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

Application due: 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: Los Angeles County Department of Health Services

Health Care System Designation: 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.

Demographics
Los Angeles County (LAC) is the most populous and most diverse county in the United States. Nearly three-quarters (72%) of the County's over 10 million residents belong to racial or ethnic groups that historically are considered minorities (in comparison to 61% of all Californians).

Access to Health Care
With such diversity comes some disparity in accessing health care. Access to health care impacts overall health status, including quality of life and life expectancy. Barriers to access include lack of availability of services, high cost of services, and lack of insurance coverage. Among persons of Latino ethnic origin, 18.9% were uninsured in 2014, compared to 15.9% of Asian non-Latinos, 7.6% of Black non-Latinos, and 3.7% of White non-Latinos.

Obesity/Diabetes
Obesity is second only to tobacco as a leading cause of preventable death in the United States. Obesity is a risk factor for a number of chronic diseases, including heart disease, hypertension, type 2 diabetes, liver disease, arthritis, and many forms of cancer. Over 60% of adults in Los Angeles County are either obese (24%) or overweight (37%). The younger adult age groups show the largest increases in obesity. Between 1997 and 2011, the rate of obesity almost doubled, from 9% to 17%, for 18-29 year olds. For those ages 30-39 years, the obesity rate more than doubled, from 13% to 28%. The adult obesity rate is higher among Latinos (32%) and Blacks (31%) than among whites (18%) and Asians (8%). Twenty-four percent

of adults 65 and older have been diagnosed with diabetes. Among adults age 65 years and older, diabetes prevalence differs by race/ethnicity: 34% of Latinos, 33% of Asians/NHOPIs, and 31% of Blacks reported being diagnosed with diabetes, compared to 17% of Whites.

Hypertension/Heart Disease
The percent of adults who have ever been diagnosed with high blood pressure is highest among Blacks (39%) compared to 27% of Whites, 25% of Asians, and 18% of Latinos. More than half a million adults ages 65 and older suffer from hypertension, with a prevalence of 58%. Black older adults have the highest prevalence of hypertension (75%), followed by Asians/NHOPIs (62%), Latinos (56%), and Whites (53%). Black older adults also have the highest rate of death from heart disease (208 per 100,000 people or 1,721 deaths/year), followed by Whites (151 per 100,000 or 6,845 deaths/year), Latinos (111 per 100,000 or 2,555 deaths/year), and Asians/NHOPIs (98 per 100,000 or 1,451 deaths/year).

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.

Los Angeles County Department of Health Services (LACDHS) provided care for over 570,000 unique patients in Fiscal Year 2014/2015. Services included 1.8 million outpatient visits, 305,000 ED visits, and 65,000 inpatient discharges. Of the individuals served by LACDHS, approximately 23% were uninsured, 65% were Medi-Cal beneficiaries, 6% were Medicare beneficiaries, 5% had third-party insurance, and 1% were unknown.

The patient population is diverse ethnically and racially. Almost two-thirds (65%) of patients identified themselves as being of Hispanic ethnicity. Regarding race, 58% of patients were White, 15% Black, 5% Asian, 1% Two-or-more races, 16% "Other," and 5% "unknown".

The age breakdown of LACDHS patient population was as follows: 18% were age 0 to 17 years; 75% age 18 to 64 years, and 7% age 65 years or older. Regarding gender, 54% of patients were female, and 46% male.

Almost half of DHS patients speak a primary language other than English, with 42% speaking Spanish.

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.

LACDHS is the core of the healthcare safety net in Los Angeles County, operating four hospitals (with three emergency departments (ED) and two trauma centers), one Regional Health Center, one large Outpatient Center, six Comprehensive Health Centers, and ten Health Centers. In addition, LAC DHS partners with 52 community providers who provide primary care services at 194 sites.

LACDHS hospitals have a total licensed bed capacity of 1,825 (LAC+USC MC– 676; Harbor UCLA MC – 453; Rancho Los Amigos NRC – 289; and Olive View-UCLA MC – 407). LACDHS operates 6% of the available general acute care beds in the county, provides 7% of all ED visits, 40% of trauma care, and 56% of all inpatient burn care. LACDHS provides a significant amount of complex, tertiary care services that are not sufficiently available in the private sector to meet the demand. LACDHS serves a disproportionate percentage of special populations and those with a high disease burden. This includes individuals with chronic medical conditions who are costly to care for and those who are homeless, mentally ill, or under the jurisdiction of child welfare and law enforcement agencies.

Patients typically receive most of their care within the healthcare facility that is most geographically convenient for them, though care for patients is also coordinated across facilities when indicated (e.g., patient needs highly specialized services that are only available in a particular facility). Rancho Los Amigos National Rehabilitation Center (RLANRC) is a nationally-recognized rehabilitation facility that provides pediatric and adult rehabilitation services that serve all LAC residents.

