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

Kern Medical Center

Health Care System Designation(DPH or DMPH)

DPH

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.

Bakersfield, California, home to Kern Medical Center (Kern Medical), represents the largest city in Kern County. Respective community and population-based health care needs and disparities can be summarily described as follows:

Physical Health: The most pressing health concerns affecting the residents of Kern County consist of obesity, diabetes, heart disease, and chronic lower respiratory disease, in addition to an inordinately high prevalence of sexually-transmitted diseases; respectively, the following statistics outline recently obtained values:

- *Obesity:* More than 50.4% of adults within our geography are obese, in comparison to 27% statewide;[1]

- *Diabetes:* Corresponding with high obesity rates, our diabetic mortality rates are 27.7%, compared to 20.8% statewide, with 13.5% of residents having been diagnosed as pre/borderline diabetic and 10.3% as diabetic, compared to statewide averages of 10.5% and 8.5%, respectively;[2]

- *Heart Disease:* Corresponding with the preceding health concerns, 9.4% of adults have been diagnosed with heart disease, compared to 6.1% statewide;[3]

- *Lower Respiratory Disease:* Lower respiratory disease mortality rates were listed at 43.7%, compared to 35.3% statewide;[45]

- *STDs:* Per 100,000 persons, there were: 719.5 cases of Chlamydia, versus 453.4 statewide; 176.8 cases of Gonorrhea, versus 116.8 statewide; and 16.2 cases of Primary and Secondary Syphilis, versus 9.9 statewide.[6]

Mental/Behavioral Health: According to values obtained from the 2014 California Health Interview, within Kern County:

- *Psychological Distress and Access:* 17.1% of reported adults experienced serious psychological distress in the corresponding year, compared to 7.7% statewide. Relative to access, 85.5% of the adults that self-reported as having experienced psychological distress during the measurement period, reported being unable to receive necessary treatment, compared to 43.4% statewide.[7]

- *Substance Use:* Nearly 41% of adults reported having engaged in binge drinking during the previous year, compared to 32.6% statewide; moreover, nearly 12% of teens reported similar behavior, compared to 3.6% statewide.[8]

Health Behavior: Consequently, the collective physical and behavioral health values that have respectively been referenced place Kern County at a health behavior ranking of 52, out of 57 evaluated counties,[9] effectively representing the bottom 20% of surveyed counties in California.

Coverage. As of March 2016, Kern Medical provides coverage to more than 38,000 assigned Medi-Cal managed care lives. Notwithstanding expansions in coverage, Kern County continues to experience significant shortages amongst available primary care providers (PCPs)—based on 2015 County Health Rankings, Kern County presently has a Population to PCP ratio of 2014:1, compared to 1294:1 statewide.[10]

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.

Population: As of the most recent census, the collective population of Kern County was 848,204,[11] with the city of Bakersfield representing the highest concentration of metropolitan residency at 529,169, or 62% of the total county population.[12]

Race/Ethnicity, and Language: The population of Kern County represents a vast geographical service coverage area, encompassing several large rural populations, and maintaining a diverse population. Respective ethnicities are currently comprised of 49.8% Hispanic, 37.9% White/Caucasian, 5.3% African American, 4.1% Asian, and 2.1% Other.[13]

While English continues to be the predominant language spoken, more than 41% of Kern County residents speak a language other than English at home.[14]

Income: Based on 2014 data, the median per capita income in Kern County was $20,467, in comparison to $29,906 statewide,[15] representing an average income disparity of more than 26%; moreover, 47.6% of the population had reported income

levels at 200% below the Federal Poverty Level (FPL), with 22.9% living at below 100% of that same line.[16]

Age: In comparison to the statewide average (35.4 years), the collective population is slightly younger, with a median age of 30.8 years; accordingly, the age breakdown is as follows:

- 0-17 years (30%);
- 18-64 years (60.8%);
- 65 and over (9.2%).[17]

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.

The County of Kern owns and operates Kern Medical, a 222-licensed bed general acute care teaching and designated safety net hospital, with a Level II Trauma Center and several outpatient clinics.

Historically, given its designation as a public, safety net provider, Kern Medical has served an integral role within the community, caring for the most socially and medically vulnerable residents of Kern County. Consequently, our acute care teaching hospital and outpatient clinics offer many services unavailable elsewhere within the community. Our Level II Trauma center, which collectively serves all of Kern County, is the only available trauma program located within a 100 mile radius.

Kern Medical is an academically-based medical center affiliated with the UCLA School of Medicine. Offering the only hospital-based residency in the county, Kern Medical trains 115 residents and fellows per year in the fields of Emergency Medicine, Family Practice, General Surgery, Internal Medicine, Obstetrics and Gynecology, and Psychiatry, while concurrently providing training to over 140 medical students from the Ross University School of Medicine.

As a whole, Kern Medical provides care for approximately 12,000 inpatients, 45,000 Emergency Department visits, 5,600 surgeries, and 110,000 general and specialty clinic visits annually. Correspondingly, our aggregate patient population is representative of a predominantly Medi-Cal payer mix, as represented in the following payer mix comparison: 67% Medi-Cal, 11% third party, 10.9% Medicare, 7.4% Uninsured, and 3.7% Other.

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.

Kern Medical currently relies on various resources for collecting, monitoring, and reporting core performance data and metrics; however, historically, oversight and governance have not been a centralized function. Furthermore, utilizing assorted forms of data retrieval, various departments have implemented dashboards and reports; however, work is often duplicated or unable to be replicated due to lack of communication across departments.

Accordingly, given the collectively decentralized nature of organization-wide data processes, Kern Medical has commenced the initial groundwork for a multi-disciplinary Data Stewardship Committee (DSC) comprised of comprehensive data stewards/stakeholders representing key hospital governance (e.g. revenue cycle, clinical/medical, etc.). The DSC will be tasked with establishing and standardizing the definitions, policies, procedures, and/or methodologies that will be needed to effectively implement core PRIME metrics and comprehensive system transformation.

Using the DSC as a starting point, Kern Medical will direct our collective vision and focus towards creating enhanced, integrated infrastructure for:

- *Data Collection:* Given the disparate nature of current practices, we will ensure that respective data practices, flows/streams, and outcome values are standardized and streamlined in order to ensure consistent definitions and retrieval methods, with the desired outcome being to realize comprehensive reduction in duplicative and/or overlapping data collection.

- *Reporting:* Various departments within Kern Medical have developed their own operational dashboards to track both quality and operational performance; however; as said processes tend to couple manual data entry with automated/semi-automated reporting, we intend to further utilize the robust, automated searching, tracking, and analytical capabilities of our disease registry. Moreover, as this system has traditionally been solely reliant on physician visit-based data capture, we intend to further integrate/expand capacity to be more inclusive of inpatient, ER, and ancillary visit data streams, coupled with additional investments in other relevant high-value infrastructure (e.g. predictive modeling software);

- *Monitoring:* As a formal data stewardship system is currently in its infancy, Kern Medical will focus on ensuring effective stewardship/oversight of the practices/approaches that will be used for collecting and reporting data resources. Therefore, respective organization-wide core reporting will be vetted and validated by key data stakeholders (e.g. physicians, clinical leads) for accuracy/integrity, allowing for the enhanced, expanded realization of data access at the point of service, and more objective, data-driven decision making.

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.*

Kern Medical's overarching goal is to improve the health of our patient populations by providing integrated health care that is patient-centered, data-driven, and founded upon evidence-based, proven best practices.

Accordingly, Kern Medical intends to effectuate systems and methodologies designed around promoting enhanced care management throughout all transitions of care delivery, with a focus on creating the settings and environments that will most effectively address the individual and collective needs of our patient populations, while reducing unnecessary and/or duplicative utilization.

As a result of these goals, Kern Medical will be better positioned to provide patient-centered population health management that is data-driven and prospectively aligned for transitions to risk-adjusted, value-based alternative payment methodologies (APMs).

