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

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

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General Instructions

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

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

Scoring

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

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

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

Section 1: PRIME Participating Entity Information

Health Care System/Hospital Name

Tulare Regional Medical Center

Health Care System Designation (DPH or DMPH)

DMPH

Section 2: Organizational and Community Landscape

The purpose of this section is to provide DHCS with an understanding of the demographic makeup of the community the applicant serves, the target population that will benefit from the PRIME activities, and any other relevant information that will help inform the state's review of this Plan.

2.1 Community Background. *[No more than 400 words]*

Drawing on available data (e.g., DHCS, Office of Statewide Health Planning and Development, U.S. Census Bureau), summarize the health care needs and disparities that affect the health of your local community.

Tulare Regional Medical Center (TRMC) is located in the San Joaquin Valley. It is a diverse populated region and home to 447,000 residents living over 4,839 square miles of agricultural lands. The health care needs and disparities are identified and summarized below.

Access to Care is defined by the timely use of personal health care services to achieve positive health care outcomes. Four components are required to access care: insurance coverage, services, provider coverage, and availability/timeliness to service.

Physical Health: The health issues facing our community's resident's impacts quality of life and includes heart disease/hypertension, diabetes/obesity and economic security.

- Heart Disease/Hypertension is the most common and leading cause of stroke and death. More than 2.7% of adults have heart disease and 29% have high blood pressure in our region. Income inequality, access to care and education may impact the rate of death.
- Diabetes/obesity, more than 36% of county's adult residents and over 44% of children are obese. This epidemic contributes to a high incidence of Type 2 diabetes.
- Economic Security, 36% of children and 67% of adults live in poverty. Over 9% of the households receive public assistance income with an unemployment rate of over 12%. The effects of long term poverty are associated with shortened life span, chronic illness, and mental health.

Cancers: Cancer mortality, age adjusted death rate, is more than 155/100,000 of the population in the service area. Health inequalities affect the annual breast cancer incidence rate which exceeds 104/100,000 cervical cancer incidence rate of 11/100,000 and colon and rectum cancer incidence rate of over 39.7/100,000.

Mental Health: Mental health problems contribute to a host of health issues that may include disability, pain, or death. The greatest challenge in this service area is the need for both mental health professionals and facilities to provide acute care.

Health Disparities: Tulare County is ranked 45 of California's 58 counties, falling in the bottom half of California counties for health outcomes, quality of life, clinical care, social & economic factors and subsequent health factors. The largest percent of racial and

ethnic minority families are Latino and African American. More than 26% live in poverty, 29% have no health insurance and 33% have no physician. These factors are recognized in preventable hospitalizations, potential years of life lost, and the lack of residents forgoing preventative health care.

We hope to utilize the opportunity to participate in PRIME and address the issues outlined.

2.2 Population Served Description. *[No more than 250 words]*

Summarize the demographic make-up of the population included in your hospital's service area, including information about per capita income, age, race, ethnicity, primary language, etc.

Tulare Regional Medical Center serves the diverse population of Tulare County, which is home to 446,644 Californians. In addition to the county's three main cities there is a large rural population which is served by our hospital and medical offices (outpatient clinics).

Income: The average per capita income in Tulare County is $17,888 and the median household income is $42,863. These income levels are more than 40% and 30% below the average for California, respectively. Additionally, 26% of the total population in Tulare County lives in poverty versus 16% of Californians.

Race/Ethnicity and Language: The population of Tulare County is 61% Hispanic/Latino, 32% White and 3% Asian. The remaining 4% is comprised of Black/African American (1%), American Indian or Alaskan native (1%), mix of 2 or more races (2%). While the primary language in Tulare County is English, more than 45% of the population speaks Spanish at home.

Age: Tulare County's population is younger than California overall, with a median age of 29 (compared to 35 statewide). 32% of the population is 0-17 years, 58% is 18-64 years and 10% is 65 years or older.

2.3 Health System Description. *[No more than 250 words]*

Describe the components of your health care system, including license category, bed size, number of clinics, specialties, payer mix, etc.

Tulare Regional Medical Center is a general acute care facility which provides acute inpatient, outpatient and emergency care. Of our 112 beds, we have 14 intensive care beds, 16 pediatric beds, 10 perinatal beds, 4 perinatal triage beds, 6 emergency beds, 6 fast track beds and 56 inpatient beds.

Our growing network of health-care centers includes Hillman Medical Office, West Street Medical Office and Women's Pavilion in Tulare, as well as offices in each of the rural communities of Lindsay and Earlimart. Our Earlimart Medical Office is unique as it is the county's only school-based clinic which also serves the local community.

Our Evolutions Fitness and Wellness Center provides a complete array of fitness programs, classes, and rehabilitation services to enhance a healthy lifestyle, welcoming 332,000 member visits annually. Services include a full range of imaging services, a clinical lab and toxicology lab, pharmacy, perinatal, home care services and a sleep disorder lab.

In fiscal year 2015, the payer mix at TRMC was comprised primarily of Medi-Cal (46%), followed by Medicare (31%) and private insurance (19%). Approximately 4% of users were uninsured. TRMC had 3,726 acute inpatient discharges and 104,572 ambulatory care visits. The average length of stay for acute care was 3.8 days. Hospital beds had a 28% occupancy rate. Staffed beds as a percentage of licensed beds was 92%.

Our current construction of the hospital tower will quadruple our Emergency department and expand our surgical suite, meeting state mandated seismic requirements and also increasing healthcare access for our community.

2.4 Baseline Data. *[No more than 300 words]*

Describe the current resources that your entity has in place to collect, report and monitor performance data and how these resources will support PRIME clinical quality reporting requirements. Please specify any anticipated limitations or barriers to meeting the PRIME reporting requirements and describe your proposed strategies to address these barriers.

Tulare Healthcare District clinics are presently running the NextGen EHR/PM solution. The inpatient side is operating the Siemens/Cerner MS4 clinical documentation and patient accounting system. Both acute care and ambulatory operating environments are in process of implementing Cerner's Community Works best of suite solution. The Community Works solution set delivers full EMR, charting and advanced clinical interoperability for inpatient, outpatient and ancillary departments.

To derive PRIME reporting requirements from NextGen and MS4 legacy data sets, the district will be using a third party application from i2i Tracks. Source data for population health analytics come from patient demographics, claims and clinical electronic health record data sources. Following the transition to Cerner Community Works the legacy data will be coalesced with current Community Works data in the i2i platform. i2i Tracks offers specific analytics reporting for the Million Hearts Initiative (PRIME 1.5) and NCQA Patient Centered Medical Home which is the guiding principal for Ambulatory re-design (PRIME 1.2) which are just two of the District's six PRIME objectives. The strong analytics platform within i2iTracks will allow for reporting through dashboards for use on either a population based report or specific to a provider that can be used in morning huddles. The importance of this cannot be overemphasized as this tool will be at the center of improvement work as the needle is moved towards specific benchmarks within the categories of PRIME TRMC has selected.

