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 Kaweah Delta Health Care District

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.

Kaweah Delta Health Care District (KDHCD), located in Visalia, is the largest city in Tulare County. KDHCD serves the healthcare needs of approximately 500,000 people across a diverse mix of races, ethnicities, income levels, education and health status.

Physical Health: The most significant health issues facing the community include diabetes, obesity, heart disease, heart failure, stroke, and hypertension:

- Type 2 diabetes at 13.2% versus 6.9% for State
- Adult obesity at 38.0% versus 24.8% for State
- Heart disease mortality rate of 206.3 per 100,000 population versus 155.2 for California (ranked 3rd highest in State)
- Heart disease morbidity rate of 24.6 per 100,000 population versus 17.4 for California (ranked 3rd highest in State)
- Stroke mortality rate of 55.6 per 100,000 population versus 50.3 for California (ranked 17th highest in State)
- Stroke morbidity rate of 7.2 per 100,000 population versus 5.9 for California (ranked 2nd highest in State)
- Heart failure mortality rate of 22.5 per 100,000 population versus 12.0 for California (ranked 9th highest in State)
- Heart failure morbidity rate of 14.7 per 100,000 population versus 10.7 for California (ranked 2nd highest in State)
- Hypertension in adults > 45 years old of 45% versus 38% for State
- 18.9% of the population smokes cigarettes

Behavioral Health: Behavioral health issues are also a challenge for Tulare County. The most recent California Health Interview Survey (CHIS) reports 11.8% of the County consider their mental health to be poor. With regard to substance use, 17.5% consider themselves to be heavy drinkers. Additionally, Tulare County had 67 opioid related overdose deaths from 2009-2013. Tulare County also has a suicide death rate of 8.9 per 100,000 of population, slightly less than California's overall rate of 9.8%.

Health Disparities: The leading causes of death for Hispanics (63% of Tulare County's population) are different than for Non-Hispanic White. The Hispanic risk of mortality from diabetes is 2.6 times greater than for Whites. Despite similarities in age-adjusted death rates, Hispanics have 1.2 times more years of life lost than Whites.

Coverage: With a significant shortage of physicians (2,400 residents per primary care physician compared to statewide average of 1,300) and overall poverty (40% of children living in poverty compared to statewide average of 24%), KDHCD is greatly challenged to meet the healthcare needs of the community it serves. From March 2013 to December 2015, KDHCD has seen a 22% increase in the number of Medi-Cal it serves, from 34.2% to 41.6%, respectively.

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.

Kaweah Delta Health Care District (KDHCD), formed in 1961, encompasses 183 square miles in northern Tulare County and includes the City of Visalia and neighboring unincorporated areas.

Income: While Tulare County is widely considered the "bread basket" of our nation, with an annual gross agricultural production of $8 billion or more, it is one of the poorest of California's 58 counties with a per capita income of less than $18,000. 22.9% of the County's population lives at or below 100% of the Federal Poverty Level ("FPL"), with 50.5% living at or below 200% of the FPL (compared to 19.3% and 32.8%, respectively, for all of California). 33% of Tulare County residents lack a high school diploma compared to 19% statewide. At 53.1% of its population, Tulare County has the highest Medi-Cal enrollment of any county in California.

Race/Ethnicity and Language: The population of Tulare County is 63% Hispanic, 30% White, 2.2% African-American, 2.8% American-Indian and 4% Asian. This diversity has significant implications for healthcare delivery and linguistic needs.

23.3% of the Tulare County population consider themselves to be linguistically isolated compared to 19.9% statewide. English is the predominant language spoken in Tulare County, followed in order by Spanish, Arabic, Filipino and Hmong.

Age and Gender: The population is slightly younger than the state overall, with an average age of 31.3 years (compared to 35.2 statewide). Gender is evenly split between male and female. The age breakdown is as follows:

- 0-17 years (33%)
- 18-64 years (58%)
- 65 and over (9%)

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.

Kaweah Delta Health Care District (KDHCD) is comprised of the following:

- Kaweah Delta Medical Center (403 licensed beds)
- Kaweah Delta Acute Rehabilitation Hospital (45 licensed beds)
- Kaweah Delta Mental Health Hospital (63 licensed beds)
- Kaweah Delta Skilled Nursing Center (70 licensed beds)
- Four rural health clinics (Exeter, Lindsay, Woodlake, and Dinuba)
- Family medicine graduate medical education residency clinic
- Two chronic dialysis centers (Visalia and Porterville)
- Level III trauma center
- Three urgent care centers (Visalia)
- Chronic disease management center (Visalia)
- Two outpatient radiation oncology centers (Visalia and Hanford)
- Outpatient specialty clinics for cardiology, neurology, urology, spina bifida, cleft palate, high-risk infant follow-up, gastroenterology, chronic migraines and synagis (respiratory syncytial virus ("RSV")). (Visalia and Exeter)

KDHCD provides many healthcare services, including but not limited to:

- Cardiac surgery
- Neurosurgery
- General and vascular surgery
- Adult, cardiac and neonatal intensive care
- Inpatient and outpatient oncology
- Maternal/child health
- Acute rehabilitation
- Acute mental health
- Skilled nursing

- Subacute
- Home health, hospice and private home care
- Outpatient and home infusion therapy
- Sleep medicine
- MRI, CT, PET, and digital mammography imaging

KDHCD is an ACGME-accredited teaching institution with physician residency programs in family medicine, emergency medicine, psychiatry, general surgery and transitional year with anesthesiology to be added this year.

KDHCD's payer mix is largely government-sponsored with approximately 43% of its inpatients covered by Medicare, 42% by Medi-Cal, 14% by commercial insurance and only 1% uninsured.

For Fiscal Year 2015, KDHCD saw 28,000 inpatient admissions, performed 8,900 surgeries, delivered 4,400 babies, and experienced 92,000 emergency department and 100,000 rural health clinic visits.

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: KDHCD has implemented an electronic health record (EHR). Data are captured and entered into the EHR during all stages of the patient visit. This same EHR system will support PRIME efforts.

Reporting*:* The EHR is augmented by powerful data extraction software that can produce reports used to establish baseline data for PRIME reporting metrics. Software applications are also available to create dashboards useful for monitoring key metrics.

Monitoring*:* The information provided in reports or dashboards can be used to identify areas where rapid cycle improvement projects will be most effective to improve the patient experience, improve overall population health and reduce costs. This monitoring process will be critically important to ensuring that the PRIME projects are effectively making improvements.

Potential Barriers: While KDHCD has a formal Performance Improvement Department and participates in various State and Federal quality reporting and

statistical reporting processes (e.g., STS, ACC, Leapfrog, Health Grades), a significant challenge for our facility will be the lack of accessible outpatient data, within our own systems, specific to the Medi-Cal population. Unlike DPHs, patients are not assigned to DMPH facilities. As such, we do not have the ability to capture data pertaining to much of the Medi-Cal population's utilization of services.

In addition, the current staffing levels of our Performance Improvement Department, and other data collection/reporting departments, are not adequate to sustain the data collection, reporting and performance monitoring requirements.

To address these barriers KDHCD plans to implement the following:

- Partner with Managed Care Organizations in Tulare County to obtain Medi-Cal outpatient utilization and health status data for measuring, reporting and monitoring performance
- Implement a dedicated PRIME project team for data collection, reporting and performance monitoring
- Leverage the newly available data collection and reporting capabilities of the patient clinical and financial system being implemented during the next year

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.*

Kaweah Delta Health Care District (KDHCD) operates under four overarching goals, including two that directly align with the PRIME initiatives and support delivery system transformation. These goals are:

- Achieve outstanding health outcomes for our patients
  - Continuously improve performance in clinical quality and patient safety
  - Meet patient and physician expectations
  - Continuously improve operating and information systems

- Provide excellent service to patients and customers
  - Exceed the expectations of patients, families, physicians, staff and other customers
  - Continuously improve customer service and patient satisfaction
  - performance
  - Anticipate and proactively respond to the needs of patients and customers

KDHCD's strategic plan includes several elements that are specifically focused on and support delivery system transformation. Element examples include:

- Develop a collaborative, widespread culture of rapid cycle improvement based on the Institute for Healthcare Improvement's FOCUS "Plan-Do-Check-Act" (PDCA) tool, across all levels of the organization.