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.*

Our primary aims relative to comprehensive system integration and respective PRIME implementation can be described as:

a) Integrating physical and behavioral health in a manner that promotes identification/screening, access, and enhanced tracking and care coordination protocols;

b) Realizing enhanced primary and specialty care delivery that is driven by intensified preventive, screening, and care coordination methodologies focused on the whole person.

c) Aligning resources and core competencies towards effectively managing all respective patient care transitions (e.g. inpatient to outpatient, correctional health to outpatient);

d) Effectuating systems and methodologies designed around promoting comprehensive care management for complex, high-risk populations;

e) Reducing unnecessary and/or duplicative utilization of system resources (imaging, ER, IP) through the implementation of technology-driven infrastructure (e.g. readmission tracking);

f) Reducing health disparities by focusing our initial efforts on those areas of highest value/return—diabetes, heart disease, and behavioral health.

Accordingly, these aims will assist Kern Medical in realizing comprehensive integration of care that improves access to health care services, effectuates enhanced care coordination across care settings/transitions, and promotes more seamless inter-system alignment;

Furthermore, these aims will assist Kern Medical in further expanding our point-of-care delivery model so as to promote more comprehensive, system-wide patient engagement and population health management, with the goal of more safely and effectively managing care transitions, resource utilization, and high-risk populations.

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;

Kern Medical selected the following projects:

- 4.1.1: Integration of Primary and Behavioral Health;
- 4.1.2: Ambulatory Care Re-design: Primary Care;
- 4.1.3: Ambulatory Care Re-design: Specialty Care;
- 4.1.4: Patient Safety in the Ambulatory Setting;
- 4.2.1: Improved Perinatal Care;
- 4.2.2: Care Transitions: Integration of Post-acute Care;
- 4.2.3: Complex Care Management for High-risk Populations;
- 4.2.5: Transition to Integrated Care: Post-incarceration;
- 4.3.2: Resource Stewardship: High-cost Imaging.

Of the referenced optional projects, patient safety in the ambulatory setting (4.1.4) and post-incarceration transitions to integrated care (4.2.5) were chosen as they most cohesively aligned with respectively identified internal analyses and other core organizational initiatives. That is, these additional projects were chosen as they most accurately align with our organizational and system-based aims targeted at:

a) Promoting enhanced, expanded care coordination throughout all transitions of care;

b) Creating an organizational culture that relies on transparent, data-driven approaches to providing safe, timely patient-centered population health management in all care settings.

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*

Inherently, many of the selected projects are mutually inclusive, sharing common core components and metrics. At the core of system transformation, is the overarching directive to more cohesively integrate health care service delivery and population health management via enhanced care coordination. As health care delivery so often starts within the primary and specialty care arenas, respectively selected projects will focus on enhancing our ability to more effectively screen, track, and manage our clientele throughout all transitions of care, ensuring that respective care is received in the most timely, appropriate manner.

Correspondingly, by further integrating physical care and behavioral health via enhanced screening and care coordination methodologies, we will become more effective in our efforts to comprehensively manage the individual and collective needs (i.e. whole person) of our patient populations. That is, we will be further enabled with the tools and mechanisms to more proactively identify at-risk individuals (high-risk, high-utilizing), connecting them with the services and resources for which they stand in need.

Ultimately, all selected projects inter-relate in the central, underlying ideology that as we progressively become more accountable stewards of our patient populations, our collective focus will progressively shift towards providing patient-centered care engagement and more effective population health management.

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

At the culmination of the five years, patient populations served by Kern Medical will receive comprehensive integrated health care in a manner that fosters:

1) Patient-centered, point-of-care delivery that proactively assists in accessing those services necessary to attain optimal health;

2) Access and utilization of the self-management tools and care management resources needed to avoid unnecessary and/or duplicative health system utilization;

3) Progressive, proportionate matriculation into value-based reimbursement models designed around supporting alternative payment methodologies and promoting greater emphasis on realizing more efficient, cost-effective utilization of provided resources.

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

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

Kern Medical will address local community health needs by establishing collaborative, inter-system infrastructures and methodologies designed to assist in comprehensively reducing the health disparities that affect the health care of our communities. Accordingly, given the current state of the combined physical health disparities (e.g. obesity, diabetes) currently plaguing Kern County, the preventive, population health management-driven enhancements that will be realized through PRIME within the primary and specialty care settings will assist in more proactively:

a) Identifying gaps in prevention, screening/identification, and collective disease management, as well as in providing the resources and tools needed to ensure effective care coordination and self-management;

b) Establishing timely, appropriate utilization and access to resources and follow-up care management/coordination (e.g. patient safety, closure of the specialty care referral loop).

Consequently, as much of the underpinnings of both PRIME and county-wide health disparities revolve around effectively and proactively managing the care of our uniquely complex patient populations (high-risk, multiple comorbidities), the combined focus on providing effective, timely case/care management during corresponding internal/external care transitions (e.g. perinatal, post-incarceration, post-acute, etc.) will fundamentally assist in establishing a model that is more patient-centric and focused on becoming more engaged, accountable patient care stewards to our communities.

Finally, given the prevalence of patients with co-occurring physical and behavioral diagnoses, coupled with disparities in respective behavioral health access and identification, Kern Medical will initiate additional collaborations with key community and county-based behavioral health services towards more fully integrating physical and behavioral health care at the primary care level; furthermore, in conjunction with the more preventive approaches to screening, identifying, and referring patients to needed services, we will focus on expanding our care management efforts to those settings and environments most accessible and appropriate to our targeted populations.

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).

In conjunction with the aforementioned creation of a data stewardship committee, Kern Medical will also establish collaborative advisory/oversight committees, departments, and work groups tasked with assisting in more completely and cohesively aligning the combined goals, objectives, and metrics of PRIME with other quality-based initiatives and improvements comprising organizational strategy—namely, Kern Medical will further develop:

- An OP Quality Department tasked with implementing rapid-cycle improvement plans and comprehensive, continuous quality assurance/improvement methodologies ;

- A Care Coordination Department tasked with establishing the methodologies/protocols necessary to achieve respective core components/metrics;

- An Outpatient Integration Team tasked with further aligning our resources and competencies with the corresponding objectives of PRIME realization;

- A LEAN Six Sigma-centered Performance Improvement Team tasked with utilizing said principles and practices towards identifying respective gaps in process, flow, and outcomes.

Ultimately, all respective programs will be designed around creating whole-person, patient-centered care methodologies focused on promoting greater value and more efficient, accountable utilization of provided resources.

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.

Kern has established ongoing collaborative relationships with many of our respective local stakeholders (e.g. Kern County Mental and Public Health, Kern Health Systems—KHS). Accordingly, these mutual collaborations have fostered the creation of several key committees and forums (e.g. KHS and Kern Medical's Joint Operations Committee) tasked with ensuring that activities and planning are representative of the diversely unique needs of our stakeholders—the patients, providers, health plans, communities, county departments, and governance boards for whom we have stewardship and accountability.

Consequently, as both internal and external stakeholder representation will collaboratively play an active role in presenting the unique perspectives of our consumers and providers, future efforts will be more centrally focused on ensuring the effective internal/external engagement of our core stakeholder—our patient populations. Internally, Kern Medical will ensure the active engagement of relevant executive, medical, and clinical committees and sub-groups, and will collaboratively include core representation from amongst our targeted patient. Externally, in conjunction with the initiatives and directives encompassed within PRIME, Kern Medical will continue to actively work towards promoting and implementing enhanced collaborative relationships with our community and county-based departments, entities, and affiliates with whom our patient populations have direct/indirect engagement.

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.

Given its historic role as the county's designated safety-net provider, coupled with the cumulative scope and breadth of our culturally and socially diverse populations, Kern Medical will maintain an ongoing focus on developing and implementing those strategies and approaches designed to most accurately reflect the diverse cultural and social traits of our clientele. Inherent with PRIME implementation is the anticipation that by more comprehensively realizing the capture of respective demographic and self-identification-based data components (e.g. REAL, SO/GI, language preferences), we will be better prepared to identify the uniquely varying health disparities affecting patient populations, and further enabled to more proactively address and target our programming and interventions respectively.

