.

5. Inpatient and Outpatient teams will collaboratively develop standardized transition workflows
   a. Develop mechanisms to support patients in establishing primary care for those without prior primary care affiliation.
   b. Develop process for warm hand-off from hospital to outpatient provider, including assignment of responsibility for follow-up of labs or studies still pending at the time of discharge.
6. Develop standardized workflows for post-discharge (outpatient) care.
   a. Deliver timely access to primary and/or specialty care following a hospitalization
   b. Standardize post-hospital visits and include outpatient medication reconciliation
7. Support patients and family caregivers in becoming more comfortable, competent and confident in self-management skills required after an acute hospitalization by providing:
   a. Engagement of patients in the care planning process
   b. Pre-discharge patient and caregiver education and coaching
   c. Written transition care plan for patient and caregiver
   d. Timely communication and coordination with receiving practitioner
   e. Community-based support for the patient and caregiver post hospitalization focusing on self-care requirements and follow-up care with primary and specialty care providers
8. 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.
9. Demonstrate engagement of patients in the design and implementation of the project
10. Implement a system for continual performance feedback and rapid cycle improvement that uses standard process improvement methodology and that includes patients, front line staff and senior leadership

Clinical Event Outcomes	

	• Transitional Care Follow-up (based on CMS Transitional Care Management codes CPT 99495 and 99496)
	  o TCM 1: All elements required:
	  ▪ Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge
	  ▪ Medical decision-making of at least moderate complexity during the service period
	  ▪ Face-to-face visit within 14 calendar days of discharge
	  o TCM 2: All elements required:
	  ▪ Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge
	  ▪ Medical decision-making of at least high complexity during the service period
	  ▪ Face-to-face visit within 7 calendar days of discharge
	• 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)
	• Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (AMA-PCPI, NQF 0648)
	  o transition record transmitted to receiving facility or health care

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	professional designated for follow-up care within 24 hours of discharge • Medication Reconciliation – 30 days (NCQA, NQF 0097) o % ≥18yo discharged & seen within 30 days with med rec • Medication Reconciliation Post-Discharge – 30 days (MRP) (NCQA, NQF 0554)(≥65yo) • Use of Medication Discrepancy Tool (MDT, Care Transitions Program) o *not endorsed but evidenced based*
Value Outcomes	• DHCS All-Cause Readmissions – Statewide Collaborative QIP measure o (Measure Specs -rationale in Appendix A & B)
Patient Experience	• H-CAHPS – Care Transition Metrics (AHRQ) o You understand the purpose of your medicine o Understanding Your Care When You Left The Hospital • Self-Management Capacity o Care Transition Measure (CTM-3)(University of Colorado Health Sciences Center, NQF 0228)

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Project 1.4 Integration of Behavioral Health and Primary Care

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

Rationale (Evidence base and reasoning behind project idea)

According to the California Department of Health Care Services' Mental Health Prevalence Estimates, 15.9% of Californian adults suffer from Mental Health Disorder (MHD). Therefore, 27.5 million Californians are in need of mental health treatment. In addition, nearly 2 million Californians are suffering from a serious mental illness (SMI); 4.3% and 7.4% of adults and children, respectively. A common co-occurring condition with Mental Health Disorder (MHD) is substance use disorder (SUD), which plagues 7.2% of Californians. A fragmented health care system is ill equipped to treat people with chronic medical and behavioral issues. In order to combat the gap in treatment of MHD and SUD, as of January 2014, Medi-Cal covers new services for members with mild to moderate mental health conditions, and has implemented an Alcohol Screening, Brief Intervention and Referral to Treatment (SBIRT) benefit for adults in primary care settings.

The prevalence of MHDs varies greatly by economic status. Adult members of households below 200% of the federal poverty level are 150% more likely to have a MHD than their more affluent counterparts. Among the SMI population, the disparity is even greater. Adult members of households below 200% of the federal poverty level are almost two times more likely to have a MHD than their more affluent counterparts. The prevalence of MHDs also varies greatly by race/ethnicity. Native Americans and Hispanics are the most likely to have MHDs (20%), followed by African Americans (9%), Whites (14%), and Asians (10%), who are the least likely to have MHDs.[3]

MHDs and SUDs reduce a person's life expectancy by 10 to 20 years, which is equivalent to the reduced life expectancy that is the result of heavy smoking.[4] People with a MHD and/or SUD die from the same causes as does the general population, such as: heart disease, diabetes, and cancer. However, these diseases are more prevalent among people who suffer from a MHD or SUD, and lead to earlier death.[5] For the entire population, the greatest indicators for such diseases are: smoking, obesity, hypertension, poor diet, and low levels of physical activity. Such health risks have an increased prevalence among those with a MHD and/or SUD, and have an earlier onset.

Because of the low rate of preventive and treatment services offered to people with a MHD and/or SUD, these individuals experience serious health burdens and are at risk of premature death.[6] The Substance Abuse and Mental Health Services Administration and Health Resources Services Administration's jointly funded Center for Integrated Health Solutions (SAMHSA-HRSA CIHS) advocates that the solution to providing better care to those with co-occurring conditions, whether medical or behavioral, is to *integrate* care. When behavioral health (BH) conditions are detected early and treated appropriately, those individuals experience a greater quality of life, better self-care, improved adherence to medical and mental health treatments, and better overall health outcomes.[7] The implementation of regular, validated screening tools along with brief intervention techniques

[3] California Mental Health Prevalence Estimates, Task Team: HSRI, TAC and Expert Consultation From Charles Holzer. http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf

[4] University of Oxford, "Many mental illnesses reduce life expectancy more than heavy smoking." ScienceDaily. ScienceDaily, 23 May 2014. www.sciencedaily.com/releases/2014/05/140523082934.htm.

[5] Druss BG, Zhao L, Von Esenwein S, et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011;49(6):599–604.

[6] Druss BG, Zhao L, Von Esenwein S, et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011;49(6):599–604.

[7] SAMHSA-HRSA Center for Integrated health Solutions. http://www.integration.samhsa.gov/

serve as strategies for early detection of SMIs and SUDs, resulting in reduced alcohol misuse and earlier intervention and treatment opportunities. When preventive efforts are combined with coordinated care efforts (e.g. psych-consultation, team-care approach, peer providers, enhanced linkages to community and BH settings), the result is a significant improvement in health outcomes. One example of such success is the IMPACT model, which led to two times better clinical outcomes than general care.[8] Programs such as the IMPACT model not only improve care at the individual and population levels, but lead to lower overall health care costs.[9]

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

To improve physical and behavioral health outcomes, care delivery 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 and ensure coordination of care for all 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; 3) improve medical and behavioral health outcomes for those patients with chronic medical disorders, and for those with co-occurring physical and behavioral health conditions

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
- Increase access to behavioral health care
- Reduce preventable acute care utilization
- Improve communication between PCP and behavioral health
- Reduce admissions for patients with behavioral health problems though earlier recognition and intervention
- Reduce admissions for medical problems by better managing co-morbid behavioral health conditions
- Improve patient experience

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

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

1. Implement an assessment tool (baseline and annual progress measurement)[10,11]
2. Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration, or other IBH resources from SAMHSA).
3. Integrate appropriate screening tools and decision support into the emergency department to ensure timely recognition of patients with mental and behavioral health problems. Enhanced access to primary care and/or to behavioral health specialists will be integrated into discharge planning for these patents. Use of 24-7 care navigators (e.g., Community Physician Liaison Program) may be

[8] IMPACT. Evidence-based depression care. http://impact-uw.org/

[9] Jurgen Unützer, Jeffrey Lieberman. Collaborative Care: An Integral Part of Psychiatry's Future. PsychiatryOnline, Psychiatric News Article, November 12, 2013.