- Improve access to care by identifying populations with specific health disparities and develop programs to address their needs.
- Identify health information technologies to evaluate population health and use technology to identify, monitor, predict and improve health outcomes.

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.*

   Through our participation in PRIME, KDHCD seeks to address the following two aims to support system transformation:

   - Improve access to primary care services for Medi-Cal patients
   - Improve efficiency, reduce cost and improve health outcomes through better management of chronic diseases and improved care coordination.

   To improve access to primary care services, KDHCD will implement a patient-centered medical home model to connect patients to primary care and reduce the unnecessary use of high cost services, such as the emergency department, due to lack of primary care access.

   For care coordination, KDHCD will standardize management services and improve coordination of care across the healthcare continuum. Additionally, KDHCD will reduce avoidable readmissions and improve the patient's ability to better manage chronic illness(es).

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;*

   KDHCD aims to significantly improve the health status of our Medi-Cal patients and reduce existing access and coordination deficiencies through the development of a patient-centered medical home (1.2), a specialty care program (1.3), implementation of the Million Hearts Initiative (1.5), a chronic disease management center (2.3), a multi-disciplinary transition-of-care team (2.2), a model for chronic non-malignant pain management (2.6), and advanced illness planning (2.7).

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*

KDHCD has selected seven projects, which span the continuum of care from primary care to chronic care to advanced illness planning, in addition to addressing transitions within the continuum of care. Each project will focus on improvements within their own space of the continuum, but throughout PRIME and beyond, these projects will meld together to create an efficient, coordinated, and cost-effective healthcare system. To ensure that the projects work in a collaborative and inter-related manner, the following tactics will be used:

- Develop a PRIME Steering Committee including project leaders, executive leadership, performance improvement, community outreach staff, and data measurement and reporting staff;
- Hire a dedicated PRIME Coordinator; and
- Develop a PRIME dashboard to ensure project transparency across the organization.

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.*

As a result of PRIME participation, KDHCD expects to transform the health system at the end of the five years in the following ways:

- **Clinical**:
  - Full implementation of a patient-centered medical home model which will increase access to primary care.
- **Population Health**:
  - Expanded use of advanced illness planning, for end-of-life care in comfortable and appropriate care settings
  - Increased use of prevention screenings and standards of care to improve outcomes and quality of life
- **Fiscal**:
  - Reduced readmission rates and cost of care due to focused management of patients with chronic illnesses.
  - Reduced average length of stay due closer coordination of care.
  - Reduced cost of healthcare for all stakeholders – patients, providers, and insurers.

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.

The physical health data described in our response to Section 2.1 underscores the importance of improving the management and coordination of services throughout the continuum of care. Through our PRIME projects, KDHCD will address the most significant local health needs, including access to care, diabetes, obesity, heart disease, congestive heart failure, and hypertension. KDHCD plans to improve access to care through the development of a patient-centered medical home model and a chronic disease management center. KDHCD also plans to address the needs of our community in obtaining access to post-acute or outpatient care through projects focused on coordination of care. Finally, due to the prevalence of diabetes and other chronic conditions in our community, KDHCD has selected projects that improve quality of care for patients suffering from chronic illnesses.

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).

KDHCD maintains a strategic plan centered around 10 objectives – including achieving outstanding health outcomes, community health, and integration across the continuum of care. Elements for the success of each key initiative, such as responsible parties, resources, timelines, and measures of success are determined and approved by the Board of Directors. The responsible parties for each key initiative are required to report back to the Board on a periodic basis concerning their progress. Further, KDHCD has adopted a FOCUS PDCA (plan-do-check-act), rapid-cycle improvement model of managing and measuring improvement initiatives. Implementation of KDHCD's PRIME projects would follow the same reporting and monitoring structures and processes as those that are used to implement and measure key initiatives pursued under our strategic plan.

To coordinate the PRIME effort and drive transformation, KDHCD will develop a PRIME Steering Committee including project leaders, executive leadership, performance improvement, community outreach staff, and data measurement and reporting staff. We will also create a dedicated PRIME Project Team to convene at least monthly in during the implementation phase. Team activities will be brought to the board of directors and will be responsible for managing the projects within their

departments. The team will be responsible for: 1) Reviewing project metrics, make recommendations for improvements, monitor for successful achievement of milestones. 2) Providing input in resolving obstacles to success. 3) Seeking ways to further integrate and expand on PRIME initiatives to insure sustainability. Lastly, KDHCD will hire a dedicated PRIME Coordinator to help coordinate and manage all requirements for the projects.

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.

KDHCD has identified the following stakeholders in planning and implementing PRIME projects:

- The Medi-Cal Managed Care health plans within Tulare County – to obtain health data to identify health disparities and track improvements
- Members of KDHCD's Community Outreach Department and other cultural and health advocates within Tulare County – to assist with identification of barriers to accessing care and sharing of ideas for how to remove those barriers
- KDHCD's publicly-elected Board of Directors and our Medical Staff – to integrate PRIME into existing quality improvement processes and strategic plans, as well as provide mechanism for ongoing feedback and monitoring related to PRIME projects.

The stakeholders identified above will be engaged in the following ways:

- Periodic meetings and updates from the PRIME Steering Committee and/or PRIME Coordinator
- Participation of certain stakeholders as members of the PRIME Steering Committee
- Distribution of a PRIME dashboard that will allow KDHCD's leaders, Board members, and Medical Staff to monitor the progress of PRIME projects.

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.

KDHCD has several means of ensuring cultural competency and addressing health disparities such as:

- The Community Outreach Department – charged with conducting outreach to underserved patient populations and populations that experience specific

health disparities such as diabetes and childhood obesity. The Department also connects individuals who frequently use emergency departments to healthcare and other community services that can assist them with better managing their health.

- The Cultural Diversity Committee – focuses on identifying causes of health disparities in our community and develops ideas for mitigating those disparities.
- Interpretation services, including in-person interpretation services through our Interpreter Services Department for the most common non-English languages, AT&T Language Line services, and in-person or video conference sign language interpretation services.
- Printed materials in both English and Spanish, in-room health education videos in both English and Spanish, and the use of specially-trained health interpreters.

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.

KDHCD plans to leverage the currently used FOCUS PDCA rapid-cycle improvement model for managing and measuring the delivery system transformation processes under PRIME. Further, under PRIME, KDHCD will develop data systems, increase personnel and expand our reporting infrastructure for measuring and reporting transformation metrics. The development of protocols, infrastructure, data reporting and review processes will enable us to sustain improvements implemented as part of PRIME once our participation has ended, as well as provide a thoroughly vetted model and process for continued improvements beyond the PRIME program into the future. KDHCD will also engage providers and staff in planning and implementation, provide intensive education and training, and ensure senior leadership support to implement and continue PRIME beyond the five years.

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

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

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]*

Rationale: KDHCD selected this project due to a Medi-Cal primary care provider shortage and high service demand in Tulare County. Currently, Tulare County experiences a patient to physician ratio of 2,400 residents per 1 primary care physician compared to the statewide ratio of 1,300 residents to 1 physician. Also, 53 percent of the county population is enrolled in the Medi-Cal program, yet many primary care providers do not accept Medi-Cal. KDHCD clinics have expanded to meet the demand, yet currently lack the infrastructure to effectively improve patient experience, improve population health, and reduce costs.