Accordingly, staff, personnel, and core stakeholders will continue to receive training and instruction adapted to the enhanced cultural, social, and linguistic needs of our clientele, coupled with an inherent directive on competently understanding and addressing the unique health disparities affecting our patient populations. Respectively, internal and external communication mediums (e.g. literature, translation services) will be adapted and tailored to reflect said needs. Furthermore, in order to ensure that our continued efforts are culturally-directed/driven and effectively communicated to our patient communities, our patient-centered/engaged advisory committees and boards will be tasked with consistently assessing and adapting our methodologies and approaches towards more accurately capturing patient information, requests, and preferences in the language and context most appropriate to community health needs.

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.

Historically, Kern Medical has utilized various approaches and methodologies centered on continuous quality improvement and change management. Given the scope and complexity underpinning comprehensive system transformation, Kern Medical has initiated strategies aimed at more effectively realizing sustainable quality, process, and performance improvement practices, and will continue to direct its core competencies and collective vision towards:

- Bridging the gaps and disparities that affect our collective health systems, models, and practices;

- Implementing the systems, infrastructure, and culture requisite to effectuate lasting, sustainable change.

- Ensuring the individual and collective support, buy-in, and engagement of our key internal and external stakeholders relative to successful implementation;

- Developing the internal and external curricula and training methodologies that will be necessary in order to provide efficient, culturally-competent, patient-centered care delivery;

- Creating a system and culture that are data-driven and focused on engaging patients, providers, and personnel towards championing the cause/vision within their respective spheres of influence.

Section 4: Project Selection

The PRIME Projects are organized into three Domains:

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

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

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

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

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

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

Instructions

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

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

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

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

   For DMPHs requiring infrastructure building metrics that are approved in the Prime Project Plan, 75% of PRIME funding for DY 11 will be based on the achievement of the approved DY 11 infrastructure building metrics through the final year-end report. Up to 40% of the total PRIME funding for DY12 will be based on the achievement of the approved DY 12 infrastructure building metrics through the mid-year and final year-end report. The proposed Process Measures should meet the following criteria:

   - *Specific*
   - *Measurable: Must be able to demonstrate progress throughout the duration of the process metric measurement period.*
   - *Evidence-based: Measures should have a strong evidence-base that can linked process to outcomes.*

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

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

Kern Medical serves a unique population of individuals facing many disparities and risk factors related to the interplay of physical and behavioral health care needs. As such, this project was selected by Kern Medical in order to further enable the organization to focus attention on those areas needed to properly identify and address the physical and behavioral healthcare needs of our patient populations.

Accordingly, our combined implementation approach includes:

SBIRT training for all Clinical Staff in Primary Care: Kern Medical will provide initial and ongoing training in the use of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) methodology with clinical staff. These training and screening methodologies will be administered at designated intervals, and will assist in realizing proven, best practices when working with patients with dual mental health and substance use concerns and that require more complete integration with primary care management.

Referral Processes: Kern Medical will continue to build upon the strategic alliances and collaborations that have heretofore been established amongst our community-based mental health service providers. These alliances will assist in:

a) More proactively identifying individuals as meeting eligibility criteria relative to specialty mental health and full-spectrum substance abuse treatment services;
b) Allowing for more clearly defined treatment protocols to be fostered within the primary care clinical environment.

Care Management: Kern Medical will develop a care management program to address the care coordination needs of patients across the primary care setting. A rubric will be developed and applied to the patient target population in order to assign patients to the appropriate level of care management services. The level of care management intervention will be determined by the patients' score on the developed rubric, which will consider social and health determinants and conditions. Furthermore, a primary component of this program will be the auto-inclusion of patients who have a diagnosis of diabetes. In addition, the care management program will include clinical and non-clinical staff members tasked with addressing both the physical and behavioral health care needs of the patients by improving integrated health efforts and increasing the knowledge base of the patient regarding diagnosis, treatment methods, and self-management techniques.

IT Support: Kern Medical will work alongside our Information Technology (IT) department to develop and implement an EHR-based template that will track behavioral health screening scores and provide instructions for real-time social service intervention in the event that the patient scores positive on the screening tool threshold for either mental health or substance use issues. Furthermore, IT will collaborate with The California Smokers' Helpline to ensure that patients confirming current use of tobacco are immediately referred via a bidirectional referral system for intervention, counseling, medication support, and other forms of support.

Target Population: Given the fundamental directives of the core components provided within this project, our initially outlined focus will be on addressing and integrating the behavioral health needs of our assigned target populations with those services rendered within the primary care clinic setting. It is anticipated that our core age group will be initially focused on adults, age 18 and over; however, screening tools, practices, and system-wide integration will be reflective of all groups.

Care Delivery Improvement: As a result of the successful implementation of this project, Kern Medical will improve the care of its patient populations by more effectively identifying, integrating, and managing respective physical and behavioral health needs. Namely, physical and behavioral health screening tools and services will become incorporated into all tiers of physical health care delivery, and will provide the organization with real-time data capabilities to be used towards eradicating the gaps, disparities, and fragmentation that presently exist. Resultantly, patients will receive accessible point-of-care delivery that is patient-centered, disease-specific, and focused on coordinated care management throughout all transitions of care.

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

Check, if applicable	Description of Core Components
Applicable	**1.1.1** Implement a behavioral health integration assessment tool (baseline and annual progress measurement)
Not Applicable	**1.1.2** Implement a physical-behavioral health integration program that utilizes a nationally-recognized model (e.g., the Four Quadrant Model for Clinical Integration, the Collaborative Care Model, or other Integrated Behavioral Health (IBH) resources from SAMHSA)
Not Applicable	**1.1.3** Integrate appropriate screening tools and decision support into the emergency department (ED) to ensure timely recognition of patients with mental health and substance use disorder problems. Enhanced access to primary care and/or to behavioral health specialists will be integrated into discharge planning for these patents. Use of 24-7 care navigators (e.g., Community Physician Liaison Program) may be used to support linkages to primary care providers (PCPs), mental health (MH) and substance use disorder (SUD) specialists and behavioral health and other community services through the discharge process.
Applicable	**1.1.4** Integrate physical and behavioral health, either through implementation of a new program or an expansion of an existing program, from pilot sites to hospital and health system primary care sites or from single populations to multiple populations (e.g., obesity, diabetes, maternal, infant, and child care, end-of-life care, chronic pain management).
Applicable	**1.1.5** Patient-Centered Medical Home (PCMH) and behavioral health providers will: • Collaborate on evidence based standards of care including medication management and care engagement processes. • Implement case conferences/consults on patients with complex needs.
Not Applicable	**1.1.6** Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families.

Check, if applicable	Description of Core Components
Applicable	**1.1.7** Ensure systems are in place to support patient linkages to appropriate specialty physical, mental and SUD services. Preventive care screenings, including behavioral health screenings (e.g., PHQ-2, PHQ-9, SBIRT), will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate steps, including the provision of brief interventions (e.g., motivational interviewing techniques) to ensure access for further evaluation and treatment when necessary. Preferably, this should include a warm transfer to the appropriate provider if the screening provider is unable to provide the service.
Not Applicable	**1.1.8** Provide cross-systems training to ensure effective engagement with patients with MH/SUD conditions. Ensure that a sufficient number of providers are trained in SBIRT and/or in other new tools used by providers to ensure effectiveness of treatment.
Applicable	**1.1.9** Increase access to Medication Assisted Treatment (MAT) for patients with alcohol and opioid addiction to assist in stabilizing their lives, reducing urges or cravings to use, and encourage greater adherence to treatment for co-morbid medical and behavioral health conditions. For alcohol use disorders these medications include naltrexone, acamprosate, and disulfiram. For opioid addiction, medication assisted treatment (MAT) includes maintenance treatment with methadone and buprenorphine.
Not Applicable	**1.1.10** Ensure the development of a single treatment plan that includes the patient's behavioral health issues, medical issues, substance abuse, social and cultural and linguistic needs. This includes incorporating traditional medical interventions, as well as non-traditional interventions such as gym memberships, nutrition monitoring, healthy lifestyle coaching, or access to culturally and linguistically appropriate peer-led wellness and symptom management groups.
Not Applicable	**1.1.11** Ensure a culturally and linguistically appropriate treatment plan by assigning peer providers or other frontline worker to the care team to assist with care navigation, treatment plan development and adherence.

