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	Antelope Valley District Hospital/Antelope Valley Hospital
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.

Physical Health. The most significant health care needs facing the Antelope Valley community are chronic illnesses relating to obesity and diabetes, coronary heart disease and respiratory diseases. Other significant needs are for prenatal care and cancer screenings.

- Coronary heart disease is the leading cause of death in Antelope Valley with a death rate of 182.7 per 100,000 residents. A major contributing factor is that within the community, 29% of the population has been diagnosed with hypertension.
- Roughly 35% of adults in Antelope Valley are currently obese as well as 20.3% of middle school-aged children. The age-adjusted death rate for diabetes is 40.6 per 100,000 population.
- The death rate for COPD/emphysema is 78.8 per 100,000 population and is the second leading cause of death in Antelope Valley.
- Only 66.7% of mothers receive prenatal care during their pregnancy. More than 8% of births have a low birth rate, and it is disproportionately higher for African Americans. Additionally, Antelope Valley has a very high rate of teen births.
- Cancer screening rates are lower than LA County averages for both pap smears and mammograms. The breast cancer death rate among females is 22.2 and the death rate for colorectal cancer in males and females is 19.6 per 100,000 population.

Behavioral Health. Mental health is a significant concern for the population of Antelope Valley especially because the rates of depression and anxiety are much higher than Los Angeles County as a whole. Depression affects 12.6% of Antelope Valley and only 8.3% of LA County. Similarly, 15.9% of Antelope Valley residents have been diagnosed with anxiety compared to only 11.3% in LA County. Another telling factor of the high rate of mental health disorder is that the second leading cause of premature death in Antelope Valley is by suicide. At AVH, providers are often faced with the reality that there is extremely limited capacity to treat behavioral health in the valley, which often results in patients staying in the ER for extended periods of time because they do not have behavioral health crisis resources readily available to them.

Health Disparities. Poor health outcomes in Antelope Valley are disproportionately distributed by race and ethnicity with over 40% of African Americans reporting being in poor health compared to just 20% of the general population. Chronic illness disproportionately affects the African American population with over 21% having been diagnosed with diabetes compared to 9% of all adults. The highest rates of depression and anxiety are both found in the white female population with a gap of at least 4%.

Coverage. In 2013 in Antelope Valley, 20% of adults and less than 5% of children are uninsured.

Citations listed in Appendix B.

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.

Antelope Valley Hospital serves as the leading health care provider for a mostly rural community of the Antelope Valley Health District. Antelope Valley has roughly 390,938 residents living primarily within two cities, Lancaster and Palmdale.

Income. The median household income in Antelope Valley is $57,423 though incomes are significantly higher for white ($68,498) and Asian ($76,263) than for African American ($43,034) and Latino households ($49,352). Additionally, 19% of the Antelope Valley population lives below 100% of the Federal Poverty Line, with 32% of African Americans and 22% of Latinos. Antelope Valley currently has the highest percent (17%) of unemployed adults looking for work in LA County.

Race/Ethnicity and Language Antelope Valley is a diverse community that is 44.3% Latino, 35.9% white, 15.3% African American, 4% Asian/Pacific Islander and 0.4% American Indian. Additionally, 27.3% of the population was foreign-born. The primary languages spoken at home are 76.8% English, followed by 21.6% Spanish.

Age The population in Antelope Valley is very young, with more than 30% of residents under the age of 18, and less than 10% over 65 years old. Compared to LA County with less than 25% under 18 and 10% over 65. The breakdown in Antelope Valley is as follows:

- 0-5 years: 9.4%
- 6-17 years: 21.7%
- 18-39 years: 29.4%
- 40-64 years: 31.3%
- 65+ years: 8.2%

Citations listed in Appendix B.

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.

Antelope Valley Hospital (AVH) is a not-for-profit district hospital with 420 beds serving over 200,000 patients annually as the only full-service hospital in Service Planning Area (SPA)1, which encompasses 1,500 square miles.

AVH is the only Level II Trauma Center in the area, receiving over 900 trauma cases annually and is also 1 of 16 STEMI Receiving Centers in LA County. The ED is complete with a unique Forensic Services Unit which provides 24/7 medical/legal support to victims of sexual assault, domestic abuse and violent crimes, including a contract with four State prisons. The Women and Infants Pavilion delivers more than 5,500 babies annually and is home to the only NICU in the area. AVH is partnered with City of Hope and other local oncology service providers to bring local residents cancer treatment in the recently accredited National Comprehensive Community Cancer Center at the hospital. In 2014, the Institute of Heart and Vascular Care opened, complete with two new Catheterization Labs available for use 24/7. Outpatient services include an Outpatient Imaging Center, an Outpatient Surgery Center, and Obstetrics Clinic, an Outpatient Lab and a Comprehensive Wound Healing Center. Additionally, there are six affiliated community clinics offering primary care services located throughout Antelope Valley.

In 2014, AVH's expected payer mix was: 44.5% Medi-Cal, 23.9% Medicare, 3.2% other government, 26.4% commercial and 1.7% self-pay. AVH had 98,837 emergency department visits and 24,927 inpatient discharges.

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.

Data collection. Antelope Valley reports on various quality metrics using an electronic medical record for multiple programs. The quality department gathers metric information from various stakeholders at the hospital and tracks progress to ensure continuous quality improvement. There are quality personnel who gather data from the system and through chart reviews. A challenge with determining PRIME baselines will be collecting data from various community partners who will be involved in the PRIME projects. AVH will conduct a system needs assessment to understand what data needs to be collected from what data sources, and develop robust data sharing agreements. It is not expected that our partners will be on the same EHR systems, so we predict a need to assess infrastructure for interoperability.

Reporting. AVH tracks multiple measures for reporting on existing programs and to track progress of existing initiatives. But, through PRIME, AVH will need to build reporting infrastructure for the remaining PRIME metrics. A dashboard will be developed to track PRIME project metrics regularly for comparison among practitioners and report to relevant stakeholders.

Monitoring. Currently, quality metrics are monitored on a regular basis to understand whether quality is increasing (improving), declining or maintaining. This monitoring process will be continued through PRIME as AVH tracks how the PRIME projects are influencing improvement of reported metrics.

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.*

   The following strategies are AVH's overarching goals for the coming years. AVH hopes to achieve them with PRIME but also plans to integrate PRIME into a larger strategic effort.

   1. Better management of specific high-risk, high cost patient populations
   2. Improving access to preventive care to reduce the need for acute care
   3. Increasing quality of services provided to ensure that resources are being used appropriately

   As a district hospital, the aim of AVH's participation in PRIME is to increase the influence of our hospital on our community's health overall to fulfill the mission of the district.

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.*

   To achieve the stated goals above, AVH will focus on the following aims. Antelope Valley's aims parallel and support the eight PRIME projects AVH will be undertaking. The four aims are:

1. **Developing strategic partnerships**. AVH will identify best-fit partners to help manage the continuum of care both inside and outside the hospital.
2. **Integrating behavioral health and physical health**. AVH will increase access to a variety of services through identification of opportunities to increase provider capacity and referrals.
3. **Optimizing appropriate utilization (right care, right time).** The goal of AVH is to ensure that patients receive appropriate whole-person centered primary, preventive care. This is linked to reducing unnecessary readmissions and avoidable admissions.
4. **Conducting consistent quality improvement.**

All of these aims are linked to the overall AVH mission of improving population health in the coming years for Antelope Valley residents. The organization is in a time of growth amidst a rapidly changing health care landscape, and with the PRIME projects AVH will develop the infrastructure necessary for success in managing care for the populations in its service area.