Project Design and Implementation Approach:

Design Process: The Project design will be based on program requirements and input from physician leadership, management, primary care providers, EHR vendors, staff, and patient input. (DY12)

Implementation Approach:

- Population health management will augment the EHR that will support care coordination, facilitate patient care, and identify lapses in preventative care screening. These PCMH approaches will also improve patient access by ensuring same day appointments, timely provider follow-up, patient access to information, and specialist referral tracking through team-based care. Tasks to begin in DY12 and be completed in DY13.
- Care coordination will require identifying and training care coordinators. Management will ensure trained staff is available to provide patients with timely referrals to specialty care. A specialty referral tracking system will be implemented to assist with access and coordination of care. Additionally, providers working in the primary care clinic will coordinate and refer patients as appropriate to the chronic pain management clinic. Educational materials and care plans will be available to help engage the patients with their care. These tasks will begin by conducting a needs assessment in DY12, and implementing a staff training program in DY12.
- REAL/SO/GI data will be collected and workflows modified to capture more detailed REAL/SO/GI information. Data will be employed to stratify results, identify areas of disparity among patients and to implement process

improvement that will result in improved health outcomes. Efforts are expected to begin in DY11 with tasks completed in DY13.

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

Target Population: Because of the nature of accessing primary care, patients are not selected for inclusion in PCMH, however, each patient will be screened for a variety of targeted interventions. As required by the metrics for this project, adult patients will be screened for tobacco use, alcohol and drugs misuse, and clinical depression. For chronic disease/clinical performance measurements (e.g., comprehensive diabetes, colorectal screening, ischemic vascular disease, hypertension), the adult population will be measured according to patients' clinical conditions and age. The REAL and SO/GI metrics will be tracked for all primary care populations (adult, adolescent, and pediatric) served in our four rural clinics. The disparities of care for vulnerable patients related to REAL and SO/GI identification will be tracked, measured and improved during this demonstration. KDHCD will be working over the next several months to further define the target population for this project based on the required metrics and the clinical literature while addressing the needs of the community.

Vision for Care Delivery: PRIME will enable KDHCD to transform clinic settings to a PCMH model, where patients will experience increased access to healthcare through coordinated care teams. Patients will be engaged in their care management and receive appropriate and timely follow-up, helping to decrease unnecessary utilization of hospital emergency and inpatient services. Patients will be better managed, improving population health within the community. These objectives will allow KDHCD to provide coordinated, efficient and effective care for clinic patients which will improve patient outcomes for the target population.

3. *KDHCD (DMPH) Project 1.2 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.*

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

Check, if applicable	Description of Core Components
Applicable	**1.2.1** Conduct a gap analysis of practice sites within the DPH/DMPH system.
Applicable	**1.2.2** Primary care practices will demonstrate advancement of their PCMH transformation through the use of a nationally-recognized PCMH methodology.

Check, if applicable	Description of Core Components
Applicable	**1.2.3** Hiring and training of frontline workforce (e.g., medical assistants, community health workers, promotoras, health navigators or other non-licensed members of the care team) to be responsible for coordination of non-clinical services and elements of the care plan.
Applicable	**1.2.4** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population/panel management activities, care coordination, patient engagement, and operational and strategic decisions including a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. • Implementation of EHR technology that meets meaningful use (MU) standards.
Applicable	**1.2.5** Ongoing identification of all patients for population management (including assigned managed care lives): • Manage panel size, assignments, and continuity to internal targets. • Develop interventions for targeted patients by condition, risk, and self-management status. • Perform preventive care services including mental health and substance misuse screenings and brief interventions (e.g., PHQ-9, SBIRT).
Not Applicable	**1.2.6** Enable prompt access to care by: • Implementing open or advanced access scheduling. • Creating alternatives to face-to-face provider/patient visits. Assigning frontline workers to assist with care navigation and non-clinical elements of the care plan.
Applicable	**1.2.7** Coordinate care across settings: • Identification of care coordinators at each primary care site who are responsible for coordinating care within the PCMH as well as with other facilities (e.g., other care coordinators or PCMH/DPH/DMPH high risk care managers): o Establish onsite care/case managers to work with high risk patients and their care teams, or develop processes for local care coordinators to work with a central complex care management program for these patients Implement processes for timely bi-directional communication and referral to specialty care (including mental health and substance use disorder services), acute care, social services and community-based services.

Check, if applicable	Description of Core Components
Applicable	**1.2.8** Demonstrate evidence-based preventive and chronic disease management.
Applicable	**1.2.9** Improve staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the team-based care model to ensure effective and efficient provision of services (e.g., group visits, medication reconciliation, motivational interviewing, cognitive behavioral therapy and Medication-Assistance Treatment (MAT)).
Applicable	**1.2.10** Engage patients using care plans, and self-management education, and through involvement in the design and implementation of this project.
Applicable	**1.2.11** Improve the accuracy and completeness of race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI) data, and use that data to identify and reduce disparities in one or more Primary Care Redesign project metrics by: • Adding granular REAL and SO/GI data to demographic data collection processes and training front-line/registration staff to gather complete and accurate REAL/SO/GI data. • Developing capacity to track and report REAL/SO/GI data, and data field completeness. • Implementing and/or refining processes for ongoing validation of REAL/SO/GI data. • Developing capacity to stratify performance metrics by REAL/SO/GI data and use stratified performance data to identify disparities for targeted interventions. • Developing capacity to plan and implement disparity reduction interventions with input from patients and community stakeholders. • Developing dashboards to share stratified performance measures with front-line staff, providers, and senior leadership.
Applicable	**1.2.12** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

☒ 1.3 Ambulatory Care Redesign: Specialty Care **(required for DPHs)**

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]*

Rationale: KDHCD plans to address the lack of access to specialty care for prevalent chronic diseases in our community. Tulare County ranks 55th out of 58 counties in access to clinical care, and 53rd, 58th and 43rd out of 58 California counties in death due to cardiovascular disease, pneumonia and diabetes. Tulare County has two endocrinologists to serve our estimated 40,000 diabetics, and has the highest incidence of diabetes (13.2%) of any county as compared to California (6.9%).

Project Design and Implementation Approach:

Patient Identification: KDHCD will work collaboratively with our community partners such as the Lindsay Health Care District, medical groups and our region's Medi-Cal Managed Care Organizations. KDHCD will identify high-risk patients and link them to our specialty care programs, both in the Chronic Disease Management Center (CDMC) and in our Rural Health Clinic located in the city of Lindsay (LRHC). (DY12)

Care Team Formation: KDHCD will increase access to specialty care by creating multidisciplinary teams comprised of physicians, nurse practitioners, clinical pharmacists, and community outreach specialists that will operate in our CDMC and at our LRHC. All staff will coordinate care and leverage the diverse scopes and skills of the team members to function at the top of their license. (DY11)

Referral Processes: Working with our community partners (i.e. managed care organizations, medical groups, primary care physicians, etc.), KDHCD will proactively identify targeted high-risk patients with known specialty care needs. KDHCD will conduct outreach as part of refining referral processes into our newly formed services. Referrals are intentionally designed to improve the outcomes of these targeted populations. (DY12)

Clinical Pathways: KDHCD will create a committee to review current clinical workflows for targeted chronic diseases. The committee will develop clinical screening, treatment and monitoring pathways according to current guidelines and best practices for targeted chronic diseases. (DY11)

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

Target Population: Two patient populations will be targeted initially. KDHCD will target Medi-Cal patients with: 1) cardiac disease, specifically heart failure and recent myocardial infarction, and 2) patients with poorly controlled diabetes. The patients

will have been referred to specialty care at least once during the demonstration year. A multi-pronged approach to identifying high-risk patient populations will use internal data from hospitalizations, ED visits, laboratory values and data from our rural health clinics; and use external data sources from health plans and medical groups. After the initial populations are targeted, KDHCD plans to expand our approach to individuals with other chronic diseases like chronic obstructive pulmonary disease, asthma and hypertension.

Vision for Care Delivery: This PRIME project will enable KDHCD to improve care for patient populations requiring specialty care in several key ways:

- Proactively identify high-risk patient populations
- Engage patients and primary care providers (PCPs) in collaborative co-management, education and strategies which will improve patient care and outcomes
- Develop a multi-disciplinary care team who practice at the top of their license; Physicians, Nurse Practitioners, Advanced Practice Pharmacists, and (non-licensed) Community Outreach Specialists/Promotora
- Expand our ability to address patients' specialty medical, social and educational needs
- Improve patient outcomes (decrease readmissions, hospitalizations, ED visits and broaden the bandwidth of our PCPs)
- Increase our reach and efficiency with telehealth strategies and patient portal communication resulting in decreased number of in-person clinic visits
- Keep patients engaged, adherent and assuming ownership of their own treatment plans.

