Attachment Q - PRIME Projects and Metrics Protocol

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II. Preface

A. Public Hospital Redesign and Incentives in Medi-Cal

On December 30, 2015 , the Centers for Medicare and Medicaid Services (CMS) approved California's request for a renewal to California's section 1115(a) Medicaid demonstration (hereinafter "demonstration") authorizing the creation of a Public Hospital Redesign and Incentives in Medi-Cal (hereinafter "PRIME"). .

B. PRIME Protocols

The PRIME requirements specified in the STCs are supplemented by the following attachments to the STCs:

Attachment D. Designated Public Hospital Systems and District/Municipal Public Hospitals that are Participating PRIME entities

Attachment Q. PRIME Projects and Metrics (this document): This Attachment details the specific delivery system improvement activities ("projects"), including requirements regarding project metrics, that are eligible for PRIME funding; for each project, Attachment Q specifies the details of the projects, projects' metrics, and metrics' targets that will be the basis for earning PRIME incentive payments. Attachment Q also specifies the key elements of and the review and approval process for participating PRIME entities' 5-year PRIME Project Plans. Participating PRIME entities will utilize this document for purposes of selecting projects (each of which specifies required metrics) to include in their 5-year PRIME Project Plans.

Attachment R. Alternative Payment Methodologies: Attachment R will outline additional payment methodologies that will qualify as APM outside of the capitation payment methodologies.

Attachment S. PRIME Evaluation and Monitoring: Attachment S will describe the state's plan for meeting PRIME monitoring requirements as well as will include the final evaluation plan.

Attachment II. PRIME Funding and Mechanics: Attachment II describes the general requirements for receiving incentive payments under PRIME, including the allocation, payment mechanisms and disbursement of pool funds; reporting requirements; and reinvestment of unallocated funds.

III. Background

A. Overview of the PRIME Program & Participating Entities

The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Pool will build upon the foundational delivery system transformation work, expansion of coverage, and increased access to coordinated primary care achieved through the prior California Section 1115 Bridge to Reform demonstration. The activities supported by the PRIME Pool are designed to accelerate efforts by participating PRIME entities (as defined in Attachment D) to change care delivery to maximize health care value and strengthen their ability to successfully perform under risk-based alternative payment models (APMs) in the long term, consistent with CMS and Medi-Cal 2020 goals. The PRIME program is intentionally designed to be ambitious in scope and time-limited. Using evidence-based, quality improvement methods, the initial work will require the establishment of performance

baselines followed by target setting and the implementation and ongoing evaluation of quality improvement interventions. Participating PRIME entities will consist of two types of entities: Designated Public Hospital (DPH) systems and the District/Municipal Public Hospitals (DMPH) (described further in Attachment II).

DPHs participating in PRIME, will be required to contract with at least one Medi-Cal Managed Care Provider (MCP) in the MCP service area that they operate using APM methodologies as part of their PRIME Project Plan by January 1, 2018. If a DPH is unable to meet this requirement and can demonstrate that it has made a good faith effort to contract with an MCP in the service area that it operates in and a gap in contract period occurs, DHCS has discretion to waive this requirement as specified in Attachment R.

Each project in PRIME has a required set of projects and metrics in which payment will be tied to performance. Domains, projects and metrics are described below in more detail.

B. Development Summary

PRIME projects have been identified and designed through a rigorous, lengthy, thoughtful and consultative process. Every project and each metric has gone through a thorough, iterative process based on detailed criteria over the past year and a half that included in-depth review by and input from:

- Over 100 clinical and quality experts with on-the-ground experience caring for California's Medi-Cal beneficiaries and most vulnerable populations,
- Experts on reporting/IT technical capabilities of the public hospital safety net that have a deep working knowledge of Medi-Cal data and state reporting,
- Public hospital leadership across the state,
- Quality improvement professionals in partnership with DHCS, and
- Public stakeholder representing statewide health care, consumer and advocacy organizations

Each project is measured by a core required set of metrics so that all participating PRIME entities are working toward industry best practices and the same desired results; as such, the program will yield comparable data across entities and throughout the Demonstration. The data to be reported through the PRIME will be meaningful and provide useful information in order to continue to drive improvement.

IV. Projects

A. Domains

Projects are organized into 3 domains. Participating DPH systems will implement at least 9 PRIME projects, and participating DMPHs will implement at least one PRIME project, as part of the participating PRIME entity's Five-year PRIME Plan. Participating DPH systems must select at least four Domain 1 projects (three of which are specifically required), at least four Domain 2 projects (three of which are specifically required), and at least one Domain 3 project.

The projects by domain are summarized in Table 1 below.

Table 1: High-Level Summary of Projects by Domain

Domain Name	Required Projects by Domain for DPHs	Project(s)	Required for DPHs
Domain 1: Outpatient Delivery System Transformation and Prevention	3 required projects + 1 additional	Project 1.1 Integration of Physical and Behavioral Health	Y
		Project 1.2 Ambulatory Care Redesign: Primary Care (includes reduction in disparities in health and health outcomes)	Y
		Project 1.3 Ambulatory Care Redesign: Specialty Care	Y
		Project 1.4 Patient Safety in the Ambulatory Setting	N
		Project 1.5 Million Hearts Initiative	N
		Project 1.6 Cancer Screening and Follow-up	N
		Project 1.7 Obesity Prevention and Healthier Foods Initiative	N
Domain 2: Targeted High Risk or High Cost Populations	3 required projects + 1 additional	Project 2.1 Improved Perinatal Care	Y
		Project 2.2 Care Transitions: Integration of Post-Acute Care	Y
		Project 2.3 Complex Care Management for High Risk Medical Populations	Y
		Project 2.4 Integrated Health Home for Foster Children	N
		Project 2.5 Transition to Integrated Care: Post Incarceration	N
		Project 2.6 Chronic Non-Malignant Pain Management	N
		Project 2.7 Comprehensive Advanced Illness Planning and Care	N
Domain 3: Resource Utilization Efficiency	1 minimum	Project 3.1 Antibiotic Stewardship	N
		Project 3.2 Resource Stewardship: High Cost Imaging	N
		Project 3.3 Resource Stewardship: Therapies Involving High Cost Pharmaceuticals	N
		Project 3.4 Resource Stewardship: Blood Products	N

Descriptions of each project can be found below in Section VI.

B. Project Selection Exclusions

Participating PRIME entities may only select projects for which the target population is sufficient to accurately measure success, as defined as having greater than or equal to 30 individuals meeting the project target population definition. Participating PRIME entities also may not select optional projects for which they have achieved top performance of the metric benchmark for > 50% of the number of a project's metrics. If a DPH is unable to select a particular optional project for the above reason, the DPH must choose another optional project from the same domain as necessary to fulfill program minimum project requirements. If a DPH is unable to select a particular required project for either of the above reasons, the DPH must choose another project from the same domain as necessary to fulfill program minimum project requirements.

V. Metrics

A. Reporting of PRIME Project Metrics

Reporting of metrics will be completed per the Program Funding and Mechanics Protocol (Attachment II, Section VII). Participating PRIME entities will report on all metrics required for each project, unless as described by Section IV.B. All PRIME metric reporting will conform to technical measure specifications as required by DHCS. Each participating PRIME entity will receive PRIME incentive payments based on the participating PRIME entity's performance on the project metrics, per Attachment II.

Each project has a required set of metrics. Section V.E lists the specific metrics that will be used to assess performance. All metrics are reported at the DPH or DMPH level.

B. Metric Types

1. Metrics are primarily clinical metrics.
2. Metrics were chosen from State, Medi-Cal, or CMS quality metrics if available.
3. Metrics were preferentially chosen from state or national metrics which have been vetted by Measure Stewards, which are defined as recognized, authoritative entities able to assess clinical relevance, feasibility and appropriateness of a metric. Examples of Measure Stewards include the NCQA, AMA, and CMS. These vetted measures have been included in PRIME as "standard metrics" where possible. Innovative metrics, representing around 20% of all metrics, are used to measure performance for PRIME projects only in instances in which a project's current set of standard metrics does not adequately assess successful transformation. Innovative metrics are defined as metrics that, at the beginning of PRIME, have not yet undergone a vetting and testing process by a Measure Steward. Measure Stewards have been identified for every innovative metric. Innovative metrics enable participating PRIME entities to demonstrate the transformation of health care towards coordinated, team-based, patient-centered care, in a manner not afforded by many of the standard metrics. Innovative metrics will go through an established metric testing process, as described in the DHCS PRIME Metrics and Specification Manual.

4. Pay for Reporting and Pay for Performance: Following the submission of baseline data for all metrics in DY 11, the majority of standard metrics will convert to pay-for-performance in DY 12. A smaller proportion of standard metrics, those which are both new to participating PRIME entities and are much more complex to report on, will convert to pay-for-performance in DY 13. The innovative metrics will convert to pay-for-performance in later years once each has completed a rigorous testing process as described in the Innovative Metric Testing summary found in D. Table 2 provides a breakdown of the transition of PRIME metrics from pay-for-reporting to pay-for-performance for each DY.

Table 2: Summary of Metric Progression from P4R to P4P

	DY 11	DY 12	DY 13	DY 14	DY 15
% of P4R Metrics	100%	40%	21%	2%	2%
% of P4P Metrics	0%	60%	79%	98%	98%

C. Metrics Governance

The measurement specifications for a PRIME metric will stay current with those of the Measure Steward and/or endorsing body. DHCS will monitor any changes to NQF-endorsed and non-NQF endorsed measures that are used in PRIME projects. If a measure is dropped or significantly changed by the measure steward, any changes will be effective at the start of the next annual PRIME Demonstration Year. Per Metric Modification Process (Attachment II, VI, C), DHCS retains authority to modify metric specifications for the program.

D. Innovative Metric Testing

Innovative metrics, are defined as metrics that at the start of PRIME have not yet undergone a vetting a testing process by a Measure Steward. All PRIME innovative metrics have a confirmed Measure Steward and will go through a formal and rigorous testing process by a DHCS PRIME Metric Technical Advisory Committee (MTAC). The Committee will test the metric against criteria including, but not limited to, importance, scientific feasibility, and usefulness as supported by evidence gathered by the Measure Steward. During the testing process, innovative metrics are pay-for-reporting until which time they have been sufficiently vetted to be pay-for performance metrics as determined by DHCS and the above referenced metric testing process.

1. **Principles Of The Process**

    a. An innovative metric is a metric that currently has no state or national metric steward or entity that has already defined and vetted the metric.

    b. An innovative metric is included only when a project's current metric set does not adequately assess successful transformation.

    c. Each PRIME innovative metric will have either DHCS or a PHS volunteering to serve as the measure steward for the duration of PRIME.

i. The measure steward is responsible for defining the specifications and providing evidence for its use.

ii. The measure steward will also recommend a reasonable high performance level based on research of evidence.

d. A in collaboration with DHCS a MTAC will govern the innovative metric testing process by which the measure will be tested against criteria including, but not limited to, importance, scientific feasibility, and usefulness as supported by evidence gathered by the measure steward.

i. The metric will be removed from PRIME if it fails to meet test criteria.

e. Testing, refinement, and baseline setting will occur over the first three years of PRIME during which the measure maintains Pay for Reporting (P4R) status.

f. MTAC will also review the reported data to test the measure for room for improvement and stability.

g. Once MTAC has vetted the metric, MTAC will recommend to DHCS to convert the status of the metric from P4R to Pay for Performance (P4P) for the last two years of PRIME.

i. For metrics that convert from P4R to P4P, DHCS will work with MTAC to establish improvement metrics for the final two years of the demonstration.

ii. On an exception basis, MTAC may recommend to maintain a metric's status as P4R status beyond the first three years based on the progress of testing.

2. **Purpose**

This PRIME Innovative Metrics Testing Process is how "innovative" measures will be defined and tested for appropriate inclusion in PRIME. An innovative measure (formerly referred to as "novel") is a measure that currently has no state or national measure steward or entity that has already defined and vetted the measure. Innovative measures will be initially included in PRIME as P4R measures and may evolve to P4P through 5 years of the program depending on the outcomes of the Metric Testing Process.