[10] *e.g.,* AIMS Center Behavioral Integration Checklist, McHAF Site Self-Assessment)

[11] Level of Integration Measure (LIM): http://integrationacademy.ahrq.gov/measures/C6%20Level%20of%20Integration%20Measure Purpose: To rate the degree to which behavioral health providers or behavioral health care is integrated into primary care settings from the perspective of staff and/or providers. Developer: Antioch University

used to support this linkage to providers and services through the discharge process

4. Physical-behavioral health integration 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.
5. PCHM and behavioral health providers will:
   a. Collaborate on evidence based standards of care including medication management and care engagement process.
   b. Implement Case conferences/consults on patients with complex needs
6. Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families.
7. Preventive care screenings including behavioral health screenings (e.g., PHQ-2, PHQ-9, SBIRT) will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps 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.
8. Provide cross-systems training to ensure effective engagement with patients with MH/SUD conditions. Ensure that a sufficient number of providers are trained in SBIRT and/or in other new tools used by providers to ensure effectiveness of treatment.
9. 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.
10. Ensure that the Treatment Plan:
    a. Is maintained in a single shared EHR/clinical record that is accessible across the treatment team to ensure coordination of care planning.
    b. Outcomes are evaluated and monitored for quality and safety for each patient.
11. Implement technology enabled data systems to support pre-visit planning, point of care delivery, care plan development, population/panel management activities, coordination and patient engagement. Programs to consider telehealth, eReferral/eConsult to enhance access to behavioral health services.
12. Demonstrate engagement of patients in the design and implementation of the project
13. Ensure integration is efficient and providing value to patients by implementing a system for continual rapid cycle improvement and performance feedback that includes patients, front line staff and senior leadership.

Project Metrics (3-7 metrics; at least one metric per metric type)	
Clinical Event Outcomes	Screening • Alcohol and Drug Misuse (SBIRT) (Oregon CCO) • Screening for Clinical Depression and follow-up (CMS, NQF 0418) Chronic Care • Controlling Blood Pressure (NCQA 0018, DMHC) • Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%), (NCQA, NQF 0059) • Depression Remission at 12 Months (MN Community Measurement, NQF 0710)

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	Care Coordination • Follow-up after hospitalization for mental illness (≥6yo) (HEDIS, NQF 0576) ▪ 2 rates:7 day f/u, 30 day f/u) • Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (AMA-PCPI, NQF 0648)
Potentially Preventable Event Outcomes	• DHCS All-Cause Readmissions – Statewide Collaborative QIP measure o (Measure Specs -rationale in Appendix A & B) • ACSC Hospitalizations: Grand mal status and other epileptic convulsions, COPD, Asthma, CHF & Pulm Edema, HTN, Angina, DM • Potentially preventable ED visits (3M)

Patient Experience	• CG-CAHPS
	  o Care Coordination
	  ▪ Provider up-to-date about care received from specialists
	  o Timely Appointments, Care, and Information
	  ▪ Getting Care Quickly (routine and urgent care appointments as soon as 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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DOMAIN 2 – CARE COORDINATION FOR HIGH RISK, HIGH UTILIZING POPULATIONS

Project 2.1 Complex Care Management for High Risk Populations

Project Domain	Domain 2: Care Coordination for High Risk, High Utilizing Populations
Project Title	Complex Care Management for High Risk Populations

Rationale (Evidence base and reasoning behind project idea)

A growing body of scientific literature is helping to characterize the small percentage of persons who consume a disproportionate share of health care resources—so-called, super-utilizers. More importantly, there is increasing understanding of methods and models that can be effectively employed to improve health status and quality of life for super-utilizers while drastically reducing health care costs. A 2013 summit supported by the Robert Wood Johnson Foundation and the National Governors' Association highlighted some of these intervention approaches being tested around the country. More recently, The Centers for Medicare and Medicaid Services released a white paper reviewing best practices in managing and caring for Medicaid super-utilizers (ref).

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

To implement, and/or improve upon, a complex care management model for targeted high risk patient populations, that facilitates the appropriate coordinated delivery of health care services, is better able to meet the patient's needs and preferences and results in improvement of the patients' health outcomes.

Specific objectives include:

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

Core Components (required steps or elements)

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

1. Develop a complex care management program at one site or with one defined cohort, or expand an existing program from a pilot site to all sites or to additional high risk groups and demonstrate engagement of patients in the design and implementation of the project
2. Utilize at least one nationally recognized complex care management program methodology[12]
3. Identify target population(s) and develop program inclusion criteria based on quantitative and qualitative data (e.g., acute care utilization, lack of primary care utilization, number of high risk medical or behavioral conditions, polypharmacy, primary care input, functional status, patient activation, social support or other factors). Include patient factors associated with a higher probability of being impacted by complex care management.
4. Conduct a qualitative assessment of high risk, high utilizing patients.
5. Establish data analytics systems using clinical (e.g., EHR, registries), utilization and other available data (e.g., financial, health plan, zip codes), to enable identification of high-risk/rising risk patients for targeted complex care management interventions, including ability to stratify impact by race, ethnicity and language.
6. Develop a multi-disciplinary care team, to which each participant is assigned, that is tailored to the

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

target population and whose interventions are tiered according to patient level of risk.

7. Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets
8. 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.
   a. Use standardized patient assessment and evaluation tools (may be developed locally, or adopted/adapted from nationally recognized sources[13])
   b. Use educational materials that are consistent with cultural and linguistic needs of the target population.
9. Ensure systems are in place to support patient linkage to appropriate physical, behavioral and social services, ensure follow-up and retention in care, and promote adherence to medications.
10. Implement technology enabled data systems to support patients and care teams throughout the care management program including patient identification, pre-visit planning, point of care delivery, care plan development and population/panel management activities.
11. To address quality and safety of patient care, implement a data driven system for rapid cycle improvement and performance feedback (e.g., outcome metrics dashboard) that includes patients, front line staff and senior leadership.