Check, if applicable	Description of Core Components
Applicable	**1.1.12** Ensure that the treatment plan: • Is maintained in a single shared Electronic Health Record (EHR)/ clinical record that is accessible across the treatment team to ensure coordination of care planning. • Outcomes are evaluated and monitored for quality and safety for each patient.
Applicable	**1.1.13** Implement technology enabled data systems to support pre-visit planning, point of care delivery, care plan development, population/panel management activities, coordination and patient engagement. Develop programs to implement telehealth, eReferral/eConsult to enhance access to behavioral health services.
Not Applicable	**1.1.14** Demonstrate patient engagement in the design and implementation of the project.
Applicable	**1.1.15** Increase team engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on care model.
Not Applicable	**1.1.16** Ensure integration is efficient and providing value to patients by implementing a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

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

At this time, Kern Medical currently serves an average of 3,500 patients per month in the primary care clinics. As such, an immense amount of efficiency and coordination is needed in order to best meet the needs and improve the outcomes of the patients that we serve. Kern Medical selected this project to provide our patients with timely, equitable access to quality-driven, patient-centered primary care. Accordingly, we will proactively identify, track, and manage our patient populations to ensure that patients are notified regarding preventive care services and procedures, and provided with the necessary support and education related to their specific disease processes.

Our planned implementation includes:

- **Population/Panel Management**: in order to realize more comprehensive panel management, Kern Medical will:

a) Develop close collaborations with our managed care partners in order to appropriately panel patients into primary and specialty clinics (e.g. Diabetes, Immunology, Hepatitis-C, Anti-Coagulation, and Hypertension etc.)—these disease-driven clinics will be founded upon patient-centered practice methodologies focused on respective disease processes. As such, patients will benefit from the team-based approach to care, which will allow for the more complete integration of physical and behavioral health care delivery.

b) Provide training to staff regarding Patient Centered Medical Home (PCMH)-based principals, which includes multidisciplinary care team approaches, integrated, individualized treatment plans, increased access to care, medication reconciliation services, management of transitions in care, patient education related to self-management techniques, and standardized screenings in behavioral health for all patients;

c) Ensure that software infrastructure and registries are properly configured and maintained in order to ensure optimal patient assignment, tracking, and scheduling with assigned providers;

d) Develop pre-visit planning protocols (e.g. chart audits and chart prep practices) by increasing our staff to prep charts for content and accuracy prior to each visit;

e) Real-time, point-of-care health management (e.g. decision support) by increasing communications with our patients through additional complimentary services to expedite appointment times, follow-up on labs and ancillary testing, increasing patient engagement, education and compliance;

f) Ensure that effective communication mediums exist relative to the patients' and providers' ability to access timely information regarding appointments, availability of services, and health care delivery (e.g. patient portals).

- **Access to Prompt Scheduling:** Kern Medical will engage in further streamlining and centralizing our scheduling processes, provider availability, and collective patient access methodologies. To accomplish these objectives, we will engage in expanding our access/visit types to be more reflective of the protocols and methodologies suitable to proposed complementary encounters (e.g. phone consultations, telemedicine).

- **Point-of-Care Delivery:** Kern Medical will implement enhanced protocols, approaches, and documentation methodologies towards effectuating technology-driven, point-of-care delivery. In order to accomplish these aims, we will utilize:

a) Comprehensive assessment and screening tools to obtain necessary information from patients—REAL-SO/GI data, behavioral history, social determinants data, medication list, etc.;

b) Enhanced information technology (IT) infrastructure in order to improve data collection and reporting relative to preventive screening tests (mammogram, colonoscopies), history of drug or alcohol misuse, and other respective metric-based data components.

Target Population: It is anticipated that the target population will include adults and children representative of all payer sources (e.g. managed care organizations, uninsured, etc.). Ultimately, as a result of the effective implementation of this project, Kern Medical will be further enabled to deliver better, more technology-driven primary care to our, achieving a care delivery model that is more patient-centered, data-driven, and accountable to the population health needs of our patient populations.

Care Delivery Improvement: As a result of the successful implementation of this project, Kern Medical will improve the care of its patient populations by more proactively identifying, coordinating, and addressing respective primary care health needs. Population health management tools and services will become incorporated into all levels of primary care delivery, and patient services and preferences will be more accurately reflected and accommodated within the plan of care. Moreover, the organization will further equipped with real-time, point-of-care resources and reporting capabilities to be used towards eradicating the gaps and disparities that exist within the care continuum. Consequently, patients will receive primary care delivery that is focused on patient engagement, driven by preventive disease management, and centered on coordinated care management throughout all transitions of care.

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

Check, if applicable	Description of Core Components
Not Applicable	**1.2.1** 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.
Not 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.
Not Applicable	**1.2.9** Improve staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the team-based care model to ensure effective and efficient provision of services (e.g., group visits, medication reconciliation, motivational interviewing, cognitive behavioral therapy and Medication-Assistance Treatment (MAT)).
Not Applicable	**1.2.10** 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.
Not 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)

Kern Medical provides a full range of specialty services to the residents of Kern County, and presently serves an average of more than 5,600 specialty visits per month. Consequently, by further integrating respective services with our existing PCMH-based primary care models, streamlining the referral process, and expanding our non-face to face encounters, we anticipate being able to further increase patient access to high-quality specialty care. Accordingly, our planned implementation includes:

- **Expansion of the Specialty Care Team**: in order to expand our specialty care teams, Kern Medical will:

  a) Continue to actively recruit physicians in order to further expand and diversify respective provider empanelment;

  b) Develop protocols to track and manage referrals to and from specialty and primary care clinics (both internal and system-wide);

  c) Develop protocols to screen patients for potential behavioral health care needs and, according to the level of need, provide the necessary referrals to internal/external behavioral health providers to ensure that appropriate treatment is received;

  d) Strengthen existing partnership with key county-based entities (e.g. Kern County Mental and Public Health) to ensure greater access for patients with identified specialty behavioral health care needs;

  e) Develop protocols to connect patients with complex and/or disease-specific needs to the appropriate PCMH-based medical home for comprehensive and integrated specialty care management;

  f) Hire and train new and existing employees in executing pre-visit planning and care transition tracking in an effort to capture necessary screenings (e.g. immunizations, tobacco assessment and counseling), as well as to decrease avoidable readmissions/acute care utilization.

- **Access to Prompt Scheduling:** in order to increase access to our specialists services, Kern Medical will:

  a) Assign additional employees to scheduling and authorization functions in order to ensure rapid review and processing of authorizations, appointment scheduling, and corresponding medical record distribution. Said distribution

will be focused on streamlining the referral loop to referring and primary managing physicians in an effort to deliver the communication required to achieve better patient outcomes. Furthermore, there will be additional hiring of support staff (medical assistants, registered nurses, care coordinators) so that corresponding specialty care metric components (e.g. pre-visit planning, specialty care referral loop closure/turnaround, etc.) are effectively managed.

b) In an effort to ensure enhanced access to specialty care, Kern Medical will engage in further streamlining and centralizing of scheduling processes and practices. Accordingly, we plan to increase provider availability by expanding our access/visit types to be more reflective of the protocols and methodologies suitable to respective traditional and complementary encounters (e.g. phone visits, telemedicine, e-Consults). Furthermore, by effectively expanding the use of non-face to face encounters, we anticipate being able to comprehensively reduce referral reply turnaround rates.