1. **Role Of The Measure Steward**

a. Draft the measure specifications, including:

i. The "narrative" version of the specifications

1. Here is an example of measure specs that include both the "narrative" version and the electronic specs (aka eCQM – electronic Clinical Quality

Metric). While we might not need all the rationale and background that is in that document, we certainly need all the specifics.

ii. Measurement period

iii. Numerator/Denominator

iv. Exclusions & exceptions

v. Methodologies for any needed calculations

vi. Data criteria, including data sources and codes needed for reporting (i.e., when your IT/Data/Business Intelligence Dept asks you for details so they can develop the query and reports)

b. Gathering evidence supporting the measure's fulfillment of the evaluation criteria as described below.

c. In conjunction with the MTAC, determine if and when the metric is "stable" enough with sufficient data to move from testing (P4R) to financial accountability (P4P.)

d. Serve as the content expert resource body for the measure in conjunction with the Metric Technical Advisory Committee (MTAC) for technical expertise

i. Answer any questions that will come back from PHS using the metric

ii. Revise the measure specifications as issues arise

2. **Role Of MTAC**

a. Composed of clinical, operational, and reporting/technical experts, MTAC will govern the testing process

b. Test the metric specifications and ask for additional clarification from measure steward

i. Is this information adequate for reporting at my system?

ii. What additional information needs to be provided to ensure standardized reporting?

iii. Other questions as they see fit

c. Evaluate the measure (via the Worksheet completed by the Measure Steward) against test criteria:

i. Importance – clinical impact to PRIME project target population

ii. Scientific acceptability – measure is evidence-based, reliable, valid, and precise

iii. Feasibility – data for the measure can be collected without undue burden;, data is auditable

iv. Usefulness – results in useful information to stakeholders; applicability to a significant population, robust results for public reporting

v. Room for improvement – based on available evidence, Measure Steward determines what would reasonably be considered high performance for this measure. MTAC, in conjunction with the Measure Steward will assess data, obtained during the testing period, against the high performance benchmark identified by the Measure Steward to determine room for improvement across the PHS.

d. Serve as the technical resource body for the measure along with the Measure Steward.

3. **Process Steps**

Responsible Entity	**Step**	**Timeframe**
Measure Steward	Completes the PRIME Innovation Metric Worksheet with measure specifications and supporting evidence.	Q1 2016
MTAC	Reviews the worksheet and conceptually tests the measure according to test criteria.	Q2 2016
Measure Steward	Refines measure specifications based on MTAC input.	Q2 2016
PHS	Mock reports on the measure, identifying reporting issues and questions.	Q3 2016
MTAC, Measure Steward	Provide additional guidance and revises measure specifications accordingly.	Q3 2016

Responsible Entity	Step	Timeframe
PHS	Collect baseline data and reports to MTAC.	Q3-Q4 2016
MTAC, Measure Steward	Test the collected data for room for improvement against the high performance level as identified by the Measure Steward. If there is no room for improvement, then the measure is dropped.	Q3 2016
PHS	Relay any issues or concerns about each innovative metric to MTAC.	Throughout DY 12 (7/16-6/17)
MTAC, MS	Revise measure specification or provide additional guidance as needed based on ongoing feedback.	Throughout DY 12
MTAC	Review PHS-reported data and feedback for each innovative measure to decide whether the P4R P4P status conversion should deviate from the original timetable (see below).	After DY 12 Annual report
PHS	Collect and report on measure, relaying issues or concerns that arise.	DY 13*
MTAC	Reviews PHS-reported data and feedback for each innovative measure. Revises if needed. Determines high performance level and performance target methodology.	After DY 13 Annual report
MTAC	Approves final measure specifications and recommends DHCS submit to CMS for approval of conversion to P4P.	After DY 13 Annual Report
DHCS	DHCS submits to CMS for approval of measure as P4P.	Q3 2017

Responsible Entity	Step	Timeframe
CMS	Approve measure for P4P.	Q4 2017
PHS	Report on measure, relaying technical issues and questions to MTAC as needed.	DY 14 and 15

* PHS get paid for reporting on the measure at the time of the Annual Report even if the measure hasn't completed the entire testing process yet and achieved stability.

4. P4R/P4P Timeline

In general, an innovative measure will be P4R in Year 1, 2, and 3; P4P in Year 4, and 5 as the metric is defined as stable and testing is complete.

E. Metrics Summary

The metrics by project are summarized in Table 2 below.

Table 2: High-Level Summary of Metrics

Table 2: Measure name	Projects Numbers Associated with Measure (DPH Required Projects underlined)	Measure Steward Innovative metrics marked by *	NQF#
Abnormal Results Follow-Up	1.4	*Alameda Health System (AHS)	N/A
Adherence to Medications	3.3	*AHS, Santa Clara Valley Health System	
Adolescent Well-Care Visit	2.4	NCQA	N/A
Advance Care Plan	2.7	NCQA	0326
Alcohol and Drug Misuse (SBIRT)	1.1, 1.2, 2.5, 2.6	Oregon CCO	N/A
Ambulatory Palliative Care	2.7[1]	*UC San Francisco	N/A

[1] The "Ambulatory Palliative Care Team Established" metric will start in DY11 and sunset once the PRIME Entity can attest to the establishment of their Ambulatory Palliative Care Team. This metric works in tandem with the metric "Palliative Care Service Offered at Time of Diagnosis of Advanced Illness".

Table 2: Measure name	Projects Numbers Associated with Measure (DPH Required Projects underlined)	Measure Steward Innovative metrics marked by *	NQF#
Team Established		(UCSF)	
Annual Monitoring for Patients on Persistent Medications	1.4	NCQA	2371
Assessment and Management of Chronic Pain: Patients with chronic pain prescribed an opioid who have an opioid agreement form and an annual urine toxicology screen	2.6	AHRQ	N/A
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	3.1	NCQA	0058
Avoidance of Antibiotic Treatment with Low Colony Urinary Cultures	3.1	*University of California Davis (UCD), UC Irvine (UCI), UC San Diego (UCSD)	N/A
Baby Friendly Hospital designation	2.1	Baby-Friendly USA/DHCS	N/A
BIRADS to Biopsy	1.6	*LA County Dept of Health Services (LAC DHS), San Francisco Health Network (SFHN)	N/A
BMI Screening and Follow-up	1.7	CMS	0421
Breast Cancer Screening	1.6	NCQA	2372
Care Coordinator Assignment	1.1, 2.3	University of Washington/ Coordinated Care Initiative	N/A
Cervical Cancer Screening	1.6	NCQA	0032
CG-CAHPS: Provider Rating	1.2	AHRQ	0005
Closing the referral loop: receipt of specialist report (CMS50v3)	1.3	CMS	N/A
Colorectal Cancer Screening	1.2, 1.6	NCQA	0034
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	1.1, 1.2	NCQA	0059
Controlling Blood Pressure	1.2, 1.5, 2.5	NCQA	0018
Depression Remission at 12 Months (CMS159v4)	1.1	Minnesota Community Measurement	0710

Table 2: Measure name	Projects Numbers Associated with Measure (DPH Required Projects underlined)	Measure Steward Innovative metrics marked by *	NQF#
Developmental Screening in the First Three Years of Life	2.4	NCQA	1448
DHCS All-Cause Readmissions	1.3, 2.2	CDHCS	N/A
Documentation of Current Medications in the Medical Record	3.3	CMS	0419
Documentation of Current Medications in the Medical Record (0-18 yo)	2.4	CMS	Variation on 0419
Documented REAL and/or SO/GI disparity reduction plan	1.2[2]	DHCS	N/A
ePBM-01 Pre-op Anemia Screening, Selected Elective Surgical Patients	3.4	AABB/TJC (approval pending)	N/A
ePBM-02 Pre-op Hemoglobin Level, Selected Elective Surgical Patients	3.4	AABB/TJC (approval pending)	N/A
ePBM-03 Pre-op Type and Crossmatch, Type and Screen, Selected elective Surgical Patients	3.4	AABB/TJC (approval pending)	N/A
ePBM-04 Initial Transfusion Threshold	3.4	AABB/TJC (approval pending)	N/A
ePBM-05 Outcome of Patient Blood Management, Selected Elective Surgical Patients	3.4	AABB/TJC (approval pending)	N/A
Exclusive Breast Milk Feeding (PC-05)	2.1	JNC	0480
H-CAHPS: Care Transition Metrics (3)	2.2	AHRQ	0166
High-Cost Pharmaceuticals Ordering Protocols	3.3	*AHS	N/A
Imaging for Routine Headaches (Choosing Wisely)	3.2	*Washington Health Alliance	N/A
Inappropriate Pulmonary CT Imaging for Patients at Low Risk for Pulmonary Embolism	3.2	ACEP	0667

[2] The "Documented REAL and/or SO/GI disparity reduction plan" metric will only be active for DY 12.

Table 2: Measure name	Projects Numbers Associated with Measure (DPH Required Projects underlined)	Measure Steward Innovative metrics marked by *	NQF#
Influenza Immunization	1.3	NCQA	0041
INR Monitoring for Individuals on Warfarin	1.4	CMS	0555
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	1.2, 1.5	NCQA	0068
Medication Reconciliation – 30 days	2.2, 2.3	NCQA	0097
MWM #8: Treatment Preferences (documentation) Inpatient	2.7	UNC Chapel Hill	1641
MWM #8: Treatment Preferences (documentation) Outpatient	2.7	*UCSF	N/A
National Healthcare Safety Network (NHSN) Antimicrobial Use Measure	3.1	CDC	2720
OB Hemorrhage: Massive Transfusion	2.1	CMQCC	N/A
OB Hemorrhage: Total Products Transfused	2.1	CMQCC	N/A
Palliative Care Service Offered at Time of Diagnosis of Advanced Illness	2.7[3]	*University of California, San Francisco (UCSF)	N/A
Partnership for a Healthier America's Hospital Health Food Initiative external food service verification	1.7	DHCS	N/A
Patients with chronic pain on long term opioid therapy checked in PDMPs	2.6	*AHRQ/SFHN, AHS, UCSD	N/A
PC-02 Cesarean Section	2.1	JNC	0471
Post Procedure ED Visits	1.3	*SFHN	N/A
PQRS # 317 Preventative Care and Screening: Screening for	1.5	CMS	N/A

[3] The "Palliative Care Service Offered at Time of Diagnosis of Advanced Illness" metric will be reported as P4R the same Demonstration Year that the PRIME Entity can attest to the establishment of their Ambulatory Palliative Care Team. For the remaining Demonstration Years the "Palliative Care Service Offered…" will be P4P.

Table 2: Measure name	Projects Numbers Associated with Measure (DPH Required Projects underlined)	Measure Steward Innovative metrics marked by *	NQF#
High Blood Pressure and Follow-Up Documented			
Prenatal and Postpartum Care	2.1	NCQA	1517
Prevention Quality Overall Composite #90	1.2, 2.3, 2.5	AHRQ	N/A
Primary Care Redesign metrics stratified by REAL categories and SO/GI	1.2	*DHCS	N/A
Prophylactic antibiotics discontinued at time of surgical closure	3.1	CMS	N/A
Proportion Admitted to Hospice for Less Than 3 Days	2.7	ASCO	0216
REAL and/or SO/GI disparity reduction	1.2[4]	*DHCS	N/A
REAL data completeness	1.2[5]	CMS	N/A
Receipt of appropriate follow-up for abnormal CRC screening	1.6	*SFHN	N/A
Reconciled Medication List Received by Discharged Patients	2.2	AMA-PCPI	0646
Reduction in Hospital Acquired Clostridium Difficile Infections	3.1	NHSN	N/A
Referral Reply Turnaround Rate	1.3	*LAC DHS, SFHN	N/A
Screening for Clinical Depression and follow-up	1.1, 1.2, 2.4, 2.5, 2.6	CMS	0418
Severe Maternal Morbidity (SMM) per 100 women with obstetric hemorrhage	2.1	CMQCC	N/A
SO/GI data completeness	1.2[6]	CMS	N/A
Specialty Care Touches: Specialty Expertise Requests Managed Via Non-Face to Face	1.3	*LAC DHS, UCD	N/A

[4] The "REAL and/or SO/GI disparity reduction" metric will be active DY 13-15, and will be P4P throughout those years.
[5] The "REAL data completeness" metric will be P4R in DY 11 and P4P in DY 12-15. Although this metric is active for all 5 years, it's status is included here for the sake of clarity.
[6] The "SO/GI data completeness" metric will become active starting in DY 12 as P4R and will be P4P in DY 13-15.