Project Metrics (all metrics required)	

Clinical Event Outcomes	• General Self-Rated Health
	• Healthy Days Core Module (CDC HRQOL– 4)
	• Medication Reconciliation – 30 days (≥18 yo) (NCQA, NQF 0097)
	  o % ≥18yo discharged & seen within 30 days with med rec
	• Medication Review – Care for Older Adults (NCQA, NQF 553)
	  o ≥65 yo with annual med rec
	• Menu based on local target population:
	  o Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%), (NCQA, NQF 0059)
	  o Adherence to Statins for Individuals with Diabetes Mellitus (CMS, NQF 0545)
	  o Tobacco: Medical Assistance With Smoking and Tobacco Use Cessation (MSC) (NCQA, NQF 0027)
	  o Controlling Blood Pressure (NCQA, NQF 0018, DMHC)
	  o HIV viral load suppression (HRSA-HAB, NQF 2082)

Potentially Preventable Event/Value/Cost Outcomes	• DHCS All-Cause Readmissions – Statewide Collaborative QIP measure
	  o (Measure Specs -rationale in Appendix A & B)
	• Potentially Avoidable Emergency Room Visits (3M)
	• Potentially Avoidable Readmissions (3M)
	• ACSC Hospitalizations
	  o Grand mal status and other epileptic convulsions, COPD, Asthma, CHF & Pulm Edema, HTN, Angina, DM

Patient Experience	• CG-CAHPS
	  o Timely Appointments, Care, and Information
	  ▪ Getting Care Quickly (routine and urgent care

[13] e.g., PHQ-9, HARMS-8, Patient Activation Measure, AHRQ Whole Person Care Assessment Tool

	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) • Recommend CCM Program to family or friend

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Project 2.2 Integrated Health Home for Foster Children

Project Domain	Domain 2: Care Coordination for High Risk, High Utilizing Populations
Project Title	Integrated Health Home for Foster Children

Rationale (Evidence base and reasoning behind project idea)

The serious medical, behavioral, and social needs of foster children, nationally and in California, have been well documented (refs). The overuse and inappropriate use of antipsychotics in the foster children population is just one example among many complex health issues that is appropriately demanding and receiving attention at the national and state levels. This project will advance the understanding of the needs of California's foster children across medical, behavioral, and social health domains and re-design the health system, accordingly, to improve health and quality of life for these Medi-Cal members

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 within the development and implementation of a patient centered medical home.

Specific objectives include:

- Improve care coordination for foster youth and their families
- Improve patient adherence to their treatment regimen
-
- Improved communication and documentation of communication and coordination with child welfare services
- Reduce avoidable acute care utilization (ER, admissions)
- Increase patient experience

Core Components (required steps or elements)

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

1) Develop or expand a multi-therapeutic support model whereby PCPs working in Public Healthcare Systems receive support in the ongoing management and treatment of foster children.
   a) Demonstrate engagement of patients and families in the design and implementation of this project
2) Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration)
3) Multi-therapeutic care team will:
   a) Identify patient risk factors using a combination of qualitative and quantitative information.
      i) Complete a patient needs assessment using a standardized questionnaire
   b) Collaborate on evidence based standards of care including medication management, care coordination and care engagement process.
   c) Implement multi-disciplinary case conferences/consults on patients with complex needs
   d) Ensure the development of a single Treatment Plan that includes the patient's behavioral health issues, medical issues, substance abuse and social needs
      i) Use of individual and group peer support
   e) Develop processes for maintaining care coordination and "system continuity" for foster youth who have one or more changes in their foster home
   f) 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.

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g) Assess and provide care for all routine pediatric issues with a specific focus on:
   i) Mental health/toxic stress
   ii) Obesity
   iii) Chronic disease management
   iv) Medication/care plan adherence which are vulnerable when kids transition care givers frequently
   v) Substance abuse issues
   vi) Developmental assessment, identification and treatment

4) Implement technology enabled data systems to support pre-visit planning, point of care delivery, population/panel management activities and care coordination. Timely, relevant and actionable data is used to support patient engagement, and drive clinical, operational and strategic decisions including continuous quality improvement activities.
5) Provide linkages to needed services that at a minimum includes child welfare agency, mental health, substance abuse and public health nursing as well as any other social services that are necessary to meet patient needs in the community
6) Develop liasons/linkage with school systems
7) Provide timely access to eligibility and enrollment services as part of the health home services
8) Evidence based practice guidelines will be implemented to address risk factor reduction (e.g., immunization, smoking cessation, behavioral health screening) as well as to ensure appropriate management of chronic diseases (e.g., Asthma, Diabetes). Assessment of social service needs will be integral to these activities. Educational materials will be utilized that are consistent with cultural and linguistic needs of the population
9) To address quality and safety of patient care, implement a system for continual rapid cycle improvement and performance feedback, that includes patients, front line staff, and senior leadership

Project Metrics (all metrics required)	
Clinical Event Outcomes	1) Prevention a) Use of Developmental Screening Guidelines (e.g., PEDS, ASQ, MCHAT)(P4R) b) Well Child Visits (HEDIS) c) 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 (HEDIS, NCQA, used by Oregon CCOs) d) Childhood IZ Status – Combination 3 (HEDIS, DMHC, NCQA, NQF 0038) e) Immunization Status for Adolescents (HEDIS) f) Tobacco Assessment and Counseling (AMA-PCQI, NQF 0028) 2) Behavioral Health a) Screening for Clinical Depression and follow-up (CMS, NQF 0418) b) Follow-Up Care for Children Prescribed ADHD Medication (ADD) (HEDIS, NCQA, NQF 0108) i) Two rates are reported- initiation and continuation phases c) Alcohol and Drug Misuse (SBIRT) (Oregon CCO) d) Follow-up after hospitalization for mental illness (≥6 yo)(HEDIS, NQF 0576) (2 rates:7 day f/u, 30 day f/u) 3) Care Coordination a) Medication Reconciliation (annual) (P4R)

Potentially Preventable Event/Value/Cost Outcomes	• Potentially preventable ED visits (P4R) • Timely Notification of ED visits (P4R) • Demonstration of contact with patient/family/home after ED visit (P4R)

Patient Experience	• Continuity with provider/care team
	• CAHPS (AHRQ)
	  o Timely Appointments, Care, and Information
	  ▪ Getting Care Quickly
	  ▪ Getting Needed Care
	  ▪ Access to Information After Hours
	  o Shared Decision Making
	  o Care Coordination
	  ▪ Provider aware of medical history

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Project 2.3 Transition to Integrated Care: Post Incarceration

Project Domain	Domain 2: Care Coordination for High Risk, High Utilizing Populations
Project Title	Transition to Integrated Care: Post Incarceration

Rationale (Evidence base and reasoning behind project idea)

Incarcerated populations have much higher prevalence of serious medical and behavioral health conditions in the general population. A 2001 class action lawsuit regarding substandard medical care in California prisons led to the appointment, in 2005, of a federal receiver to oversee health care in the state's correctional system. In light of the significant health needs of the California prison population and county jails, this project is designed to ensure a well-planned transition into the public health care system for former inmates. This transition will occur in a re-designed care system that addresses health issues from medical, behavioral, and social perspectives. Early engagement of individuals as they transition into society from incarceration will optimize opportunities to prevent avoidable health care costs and may also reduce recidivism.

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, primary care, and appropriate behavioral health, substance use and social services, reduce avoidable acute care utilization, and improve the immediate and long term health of the patients.