3. *KDHCD (DMPH) Project 1.3 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.*

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

Check, if applicable	Description of Core Components
Applicable	**1.3.1** Develop a specialty care program that is broadly applied to the entire target population.
Applicable	**1.3.2** Conduct a gap analysis to assess need for specialty care including mental health and SUD services (analysis to include factors impacting ability to access specialty care), and the current and ideal state capacity to meet that need. Benchmark to other CA Public Health Care systems.

Check, if applicable	Description of Core Components
Applicable	**1.3.3** For ideal state analysis, include potential impact of increased primary care capacity to manage higher acuity conditions either independently, or in collaboration with, specialty care, so as to reduce the need for in-person specialty care encounters (e.g., insulin titration, IBS management, joint injections, cognitive behavioral therapy (CBT) or MAT).
Applicable	**1.3.4** Engage primary care providers and local public health departments in development and implementation of specialty care model.
Applicable	**1.3.5** Implement processes for primary care/specialty care co-management of patient care.
Applicable	**1.3.6** Establish processes to enable timely follow up for specialty expertise requests.
Applicable	**1.3.7** Develop closed loop processes to ensure all requests are addressed and if in person visits are performed, that the outcome is communicated back to the PCP.
Applicable	**1.3.8** Ensure that clinical teams engage in team- and evidence-based care.
Applicable	**1.3.9** Increase staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the care model.
Applicable	**1.3.10** Develop and implement standardized workflows for diversified care delivery strategies (e.g., shared medical visits, ancillary led services, population management, telemedicine services) to expand access and improve cost efficiency.
Applicable	**1.3.11** Adopt and follow treatment protocols mutually agreed upon across the delivery system.
Applicable	**1.3.12** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population management activities and care coordination/transitions of care. Ensure that timely, relevant, and actionable data are used to support patient engagement, PCP collaboration, and drive clinical, operational and strategic decisions including continuous quality improvement (QI) activities.

Check, if applicable	Description of Core Components
Applicable	**1.3.13** Implement EHR technology that meets MU standards.
Applicable	**1.3.14** Patients have care plans and are engaged in their care. Patients with chronic disease (including MH/SUD conditions) managed by specialty care have documented patient-driven, self-management goals reviewed at each visit.
Applicable	**1.3.15** Improve medication adherence.
Applicable	**1.3.16** Implement population management strategies for patients in need of preventive services, with chronic conditions, or with recurring long term surveillance needs.
Applicable	**1.3.17** Implement or expand use of telehealth based on DPH/DMPH capacity to address patient and PCP barriers to accessing specialty expertise. Implement a telehealth platform with communication modalities that connect between specialty care and primary care (e.g., eConsult/eReferral).
Applicable	**1.3.18** Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**1.3.19** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.
Applicable	**1.3.20** Test use of novel performance metrics for redesigned specialty care models.

☒ 1.5 – Million Hearts Initiative

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]*

Rationale: KDHCD chose this project because it addresses some of the greatest health needs of our county; cardiovascular and cerebrovascular health. Tulare County ranks 55th out of 58 counties in access to clinical care, and 53rd and 52nd out of 58 counties in death due to coronary heart disease and stroke. The interventions of the Million Hearts Initiative (i.e. the ABCS), which include Aspirin use, Blood pressure control, Cholesterol management, and Smoking cessation, are well demonstrated to improve these outcomes.

Planned Design and Implementation Approach:

Intervention Strategy: A workgroup will be created to assist in the design, implementation and monitoring of the Million Hearts program. Medical, diagnostic, atherosclerosis cardiovascular disease (ASCVD) risk, team assessments and self-care measures will be used in motivational interviewing and goal development with the patient (family). KDHCD will integrate the recommendation of clinical preventive services into clinical workflows. Specific screening, education and treatment will be designed and implemented for tobacco cessation. KDHCD will identify existing community-based tobacco cessation resources to link our patients to and the defined insurance benefits available through Medi-Cal (both FFS and MCO) will be understood and utilized. (DY12)

Referral Process: Working with our community partners (i.e. Medi-Cal managed care organizations, medical groups, PCPs, specialists, etc.), KDHCD will proactively identify patients with, or at high-risk for, cardio/cerebrovascular disease utilizing the risk stratification tools such as ASCVD risk factors and conduct outreach as part of developing referral processes into our services intentionally designed to improve the outcomes of these targeted populations, such as our Chronic Disease Management Center. (DY12)

Care Team Formation: A multidisciplinary team of health care providers and support staff will implement the protocols for care, education, monitoring, and reporting for the Million Hearts Initiative. (DY12)

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

Target Population: KDHCD will target patients in our community who would benefit from the interventions of the Million Hearts Initiative. Working with our internal data from our electronic medical record in addition to partnering with our Medi-Cal MCOs and medical group partners and their data sources, KDHCD will identify patients who

have, or are at high-risk for, cardio/cerebrovascular disease using risk stratificatoin tools such as the ASCVD risk factors.

Vision for Care Delivery: KDHCD will deliver evidence-based preventive care, screening, education and treatment for patients at risk for heart attacks and strokes, by incorporating the interventions of the Million Hearts initiative. Patients will be linked to local, state and national tobacco cessation resources. Our Chronic Disease Management Center will work collaboratively with community PCPs to expand access to care for identified high-risk patients, and ensure patients are screened, educated, engaged and adherent to the plan of care which will improve care and patient outcomes. . KDHCD will achieve this by employing community outreach specialists to do home visits, phone calls and link identified patients to community resources. The end goal of these efforts is to ensure at-risk patients are identified through validated screening tools, referred through coordinated efforts, educated, treated and adherent to evidence based treatments proven to decrease heart attacks and strokes.

3. *KDHCD (DMPH) Project 1.5 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.*

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

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

Check, if applicable	Description of Core Components
Applicable	**1.5.6** Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.
Applicable	**1.5.7** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. • Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts.
Applicable	**1.5.8** Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.

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):		**3**
Domain 1 Total # of Projects:		**3**

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

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

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]*

Rationale: KDHCD selected this project to improve coordination and continuity of health care management for our high-risk Medi-Cal patients. In 2015, KDHCD's Medi-Cal readmission rates were 15% and the emergency utilization rates within 30 days of discharge were 24%. Lack of care coordination results in poor medical management of disease processes which leads to higher readmission rates and utilization of emergency services for episodic care.

Planned Design and Implementation Approach: KDHCD will develop a transition of care program that will equip patients with knowledge and follow up care to be successful in their transition to the community. KDHCD will establish a workgroup comprised of KDHCD staff including physicians, nurses, case managers, social workers, and community leaders including skilled nursing representatives and primary care providers, to assist in project design and implementation.

Transition of Care Team (TOC) Structure: KDHCD will conduct a workforce gap analysis to determine TOC team staffing needs. KDHCD will recruit for nurses and pharmacists as determined by this analysis. (DY11)

Inpatient Discharge Pathways: KDHCD will review validated risk stratification tools, and develop workflows around a risk stratification tool including an identification process for patients at risk for readmission. KDHCD will review current discharge pathways and develop new pathways to improve care coordination for patients identified as being at risk for readmission. (DY12)

Care Team Training: KDHCD will educate the team on the discharge pathways and risk stratification tool as well as mission, vision and goals of the project. (DY12)

Data and Technology: KDHCD will conduct a gap analysis to understand our current reporting systems, and design reports, workflows and systems if necessary to report on required metrics. (DY12)

Patient Engagement: KDHCD will engage patients in the care planning process. Through education and coaching around their disease process and medication management, the TOC team will create and communicate discharge care plans to the patient and their primary care provider. (DY12)

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

Target Population: This project will target Medi-Cal patients being discharged from the hospital identified as a high risk for readmission through our risk-stratification tool due to factors such as multiple medications, high risk medications, poor social support and lack of access to primary care.