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.

LACDHS has implemented a new integrated Electronic Health Record called ORCHID (Online Real-time Centralized Health Information Database). ORCHID is being used by all DHS hospitals and outpatient sites where LACDHS health care services are delivered. It has standardized how we capture patient information, and improved LACDHS' ability to coordinate care and reduce unnecessary tests. It has also helped LACDHS document patient information more consistently, allowing us to reduce errors and improve the quality of care.

In conjunction with the implementation of ORCHID, LACDHS is also developing a new Comprehensive Enterprise Data and Analytics Repository (CEDAR), an integrated data warehouse for clinical, utilization, and financial reporting that will help us improve decision making and better match services and resources to patient needs. The CEDAR will include data from several sources including the new Electronic Health Record (ORCHID), managed care enrollment data, pharmacy and laboratory systems, and the patient accounting system. This integration will prepare us to function optimally in the new age of managed care under the Affordable Care Act by allowing us to monitor and evaluate departmental operations, understand and improve services and resource utilization, and make system and patient healthcare delivery improvements.

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 review each entity's overall goals and objectives. 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 summarize the goals and objectives for your 5-year PRIME Plan. Include specific information, including:

1. *Organizational goals and objectives that will support delivery system transformation;*

2. *Two or three aims related to your participation in PRIME and how they will contribute to the overall transformation of your health system;*

3. *A statement of how the selected projects will support the identified organizational goals and project aims. Note that the narrative should connect the aims identified in Section 3.1.2 to the projects you select in Section 4. Each project does not require a separate aim statement;*

4. *If more than one project is selected, describe how the projects will inter-relate to achieve system transformation;*

5. *A description of your vision for the delivery system at the end of the five years, including specific clinical, infrastructure and financial improvements that will support transformation. The narrative should identify a minimum of one clinical, infrastructure and financial improvement that you anticipate as a result of PRIME participation.*

The mission of LACDHS is to ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services and through collaboration with community and university partners. To accomplish this, LACDHS is transforming the safety-net from an episodic care orientation to an integrated care system that provides the right care at the right time by right provider in the right setting. LACDHS is working closely with its health plan partners to engage in care newly insured patients under Medicaid expansion and residually uninsured patients in Los Angeles County.

LACDHS has also recently spearheaded the development of the new LA County Health Agency. The mission of the Health Agency is to improve the health and wellness of LA County residents through provision of integrated, comprehensive, culturally appropriate services, and programs that promote healthy people living in healthy communities. This will be achieved through the aligned efforts of the Departments of Health Services, Mental Health, and Public Health and in partnership with our clients and their families and communities and other stakeholders.

Over the next five years, LACDHS' organizational triple aim is to provide more appropriate care to more patients, at higher quality, and at lower cost. LACDHS defines care broadly to include physical as well as behavioral health. To achieve these aims, LACDHS must a) successfully transform the outpatient delivery system so that prevention and early intervention is optimized; b) develop interventions that focus specifically on the needs of high-risk/cost populations, and c) reduce the unnecessary use of care that is high-cost or results in potentially adverse outcomes for patients. The health system transformation work LACDHS must do to accomplish its aims are well-aligned with PRIME Program participation and map very well to each of the PRIME Project Domains.

In Domain 1, LACDHS selects projects 1.1 (Integration of Physical and Behavioral Health), 1.2 (Primary Care Redesign), 1.3 (Specialty Care Redesign), 1.4 (Patient Safety in the Ambulatory Setting), 1.6 (Cancer Screening and Follow-up), and 1.7 (Obesity Prevention and Healthier Food Initiative). Each of these Domain 1 projects will enable DHS to build the necessary infrastructure and processes to enable our outpatient delivery system to optimize prevention and early intervention.

In Domain 2, LACDHS selects projects 2.1 (Improved Perinatal Care), 2.2 (Care Transitions: Integration of Post-Acute Care, 2.3 (Complex Care Management for High Risk Populations, 2.5 (Transition to Integrated Care Post Incarceration), and 2.7 Comprehensive Advanced Illness Planning and Care). Projects 2.1, 2.3, and 2.5 will enable DHS to design and deploy interventions that target high risk/cost populations who need additional support. Projects 2.2 and 2.6 will help DHS develop system of care components that integrate services and enable patients to receive the right care and the right time in the right setting.

In Domain 3, LACDHS selects projects 3.1 (Antibiotic Stewardship) and 3.3 (Therapies Involving High-Cost Pharmaceuticals). Both of these projects support DHS reducing unnecessary costs and potentially avoidable adverse outcomes while preserving high quality and evidence-based care.