Specific objectives include:

- Increase enrollment into health coverage
- Improve establishment of, and engagement with, primary care, and coordination with behavioral health care and necessary social services
- Improve health indicators for patients with chronic condition(s)
- Decrease preventable acute care utilization
- Link patients to necessary social services for housing, employment and other services to reduce risk of recidivism

Core Components (required steps or elements)

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

1. Develop a care transitions program for those individuals who have been individuals sentenced to prison or jail that are soon-to-be released/or released in the prior 6 months who have at least one chronic health condition and/or over the age of 50
2. Develop processes for seamless transfer of patient care upon release from correctional facilities, including:
   a. Identification of high risk individuals (e.g, medical, behavioral health, recidivism risk) prior to time of release
   b. Linkage to primary care medical home at time of release
   c. Ensuring primary care medical home has adequate notification to schedule initial post-release intake appointment and has appropriate medical records prior to that appointment, including key elements for effective transition of care.
   d. Establishing processes for follow-up and outreach to individuals who do not successfully establish primary care following release
   e. Establishing a clear point of contact within the health system for prison discharges
3. Develop a system to increase rates of enrollment into coverage and assign patients to a health home, preferably prior to first medical home appointment

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4. Health System ensures completion of a patient medical and behavioral health needs assessment by the second primary care visit, using a standardized questionnaire including assessment of social service needs. Educational materials will be utilized that are consistent with cultural and linguistic needs of the population
5. Identify specific patient risk factors which contribute to high medical utilization
   a. Develop risk factor specific interventions to reduce avoidable acute care utilization
6. Provide coordinated care that addresses co-occurring mental health, substance use and chronic physical disorders, including management of chronic pain
7. Identify a team member with a history of incarceration (e.g., community health worker) to support system navigation and provide linkages to needed services if the services are not available within the primary care home (e.g., social services and housing) and are necessary to meet patient needs in the community.
8. Evidence based practice guidelines will be implemented to address risk factor reduction (e.g., immunization, smoking cessation, screening for HCV, trauma, safety, and overdose risk, behavioral health screening and treatment, individual and group peer support) as well as to ensure appropriate management of chronic diseases (e.g., Asthma, Cardiovascular Disease, COPD, Diabetes).
9. Develop processes to ensure access to needed medications, DME or other therapeutic services (dialysis, chemotherapy) immediately post-incarceration to prevent interruption of care and subsequent avoidable use of acute services to meet those needs
10. Engage health plan partners to pro-actively coordinate Long Term Care services prior to release for timely placement according to need
11. Establish or enhance existing 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.
12. Implement technology enabled data systems to support pre-visit planning, point of care delivery, population/panel management activities, care coordination, and patient engagement, and to drive operational and strategic decisions including continuous quality improvement activities.
13. To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff, and senior leadership.
14. Improve staff engagement by:
    a. Implementing a model for team-based care in which staff performs to the best of their abilities and credentials.
    b. Providing ongoing staff training on care model
    c. Involving staff in the design and implementation of this project
15. Engage patients and families using care plans, and self-management education, including individual and group peer support, and through involvement in the design and implementation of this project.
16. Participate in the testing of novel metrics for this population

Project Metrics (all metrics required)	

Clinical Event Outcomes	• Prevention:
	  o Tobacco Assessment and Counseling (AMA-PCQI, NQF 0028)
	• Chronic Care
	  o Controlling Blood Pressure (DMHC, NCQA, NQF 0018)
	• Behavioral Health
	  o Screening for Clinical Depression and follow-up (CMS, NQF 0418)
	  o Alcohol and Drug Misuse (SBIRT) (Oregon CCO)
	• Care Coordination*: Measures would need modifications for correctional facilities*
	  o Medication Reconciliation– 30 days (MRP) (NCQA, NQF 0097)

	o % ≥18yo discharged & seen within 30 days with med rec • 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 Event/Value	• % of Uninsured Individuals o *Would need to determine feasibly of PHS tracking* • Preventable ER visits (3M) for ambulatory sensitive care conditions • ACSC Hospitalizations: Grand mal status and other epileptic convulsions, COPD, Asthma, CHF & Pulm Edema, HTN, Angina, DM
Patient Experience	• CG-CAHPS currently used composite measures: o Timely Appts, Care & Info o Provider Communication o Respectful staff o Provider rating o Shared decision making

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Project 2.4 Chronic Non-Malignant Pain Management

Project Domain	Domain 2: Care Coordination for High Risk, High Utilizing Populations
Project Title	Chronic Non-Malignant Pain Management

Rationale (Evidence base and reasoning behind project idea)

Over the last decade, there has been a dramatic rise in deaths linked to prescription opiates. Drug-related deaths in the U.S. each year now exceed those due to motor vehicle accidents. However, it is equally clear that a significant number of individuals have severe, non-malignant, chronic pain that may even be disabling. Thus, there is a pressing need in the health care system to address the needs of these chronic pain patients using interventions that maximize benefit while minimizing risk and potential side effects. This project will develop evidence-based protocols and guidelines employing non-pharmacologic treatment while also better defining the role of pain medications. These protocols and guidelines will be part of broader system re-design to better manage pain.

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

To improve primary care providers' and care teams' ability to identify, and manage chronic non-malignant pain using a function-based, multimodal approach, and to improve outcomes by distinguishing between, and implementing appropriate care plans, for patients who will benefit from opioids and patients who are likely to be harmed by them.

Specific objectives include:

- Improve the function and/or health related quality of life 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 use of multi-modal pain management strategies, including but not limited to physical and occupational therapy, group or individual psychotherapy/counseling, and other complementary and alternative therapies for patients age 18 years and older with chronic pain.
- Develop safe and effective prescribing practices for providers caring for patients age 18 years and older with chronic pain.
- Improve the effective use of non-opioid medications in the management of patients age 18 years and older with chronic pain.
- Improve the rate of identification and treatment of prescription opioid use disorders in primary care patients age 18 and older with a diagnosis of chronic pain.
- Decrease the rate of opioid prescriptions for adults 18 years and older who have ongoing substance abuse and/or diagnoses that do not warrant opioids (e.g., fibromyalgia, neuropathy, headache, sore throat, uncomplicated neck and back pain, uncomplicated musculoskeletal pain, non-traumatic tooth pain).
- Decrease the rate of ED visits/acute care utilization related to opioid overdose of patients age 18 years and older with chronic pain
- Increase access to naloxone for patients with chronic opioid prescriptions

Core Components (required steps or elements)