Vision for Care Delivery: The TOC team will improve the discharge process to incorporate patients and families, improve knowledge about disease processes and improve communication between the healthcare team, primary care physician and the patient. Patients are ill-prepared to care for themselves at home with limited access to outpatient services or lack of knowledge about their disease process. The TOC program, through a multidisciplinary approach, will prepare patients and their families for discharge and increase adherence to post discharge care plans. The TOC team will be part of the healthcare team, facilitating communication between healthcare providers (both internal and external), patients and their families. With the added support to the patient and their families during the transition, the program will help reduce 30-day avoidable readmission rates, length of stay, and inappropriate emergency usage for episodic care. In addition, it will improve patient and caregiver "readiness for discharge", patient experience, chronic disease management, communication and coordination between providers, and access to post discharge primary and specialty care follow up.

3. *KDHCD (DMPH) Project 2.2 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.*

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.
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.

Check, if applicable	Description of Core Components
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.
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.
Applicable	**2.2.6** Develop standardized workflows for post-discharge (outpatient) care: • Deliver timely access to primary and/or specialty care following a hospitalization. • Standardize post-hospital visits and include outpatient medication reconciliation.

Check, if applicable	Description of Core Components
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.
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.
Applicable	**2.2.9** Demonstrate engagement of patients in the design and implementation of the project.
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.
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)

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]

Rationale: KDHCD will address medical and non-medical needs of our high-risk, medically complex Medi-Cal population. Tulare County ranks 55th out of 58 counties in access to clinical care, and 53rd, 58th and 43rd out of 58 counties in death due to

cardiovascular disease, pneumonia and diabetes. Additionally, Tulare County has a patient to physician ratio of 2,400 residents per 1 primary care physician compared to the statewide ratio of 1,300 residents to 1 physician.

Planned Design and Implementation Approach:

Care Management Program Workgroup: The Care Management Program workgroup will identify, evaluate, and expand services provided to patients such as case management, discharge planning, community outreach, and resource navigation assistance. (DY12)

Workforce Gap Analysis: Determine current caseload ratios for community health outreach specialists and create a workforce plan to recruit/hire/train staff. (DY12)

Tiered Service Delivery: Develop a tiered approach to service delivery so that intensity and frequency of services match the patient's needs. This will include determining what services are provided in-home, in a patient care setting, or via telephone. (DY12)

Quality Improvement: Review current risk assessment process to determine areas of improvement and develop a uniform process/tool. (DY12)

Risk Stratification: Develop a risk stratification process to identify high-risk/rising-risk patients. (DY12)

Care Coordination: Assign identified patients to community health outreach specialists who will link them to available social and medical resources and assist them with navigating available social and medical resources. (DY12)

Patient Engagement: Engage patients to self-manage their health conditions by supporting the adoption of healthy behaviors through our Empowerment for Better Living (EBL) program which is licensed by Stanford University's Chronic Disease Self-Management Program. EBL participants learn from trained leaders who either have a chronic illness or have a family member with a chronic illness. (DY12)

2. *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 for this project is adult Medi-Cal beneficiaries with uncontrolled disease state(s) amongst the 13 specified chronic conditions in the PRIME guidance document with a focus on heart failure, coronary heart disease and/or diabetes. KDHCD will employ a multi-pronged approach to identify these high-risk patient populations utilizing both internal (i.e. hospitalizations, ED visits, and data from our rural health clinics) and external data sources (i.e. collaborating with health plans and medical groups).

Vision for Care Delivery: A complex care management program will decrease unnecessary ED visits and avoidable readmissions/admissions amongst high-risk patients through access to additional supportive services. By developing a Care Management Team which utilizes community health outreach specialists, KDHCD's program aims to empower the patient to self-advocate and self-navigate the healthcare system. KDHCD creates this empowerment by:

- Identifying patients' post-acute or post-ED discharge needs
- Linking patients with primary and specialty health care providers
- Ensuring access to continuous health insurance
- Providing linkage to mental health and substance abuse counseling and treatment
- Identification and connection with various other social and medical services
- Participating with the healthcare team to develop a care plan
- Monitoring adherence to care plan.

3. *KDHCD (DMPH) Project 2.3 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.*

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.
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.

Check, if applicable	Description of Core Components
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.
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.
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.
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.
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.

☒ 2.6 – Chronic Non-Malignant Pain Management

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]*

Rationale: KDHCD chose this project to increase access to specialists with advanced training in the pharmacotherapy of pain management in the outpatient setting. KDHCD established an inpatient pain management service during 2014 to reduce opioid associated adverse events (OAAE). KDHCD's 2015 data demonstrates greater than 1500 interventions with an estimated cost avoidance of $1.6 million. In 2013, Tulare County had a 47% increase in ER visits from opioid overdoses with a 35% increase in hospitalizations (CDPH 2007-2013). The CDC showed Tulare County had 67 opioid related overdose deaths from 2009-2013.

Planned Design and Implementation Approach:

Multidisciplinary Workgroup: KDHCD will convene a multidisciplinary workgroup to design, implement, and monitor the Chronic Care Program. (DY11)

Chronic Pain Management Service Expansion: KDHCD will expand and champion this program with pain management specialists and primary care providers in an outpatient clinic serving as a referral center for community primary care providers who are seeking to appropriately manage chronic pain patients and those that need to be safely tapered off opioids at time of hospital discharge. (DY12)

Identification - Referral Processes: Patients at risk for OAAE will be identified by screening patients admitted to the hospital and through the use of our already developed in-patient opioid stewardship program. At risk patients would be referred for outpatient pharmacotherapy management. Outreach to community primary care providers to invite patient referrals for those at risk for OAAE. Identify gaps in treating chronic pain amongst care team members/community providers. Address gaps by developing educational material, resources and training to standardize care within the community. (DY12).

Patient – Provider Education: Emphasis will be placed on adequate patient education during visits to establish goals of care and expectations. Multimodal therapy will be targeted to minimize use of opioid analgesics and long-term morbidity/mortality risks associated with their use. Providers within the community will also be educated as to proper treatment approaches. (DY12)

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

Target Population: KDHCD expects to establish the target population as part of our planning activities. However, KDHCD anticipates that the target population will be determined based on both clinical and utilization criteria, but will include the Medi-Cal population that has a diagnosis of moderate to severe pain lasting greater than 90 days.

Vision for Care Delivery: As a result of this PRIME project, patients and providers within the community will have access to a multi-disciplinary clinic focused on maximizing patient care and minimizing adverse drug events. KDHCD's pain management pharmacists will individually tailor patients' pain regimens using multi-modal pharmacotherapy and potential referrals for psychotherapy and/or addiction treatment options. This will optimize care, reduce readmissions, reduce emergency department visits, reduce adverse drug events, and provide better control of pain management. Pharmacists will provide education to providers and patients on evidence based practices, including pharmacologic and non-pharmacologic treatment options.

3. *KDHCD (DMPH) Project 2.6 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.*

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

Check, if applicable	Description of Core Components
Applicable	**2.6.1** Develop an enterprise-wide chronic non-malignant pain management strategy.
Not Applicable	**2.6.2** Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**2.6.3** Implement or adapt a state or nationally recognized methodology for the assessment and management of chronic pain.
Applicable	**2.6.4** Implement protocols for primary care management of patients with chronic pain including: • A standard standardized Pain Care Agreement. • Standard work and policies to support safe prescribing practices. • Comprehensive pain history including psycho/social evaluation, functional evaluations, care plan, pain medication risk/benefit informed consents, ongoing monitoring of plan/outcomes (e.g., use of standardized monitoring template for follow-up visits for CNP), aberrant behavior screening and management protocols. • Guidelines regarding maximum acceptable dosing.