Target Population: It is anticipated that the target population will include adults and children representative of all payer sources (e.g. managed care organizations, uninsured, etc.).

Care Delivery Improvement: As a result of the successful implementation of this project, Kern Medical will improve the care of its patient populations by more effectively connecting patients to needed specialty care services, creating a system that is more integrated with primary care, and driven by preventive screening and care coordination practices. Specifically, patients will be further engaged and empowered with the tools and resources necessary to more effectively navigate primary and specialty care access and transitions, and will receive the requisite screenings, interventions, and care management resources to assist in attaining optimal health. Likewise, providers will be empowered with the resources and communication mediums to ensure effective disease management, timely preventive screenings, and real-time care coordination with the primary care provider. Resultantly, patients will receive specialty care delivery that is accessible, patient-centered, and focused on effective disease management and care coordination throughout all care transitions.

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.
Not 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.
Not 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).
Not Applicable	**1.3.4** Engage primary care providers and local public health departments in development and implementation of specialty care model.
Not Applicable	**1.3.5** Implement processes for primary care/specialty care co-management of patient care.
Not 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.
Not Applicable	**1.3.8** Ensure that clinical teams engage in team- and evidence-based care.
Not 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.

Check, if applicable	Description of Core Components
Applicable	**1.3.11** Adopt and follow treatment protocols mutually agreed upon across the delivery system.
Not 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.
Not Applicable	**1.3.13** Implement EHR technology that meets MU standards.
Not 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.
Not Applicable	**1.3.15** Improve medication adherence.
Not 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.
Not 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).
Not Applicable	**1.3.18** Demonstrate engagement of patients in the design and implementation of the project.
Not Applicable	**1.3.19** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.
Not Applicable	**1.3.20** Test use of novel performance metrics for redesigned specialty care models.

☒ 1.4 – Patient Safety in the Ambulatory Setting

Kern Medical has selected this project as part of its continuing effort towards improving the collective flow of patient information and communication, and decreasing the safety gaps and disparities that present within the ambulatory setting. Accordingly, our efforts will be directed towards:

a) More timely and accurate medical diagnosing;

b) Real-time identification and reporting of abnormal lab values (e.g. PT/INR), persistent medication utilization and monitoring, and relevant medication error rates;

c) Addressing the corresponding delays that transpire within the treatment and preventive services referral continuum.

Accordingly, in order to properly address these disparities, Kern Medical will engage in the following core approaches:

Collaborative Leadership: Based on analyses of current processes and procedures, Kern Medical will build upon existing strategic and academic alliances and core collaborations. Correspondingly, we will collaboratively work towards implementing vetted, proven best practices in addressing patient safety gaps within the ambulatory care setting, ensuring that the necessary infrastructure, processes, and workflows are established to ensure timely, appropriate monitoring and follow-up for standard and routine clinical pathways.

IT Support/Quality Improvement: In conjunction with the organization's Data Stewardship Committee, Kern Medical will work towards implementing data-driven, technology-enabled systems designed around providing real-time decision support, performance feedback, and point-of-care tracking. Respective systems will promote enhanced pre-visit planning, patient and provider engagement, and comprehensive population health management.

In addition, as part of real-time, data-driven quality improvement, Kern Medical will establish an outpatient-centered quality improvement team tasked with engaging in continuous quality improvement at all levels of care delivery, and will utilize performance-based methodologies such as Plan-Do-Study-Act and LEAN Six Sigma as a foundation for effective improvement protocol.

Standardized Workflows: Based on internal analyses, and in conjunction with collaborative partnerships, Kern Medical will provide standardized workflows designed around ensuring sound documentation, timely follow-up on relevant values, preventive care management and monitoring, and decision support protocols based on established, proven best practices and approaches. Accordingly, said workflows will directly focus on establishing and disseminating protocols for monitoring and reporting critical abnormal lab values, provider and patient notifications, and follow-up-based notifications for returning and difficult to reach patients.

Target Population: Our initial target population will be centered on adults, age 18 and over, that are assigned to Kern Medical as their medical home; however, as we intend to focus our initial efforts within the primary care setting, our established protocols and workflows will be vetted, tracked, and reported within all settings (inclusive of Pediatrics), with the anticipation that such approaches and practices will subsequently be promulgated within the remaining care practices.

Care Delivery Improvement: As a result of the successful implementation of this project, Kern Medical will improve the care of its patient populations by more effectively: a) identifying the gaps and disparities that exist within the patient/provider information and communication exchange, and b) establishing systems and methodologies to ensure sustainable, lasting patient safety practices and outcomes. Specifically, screening, identification, and notification practices will be driven by real-time data capture and reporting capability, and will enable providers and personnel to more effectively identify and report erroneous, critical, and/or abnormal values and results. Accordingly, patients will be more effectively notified of corresponding safety issues, and will be provided with the resources needed to ensure appropriate, timely follow-up care coordination.

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

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

Check, if applicable	Description of Core Components
Applicable	**1.4.3** Develop a standardized workflow so that: • Documentation in the medical record that the targeted test results were reviewed by the ordering clinician. • Use the American College of Radiology's Actionable Findings Workgroup[1] for guidance on mammography results notification. • Evidence that every abnormal result had appropriate and timely follow-up. Documentation that all related treatment and other appropriate services were provided in a timely fashion as well as clinical outcomes documented.
Applicable	**1.4.4** In support of the standard protocols referenced in #2: • Create and disseminate guidelines for critical abnormal result levels. • Creation of protocol for provider notification, then patient notification. • Script notification to assure patient returns for follow up. Create follow-up protocols for difficult to reach patients.
Applicable	**1.4.5** Implement technology-enabled data systems to support the improvement and performance feedback system as well as engage patients and support care teams with patient identification, pre-visit planning, point of care delivery, and population/panel management activities.

Please complete the summary chart:

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

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

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

☒ 2.1 – Improved Perinatal Care (required for DPHs)

Owing to the volume of high-risk neonates that are routinely born at Kern Medical, we have selected this project as it aligns with our commitment to ensuring safe, quality care throughout the prenatal, birth, and early life phases of development. Accordingly, implementation of the project will help develop a more comprehensive approach to care delivery, with an enhanced focus on optimizing outcomes while ensuring that services are centered on the individual.

While our historical participation in programs such as the California Perinatal Quality Care Collaborative (CPQCC) and Patient Safety First has rendered good results, we currently do not have the necessary infrastructure, knowledge, and skills to impact the program in a substantial or sustainable manner. Consequently, our goal is to imbed respective improvements into our day- to-day operations so that the collective impact will be visible to every parent and baby for whom we provide care, as well as to those providing such care.

Our work plan includes:

Process Analysis: Kern Medical will appoint a multi-disciplinary perinatal team that will be inclusive of members from the bedside, medical staff, and leadership teams. The initial work plan will encompass a thorough analysis of all services offered in the prenatal, intrapartum, and postpartum spectrums, and corresponding analyses will be conducted from the outpatient setting through hospitalization and post-delivery out-patient care. Outcomes and current practice will be documented in conjunction with comprehensive reviews of maternal and newborn mortality, morbidity, and potential safety issues.

Planning/Implementation: Based on the team's findings, plans will be developed, detailing approaches for changing practices in order to facilitate improvement in the initiatives involving:

a) Maternal morbidity and mortality;
b) Exclusive breast milk feeding;
c) Cesarean section;
d) Unexpected newborn complications;
e) Prenatal and postpartum care;
f) OB hemorrhage;
g) Progression towards becoming a "baby friendly" hospital.

The team will define necessary changes with time frames as a part of the work plan, and progress will be tracked, at least, on a monthly basis. Alterations to the plan will be initiated based on rapid-cycle improvement methodology. Accordingly, respective implementation actions will be initiated in the outpatient clinic setting and will cycle/span throughout hospitalization and other outpatient settings. As initial points of focus, we will ensure that as patients are identified as high-risk (secondary to potential or diagnosed maternal and/or fetal complications), appropriate, timely referrals will be made immediately. Furthermore, both the avoidance of a cesarean section in the nulliparous population as well as reinforcement of the benefits of breastfeeding will be additional areas of enhanced focus.