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

1. Develop an enterprise-wide Chronic Non-Malignant Pain management strategy.

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2. Demonstrate engagement of patients in the design and implementation of the project
3. Implement or adapt a state or nationally recognized methodology[14] for the assessment and management of chronic pain.
4. Implement protocols for primary care management of patients with chronic pain including:
   a. A standard standardized Pain Care Agreement
   b. Standard work and policies to support safe prescribing practices
   c. (optional) 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
   d. (optional) Guidelines regarding maximum acceptable dosing
5. Provide culturally, linguistically and literacy level appropriate patient education on the pathology of chronic pain, rationale for rehabilitation and expected goals of treatment
6. Coordinate a chronic pain care team that minimally consists of a physician champion and medical support staff. Suggestions for care clinicians from other disciplines include occupational and physical therapy, behavioral health, pharmacy, substance use disorder specialists, neurology, occupational medicine, anesthesiology/pain management, home care, social work, and physical medicine and rehabilitation.
7. Implement technology enabled data systems to support pre-visit planning, point of care delivery, and team based population/panel management and care coordination.
8. Determine population ICD-9/ICD-10 codes for data collection that is unique to patients with chronic pain on opioids and develop a registry for pain assessments, care agreements, medication refill standing orders and urine toxicology screening
9. Utilize provider activity report card to provide feedback to providers on how their chronic pain management practice compares to peers and benchmarks
10. Establish a policy for monitoring and maintaining opioid agreements for prescription refills with other clinics, pharmacies, dentists and specialists.
11. Develop a process for scheduling pain focused follow-up patient visits to ensure that patients receive refills in a timely manner while also receiving recommended monitoring for signs of diversion or misuse
12. Develop staff and clinician training regarding the organization's process for managing patients with chronic non-malignant pain
13. Train providers to identify signs of prescription opioid use disorders and provide treatment options for patients diagnosed with opioid use disorders, including suboxone treatment, referral to methadone maintenance, referral to inpatient and outpatient substance use disorder treatment facilities, and referral to needle exchanges.
14. Develop and implement protocols for prescribing naloxone to patients receiving opioids for chronic pain.
15. Identify standardized multidimensional pain assessment, functional assessment, psychological assessment[15], and opioid assessment tools[16] that meet the needs of the care clinicians and are appropriate for the patient populations

[14] Institute for Clinical Systems Improvement, Medical Board of California September 2014 (DRAFT) Guidelines for Prescribing Controlled Substances for Pain, The American Pain Society, or The American Society of Anesthesiologists

[15] 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

[16] 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®),

16. Implement a system for continual rapid cycle improvement and performance feedback that includes both front line and senior leadership. Timely, relevant and actionable data is used to support patient engagement, and drive clinical, operational and strategic decisions including continuous quality improvement activities.	
Project Metrics (all metrics required)	
Clinical Event Outcomes	• Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (NQF) • Alcohol and Drug Misuse (SBIRT) (Oregon CCO) • **Patients with on long term opioid therapy checked in PDMPs (**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 **an annual** urine toxicology screen documented in the medical record. (Variation on 2013 Nov. NQMC:009368) • Assessment and management of chronic pain: percentage of patients diagnosed with chronic pain with a diagnosis of neuropathic pain who are prescribed an **anti-neuropathic non-opioid medication** prior to use of opioids. (Variation on 2013 Nov. NQMC:009366)
Potentially Preventable Event/Value	• P4P: ED visits for prescribed opiate overdose • P4R: ED visits for opiate overdose

Patient Experience	• CG-CAHPS
	  o Timely Appointments, Care, and Information
	  o Shared Decision Making
	• Healthy Days Core Module (CDC HRQOL– 4) (P4R)

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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)

Project 2.5 Comprehensive Advanced Illness Planning and Care

Project Domain	Domain 2: Care Coordination for High Risk, High Utilizing Populations
Project Title	Comprehensive Advanced Illness Planning and Care

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.

Community-based palliative care services: A number of initiatives have resulted in a significant proportion of public hospitals (63 percent) offering palliative services. According to an estimate by the Berkeley Forum, however, only 20 percent of potentially appropriate patients have access to community-based palliative care services.

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 Triple Aim goals and expected project outcomes)

To ensure access to comprehensive care in alignment with patient preferences in hospital and community settings for all patients facing advanced illness.

Specific objectives include:

- Increase timely access to ambulatory and inpatient palliative care services
- Introduction of Primary and/or Specialty Palliative Care services at time of diagnosis of

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advanced illness
- Relieve pain and other distressing symptoms
- Improve quality of life for both the patient and the family
- Improve concordance between patient/family preference and provision of care
- 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, including comprehensive assessment, inter-professional care planning and care delivery
  - Support for the family
  - Interdisciplinary teamwork
  - Effective communication
  - Effective coordination
  - Attention to quality of life and reduction of symptom burden
  - Engagement of patients and families in the design and implementation of the program
- Develop criteria for program inclusion based on quantitative and qualitative data
  - Establish data analytics systems to capture program inclusion criteria data elements
- Implement, expand, or link with, a Primary Palliative Care training program for front-line clinicians to receive basic PC training, including Advanced Care Planning, as well as supervision from specialty PC clinicians.
  - Assure key palliative care competencies for primary care providers by mandating a minimum of 8 hours of training for front line clinicians in communication skills and symptom management
- Develop comprehensive advance care planning processes and improve implementation of advance care planning with advanced illness patients
- Establish care goals consistent with patient and family preferences, and develop protocols for management/control of pain and other symptoms in patients with advanced illness, including a holistic approach that includes spiritual and emotional needs
- Improve completion of POLST with eligible patients and participate in the state-wide POLST registry
- Provide access to clinical psychologist on the Palliative care team to address psychological needs of patient and the family members during the advanced illness and provide grief counseling and support to the family after death of their loved ones.
- 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 linkage with PC training program
- For advanced illness patients transitioning between primary care, hospital, skilled nursing facilities (SNFs), and/or home-based environments, ensure that the advance care plan is clearly documented in the medical record and transmitted in a timely manner to the receiving facilities and care partners who do not have access to the health system's medical record.
- Engage staff in trainings to increase role-appropriate competence in palliative care skills, with an emphasis on communication skills
- Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership

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Project Metrics	

Clinical Event Outcomes	• Proportion of patients with palliative care service offered at time of diagnosis of advanced illness (P4R)
	  o Numerator:
	  ▪ ≥1 of the following:
	  • Family meeting to discuss goals of care
	  • Focused symptom management
	  • POLST discussion
	  • Visit by chaplain
	  • Hospice referral
	  • Social worker consult for advanced care planning
	  o Denominator:
	  ▪ All stage 4 cancers
	  ▪ Advanced end organ failure (ESRD in pts > 80 yo, ESLD (MELD Score ≥30), Class IV CHF, Stage IV COPD, Advanced dementia (CDR 3), Neurodegenerative disease who are non-ambulatory)
	
	• Advance Care Plan (NCQA, NQF 0326)
	  o % patients ≥65 yo 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.
	
	Measuring What Matters:
	• MWM #10: Treatment Preferences (UNC-Chapel Hill, NQF 1641)
	  o Percentage of patients with chart documentation of preferences for life sustaining treatments.
	  ▪ This item is meant to capture evidence of discussion and communication. Therefore, "full code" (FC) or (DNR/DNI) do not count by themselves.
	• MWM #11: Treatment Preferences Followed
	  o (ACOVE Measures Set) If a vulnerable elder has documented treatment preferences to withhold or withdraw life-sustaining treatment (eg, a donot-resuscitate order, no tube feeding, no hospital transfer), then these treatment preferences should be followed

Potentially Preventable Event/Value[17]	• NQF 0210: Proportion receiving chemotherapy in the last 14 days of life • NQF 0215: Proportion not admitted to hospice

[17] NQF-Endorsed® Palliative Care and End-of-Life Care, Endorsement Maintenance Standards, file:///C:/Users/dlown/Downloads/tb_pallcare_maintenancespecs_20110412_backup_final.pdf, Accessed on 10/10/14