Check, if applicable	Description of Core Components
Applicable	**2.6.5** Provide culturally, linguistically and literacy level-appropriate patient education on the pathology of chronic pain, rationale for rehabilitation and expected goals of treatment.
Applicable	**2.6.6** Coordinate a chronic pain care team that minimally consists of a physician champion and medical support staff. Suggestions for care clinicians from other disciplines include occupational and physical therapy, behavioral health, pharmacy, substance use disorder specialists, neurology, occupational medicine, anesthesiology/pain management, home care, social work, and physical medicine and rehabilitation.
Applicable	**2.6.7** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, and team based population/panel management and care coordination.
Applicable	**2.6.8** Determine population ICD-9/ICD-10 codes for data collection that is unique to patients with chronic pain on opioids and develop a registry for pain assessments, care agreements, medication refill standing orders and urine toxicology screening.
Not Applicable	**2.6.9** Utilize provider activity report card to provide feedback to providers on how their chronic pain management practice compares to peers and benchmarks.
Applicable	**2.6.10** Establish a policy for monitoring and maintaining opioid agreements for prescription refills with other clinics, pharmacies, dentists and specialists.
Applicable	**2.6.11** Develop a process for scheduling pain focused follow-up patient visits to ensure that patients receive refills in a timely manner while also receiving recommended monitoring for signs of diversion or misuse.
Applicable	**2.6.12** Develop staff and clinician training regarding the organization's process for managing patients with chronic non-malignant pain.
Applicable	**2.6.13** Train providers to identify signs of prescription opioid use disorders and provide treatment options for patients diagnosed with opioid use disorders, including suboxone treatment, referral to methadone maintenance, referral to inpatient and outpatient substance use disorder treatment facilities, and referral to needle exchanges.
Applicable	**2.6.14** Develop and implement protocols for prescribing naloxone to patients receiving opioids for chronic pain.

Check, if applicable	Description of Core Components
Applicable	**2.6.15** Identify standardized multidimensional pain assessment, functional assessment, psychological assessment, and opioid assessment tools that meet the needs of the care clinicians and are appropriate for the patient populations.
Applicable	**2.6.16** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. Timely, relevant and actionable data is used to support patient.

☒ 2.7 – Comprehensive Advanced Illness Planning and Care

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]*

Rationale: Access to specialty palliative care at KDHCD is currently limited. Inpatient palliative care consultations occur only AFTER symptom exacerbation has resulted in hospital admission or for outpatients who meet the stringent regulatory criteria for home health. This structure has resulted in patients having limited, untimely or no access to this service. In fact, Tulare County was assessed as being capable of meeting only 2% of its estimated need for community based palliative care compared to the 18% capability estimated in Fresno County. In comparison, estimates for metropolitan areas show far greater access to specialty palliative care services (Los Angeles County = 46%).

Planned Design and Implementation Approach:

Multidisciplinary Workgroup: Convene a multidisciplinary workgroup to design, implement, and monitor the Palliative Care Program using rapid-cycle improvement methods. (DY11)

Referral Processes: Develop referral process to the Palliative Care Program from inpatient, outpatient and community based services. The referral process will include criteria and triggers which identify patients appropriate for palliative care services. Key champions will be identified in each service line and monthly contact will be maintained with a palliative care team member. (DY12)

Clinical Pathways: Develop patient-centered assessment and care plan tools to support evidence-based palliative care. Comprehensive advance care planning

processes will be developed to assist in clarification of goals, medical decision making and Physician Orders for Life Sustaining Treatment (POLST) form completion and inclusion in the POLST Registry. Develop processes that ensure advance care plan is documented and transmitted to collaborating providers (e.g, primary care, hospital, skilled nursing facilities (SNFs), home-based environments). (DY12)

Care Team Training: Develop training program for healthcare team with focus on communication skills, advance care planning and symptom management. Pre/post evaluations of knowledge/understanding of primary palliative care principles will be conducted. Ongoing education will target areas/issues identified as being in need of additional education. (DY12)

2. *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 for this project is as follows: 1) all Medi-Cal patients who received an inpatient palliative care consultation and discharge from the hospital, unless otherwise specified; 2) all Medi-Cal patients currently participating in the home health-based outpatient palliative care program will be screened for referral to the center-based palliative care program, unless otherwise specified; and 3) Medi-Cal patients with one or more serious illnesses (i.e., cancer, CHF, ESRD, ESLD, COPD, dementia) who have two or more emergency department visits or hospitalizations per measurement period.

Vision for Care Delivery: By providing specialty level palliative care services, KDHCD will offer an essential support to our patients with complex medical conditions and their families and improve their quality of life. Our Palliative Care Program will increase access to care for symptom management, advance care planning, and engagement of the patient around shared medical decision-making and setting goals of care. The enhanced social, emotional and spiritual support provided by the palliative care service will positively impact overall chronic disease management as well as improve quality of life for patients and families served. By partnering with community and provider resources, the palliative care service will support improved communication and continuity of care. The expected reduction in emergency department visits and hospitalizations will free resources for new services that promote innovative advanced illness management strategies and programs within our system and the community.

3. *KDHCD (DMPH) Project 2.7 will require infrastructure-building process measures. See the supplemental document (Appendix) for identification and description of proposed process measures.*

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.
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.
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.
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 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.

Check, if applicable	Description of Core Components
Not Applicable	**2.7.8** Enable concurrent access to hospice and curative-intent treatment, including coordination between the providing services.
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.
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.
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 table below:

	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 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 $ 31,580,000
- DY 12 $ 31,580,000
- DY 13 $ 31,580,000
- DY 14 $ 28,422,000
- DY 15 $ 24,158,700

Total 5-year prime plan incentive amount: $ 147,320,700

Section 9: Health Plan Contract (DPHs Only)