Section 3: Executive Summary

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

3.1 PRIME Project Abstract [No more than 600 words]

Please address the following components of the Abstract:

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

TRMC's primary goal is to create the finest integrated health system for Tulare Healthcare District by providing state-of-the-art technology solutions that will enhance coordinated patient centered care across the continuum. The care model will be patient centric, accessible, coordinated, and supportive of the patient's cultural and linguistic needs.

As a component of PRIME, TRMC will implement more effective approaches that are data driven and will utilize evidence-based guidelines in its approach. This will assist the Organization to move systemic transformation more quickly to achieve high yielding results.

By implementing the Patient Centered Medical Home Model, TRMC will meet community need by addressing care coordination for Behavioral Health, assuring medication reconciliation and lab follow up are addressed, chronic care management for hypertension and diabetes are managed through standardized protocols and cancer screening and follow up for colorectal, breast and cervical are implemented using USPSTF guidelines. All of the aforementioned areas of focus are directly related to the identified community needs in Section 2.

2. *List specific aims** for your work in PRIME that relate to achieving the stated goals;*
   Note:

*** Specific aims (generally 2-5) relate to the goals but provide more detail on how the goals will be achieved.*

TRMC has three specific aims for our participation in PRIME: (1) to improve the overall health of the community through a PCMH model; (2) utilize evidenced-based guidelines in the care delivery model and (3) to assure a well-coordinated approach to reduce gaps in care.

Specific goals for Behavioral Health Integration is to implement SBIRT (Screening, Brief Intervention and Referral to Treatment) and to ensure collaboration with the patient's Primary Care Provider within the Medical Home.

Cancer Screening and Follow-up is an integral component of PCMH. It is the intent to introduce USPSTF recommendations and to develop processes to ensure patients are screened at recommended intervals as well as to ensure that follow up referrals are coordinated if needed. Patient safety is always a core component of delivering high quality care. With the adoption of new processes, TRMC can assure that medication reconciliation and laboratory results are managed appropriately. The Patient-Centered Medical Home is the core of most of the PRIME projects and engaging in this endeavor will allow TRMC to provide the patients and potential patients an environment which will support care coordination, self-management, preventative health and management of chronic disease. This care will be provided in a manner that is supportive of the cultural and linguistic diversity Tulare represents.

TRMC is pleased to adopt the Million Hearts campaign. Again, this evidence-based program will assist TRMC in addressing the high number of residents who suffer from Coronary Artery Disease or high blood pressure.

And lastly, Post Incarceration transitions are very important to this community. There are (3) California State prisons (CDCR) within 60 miles of Tulare and with Governor Brown's initiative for early release to County jails, we anticipate many prisoner releases within Tulare County. Given the high propensity for chronic disease within this population, it becomes more critical to assure continuity and well-managed care.

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

TRMC has selected (6) projects; Integrated Behavioral Health (Project 1.1), Ambulatory Care Redesign (Project 1.2), Patient Safety in an Ambulatory setting (Project 1.4), Million Hearts (Project 1.5), Cancer Screening and Follow-up (Project 1.6) and Post Incarceration (Project 2.5). Most of these projects with the exception of Post Incarceration are directly related to TRMC's goal of attaining NCQA PCMH recognition.

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

As stated above, most projects have a direct relationship with each other in a PCMH model. The use of technology will be inherently important in achieving measurable results. TRMC will adopt a philosophy of data driven decision making, utilization of evidenced based protocols, and process improvement techniques which all projects will be dependent upon.

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

At the end of the 5-year project period, TRMC will have achieved higher patient satisfaction; higher level of coordinated care and patients will be less dependent on receiving care in Emergency Department. TRMC will reduce avoidable admissions by delivering and managing chronic care using best practice methodology. This will place TRMC in a position to receive NCQA PCMH recognition and achieve the Triple Aim.

3.2 Meeting Community Needs. [No more than 250 words]

Describe how your organization will address health needs at a local level as described in Section 2 of the Plan. The narrative should clearly link the projects you select in Section 4 with the community needs identified in your response to Section 2.1.

Physical and behavioral health data regarding the impact on our community is described in our response to Section 2.l. TRMC's rationale for selecting this project underscores the significance of the health issues facing our residents; this includes mental illness or substance abuse. Mental illnesses are health conditions that are associated with chronic illness and or behaviors associated with impaired functioning, disability, and pain also noted in patients with heart disease and cancers.

Integrating tele-psychiatry and collaborating with the California Telehealth Network (CTH) and the National Allegiance on Mental Illness (NAMI) will facilitate our ability to deliver mental health services in our patient-centered medical homes. We anticipate these strategies will address residents with chronic health conditions and adult patients age 50 and older released from correctional facilities within our service area. Mental health and substance disorders often go undetected and untreated, resulting in higher utilization of Emergency Department visits and hospitalizations.

TRMC will foster mutual partnerships between patients, providers, and the patient's care team to standardize processes and coordinate treatment for our patients. We believe this coordinated approach is essential to organizing patient care activities which include: implementing behavioral health screening, support peer groups, establish specialty referrals, and timely appointments. Our goal is to enhance our ability to identify behavior health conditions, address disparities as they relate to health care needs, and increase access to care for the population served.

As described in Section 2, the community experiences higher than state averages for Diabetes, breast and cervical cancers, hypertension. Access to Behavioral Health Services for those patients experiencing mild to moderate mental health issues is challenging. TRMC believes that through the PRIME Initiative laser focus on these specific areas will yield better outcomes for patients whereby meeting the health needs of the community. The PCMH Model supports this transformative approach to whole person coordinated care.

3.3 Infrastructure and Alignment with Organizational Goals. [No more than 250 words]

Describe the organizational infrastructure that exists or will be established for purposes of implementing PRIME (e.g., current strategic plan, goals related to quality improvement, monitoring/feedback mechanisms, data-driven decision-making practices).

TRMC's governance strategy is focused on our commitment to serve the patients of our communities. As a district hospital, the board of directors consists of publicly elected officials. Each board member is robustly engaged and knowledgeable about the health care needs of the community and will provide oversight of the PRIME-related activities.

A PRIME Advisory Committee was established in January 2016 to begin the planning and participation in the new program. The committee will convene monthly or more frequently if deemed by the committee during the implementation phase in 2016. A charter was developed to guide committee members in the development of TRMC's PRIME plan. The committee will recommend to the Senior Leadership and the Board of Directors infrastructure investments to assist in monitoring progress towards TRMC's efforts to meet its PRIME goals and performance standards.

The PRIME Advisory Committee is led by the Vice President of Ambulatory Care Services and is supported by the Director of Strategic Planning and Development, Ambulatory Care Quality Manager, Clinical Supervisor, Chief Nursing Officer, the Controller and Director of Ancillary Services. The VP of ACS will have primary responsibility and oversight for PRIME implementation and reporting.