The projects across the three domains are each essential components of the overall system transformation strategy. The Domain 1 Projects assist LACDHS in developing the strong foundation of ambulatory care that optimizes the use of higher cost procedures and acute care. Domain 2 builds on Domain 1 by enabling the deployment of population and care-specific interventions on top of a strong foundation of ambulatory care designed to address the special and additional needs of vulnerable sub-populations in the safety-net. In health care, more is not always better; more spending and treatment does not translate into better patient outcomes. The Domain 3 projects tackle the issues of overuse and misuse of health care services (e.g., inappropriate use of antibiotics), and ensure effective and efficient care to LACDHS patients while reducing health care costs.

At the end of five years, the LACDHS patient population will receive integrated physical, mental, and substance use services that prioritize prevention and early intervention, with special emphases on vulnerable populations such as justice-involved, homeless, and severely mentally ill.

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

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

The chronic health conditions and access to care challenges of the safety-net healthcare population LACDHS serves is described in Section 2.1. LACDHS' participation in Domain 1 projects will enable the delivery system to improve access to important clinical preventative services such as blood pressure control, diabetes screening and medication management, and cancer screening that will help address key disparities in care and outcomes. The LACDHS patient population is also challenged with co-occurring behavioral health conditions and social needs deprivations including homelessness and post-incarceration transitions. Projects in Domains 1 and 2 including the integration of physical and behavioral health, complex care management, and improving transitions between incarceration and reentry in society will help LACDHS meet critical needs and offer meaningful support to its patient population, support that will translate to improved patient outcomes.

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).

LACDHS has established system-wide committees around core functions that enables its multiple hospitals, health centers, and clinics to strategize, implement, and govern programs such as PRIME. Many of these committees and their processes were stood up during the previous 1115 Waiver DSRIP Program. The primary committee responsible for the PRIME Program is the Waiver/Performance Measures Committee, which includes Chief Quality Officers, Medical Directors, Managed Care Services personnel, and Data Analytics staff. This committee has broad oversight over monitoring data and facilitating intervention efforts around performance improvement related to the 1115 Waiver, HEDIS, Joint Commission Core Measures, and patient satisfaction measures. Other key system-wide committees that will serve as accountable leaders of individual PRIME projects in Domains 1 and 2 include the Primary Care Workgroup, the Specialty Care Workgroups, Women's Health and Innovations Group, the Office of Diversion and Reentry, Infection Control, and the Pharmacy and Therapeutics Committee. LACDHS will be creating a new system-wide group to direct advanced illness and palliative care approaches in support of Project 2.7 (Comprehensive Advanced Illness Planning and Care).

The LACDHS leadership will provide routine updates to its governing body, the LAC Board of Supervisors. The Board of Supervisors has taken a keen interest in supporting LACDHS in succeeding under PRIME.

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.

LACDHS will work with stakeholders and beneficiaries so that they have multiple opportunities to be engaged in PRIME planning and implementation. LACDHS has already engaged its union partner SEIU 721 on the 1115 Waiver, the PRIME Program specifically, and the development of a strategy to energize and prepare the workforce for implementing PRIME. LACDHS and SEIU 721 have already collaboratively launched the development of customer service training for all LACDHS staff, with over 6,000 staff persons already completing the training. The training is designed to improve patient experience by emphasizing the workforce's important role at every level in deploying a patient-centered model of care at LACDHS. LACDHS will also engage with its health plan and community clinic partners in system redesign related to Domain 1 and 2 projects.

LACDHS will also provide quarterly updates on PRIME to the public LAC Board of Supervisor meetings. Members of the public and beneficiaries are provided the opportunity to ask questions and offer input on PRIME at these meetings. The input

of the public and beneficiaries is an important component of the LACDHS process of PRIME program planning and implementation.

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.

LACDHS utilizes multiple approaches to ensure cultural competency in the services provided to our diverse population. Approaches include working to ensure that providers and staff reflect the diversity of our patients and that all of our patients have access to health information in their language of choice. LACDHS will also continue ensure clinical sites are able to provide real-time professional interpreter/translation services when required or requested by the client through building both in-person and technology-based (e.g., telephone, video-conferencing) resources; ensure clients are proactively made aware of their right to receive and the availability of such services. LACDHS intends to continue these activities as part of our commitment to providing culturally competent service and care.

As part of PRIME Domain 1, LACDHS will implement a mechanism to systematically collect and analyze Race, Ethnicity and Language (REAL) data and data for other culturally relevant factors (e.g., LGBTQ, physical disability) among our patients; use data to identify and report relevant health-related disparities; and inform ongoing program design to address disparities.