Target Population: Kern Medical's target population will focus on gravid women and their newborns during the antepartum, intrapartum, and post-partum periods.

Care Delivery Improvement: As a result of the successful implementation of this project, Kern Medical will improve the care of its patient populations by establishing the protocols and practices necessary to effectively address corresponding disparities and fragmentation within the perinatal care continuum. That is, both patients and providers will be provided with the tools and resources needed to realize enhanced education, prevention, and care management. Consequently, maternal and neonatal complications and morbidity will decrease, patient/provider best-practices improve, and ideal health care outcomes advance. Ultimately, Kern Medical will become a perinatal center of excellence, where patients are provided with integrated health care that is patient-centered, evidence-based, and outcomes-driven.

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

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

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

Kern Medical selected this project as a result of our commitment towards improving the quality of post-acute transitions of care. As our all-cause, 30-day readmission rate has steadily increased over the past two years; therefore, implementing a comprehensive transition of care program for our at-risk patient populations will invariably improve patient satisfaction, care-plan compliance, and assist in decreasing our all-cause readmission rate.

Consequently, in order to accomplish these directives, we propose implementing a follow-up program to provide expedited care with a practitioner in the immediate post-discharge period. The goal of the follow-up care will be based on providing well-coordinated, multi-disciplinary whole-person management following the post-acute hospital stay.

Accordingly, the following operational components are being considered:

1. A readmission task force that will be tasked with developing screening tools to be used in identifying patients at risk for readmission, as well as protocols for warm-handoff transition at the conclusion of participation in the post-hospitalization program;

2. A referral management system focused on identifying patients deemed at risk for readmission, and centered on offering follow-up care with a provider prior leaving the acute environment;

3. A patient-centered coalition that will be established in order to develop a program methodology for promoting safe, effective care transitions; moreover, a comprehensive care methodology will be developed for providing follow-up care management for high-risk medical patients during transitions to the post-acute environment;

4. As part of a hospitalist service, physician extensivists will be utilized to man a 24 to 48-hour post-discharge, high-risk readmission clinic (HRRC) in order to provide appropriate, timely post-discharge follow up. Such services will improve the likelihood of intercepting post-discharge complications prior to readmission escalation, and will allow for follow-up as frequently as is warranted;

5. A Pharm-D will be provided to assist with medication reconciliation, with particular focus on high-risk medications and the provision of relevant education on side effects and contraindications.

Planning/Implementation:

Our implementation of these operational components will begin within the acute care setting by incorporating a nationally recognized readmission risk assessment tool into case management screening procedures for all patients admitted to Kern Medical. As patients are deemed at greater risk for readmission, additional consideration will be made relative to aftercare treatment planning, and participation will be offered and coordinated within the HRRC program.

In order to ensure that patient needs (e.g. care access barriers, readmission triggers) are identified and considered in a timely manner, management of targeted high-risk patients will be discussed during daily Interdisciplinary Team (IDT) rounds. Furthermore, proactive discharge planning will be coordinated across all relevant disciplines, with protocols being inclusive of pharmacy-driven initiatives focused on providing enhanced medication education at the bedside. Correspondingly, patients will be offered the “Meds to Beds” program, wherein they may receive their medications at bedside on the day of discharge from the acute care setting, allowing for more proactive management of any medication-related barriers, and improving the likelihood of medication compliance.

Accordingly, as patients consent to participate in the HRRC program prior to leaving the acute care environment, a follow up appointment will be provided within 72 hours of discharge. Inpatient care providers will be tasked with providing a warm handoff to the HRRC providers, with the care management team ensuring that all medical records are sent to the HRRC prior to the follow-up appointment. Within the HRRC, patients will be provided with medical care, medication reconciliation, behavioral health support, case management, and community resource linkage services, all within 30 days of discharge.

Prior to the conclusion of the initial 30 day period, HRRC staff will reach out to the patient’s primary care provider in order to coordinate a warm handoff. In the event that the patient is not established with a primary care provider, the patient may be considered for enrollment within an appropriate patient-centered medical home, or transitioned to an affiliated primary care provider for continued wellness management.

Target Population:

Our initial target population will include patients of all age ranges that have been deemed as at high-risk according to pre-established criteria. Criteria will be based on standardized risk assessment tools that have been vetted and approved by the re-admission task force.

Care Delivery Improvement: As a result of the successful implementation of this project, Kern Medical will improve the care of its patient populations through the continued development of comprehensive care transition methodologies and best practices. Patient populations will be provided with enhanced, multidisciplinary support and care coordination throughout respective care transitions, and expanded patient-

centered practices beyond the physical health setting. Established infrastructure will promote enhanced communication and information exchange, ensuring timely, appropriate delivery of care, enhanced preventive practices, and improved outcomes. Ultimately, patient care outcomes will improve as a result of systems and practices that are more integrated across settings, focused on patient engagement and care coordination, and centered on effective matriculation into the medical home setting.

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

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

Check, if applicable	Description of Core Components
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.
Not 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.
Not Applicable	**2.2.9** Demonstrate engagement of patients in the design and implementation of the project.
Not Applicable	**2.2.10** Increase multidisciplinary team engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on care model.

Check, if applicable	Description of Core Components
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)

Kern Medical selected this project as it fundamentally aligns with our strategic objectives in establishing comprehensive, system-wide care management practices and curricula, as well as in creating the requisite programs and models that will comprehensively meet the complex medical needs of our patient populations. At the core of these objectives, Kern Medical will works towards the establishment of a multi-disciplinary Complex Care Management Program (CCMP) tasked with collaboratively assisting high-risk patients in being matriculated into patient-centered models of care delivery.

Accordingly, our planned implementation plan includes:

Risk Assessment Development:

In order to identify those patients that will benefit from more intensive case management services, we will commence with reassessing the patient populations currently enrolled in the High-Risk Readmission Clinic (HRRC) program. Based on respective assessment scores, patients that meet the criteria for inclusion in the CCMP will be assigned accordingly. As patients are progressively enrolled into the program, specific protocols will continue to be developed to assist in identifying additional referral sources/opportunities.

CCMP and PCMH collaboration:

The CCMP will be added to those services currently available in our Patient-Centered Medical Home-based (PCMH) clinics. Corresponding referral criteria will be developed to effectively identify and refer patients that meet the thresholds for clinic matriculation. In addition, patients enrolled in the CCMP program will be provided with the opportunity to likewise be enrolled in the PCMH clinic, and will have access to a multi-disciplinary team designed to address complex care needs—inclusive of behavioral, social, medical, and care coordination services.

Rubric Development:

Within the CCMP, a rubric will be developed to assign patients to level of care coordination interventions based upon their respectively identified needs.

Medication Reconciliation:

Patients that are positively identified as being in need of CCMP program services will be automatically scheduled to see a provider or mid-level upon discharge from the hospital, or upon being identified or enrolled in the CCMP program. During respective visits, medication reconciliation and other clinically indicated services will be provided as warranted by the patients' medical condition.

Target Population:

The target population is the high-risk, high-utilizing, medically fragile patients that will be identified via the risk assessment tool, or via provider recommendation and referral.

Care Delivery Improvement: As a result of the successful implementation of this project, Kern Medical will improve the care of its patient populations by more effectively identifying, managing, and addressing the complex care needs of its high-risk populations. Namely, care coordination screening tools and services will become incorporated into all tiers of care delivery, and will provide the organization with real-time data capabilities to be used towards eradicating the gaps, disparities, and fragmentation that presently exist. This project will establish the communication and information mediums that will be necessary to promote effective care coordination, enhanced care transition management, and decreased utilization of resources. Consequently, patient care will improve through enhanced access to care services, prevention-driven disease management, and focused initiative on coordinated care management throughout all transitions of care.