Patient Experience	• CG-CAHPS - Shared Decision Making • PROMISE Survey: CAHPS equivalent for families of patients who've died • Zarit Burden Interview (caregiver burden scale – where applicable) • Location of death in place of preference

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Project 2.6 Palliative Care and End of Life Planning

Project Domain	Domain 2: Care Coordination for High Risk, High Utilizing Populations
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 all of CA public hospitals offering in-patient palliative services, according to OSHPD 2013 data. Statewide, only 22-34 % of individuals who might benefit have access to palliative care in the community services. Crucial to improving quality of life for patients with serious illness 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 participation in advance care planning and completion of POLST forms
- Increase access to community-based 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
- Increase use of hospice as appropriate

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 including a physician, nurse, social worker and chaplain
  - Effective communication among providers and with patients and families
- Implement or expand a Primary Care Palliative Care training program for front-line clinicians to receive basic PC training, including Advance Care Planning and POLST, 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) (as appropriate by location)

Clinical Event Outcomes	• Advance Care Plan (NCQA, NQF 0326)
	  o 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)
	  o 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)

	o 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) o 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) o Percentage of patients with chart documentation of preferences for life sustaining treatments. • Patients with Advanced Cancer Screened for Pain at Outpatient Visits (RAND, NQF 1628) o 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 • 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 • 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 • Palliative Performance Scale • Zarit Burden Interview (caregiver burden scale) • Location of death in place of preference

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DOMAIN 3 – RESOURCE UTILIZATION EFFICIENCY

Project 3.1 Antibiotic Stewardship

Project Domain	Domain 3: Resource Utilization Efficiency
Project Title	Antibiotic Stewardship
Rationale (Evidence base and reasoning behind project idea)	
Antibiotic overuse and misuse constitute the leading cause of adverse drug events in the U.S. and lead to significant morbidity and mortality through increases in antibiotic resistance. Fortunately, however, this clinical problem has been well studied in the quality improvement literature and successful system-based interventions have demonstrated dramatic practice improvements. This project will build on this experience employing tools such as evidence-based guidelines, learning collaboratives, comparative data and benchmarking, and patient engagement to drive improvement in antibiotic stewardship from a system perspective.	
Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)	
To improve the appropriate use of antimicrobials by reducing overall antibiotic use for non-bacterial diseases, and optimizing antibiotic use for bacterial infections, with a special emphasis on agents with broad spectrum activity, in order to improve patient outcomes and eliminate unnecessary patient care costs. Specific objectives include: • Reduce broad-spectrum antibiotic use • Decrease inappropriate use of antibiotics across hospital and health care system • Reduce hospital associated Clostridium difficile infections	
Core Components (required steps or elements)	
Systems undertaking this project will be required to complete the following components: 1. Utilize state and/or national resources to develop and implement an antibiotic stewardship program, such as the California Antimicrobial Stewardship Program Initiative, or the IHI-CDC 2012 Update "Antibiotic Stewardship Driver Diagram and Change Package"[18] a. Demonstrate engagement of patients in the design and implementation of the project 2. Develop antimicrobial stewardship policies and procedures 3. Participate in a learning collaborative or other program to share learnings, such as the "Spotlight on Antimicrobial Stewardship" programs offered by the California Antimicrobial Stewardship Program Initiative[19] **4.** Create standardized protocols for ordering and obtaining cultures and other diagnostic tests prior to initiating antibiotics 5. Develop a method for informing clinicians about unnecessary combinations of antibiotics 6. Based on published evidence, reduce total antimicrobial Days of Therapy (DOT) by providing standards and algorithms for recommended agents by disease type, focusing on short course regimens (e.g., 3-5 days of therapy for uncomplicated cystitis, 7 days for uncomplicated pyelonephritis, 5-7 days for uncomplicated non-diabetic cellulitis, 5 day therapy for community acquired pneumonia (CAP), 7-8 days for therapy for VAP or hospital acquired pneumonia).	

[18] 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).

[19] 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.

7. Develop evidence-based CPOE algorithms and associated clinician training, to support antibiotic stewardship choices during order entry. These could include approaches such as guidelines for duration of antibiotics, within drug class auto-switching for specific antibiotics and doses, or restriction of specific antibiotics at the point of ordering (e.g., broad spectrum agents)
8. Implement stewardship rounds focusing on high yield drugs to promote de-escalation after the drugs are started, such as regular antibiotic rounds in the ICU
9. Improve diagnostic and de-escalation processes to reduce unnecessary antibiotic use based upon length of therapy or antibiotic spectrum. , such as:
    a. Procalcitonin as an antibiotic decision aid
    b. Timely step down to oral antibiotic therapy to support early discharge from the hospital for acute infections
    c. Use of oral antibiotics for osteomyelitis to reduce prolonged IV exposures
10. Evaluate the use of new diagnostic technologies for rapid delineation between viral and bacterial causes of common infections
11. Adopt the recently described "public commitment" strategy in outpatient clinics to encourage providers not to prescribe antibiotics for URIs
12. Publish organization-wide provider level antibiotic prescribing dashboards with comparison to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems
13. 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	1. Days of targeted antibiotic therapy/# cultures of asymptomatic bacteriuria/funguria for a random sample of 100 cultures, regardless of urinary catheter a. Alternate: Days of antifungal therapy/# cultures of asymptomatic funguria for a random sample of 100 cultures, regardless of urinary catheter. 2. Community-Acquired Bacterial Pneumonia (CAP): Empiric Antibiotic (AMA-PCPI, NQF 0096) 3. Prophylactic antibiotics discontinued within 24 hours after surgery end time (CMS, NQF 0529) (Already a Core Measure) 4. Discontinuation of prophylactic antibiotics (cardiac procedures) (AMA/PCPI, PQRS #45, NQF 0637) 5. RANDY: # Prescriptions for agents with activity against Pseudomonas aeruginosa used to treat infections commonly caused by Staphylococcus or Streptococcal species (e.g., skin infections, CAP).
Potentially Preventable Event/Value	• Antimicrobial Days of Therapy (DOT) per 1000 Patient Days (Inpatient)

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Project 3.2 Resource Stewardship: High Cost Imaging

Project Domain	Domain 3: Resource Utilization Efficiency
Project Title	Resource Stewardship: High Cost Imaging

Rationale (Evidence base and reasoning behind project idea)

Overuse of imaging has been identified as an important quality issue by radiologists and other medical specialties. The *Choosing Wisely Campaign*, for example, has identified a number of specific imaging tests that have the potential for overuse or misuse. This project will use proven intervention methods addressing health care providers and patients since imaging is an area often identified as in need of shared decision-making.