3.6 Sustainability. [No more than 150 words]

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

LACDHS employs multiple approaches to quality improvement. Quality officers at our hospitals and clinics utilize PDSA cycles, TeamSTEPPS, and LEAN, among other approaches to improve primary care medical home processes, address core measures, HEDIS, and previous DSRIP targets. LACDHS is also investing in a population health module for its EHR that will be configured to monitor progress and provide decision support on PRIME metrics in the delivery of care to the PRIME Eligible Population.

The PRIME Program will not only help LACDHS achieve measureable improvements across a range of clinical quality indicators, but it will also by its conclusion leave our system with new tools, infrastructure, and processes that will continue to support the improvements after the program has ended. In addition, perhaps most importantly, a successful PRIME Program at LACDHS will

demonstrate for our staff and patients that a population health approach that optimizes care delivery and patient-centered outcomes is possible in the safety-net.

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)**

Mental health disorders (MHD) and Substance Abuse Disorders (SUD) often co-occur with chronic medical conditions and can substantially worsen associated health outcomes and lead to higher complication and mortality rates.

Individuals who suffer from both physical and MHD and/or SUD face challenges in accessing care. LACDHS has collaborated with LAC Department of Mental Health (LACDMH) to improve patient access to mental health services and to integrate mental health services into the primary care setting by the creation of co-location sites. This collaboration includes: the development of a tracking mechanism for referrals from primary care providers to on-site mental health professionals; the use of joint consultations and treatment planning, and coordination of resources to improve patient education, support, and compliance with the medication regimen; the implementation of a structured care algorithm for selection of pharmacologic therapy for depression; the integration of depression screening of diabetics assigned to a medical home in co-location sites; and timely initial behavioral health visit wait times.

In addition, LACDHS is dedicated to ensuring that patients empaneled to LACDHS facilities receive Screening, Brief Intervention, and Referral to Treatment (SBIRT) services. SBIRT consists of three major components: patient assessment for potential alcohol use disorders using standardized screening tools; patient-centered strategy which motivates behavior change and prevents the progression of alcohol abuse; and providing a referral to brief therapy or additional treatment to patients who are in need of additional services.

Such collaboration of physical health and behavioral health services will improve diagnosis of mental health conditions in primary care settings, reduce alcohol misuse, improve patient health outcomes and functioning, reduce medication errors, and reduce avoidable emergency department and hospital services.

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.
Applicable	**1.1.6** Ensure coordination and access to chronic disease (physical or behavioral) management, including self-management support to patients and their families.
Applicable	**1.1.7** Ensure systems are in place to support patient linkages to appropriate specialty physical, mental and SUD services. Preventive care screenings, including behavioral health screenings (e.g., PHQ-2, PHQ-9, SBIRT), will be implemented for all patients to identify unmet needs. When screenings are positive, providers will take immediate

Check, if applicable	Description of Core Components
	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.
Not Applicable	**1.1.9** Increase access to Medication Assisted Treatment (MAT) for patients with alcohol and opioid addiction to assist in stabilizing their lives, reducing urges or cravings to use, and encourage greater adherence to treatment for co-morbid medical and behavioral health conditions. For alcohol use disorders these medications include naltrexone, acamprosate, and disulfiram. For opioid addiction, medication assisted treatment (MAT) includes maintenance treatment with methadone and buprenorphine.
Applicable	**1.1.10** Ensure the development of a single treatment plan that includes the patient's behavioral health issues, medical issues, substance abuse, social and cultural and linguistic needs. This includes incorporating traditional medical interventions, as well as non-traditional interventions such as gym memberships, nutrition monitoring, healthy lifestyle coaching, or access to culturally and linguistically appropriate peer-led wellness and symptom management groups.
Applicable	**1.1.11** Ensure a culturally and linguistically appropriate treatment plan by assigning peer providers or other frontline worker to the care team to assist with care navigation, treatment plan development and adherence.
Not 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.
Not 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

Check, if applicable	Description of Core Components
	engagement. Develop programs to implement telehealth, eReferral/eConsult to enhance access to behavioral health services.
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)

Five years ago, the LACDHS Ambulatory Care Network (ACN) was created to transform the way that LACDHS approaches and delivers care for our patients. Ambulatory care, and specifically primary care, has become the focus and a critical strategy for the entire Department of Health Services. Accordingly, ACN has established over 130 patient-centered medical homes and has empaneled over 400,000 patients to teams that have been trained to improve the overall patient experience by establishing meaningful patient-provider relationships, enhancing continuity of care, and ensuring access to and coordination of medical services. In addition, we have strengthened our use of electronic technology so that medical home teams are better able to track referrals, follow up on lab results and manage a patient's care with an emphasis on better disease outcomes.