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

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

Section 10: Certification

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

Appendix- Infrastructure Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
1.	PRIME workforce gap analysis and staffing plan	• Conduct a gap analysis of current workforce resources and ability to support PRIME • Identify resource/staffing requirements needed to support PRIME data collection, reporting and monitoring • Create staff specific competencies for PRIME resources • Develop training program for staff supporting PRIME • Develop job descriptions • Recruit team members • Hire team members • Train new team members	1.2, 1.3, 1.5, 2.2, 2.3, 2.6, 2.7	January 1, 2016-December 31, 2016
2.	Develop mechanism to engage patients in the design and implementation of the project and in participating in their plans of care and self-management behaviors	• Develop patient surveys for targeted feedback of service design and implementation • Design workflows and documentation to reinforce patient-driven, self-management goals and plans of care	1.2, 1.3, 1.5, 2.2, 2.3, 2.6, 2.7	January 1, 2016-December 31, 2016
3.	Development of telehealth platform	• Convene workgroup to assess and determine District's current and future capacity and resources needed to operate and sustain a patient portal • Determine minimum requirements needed for patient portal • Identify and develop	1.3, 2.3	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		cross-functional team to create and implement patient portal • Determine desired patient portal functionality (e.g. secure email, text, sharing lab tests) • Develop plan to build or select and implement a patient portal • Establish patient portal • Train staff on how to use patient portal • Develop educational materials for patients on how to use patient portal • Establish telehealth workflow for patient and referring/consulting provider and staff communication		
4.	Develop discharge medication reconciliation process and patient education about medications (where applicable)	• Develop education and training program for staff involved in performing discharge medication reconciliation and education • Assess resources and tools needed to support patient education • Develop workflow • Develop documentation tools	1.2, 2.2	January 1, 2016-December 31, 2016
5.	Establish team-based care values	• Convene a workgroup of providers and staff to identify standards of team-based care • Develop team based care training modules • Provide staff training on	1.2, 2.2	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		team-based care to ensure effective provision of services • Implement a team-based model in which staff performs at full capacity and credentials • Seek feedback from providers and staff on effective use of team		
6.	Develop technology-enabled data system to support –PRIME projects via CERNER implementation and incorporation of PRIME metrics into EHR workflow	• Convene a workgroup to evaluate and identify all reporting and process needs for PRIME metrics • Identify data to collect, ability to produce data, and barriers to data reporting • Develop a plan to collect the data • Develop a mock report for PRIME factors • Deliver to staff and providers the reports for PRIME factors • Establish reportable baselines for PRIME factors • Select a vendor for new EHR system • Convene a workgroup to address PRIME metrics in new EHR • Develop workflows and data reports into new EHR system • Validate system build for PRIME metrics • Complete end user training prior to CERNER	1.2, 1.3, 1.5, 2.2, 2.3, 2.6, 2.7	January 1, 2016-June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		EHR go-live		
7.	Develop multidisciplinary care team and design workflows	• Convene a workgroup to assess current needs of target population and identify types of staff that can address those needs • Create job descriptions and defined duties for each team member • Recruit for each position • Design and budget for initial and continual training for team members on care model • Develop policies and/or protocols that enable team members to practice at the top of their license and include communication and collaboration with primary care provider • Develop and implement standardized workflows for diversified delivery strategies	1.2, 1.3, 2.2, 2.3, 2.7	January 1, 2016-June 30, 2017
8.	Develop patient registry/dashboard	• Assess and determine hospital's current and future capacity and resources needed to operate and sustain a patient registry • Identify and develop cross-functional team to create and implement registry	1.2, 1.3, 1.5, 2.2, 2.3, 2.6, 2.7	January 1, 2016-June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Determine desired patient registry functionality (e.g. pre-visit planning, point of care, outreach, monitoring, population reporting, ensure all referrals have been responded to, tracking timeliness of response to referral, closing the loop with primary care provider, track/report outcomes, medication adherence, and support continuous quality improvement activities, etc.) • Develop plan to build or purchase registry • Train staff on how to use registry • Design workflows and documentation to encourage usage of registry • Implement registry		
9.	Ensure patients have care plans in place	• Convene a workgroup to review the literature • Develop a draft care plan template • Work with vendor to integrate the care plan into the EHR by developing a module/ template • Train staff on how to use the care plan • Pilot the care plan in designated settings • Implement the care plan	1.2, 1.3, 2.2, 2.3	January 1, 2016-June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		in all settings so that all participating patients have a care plan in place • Develop and implement a system where the care coordinator reviews the care plan with the patient to ensure engagement and understanding of course of care		
10.	Implement system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership	• Develop process to provide feedback to care teams around preventive service benchmarks and QI efforts • Development of patient and staff surveys for targeted feedback of service design and implementation • Design workflows and documentation to reinforce patient engagement in plans of care	1.2, 1.3, 1.5, 2.2	January 1, 2016- June 30, 2017
11.	Develop and implement care management model	• Convene a workgroup to conduct a needs assessment, research evidence based practice guidelines, best practices and make recommendations on an approach • Develop curricula/training modules for staff • Train staff and providers • Assess effectiveness of trainings • Develop and implement care management tools (e.g. comprehensive	1.2, 2.2, 2.3	January 1, 2016 – June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		assessment, care plan, referral form, staffing plan) • Pilot care management model • Expand care management coordination		
12.	Develop a plan to achieve PCMH recognition	• Convene a workgroup to perform a gap analysis for NCQA recognition • Contract with EHR vendor to implement workflow and reporting for PCMH • Develop a Master Schedule for implementation of PCMH Standards with responsibility assigned • Develop staffing model and position responsibility for PCMH • Complete/revise policies, documents, workflows necessary for selected standards and begin review of required reports • Register Exeter, Dinuba, Woodlake and Lindsay clinics and prepare NCQA application • Submit evidence and final application for all rural sites to NCQA to receive recognition as PCMH	1.2	January 1, 2016-June 30, 2017
13.	Train clinic staff and providers on PCMH concepts	• Convene a workgroup; make recommendation on approach to train adult learners on PCMH concepts • Develop and implement	1.2	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		PCMH training curriculum for staff and providers • Assess effectiveness of PCMH trainings and improve training as needed		
14.	Improve accuracy and completeness of REAL and SO/GI data	• Organize a team to discuss collection and reporting of demographic data in this project: race, ethnicity, language, sexual orientation, and gender identification. Identify responsible party and process to add demographics to the system. • Distribute articles from the PRIME project addressing categories of SO/GI; collect Tulare County REAL demographics to assure all REAL items are in the data system and the printed forms. Capture any national/state standards for procuring information. Ensure all demographics categories can be collected and entered within clinical workflow and/or downtime procedures. Set the REAL/SO/GI data fields as mandatory. Create data forms. • Develop training to procure and enter REAL/SO/GI data. Explain why the data is	1.2	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		collected and how the data will be used to improve care for at-risk Medi-Cal populations. Teach the national/state standards for collecting information. The training will stress data completeness and validity processes. • Create reports on all REAL/SO/GI data and check for 100% completeness. Run reports on a monthly basis. Correct the errors by reviewing the demographics on scanned copy of the admission sheet to the data entered by the front office staff. Perform education, as needed. Continue monitoring throughout the process measure period. • Develop reports and perform a sampling strategy to validate data. The sample strategy must take into account the margin of error (1%), the confidence interval (99%), the population size (40,000 visits) and the response distribution (1%). n=650 is a reasonable sample for the six month period during the process measure ramp up.		

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		Comparison of the scanned admission sheet to the electronic data will ensue. The admission sheet will serve as original source data. If greater than 1% error is sampled, the staff committing the errors will be retrained and monitored until data entry is error free. • Develop capacity to stratify performance metrics by REAL/SO/GI data and use stratified performance data to identify disparities for targeted interventions. Produce report. • Develop dashboards and communicate regularly share stratified performance measures with front-line staff, providers, and senior leadership.		
15.	Evaluate current state of payment and authorization processes for specialty care with FFS and Medi-Cal MCOs	• Form committee to identify barriers to care around authorizations and payment for new specialty services being created • Develop referral/prior authorization workflows to minimize delays in care • Make adjustments, if needed, to contracts to enable patients to be seen in our clinics	1.3	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Referrals for specialty care will be tracked by referring provider, indication and payer o Denominator = Total referrals for specialty care o Numerator = Total number of approved referrals • Reimbursement for services will tracked for care provided by payer o Denominator = Total charges o Numerator = Total reimbursement		
16.	Development and deployment of clinical and staff education on care model	• Convene a workgroup that includes clinical team to conduct a needs assessment, to assess need for specialty care including mental health and SUD services, research best practices and ensure evidence-based care is provided in a team model • Develop curricula modules for targeted disease states and patient engagement and education strategies • Schedule and conduct ongoing trainings • Assess effectiveness of trainings o Conduct pre-training	1.3	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		assessment surveys to gauge subject matter competence prior to training o Effectiveness of trainings for specialty care will be assessed via post-training surveys of trainees using Lichert Scale 1-5 to assess increased competence of subject matter		
17.	Conduct outreach to community-based resources to improve referral and follow up processes for specialty care	• Develop job description for a staff person to engage in this work • Recruit and Hire staff person • Train staff person • Engage primary care and specialist providers and local public health departments in the design and implementation of the specialty care model • Asses current referral and follow up processes and identify gaps • Develop process to screen new referrals • Develop/Enhance follow up process • Identify community based resources to target for referrals • Identify specialty care providers to target for follow up • Develop plan for educating community organizations and	1.3	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		providers on the services KDHCD provides • Create educational/marketing materials to promote services • Develop systems to communicate to primary care physicians their patients that have been identified as high-risk for targeted disease states to facilitate referral process		
18.	Engage primary care providers and other providers, specialists, and local public health departments in development and implementation of specialty care model for chronic diseases	• Develop a survey to determine needs of PCPs and the public health department for a specialty care model as well as PCP's capacity to manage higher acuity conditions either independently, or in collaboration with, specialty care • Survey PCPs, other providers and public health department • Analyze survey results and incorporate feedback in implementation of specialty care model	1.3	January 1, 2016-December 31, 2016
19.	Develop and implement processes to ensure preventative screening is consistently performed under Million Hearts initiative	• Collect or use baseline demographic (e.g. race, gender, language etc.) data on receipt and use of targeted preventive services • Ensure US PSTF Grade A and B screening recommendations	1.5	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		pertaining to cardio-cerebrovascular disease are incorporated into clinic workflow and documentation		
20.	Development and deployment of clinical and staff education on Million Hearts care model	• Convene a workgroup that includes clinical team to conduct a needs assessment, research best practices and ensure evidence-based care is provided in a team model for hypertension, aspirin utilization, cholesterol and smoking cessation • Identify community based and state or federal resources for tobacco cessation services • Assess current referral and follow up processes and identify gaps • Understand FFS and MCO Medi-Cal defined benefits for tobacco cessation services to make appropriate referrals to local, state, and national resources to affirm coverage • Create and/or adopt educational/marketing materials to promote tobacco cessation • Develop curricula modules for targeted disease states (i.e. hypertension, aspirin utilization, cholesterol	1.5	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		and smoking cessation) and patient engagement and education strategies • Schedule and conduct ongoing trainings • Assess effectiveness of trainings o Conduct pre-training assessment surveys to gauge subject matter competence prior to training o Effectiveness of trainings for Million Hearts care model will be assessed via post-training surveys of trainees using Lichert Scale 1-5 to assess increased competence of subject matter		
21.	Improve care transitions program by establishing a transition care team	• Create a strategic plan for the program, including the mission, vision and goals • Conduct a workforce gap analysis to determine staffing needs for program • Develop staffing plan based on need • Develop a job description for staff based on needs of program • Recruit and hire staff for all project components based on need	2.2	January 1, 2016-December 31, 2016
22.	Develop and implement structure for obtaining best	• Conduct an overall analysis of the accuracy of current home	2.2	January 1, 2016-December