Table 2: Measure name	Projects Numbers Associated with Measure (DPH Required Projects underlined)	Measure Steward Innovative metrics marked by *	NQF#
Specialty Encounters			
Timely Transmission of Transition Record	2.2, 2.3	AMA-PCPI	0648
Tobacco Assessment and Counseling	1.1, 1.2, 1.3, 1.5, 2.5	AMA-PCPI	0028
Tobacco Assessment and Counseling (13 yo and older)	2.4	AMA-PCPI	Variation on 0028
Treatment of Chronic Non-Malignant Pain with Multi-Modal Therapy	2.6	*SFHN, AHS, UCSD	N/A
Unexpected Newborn Complications (UNC)	2.1	California Maternal Quality Care Collaborative (CMQCC)	0716
Use of Imaging Studies for Low Back Pain	3.2	NCQA	0052
Use of Imaging Studies for Low Back Pain (red flags, no time limit)	3.2	*LAC Department of Health Services	Variation on NQF 0052
Well Child Visits - First 15 months of life	2.4	NCQA	1392
Well Child Visits - Third, Fourth, Fifth, and Sixth Years of life	2.4	NCQA	1516
Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents	1.7	NCQA	0024

Below are further details for metric measurement.

F. Measurement Period

Measurement periods are summarized in Table 3 below.

Table 3: Measurement Periods

Demonstration Year (DY)	Mid-Year Report Measurement Period	Mid-Year Report Due	Year-End Report Measurement Period	Year-End Report Due
DY 11	Not applicable	Not applicable	July 1, 2015 – June 30, 2016	September 30, 2016
DY12	January 1, 2016 – December 31, 2016	March 31, 2017	July 1, 2016 – June 30, 2017	September 30, 2017
DY13	January 1, 2017 – December 31, 2017	March 31, 2018	July 1, 2017 – June 30, 2018	September 30, 2018
DY14	January 1, 2018 – December 31, 2018	March 31, 2019	July 1, 2018 – June 30, 2019	September 30, 2019
DY15	January 1, 2019 – December 31, 2019	March 31, 2020	July 1, 2019 – June 30, 2020	September 30, 2020

G. DMPH Infrastructure Building

Subject to the funding limits in PRIME Funding and Mechanics (Attachment II), DHCS shall review, approve, and make payments for DMPHs in accordance with the requirements in PRIME Funding and Mechanics (Attachment II). DMPH infrastructure building payments shall be paid in accordance with PRIME Funding and Mechanics (Attachment II). DMPH infrastructure building payments shall support 1) infrastructure activities to integrate services among local entities that serve the target population; 2) services not otherwise covered or directly reimbursed by Medi-Cal to improve care for the target population; and 3) other strategies including data and related quality improvement systems, to advance integration, reduce unnecessary utilization of health care services, and improve health outcomes. Infrastructure building metrics must be reported mid-year and annually, with reporting of process pay for performance (P4P) metrics beginning no later than one year following the start of the demonstration. These metrics will allow DMPHs to establish the essential infrastructure necessary to drive healthcare system transformation. DMPHs will be able to develop a set of infrastructure building metrics that are linked to their selected project metric(s) set outlined in sections V.A-C below (Domains 1-3). The infrastructure building metrics will be included as part of DMPHs five-year PRIME Pool Plans and approved of by DHCS and CMS.

H. Establishing Baseline Performance During PRIME

To fulfill metric reporting for all PRIME projects for DY 11, Participating PRIME entities will submit reports on metric baseline performance, per the PRIME Program and Funding Mechanics Attachment II. The DY11 report will include baseline data for all relevant project metrics and will identify data sources, consolidating data from multiple inpatient and ambulatory systems, and including data reported from health plans.

I. Target Setting for Pay-for-Performance Metrics

By DY12, the majority of standard metrics will convert to P4P status. All metrics classified as P4P will have annual P4P targets for each of the DYs. At the beginning of each Demonstration Year, participating PRIME entities will know the annual performance target to be achieved by the end of that Demonstration Year. The method for determining the annual performance target will remain the same throughout the PRIME years for that metric. The participating PRIME entity will earn incentive payments on P4P measures proportional to the achievement value, per Program Funding and Mechanics Protocol (Attachment II).

Below are target setting methodologies for PRIME:

1. **10% Gap Closure:** This methodology will be used for metrics that have available state or national Medicaid, or other comparable populations, 90th percentile benchmarks. The gap is defined as the difference between the end of demonstration year performance and the 90th percentile benchmark. The target setting methodology will be a 10% gap closure year over year. This is the preferred methodology because top performance is defined relative to state or national top performance and targets are relative to individual performance. This methodology has been widely adopted in pay-for-performance programs across the nation.
2. **Improvement Over Self:** For those metrics without a state or national Medicaid benchmark available, including innovative metrics using pay-for-performance, DHCS will set a standard percent improvement (e.g. 10%) relative to individual current annual performance. On a metric by metric basis, DHCS will determine the percent improvement based on available evidence of what is a reasonable expectation for magnitude of clinical change. This standard relative improvement will be used by every participating PRIME entity reporting on that metric.

DHCS will set a high performance level and a minimum performance level for pay-for-performance measures. These levels will be used as guidelines to set targets. Each subsequent year, the annual target will be reset based on performance at the end of the prior year. Over the course of the PRIME, DHCS will update the high and minimum performance levels, i.e., the benchmark performance levels, as they may be revised by Metric Stewards. Any change will be effective at the start of the next annual reporting period.

J. Minimum Number of Cases

A participating PRIME entity must have a minimum of 30 individuals or cases in a metric denominator in order to be eligible to report on that metric, as determined by DHCS. If a participating PRIME entity meets this minimum, then the participating PRIME entity must report the metric. If a participating PRIME entity has

fewer than 30 cases, then the participating PRIME entity is not eligible to report on the metric for the reporting period.

K. Sampling

1. Indication for Use of Sampling

For each measure, the participating PRIME entity has the option to either report on the entire measure population or on a sample, adhering closely to sampling criteria published and maintained in the CMS Hospital Outpatient Quality Reporting Program Specifications Manual. For each measure, participating PRIME entities are required to indicate if sampling was used when reporting performance data.

Participating PRIME entities are encouraged to submit as many cases as possible up to the entire population of cases if reasonably feasible. If the raw data can be easily extracted from an existing electronic database or the abstraction burden is manageable, the participating PRIME entity should submit the entire population of cases that meet the initial selection criteria. Otherwise, a statistically valid sample can be selected.

If the participating PRIME entity is not sampling, the entity should use all medical records identified in the population. If the participating PRIME entity is sampling, the entity should use the medical records from the cases in the identified sample.

When a measure population size is less than the minimum number of cases for the sample size, sampling cannot be used, as determined by DHCS.

L. Defining the Denominator

The denominator for each metric is determined uniformly through a standardized process (outlined below). When reporting the baseline data for the metric, the participating PRIME entity must report to DHCS the methodology for determining the denominator in order to demonstrate uniformity with other participating PRIME entities also reporting that metric for that project. For each subsequent report on that metric, the same methodology, as approved by DHCS, must be applied for determining the population to include in the metric denominator.

Step 1) For DPHs: Determine the PRIME Defined Population composed of (a) all Medi-Cal Managed Care primary care lives assigned to the participating PRIME[7] entity as listed by DHCS at the end of each measurement period; and (b) all individuals with at least two encounters by the participating PRIME entity for an eligible primary care service[8] during the measurement period. This Defined Population serves as the starting point for all metric denominators, and then for each project is refined in Step 2 below.

[7] Assigned lives must have been continuously enrolled with the participating PRIME entity during the preceding 12 months, have no gaps in enrollment greater than 45 days, and be enrolled with the participating PRIME entity on the last day of the measurement period.

[8] Eligible Primary Care Services include both traditional face-to-face encounters with a provider, as well as any Complementary Service Encounter defined through the Global Payment Program for the Remaining Uninsured under this same 1115 Medicaid Waiver. See Global Payment Program Attachment EE for details.

For DMPHs: Determine the PRIME Defined Population composed of all individuals with at least two encounters by the participating PRIME entity among Medi-Cal beneficiaries. This Defined Population serves as the starting point for all metric denominators, and then for each project is refined in Step 2 below.

Step 2) Determine the Project Population. The Project Population for each project is further refined based on the focus of the project, which includes narrowing or expanding the Program Population to best align with the goals of the project..

Step 3) Determine the Metric Denominator by only including those individuals or visits from the Project Population that meet the metric measurement specifications.

VI. Project Toolkit

Each project description includes the:

- Rationale for the proposed project (evidence base and reasoning behind project idea),
- Goals and objectives of the project (project-specific Triple Aim goals and expected project outcomes),
- Core components, or key activities to guide project development and implementation, and
- Metrics required for the project, including clinical event outcomes, potentially preventable events, and patient experience measures.

The Core Components for projects are not required. However, most will be necessary to achieve the required results. The core components provide a guide for participating PRIME entities as they develop and implement the projects. In this way, the core components promote standardization across the program, while allowing participating PRIME entities to tailor program activities to meet local needs.

A. Domain 1: Outpatient Delivery System Transformation and Prevention

Projects 1.1-1.3 Required for DPHs

Projects included in Domain 1 are designed to ensure that patients experience timely access to high-quality and efficient patient-centered care. Participating PRIME entities will improve physical and behavioral health outcomes, care delivery efficiency and patient experience, by establishing or expanding fully integrated care, culturally and linguistically appropriate teams—delivering coordinated comprehensive care for the whole patient.

Primary and specialty care will be integrated and designed to work collaboratively with patients and care providers. Patients will receive appropriate preventive services, early diagnosis and treatment, and will be supported in improving their ability to care for themselves through access to other needed services including those that support social and well-being needs. Particular attention will be focused on optimizing care experience and outcomes, and improving patient safety in the outpatient setting where an increasing volume of care is being provided.

Multi-disciplinary care teams will provide coordinated care that meets the patient's needs and preferences, and results in improved capacity for patient self-management and a reduction in avoidable acute care and interventions, thereby improving quality of life and health outcomes. Several projects in this Domain will also identify and increase rates of cost-effective standard approaches to prevention services for a select group of high-impact clinical conditions and populations (cardiovascular disease; breast, cervical and colorectal cancer; and obesity).

1. Project 1.1 Integration of Behavioral Health and Primary Care Required Project for DPHs

Project Domain
Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title
1.1 Integration of Behavioral Health and Primary Care
Rationale
According to the DHCS Mental Health Prevalence Estimates, 15.9% of Californian adults suffer from Mental Health Disorder (MHD). This translates to 4.4 million Californians that are in need of mental health treatment. 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 8.8% 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 (19%), Whites (14%), and Asians (10%), who are the least likely to have MHDs.[9] Within distinct cultures and communities of color, stigma and cultural attitudes about behavioral health have a large impact on whether individuals seek care, and adherence to care plans and will need to be a factor in designing care teams and treatment plans. MHDs and SUDs reduce a person's life expectancy by 10 to 25 years, which is equivalent to the reduced life expectancy that is the result of heavy smoking.[10] 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.[11] 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.

[9] California Mental Health Prevalence Estimates, Task Team: HSRI, TAC and Expert Consultation From Charles Holzer. http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf
[10] 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.
[11] 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.