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;*

The projects selected greatly bolster the organizational goals of quality improvement, appropriate utilization, and developing community partners. The stewardship projects selected -- 3.1, 3.2, and 3.4 -- all directly focus on developing processes to improve utilization and quality of services (Aim 3). AVH will be able to reduce unnecessary healthcare costs with more appropriate usage of blood products, antibiotics and high-cost imaging. As these measures are interwoven with inpatient and outpatient management, utilizing community partnerships to improve information flow, service allocation, and processes will be paramount.

Projects 2.1, 2.2, 2.3 and 2.7 will move AVH toward developing relationships with community health providers in Antelope Valley to create care coordination efforts and synergies between healthcare stakeholders. Potential partnerships may include City of Hope, Antelope Valley Community Clinic and LA County clinic. Many of the patients who will be affected by PRIME also seek care at these community partners, and we will identify where those referral patterns and shared patients exist. Then, AVH will develop strategies to implement changes with these partners to continue to make an impact on the PRIME metrics. These projects will be successful through partnerships and improvement of care transitions. (Aim 2)

Lastly, Project 1.6 really focuses on increasing access to preventive care specifically for cancer, which can be managed if detected early. (Aim 1)

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*

All eight projects being undertaken by AVH interrelate as they aim to address the "whole person" in providing care, and work to address health from all perspectives. Some of the projects (1.6, 2.2) focus on treating patients in the ambulatory setting before an acute need to prevent late-stage cancer and complications from complex diseases through early diagnosis and treatment. However, once patients are in the hospital, projects in Domain 2 (2.1, 2.2, and 2.7) really focus on ensuring that patients receive best care, effective care transition support and palliative care as needed. Throughout this care continuum, projects in Domain 3 ensure that resources are used effectively according to evidenced-based best practices. In choosing the wide variety of projects, AVH aims to impact care at all points in the care continuum.

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 period, AVH will have made significant strides toward developing a network of care. This will begin with identifying natural strategic partners in care coordination and preventive care. This will include far more robust partnerships with post-acute care providers as well as community health care providers. Some additional aspects of transformation will include:
Clinical: Better quality care at the hospital level for antibiotic use, high-cost imaging and blood products management.
Population health: Better outcomes for targeted populations in cancer screening, perinatal care and care transitions
Finance: Contributing to the reduction in total cost of care through prevention, better management and appropriate utilization of resources.

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.

Antelope Valley has selected eight projects that will all directly address local health needs including chronic illness, cancer and prenatal care. Health needs and disparities discussed in Section 2 identified below in **bold.**

Project 1.6 directly addresses the low rates of **cancer screenings**, particularly pap smears and mammograms, as well as high death rates from **breast and colorectal cancer.** The Antelope Valley (AV) has a high disparity of cervical cancer diagnosis when compared to California and the United States average. Cervical cancer rates in the AV (10%) are higher than the state (8.3%) and the nation (8%) and Healthy People 2020 (less than or = 7). Hispanic women (13.7%) have a higher rate of cervical cancer when compared to the state (11.9%) and nation (11.8%) and White women (10.6%) when compared to the state (8.5%) and nation (7.7%). Cervical cancer risks may be decreased by having regular screenings for cervical cancer. AVH will leverage partners to provide screenings, education and other preventative activities.

Project 2.1 addresses the established need in Antelope Valley to provide **prenatal care** to more women and improve health outcomes. Of particular concern is the number of **low birth weight** newborns in the African American community.

Projects 2.2, 2.3 and 2.7 will address the need for improvements in coordinated care for chronic illnesses with high prevalence in the region, such as **heart disease**, **COPD**, **diabetes** and **mental health.** AVH will link patients with outpatient services, provide tools to self-manage conditions, and improve incorporation of patients in decision-making processes.

Projects 3.1, 3.2, and 3.4 will all address the need to improve the quality and total cost of care that patients receive at Antelope Valley Hospital while addressing prevention, chronic disease management and mental health. 3.1 will also address prevention of the emergence of resistant organisms, occurring through the utilization of optimal antimicrobial choices for appropriate durations of therapy.

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).

To be successful in PRIME, AVH will work on implementing the following infrastructure:

1. **Robust reporting workflows and mechanisms**
   As mentioned previously, Meaningful Use protocols for AVH's EHR have already been in place for several years, establishing a strong baseline for infrastructure and a reporting culture. A big portion of this interrelation is the collection, synthesis, and analysis of patient data to drive improved outcomes. AVH has made significant strides in meaningful use but still has large room for improvement in terms of diversified data collection and analysis. This will again drive the consistent strategic objective of forming partnerships with healthcare entities in the community. A meaningful partner for AVH in this space will be providers for outpatient data who will deliver services and data elements necessary to track care improvement.

2. **PRIME project owners and project management capabilities**
   AVH has some components for process improvement but will need to expand them to include project management. AVH has existing quality improvement capabilities in place currently to ensure continuous process improvement within the hospital. The quality improvement structures will be expanded to include the PRIME projects and transform with project management competencies to ensure success in the next five years.
3. **Strategic goals and initiatives**
   AVH will leverage PRIME to refine and develop additional further strategic goals and initiatives for the hospital.

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.

AVH has already begun engaging stakeholders as part of the PRIME selection. The board of AVH was integral in choosing the projects that would be most impactful on the hospital and the community, in a public session that was open to public comment on the projects. Moving forward, the PRIME planning and implementation process will involve necessary clinical partners to ensure full success in driving change. This will include community partners such as clinics, public health, county and local providers. The community will be informed of PRIME progress on a regular basis through public board meetings.

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.

AVH will be incorporating cultural competencies into all training programs related to PRIME projects. In particular for projects that will attempt to improve incorporation of the patient in the decision making process, clinicians will become well-versed in the most culturally and linguistically appropriate ways to do so. For instance, education for both the palliative care and complex care management programs will emphasize the importance of culturally competent clinicians and provide the skills and tools necessary to make the most appropriate decisions for each individual patient. Several of the projects will incorporate a needs assessment to identify health disparities in the population and will then directly address improving health outcomes of those individuals. Resources that will be crucial to ensure cultural competencies will be effective trainings and data reporting to identify 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.

Data infrastructure

With PRIME's investment, AVH will be able to bolster a fully comprehensive electronic medical record system that will be utilized for analysis and consistent quality improvements. Many of the departments within AVH have already integrated this workstream into their quality improvement initiatives, however, there are some that still need infrastructure in order to capitalize on electronic collection of data. Additionally, PRIME will incentivize the continued integration of partner organizations with Antelope Valley Hospital to gather PRIME metrics. These data workflows and sharing agreements will exist beyond the PRIME participation, and contribute to a further integration of providers.