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
	possible medication history and assessing accuracy of list for care transitions program	medication list tool • Develop education and training program for staff involved in the collection of medication histories for hospitalized patients • Develop clinical workflow • Develop documentation tools • Develop policies and procedures • Conduct a follow up overall analysis of the accuracy of changed home medication list tool		31, 2016
23.	Develop post-discharge follow-up process based on risk of re-admission for medication misadventures	• Develop education and training program for staff involved in performing post-discharge follow-up • Develop workflow • Develop documentation tools	2.2	January 1, 2016-December 31, 2016
24.	Develop services that support receipt of discharge prescriptions and medication consultation prior to discharge	• Develop and implement retail pharmacy • Develop workflow • Develop documentation tools • Develop education and training materials • Train staff on documentation tools and workflow changes	2.2	January 1, 2016-December 31, 2016
25.	Develop standardized workflow for transition of care team	• Conduct literature review to determine and select the most appropriate model to use for standardized workflows • Standardize all workflows and protocols for the program to include	2.2	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		discharge planning, access to PCP, multidisciplinary involvement, medication reconciliation and post-acute care needs • Develop training materials on role of the discharge advocate in the discharge workflow. • Train staff on protocols and workflows • Engage local health plans to develop and implement transition of care protocols for post-acute needs: mental health, substance abuse and physical health, PCP follow-up and post-acute and DME availability		
26.	Develop discharge process for care transitions program	• Develop discharge tools for engagement of patients, caregivers and families in care planning process to include education, coaching, transition care plan and communication about post-acute care needs • Develop and implement training and education program to staff for patient's caregivers and families on the discharge resources available. • Train hospital staff who are involved in the discharge process (i.e. bedside nurses) on the role of discharge	2.2	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		advocates • Develop and implement a plan to increase the number of strategic relationships with community based agencies		
27.	Conduct a qualitative assessment of high-risk, high-utilizing patients. Include development of a mechanism to engage patients in the complex care management program in the design and implementation of the project and in participating in their plans of care and self-management behaviors	• Convene a workgroup with a background in qualitative research and needs of high-risk utilizing patients • Develop a survey tool to assess the needs and utilization patterns of high risk, high-utilizing patients • Develop patient surveys for targeted feedback of service design and implementation • Survey sample of patient population • Analyze survey results • Design workflows and documentation to reinforce patient engagement in plans of care • Incorporate findings into strategy to better manage this population	2.3	January 1, 2016 – December 31, 2016
28.	Development of a multidisciplinary pain team	• Perform an evidence-based literature review to identify best practices • Determine resource needs and develop job descriptions • Gather baseline performance metrics and develop short term goals and tactics to accomplish	2.6	January 1, 2016 – June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		objectives • Recruit and hire staff • Identify reporting structure and develop charter (roles of team members) • Develop policies/procedures/ protocol of operation including patient safety measures with opioid prescribing		
29.	Development of protocols/procedures for pain management	• Perform an evidence-based literature review to identify best practices and validated tools • Develop documentation tools • Develop patient monitoring parameters • Develop patient opioid agreement template • Develop and implement electronic files identifying patients' participation in program, progress, fill history, depression screening, opioid agreement, and toxicology screenings • Develop policy/protocols for naloxone prescribing, education and management	2.6	January 1, 2016 – June 30, 2017
30.	Development of process for patient identification and referral to pain management service	• Develop a process to identify and target inpatients for outpatient referral via opioid stewardship • Perform an evidence-	2.6	January 1, 2016 – June 30, 2017

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		based literature review to identify best practices and validated tools • Develop education materials for outpatients to help guide therapy and expectations • Develop modules/competencies for treatment of chronic pain patients for staff involved in patient care • Develop modules/competencies to identify patients with opioid misuse disorders • Develop policies/protocols in collaboration with physicians on when to refer patient to addiction treatment clinics • Develop systems around patient follow-up to ensure that patients receive refills in a timely manner while also receiving recommended monitoring for signs of diversion or misuse • Develop naloxone educational material for patient use • Develop education and training program for providers involved in patient care • Identify standardized		

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		multidimensional pain assessment, functional assessment, psychological assessment, and opioid assessment tools to meet the needs of patients • Develop education material for community providers to help identify patients that may need referral to clinic • Implement risk factors for opioid associated adverse events into electronic medical record to help identify in-patients needing referral to clinic if feasible.		
31.	Development of patient monitoring under pain management service	• Perform an evidence-based literature review to identify validated monitoring tools for patients at risk for opioid misuse • Establish methods to report and monitor performance • Establish initial performance targets and reassess on an ongoing basis • Utilization of State prescription monitoring programs to identify controlled substance fills by other providers	2.6	January 1, 2016 – June 30, 2017
32.	Establish palliative	• Develop Job descriptions	2.7	January

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
	care team members and a strategic plan	• Recruit team members • Hire team members • Train new team members • Establish Palliative Care Program Committee • Establish Inpatient Palliative Care Program sub-committee • Establish Outpatient Palliative Care Program sub-committee • Create mission & vision statement • Establish long-term and short-term goals and objectives for the inpatient and new outpatient Palliative Care Program • Develop plan for increasing community awareness • Perform workforce gap analysis to project future staffing needs for program expansion		1, 2016-December 31, 2016
33.	Develop a primary palliative care training program	• Develop training program with focus on communication and symptom management • Create staff specific competencies that ensure staff have the understanding and skills necessary to provide Palliative Care Services • Develop and implement Primary Palliative Care Training for frontline staff	2.7	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		and clinicians, and process for updating and evaluating competencies		
34.	Establish referral process to the palliative care service	• Develop referral process for inpatient • Develop referral process for outpatient - Internal - External • Develop referral process for home health - Internal - External • Develop referral process for skilled nursing facilities - Internal - External • Work with community partners to understand criteria and to develop referral process for community based services (e.g. hospice, grief support, addiction recovery, etc.) • Draft policies and procedures for internal referral processes • Draft policies and procedures for external referral processes • Train internal and external staff on referral process	2.7	January 1, 2016-December 31, 2016
35.	Develop a comprehensive advance care planning process	• Review literature around advanced care planning best practices. • Develop protocols for advanced care planning	2.7	January 1, 2016-December 31, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
		• Develop advance care planning tools • Develop training modules on advance care planning • Train staff • Implement advance care planning process • Documentation of advance care planning preferences • POLST completion • Participation in POLST statewide registry • Develop a process to ensure 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		
36.	Coordinate and partner with Hospice programs	• Identify potential Hospice program partners • Develop communication and referral processes with Hospice programs • Each participating hospice organization will be documented • Communication and referral processes that are developed will be documented	2.7	January 1, 2016-December 31, 2016

Reference List:

"2013 Community Health Needs Assessment: Fresno, Kings, Madera and Tulare Counties", Hospital Council of Northern & Central California, March 8, 2013

"County Health Status Profiles 2015", California Department of Public Health

"Medi-Cal Quick Stats: Proportion of California Population Certified Eligible for Medi-Cal by County and Age Group – September 2015", Research and Analytic Studies Division, California Department of Health Care Services, Volume 2016-001