3.4 Stakeholder Engagement. [No more than 200 words]

Describe plans for engaging with stakeholders and beneficiaries in the planning and implementation of PRIME projects. Describe how these activities will complement or augment existing patient engagement efforts.

TRMC will ensure opportunities for stakeholders and beneficiaries to be engaged in PRIME plan and implementation to include: patients, residents in the hospitals service areas, health providers, and community leaders and the public health department's staff within Tulare County. This will be accomplished in several ways. Monthly presentations to Senior Leadership and annual presentations to the Board of Directors will keep these stakeholders informed as to the progress in reaching PRIME goals. The period of public comment is available for any community member to speak to issues presented before the Board. Patients will be engaged through ongoing feedback surveys that are disseminated in threshold languages. This will be continuous throughout the PRIME project period. The Vice President of Ambulatory Care Services attends the monthly Tulare County Health and Human Services Advisory Committee and will make presentations and solicit feedback from that stakeholder group.

TRMC will continue to establish and cultivate relationships with community-based organizations that will provide support services to our patients. Stakeholders will continue to identify additional organizations that may be added to the planning activities during the implementation phase.

3.5 Cultural Competence and Addressing Health Disparities. [No more than 200 words]

Describe planned efforts to ensure cultural competency in implementing PRIME projects and the strategies to reduce healthcare disparities that will be adopted. Identify the resources that the entity has available for this purpose.

TRMC is committed to meeting the diverse needs of our community's population. This includes working to ensure that our providers and staff reflect the diversity of our patients and that all patients have access to health information in their language of choice. We intend to continue our efforts to provide culturally competent service and care to the diverse population we serve.

To support the health information needs of our patients, we will continue to translate educational materials into Spanish, our identified threshold language, and provide real-time access to interpreter services as a complement to our providers' language capabilities, many of whom are bilingual. In addition, we intend to continue to develop provider and staff trainings on issues related to cultural competence. One of our community goals is to build on our existing outreach programs to engage our community in events that include support groups, health fairs, prevention screenings, and flu/immunization programs related to health disparities.

3.6 Sustainability. [No more than 150 words]

Provide a high-level description of the systematic approach for quality improvement and change management that your organization plans to use. The narrative should describe the specific components you have in place, or will implement as part of PRIME, which will enable you to sustain improvements after PRIME participation has ended.

TRMC has a strong commitment to efficient delivery of healthcare to the residents of Tulare that is provided in the most appropriate setting. TRMC patients will experience less complex and more coordinated care provided by a staff which has a keen understanding of system changes that can facilitate whole person care. This will continue to be done by developing at ground level, a systematic approach that is sufficiently strong enough to move system level results. Several objectives include Institute for Health Improvement (IHI) components that focus on integrated information technology, new models of primary care such as PCMH, population health analytics and rapid testing and scale up approach to change. Tulare will have a healthier population in part because TRMC can better identify problems and solutions further upstream and outside of the acute health care setting.

The PRIME Initiative will enable TRMC to systemically change how services are delivered and thereby create a platform that will allow for continuous performance improvement by utilizing standardized processes and protocols in all areas. The delivery system transformation which was once considered innovative and novel will become the standard of a high performing health care system for the benefit of the community of Tulare.

Section 4: Project Selection

The PRIME Projects are organized into three Domains:

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

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

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

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

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

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

Instructions

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

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

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

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

   For DMPHs requiring infrastructure building metrics that are approved in the Prime Project Plan, 75% of PRIME funding for DY 11 will be based on the achievement of the approved DY 11 infrastructure building metrics through the final year-end report. Up to 40% of the total PRIME funding for DY12 will be based on the achievement of the approved DY 12 infrastructure building metrics through the mid-year and final year-end report. The proposed Process Measures should meet the following criteria:
   - *Specific*
   - *Measurable: Must be able to demonstrate progress throughout the duration of the process metric measurement period.*
   - *Evidence-based: Measures should have a strong evidence-base that can linked process to outcomes.*

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

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

Approximately 1 in 25 adults in the U.S.—10 million, or 4.2%—experiences a serious mental illness in a given year that substantially interferes with or limits one or more major life activities (http://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml). Approximately 68% of individuals with a mental illness have a medical condition (The Synthesis Project, Policy Brief No. 21). Adults with comorbidities are likely to have a lower quality of life, a shorter life expectancy and contribute to the high cost of health care due to avoidable utilization of emergency room services and hospitalizations. TRMC selected this project because we are committed to improving the quality of life of our target population, adults with comorbidities including mental or substance abuse issues. We recognize that mental and physical health are interwoven; in order to improve health outcomes both mental and physical needs must be assessed, addressed and treated.

TRMC's design approach for an integrated physical and behavioral health program shadows the NCQA PCMH methodology which requires collaboration between the patient, the patient's primary care provider, the care team/ support staff, specialists and the community. This model care must be accessible, comprehensive and well-coordinated.

Team approach and expansion of the care team**:** TRMC will implement Patient Health Questionnaire (PHQ) and Screening, Brief Intervention, and Referral to Treatment (SBIRT) screenings in primary care clinics for patients 18 years of age and older.

These screenings will enable early intervention and treatment for people with mental health and substance abuse issues, including those at risk. Staff training will be a key component for the successful implementation of the screening process. Front office staff and medical assistants will train to initiate screenings, initiate algorithms of care and assist PCPs with specialty referrals when screening results warrant additional resources.

TRMC will improve the care for the target population by collaborating with TRMC Emergency Department to replicate implementation of behavioral health screening tools. Coordinated care efforts for patients with positive screenings in the ED will facilitate post ED follow-up in Ambulatory care. Collaboration with inpatient staff will ensure an effective warm hand off and referral process from the Emergency Department to Ambulatory care. The Ambulatory care team will then have the opportunity to assess and address both behavioral and physical needs of the patient and consequently see improvements in health outcomes.

The integration of tele-psychiatry into the primary care arena will facilitate the delivery of care for empaneled patient and those without a medical home or designated primary care provider; including patients referred from TRMC Emergency Department for psychiatric consults. Collaboration with community partners such as CTN (California Telehealth Network) will assist TRMC in the implementation phase of the tele-psych program. CTN will also facilitate staff training; provide recommendations as well as resources of telehealth provider groups.

The expansion of the care team and maximization of roles and responsibilities will support a well-orchestrated delivery model of care and increase staff engagement. Collaboration with organizations such as NAMI (National Allegiance on Mental Illness) will incorporate non-traditional interventions in the form of patient advocacy, education, empowerments and peer support groups. Such resources will be facilitated by various members of the care team for the benefit of our target population.

All Patients age 18 and older who have had at least two clinical visits within the last two years.

The general target population for projects 1.1, 1.2, 1.4, 1.5 is the patient population over age 18 that has had at least two clinical visits within the last two years. For Project 2.5, the target population is current incarcerated adult (over age 18) who are scheduled for release into the general population within 60 days.