Project management

The PRIME project management infrastructure put in place will also carry on past PRIME participation and be leveraged to continue to make improvements in the health system.

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

☒ 1.6 – Cancer Screening and Follow-up

Antelope Valley selected this project to address the high incidence of stage 3 and stage 4 cancer diagnoses, which outnumber stage 1 and stage 2 diagnoses in our hospital. The existence of our recently accredited National Comprehensive Community Cancer Center provides the Antelope Valley with partnership resources to offer local cancer treatment to our residents, but we need to identify barriers to screenings and prevention that cause high rates of late stage cancer diagnoses. Patients in Antelope Valley previously had to travel over 50 miles to LA County to receive cancer care, however AVH aims to bring cancer care locally to the community.

Our planned implementation approach includes:

- Create a standardized approach to risk assessment, the screening process as well as follow-up techniques for abnormal screenings during DY11, and prepare to implement in DY12.
- Adhere to recommended screening guidelines and integrate into protocols in DY12
- Develop partnerships with FQHCs and local providers to align AVH patients with providers for routine screenings and follow-up appointments starting in DY12.
- Conduct needs assessment in DY11 to identify disparities and utilize community prevention resources for outreach and education aimed at improving population health.
- Emphasize the role of existing nurse navigators to aid patients in accessing resources in the community and self-managing care.

Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]

Target Population. The initial target population for increased screening will include the patients of Antelope Valley Community Clinic and the LA County clinic partners. We will further target our interventions based upon identification of gaps in screenings and follow-up care trends. We intend to address our target populations both within the cancer center as well as in ambulatory settings of partnered providers in the community.

The patient population for this project is:

1. Colon cancer screening for adults between 50 and 75 years old
2. Breast cancer screening for women 50-74 years on a biannual basis
3. Cervical cancer screening every three years for women age 21 to 65

Vision for Care Delivery. PRIME will provide the opportunity to establish improvements in screening mechanisms in our community and therefore contribute to overall

improvement in health outcomes across Antelope Valley. Antelope Valley has two key objectives for this project. First, to improve upon the existing infrastructure in the AV Cancer Treatment Center and second to align these services with community providers and specific populations in need. Within our existing infrastructure, we intend to develop a standardized approach to administering cancer screenings in order to uniformly assess and report within AV. Additionally, utilizing data we will identify gaps in screening. The development of community partners is especially critical to addressing these gaps by reaching populations that are not already patients of the cancer center and providing them with preventative care.

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.

AVH will perform infrastructure metrics for this project.

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

Check, if applicable	Description of Core Components

Not 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).
	• 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.
Not 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.

Check, if applicable	Description of Core Components
Applicable	**1.6.5** Improve access to quality care and decrease disparities in the delivery of preventive services.
Not 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.
Not 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.
Not 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):		**1**
Domain 1 Total # of Projects:		**1**

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

☒ 2.1 – Improved Perinatal Care (required for DPHs)

Antelope Valley has selected this project to support our Women and Infants Pavilion which delivers more than 5,500 babies annually, and two OB Clinics. This project will be a significant opportunity to provide additional training and education to our physicians and nurses within all three locations. Antelope Valley not only has a high birth rate, but also significant rates of diabetes and hypertension as demonstrated in Section 2. This project is needed to address the potential co-morbid conditions that occur during pregnancy and ensure maternal health through delivery. Our emphasis for implementing this project will be a coordinated effort to address prenatal and postpartum care, in particular breastfeeding and the treatment of comorbidities, across all AVH locations.

Our planned implementation approach includes:

- Encourage best practices by educating physicians and nurses with the aim to lower the rate of cesarean sections and risk of obstetrical hemorrhage in DY12
- Develop a plan for coordinated care for women with chronic conditions such as diabetes and hypertension during pregnancy in our OB Clinics in DY12.
- Ensure that patients have a follow-up postpartum appointment within the specific time frame, and develop strategies for increasing adherence in DY12.
- Initiating breastfeeding in the hospital with the assistance of a lactation consultant while advising breastfeeding for six months following delivery in line with the Baby-Friendly Hospital designation in DY12.
- Maintain baby-friendly hospital designation throughout demonstration.

Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]

Target Populations. The target population for this project will be perinatal patients served at the hospital and through the two OB clinics in Lancaster and Palmdale. Within this population, AVH has selected two subsets for this project. The first will encompass all pre and postpartum women with the goal to coordinate them with appropriate care. In Antelope Valley, only 66% of women received prenatal care during their first trimester, and over 8% of infants were born at a low weight. The second target population will be perinatal women with diabetes and/or hypertension, in particular African American women as they are the most likely to have cesarean birth and also are at increased risk for comorbidities. African American women make up 15% of the population in Antelope Valley, of which 19.4% have diabetes.

Vision for Care Delivery. Our key objectives for this project are to improve provider education and to develop the infrastructure necessary to coordinate care for women with co-morbid conditions. Improving provider education will facilitate efforts to decrease maternal morbidity, and mortality related to obstetrical hemorrhage as well as lower rates

of cesarean births and reduce associated mortality. Additionally, providing education to staff working in the maternal/newborn nursing units regarding Baby-Friendly Hospital recommendations for breastfeeding will support the initiatives and further help to maintain our designation. The coordinated effort between our Women and Infants Pavilion and OB Clinics to address comorbidities during pregnancy will support healthier pregnancies and assist in decreasing maternal morbidity.

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.

AVH will perform infrastructure metrics for this project

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

Check, if applicable	Description of Core Components
Applicable	**2.1.1** DPHs/DMPHs engagement in best practice learning collaborative to decrease maternal morbidity and mortality related to obstetrical hemorrhage (CMQCC/PSF/HQI combined effort).
Not Applicable	**2.1.2** Achieve baby-friendly hospital designation through supporting exclusive breastfeeding prenatally, after delivery, and for 6 months after delivery and using lactation consultants after delivery.
Applicable	**2.1.3** Encourage best practice and facilitate provider education to improve cesarean section rates, and decrease inequities among cesarean section rates. Participate, as appropriate, in statewide QI initiatives for first-birth low-risk cesarean births.
Not Applicable	**2.1.4** Coordinate care for women in the post-partum period with co-morbid conditions including diabetes and hypertension.

☒ 2.2 – Care Transitions: Integration of Post-Acute Care (required for DPHs)

Antelope Valley has selected this project because as a primarily inpatient facility, our patients stand to benefit from improved access to post-acute care resources. Implementing this project will encourage the development of relationships with behavioral health and community services outside of the hospital post-inpatient stay. Additionally, it will incentivize best practices upon discharge complete with a transition plan developed collaboratively with the patient and providers. AVH will enhance standardized protocols for transitions that specifically addresses outpatient risks such as co-morbid conditions, low income and mental health disorders.

Our planned implementation approach includes:

- Creation of standardized protocols during DY12 for transition from inpatient to outpatient care to be followed upon discharge. Protocols will address the specific needs of the patient including co-morbid conditions, low income or mental health disorders in order to link them with the most appropriate post-acute care services.
- Development of partnerships with community organizations in DY12 that stress the importance of the relationship between inpatient and outpatient providers to facilitate a smooth transition to coordinated care approach in DY12. Community partners will include providers in physical, behavioral and social health.
- Provider education in DY12 to discharging providers to align new protocols with expected standard of care as part of our care transitions program.
- Incorporation of self-management learning in our care transitions program to aid patients in monitoring their health post-discharge in DY12.

Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]

Targeted Population. Our target population will be high-risk, high-utilizing patients who are being discharged from AVH, with the intention of addressing 30-day readmissions. Specifically, there will be sub-categories for addressing the needs of patients with chronic illnesses such as diabetes and mental health disorders. These patients will be identified additionally based on specific risks such as co-morbid conditions and low income level. We feel that it is important to establish our population on the basis of social determinants of health in addition to health indicators in order to better address the conditions that contribute to hospital admissions.

Vision for Care Delivery. PRIME will allow AVH to achieve several improvements to our current transitions to post-acute care. It will provide the opportunity for AVH to create new and enhance existing relationships with outpatient services in our community. As a result, patients will experience not only a more smooth transition to post-acute care, but also improved health outcomes. Additionally, improving our care transitions program will help providers better prepare patients for their discharge. Patients will leave the hospital with a clear transitions plan, skill to self-manage their conditions and established connections to outpatient resources in the community to aid in their transition.

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.

AVH will perform infrastructure metrics for this project.

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

Check, if applicable	Description of Core Components
Applicable	**2.2.1** Develop a care transitions program or expand a care transitions program to additional settings (e.g., emergency department), or to additional populations, using or adapting at least one nationally recognized care transitions program methodology.
Not Applicable	**2.2.2** Establish or expand on a system to track and report readmission rates, timeliness of discharge summaries, and other transition processes, and investigate system-specific root causes/risk factors for readmission, using quantitative and qualitative information to identify the key causes of readmissions, including physical, behavioral and social factors.
Not Applicable	**2.2.3** Develop and implement a process, including utilization of data and information technology, to reliably identify hospitalized patients at high-risk for readmission.

Applicable	**2.2.4** Develop standardized workflows for inpatient discharge care:
	• Optimize hospital discharge planning and medication management for all hospitalized patients.
	• Implement structure for obtaining best possible medication history and for assessing medication reconciliation accuracy.
	• Develop and use standardized process for transitioning patients to sub-acute and long term care facilities.
	• Provide tiered, multi-disciplinary interventions according to level of risk:
	  o Involve mental health, substance use, pharmacy and palliative care when possible.
	  o Involve trained, enhanced IHSS workers when possible.
	  o 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.

Not Applicable	**2.2.5** Inpatient and outpatient teams will collaboratively develop standardized transition workflows: • Develop mechanisms to support patients in establishing primary care for those without prior primary care affiliation. Develop process for warm hand-off from hospital to outpatient provider, including assignment of responsibility for follow-up of labs or studies still pending at the time of discharge.
Not Applicable	**2.2.6** Develop standardized workflows for post-discharge (outpatient) care: • Deliver timely access to primary and/or specialty care following a hospitalization.

Check, if applicable	Description of Core Components
	• Standardize post-hospital visits and include outpatient medication reconciliation.
Applicable	**2.2.7** Support patients and family caregivers in becoming more comfortable, competent and confident in self-management skills required after an acute hospitalization by providing: • Engagement of patients in the care planning process. • Pre-discharge patient and caregiver education and coaching. • Written transition care plan for patient and caregiver. • Timely communication and coordination with receiving practitioner. Community-based support for the patient and caregiver post hospitalization focusing on self-care requirements and follow-up care with primary and specialty care providers.
Not Applicable	**2.2.8** Engage with local health plans to develop transition of care protocols that ensure: coordination of care across physical health, substance use disorder and mental health spectrum will be supported; identification of and follow-up engagement with PCP is established; covered services including durable medical equipment (DME) will be readily available; and, a payment strategy for the transition of care services is in place.
Not Applicable	**2.2.9** Demonstrate engagement of patients in the design and implementation of the project.
Not Applicable	**2.2.10** Increase multidisciplinary team engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on care model.
Not Applicable	**2.2.11** Implement a system for continual performance feedback and rapid cycle improvement that uses standard process improvement methodology and that includes patients, front line staff and senior leadership.

☒ 2.3 – Complex Care Management for High Risk Medical Populations (required for DPHs)

Antelope Valley has selected this project on the basis of chronic and mental illness prevalence in our district. As section 2 demonstrates, our population has uniquely high rates of chronic conditions such as diabetes, hypertension, COPD and emphysema, as well as high prevalence of mental illness. Because many of these conditions are co-occurring, AVH patients stand to benefit immensely from the implementation of a complex care management program within our hospital. This program will encourage a coordinated team approach and prepare them to not only access preventative and primary care services, but also learn the skill set to self-manage their conditions. In doing so, patients will be able to improve their health indicators and experience an overall greater quality of health while also reducing preventable acute care costs to the hospital.

Our planned implementation approach includes:

- Training program in DY11 for educating providers of care management skills. Providers will learn to coordinate their efforts with a care management team including outpatient resources such as primary care physicians and clinics for preventative services.
- Identification of high-utilizing acute care patient populations throughout DY11 and beginning of DY12 through quantitative and qualitative assessments.
- Develop standardized protocol in DY11 for coordinating target population patients with preventative and primary care services in the community including a list of available resources.
- Focus on teaching patients the skills necessary to self-manage their conditions and appropriately use the most relevant health care services. This will include information patients of options outside of the emergency department for additional assistance managing their conditions.
- Incorporation of medication reconciliation during visits with provider.

Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]

Target Population. The main target population will be refined after an assessment of data to identify specific patients populations identified as high utilizers of acute care resources. These will be populations who are identified as frequenting the AVH emergency department and/or with high inpatient admissions. Most likely, this population will center around a disease state or co-morbid combination.

Vision for Care Delivery. Identifying this population provides an opportunity to engage these patients in their care, teach them the self-management skills necessary to monitor their illnesses, and align the right patients with providers that can be the most useful. Patients will be able to make greater use of community services including preventative and primary care, and likely experience improvements in health indicators that will reduce their likelihood of needing emergency services. Our key objectives for this project are to align patients with the appropriate resources to manage their care, and to reduce the number of acute care admissions among patients with comorbid conditions. PRIME will

enable us the ability to provide the necessary education to both our providers and patients to help improve health indicators. The project will encourage improved coordination among providers and resources among acute care and preventative and primary care services. This provider coordination will empower patients to more efficiently self-manage their conditions with the support of a multi-setting care management team. As a result, patients will spend less time in acute care and will decrease spending associated with preventable hospital admissions.

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.

AVH will perform infrastructure metrics for this project.