Project Domain
Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title
1.1 Integration of Behavioral Health and Primary Care
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.[12] 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.[13] The implementation of regular, validated screening tools along with brief intervention techniques 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.[14] Programs such as the IMPACT model not only improve care at the individual and population levels, but lead to lower overall health care costs.[15]
Goals/Objectives
To improve physical and behavioral health outcomes, care delivery efficiency and patient experience by establishing or expanding fully integrated care, culturally and linguistically appropriate teams—with expertise in primary care, substance use disorder conditions and mental health conditions 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 physical and behavioral chronic conditions

[12] 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.
[13] SAMHSA-HRSA Center for Integrated health Solutions. http://www.integration.samhsa.gov/
[14] IMPACT. Evidence-based depression care. http://impact-uw.org/
[15] Jurgen Unützer, Jeffrey Lieberman. Collaborative Care: An Integral Part of Psychiatry's Future. Psychiatry Online, Psychiatric News Article, November 12, 2013.

Project Domain
Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title
1.1 Integration of Behavioral Health and Primary Care

- Increase access to mental health and substance use disorder services
- Reduce preventable acute care utilization
- Reduce ED visits for patients with behavioral health conditions
- Improve communication between PCP and behavioral health providers
- Reduce admissions for patients with behavioral health problems through earlier recognition and intervention
- Reduce admissions for physical problems by better managing co-morbid behavioral health conditions
- Improve patient experience
- Reduce disparities in health and health care

Core Components

Systems undertaking this project may complete the following components:

1. Implement a behavioral health integration assessment tool (baseline and annual progress measurement)[16,17]
2. Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration, the Collaborative Care Model, or other IBH resources from SAMHSA).
3. Integrate appropriate screening tools and decision support into the emergency department to ensure timely recognition of patients with mental health and substance use disorder problems. Enhanced access to primary care and/or to behavioral health specialists will be integrated into discharge planning for these patents. Use of 24-7 care navigators (e.g., Community Physician Liaison Program) may be used to support linkages to PCPs, MH and SUD specialists and behavioral health and other community 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 hospital and health system primary care sites or from single populations to multiple populations, (e.g., obesity, diabetes, maternal, infant, and child care, end-of-life care, chronic pain management).
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.

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

[17] 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

Project Domain
Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title
1.1 Integration of Behavioral Health and Primary Care

7. Ensure systems are in place to support patient linkage to appropriate specialty physical, mental and SUD services. Preventive care screenings including behavioral health screenings (e.g., PHQ-2, PHQ-9, SBIRT) will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including provision of brief interventions (e.g., MI techniques) to ensure access for further evaluation and treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.
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. Increase access to Medication Assisted Treatment (MAT) for patients with alcohol and opioid addiction to assist in stabilizing their lives, reducing urges or cravings to use, and encourage greater compliance with treatment for co-morbid medical and mental health conditions. For alcohol use disorders these medications include naltrexone, acamprosate, and disulfiram. For opioid addiction, medication assisted treatment includes maintenance treatment with methadone and buprenorphine.
10. Ensure the development of a single Treatment Plan that includes the patient's behavioral health issues, medical issues, substance abuse, social and cultural and linguistic needs. This includes incorporating traditional medical interventions, as well as non-traditional interventions such as gym memberships, nutrition monitoring, healthy lifestyle coaching, or access to culturally and linguistically appropriate peer-led wellness and symptoms management groups.
11. Ensure a culturally and linguistically appropriate treatment plan by assigning peer providers or other frontline workers to the care team to assist with care navigation, treatment plan development and adherence.
12. 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.
13. Implement technology-enabled data systems to support pre-visit planning, point-of-care delivery, care plan development, population/panel management activities, coordination and patient engagement. Develop programs to implement telehealth, eReferral/eConsult to enhance access to behavioral health services.
14. Demonstrate engagement of patients in the design and implementation of the project
15. Increase team 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.
16. Ensure integration is efficient and providing value to patients by implementing a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

Project Domain		
Domain 1: Outpatient Delivery System Transformation and Prevention		
Project Title		
1.1 Integration of Behavioral Health and Primary Care		
Required Project Metrics		
Measure name	NQF#	Measure Steward (*Innovative metrics)
Alcohol and Drug Misuse (SBIRT)	N/A	Oregon CCO
Care coordinator assignment	N/A	*University of Washington/ Coordinated Care Initiative
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	0059	NCQA
Depression Remission at 12 Months CMS159v4	0710	MN Community Measurement
Screening for Clinical Depression and follow-up	0418	CMS
Tobacco Assessment and Counseling	0028	AMA-PCPI

2. Project 1.2 Ambulatory Care Redesign: Primary Care Required Project for DPHs

Project Domain
Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title
1.2 Ambulatory Care Redesign: Primary Care
Rationale
Under the Affordable Care Act primary care providers are seeing an unprecedented increase in the demand for services, with 2.3 million new Californians receiving coverage during the first year of implementation.[18] Demand will continue to grow over the next five years, yet the supply of primary care providers remains relatively static, with fewer than 20% of medical school students choosing a career in primary care.[19] By 2020, the demand for care is expected to outpace the supply of primary care providers.[20] In order to meet the growing demand for services, participating PRIME entities must become more efficient, better-coordinated systems of care. Patient-centered medical homes (PCMH) show promise for improving the efficiency and effectiveness of primary care by leveraging the skills of non-physicians and sharing responsibilities among a care team. Nurse practitioners and physicians assistants, for example, are entering the field at a greater rate than primary care providers[3] and can offer increased capacity and quality to the primary care team. By sharing responsibilities among members of the care team, the medical home can relieve the burden on primary care providers and allow all staff to maximize their skills, resulting in enhanced collaborative care with patients. In addition to redesigning care to support the medical home model, participating PRIME entities can leverage new technologies to expand primary care access and improve quality of care. Reaching patients through alternate modes, such as patient portals, is both convenient for patients and shown to improve clinical quality measures.[21] Disease registries and electronic reminders can increase screening rates for chronic illness and keep vulnerable patients from "falling through the cracks." Under the PCMH model, the care team uses data to drive decision-making, becoming more efficient and effective providers of care. This delivery system transformation will require re-thinking traditional provider roles and engaging all levels of staff to work together in coordinated teams. It will require processes for improved provider-provider and provider-patient communication, both in-person and remote.

[18] Medicaid Marketplace Overview. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/california.html. Accessed Jan 21, 2015.
[19] Harris, Scott. Primary Care in Medical Education: The Problems, The Solutions. Association of American Medical Colleges. https://www.aamc.org/newsroom/reporter/march10/45548/primary_care_in_medical_education.html. Accessed Jan 21, 2015.
[20] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. Projecting the Supply and Demand for Primary Care Practitioners Through 2020. Rockville, Maryland: U.S. Department of Health and Human Services, 2013.
[21] Yi Yvonne Zhou, Michael H. Kanter, Jian J. Wang and Terhilda Garrido. Improved Quality At Kaiser Permanente Through E-Mail Between Physicians And Patients. Health Affairs, 29, no.7 (2010):1370-1375.

Project Domain
Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title
1.2 Ambulatory Care Redesign: Primary Care
Transformation will also require building the data capacity to support alternate modes of care delivery, build robust disease registries, and make data available to care teams in real time, so they can work collaboratively with patients to make the best decisions for optimum health outcomes. Furthermore, in addition to transforming care for all patients, participating PRIME entities must reduce disparities in health and healthcare between patient populations. The PRIME Primary Care Redesign project will require participating PRIME entities deliver targeted interventions that address the specific needs of underrepresented populations and communities of color, and target resources to improve health equity. The approach to incorporate disparities reduction into quality improvement initiatives aligns with direction from the Institute of Medicine, which includes equity as a cross-cutting dimension of all quality care.[22]
Goals/Objectives
Patients will experience timely access to high quality, efficient, and equitable 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, most notably implementing team based care and better utilization of front line workers • Increase provision of recommended preventive health services • Improve health indicators for patients with chronic condition(s) (including mental health and substance use disorder conditions) • Increase patient access to care • Decrease preventable acute care utilization • Improve patient experience of care • Increase staff engagement • Improve the completeness, accuracy, and specificity of race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI) data • Reduce disparities in health and health care
Core Components
Systems undertaking this project may complete the following components:

[22] Ulmer C, Bruno M, Burke S, eds. Future Directions for the National Healthcare Quality and Disparities Reports. Washington, D.C.: National Academies Press; 2010.

Project Domain
Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title
1.2 Ambulatory Care Redesign: Primary Care

1. Gap analysis of practice sites within the DPH/DMPH system.
2. Primary Care practices will demonstrate advancement of their PCMH transformation through the use of a nationally recognized PCMH methodology[23]
3. Hiring and training of frontline workforce (e.g., medical assistants, community health workers, promotoras, health navigators or other non-licensed members of the care team) to be responsible for coordination of non-clinical services and elements of the care plan.
4. Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population/panel management activities, care coordination, patient engagement, and operational and strategic decisions including a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.
    a. Implementation of Electronic Health Record (EHR) technology that meets meaningful use standards (MU)
5. Ongoing identification 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 targeted patients by condition, risk, and self-management status.
    c. Perform preventive care services including mental health and substance misuse screenings and brief interventions (e.g., PHQ-9, SBIRT).
6. Enable prompt access to care by:
    a. Implementing open or advanced access scheduling
    b. Creating alternatives to face-to-face provider/patient visits
    c. Assigning frontline workers to assist with care navigation and non-clinical elements of the care plan.
7. 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/DPH/DMPH 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, (including mental health and substance use disorder services), acute care, social services and community based services

[23] 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

Project Domain

Domain 1: Outpatient Delivery System Transformation and Prevention

Project Title

1.2 Ambulatory Care Redesign: Primary Care

8. Demonstrate evidence-based preventive and chronic disease management
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 the team-based care model to ensure effective and efficient provision of services (e.g., group visits, medication reconciliation, motivational interviewing, cognitive behavioral therapy and Medication-Assistance Treatment (MAT)).
10. Engage patients using care plans, and self-management education, and through involvement in the design and implementation of this project.
11. Improve the accuracy and completeness of race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI) data, and use that data to identify and reduce disparities in one or more Primary Care Redesign project metrics by:
    a. Adding granular REAL and SO/GI data to demographic data collection processes and training front-line/registration staff to gather complete and accurate REAL/SO/GI data
    b. Developing capacity to track and report REAL/SO/GI data, and data field completeness
    c. Implementing and/or refining processes for ongoing validation of REAL/SO/GI data
    d. Developing capacity to stratify performance metrics by REAL/SO/GI data and use stratified performance data to identify disparities for targeted interventions
    e. Developing capacity to plan and implement disparity reduction interventions with input from patients and community stakeholders
    f. Developing dashboards to share stratified performance measures with front-line staff, providers, and senior leadership.
12. To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Alcohol and Drug Misuse (SBIRT)	N/A	Oregon CCO
CG-CAHPS: Provider Rating	0005	AHRQ
Colorectal Cancer Screening	0034	NCQA
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	0059	NCQA
Controlling Blood Pressure	0018	NCQA
Documented REAL and/or SO/GI disparity reduction	N/A	*DHCS
Ischemic Vascular Disease (IVD): Use of	0068	NCQA

Measure name	NQF#	Measure Steward (*Innovative metrics)
Aspirin or Another Antithrombotic		
Prevention Quality Overall Composite #90	N/A	AHRQ
Primary Care Redesign project metrics stratified by REAL and SO/GI categories	N/A	*DHCS
REAL and/or SO/GI disparity reduction	N/A	*DHCS
REAL[24] data completeness	N/A	CMS
Screening for Clinical Depression and follow-up	0418	CMS
SO/GI [25] data completeness	N/A	CMS
Tobacco Assessment and Counseling	0028	AMA-PCPI

[24] As per the 2015 Final Rule on Certified EHR Technology, record each one of a patient's races and ethnicities in accordance with, at a minimum, the "Race & Ethnicity – CDC" code system in the PHIN Vocabulary Access and Distribution System (VADS), Release 3.3.918 and use the Internet Engineering Task Force (IETF) Request for Comments (RFC) 564619 standard for preferred language
[25] Refer to 2015 Final Rule on Certified EHR Technology, pages 56-57 for recommended SO/GI "best practice" questions, and pages 495-497 for SO/GI SNODMED and HL7 codes sets.