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

Check, if applicable	Description of Core Components
Applicable	**2.3.1** Develop a complex care management program at one site or with one defined cohort, or expand an existing program from a pilot site to all sites or to additional high-risk groups and demonstrate engagement of patients in the design and implementation of the project.
Not Applicable	**2.3.2** Utilize at least one nationally recognized complex care management program methodology.

Check, if applicable	Description of Core Components
Applicable	**2.3.3** Identify target population(s) and develop program inclusion criteria based on quantitative and qualitative data (e.g., acute care utilization, lack of primary care utilization, number of high-risk medical mental or SUD conditions, polypharmacy, primary care input, functional status, patient activation, social support or other factors). Include patient factors associated with a higher probability of being impacted by complex care management.
Applicable	**2.3.4** Conduct a qualitative assessment of high-risk, high-utilizing patients.
Not Applicable	**2.3.5** Establish data analytics systems using clinical data sources (e.g., EHR, registries), utilization and other available data (e.g., financial, health plan, zip codes), to enable identification of high-risk/rising risk patients for targeted complex care management interventions, including ability to stratify impact by race, ethnicity and language.
Not Applicable	**2.3.6** Develop a multi-disciplinary care team, to which each participant is assigned, that is tailored to the target population and whose interventions are tiered according to patient level of risk.
Applicable	**2.3.7** Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets.
Not Applicable	**2.3.8** Implement evidence-based practice guidelines to address risk factor reduction (smoking cessation/immunization/substance abuse identification and referral to treatment/depression and other behavioral health screening, etc.) as well as to ensure appropriate management of chronic diseases: • Use standardized patient assessment and evaluation tools (may be developed locally, or adopted/adapted from nationally recognized sources). Use educational materials that are consistent with cultural, linguistic and health literacy needs of the target population.
Not Applicable	**2.3.9** Ensure systems and culturally appropriate team members (e.g. community health worker, health navigator or promotora) are in place to support system navigation and provide patient linkage to appropriate physical health, mental health, SUD and social services. Ensure follow-up and retention in care to those services, which are under DPH/DMPH authority, and promote adherence to medications.

Check, if applicable	Description of Core Components
Not Applicable	**2.3.10** Implement technology-enabled data systems to support patients and care teams throughout the care management program including patient identification, pre-visit planning, point-of-care delivery, care plan development and population/panel management activities.
Not Applicable	**2.3.11** Implement a data-driven system for rapid cycle improvement and performance feedback to address quality and safety of patient care, which includes patients, front line staff and senior leadership.

☒ 2.5 – Transition to Integrated Care: Post Incarceration

Kern Medical is currently the health care provider responsible for the provision of medical services to the incarcerated individuals being housed within the county-based correctional facility. According to the most recent statistics available through correctional medicine databases, the correctional facility currently maintains an average population of 2,200 per day, with approximately 70% of said individuals receiving services from both the site-based correctional medical clinics as well as at Kern Medical.

Correspondingly, average monthly visit volumes have generally been comparatively high relative to Kern Medical averages. As an example, during the month of February 2016, there were 20,287 correctional medicine encounters that transpired, in comparison to the 8,939 non-correctional encounters that occurred at Kern Medical. Accordingly, given the myriad challenges and barriers that present within this unique demographic, Kern Medical selected this project in an effort to further assist in connecting said populations to necessary primary care services, as well as to establish the necessary resources, methodologies, and infrastructure to ensure effective care coordination and population health management.

Accordingly, our planned implementation approach includes:

Care Coordination Program and Protocol Development:

Kern Medical will enhance collaboration with internal and external departments and stakeholders in working towards establishing standardized practices, methodologies, and curricula to be used towards effectively connecting patient populations with the services and resources for which they stand in need.

Kern Medical will review current processes to ensure that inmates pending release obtain the information and support necessary to successfully access respective health services (e.g. assistance in Medi-Cal/insurance coverage applications).

Correspondingly, a Transitional Care Collaborative (TCC) will be established in order to expand the current capabilities of respective services, as well as to establish appropriate protocols related to the collective process. Furthermore, the TCC will establish appropriate protocols related to billing processes and the collection of funds from respective payer sources relative to patient-required Durable Medical Equipment (DME) provisions from Medi-Cal and other available insurances.

Additionally, in order to address the specific disparities that present during post-incarceration medical care transitions, said care coordination programs and protocols will be developed and implemented according to uniquely specialized needs that correspond with this population. Accordingly, at a minimum, care coordination protocols will include standards and expectations related to:

a) Primary and specialty care access (e.g. scheduling of post-release scheduled follow-up medical appointments);

b) Access to necessary support services (transportation arrangements);

c) Durable Medical Equipment (DME) requests;

d) Prescribed medication management/reconciliation.

In addition, standardized pre and post-assessment screening tools (e.g. PHQ-9, Gad-7, and Audit-C) will be developed and implemented, with an enhanced focus on identifying and connecting patient populations to those services and resources needed to most effectively realize whole-person, patient-centered care delivery.

Target Population:
Owing to the specificity of this project, the initial target population will include those incarcerated individuals that are actively or will prospectively be established with medical services, as well as those that will be identified through respective pre-discharge screening assessments.

Care Delivery Improvement: As a result of the successful implementation of this project, Kern Medical will improve the care by of respective patient populations by more effectively identifying, integrating, and addressing corresponding physical, behavioral, and correctional health care needs. Namely, physical and behavioral health screening tools and care coordination services will become incorporated into all tiers of pre and post-correctional health care delivery, and will assist the organization in properly identifying and linking patient populations to the primary and follow-up care management services needed for successful re-integration. Furthermore, this project will improve patient care by providing the organization with the real-time data analytics and reporting capabilities needed to effectively eradicate care transition gaps, improve

disparities in care integration, and reduce the costs that occur as a result of poor care management and inappropriate system utilization.

As a result of these initiatives, patients will receive integrated point-of-care delivery that is focused on effective matriculation into the primary care setting, driven by effective disease management, and centered on effective care management delivery and warm-handoff care coordination throughout corresponding transitions of care.

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

Check, if applicable	Description of Core Components
Applicable	**2.5.1** Develop a care transitions program for those individuals who have been individuals sentenced to prison and/or jail that are soon-to-be released/or released in the prior 6 months who have at least one chronic health condition and/or over the age of 50.
Applicable	**2.5.2** Develop processes for seamless transfer of patient care upon release from correctional facilities, including: • Identification of high-risk individuals (e.g., medical, behavioral health, recidivism risk) prior to time of release. • Ongoing coordination between health care and correctional entities (e.g., parole/probation departments). • Linkage to primary care medical home at time of release. • Ensuring primary care medical home has adequate notification to schedule initial post-release intake appointment and has appropriate medical records prior to that appointment, including key elements for effective transition of care. • Establishing processes for follow-up and outreach to individuals who do not successfully establish primary care following release. • Establishing a clear point of contact within the health system for prison discharges.
Not Applicable	**2.5.3** Develop a system to increase rates of enrollment into coverage and assign patients to a health home, preferably prior to first medical home appointment.
Not Applicable	**2.5.4** Health System ensures completion of a patient medical and behavioral health needs assessment by the second primary care visit, using a standardized questionnaire including assessment of social service needs. Educational materials will be utilized that are consistent with the cultural and linguistic needs of the population.