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

Check, if applicable	Description of Core Components	
Applicable	**1.1.1**	Implement a behavioral health integration assessment tool (baseline and annual progress measurement)

Check, if applicable	Description of Core Components
Not Applicable	**1.1.2** Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration, the Collaborative Care Model, or other Integrated Behavioral Health (IBH) resources from SAMHSA)
Applicable	**1.1.3** Integrate appropriate screening tools and decision support into the emergency department (ED) to ensure timely recognition of patients with mental health and substance use disorder problems. Enhanced access to primary care and/or to behavioral health specialists will be integrated into discharge planning for these patents. Use of 24-7 care navigators (e.g., Community Physician Liaison Program) may be used to support linkages to primary care providers (PCPs), mental health (MH) and substance use disorder (SUD) specialists and behavioral health and other community services through the discharge process.
Not Applicable	**1.1.4** Integrate physical and behavioral health, either through implementation of a new program or an expansion of an existing program, from pilot sites to hospital and health system primary care sites or from single populations to multiple populations (e.g., obesity, diabetes, maternal, infant, and child care, end-of-life care, chronic pain management).
Applicable	**1.1.5** Patient-Centered Medical Home (PCMH) and behavioral health providers will: • Collaborate on evidence based standards of care including medication management and care engagement processes. • Implement case conferences/consults on patients with complex needs.
Applicable	**1.1.6** Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families.
Applicable	**1.1.7** Ensure systems are in place to support patient linkages to appropriate specialty physical, mental and SUD services. Preventive care screenings, including behavioral health screenings (e.g., PHQ-2, PHQ-9, SBIRT), will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including the provision of brief interventions (e.g., motivational interviewing techniques) to ensure access for further evaluation and treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.

Check, if applicable	Description of Core Components
Applicable	**1.1.8** Provide cross-systems training to ensure effective engagement with patients with MH/SUD conditions. Ensure that a sufficient number of providers are trained in SBIRT and/or in other new tools used by providers to ensure effectiveness of treatment.
Not Applicable	**1.1.9** Increase access to Medication Assisted Treatment (MAT) for patients with alcohol and opioid addiction to assist in stabilizing their lives, reducing urges or cravings to use, and encourage greater adherence to treatment for co-morbid medical and behavioral health conditions. For alcohol use disorders these medications include naltrexone, acamprosate, and disulfiram. For opioid addiction, medication assisted treatment (MAT) includes maintenance treatment with methadone and buprenorphine.
Not Applicable	**1.1.10** Ensure the development of a single treatment plan that includes the patient's behavioral health issues, medical issues, substance abuse, social and cultural and linguistic needs. This includes incorporating traditional medical interventions, as well as non-traditional interventions such as gym memberships, nutrition monitoring, healthy lifestyle coaching, or access to culturally and linguistically appropriate peer-led wellness and symptom management groups.
Applicable	**1.1.11** Ensure a culturally and linguistically appropriate treatment plan by assigning peer providers or other frontline worker to the care team to assist with care navigation, treatment plan development and adherence.
Applicable	**1.1.12** Ensure that the treatment plan: • Is maintained in a single shared Electronic Health Record (EHR)/ clinical record that is accessible across the treatment team to ensure coordination of care planning. • Outcomes are evaluated and monitored for quality and safety for each patient.
Applicable	**1.1.13** Implement technology enabled data systems to support pre-visit planning, point of care delivery, care plan development, population/panel management activities, coordination and patient engagement. Develop programs to implement telehealth, eReferral/eConsult to enhance access to behavioral health services.
Not Applicable	**1.1.14** Demonstrate patient engagement in the design and implementation of the project.

Check, if applicable	Description of Core Components
Applicable	**1.1.15** Increase team engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on care model.
Not Applicable	**1.1.16** Ensure integration is efficient and providing value to patients by implementing a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

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

TRMC's approach to redesign primary care will utilize the NCQA's PCMH (Patient Centered Medical Home) program framework and recognition requirements to lead improvement efforts. Since one primary goal of a PCMH is relationship building between the patient and the care team in order to better meet the needs of the patient, evaluation and full revamp of existing practices is imperative to successfully achieve this objective. Of equal importance is the opportunity to improve patient and provider experience, improve quality of care and reduce cost through coordinated care.

TRMC's planned approach to redesign Ambulatory Care will focus on these main areas:

Enhance Access and Continuity**:** TRMC will build the necessary infrastructure to ensure access to care, for both routine and urgent needs, at all times. Offering extended hours beyond the traditional 8am to 5pm schedule for in-person encounters will be a starting point. Identifying alternatives to in person encounters during non-business hours will likely be accomplished through the use of an afterhours exchange or nurse triage services. And to leverage the capabilities of modern technology, TRMC will create a patient portal that will allow communication between patients and PCPs, give patients the ability to access their own health information and request appointments electronically.

Population Health Management, Care**:** TRMC will implement a population management system (i2iTracks) that will transform the manner in which care needs are identified, coordinated and tracked for the larger population of patients. Based on clinical data, health assessments and evidence-based guidelines, care teams will proactively identify patients in need of specific care; basic preventive care such as annual assessments, cancer screenings and immunizations among others, and/or those with certain chronic disease in need of follow-up.

Track and Coordinate Care**:** TRMC will improve the quality of care for patients through effective care coordination and intentional organization of patient care activities; tracking of orders, tests and results, referrals and proper follow- up. As we transition in a few

months to a new and robust Electronic Health Record we will set up the system to support effective care coordination between facilities and specialty care. Functionalities such as flagging of abnormal lab and imaging results will be essential system set ups. Reporting of such results to trigger action by the care team will also be an area of focus. This will support prompt follow-up and reporting of results to patients.

Referral Managers and Care coordinators will be instrumental in facilitating care for patients in need of services outside of the medical home. Areas of focus will include facilitating delivery of care and services by mental health entities and other community resources such as substance abuse programs.

Coordinated Care, Panel and Referral Management: The TRMC primary care team will expand to include promotoras (aka outreach workers) and care coordinators. These roles are essential to better organize patient care activities, ensure prompt follow-up to specialty referrals and clarify questions patients may have - reason for the referral, how to make an appointment for specialty services and what to expect following a specialty visit. In addition to these duties, promotoras and care coordinators will fulfill panel management functions. Through the use of a robust population management system such as i2iTracks, staff will be able to readily access data that identifies patients in need of basic preventive care such as cancer screenings and immunizations. i2i Tracks will facilitate outreach for patients in need of services of which they may not be aware.