3. Project 1.3 Ambulatory Care Redesign: Specialty Care
Required Project for DPHs

Project Domain
Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title
1.3 Ambulatory Care Redesign: Specialty Care
Rationale

While a strong primary care service is an essential component of an effective health system, efficient linkage to specialty care, including mental health and substance use services, is also critical. 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. Increased "supply" is achievable through expansion of the specialty care team, improved efficiency in the provision of care (both in person and virtual), improved coordination and collaboration with referring providers, and enhanced engagement of patients and families.

Timely access to specialty care continues to be a challenge for patients of DPHs, the largest provider of specialty care in California's safety net, and DMPHs.[26] Delays can lead to adverse medical outcomes,[27] increased ED utilization,[28] and higher health care costs.[29] Many patients experience fragmented care, with multiple care plans and little communication between providers. To improve timely access to specialty care, DPHs/DMPHs are redesigning processes that link patients and providers to specialists, particularly by leveraging new technology for remote communication.

Participating PRIME entities transformation into patient-centered medical homes involves improving the collaborative partnership between specialists and the primary care team. The proposed PRIME project provides a structure and goals to guide this transformation. Primary care providers and specialists develop a co-management plan, which clearly defines their roles and responsibilities in caring for a patient, and outlines the protocol for care coordination. Increasingly, this coordination involves the use of telehealth technology, such as electronic referrals and consults, and real time patient/provider virtual visits. Telehealth is a promising strategy for improving coordination between all parties. Electronic referrals and consultations allow bi-directional primary care-specialist communications, coordination and co-management to minimize the number of visits a patient will need and optimize required visits thus reducing historically long wait-times for new and follow-up appointments[30]. In addition to increasing coordination, technology can also improve the quality of care.

Redesigning specialty care will involve more than new technology — it will require a shift in the relationship between primary care providers (PCPs) and specialists. Under the patient-centered medical

[26] Specialty Care in the Safety Net: Efforts to Expand Timely Access. California HealthCare Foundation and Kaiser Permanente Community Benefit Programs. May 2009.
[27] Prentice, J. C. and Pizer, S. D. (2007), Delayed Access to Health Care and Mortality. Health Services Research, 42: 644–662. doi: 10.1111/j.1475-6773.2006.00626.x
[28] AskCHIS, California Health Interview Survey, 2011-2012.
[29] Improving Access to Specialty Care for Medicaid Patients: Policy Issues and Options. The Commonwealth Fund. June 2013.
[30] Chen, A, Murphy, E.J., and Yee, H.F. (2013) eReferral — A New Model for Integrated Care. New England Journal of Medicine, N Engl J Med 2013; 368:2450-2453June 27, 2013DOI: 10.1056/NEJMp1215594

Project Domain
Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title
1.3 Ambulatory Care Redesign: Specialty Care

home model, PCPs and specialists work together as part of a single care team, organized around the needs of the patient. The project involves enhancing the engagement of patients and families, expanding the roles of non-providers on the specialty care team, leveraging technology to increase timely access to specialty care expertise, integrating specialists into the system care team through improved communication and coordination between providers, and implementing data systems and workflows to support more efficient care delivery.

Goals/Objectives

Patients will experience timely access to high quality, effective specialty care, including care for mental health and substance use services, 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
- Reduce disparities in health and health care

Core Components

Participating PRIME entities undertaking this project may 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 mental health and SUD services (analysis to include factors impacting ability to access specialty care), and the *current* and *ideal state* capacity to meet that need. Benchmark to other CA Public Health Care systems.
    a. For *ideal state* analysis, include potential impact of increased primary care capacity to manage higher acuity conditions either independently, or in collaboration with, specialty care, so as to reduce the need for in-person specialty care encounters. (e.g., insulin titration, IBS management, joint injections, cognitive behavioral therapy (CBT) or Medication Assisted Treatment (MAT)).
3. Engage primary care providers and local public health departments 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.

Project Domain

Domain 1: Outpatient Delivery System Transformation and Prevention

Project Title

1.3 Ambulatory Care Redesign: Specialty Care

4. Clinical teams engage in team- and evidence-based care
5. Increase 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
6. 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
7. Adopt and follow treatment protocols mutually agreed upon across the delivery system
8. Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population management activities and care coordination/transitions of care. Timely, relevant and actionable data is used to support patient engagement, PCP collaboration, and drive clinical, operational and strategic decisions including continuous QI activities.
   a. Implement EHR technology that meets meaningful use standards (MU)
9. Patients have care plans and are engaged in their care. Patients with chronic disease (including MH/SUD conditions) managed by specialty care have documented patient-driven, self-management goals reviewed at each visit
10. Improve medication adherence
11. Implement population management strategies for patients in need of preventive services, with chronic conditions, or with recurring long term surveillance needs
12. Implement or expand use of telehealth based on DPH/DMPH capacity to address patient and PCP barriers to accessing specialty expertise. Implement a telehealth platform with communication modalities that connect between specialty care and primary care (e.g., eConsult/eReferral)
13. Demonstrate engagement of patients in the design and implementation of the project
14. Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.
15. Test use of novel performance metrics for redesigned specialty care models

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Closing the referral loop: receipt of specialist report (CMS50v3)	N/A	CMS
DHCS All-Cause Readmissions	N/A	DHCS
Influenza Immunization	0041	NCQA
Post procedure ED visits	N/A	*San Francisco Health Network (SFHN)
Referral Reply Turnaround Rate	N/A	*Los Angeles County Department of Health Services (LAC DHS), SFHN
Specialty Care Touches: Specialty expertise requests managed via non-face to face specialty encounters	N/A	*LAC DHS, UC Davis
Tobacco Assessment and Counseling	0028	AMA-PCPI

4. Project 1.4 Patient Safety in the Ambulatory Setting

Project Domain
Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title
1.4 Patient Safety in the Ambulatory Setting
Rationale
Despite the fact that the vast majority of health care takes place in the ambulatory care setting, efforts to improve safety have mostly focused on the inpatient setting. The ambulatory environment is prone to problems and errors that include missed/delayed diagnoses, delay of proper treatment or preventive services, medication errors/adverse drug events, and ineffective communication and information flow. However, compared with the hospital environment, there has been considerably less research, metric development, and interventions implemented to address these identified patient safety concerns[31]. Because it is self-evident that outpatient patient safety issues can lead to preventable morbidity and mortality, improving quality in this domain remains a critical target even though some approaches will need to be developmental and innovative in the absence of consensus national measures and guidelines. Participating PRIME entities will focus their improvement efforts on the most common tests ordered in the outpatient setting for which prompt follow-up is typically required of clinically significant and either critical or sub-critical abnormal results. The focus on annual monitoring of patients on persistent medications and abnormal but subcritical results is impactful because no standard or workflow governs management of such results, in contrast to critical-range abnormal results, and these tests are a known vulnerability.[32]
Goals/Objectives
To implement standardized monitoring, alert notification and response workflows to ensure the health and safety of individuals for whom diagnostic testing has been performed and for those on medications for chronic conditions. Specific objectives include: • Ensure that abnormal test results are conveyed to the ordering clinician and that appropriate follow-up is implemented. • Ensure annual monitoring being done for patients on persistent medications
Core Components
Participating PRIME entities undertaking this project may complete the following components: 1. Perform a baseline studies to examine the current workflows for abnormal results follow-up and monitoring of individuals on persistent medications. 2. Implement a data-driven system for rapid cycle improvement and performance feedback based on the baseline study that effectively addresses all identified gaps in care and which targets clinically significant improvement in care. The improvement and performance feedback system should

[31] Gandhi and Lee. (2010) Patient Safety Beyond the Hospital. *New England Journal of Medicine* 363:1000-1003
[32] Casalino, LP et al. "Frequency of failure to inform patients of clinically significant outpatient test results.", Arch Intern Med. 2009 Jun 22;169(12):1123-9. http://www.ncbi.nlm.nih.gov/pubmed/19546413, Accessed 11/16/2015.

Project Domain
Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title
1.4 Patient Safety in the Ambulatory Setting

include patients, front line staff from testing disciplines (such as, but not limited to, radiology and laboratory medicine) and ordering disciplines (such as primary care) and senior leadership.

3. Develop a standardized workflow so that:
    - Documentation in the medical record that the targeted test results were reviewed by the ordering clinician;
        - Use the American College of Radiology's Actionable Findings Workgroup[33] for guidance on mammography results notification.
    - Evidence that every abnormal result had appropriate and timely follow-up; and
    - Documentation that all related treatment and other appropriate services were provided in a timely fashion as well as clinical outcomes documented.
4. In support of the standard protocols referenced in #2:
    - Create and disseminate guidelines for critical abnormal result levels
    - Creation of protocol for provider notification, then patient notification
    - Script notification to assure patient returns for follow up
    - Create follow-up protocols for difficult to reach patients
5. Implement technology-enabled data systems to support the improvement and performance feedback system as well as engage patients and support care teams with patient identification, pre-visit planning, point of care delivery, and population/panel management activities.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Abnormal Results Follow-Up	N/A	*Alameda Health System (AHS)
Annual Monitoring for Patients on Persistent Medications	2371	NCQA
INR Monitoring for Individuals on Warfarin	0555	CMS

[33] Actionable Findings and the Role of IT Support: Report of the ACR Actionable Reporting Work Group. Larson, Paul A. et al. Journal of the American College of Radiology , Volume 11 , Issue 6 , 552 – 558. ***http://www.jacr.org/article/S1546-1440(13)00840-5/fulltext#sec4.3***, Accessed 11/16/15.

5. Project 1.5 Million Hearts Initiative

Project Domain
Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title
1.5 Million Hearts® Initiative
Rationale
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.[34] 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.[35,36] In addition, 37 percent of adult Medi-Cal members have been diagnosed with hypertension at some point in their lives.[37] 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.[38] 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 QI 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®. The Department also supports the efforts of the $10 million, 5-year Medi-Cal Incentives to Quit Smoking Project to significantly reduce tobacco use. These activities and partnerships make the designated public hospitals well positioned to meet the clinical goals of Million Hearts®.
Goals/Objectives
Implement collaboratively identified and standardized, evidence-based and population resource stewardship approaches to the use of targeted preventive services across multiple participating PRIME entities. Collaborate among participating PRIME entities on approaches to meet clinical targets that support the Million Hearts® initiative, starting with tobacco cessation, hypertension control, and

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

Project Domain

Domain 1: Outpatient Delivery System Transformation and Prevention

Project Title

1.5 Million Hearts® Initiative

appropriate low-dose aspirin use.