In 2015, ACN developed a list of four core values: Quality affordable and accessible health care; Compassion for patients and each other, Responsibility in planning and managing of resources; and Patient-Centeredness. These work together to achieve the ACN Purpose: "to heal and empower our patients to live healthier and better lives". These values as well as meaningful relationships between patients and providers will lead to better access to medical services and enhanced continuity of care, resulting in more efficient preventive care and better management of chronic conditions.

With these fundamentals in place, we plan to implement the following improvements in care for LACDHS empaneled patients: electronic inpatient discharge notifications to DHS primary care providers, using the new EHR; facilitated outpatient follow-ups for discharged patients without a primary care provider; tracking and reporting on ER visits, admissions and re-admissions; identification of high-risk patients who are at risk for frequent ED visits or re-admissions; risk-stratification and tailored care plans to meet patients' clinical and social service needs; and multi-disciplinary teams to engage patients and/or family care givers.

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.
Applicable	**1.2.3** Hiring and training of frontline workforce (e.g., medical assistants, community health workers, promotoras, health navigators or other non-licensed members of the care team) to be responsible for coordination of non-clinical services and elements of the care plan.
Applicable	**1.2.4** Implement technology-enabled data systems to support pre-visit planning, point of care delivery, population/panel management activities, care coordination, patient engagement, and operational and strategic decisions including a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership. • Implementation of EHR technology that meets meaningful use (MU) standards.
Applicable	**1.2.5** Ongoing identification of all patients for population management (including assigned managed care lives): • Manage panel size, assignments, and continuity to internal targets. • Develop interventions for targeted patients by condition, risk, and self-management status. • Perform preventive care services including mental health and substance misuse screenings and brief interventions (e.g., PHQ-9, SBIRT).

Check, if applicable	Description of Core Components
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.
Not 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.
Applicable	**1.2.8** Demonstrate evidence-based preventive and chronic disease management.
Applicable	**1.2.9** Improve staff engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on the team-based care model to ensure effective and efficient provision of services (e.g., group visits, medication reconciliation, motivational interviewing, cognitive behavioral therapy and Medication-Assistance Treatment (MAT)).
Not Applicable	**1.2.10** 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.

Check, if applicable	Description of Core Components
	• Developing capacity to track and report REAL/SO/GI data, and data field completeness. • Implementing and/or refining processes for ongoing validation of REAL/SO/GI data. • Developing capacity to stratify performance metrics by REAL/SO/GI data and use stratified performance data to identify disparities for targeted interventions. • Developing capacity to plan and implement disparity reduction interventions with input from patients and community stakeholders. • Developing dashboards to share stratified performance measures with front-line staff, providers, and senior leadership.
Applicable	**1.2.12** To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

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

To successfully attain our goals in specialty care, LACDHS will leverage and build on investments we have made in our Integrated Delivery System. Across a large geography and many users, we have invested in communication technology (eConsult), a unified electronic health record, over two dozen specialty-primary care workgroups, a robust library of clinically relevant Expected Practices and a new data management and reporting system. We will work in close partnership with the Community Clinics who look to us to partner in the provision of specialty services.

Under the PRIME Specialty Care Improvement Project, LACDHS intends to further engage primary care providers within LACDHS and those at our Community Partner clinics in development and implementation of the specialty care model; implement processes for primary care/specialty care co-management of patient care, timely follow-up for specialty expertise requests, and effective communication between PCP and specialist; and ensure that clinical teams engage in team- and evidence-based care.

We have outstanding participation from our system and facility executives, IT department, data analytics, workgroup chairpersons and labor leaders. The process will be collaborative, with an emphasis on tangible and practical interventions which will result in improved care. Our workgroups will provide a key forum for discussing ideas, vetting solutions and leading implementation of chosen projects. We have a monthly

Steering Committee meeting that will receive regular updates on the Specialty Care projects and mobilize expertise and resources as needed.

We expect that this project will improve care in the areas of timely access, coordination of service, more effective use of provider and patient time, clinical resources and smooth transitions between care settings. We anticipate that through this project we will improve our community of care providers, our “patient centered medical neighborhood” and thus improve care for each patient we serve. Many of the core components focus on the primary care – specialty care interface and we will invest substantially (even more than we already have) in this this coordinated partnership.