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

Check, if applicable	Description of Core Components
Applicable	**2.3.1** Develop a complex care management program at one site or with one defined cohort, or expand an existing program from a pilot site to all sites or to additional high-risk groups and demonstrate engagement of patients in the design and implementation of the project.
Not Applicable	**2.3.2** Utilize at least one nationally recognized complex care management program methodology.
Applicable	**2.3.3** Identify target population(s) and develop program inclusion criteria based on quantitative and qualitative data (e.g., acute care utilization, lack of primary care utilization, number of high-risk medical mental or SUD conditions, polypharmacy, primary care input, functional status, patient activation, social support or other factors). Include patient factors associated with a higher probability of being impacted by complex care management.
Applicable	**2.3.4** Conduct a qualitative assessment of high-risk, high-utilizing patients.
Not Applicable	**2.3.5** Establish data analytics systems using clinical data sources (e.g., EHR, registries), utilization and other available data (e.g., financial, health plan, zip codes), to enable identification of high-risk/rising risk patients for targeted complex care management interventions, including ability to stratify impact by race, ethnicity and language.

Check, if applicable	Description of Core Components
Not Applicable	**2.3.6** Develop a multi-disciplinary care team, to which each participant is assigned, that is tailored to the target population and whose interventions are tiered according to patient level of risk.
Applicable	**2.3.7** Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets.
Applicable	**2.3.8** Implement evidence-based practice guidelines to address risk factor reduction (smoking cessation/immunization/substance abuse identification and referral to treatment/depression and other behavioral health screening, etc.) as well as to ensure appropriate management of chronic diseases: • Use standardized patient assessment and evaluation tools (may be developed locally, or adopted/adapted from nationally recognized sources). Use educational materials that are consistent with cultural, linguistic and health literacy needs of the target population.
Not Applicable	**2.3.9** Ensure systems and culturally appropriate team members (e.g. community health worker, health navigator or promotora) are in place to support system navigation and provide patient linkage to appropriate physical health, mental health, SUD and social services. Ensure follow-up and retention in care to those services, which are under DPH/DMPH authority, and promote adherence to medications.
Not Applicable	**2.3.10** Implement technology-enabled data systems to support patients and care teams throughout the care management program including patient identification, pre-visit planning, point-of-care delivery, care plan development and population/panel management activities.
Not Applicable	**2.3.11** Implement a data-driven system for rapid cycle improvement and performance feedback to address quality and safety of patient care, which includes patients, front line staff and senior leadership.

☒ 2.7 – Comprehensive Advanced Illness Planning and Care

Antelope Valley Hospital has selected this project based on the increasing population in our community with long-term chronic illnesses that may require palliative care planning. The hospital currently has a palliative care program but would like to expand the scope and effectiveness of the program. Our population suffers from high rates of late-stage

cancer, diabetes, COPD and emphysema which are all likely to be associated with advanced illness planning and care. AVH is in need of an extended program that will introduce palliative care options earlier, and incorporate the family and patient in the development of an advanced illness plan. Additionally, AVH has chosen this project to provide our clinicians with training to improve their knowledge of palliative care options and resources to help them prepare better treatment plans for their patients, and enroll appropriate patients earlier in the treatment plans.

Our planned implementation approach includes:

- Develop a protocol for ensuring that patients receive end of life care/palliative care discussions within 3 days of admittance to the ICU in DY11
- Hire a full-time nurse for palliative care outreach in DY12
- Training during DY12 for all front-line clinicians and additional education for clinicians that may also be involved with advanced illness planning. Primary Palliative Care Training will include information regarding identifying patients that are likely to benefit from palliative care, how to introduce palliative care early in diagnosis of advanced illness, the most effective ways to manage symptoms and finally, education to improve communication skills.
- Development of standardized methodology in DY11 for creating patient goals in line with prognosis that incorporates symptom management and an interdisciplinary care team.
- Improve ease of sharing medical records between hospital and palliative care facilities/providers. Ensure that an advanced illness plan is clearly developed and accessible.

Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]

Target Population. Our primary target for this project will be patients in the hospital ICU department. This population was selected because they have the most to gain from advanced care planning given their acuity level. These patients will be quickly introduced to palliative care and have access to trained physicians with improved knowledge of symptom management and care planning. Identification of these patients will begin in the inpatient setting. As a result, they will benefit from the coordination of their care team in the development of their advanced care planning and will have access to multiple coordinated resources.

Vision for Care Delivery. The key objectives for implementing this project will focus on the development of an advance care plan for each patient, and to improve physician decision-making to include palliative care in treatment plan. PRIME enables AVH to redesign our approach to palliative care in particular by encouraged a more coordinated approach. Physicians will improve their engagement of the patient and family in decision making in addition to facilitating access to outpatient palliative care resources. Our clinicians will undergo extensive training in best practices resulting in better symptom management, more comprehensive care plans, increased coordination of care and improved communication skills that will provide patients with a more appropriate care

experience. This project will improve the quality of life of advanced care patients and their families and is also likely to reduce the number of acute care visits for advanced illness.

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.

AVH will perform infrastructure metrics for this project.

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

Check, if applicable	Description of Core Components
Applicable	**2.7.1** Establish or expand both ambulatory and inpatient palliative care (PC) programs that provide: • Total, active and individualized patient care, including comprehensive assessment, inter-professional care planning and care delivery. • Support for the family. • Interdisciplinary teamwork. • Effective communication (culturally and linguistically appropriate). • Effective coordination. • Attention to quality of life and reduction of symptom burden. • Engagement of patients and families in the design and implementation of the program.
Not Applicable	**2.7.2** Develop criteria for program inclusion based on quantitative and qualitative data: • Establish data analytics systems to capture program inclusion criteria data elements.
Not Applicable	**2.7.3** Implement, expand, or link with, a Primary Palliative Care training program for front-line clinicians to receive basic PC training, including advanced care planning, as well as supervision from specialty PC clinicians. Assure key palliative care competencies for primary care providers by mandating a minimum of 8 hours of training for front line clinicians in communication skills and symptom management.
Not Applicable	**2.7.4** Develop comprehensive advance care planning processes and improve implementation of advance care planning with advanced illness patients.
Applicable	**2.7.5** Establish care goals consistent with patient and family preferences, and develop protocols for management/control of pain and other

Check, if applicable	Description of Core Components
	symptoms in patients with advanced illness, including a holistic approach that includes spiritual and emotional needs.
Applicable	**2.7.6** Improve completion of Physician Orders for Life-Sustaining Treatment (POLST) with eligible patients and participate in the state-wide POLST registry.
Not Applicable	**2.7.7** Provide access to clinical psychologist on the palliative care team to address psychological needs of patient and the family members during the advanced illness and provide grief counseling and support to the family after death of their loved ones.
Not Applicable	**2.7.8** Enable concurrent access to hospice and curative-intent treatment, including coordination between the providing services.
Not Applicable	**2.7.9** Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice, including linkage with PC training program.
Not Applicable	**2.7.10** For advanced illness patients transitioning between primary care, hospital, skilled nursing facilities (SNFs), and/or home-based environments, ensure that the advance care plan is clearly documented in the medical record and transmitted in a timely manner to the receiving facilities and care partners who do not have access to the health system's medical record.
Applicable	**2.7.11** Engage staff in trainings to increase role-appropriate competence in palliative care skills, with an emphasis on communication skills.
Not Applicable	**2.7.12** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

Please complete the summary chart:

	For DPHs	For DMPHs
Domain 2 Subtotal # of DPH-Required Projects:	**3**	**0**
Domain 2 Subtotal # of Optional Projects (Select At Least 1):		**4**
Domain 2 Total # of Projects:	**4**	

Section 4.3 – Domain 3: Resource Utilization Efficiency

☒ 3.1 – Antibiotic Stewardship

AVH has had an antibiotic stewardship program but selected this project in order to further improve our antibiotic use. This project is in an important step toward advancing a hospital-wide approach to the optimization of the selection and usage of antibiotics while continuing to educate our physicians. This project will allow for further learning with a focus on appropriate dosing, duration, route of antibiotic prescriptions and helping them to better align their practices with evidence-based medicine. Patients will benefit from this training with more appropriate therapy including the avoidance of antibiotic use for non-bacterial infections and an enhanced de-escalation process with leverage from a program such as this, that supports optimal practice that AVH Pharmacy recommends, yet it challenged by some providers currently. Additionally, the hospital is in need of this program to aid in continuing to lower the cost of antibiotics and reduce the number of medication-based adverse events as well as complications incurred from increased antimicrobial resistance in our patients.