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
- Reduce disparities in receipt of targeted prevention services
- Reduce variation and improve performance on Million Hearts® initiative goals across multiple DPHs/DMPHs

Core Components

Systems undertaking these projects may 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. See figures 1 and 2 for related data among the Medi-Cal population.
- 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 feedback and rapid cycle improvement that includes patients, front line staff and senior leadership
  - Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts.
- Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Controlling Blood Pressure	0018	NCQA
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	0068	NCQA
PQRS # 317 Preventative Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	N/A	CMS
Tobacco Assessment and Counseling	0028	AMA-PCPI

6. Project 1.6 Cancer Screening and Follow-up

Project Domain
Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title
1.6 Cancer Screening and Follow-up
Rationale
Cancer is the second leading cause of mortality in California, accounting for nearly 1 out 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.[39] 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 percent to 100 percent if they are discovered before having spread beyond the organ where the cancer began.[40]
Goals/Objectives
Implement collaboratively-identified, standardized, evidence-based and population resource stewardship approaches to the use of targeted preventive services across multiple participating PRIME entities. Develop consensus across participating PRIME entities 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 participating PRIME entity patients while reducing associated participating PRIME entity 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 participating PRIME entities
Core Components
Systems undertaking this project may complete the following components:

[39] American Cancer Society and the California Cancer Registry of the California Department of Public Health, California Cancer Facts & Figures, 2014. http://www.ccrcal.org/pdf/Reports/ACS_2014.pdf
[40] *Ibid*. p. 3

Project Domain

Domain 1: Outpatient Delivery System Transformation and Prevention

Project Title

1.6 Cancer Screening and Follow-up

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

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
BIRADS to Biopsy	N/A	*Los Angeles County Department of Health Care Services, San Francisco Health Network
Breast Cancer Screening	2372	NCQA
Cervical Cancer Screening	0032	NCQA
Colorectal Cancer Screening	0034	NCQA
Receipt of appropriate follow-up for abnormal CRC screening[41]	N/A	*San Francisco Health Network

[41] Proposed measure is a variation on the San Francisco Health Plan's Performance Improvement Plan measure entitled "Population Management for Colorectal Cancer Screening" http://www.sfhp.org/files/providers/incentive_programs/2015_PIP_Guide_CPG.pdf,

7. Project 1.7 Obesity Prevention and Healthier Foods Initiative

Project Domain
Domain 1: Outpatient Delivery System Transformation and Prevention
Project Title
1.7 Obesity Prevention and Healthier Foods Initiative
Rationale
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.[42] 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, as appropriate.[43] 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.[44,45] Hundreds of hospitals have successfully implemented the Partnership for a Healthier America's Hospital Healthier Foods Initiative guidelines, including well-known teaching hospitals, such as the Cleveland Clinic Foundation and the Henry Ford Health System. There is a wide variety of obesity prevention and management efforts occurring throughout the state of California. The California Department of Health Care Services partners with the California Department of Social Services to reduce overweight and obesity among Medi-Cal members. This project serves as a natural complement to obesity prevention and management activities happening throughout California.
Goals/Objectives
Implement collaboratively identified and standardized, evidence-based and population resource stewardship approaches to the use of targeted preventive services across participating PRIME entities. Collaborate among participating PRIME entities on approaches to meet obesity screening and referral to treatment targets, and the Partnership for a Healthier America's Hospital Healthier Food Initiative. Specific objectives include: • Identify cost-effective, evidence-based approaches to: o 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 obesity screening and referral to treatment across multiple participating PRIME entities

page 22; and the measure "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

[42] U.S. Department of Health and Human Services, Overweight and Obesity Statistics. http://win.niddk.nih.gov/publications/PDFs/stat904z.pdf Updated October, 2012. Accessed October 29, 2014.

[43] U.S. Preventive Services Task Force, A and B Recommendations. http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

[44] Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. http://www.cdc.gov/mmwr/pdf/rr/rr5807.pdf Published July 24, 2009.

[45] Harvard School of Public Health, Obesity Prevention Source. http://www.hsph.harvard.edu/obesity-prevention-source/obesity-prevention/food-environment/healthy-food-environment-recommendations-for-obesity-prevention-complete-list/

Project Domain

Domain 1: Outpatient Delivery System Transformation and Prevention

Project Title

1.7 Obesity Prevention and Healthier Foods Initiative

- Support the provision of healthful foods in clinical facilities by implementing the Partnership for a Healthier America's Hospital Healthier Food Initiative

Core Components

Systems undertaking these projects may 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 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 QI 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

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
BMI Screening and Follow-up	0421	CMS
Partnership for a Healthier America's Hospital Health Food Initiative external food service verification	N/A	DHCS
Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents	0024	NCQA

B. Domain 2: Targeted High-Risk or High-Cost Populations

Projects 2.1-2.3 Required for DPHs

The projects in this domain focus on specific populations that would benefit most significantly from care integration and coordination: individuals with chronic non-malignant pain and those with advanced.
The projects on Improved Perinatal Care, Care Transitions: Integration of Post-Acute Care and Complex Care Management for High-Risk Medical Populations will be required of all participating DPH systems.

1. Project 2.1 Improvements in Perinatal Care
Required Project for DPHs

Project Domain
Domain 2: Targeted High Risk Or High Cost Populations
Project Title
2.1 Improvements in Perinatal Care
Rationale (Evidence base and reasoning behind project idea)
Approximately 500,000 babies are born each year in California[46], and ensuring a healthy pregnancy, delivery, and beginning 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 doubled in the 10 years between 1999 and 2008 in California[47]. 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 indicate 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[48]. 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[49]. On the other hand, 36 percent of California hospitals were already meeting the national Healthy People 2020 target of 23.9 percent 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. Participating PRIME entities 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. 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 (CMDC) supports QI activities by generating perinatal performance metrics. • The Patient Safety First (PSF) initiative funded by Anthem Blue Cross has been working with

[46] State of California, Department of Finance, Demographic Research Unit. Historical and Projected State and County Births, 1970-2021, with Actual and Projected Fertility Rates by Mother's Age and Race/Ethnicity, 2000-2021, 2012. http://www.dof.ca.gov/research/demographic/reports/projections/births/.
[47] State of California, Department of Public Health, Maternal Child and Adolescent Health. Maternal Mortality Rates for U.S. and CA, 1999-2013. https://www.cdph.ca.gov/data/statistics/Documents/2013MaternalMortalityRates-CA%20and%20US.pdf
[48] Main, Elliott et al. Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Quality, 2011
[49] Personal Communication with Elliot Main. The California Maternal Data Center (CMDC) slide deck, California Maternal Quality Care Collaborative, July 24, 2013

Project Domain
Domain 2: Targeted High Risk Or High Cost Populations
Project Title
2.1 Improvements in Perinatal Care

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 in 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.

Goals/Objectives

- 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, evidenced-based, and timely prenatal and postpartum care.
- Postpartum care should effectively address and support breastfeeding initiation and continuation, contraception, and ensure follow-up and treatment of medical co-morbidities.

Core Components

Systems undertaking this project may complete the following components:

- DPHs/DMPHs 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 statewide 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

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Baby Friendly Hospital designation	N/A	Baby-Friendly USA
Exclusive Breast Milk Feeding (PC-05)	0480	JNC
OB Hemorrhage: Massive Transfusion	N/A	CMQCC
OB Hemorrhage: Total Products Transfused	N/A	CMQCC
PC-02 Cesarean Section	0471	JNC
Prenatal and Postpartum Care (PPC)	1517	NCQA

Measure name	NQF#	Measure Steward (*Innovative metrics)
Severe Maternal Morbidity (SMM) per 100 women with obstetric hemorrhage	N/A	CMQCC
Unexpected Newborn Complications (UNC)	0716	CMQCC

2. Project 2.2 Care Transitions: Integration of Post-Acute Care Required Project for DPHs

Project Domain
Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title
2.2 Care Transitions: Integration of Post-Acute Care
Rationale
The transition from inpatient to outpatient settings is a critical point in the care continuum, when providers can link patients to appropriate, ongoing care. All too often, patients are discharged from the hospital without an adequate transition plan and return within the month. According to the Center for Medicare and Medicaid Services, nearly one in five Medicare patients discharged from a hospital are readmitted within 30 days, at a cost of $26 billion each year in Medicare spending.[50] While some readmissions are appropriate, many are due to preventable events that could have been avoided.[51] Across the country public hospitals readmissions rates rise above the national average.[52] This may be in part because public hospitals serve a large volume of patients with risk factors associated with increased 30-day readmissions, such as co-morbid conditions, low-income status, and mental illness.[53] Safety net patients being discharged from inpatient care may not have a stable environment to return to or lack access to reliable care. Given the complex needs of their patients, participating PRIME entities must continue to develop robust care transitions programs that equip patients with a clear discharge plan, empanel them in patient-centered medical homes in collaboration with health plans, and link them to behavioral health and community services. Continued investment in care transitions programs through the PRIME will allow participating PRIME entities to improve coordination between inpatient and outpatient settings and reduce avoidable readmissions across the state.
Goals/Objectives
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

[50] Center for Medicare and Medicaid Services. Community Based Care Transitions Program. http://innovation.cms.gov/initiatives/CCTP/. Accessed Jan 28, 2015.
[51] S. Jencks, M. Williams, and E. Coleman, "Rehospitalizations Among Patients in the Medicare Fee-for-Service Program," New England Journal of Medicine, April 2009 360(14):1418–28.
[52] Higher Readmissions at Safety-Net Hospitals and Potential Policy Solutions. The Commonwealth Fund. December 2012.
[53] Examining the Drivers of Readmissions and Reducing Unnecessary Readmissions for Better Patient Care. American Hospital Association. September 2011.

Project Domain
Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title
2.2 Care Transitions: Integration of Post-Acute Care
• Improve patient experience • Reduce avoidable acute care utilization • Reduce disparities in health and health care
Core Components
Systems undertaking this project may 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[54]. 2. Establish or expand on a system to track and report readmission rates, timeliness of discharge summaries, and other transition processes, and investigate system-specific root causes /risk factors for readmission, using quantitative and qualitative information to identify the key causes of readmissions, including physical, behavioral and social factors. 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 mental health, substance use, pharmacy and palliative care when possible ii. Involve trained, enhanced IHSS workers when possible iii. Develop standardized protocols for referral to and coordination with community behavioral health and social services (e.g., visiting nurses, home care services, housing, food, clothing and social support). Identify and train personnel to function as care navigators for carrying out these functions. 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:

[54] 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

Project Domain
Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title
2.2 Care Transitions: Integration of Post-Acute 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 to develop transition of care protocols that ensure: coordination of care across physical health, substance use disorder and mental health spectrum will be supported, identification of and follow-up engagement with PCP is established, covered services including DME will be readily available; and a payment strategy for the transition of care services is in place.
9. Demonstrate engagement of patients in the design and implementation of the project.
10. Increase multidisciplinary team 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.
11. Implement a system for continual performance feedback and rapid cycle improvement that uses standard process improvement methodology and that includes patients, front line staff and senior leadership.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
DHCS All-Cause Readmissions	N/A	DHCS
H-CAHPS: Care Transition Metrics	0166	AHRQ
Medication Reconciliation: 30 days	0097	NCQA
Reconciled Medication List Received by Discharged Patients	0646	AMA-PCPI
Timely Transmission of Transition Record	0648	AMA-PCPI

3. Project 2.3 Complex Care Management for High Risk Medical Populations Required Project for DPHs

Project Domain
Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title
2.3 Complex Care Management for High-Risk Medical Populations
Rationale
A disproportionate share of Medicaid spending in the United States is used to provide care for a relatively small number of patients, with 1% of beneficiaries accounting for the top quartile of total Medicaid expenditures.[55] Among high-cost beneficiaries, nearly two-thirds have co-morbid conditions and one third have co-occurring physical and mental health conditions.[56] These patients incur frequent emergency department (ED) visits and hospitalizations that might have been prevented with less expensive preventive and primary care.[57] Increasingly, payers and providers are investing in complex care management programs that target super-utilizers with coordinated outpatient care to keep them healthy and out of the hospital. Complex care management programs address patients' physical conditions as well as the co-occurring behavioral health and socioeconomic challenges that increase their likelihood of hospitalization. Successful complex care management programs can improve quality of life for complex patients while dramatically reducing costly ED and hospital stays. A growing body of literature provides evidence for effective strategies in complex care management. Dr. Clemens Hong, a leader in complex care management research, identifies seven strategies that are commonly used in successful programs: adopt a patient-centered, customized approach to care; use qualitative and quantitative methods to identify high-utilizing patients; prioritize care coordination; build trust between patients and primary care providers; form care teams that meet the patient's needs; and use technology to enhance care management activities.[58] The proposed PRIME project incorporates these evidence-based best practices and provides a structure for participating PRIME entities to target super-utilizers in their systems. Participating PRIME entities will build on existing care management infrastructure to develop intensive, integrated programs for their most vulnerable patients, with the goal of improving lives and reducing excessive spending.
Goals/Objectives
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

[55] Mann C. Medicaid and CHIP: On the Road to Reform. Presentation to the Alliance for Health Reform/Kaiser Family Foundation. March 2011. Based on FY 2008 MSIS claims data.
[56] Where the Money Goes: Understanding Medi-Cal's High-Cost Beneficiaries. The California HealthCare Foundation. 2010http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/W/PDF%20WhereTheMoneyGoesMediCalHighCostSnapshot.pdf, Accessed 1/29/30.
[57] Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality. Center for Medicare and Medicaid Services Informational Bulletin. July 2013.
[58] C. S. Hong, A. L. Siegel, and T. G. Ferris, ***Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?*** The Commonwealth Fund, August 2014.