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, in order to reduce inappropriate utilization of imaging, and increase the amount of cost-effective and evidence based imaging performed in the system of care.
"The right study for the right patient at the right time"

Specific objectives include:

- Reduce the number of unnecessary/inappropriate studies
- Improve the use of evidence based, lower cost imaging modalities when imaging is warranted

Core Components (required steps or elements)

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

1. Implement an imaging management program, demonstrating engagement of patients in the design and implementation of components of the project.
2. Program should include identification of top imaging tests whose necessity should be assessed for possible overuse. Criteria for assessment could include:
   a. Frequency and cost of inappropriate/unnecessary imaging
      i) Appropriate Use: Beginning with state or nationally recognized models or guidelines (e.g., American College of Radiology Appropriateness Criteria, American College of Cardiology Appropriate Use Criteria) and incorporating pertinent local factors, programs will set out definitions for appropriateness
      ii) Cost: Programs will identify imaging studies associated with high costs due to high cost per study or high volume across the system
   b. Unwarranted practice variation within the participating PHS
   c. Data completeness and ability to report the extent of a-c, building data capacity where needed
   d. Whether there are established, tested and available evidence-based clinical pathways to guide cost-effective imaging choices
3. Establish standards of care regarding use of imaging, including:
   a. Costs are high and evidence for clinical effectiveness is highly variable or low.
   b. The imaging service is overused compared to evidence-based appropriateness criteria.
   c. Lack of evidence of additional value (benefits to cost) compared to other imaging options available to answer the clinical question.
4. Incorporate cost information into decision making processes:
   a. Develop recommendations as guidelines for provider-patient shared decision conversations in determining an appropriate treatment plan.
   b. Implementation of decision support, evidence based guidelines and medical criteria to recommend best course of action
5. Provide staff training on project components including implementation of recommendations, and methods for engaging patients in shared decision making as regards to appropriate use of imaging

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6. Implement a system for continual rapid cycle improvement and performance feedback that includes patients, front line staff and senior leadership	
Project Metrics	

Potentially Preventable Event/Value/Cost Outcomes	• Use of Imaging Studies for Low Back Pain (NCQA, NQF 0052)
	  o Percent of members 18-50 years old with a primary diagnosis of low back pain with and outpatient or ED encounter who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis
	• Inappropriate Pulmonary CT Imaging for Patients at Low Risk for Pulmonary Embolism (ACEP, NQF 0667)
	  o Numerator: Percent of patients with either: a low clinical probability and any negative D-dimer, or a low clinical probability and no D-dimer performed, or no pretest probability documented.
	  o Denominator: Number of patients with a CT pulmonary angiogram (CTPA) for the evaluation of possible Pulmonary Embolism
	• Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative evaluation in low risk surgery patients (ACC, NQF 0670)
	  o Number of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) primarily performed in low risk surgery patients for preoperative evaluation within 30 days preceding low-risk non-cardiac surgery

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Project 3.3 Resource Stewardship: Therapies Involving High Cost Pharmaceuticals

Project Domain	Domain 3: Resource Utilization Efficiency
Project Title	Resource Stewardship: Therapies Involving High Cost Pharmaceuticals

Rationale (Evidence base and reasoning behind project idea)

Pharmaceuticals represent a significant portion of health care costs for many segments of the Medi-Cal population. Thus, applying value-based principles to the use of pharmaceuticals is essential to advance the Triple Aim. This project will study patterns of medication use looking at efficacy and cost. It will use such analyses to drive systems of performance feedback and shared decision-making to move pharmaceutical use to higher levels of cost-effectiveness.

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 therapies involving high cost 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 pharmaceutical therapies
- Decrease inappropriate use of high cost pharmaceutical therapies
- Improve use of shared decision making with patients
- Drive down health-care costs through improved use of targeted medications and prescribing behaviors
- Optimize 340b if eligible

Core Components (required steps or elements)

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

1) Implement or expand a high cost pharmaceuticals management program
2) Implement a multidisciplinary pharmaceuticals stewardship team
3) 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.
   a) Using purchase price data, Identify the Top 20 medications and medication classes, focusing on the following: Analgesics, Anesthetics, Anticoagulants, Anti-Neoplastics, Diabetes, Hepatitis C, Immunoglobulins, Mental Health (Anti-Depressants/Sedatives/Anti-Psychotics), Respiratory (COPD/Asthma), Rheumatoid Arthritis
      i) Exclude Anti-Infectives and Blood Products (addressed in separate DSRIP Projects)
4) Develop processes for evaluating impact of high cost, high efficacy drugs, particularly drugs to treat conditions (e.g., HCV) or to address circumstances (e.g., oral anticoagulants for patients without transportation for blood checks) more prevalent in safety net populations.
   a) Consider criteria that include ability of identified medications to improve patient health, improve patient function and reduce use of health care services
5) Develop processes to impact prescribing by providers by establishing standards of care regarding prescribing of high cost pharmaceuticals, including
   a) Use of decision support/CPOE, evidence-based guidelines and medical criteria to support established standards
   b) Develop processes to improve the appropriate setting for medication delivery

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including, transitioning pharmaceutical treatment to the outpatient setting wherever possible
   c) Promote standards for generic prescribing
   d) Promote standards for utilizing therapeutic interchange
6) Improve the process for proper billing of medications, through clinician education and decision support processes
7) Develop formulary alignment with local health plans
8) 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
9) Develop organization-wide provider level dashboards to track prescribing patterns for targeted high cost pharmaceuticals. Dashboard to include comparisons to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.
10) Develop processes for working with providers with prescribing patterns outside established standards, to identify and reduce barriers to meeting prescribing standards.
   a) 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
11) Maximize access to 340b pricing
   a) Share templates for contracting with external pharmacies
   b) To improve program integrity, share tools for monitoring of 340b contract compliance

Project Metrics	
Potentially Preventable Event/Value/Cost Outcomes	• Inpatient: Average Medications cost/patient/day • Outpatient: o Average cost/patient/day of infusion/clinic dispensed medications o Average cost/patient/day of take home/pharmacy dispensed medications
Patient Experience	• CAHPS o Shared decision making

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Project 3.4 Resource Stewardship: Blood Products

Project Domain	Domain 3: Resource Utilization Efficiency
Project Title	Resource Stewardship: Blood Products

Rationale (Evidence base and reasoning behind project idea)

Management of blood products is an important health care issue for a number of reasons, including: (1) delivery of blood products entails significant risk; (2) blood products are provided to as many as 1/5 patients in the hospital; (3) costs are considerable; (4) overuse and misuse of blood products are common. This project will use established guidelines, performance feedback, dashboards, and other methods to systematize better management of 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:

- Promote reduced wastage of blood products that have been dispensed to the patient care area
- Promote reduced wastage of blood products that are in the hospital inventory but never get dispensed
- To identify, develop and promote the implementation of patient blood management (PBM) to improve appropriate use of blood and blood products by health providers.
- To improve clinical outcomes of transfusion and reduce adverse events from transfusion

Core Components (required steps or elements)

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

1. Implement or expand a patient blood products management (PBM) program.
2. Implement or expand a Transfusion Committee consisting of key stakeholder physicians and medical support services, and hospital administration.
3. Utilize at least one nationally recognized patient blood management program methodology (e.g., The Joint Commission[20], AABB)
4. Develop processes for evaluating impact of blood product use including appropriateness of use, adequacy of documentation, safety implications, cost, and departmental budget impact. Develop a data analytics process to track these and other program metrics.
5. Establish standards of care regarding use of blood products, including:
   a. Use of decision support/CPOE, evidence based guidelines and medical criteria to support and/or establish standards
6. Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership
7. Develop organization-wide dashboards to track provider level blood use patterns. Dashboard to include comparisons to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.
8. Participate in the testing of novel metrics for PBM programs

Project Metrics (all metrics required)

Clinical Event Outcomes	• PBM-01 Transfusion Consent • PBM-02 RBC Transfusion Indication

[20] 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.