Through this project TRMC will improve the care for the target population by addressing both chronic and preventive care needs in a cost effective, efficient and patient-centered manner that requires a team based approach where the skillset and talents of every member of the team are maximized. As the number of insured Californians continues to increase, TRMC will need to expand access to care by expanding service sites/medical homes. This will require the shift in focus from a provider-driven care model to a multidisciplinary team model, which supports provider efforts while also working directly with the patients to meet the individual's distinct needs. To support expansion of primary care services, to maintain staff and patient satisfaction, and to see improved health outcomes, staff roles and the care delivery model will change. There will be shared responsibilities in the management of patient care with a keen focus on coordination of care. A robust electronic heath record and population management system will be tools used to organize daily clinic activities and in reach and outreach activities, among other things. This organized delivery system will benefit the patients and improve outcomes because vulnerable populations will be prompted by the care team to receive care that they do not realize is needed. Having a parallel focus on prevention and evidence-based disease management, and with the implementation of a patient-centered medical home care model requiring the redesign of primary care, TRMC will positively impact health outcomes for residents of Tulare and surrounding areas. This will result in reducing the incidence of chronic disease and reducing disparities in care for this population.

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

Check, if applicable	Description of Core Components
Applicable	**1.2.1** Conduct a gap analysis of practice sites within the DPH/DMPH system.
Applicable	**1.2.2** Primary care practices will demonstrate advancement of their PCMH transformation through the use of a nationally-recognized PCMH methodology.
Applicable	**1.2.3** Hiring and training of frontline workforce (e.g., medical assistants, community health workers, promotoras, health navigators or other non-licensed members of the care team) to be responsible for coordination of non-clinical services and elements of the care plan.
Applicable	**1.2.4** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population/panel management activities, care coordination, patient engagement, and operational and strategic decisions including a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. • Implementation of EHR technology that meets meaningful use (MU) standards.
Applicable	**1.2.5** Ongoing identification of all patients for population management (including assigned managed care lives): • Manage panel size, assignments, and continuity to internal targets. • Develop interventions for targeted patients by condition, risk, and self-management status. • Perform preventive care services including mental health and substance misuse screenings and brief interventions (e.g., PHQ-9, SBIRT).
Applicable	**1.2.6** Enable prompt access to care by: • Implementing open or advanced access scheduling. • Creating alternatives to face-to-face provider/patient visits. Assigning frontline workers to assist with care navigation and non-clinical elements of the care plan.
Applicable	**1.2.7** Coordinate care across settings: • Identification of care coordinators at each primary care site who are responsible for coordinating care within the PCMH as well as with other facilities (e.g., other care coordinators or PCMH/DPH/DMPH high risk care managers): o Establish onsite care/case managers to work with high risk patients and their care teams, or develop processes

Check, if applicable	Description of Core Components
	for local care coordinators to work with a central complex care management program for these patients Implement processes for timely bi-directional communication and referral to specialty care (including mental health and substance use disorder services), acute care, social services and community-based services.
Applicable	**1.2.8** Demonstrate evidence-based preventive and chronic disease management.
Applicable	**1.2.9** Improve staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the team-based care model to ensure effective and efficient provision of services (e.g., group visits, medication reconciliation, motivational interviewing, cognitive behavioral therapy and Medication-Assistance Treatment (MAT)).
Not Applicable	**1.2.9** Engage patients using care plans, and self-management education, and through involvement in the design and implementation of this project.
Applicable	**1.2.11** Improve the accuracy and completeness of race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI) data, and use that data to identify and reduce disparities in one or more Primary Care Redesign project metrics by: • Adding granular REAL and SO/GI data to demographic data collection processes and training front-line/registration staff to gather complete and accurate REAL/SO/GI data. • Developing capacity to track and report REAL/SO/GI data, and data field completeness. • Implementing and/or refining processes for ongoing validation of REAL/SO/GI data. • Developing capacity to stratify performance metrics by REAL/SO/GI data and use stratified performance data to identify disparities for targeted interventions. • Developing capacity to plan and implement disparity reduction interventions with input from patients and community stakeholders. • Developing dashboards to share stratified performance measures with front-line staff, providers, and senior leadership.

Check, if applicable	Description of Core Components
Applicable	**1.2.12** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

☒ 1.4 – Patient Safety in the Ambulatory Setting

TRMC has selected this project because it recognizes that there is a prevalent need in healthcare to identify and implement effective standardized guidelines. These guidelines are essential in promoting and ensuring the safety of our target population, patients 18 years of age and older receiving primary care services in ambulatory, as it pertains to 1) handling of abnormal lab results-both diagnostic imaging and laboratory testing, and 2) monitoring of medication regimen for those adults on persistent medications. Historically, patient safety improvement efforts have primarily focused on and addressed inpatient needs. In Ambulatory there are added complexities that require distinct approaches. Nonetheless, the consequences of poor communication, a lack of effective workflows, missed or delayed interventions or follow-up all have a direct impact on patient outcomes, particularly in regards to those individuals with one or more chronic conditions.

TRMC will take the following design and implementation approaches to address Patient Safety issues in Ambulatory:

Policy and Procedure: TRMC will create policies that outline consistent reporting practices for abnormal test results. These will follow recommendations by the American College of Radiology's Actionable Findings Workgroup for reporting of abnormal diagnostics and their recommendations and classification of "actionable findings"; category 1, category 2 and category 3. Training of the entire care team to clearly understand and consistently adhere to these policies is inherent.

Medication Reconciliation: Processes will be put in place to hardwire medication reconciliation, the process of identifying the most accurate list of medications and doses the individual is taking. Staff will be trained to initiate the process at the time of intake for each clinic visit, following clearly identified workflows. Appointment letters and telephone reminders will direct individuals to present medication bottles to every clinic visit. This practice will help the care team identify inconsistent medication regimens that are frequently evident with transitions of care, when individuals have a language or literacy deficit, or when the individual is faced with other barriers that prevent him/her from adhering to the prescribed regimen.

Leverage Technology: In the next few months TRMC will transition to a new and robust EHR. Ambulatory leadership will work closely with the build and implementation team to include processes that support patient safety. TRMC will optimize technology for electronic communication of diagnostic test results and better management of these

results. Functionalities such as patient alerts and decision support to flag contraindicated medications will be embedded in the system. Furthermore, Leadership will work towards having a direct feed for lab results into the EHR, a system set up that is not available with the current EHR. The use of a population management system such as i2i Tracks will also be utilized to track, identify and reach out to individuals in need of future follow-up care.

TRMC will improve the care for the target population because TRMC is committed to dedicating the required resources to make necessary improvements to mitigate the safety issues related to test results in Ambulatory. Safety issues in this setting have not received the required attention that is warranted. Consequently, we have seen numerous cases of individuals who have fallen through the cracks as a result of these gaps in care and suffered poor outcomes. Improvements set forth that are clearly monitored, proven to be effective in yielding the desired positive results and consequently sustained, will contribute to a more effective health care system and overall population health. In essence, the improvements set forth to improve better management of the target population will support the Triple Aim. As described by the Institute of Healthcare Improvement, this model of care identifies three goals of equal importance that must be equally balanced to achieve an optimal care delivery system: simultaneously improving the health of the population, enhancing the experience and outcomes of the patient (improved quality and satisfaction), and reducing per capita cost of care.