Our planned implementation approach includes:

- Improvement of policies and procedures in DY12 for more appropriately addressing antibiotic use within the hospital starting in DY12. These are to include protocols for diagnosis and subsequent treatment, as well as promotion of the de-escalation process and introduction of oral antibiotics during the inpatient stay.
- Training organized to introduce all clinicians to the new protocols and ensure that best practices are in place throughout AVH by start of DY12. Training will encompass consideration of implementation and interpretation of new laboratory diagnostics, review of appropriate medications and education to aid physicians in preparing patients to leave the hospital.
- Creation of organization-wide dashboards with established, evidence-based benchmarks to ensure prescribing accountability among peers in DY12.

Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]

Target Population. Our target population for the inpatient metrics will be all admitted patients. This breadth is intentional, and can be further divided into two populations. First, patients that are not yet receiving antibiotics. The goal will be to implement appropriate diagnostic techniques and ensure appropriate antimicrobial selection (or lack thereof) limiting inappropriate and indiscriminate use, and optimizing dosing, route, and duration of therapy. The second population of interest will be patients that have begun receiving antibiotics, with the intent to ensure that they are prepared to leave the hospital. Clinicians will be responsible for promoting de-escalating, and moving to oral antibiotics sooner to prepare their patients for discharge; finally creating a discharge treatment plan. We will consider benchmarking against ourselves and similar hospital statewide through the HNSN AUR program. For the outpatient metrics, AVH will partner with a community provider to focus on their population to decrease antibiotic use for acute bronchitis and urinary tract infections.

Vision for Care Delivery. Our vision for the execution of this project is to ultimately provide a higher quality of care to our patients while in the hospital and to reduce adverse effects from antibiotic use. PRIME will enable AVH to provide extensive training to our physicians and develop the infrastructure necessary to develop standards for accountability. Additionally, PRIME will contribute to an improved patient experience by emphasizing the importance of most appropriate diagnosis and treatment for promoting improved outcomes, lowered cost and reduced resistance.

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.

AVH will perform infrastructure metrics for this project.

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

Check, if applicable	Description of Core Components
Applicable	**3.1.1** Utilize state and/or national resources to develop and implement an antibiotic stewardship program, such as the California Antimicrobial Stewardship Program Initiative, or the IHI-CDC 2012 Update "Antibiotic Stewardship Driver Diagram and Change Package.[1]

[1] 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).

Check, if applicable	Description of Core Components
	• Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**3.1.2** Develop antimicrobial stewardship policies and procedures.
Not Applicable	**3.1.3** Participate in a learning collaborative or other program to share learnings, such as the "Spotlight on Antimicrobial Stewardship" programs offered by the California Antimicrobial Stewardship Program Initiative.[2]
Applicable	**3.1.4** Create standardized protocols for ordering and obtaining cultures and other diagnostic tests prior to initiating antibiotics.
Applicable	**3.1.5** Develop a method for informing clinicians about unnecessary combinations of antibiotics.
Applicable	**3.1.6** Based on published evidence, reduce total antimicrobial Days of Therapy (DOT) by providing standards and algorithms for recommended agents by disease type, focusing on short course regimens (e.g., 3-5 days of therapy for uncomplicated cystitis, 7 days for uncomplicated pyelonephritis, 5-7 days for uncomplicated non-diabetic cellulitis, 5-day therapy for community acquired pneumonia (CAP), 7-8 days for therapy for VAP or hospital acquired pneumonia).
Applicable	**3.1.7** Develop evidence-based computerized provider order entry (CPOE) algorithms and associated clinician training, to support antibiotic stewardship choices during order entry. These could include approaches such as guidelines for duration of antibiotics, within drug class auto-switching for specific antibiotics and doses, or restriction of specific antibiotics at the point of ordering (e.g., broad spectrum agents).
Applicable	**3.1.8** Implement stewardship rounds focusing on high yield drugs to promote de-escalation after the drugs are started, such as regular antibiotic rounds in the ICU.
Not Applicable	**3.1.9** Improve diagnostic and de-escalation processes to reduce unnecessary antibiotic use based upon length of therapy or antibiotic spectrum, such as: • Procalcitonin as an antibiotic decision aid. • Timely step-down to oral antibiotic therapy to support early discharge from the hospital for acute infections.

[2] Launched in February 2010, this statewide antimicrobial stewardship program expands use of evidenced-based guidelines to prevent and control infections and improve patient outcomes: Click here to see this statistic's source webpage.

Check, if applicable	Description of Core Components
	• Use of oral antibiotics for osteomyelitis to reduce prolonged IV exposures.
Not Applicable	**3.1.10** Evaluate the use of new diagnostic technologies for rapid delineation between viral and bacterial causes of common infections.
Not Applicable	**3.1.11** Adopt the recently described "public commitment" strategy in outpatient clinics to encourage providers not to prescribe antibiotics for upper respiratory tract infections (URIs).
Not Applicable	**3.1.12** Publish organization-wide provider level antibiotic prescribing dashboards with comparison to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.
Not Applicable	**3.1.13** Implement a system a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

☒ 3.2 – Resource Stewardship: High Cost Imaging

Antelope Valley has selected this project because we currently do not have the existing infrastructure in place to monitor the cost-effectiveness of our imaging services. As a result, few steps have been taken to date to encourage more appropriate use of high-cost imaging services. This program will allow us the opportunity to investigate evidence-based best practices and begin to not only implement these techniques in our hospital but also track their progress. AVH will need to develop both a new data-reporting system and a training program to inform physicians of new standards and protocols.
Our planned implementation approach includes:

- Thorough examination of evidence-based studies detailing recommendations for tests commonly identified as overused early in DY12. This information will be critical to the development of our own imaging management program in DY12.
- Identification of tests within Antelope Valley Hospital that are high-cost and subject to unwarranted use as well as the development of new recommendations for these tests in particular to be completed during DY12.
- Development of an AVH-specific imagining management program in DY12 for use throughout the hospital to detail the most appropriate use of imaging as well as the costs associated.
- Physicians will undergo training in DY12 to improve their prescribing habits in favor of uniform practice that takes both cost and necessity into account. Training will

include information surrounding new standards of care for imaging services that are costly and have low benefit to cost. Physicians will then be expected to understand the process of incorporating patients into the decision making process and appropriately do so in practice.

Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]

Target Population. The target population selected for this project will focus on admitted patients, in particular those who may be prescribed high-cost imaging studies. These patients were previously likely to undergo multiple imaging services that are not only costly but often provided no additional clinical effectiveness. As a direct result of this program this population will have a more cost-effective experience. This population is also integral to the execution of our objectives to incorporate the patient in the decision making process. Patients and physicians will engage in conversation of the most beneficial decision for the patient that is mutually acceptable to new hospital standards.
Vision for Care Delivery. PRIME will enable AVH to develop the infrastructure necessary to accomplish two main key objectives. First, AVH will create the data-reporting systems necessary to evaluate and monitor imaging practices. In doing so, we will be able to identify key areas for improvement based on their cost and demonstrated clinical effectiveness. Second, as a result of the former, AVH will be able to provide training to our clinicians that will equip them with the knowledge necessary to make more cost-effective decisions. Throughout the demonstration period we anticipate the implementation of the data-reporting system and physician training will contribute to lowered use of high-cost imaging and the reduction of unnecessary testing.

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.

AVH will perform infrastructure metrics for this project.

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

Check, if applicable	Description of Core Components
Applicable	**3.2.1** Implement an imaging management program, demonstrating engagement of patients in the design and implementation of components of the project.

Not Applicable	**3.2.2** Program should include identification of top imaging tests whose necessity should be assessed for possible overuse. Criteria for assessment could include:
	• Frequency and cost of inappropriate/unnecessary imaging:
	  o 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.
	  o Cost: Programs will identify imaging studies associated with high costs due to high cost per study or high volume across the system.
	• Unwarranted practice variation within the participating DPHs/DMPHs. Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed.
	• Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed.
	• Whether there are established, tested and available evidence-based clinical pathways to guide cost-effective imaging choices.

Applicable	**3.2.3** Establish standards of care regarding use of imaging, including: • Costs are high and evidence for clinical effectiveness is highly variable or low. • The imaging service is overused compared to evidence-based appropriateness criteria. Lack of evidence of additional value (benefits to cost) compared to other imaging options available to answer the clinical question.
Not Applicable	**3.2.4** Incorporate cost information into decision making processes: • Develop recommendations as guidelines for provider-patient shared decision conversations in determining an appropriate treatment plan. • Implementation of decision support, evidence-based guidelines and medical criteria to recommend best course of action.

Check, if applicable	Description of Core Components
Not Applicable	**3.2.5** Provide staff training on project components including implementation of recommendations, and methods for engaging patients in shared decision making as regards to appropriate use of imaging.
Not Applicable	**3.2.6** Implement a system for continual rapid cycle improvement and performance feedback that includes patients, front line staff and senior leadership.

☒ 3.4 – Resource Stewardship: Blood Products

Antelope Valley has selected this project as a method to improvement the management of hospital blood products and health outcomes associated with transfusion. This project would allow our transfusion committee the opportunity to develop a reporting mechanism to track blood product use and health outcomes. From this data reporting we would be able to extract metrics and make recommendations based on the methodologies created by the Joint Commission. This project would greatly help to improve the safety and appropriate use of blood products within our hospital and foster the development of greater health care quality and resource utilization throughout AVH.
Our planned implementation approach includes:

- Existing multidisciplinary Transfusion Committee to oversee the development of our patient blood products management program, to occur during DY12. The committee will also be newly responsible for generating an evaluation process for blood product utilization and overseeing the development of subsequent new set of standards.
- Development of AVH patient blood management program based on or similar to the Joint Commission methodology during DY12 for implementation in DY12.
- The creation of a data analytics program during DY12 that will provide the Transfusion Committee and clinicians with data regarding blood product use and documentation for reporting the necessary metrics during DY12 and beyond.
- Establish standards of care and training method for clinicians including decision support and newly developed evidence-based guidelines for blood product use during DY12.

Describe how the project will enable your entity to improve care for the specified population [No more than 250 words]

Target Population. The selected target population will be all patients admitted to AVH that are recipients or potential recipients of blood products during admission. Focus will be on improving patient outcomes with the implementation of new evidence based decision-making processes.

Vision for Care Delivery. PRIME will enable AVH to expand our patient blood management program. Implementing this project will result in the development of a Transfusion Committee to oversee our approach to blood product utilization and guide AVH towards more efficacious use. Physicians will be given new standards to follow that will promote reduced wastage of blood products, more appropriate use of blood products and improved patient outcomes. Additionally, we will be able to develop an evaluation program to assess the impact of blood product use and more adequately report on relevant metrics. This project will overall create a safer, more cost-efficient blood product environment in Antelope Valley Hospital.

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.

AVH will perform infrastructure metrics for this project.

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

Check, if applicable	Description of Core Components
Applicable	**3.4.1** Implement or expand a patient blood products management (PBM) program.
Applicable	**3.4.2** Implement or expand a Transfusion Committee consisting of key stakeholder physicians and medical support services, and hospital administration.
Not Applicable	**3.4.3** Utilize at least one nationally recognized patient blood management program methodology (e.g., The Joint Commission, AABB).
Applicable	**3.4.4** Develop processes for evaluating impact of blood product use including appropriateness of use, adequacy of documentation, safety implications, cost, and departmental budget impact. Develop a data analytics process to track these and other program metrics.
Not Applicable	**3.4.5** Establish standards of care regarding use of blood products, including: Use of decision support/CPOE, evidence based guidelines and medical criteria to support and/or establish standards.
Not Applicable	**3.4.6** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.
Not Applicable	**3.4.7** Develop organization-wide dashboards to track provider level blood use patterns. Dashboard to include comparisons to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.

Check, if applicable	Description of Core Components
Not Applicable	**3.4.8** Participate in the testing of novel metrics for PBM programs.

Please complete the summary chart:

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

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 $ 23,860,000
- DY 12 $ 23,860,000
- DY 13 $ 23,860,000
- DY 14 $ 21,474,000
- DY 15 $ 18,252,900