	• PBM-03 Plasma Transfusion Indication
	• PBM-04 Platelet Transfusion Indication
	• PBM-05 Blood Administration Documentation
	• (P4R) PBM-06 (variation) Preoperative Anemia Screening
	  o "Anemia screening before elective scheduled surgery AND a plan of action if the patient is anemic"
	• PBM-07 Preoperative Blood Type Testing and Antibody Screening
	• (P4R) PBM-yy Direct observation (documentation) of proper blood product administration procedure/protocol
	  o ID of patient, ID of unit of blood product are compared and confirmed
	• (P4R) PBM-xx Cryoprecipitate Transfusion Indication

Potentially Preventable Event/Value/Cost Outcomes	• (P4R/P4P) Medical expenditures for blood products (per patient days) • (P4R/P4P) Total transfusions per patient days • (P4R) Transfusing the wrong patients • (P4R) Transfusing the wrong product to the patient • (P4R) Wrong Blood In Tube (WBIT): Wrong person's blood in a specimen intended for pre-transfusion testing

Patient Experience	• (P4R/P4P) Transfusion reactions, of any severity, due to any error by lab or nursing
	  o *If mistakes occurred d/t lab processes control failure – required to report to FDA*
	  o *If d/t nursing error – not reportable*

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DOMAIN 4 – PREVENTION

Project 4.1 Million Hearts Initiative, Obesity Prevention, and Healthier Foods Initiative

Project Domain	Domain 4: 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 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 Triple Aim goals and expected project outcomes)

Implement collaboratively identified and standardized, evidence-based and population resource

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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 this project 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 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)

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	o 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) o 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) o 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) o 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 Activityfor Children & Adolescents (NCQA, NQF 0024) o 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
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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Project 4.2 Cancer Screening and Follow-up

Project Domain	Domain 4: 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 Triple Aim goals and expected project outcomes)

Implement collaboratively-identified, standardized, evidence based and population resource stewardship approaches to the use of targeted preventive services across multiple Public Health Systems (PHS). Develop consensus across participating PHS on approaches to a select group of cancer screening and follow-up services with high clinical impact, and variation in resource utilization and 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 standard approaches to Breast, Cervical and Colorectal Cancer screening and completion of follow-up on abnormal screening tests
- Increase rates of screening and completion of follow-up across targeted prevention services
- Reduce disparities in receipt of targeted prevention services
- Reduce variation in performance of targeted prevention services across multiple CA PHS
- Reduce the prevalence of late presentation of targeted cancers due to lack of screening

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

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

- Develop a multi-disciplinary cross-PHS task force to identify principle-based expected practices for screening and follow-up for the targeted services including, but not limited to:
  - Standard approach to screening and follow-up within each DPH
  - Screening:
    - Enterprise wide standard approach to screening (e.g., ages, frequency, diagnostic tool)
  - Follow-up for abnormal screening exams:
    - Clinical risk- stratified screening process (e.g., Family History, red flags)
    - Timeliness (specific time benchmark for time from abnormal screening

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exam to diagnostic exam)

- Demonstrate patient engagement in the design and implementation of programs.
- 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 continual performance management and rapid cycle improvement that includes feedback from patients, community partners, front line staff, and senior leadership

Project Metrics (all metrics required)	
Clinical Event Outcomes	• Breast Cancer Screening (NCQA, NQF 2372) • CMS OP-9: Mammography Follow-Up Rates (% of patients with screening mammogram that are followed by a Diagnostic mammogram, Ultrasound or MRI of the breast within 45 days) • Cervical Cancer Screening (DMHC CCS, NCQA, NQF 0032) • (P4R/P4P) Receipt of appropriate follow-up for abnormal screening pap smear • Colorectal Cancer Screening (NCQA, NQF 0034) • (P4R/P4P) % of patients with a positive colon cancer screening test who receive a diagnostic colonoscopy, or radiology-based evaluation (dual-contrast BE or CT colonoscopy) within xx weeks of the initial test result being performed [21]
Potentially Preventable Event/Value	• IHA Evidence-Based Cervical Cancer Screening of Average of Average--Risk, Asymptomatic Women (3 rates)[22]: o Appropriately Screened o Not Screened o Screened Too Frequently
Patient Experience	• CG-CAHPS:

[21] Proposed measure is a variation on "Patients with positive FOBT who underwent an appropriate evaluation" as discussed in AHRQ Cancer Care Quality Measures: Diagnosis and Treatment of Colorectal Cancer, pages 31-32, E-5 Accessed 10/6/14

[22] http://www.iha.org/pdfs_documents/p4p_california/ECS_July2009.pdf

	o "Did someone from this provider's office follow up to give you those results?"

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Project 4.3 Prevention: Perinatal Care

Project Domain	Domain 4: 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.

- 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-

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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 Triple Aim 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 this project 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)
	  o 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 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)
	  o Number of newborns exclusively fed breast milk during the newborn´s entire hospitalization
	• Prenatal and Postpartum Care (NCQA, NQF 1517)
	  o 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

	o Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery • Baby Friendly Hospital designation
Patient Experience	• CG-CAHPS: Patient would recommend provider to family and friends

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DOMAIN 5: PATIENT SAFETY

Project 5.1 Patient Safety Culture

Project Domain	Domain 5: Patient Safety
Project Title	Promoting a Culture of Patient Safety

Rationale (Evidence base and reasoning for project)

A recent study estimates that there are 200,000-400,000 deaths due to medical error in the U.S. each year. This underscores the need to continue aggressive efforts to improve patient safety. A focus on advancing a safety culture is important because there is growing evidence that such an approach is needed to advance and sustain improvements in patient safety over time. In addition, advancing a safety culture addresses the concern that focusing on a handful of safety targets reduces attention to many other critical issues that don't happen to be the immediate focus of attention. Advancing a safety culture implies a commitment to a more comprehensive approach to improving quality and reducing preventable adverse events.

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

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 (required steps or elements)

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.

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

- Make safety a priority
- Analyze problems with rigorous methods
- There are no one-size fits all approaches; DPHs should develop approaches to optimize safety across care delivery

Project Metrics (all metrics required)

Potentially Preventable Event/Value	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.

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Hospital-Acquired Condition (HAC) Measure

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:

- All software necessary for estimation is in the public domain.
- Components except for the weighting system are all endorsed by NQF.
- Hospitals are familiar with the Medicare HAC Reduction program.
- 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. he 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

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	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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Project 5.2 Reducing Inappropriate Surgical Procedures

Project Domain	Domain 5: Patient Safety
Project Title	Reducing Inappropriate Surgical Procedures

Rationale (Evidence base and reasoning behind project idea)

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.

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

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 over utilized. 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 (required steps or elements)

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

- Promote shared decision making (SDM)

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

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Project Metrics (all metrics required)	
Potentially Preventable Event/Value	• TBD
Patient Experience	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 INTERVENTION)? • 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."

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