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

Check, if applicable	Description of Core Components
Not Applicable	**1.4.1** Perform a baseline studies to examine the current workflows for abnormal results follow-up and monitoring of individuals on persistent medications.
Applicable	**1.4.2** Implement a data-driven system for rapid cycle improvement and performance feedback based on the baseline study that effectively addresses all identified gaps in care and which targets clinically significant improvement in care. The improvement and performance feedback system should include patients, front line staff from testing disciplines (such as, but not limited to, radiology and laboratory medicine) and ordering disciplines (such as primary care) and senior leadership.
Applicable	**1.4.3** Develop a standardized workflow so that: • Documentation in the medical record that the targeted test results were reviewed by the ordering clinician.

Check, if applicable	Description of Core Components
	• Use the American College of Radiology's Actionable Findings Workgroup[1] for guidance on mammography results notification. • Evidence that every abnormal result had appropriate and timely follow-up. Documentation that all related treatment and other appropriate services were provided in a timely fashion as well as clinical outcomes documented.
Applicable	**1.4.4** In support of the standard protocols referenced in #2: • Create and disseminate guidelines for critical abnormal result levels. • Creation of protocol for provider notification, then patient notification. • Script notification to assure patient returns for follow up. Create follow-up protocols for difficult to reach patients.
Applicable	**1.4.5** Implement technology-enabled data systems to support the improvement and performance feedback system as well as engage patients and support care teams with patient identification, pre-visit planning, point of care delivery, and population/panel management activities.

☒ 1.5 – Million Hearts Initiative

In the United States heart attacks cause 122,000 deaths each year and continue to be leading cause of death for both men and women. Coronary artery disease is the most common type of heart disease, causing nearly a 100,000 deaths each year and is associated with risk factors such as high blood pressure, high LDL, and smoking. Hundreds of thousands of Americans survive heart attacks and strokes, but they may suffer lasting damage and reduced quality of life. The Centers for Disease and Prevention (CDC) estimates that more than 200,000 deaths from heart disease and stroke could be prevented each year.

Tulare County has a death rate of 202% due to coronary heart disease per 100,000. More than 29% of adults 18 and older have high blood pressure or hypertension. In addition, 3% of adults in this service area have coronary heart disease or angina.

TRMC selected this project because through the Million Hearts Initiative we intend to have a positive impact in the lives of our target population, adults 18 years of age and older with specific risk factors such as high blood pressure, high LDL and smoking that

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

when left untreated can contribute to the development of coronary heart disease. For residents in our community who do need care, professionals can harness the power of health information technology and deploy new models of care that educate patients about their condition and the ABCS of heart health (**A**spirin when appropriate, **B**lood pressure control, **C**holesterol management, and **S**moking cessation).

TRMC will successfully meet Million Heart goals by educating clinicians in the use of evidence based guidelines for the prevention and treatment of high blood pressure and hyperlipidemia. An EHR decision support system will facilitate next levels of care for at risk patients, as well as those in need of a treatment regimen. Furthermore, the care team will utilize standing orders that guide them with routine assessments-blood pressure and lipid levels. In addition, assessing smoking status will be incorporated into the intake process at each primary care visit. Smoking cessation resources and educational material describing the effects of smoking on cardiovascular health will be distributed to active smokers.

TRMC can achieve sustainable prevention of heart disease and stroke through innovative collaborative efforts like Million Hearts.

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

Check, if applicable	Description of Core Components
Applicable	**1.5.1** Collect or use preexisting baseline data on receipt and use of targeted preventive services, including any associated disparities related to race, ethnicity or language need.
Applicable	**1.5.2** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to the US Preventive Services Task Force (USPSTF) A and B Recommendations.
Applicable	**1.5.3** Improve access to quality care and decrease disparities in the delivery of preventive services.
Applicable	**1.5.4** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
Applicable	**1.5.5** Adopt and use certified electronic health record systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population management approaches (e.g., in-reach, outreach) to reduce gaps in receipt of care.

Check, if applicable	Description of Core Components
Not Applicable	**1.5.6** Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.
Applicable	**1.5.7** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. • Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts.
Applicable	**1.5.8** Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.

☒ 1.6 – Cancer Screening and Follow-up

This project was selected by TRMC because of the high percentages of cervical, breast and colon cancer as described in Section 2.1. TRMC is under the belief that screenings for cancer has either been delayed beyond the USPSTF recommended intervals, has not been offered or patients have not been made aware of the importance of early detection. Therefore, following USPSTF recommended time frames and NCQA PCMH Section 6, Factor 2, TRMC will use the outline of aims below to identify, outreach, inform, provide care or refer as appropriate all adult patients within the PCMH. This will improve disparate health conditions that prevent Tulare from being the best in class for cancer screening. Currently staff has had little training in prompting referrals for these preventative screenings. Protocols will be developed to assure all eligible candidates are referred and through the use of i2i Tracks, technology will be leveraged to manage referrals and patient compliance. Reports driven from i2i Tracks will be utilized by staff to conduct both in reach and outreach to patients who have fallen out of the recommended parameters. TRMC will demonstrate a marked improvement in cancer screening due to these efforts in the PRIME Project. Increased focus on prevention and timely screenings will lower end costs associated with these cancers and ultimately create a healthier population with a better quality of life.

Care Team Training-All care team members including physicians, mid-level providers, nursing and medical assistants will be educated to recognize time intervals, age requirements and risk factors necessary that meet screening criteria for specific cancers- breast, cervical and colon cancers. While the target population includes all patients 18 years of age and older, screening criteria will be enforced as per the recommendations of USPSTF recommended screening intervals.

These recommendations are as follows:

- Breast Cancer Screening: biennial screening mammography is recommended for women aged 50-74. Women who are at average risk for breast cancer should be screened at a younger age. See USPSTF guidelines for details.
- Cervical Cancer Screening: screening is recommended for women age 21 to 65 with cytology (Pap smear) every 3 years, or for women 30 to 65 years of age with a combination of cytology and HPV testing every 5 years. See USPSTF guidelines for details.
- Colon Cancer Screening: screening is recommended starting at 50 years and continuing until age75. Risk factors must be considered when determining screening need for patients with less than 50 years of age and 76 years and older. See USPSTF guidelines for details.

Identifying needs: An initial gap analysis will be completed in DY 11. This will be done through the current system, Nextgen, and will continue to be monitored monthly in DY 12 and thereafter through reporting capabilities in i2iTracks.

Referral Process: Referrals for screening colonoscopy and mammography may be initiated by the medical assistant or provider during a patient visit. Additionally, panel managers will provide in reach to patients that have been identified on reports from i2iTracks as being due for preventative maintenance in these areas. Panel managers and patient navigators will then outreach these patients via phone, text or mail to encourage patient engagement. Standing orders will be developed to assure that barriers to preventative screenings are reduced. This will be continuously monitored to assure patient compliance and support data integrity as reported through i2iTracks.