Check, if applicable	Description of Core Components
Not Applicable	**2.5.5** Identify specific patient risk factors which contribute to high medical utilization Develop risk factor-specific interventions to reduce avoidable acute care utilization.
Not Applicable	**2.5.6** Provide coordinated care that addresses co-occurring mental health, substance use and chronic physical disorders, including management of chronic pain.
Not Applicable	**2.5.7** Identify a team member with a history of incarceration (e.g., community health worker) to support system navigation and provide linkages to needed services if the services are not available within the primary care home (e.g., social services and housing) and are necessary to meet patient needs in the community.
Not Applicable	**2.5.8** Evidence-based practice guidelines will be implemented to address risk factor reduction (e.g., immunization, smoking cessation, screening for HCV, trauma, safety, and overdose risk, behavioral health screening and treatment, individual and group peer support) as well as to ensure appropriate management of chronic diseases (e.g., asthma, cardiovascular disease, COPD, diabetes).
Applicable	**2.5.9** Develop processes to ensure access to needed medications, DME or other therapeutic services (dialysis, chemotherapy) immediately post-incarceration to prevent interruption of care and subsequent avoidable use of acute services to meet those needs.
Not Applicable	**2.5.10** Engage health plan partners to pro-actively coordinate long-term care services prior to release for timely placement according to need.
Not Applicable	**2.5.11** Establish or enhance existing data analytics systems using health, justice and relevant community data (e.g., health plan data), to enable identification of high-risk incarcerated individuals for targeted interventions, including ability to stratify impact by race, ethnicity and language.
Not Applicable	**2.5.12** Implement technology-enabled data systems to support pre-visit planning, point-of-care delivery, population/panel management activities, care coordination, and patient engagement, and to drive operational and strategic decisions including continuous QI activities.
Not Applicable	**2.5.13** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff, and senior leadership.

Check, if applicable	Description of Core Components
Applicable	**2.5.14** Improve staff engagement by: • Implementing a model for team-based care in which staff performs t of their abilities and credentials. • Providing ongoing staff training on care model. • Involving staff in the design and implementation of this project.
Not Applicable	**2.5.15** Engage patients and families using care plans, and self-management education, including individual and group peer support, and through involvement in the design and implementation of this project.
Not Applicable	**2.5.16** Participate in the testing of novel metrics for this population.

Please complete the summary chart:

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

Section 4.3 – Domain 3: Resource Utilization Efficiency

☒ 3.2 – Resource Stewardship: High Cost Imaging

Kern Medical has selected this project as it aligns well with existing gaps and disparities that have been identified regarding the overuse of medical imaging for the clinical entities of headache, back pain, and pulmonary embolism. As an industry-wide example, studies[18][19] have shown that only 7-14% of patients referred from emergency departments to radiology for CT pulmonary artery angiography have pulmonary emboli, with cough or shortness of breath often being the trigger precipitating the order for the chest CT. Accordingly, this unnecessary exam often occurs in patients who are at low-risk for pulmonary embolism, thus exposing the individual to potentially harmful and unnecessary radiation, while carrying a proportionately high economic cost.

Consequently, our overarching approach to this project is to design an imaging program that is centered on ensuring that the "right imaging study is obtained for the right patient at the right time" with the least possible radiation dose; accordingly, our initially proposed approach is as follows:

Multi-Disciplinary Care Teams:

Multidisciplinary teams will be formed consisting of physician specialists, residents, mid-level providers, radiologists, department managers, and patient care coordinators. The teams will formalize protocols for determining when patients should be referred for imaging, with respective protocols being based on appropriateness criteria, as provided in medical literature specific to the medical specialty. As an example, the pulmonary embolism team is considering the development of a protocol that indicates use of the Wells' criteria, including utilization of a D-dimer blood assay prior to medical imaging; correspondingly, the clinical team would also reference and review the American College of Radiology for appropriateness criteria relative to imaging.

Standardized Screening and Education Protocols:

After developing comprehensive screening and imaging protocols, the team will be charged with implementing and standardizing education criteria for referring clinicians and mid-level providers. These screening and education-based protocols will regularly be performed during the Kern Medical multi-disciplinary weekly conference.

As Kern Medical primarily serves a population that is medically underserved and that often seeks medical help only when desperately ill, our multi-disciplinary teams will participate in medical outreach to provide forums on our PRIME imaging projects. Accordingly, based on patient preferences and relative accessibility, Kern Medical will

utilize a variety of internal and external forums (e.g. community centers, health fairs) in order to accommodate these respective education-centered iniatives. Consequently, patients will be educated on appropriate criteria for seeking medical care, as well as how they can more easily access our primary and specialty health care systems in order to prevent overutilization of inpatient and emergency department-based services.

Target Population:

Our initial target population will be individuals of all ages that have been referred to radiology services via respective inpatient, outpatient, and ER-based referral mediums.

Care Delivery Improvement: As a result of the successful implementation of this project, Kern Medical will improve the care of its patient populations by more effectively identifying inappropriate imaging resource utilization, reducing gaps within the patient/provider information exchange, and ensuring sustainable, lasting patient safety practices and outcomes. From a provider perspective, screening, referral, and imaging practices will be driven by real-time data capture and reporting capability, and will enable providers and personnel to more effectively identify and report inappropriate, unnecessary, or unsafe practices. From a patient perspective, protocols will be established to ensure that the right imaging study will be obtained for the right patient at the right time for a multitude of clinical issues, preventing high-cost and/or high-dose imaging utilization.

Accordingly, as a result of these initiatives, both patients and provider will be more effectively apprised of corresponding imaging issues or concerns, and will be provided with the resources and tools needed to ensure the delivery of appropriate, proven best practices. Ultimately, as a result of the successful implementation of these core components, imaging practices will become safer, more efficient/cost-effective, and more accountable to the collective stewardship of our patient populations.

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

Check, if applicable	Description of Core Components
Not Applicable	**3.2.1** Implement an imaging management program, demonstrating engagement of patients in the design and implementation of components of the project.
Applicable	**3.2.2** Program should include identification of top imaging tests whose necessity should be assessed for possible overuse. Criteria for assessment could include:

Check, if applicable	Description of Core Components
	• Frequency and cost of inappropriate/unnecessary imaging: o Appropriate Use: Beginning with state- or nationally-recognized models or guidelines (e.g., American College of Radiology Appropriateness Criteria, American College of Cardiology Appropriate Use Criteria) and incorporating pertinent local factors, programs will set out definitions for appropriateness. o Cost: Programs will identify imaging studies associated with high costs due to high cost per study or high volume across the system. • Unwarranted practice variation within the participating DPHs/DMPHs. Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed. • Data completeness and ability to report the extent of appropriateness criteria, building data capacity where needed. • Whether there are established, tested and available evidence-based clinical pathways to guide cost-effective imaging choices.
Not Applicable	**3.2.3** Establish standards of care regarding use of imaging, including: • Costs are high and evidence for clinical effectiveness is highly variable or low. • The imaging service is overused compared to evidence-based appropriateness criteria. Lack of evidence of additional value (benefits to cost) compared to other imaging options available to answer the clinical question.
Not Applicable	**3.2.4** Incorporate cost information into decision making processes: • Develop recommendations as guidelines for provider-patient shared decision conversations in determining an appropriate treatment plan. • Implementation of decision support, evidence-based guidelines and medical criteria to recommend best course of action.
Not Applicable	**3.2.5** Provide staff training on project components including implementation of recommendations, and methods for engaging patients in shared decision making as regards to appropriate use of imaging.
Not Applicable	**3.2.6** Implement a system for continual rapid cycle improvement and performance feedback that includes patients, front line staff and senior leadership.

Please complete the summary chart:

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

Section 5: Project Metrics and Reporting Requirements

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

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

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

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

Section 6: Data Integrity

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

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

Section 7: Learning Collaborative Participation

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

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

Section 8: Program Incentive Payment Amount

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

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

- DY 11 $ 63,414,400
- DY 12 $ 63,414,400
- DY 13 $ 63,414,400
- DY 14 $ 57,072,960
- DY 15 $ 48,512,016

Total 5-year prime plan incentive amount: $ 295,828,176

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.				
2.				
3.				
4.				
5.				

Appendix—Works Cited:

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[9] County Health Rankings, 2015. http://www.countyhealthrankings.org/app/california/2015/rankings/outcomes/overall

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[19] Shahriar Z- Could the Number if CT angiograms be reduced in emergency department patients suspected of Pulmonary Embolism?
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