Project Domain
Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title
2.3 Complex Care Management for High-Risk Medical Populations

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 including those with mental health and substance abuse disorders
- Reduce avoidable acute care utilization (readmissions, admissions & ED visits)
- Improve patient experience

Core Components

Participating PRIME entities undertaking this project may 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.[59]
3. Identify target population(s) and develop program inclusion criteria based on quantitative and qualitative data (e.g., acute care utilization, lack of primary care utilization, number of high-risk medical mental or SUD conditions, polypharmacy, primary care input, functional status, patient activation, social support or other factors). Include patient factors associated with a higher probability of being impacted by complex care management.
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 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. Implement evidence-based practice guidelines to address risk factor reduction (smoking cessation/immunization/substance abuse identification and referral to treatment/depression and other behavioral health screening/etc.) as well as to ensure appropriate management of chronic diseases:
   a. Use standardized patient assessment and evaluation tools (may be developed locally, or adopted/adapted from nationally recognized sources[60])

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

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

Project Domain
Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title
2.3 Complex Care Management for High-Risk Medical Populations

b. Use educational materials that are consistent with cultural, linguistic and health literacy needs of the target population.

9. Ensure systems and culturally appropriate team members (e.g. community health worker, health navigator or promotora) are in place to support system navigation and provide patient linkage to appropriate physical health, mental health, SUD and social services. Ensure follow-up and retention in care to those services, which are under DPH/DMPH authority, and promote adherence to medications.
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. Implement a data-driven system for rapid cycle improvement and performance feedback to address quality and safety of patient care, which includes patients, front line staff and senior leadership.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Care Coordinator Assignment	N/A	*University of Washington/Coordinated Care Initiative
Medication Reconciliation – 30 days	0097	NCQA
Prevention Quality Overall Composite PQI #90	N/A	AHRQ
Timely Transmission of Transition Record	0648	AMA-PCPI

4. Project 2.4 Integrated Health Home for Foster Children

Project Domain
Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title
2.4 Integrated Health Home for Foster Children
Rationale
Many of the 55,000 foster children in California are at risk of caretaker, food, housing, and health provider insecurity, or some combination thereof.[61] These challenges lead to an increase in their medical, behavior and social needs. Over half of foster children demonstrate behavioral issues calling for mental health treatment, and 35% to 60% show signs of acute or chronic health condition.[62] Provisions at the federal level in the ACA adopted in California are recent efforts to support this vulnerable population. To provide the best care to foster children, an integrated health home offers important stability, improved primary care outcomes and timely specialty care. Under the health home model, DPH/DMPH would serve as a central entity to facilitate connections between the patient and the medical, behavioral, social and legal entities operating in a foster child's life would increase case continuity and remove system inefficiencies**.** An integrated health home, including medication management and integrated behavioral health, would also be a tool used to reduce the inappropriate use of psychotropic medications for foster children, which have been found to be prescribed without accompanying mental health treatment, in high doses, and to very young children**.**[63] Foster children are found to receive psychotropic medication in 16% to 23% of cases, compared to 5% to 6% of children on Medicaid.[64] PRIME investments in an integrated health home of the foster child population would provide opportunities for early identification of risk factors, improved medication management and treatment plan continuity and engagement with caretakers that will best improve this population's quality of care.
Goals/Objectives
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.

[61] California Child Welfare Indicators Project. http://cssr.berkeley.edu/ucb_childwelfare/
[62] Stoltzfus E, Baumrucker E, Fernandes-Alcanra A, Ferdandez B. (2014). Child Welfare: Health Care Needs of Children in Foster Care and Related Federal Issues (CRS Report No. R42378). Retrieved from Congressional Research Service website: http://www.fas.org/sgp/crs/misc/R42378.pdf
[63] Medicaid Medical Directors Learning Network and Rutgers Center for Education and Research on Mental Health Therapeutics. Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide from a 16-State Study. MMDLN/Rutgers CERTs Publication #1. July 2010. Distributed by Rutgers CERTs at http://rci.rutgers.edu/~cseap/MMDLNAPKIDS.html.
[64] Ibid.

Project Domain
Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title
2.4 Integrated Health Home for Foster Children

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)
- Improve patient experience

Core Components

Participating PRIME entities undertaking this project may 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.
      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.
   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

Project Domain
Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title
2.4 Integrated Health Home for Foster Children

and actionable data is used to support patient engagement, and drive clinical, operational and strategic decisions including continuous QI 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 liaisons/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 performance feedback and rapid cycle improvement, that includes patients, front line staff, and senior leadership.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Adolescent Well-Care Visit	N/A	NCQA
Developmental Screening in the First Three Years of Life	1448	NCQA
Documentation of Current Medications in the Medical Record (0-18 yo)	Variation on 0419	CMS
Screening for Clinical Depression and follow-up	0418	CMS
Tobacco Assessment and Counseling (13 yo and older)	Variation on 0028	AMA-PCPI
Well Child Visits - First 15 months of life	1392	NCQA
Well Child Visits - Third, Fourth, Fifth, and Sixth Years of life	1516	NCQA

5. Project 2.5 Transition to Integrated Care: Post Incarceration

Project Domain
Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title
2.5 Transition to Integrated Care: Post Incarceration
Rationale
Incarcerated populations have much higher prevalence of serious medical and behavioral health conditions than the non-incarcerated population. In light of the significant health needs of formerly incarcerated Californians, this project is designed to ensure a well-planned transition into the public health care system for former inmates. Release from incarceration represents a significant public health opportunity to continue treatment of critical conditions, increase engagement of former inmates and drive down avoidable health care costs.[65] For the 130,000 individuals leaving a California prison each year, transitioning into society from incarceration presents an opportunity to promote health care enrollment, interaction with medical providers, and coordination of other social services. A community health worker-led care management program reduced ED utilization through increasing primary care engagement with individuals transitioning from prison.[66] The San Francisco-based Transitions Clinic, a community health center focused on transitional health care services, has shown increased patient engagement through medical care and coordinated support with services such as assistance with housing, jobs, legal aid, substance abuse counseling, health care system navigation, and chronic disease self-management support.[67] By incorporating these evidence-based approaches, proposed PRIME initiatives would utilize community health workers and leverage partnerships with prisons, jails, social services and housing to create seamless transitions and improved care for these recently released populations.
Goals/Objectives
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, the local public health department, and coordination with behavioral health care and necessary social services

[65] Gorenstein, D. “In prison you get health care. When you're released ... “ 30 December 2013. *Marketplace.org* http://www.marketplace.org/topics/health-care/prison-you-get-health-care-when-youre-released

[66] Wang EA, Hong CS, Shavit S, Sanders R, Kessell E, Kushel MB. “Engaging individuals recently released from prison into primary care: a randomized trial.” American Journal of Public Health. 2012 Sep;102(9):e22-9. Epub 2012 Jul 19.

[67] Wang A, Hong C, Samuels L, Shavit S, Sanders R, Kushel M. 2010. “Transitions Clinic: Creating a Community-Based Model of Health Care for Recently Released California Prisoners.” Public Health Report. 2010 Mar-Apr; 125(2): 171–177.

Project Domain
Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title
2.5 Transition to Integrated Care: Post Incarceration
• 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
Participating PRIME entities undertaking this project may complete the following components: 1. Develop a care transitions program for those individuals who have been individuals sentenced to prison and/or jail that are soon-to-be released/or released in the prior 6 months who have at least one chronic health condition and/or over the age of 50. 2. 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. Ongoing coordination between health care and correctional entities (e.g, parole/probation departments) c. Linkage to primary care medical home at time of release d. 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 e. Establishing processes for follow-up and outreach to individuals who do not successfully establish primary care following release f. 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. 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).

Project Domain

Domain 2: Targeted High-Risk Or High-Cost Populations

Project Title

2.5 Transition to Integrated Care: Post Incarceration

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 QI 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.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Alcohol and Drug Misuse (SBIRT)	N/A	Oregon CCO
Controlling Blood Pressure	0018	NCQA
Prevention Quality Overall Composite #90	N/A	AHRQ
Screening for Clinical Depression and follow-up	0418	CMS
Tobacco Assessment and Counseling	0028	AMA-PCPI

6. Project 2.6 Chronic Non-Malignant Pain Management

Project Domain
Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title
2.6 Chronic Non-Malignant Pain Management
Rationale
Thirty-four million Americans suffer from chronic non-malignant pain (CNMP), defined as pain lasting six months or more unrelated to cancer that does not respond to conventional medical treatment. The high prevalence of CNMP results in annual total costs of $85 to $90 billion in the United States, including medical costs and loss in productivity.[68] For patients, risks include pain from failure to get treatment, possible addiction to prescribed medication and a high risk of depression and/or suicide from untreated pain. Over the last decade deaths involving opioid analgesics has more than tripled, with the majority of those deaths due to prescription drugs[69]. Opiates were the most commonly involved medication although often these were used in combination with other drugs. 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 recognize current or potential substance abuse disorders and can maximize benefit while minimizing risk and potential side effects. Research on effective pain management supports a multi-modal approach, incorporating physical and occupational therapy and other complementary disciplines.[70] Participating PRIME entities can best provide high-quality care to these patients through the adoption of evidence-based protocols and guidelines employing non-pharmacologic treatment. Additionally, training on these new processes should be provided to educate and engage clinicians and non-clinical staff. The proposed PRIME project incorporates these modified protocols and guidelines as system re-design to better manage patients' pain.
Goals/Objectives
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:

[68] Carter C, Goldfarb NI, Hartmann CW, Roumm AR, Vallow SM, Durkin M. Chronic pain management in managed care organizations: a national survey of medical directors. Pharmacol Ther. 2003;28(3):179–215.
[69] Margaret Warner, PhD, Holly Hedegaard, MD, MSPH, and Li-Hui Chen, MS, PhD, Trends in Drug-poisoning Deaths Involving Opioid Analgesics and Heroin: United States, 1999–2012. NCHS Health E-Stat. Hyattsville, MD: National Center for Health Statistics, December 2014, p. 1.
http://www.cdc.gov/nchs/data/hestat/drug_poisoning/drug_poisoning.htm
[70] Ibid.

Project Domain
Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title
2.6 Chronic Non-Malignant Pain Management
• 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
Participating PRIME entities undertaking this project may complete the following components: 1. Develop an enterprise-wide Chronic Non-Malignant Pain management strategy. 2. Demonstrate engagement of patients in the design and implementation of the project. 3. Implement or adapt a state or nationally recognized methodology[71] 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. 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. Guidelines regarding maximum acceptable dosing. 5. Provide culturally, linguistically and literacy level-appropriate patient education on the

[71] 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

Project Domain
Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title
2.6 Chronic Non-Malignant Pain Management

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[72], and opioid assessment tools[73] that meet the needs of the care clinicians and are appropriate for the patient populations.
16. Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. Timely, relevant and actionable data is used to support patient engagement, and drive clinical, operational and strategic decisions including continuous QI activities.

[72] 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

[73] Examples of opioid and substance abuse assessment tools are, but are not limited to:CAGE and CAGE-AID, Webster's Opioid Risk Tool (ORT), DIRE Tool, Screener and Opioid Assessment for Patients in Pain (SOAPP®), Current Opioid Misuse Measure (COMMTM), Prescription Drug Use Questionnaire (PDUQ), Screening Tool for Addiction Risk (STAR), Screening Instrument for Substance Abuse Potential (SISAP), Pain Medicine Questionnaire (PMQ), Audit-C, Screening, Brief Intervention, Referral to Treatment (SBIRT)

Project Domain		
Domain 2: Targeted High-Risk Or High-Cost Populations		
Project Title		
2.6 Chronic Non-Malignant Pain Management		
Required Project Metrics		
Measure name	NQF#	Measure Steward (*Innovative metrics)
Alcohol and Drug Misuse (SBIRT)	N/A	Oregon CCO
Assessment and Management of Chronic Pain: Patients with chronic pain prescribed an opioid who have an opioid agreement form and an annual urine toxicology screen	N/A	AHRQ
Patients with chronic pain on long term opioid therapy checked in PDMPs	N/A	*AHRQ/SFHN, AHS, UCSD
Screening for Clinical Depression and follow-up	0418	CMS
Treatment of Chronic Non-Malignant Pain with Multi-Modal Therapy	N/A	*SFHN, AHS, UCSD

7. Project 2.7 Comprehensive Advanced Illness Planning and Care

Project Domain
Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title
2.7 Comprehensive Advanced Illness Planning and Care
Rationale
Palliative care and end of life planning have the potential to increase quality of life for those most in need of sensitive, cohesive care. Only 20 percent of potentially appropriate patients have access to community-based palliative care services, according to an estimate by the Berkeley Forum[74]. Crucial to improving quality of life for patients with chronic or terminal illnesses is ensuring smooth transitions of care, and excellent care in every setting, including hospitals, skilled nursing facilities, and home-based environments. Several concurrent statewide end of life care programs and initiatives exist with the goal to increase quality of end of life care. PRIME 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, impart quality metrics, and provide technical assistance to Medi-Cal managed care plans to ensure delivery of palliative care services, including hospice benefits. • Health Homes for Complex Patients Initiative: This effort, in part, 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 Physician Orders for Life-Sustaining Treatment (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
To ensure access to comprehensive care in alignment with patient preferences in hospital and community settings for all patients facing advanced illness.