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).
Applicable	**1.3.4** Engage primary care providers and local public health departments in development and implementation of specialty care model.
Applicable	**1.3.5** Implement processes for primary care/specialty care co-management of patient care.
Applicable	**1.3.6** Establish processes to enable timely follow up for specialty expertise requests.
Applicable	**1.3.7** Develop closed loop processes to ensure all requests are addressed and if in person visits are performed, that the outcome is communicated back to the PCP.
Applicable	**1.3.8** Ensure that clinical teams engage in team- and evidence-based care.
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.
Not 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.
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.
Applicable	**1.3.15** Improve medication adherence.
Applicable	**1.3.16** Implement population management strategies for patients in need of preventive services, with chronic conditions, or with recurring long term surveillance needs.
Applicable	**1.3.17** Implement or expand use of telehealth based on DPH/DMPH capacity to address patient and PCP barriers to accessing specialty expertise. Implement a telehealth platform with communication modalities that connect between specialty care and primary care (e.g., eConsult/eReferral).
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

Ambulatory care reform is a key strategic priority for LACDHS. Therefore, this project to improve patient safety in the ambulatory setting is a natural fit. We first plan to delve into the current workflows for follow-up on abnormal results and monitoring of individuals on persistent medications. Based on the findings from this analysis, we will develop a standardized workflow and protocols that include appropriate documentation of clinician review and follow-up for all targeted abnormal results. By the end of 2016, LACDHS plans to implement Healthe Intent, a disease registry and panel management module addition to our electronic health record. This module will include decision support tools that will alert clinicians to order appropriate tests and take other actions based on clinical information in the system.

Another key component of this project will include provider communication. Once standard protocols have been developed and the enabling technology is in place, providers will be educated on the recommended processes and will receive training on the Healthe Intent module.

The target population includes all adult and pediatric patients who are empaneled to LACDHS primary care providers. Successful implementation of this project will result in increases in the number of women with abnormal mammograms receiving timely follow-up, the number of diabetics receiving appropriate medications, and appropriate follow-up for other patients with actionable results.

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.
Not Applicable	**1.4.2** Implement a data-driven system for rapid cycle improvement and performance feedback based on the baseline study that effectively addresses all identified gaps in care and which targets clinically significant improvement in care. The improvement and performance feedback system should include patients, front line staff from testing disciplines (such as, but not limited to, radiology and laboratory medicine) and ordering disciplines (such as primary care) and senior leadership.
Applicable	**1.4.3** Develop a standardized workflow so that: • Documentation in the medical record that the targeted test results were reviewed by the ordering clinician.

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

☒ 1.6 – Cancer Screening and Follow-up

An estimated 172,000 Californians were diagnosed with cancer and 58,000 died of the disease in 2015. Cancer screening can prevent premature deaths and reduce morbidity. Screening is especially helpful in preventing cancers of the cervix, colon, and rectum, as well as detecting other cancers (e.g., breast cancer) at an early stage, when treatment can be most effective. Therefore, LACDHS intends to increase its efforts to improve cancer screening, focusing on breast, cervical, and colorectal cancers, and follow-up for abnormal results. The target population includes all adult patients who are empaneled to LACDHS primary care clinics.

LACDHS has developed a curriculum and will provide Certified Medical Education (CME) for cervical cancer screening guidelines for primary care providers. In addition, LACDHS plans to test an innovative model of assigning a dedicated nurse practitioner to primary care sites to perform cervical cancer screening.

Women's Health clinics at LACDHS provide high-quality screenings and diagnostic services to detect breast and cervical cancers. Seventeen DHS facilities offer the

[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.*

"Every Women Counts" (EWC) Program which provides free exams for low-income and uninsured women. The EWC Program will save lives by preventing and reducing the devastating effects of cancer for underserved Californian women through education, early detection, diagnosis, treatment, and integrated preventive services.

LACDHS has made a significant investment to improve access and quality of mammography services by purchasing and installing several new digital mammography machines. The digital images can be manipulated for better clarity and visibility, so that abnormalities can be seen more easily. Digital mammograms can also be easily sent electronically. This will allow patients to get second opinions much more timely.

LACDHS has adopted the Breast Imaging Reporting and Data System (BI-RADS) that allows putting the findings of mammograms into a small number of well-defined categories. After the initial breast cancer screening, a follow-up mammogram is recommended when the BI-RAD category is 3 or higher. LACDHS plans to improve timely follow-up to ensure breast biopsy is performed within 14 business days of the date of a screening or diagnostic mammogram being given a BIRADS 4 or 5.

Healthe Intent, the Cerner Population Health Module, the center of workflow in the PCMH, will be implemented by the end of 2016. One of its main functions is to provide alerts for preventive health measures. LACDHS will be creating patient lists and scorecards for breast, cervical, and colorectal cancer screenings in Healthe Intent, which will be communicated to DHS providers. Providers will be required to utilize these lists to monitor preventive care services for their patients, and provide prompt follow-up on abnormal screening results. For example, one of the LACDHS goals is to improve the percentage of patients receiving timely colonoscopy following a positive colorectal cancer screening test.