Outreach: TRMC will use patient navigators and panel managers to perform in reach to established patients. Promotoras will be used to present materials on cancer screening weekly at the local Flea Market to the general public. TRMC will engage in October Breast Cancer Awareness month activities and will promote those activities through our Marketing Department.

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

Check, if applicable	Description of Core Components
Applicable	**1.6.1** Develop a multi-disciplinary cross-participating PRIME entity task force to identify principle-based expected practices for screening and follow-up for the targeted services including, but not limited to: • Standard approach to screening and follow-up within each DPH/DMPH. • Screening: o Enterprise-wide standard approach to screening (e.g., ages, frequency, diagnostic tool).

Check, if applicable	Description of Core Components
	• Follow-up for abnormal screening exams: o Clinical risk-stratified screening process (e.g., family history, red flags). Timeliness (specific time benchmark for time from abnormal screening exam to diagnostic exam).
Not Applicable	**1.6.2** Demonstrate patient engagement in the design and implementation of programs.
Applicable	**1.6.3** Collect or use preexisting baseline data on receipt and use of targeted preventive services, including any associated disparities related to race, ethnicity or language need.
Applicable	**1.6.4** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to USPSTF A and B Recommendations.
Applicable	**1.6.5** Improve access to quality care and decrease disparities in the delivery of preventive services.
Applicable	**1.6.6** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
Applicable	**1.6.7** Adopt and use certified electronic health record systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population management approaches (e.g., in-reach, outreach) to reduce gaps in receipt of care.
Applicable	**1.6.8** Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.
Applicable	**1.6.9** Implement a system for continual performance management and rapid cycle improvement that includes feedback from patients, community partners, front line staff, and senior leadership.

Please complete the summary chart:

	For DPHs	For DMPHs
Domain 1 Subtotal # of DPH-Required Projects:	**3**	**0**
Domain 1 Subtotal # of Optional Projects (Select At Least 1):		**5**
Domain 1 Total # of Projects:		**5**

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

☒ 2.5 – Transition to Integrated Care: Post Incarceration

According to the Public Policy Institute of California (publication April 2015) between 1990 and 2013, the share of prisoners 50 and older grew from 4% to 21%. Since aging populations as a whole tend to have greater health issues, it is expected that a substantial number of these incarcerated individuals suffer from at least one chronic disease. It is also known that the incarcerated population tends to have more serious physical and behavioral health conditions when compared to non-incarcerated populations. For these reasons TRMC will allocate resources to create an effective care transition program for the target population, adults 18 years of age and older due to be released from the Tulare County jail. We will work with the Tulare County jail and other community partners to facilitate health care services for those soon to be released, particularly those who reside or remain in Tulare County after their release.

TRMC's design approach to Transitions to Integrated Care: Post Incarceration includes the following:

Enrollment for health care coverage: TRMC will hire an outreach worker/care coordinator to work with County personnel in facilitating the application and enrollment process for parolees in need of health care coverage, and possibly initiate the process prior to their release from jail. If the medical enrollment process is maintained by County personnel, the outreach worker will work collaboratively to support the existing processes. Individuals in need of, or in the process of, obtaining medical coverage will be assigned to the outreach worker to monitor the process and subsequently introduce these individuals to a TRMC medical home. Individuals who do not quality for coverage will be introduced to a TRMC medical home as a self-pay patient.

Pre and post case management: TRMC's outreach worker/care coordinator will work with the jail's medical and/or care coordination team to ensure a seamless system of care from pre to post incarceration in order to maximize results. The goal of TRMC will be to 1) introduce the individual to a medical home that is convenient to their area of residence within Tulare County, 2) facilitate appointment(s) to establish care with a primary care provider, 2) educate the individual about services offered by TRMC including mental health and Specialty, 3) offer community resources such as alcohol and drug programs, employment and housing, all in an effort to reduce recidivism, decrease preventable acute care utilization, and avoid alcohol and drug use.

Care Coordination/ panel management**:** After an individual has established care with a PCP they will be assigned to an outreach worker/care coordinator who will help identify preventive care needs. Through the use of a population management system (i2iTracks) preventive care needs such as immunizations and routine cancer screenings will address augmenting the PCP and the care team efforts to maintain good health.

This project will enable TRMC to improve the care for the target population by addressing core components of care that in the absence of a transition of care program

have been poorly managed, and continuously contribute to high health care costs and poor health outcomes. Avoidable overutilization of resources for issues that can be managed in a primary care setting must be controlled. Having a workforce dedicated to directing healthcare activities of this target population is instrumental. Hiring and training staff to carry out transition of care activities such as those described above, with care coordination and population management as main responsibilities to improve outcomes is key. Furthermore, since TRMC has adopted the framework of NCQA's PCMH program to direct primary care improvement activities, post incarceration care will include a whole person and patient-centered approach. By establishing care within a TRMC medical home individuals will receive full medical and behavioral health needs assessments to include but not limited to PHQ and SBIRT screenings. Through the use of evidence-based guidelines the medical team will reduce risk factors and ensure appropriate follow up of chronic disease. The medical home will leverage technology to implement systems that enhance existing analytics making to will pre-visit planning, population management activities and care coordination feasible.

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

Check, if applicable	Description of Core Components
Applicable	**2.5.1** Develop a care transitions program for those individuals who have been individuals sentenced to prison and/or jail that are soon-to-be released/or released in the prior 6 months who have at least one chronic health condition and/or over the age of 50.
Applicable	**2.5.2** Develop processes for seamless transfer of patient care upon release from correctional facilities, including: • Identification of high-risk individuals (e.g., medical, behavioral health, recidivism risk) prior to time of release. • Ongoing coordination between health care and correctional entities (e.g., parole/probation departments). • Linkage to primary care medical home at time of release. • Ensuring primary care medical home has adequate notification to schedule initial post-release intake appointment and has appropriate medical records prior to that appointment, including key elements for effective transition of care. • Establishing processes for follow-up and outreach to individuals who do not successfully establish primary care following release. • Establishing a clear point of contact within the health system for prison discharges.
Applicable	**2.5.3** Develop a system to increase rates of enrollment into coverage and assign patients to a health home, preferably prior to first medical home appointment.