[74] University of California, Berkeley, School of Public Health. (2014). Honoring Patient's Wishes: Expanding Palliative Care in California. http://berkeleyhealthcareforum.berkeley.edu/wp-content/uploads/BerkeleyForum_PalliativeBrief_nov18.pdf. Accessed July 2015.

Project Domain
Domain 2: Targeted High-Risk Or High-Cost Populations
Project Title
2.7 Comprehensive Advanced Illness Planning and Care

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 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

Participating PRIME entities undertaking this project may complete the following components:

1. Establish or expand both ambulatory and inpatient palliative care programs that provide:
    a. Total, active and individualized patient care, including comprehensive assessment, inter-professional care planning and care delivery
    b. Support for the family
    c. Interdisciplinary teamwork
    d. Effective communication (culturally and linguistically appropriate)
    e. Effective coordination
    f. Attention to quality of life and reduction of symptom burden
    g. Engagement of patients and families in the design and implementation of the program.
2. Develop criteria for program inclusion based on quantitative and qualitative data:
    a. Establish data analytics systems to capture program inclusion criteria data elements.
3. Implement, expand, or link with, a Primary Palliative Care training program for front-line clinicians to receive basic PC training, including Advanced Care Planning, as well as supervision from specialty PC clinicians.
    a. 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
4. Develop comprehensive advance care planning processes and improve implementation of advance care planning with advanced illness patients.
5. Establish care goals consistent with patient and family preferences, and develop protocols for management/control of pain and other symptoms in patients with advanced illness, including a holistic approach that includes spiritual and emotional needs .
6. Improve completion of POLST with eligible patients and participate in the state-wide POLST registry.
7. Provide access to clinical psychologist on the Palliative care team to address psychological needs of patient and the family members during the advanced illness and provide grief counseling and support to the family after death of their loved ones.
8. Enable concurrent access to hospice and curative-intent treatment, including

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2.7 Comprehensive Advanced Illness Planning and Care

coordination between the providing services.

9. Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice, including linkage with PC training program.
10. For advanced illness patients transitioning between primary care, hospital, skilled nursing facilities (SNFs), and/or home-based environments, ensure that the advance care plan is clearly documented in the medical record and transmitted in a timely manner to the receiving facilities and care partners who do not have access to the health system's medical record.
11. Engage staff in trainings to increase role-appropriate competence in palliative care skills, with an emphasis on communication skills.
12. Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Advance Care Plan	0326	NCQA
Ambulatory Palliative Care Team Established	N/A	*University of California, San Francisco (UCSF)
MWM#8 - Treatment Preferences (Inpatient)	1641	UNC Chapel Hill
MWM#8 - Treatment Preferences (Outpatient)	N/A	*University of California, San Francisco (UCSF)
Palliative Care Service Offered at Time of Diagnosis of Advanced Illness	N/A	*University of California, San Francisco (UCSF)
Proportion Admitted to Hospice for Less than 3 Days	0216	ASCO

C. Domain 3: Resource Utilization Efficiency
Minimum of One Project Required for DPHs

Projects in Domain 3 will reduce unwarranted variation in the use of evidence-based, diagnostics and treatments (antibiotics, blood or blood products, and high cost imaging studies and pharmaceutical therapies) targeting overuse, misuse, as well as inappropriate underuse of effective interventions. Projects will also eliminate the use of ineffective or harmful targeted clinical services. Participating DPH systems must select at least one project in this domain.

1. Project 3.1 Antibiotic Stewardship

Project Domain
Domain 3: Resource Utilization Efficiency
Project Title
3.1 Antibiotic Stewardship
Rationale
Proper use of antibiotics has become a pressing healthcare quality concern as antimicrobial resistance has been documented across several pathogens in increasing numbers throughout the United States. [75] Infections resistant to antibiotic treatment put patient health at risk and also add to healthcare costs through extended patient treatment. The CDC has identified antibiotic stewardship as a key strategy to combat pathogen resistance through incorporating best clinical practices based on antibiotic dosing, duration and route. For participating PRIME entities, a stewardship program can be implemented through policies and procedures, training, and a reporting system. In addition to reducing resistance, promoting antimicrobial stewardship has proven to lower costs, minimize medication-based adverse events and improve patient quality of care.[76] California continues to be the sole state with legislation passed targeting antimicrobial stewardship. Participating PRIME entities can participate in learning forums such as the Antimicrobial Stewardship Program Collaborative facilitated by the California Department of Public Health, to continue the cross-pollination of best practices.
Goals/Objectives
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
Systems undertaking this project may 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

[75] Infection Control and Hospital Epidemiology, Vol. 33, No. 4, Special Topic Issue: Antimicrobial Stewardship (April 2012), pp. 322-327
[76] "Promoting Antimicrobial Stewardship in Human Medicine." Infectious Diseases Society of America : Antimicrobial Stewardship. Web. 23 Jan. 2015.

Project Domain
Domain 3: Resource Utilization Efficiency
Project Title
3.1 Antibiotic Stewardship

Initiative, or the IHI-CDC 2012 Update "Antibiotic Stewardship Driver Diagram and Change Package"[77]

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.[78]
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).
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

[77] 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).

[78] 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.

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Domain 3: Resource Utilization Efficiency
Project Title
3.1 Antibiotic Stewardship

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

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Avoidance of antibiotic treatment in adults with acute bronchitis	0058	NCQA
Avoidance of Antibiotic Treatment with Low Colony Urinary Cultures	N/A	*UC Davis, UC Irvine, UC San Diego
National Healthcare Safety Network (NHSN) Antimicrobial Use Measure	2720	CDC
Prophylactic antibiotics discontinued at time of surgical closure	N/A	CMS
Reduction in Hospital Acquired Clostridium Difficile Infections	N/A	NHSN

2. Project 3.2 Resource Stewardship: High-Cost Imaging

Project Domain
Domain 3: Resource Utilization Efficiency
Project Title
3.2 Resource Stewardship: High-Cost Imaging
Rationale
Over-ordering diagnostic tests increases healthcare costs, inefficiency for patients, and produces no valuable clinical information. Imaging studies represent a very high percentage of these tests.[79] The Choosing Wisely initiative, a joint effort between the American Board of Internal Medicine Foundation and *Consumer Reports*, produced a series of evidence-based recommendations for certain tests identified as overused. Participating PRIME entities will incorporate learnings from the Choosing Wisely program, as well as other resources like the American College of Radiology's Appropriateness Criteria, in creating their own imaging management program meant to combat imaging overuse and misuse. Elements of the program will include established standards of care, data capacity improvements and the incorporation of cost information into the decision making process.
Goals/Objectives
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
Participating PRIME entities undertaking this project may 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

[79] Rao VM, Levin DC. The Overuse of Diagnostic Imaging and the Choosing Wisely Initiative. Annals of Internal Medicine. 2012;157:574-576.

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

cost per study or high volume across the system
   b. Unwarranted practice variation within the participating DPHs/DMPHs
   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.
6. Implement a system for continual rapid cycle improvement and performance feedback that includes patients, front line staff and senior leadership.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Imaging for Routine Headaches (Choosing Wisely)	N/A	*Washington Health Alliance
Inappropriate Pulmonary CT Imaging for Patients at Low Risk for Pulmonary Embolism	0667	ACEP
Use of Imaging Studies for Low Back Pain	0052	NCQA
Use of Imaging Studies for Low Back Pain (red flags, no time limit)	N/A	*LAC Department of Health Services (variation on NQF 0052)

3. Project 3.3 Resource Stewardship: Therapies Involving High-Cost Pharmaceuticals

Project Domain
Domain 3: Resource Utilization Efficiency
Project Title
3.3 Resource Stewardship: Therapies Involving High-Cost Pharmaceuticals
Rationale
Expanded coverage under the Affordable Care Act has dramatically increased demand for prescription drugs in recent years. Nationwide, spending on prescription drugs reached $329.2 billion in 2013, up 3.2% from 2012.[80] The recent surge in high-cost specialty drugs – popularly debated with the release an effective hepatitis C treatment costing $84,000 -- is expected to further increase drug spending by 6.6% per year between 2015 and 2021.[81] In response to rapid spending increases, payers and providers are gaining interest in resource stewardship programs that can curb unnecessary costs. These programs employ evidence-based strategies, such as utilization management, drug formularies, and prior authorization protocols. Under the proposed PRIME project, participating PRIME entities will develop robust resource stewardship programs. The project will establish multidisciplinary teams of experts with committed time to monitor and contain drug costs. By investing in resource stewardship, the project has the potential to yield significant savings, transforming participating PRIME entities into more efficient, cost-effective providers of care.
Goals/Objectives
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 PRIME entity 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
Participating PRIME entities undertaking this project may complete the following

[80] National Conference of State Legislatures. Pharmaceuticals: Facts, Policies, and NCSL Resources. http://www.ncsl.org/research/health/pharmaceuticals-facts-policies-and-ncsl-resources.aspx. Accessed Jan 29, 2015.
[81] National Health Expenditure Projections: 2011-2021. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

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

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 participating PRIME entity highest cost pharmaceuticals (high-cost medications or moderate-cost meds with high prescribing volume). Identify high-cost medications whose efficacy is significantly greater than available lower cost medications.
    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 PRIME 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 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 continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership 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

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

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.

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
Adherence to Medications	Variation on NQF 2467	*Alameda Health Systems (AHS)
Documentation of Current Medications in the Medical Record	0419	CMS
High-cost pharmaceuticals ordering protocols	N/A	*AHS

4. Project 3.4 Resource Stewardship: Blood Products

Project Domain
Domain 3: Resource Utilization Efficiency
Project Title
3.4 Resource Stewardship: Blood Products
Rationale
Blood transfusions are one of the most common procedures performed in hospitals in the United States, but are also associated with significant risk for the patients.[82] With over 15 million units of red blood cells transfused annually, quality organizations have focused on appropriate blood management as an area of massive opportunity to improve clinical outcomes through evidence-based standardization. Through the implementation of a blood management program, participating PRIME entities will develop and streamline clinical processes, closely track clinical outcomes on dashboards and better manage blood products. Existing patient blood management methodologies, like those created by the Joint Commission, will be adopted locally, as will an interdisciplinary Transfusion Committee to drive change.
Goals/Objectives
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
Participating PRIME entities undertaking this project may 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[83], AABB)

[82] Blood transfusion. (n.d.). In Wikipedia. Retrieved January 28, 2015, from http://en.wikipedia.org/wiki/Blood_transfusion
[83] 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.

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

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

Required Project Metrics

Measure name	NQF#	Measure Steward (*Innovative metrics)
ePBM-01 Pre-op Anemia Screening, Selected Elective Surgical Patients	N/A	AABB/TJC (approval pending)
ePBM-02 Pre-op Hemoglobin Level, Selected Elective Surgical Patients	N/A	AABB/TJC
ePBM-03 Pre-op Type and Crossmatch, Type and Screen, Selected elective Surgical Patients	N/A	AABB/TJC
ePBM-04 Initial Transfusion Threshold	N/A	AABB/TJC
ePBM-05 Outcome of Patient Blood Management, Selected Elective Surgical Patients	N/A	AABB/TJC