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

Check, if applicable	Description of Core Components
Applicable	**1.6.1** Develop a multi-disciplinary cross-participating PRIME entity task force to identify principle-based expected practices for screening and follow-up for the targeted services including, but not limited to: • Standard approach to screening and follow-up within each DPH/DMPH. • Screening: o Enterprise-wide standard approach to screening (e.g., ages, frequency, diagnostic tool). • Follow-up for abnormal screening exams: o Clinical risk-stratified screening process (e.g., family history, red flags). Timeliness (specific time benchmark for time from abnormal screening exam to diagnostic exam).

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

☒ 1.7 – Obesity Prevention and Healthier Foods Initiative

The obesity epidemic has emerged as one of the most significant public health threats in Los Angeles County. According to the Key Indicators of Health in 2013, in Los Angeles County, 23.6% of adults, and 22.4% of children in grades 5, 7, and 9 were obese; and 37.1% of adults were overweight. Obesity is the leading cause of type 2 diabetes and an important risk factor for heart disease, stroke, arthritis, and many forms of cancer. For this preventive care project, LAC DHS will be focusing on the following areas: BMI screening and follow-up; weight assessment and counseling; and the Healthier Foods Initiative.

Healthe Intent, the Cerner Population Health Module that will drive workflow in the PCMH, will be implemented by the end of 2016. Healthe Intent will include pre-programmed alerts that will prompt staff to ensure that patients' height, weight, and BMI are measured and recorded during the patient's primary care visit; and if the BMI is outside of normal parameters, staff will be prompted to document a follow-up plan. The follow-up plan may include education, referral, pharmacological interventions, dietary supplements, exercise and nutrition counseling. The target population for BMI Screening and Follow-up is PRIME eligible population who are 18 years or older.

Weight assessment and counseling for nutrition and physical activity for children and adolescents is also an important HEDIS measure. In an effort to reduce obesity in children, this measure looks at the child's height and weight, as well as their physical activity and dietary habits. DHS Primary care providers will take advantage of every office visit to capture BMI and to counsel on nutrition and physical activity, and to ensure proper documentation in ORCHID. The target population for Weight assessment and counseling is the PRIME eligible population who are between three and 17 years old.

Finally, for the Healthier Foods Initiative, LACDHS plans to revise its contract with the hospital food providers, to ensure that healthier options will be available to patients, visitors, and staff throughout the facilities; and the nutrition of patient meals will be improved.

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

Check if Applicable	Description of Core Component
☐	**1.7.1** Collect or use preexisting baseline data on receipt and use of targeted preventive services, including any associated disparities related to race, ethnicity or language need.
☐	**1.7.2** Implement processes to provide recommended clinical preventive services in line with national standards, including but not limited to USPSTF A and B Recommendations.

Check if Applicable	Description of Core Component
☒	**1.7.3** Improve access to quality care and decrease disparities in the delivery of preventive services.
☒	**1.7.4** Employ local, state and national resources, and methodologies for improving receipt of targeted preventive services, reducing associated disparities, and improving population health.
☒	**1.7.5** Adopt and use certified electronic health record systems, including clinical decision supports and registry functionality to support provision of targeted preventive services. Use panel/population management approaches (e.g., in-reach, outreach) to reduce gaps in receipt of care.
☐	**1.7.6** Based on patient need, identify community resources for patients to receive or enhance targeted services and create linkages with and connect/refer patients to community preventive resources, including those that address the social determinants of health, as appropriate.
☐	**1.7.7** Implement a system for performance management that includes ambitious targets and feedback from patients, community partners, front line staff, and senior leadership, and a system for continual rapid cycle improvement using standard process improvement methodology.
☒	**1.7.8** Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts.
☒	**1.7.9** Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.
☒	**1.7.10** Prepare for and implement the Partnership for a Healthier America's Hospital Healthier Food Initiative.

Please complete the summary chart:

	For DPHs	For DMPHs
Domain 1 Subtotal # of DPH-Required Projects:	**3**	**0**
Domain 1 Subtotal # of Optional Projects (Select At Least 1):	**3**	
Domain 1 Total # of Projects:	**6**	

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

☒ 2.1 – Improved Perinatal Care (required for DPHs)

Improving the health of mothers and babies has always been a high priority for LACDHS. In 2013, LACDHS received a Centers for Medicare & Medicaid Innovation (CMMI) Challenge Grant called the Strong Start for Mothers and Newborns Initiative. The initiative aims to reduce preterm births and improve outcomes for newborns and pregnant women. The target population includes women with two primary care visits or two prenatal visits.