Check, if applicable	Description of Core Components
Applicable	**2.5.4** Health System ensures completion of a patient medical and behavioral health needs assessment by the second primary care visit, using a standardized questionnaire including assessment of social service needs. Educational materials will be utilized that are consistent with the cultural and linguistic needs of the population.
Applicable	**2.5.5** Identify specific patient risk factors which contribute to high medical utilization Develop risk factor-specific interventions to reduce avoidable acute care utilization.
Not Applicable	**2.5.6** Provide coordinated care that addresses co-occurring mental health, substance use and chronic physical disorders, including management of chronic pain.
Not Applicable	**2.5.7** Identify a team member with a history of incarceration (e.g., community health worker) to support system navigation and provide linkages to needed services if the services are not available within the primary care home (e.g., social services and housing) and are necessary to meet patient needs in the community.
Applicable	**2.5.8** Evidence-based practice guidelines will be implemented to address risk factor reduction (e.g., immunization, smoking cessation, screening for HCV, trauma, safety, and overdose risk, behavioral health screening and treatment, individual and group peer support) as well as to ensure appropriate management of chronic diseases (e.g., asthma, cardiovascular disease, COPD, diabetes).
Applicable	**2.5.9** Develop processes to ensure access to needed medications, DME or other therapeutic services (dialysis, chemotherapy) immediately post-incarceration to prevent interruption of care and subsequent avoidable use of acute services to meet those needs.
Applicable	**2.5.10** Engage health plan partners to pro-actively coordinate long-term care services prior to release for timely placement according to need.
Not Applicable	**2.5.11** Establish or enhance existing data analytics systems using health, justice and relevant community data (e.g., health plan data), to enable identification of high-risk incarcerated individuals for targeted interventions, including ability to stratify impact by race, ethnicity and language.

Check, if applicable	Description of Core Components
Not Applicable	**2.5.12** Implement technology-enabled data systems to support pre-visit planning, point-of-care delivery, population/panel management activities, care coordination, and patient engagement, and to drive operational and strategic decisions including continuous QI activities.
Not Applicable	**2.5.13** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff, and senior leadership.
Not Applicable	**2.5.14** Improve staff engagement by: • Implementing a model for team-based care in which staff performs t of their abilities and credentials. • Providing ongoing staff training on care model. • Involving staff in the design and implementation of this project.
Not Applicable	**2.5.15** Engage patients and families using care plans, and self-management education, including individual and group peer support, and through involvement in the design and implementation of this project.
Applicable	**2.5.16** Participate in the testing of novel metrics for this population.

Please complete the summary chart:

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

Section 5: Project Metrics and Reporting Requirements

Each project includes a required set of metrics, as specified in Attachment Q: PRIME Project and Metrics Protocol. All of the metrics for the required and selected projects must be reported each demonstration year (DY) in compliance with Attachment Q.

Participating entities must report and include baseline data for all relevant project metrics and will identify data sources, consolidating data from multiple inpatient and ambulatory systems, and including data on assigned lives reported from health plans reporting on this data semi-annually. Report submissions must include the numerator and denominator data for each of the metrics for which the entity is seeking payment under PRIME. A PRIME participating entity may provide estimates or reasonable projections if particular data is unavailable due to circumstances beyond the PRIME entity's control, including data that is collected and maintained by an external entity, such as an MCP, which has not been provided to the participating PRIME entity in a timely and accurate manner.

DPHs are required to strengthen data and information sharing with MCPs under the PRIME. To support this requirement, DHCS will establish data and information sharing guidelines and/or mechanisms, which DPHs and DMPHs must follow, consistent with applicable state and federal data privacy and security law, to provide for timely sharing of beneficiary data, assessment, and treatment information, for purposes of identifying and treating the beneficiary for PRIME and Whole-Person Care (WPC). DPHs must demonstrate establishment of new and/or strengthened data and information sharing with MCPs during the demonstration. In particular, the following must occur: reporting of complete, accurate, reasonable and timely reporting of encounter data; sharing of treatment and assessment data for care coordination purposes; and, establishment of processes and infrastructure to support MCP achievement of quality improvement efforts when aligned with PRIME projects.

☒ I understand and accept the responsibilities and requirements for reporting on all metrics for required and selected projects

Section 6: Data Integrity

Each PRIME participating entity must establish and adhere to a data integrity policy throughout the execution of the PRIME Program. Participating entities must be able to verify that all fiscal, clinical, and quality improvement work for which a metric claim is reported. State and federal officials reserve the right to require additional substantiation or verification of any data claim or related documentation and may conduct periodic audits when indicated.

☒ I understand and accept the responsibilities and requirements for establishing and adhering to a data integrity policy.

Section 7: Learning Collaborative Participation

All PRIME participating entities are encouraged to actively participate in learning collaboratives that will be launched by DHCS or their designees for purposes of providing technical assistance and information exchange opportunities as PRIME implementation gets underway. At a minimum, each PRIME participating entity is required to participate in at least one face-to-face statewide learning collaborative per PRIME year. Please acknowledge your understanding and acceptance of this responsibility below.

☒ I understand and accept the responsibility to participate in-person at the annual statewide collaborative.

Section 8: Program Incentive Payment Amount

Please indicate the total computable PRIME incentive payment amount for this 5-year plan, consistent with the PRIME Funding and Mechanics Attachment:

Total computable 5-year PRIME plan incentive payment amount for:

- DY 11 $ 6,120,000
- DY 12 $ 6,120,000
- DY 13 $ 6,120,000
- DY 14 $ 5,508,000
- DY 15 $ 4,681,800

Total 5-year prime plan incentive amount: $ 28,549,800

Section 9: Health Plan Contract (DPHs Only)

DPHs are required to commit to contracting with at least one Medi-Cal managed care health plan (MCP) in the MCP service area that they operate using alternative payment methodologies (APMs) by January 1, 2018.

☐ I understand and accept the responsibility to contract with at least one MCP in the service area that my DPH operates no later than January 1, 2018 using an APM.

Section 10: Certification

☒ I hereby certify that all information provided in this Plan is true and accurate to the best of my knowledge, and that this plan has been completed based on a thorough understanding of program participation requirements as specified in Attachment Q and Attachment II of the Waiver STCs.

Appendix- Infrastructure Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
1.	Develop uniform care plans for Behavioral Health and Chronic Disease Management	• Review all standardized recommendations • Develop processes • Develop templates	1.1, 1.2, 2.5	July 2016-Dec 2016
2.	Develop staff training on new process protocols	• Develop training modules • Schedule and conduct trainings • Assess effectiveness of trainings	1.1, 1.2, 1.6, 1.4, 1.5, 2.5	July 2016-March 2017
3.	Collect baseline data on clinic patients over the age of 18 who have had at least two clinical visits within the last two years	• Review current data collection methods • Conduct gap analysis	1.1, 1.2, 1.5	July 2016-June 2017
4.	Introduce new processes and pathways for addressing preventative care, chronic disease management and follow up.	• Conduct staff training • Assess training effectiveness • Process Implementation	1.1, 1.2, 1.4, 1.6, 1.5, 2.5	July 2016-June 2017
5.	Purchase and implement Cerner and i2i technology platforms	• Implement Cerner EHR • Conduct staff training • Deploy solutions	1.1, 1.2, 1.4, 1.6, 1.5, 2.5	July 2016-Dec 2016

Work Cited

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