Total 5-year prime plan incentive amount: $ 111,306,900

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 A - Infrastructure Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
1.	Collect measure specifications into AVH reporting manual	• Create a reporting manual in Word or Excel format that captures all of the PRIME metric specifications, with notes on AVH-specific guidelines/data sources. • Train a registered nurse and a data analyst/quality staff member in PRIME guidelines and review metrics during data discussion meeting. Provide minutes from meeting and action items to improve data collection.	All	April 4, 2016- June 30, 2016
2.	Identify reporting workflow for metrics	• Identify preliminary data sources for each metric • Identify gaps in data sources and reporting workflows, including list of missing data elements • Determine metric reporting workflow and timelines, with built-in review processes and assigned stakeholders who will review at designated intervals. Develop a policies and procedures document.	All	July 1, 2016- June 30, 2017
3.	Conduct review of clinical protocols with appropriate stakeholders	• Conduct literature review and develop report of best practices for cancer screenings, in specific target populations if possible. • Identify group of four (1 Cancer Center Manager, 1 Cancer Coordinator, and 2 City of Hope stakeholder representatives) who will	1.6	April 4, 2016- June 30, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		participate in clinical protocols development • Distribute best practices literature to identified stakeholders. • Document where current protocols do not exist or differ from best practices (gap analysis) • Create list of five short-term action items to improve clinical protocols that can take place before clinical protocols are formally changed		
4.	Update clinical protocols based on best practices	• Convene stakeholder workgroup of cancer center staff and/or hospital staff to review and appropriately revise and update cancer screening protocols. Establish a meeting schedule with 2-3 meetings where clinical protocols are updated by the stakeholders on an iterative basis. • Obtain sign-off of updated protocols from the Executive Director of Quality • Distribute updated protocols to all staff via email and/or organizational intranet • Conduct two trainings for at least 5-10 staff members each on updated protocols • Conduct analysis of adherence to updated protocols – the results of which will be formally reported and reviewed with the Executive Director of Quality within 3 months of observation completion. Provide minutes from meeting.	1.6	July 1, 2016- June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
5.	Conduct analysis of population to identify target populations for prenatal and postpartum intervention.	• Interview 20 patients who are admitted to the hospital for labor and delivery who did not receive any prenatal care, and document stated causes for not receiving prenatal care. • Review findings with the Executive Director of Quality and distribute results and analysis document to staff in at least one department	2.1	April 4, 2016- June 30, 2016
6.	Increased accessibility and use of pre and post-partum care services	• Identify one area for protocol improvement (for example, OB hemorrhage) and create a policies and procedures document • Hold one training for 5 staff in updated policy and procedure • Perform one PDSA cycle on exclusive breast feeding in hospital to improve rates of breast feeding. • Develop community outreach plan for health education and promotion for the target population (prenatal and postpartum mothers) and conduct at least two meetings with community partners on outreach.	2.1	July 1, 2016- June 30, 2017
7.	Identify post-acute care resources and make a list of referral options	• Conduct research of post-acute care resources within the Antelope Valley service area, identifying type, capacity and services offered. • Conduct educational session with care transitions staff on linking patients to post-acute care resources Create and publish a hard copy resource list of post-acute care resources for use by transition staff	2.2	April 4, 2016- June 30, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
8.	Update protocols with referral list and create post-acute care linkages	• Contact all post-acute care resources on the referral list, setting up meetings with partners who respond • Discuss with each responsive post-acute care partner how to strengthen referrals upon discharge and strategies to reduce readmissions. Write up notes from each meeting and action items that result. • Revise referral list from DY11 to incorporate additional information on available resources learned through conversations and distribute to staff	2.2	July 1, 2016- June 30, 2017
9.	Create standardized protocols for discharge	• Convene stakeholder committee of hospital staff to provide recommendations for updating discharge care clinical protocols through a series of 2-3 meetings, incorporating lessons learned from partner meetings • Obtain sign-off of updated protocols from the Executive Director of Quality • Distribute updated protocols to appropriate staff members through email or other avenue • Conduct two trainings for at least 5-10 staff members on updated protocols and/or care transitions principles and care management models	2.2	July 1, 2016- June 30, 2017
10.	Identify complex care, high-risk/high-utilizing population based on data and create a report for	• Perform an extract of current systems to identify patients suffering from chronic conditions from two years back of emergency department data from the report date	2.3	April 4, 2016- June 30, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
	use in improvements.	• Perform an extract of current systems to identify patients who have been high utilizers from two years back of emergency department data from the report date • Conduct analysis of patients based on age, location, payor, provider, and/or socioeconomic status to identify risk-factors for utilizing high-cost care. • Create a report on which factors indicate high priority for intervention • Review findings with the Executive Director of Quality and distribute to care management staff		
11.	Create protocols for care for complex populations	• Conduct literature review and develop report of best practices for care management of complex populations, in specific target populations if possible. • Convene stakeholder committee of hospital staff and/or community partners to review, and appropriately update care management clinical protocols through a series of 2-3 meetings, identifying additional resources that are needed to be successful in this project • Obtain sign-off of updated protocols from the Executive Director of Quality • Distribute updated protocols to all staff through email • Conduct two trainings for at least 5-10 staff members on updated protocols and/or	2.3	July 1, 2016- June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		complex care management protocols and how to access the complex care team services		
12.	Identify palliative care best practices	• Conduct literature review and develop report outlining best practices for palliative care. • Identify group of four stakeholders of hospital staff who will participate in clinical protocols development for palliative care • Distribute best practices report to stakeholders. • During a meeting, identify and document where current protocols do not exist or differ from best practices • Create list of five short-term action items to improve clinical protocols that can take place before clinical protocols are formally changed	2.7	April 4, 2016- June 30, 2016
13.	Update palliative care clinical protocols and improve workflows	• Convene stakeholder committee of hospital staff to update discharge care clinical protocols through a series of 2-3 meetings, incorporating lessons learned from partner meetings • Obtain sign-off of updated protocols from medical director of the critical care unit or CMO • Distribute updated protocols to all staff through email • Conduct two trainings for at least 5-10 staff members on updated protocols and/or palliative care concepts, identifying patients and accessing the palliative care team services	2.7	July 1, 2016- June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Create a map demonstrating current state and future state workflow for palliative care/advanced illness discussion within 3 days of admittance to ICU. Create a list of changes that will be implemented to improve workflow. • Assign or hire a palliative care nurse, whose responsibilities will include overseeing PRIME project		
14.	Identify resource stewardship best practices	• Conduct literature review and develop report outlining best practices for resource stewardship: blood products, high imaging and antibiotic use. • Identify group of four stakeholders of hospital staff for each project (12 members total) who will participate in clinical protocols development for each of the resource stewardship projects. • Distribute best practices literature to stakeholders. • During a meeting for all three projects (one meeting total), identify and document where current protocols do not exist or differ from best practices • Create list of five short-term action items for each project to improve clinical protocols that can take place before clinical protocols are formally changed (15 action items total)	3.1, 3.2, 3.4	April 4, 2016- June 30, 2016
15.	Improve resource stewardship programs	• Convene stakeholder committee of hospital staff to update discharge care clinical	3.1, 3.2, 3.4	July 1, 2016- June 30, 2017

Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
	protocols through a series of 2-3 meetings, incorporating lessons learned from partner meetings • Obtain sign-off of updated protocols from Executive Director of Quality • Distribute updated protocols to all appropriate staff through email • Conduct three trainings for at least 5-10 staff members on updated protocols (one for each project, three trainings total, between 15 and 30 staff trained) • Integrate PRIME metrics for these three projects into hospital-wide dashboard where quarterly data is published and shared via an excel spreadsheet, web-based document, or other sharing platform.		

Appendix B - Citations

Section 2.1

- Los Angeles County Department of Public Health, SPA 1 Supplement 2013
- Los Angeles County Department of Public Health, Key Indicators of Health March 2013
- Los Angeles County Department of Public Health, Health Survey 2011 Data Set

Section 2.2

- US Census Bureau, multiple years

Section 3.2

- NCI, What You Need to Know about Cervical Cancer, 2012