Perinatal Care improvement will continue to be a focus for the LACDHS through our work to optimize perinatal care throughout the antenatal, delivery and postpartum course. We regularly use care coordinators and care managers to identify and coordinate the care of women with high-risk medical and social needs. This will continue through the postpartum with linkages to care for those requiring chronic disease management for conditions such as diabetes and hypertension. Improvements to inpatient care will be aided by involvement with CMQCC via the California Maternal Data Center (CMDC). This platform will leverage real-time data reporting and outcomes evaluation for performance improvement on best practice measures such as first-birth low-risk cesarean births. LACDHS will also participate in the learning collaborative with CMQCC for hemorrhage. We plan to utilize the hemorrhage toolkits provided by CMQCC to optimize our team approach to safe delivery in our maternity hospitals. Finally, our maternity hospitals are already baby-friendly and we will continue to support on-going patient engagement in our lactation program provided by lactation consultants in the in-patient setting and perinatal health workers, nurses and health education team in the outpatient setting.

The focused activities listed above will enable LACDHS to improve health outcomes for women and babies throughout the prenatal, delivery, and postpartum periods.

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).
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.

Check, if applicable	Description of Core Components
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)

Effective care transition from hospital to patient's home and outpatient clinical venue(s) is critical for safe and effective care as well as ensuring positive patient and staff experience. In response to the 1115 Bridge to Reform Waiver, DHS established multiple patient-centered medical home teams and an empanelment process for managed care assigned patients and uninsured patients who have an established relationship with a DHS primary care provider. Another major milestone for DHS occurred on March 1, 2016, when LACDHS successfully completed implementation of a unified electronic health record system across its four hospitals and 23 ambulatory care clinics.

With these fundamentals in place, the following are expected to be completed by Demonstration Year (DY) 12 for empaneled patients: Inpatient discharge notifications to DHS primary care providers for empaneled patients; establishing communication exchange expectations between DHS hospital and outpatient staff; facilitating outpatient follow-ups for discharged patients without a primary care provider; and tracking and reporting on emergency room visits, admissions and re-admissions.

For DY 12-15, LACDHS plans to focus on the following: Convening multi-disciplinary teams to engage patients and/or family care givers; identifying a medical home for non-DHS insured patients; coordinating and communicating discharge plans with the patient, family caregiver and/or patient's primary care provider; identifying patients who are at risk for frequent ED visits or re-admissions; risk-stratifying and tailoring appropriate care plans and resources to meet the patient's clinical and social service needs; and working with health plans and community based organizations to facilitate care in the community setting.

Since LACDHS is an open-network public safety-net delivery system, processes and tools are in place to manage three distinct populations with a variety of social and economic challenges. The three hospitalized populations are LACDHS-empaneled managed-care assigned patients; LACDHS-empaneled uninsured with an existing

relationship to LACDHS primary care providers, and non-empaneled insured and uninsured patients. Care transition work will begin with the two groups of LACDHS empaneled patients (managed care or uninsured) because these patients will primarily receive their care and have their medical records with LACDHS. Thereafter, workflows and processes will be developed for patients with non-LACDHS insurance coverage.

Establishing care coordination and communication processes with out-of-network providers will be a challenge for both private and public hospitals. Furthermore, since Los Angeles County has a large population with chronic medical, mental, and substance use conditions, social challenges (e.g., homelessness or food insecurity), English proficiency and health literacy limitations, it is important to establish and train multi-disciplinary teams to provide patient-centered discharge plans, and work with patients and/or family caregivers on self-management.

The target population for this project includes patients who are empaneled to LACHDS facilities and have at least one inpatient discharge from a LACHDS hospital.

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

Check, if applicable	Description of Core Components
Not 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:

Check, if applicable	Description of Core Components
	o Involve mental health, substance use, pharmacy and palliative care when possible. o Involve trained, enhanced IHSS workers when possible. o Develop standardized protocols for referral to and coordination with community behavioral health and social services (e.g., visiting nurses, home care services, housing, food, clothing and social support). Identify and train personnel to function as care navigators for carrying out these functions.
Applicable	**2.2.5** Inpatient and outpatient teams will collaboratively develop standardized transition workflows: • Develop mechanisms to support patients in establishing primary care for those without prior primary care affiliation. Develop process for warm hand-off from hospital to outpatient provider, including assignment of responsibility for follow-up of labs or studies still pending at the time of discharge.
Applicable	**2.2.6** Develop standardized workflows for post-discharge (outpatient) care: • Deliver timely access to primary and/or specialty care following a hospitalization. • Standardize post-hospital visits and include outpatient medication reconciliation.
Applicable	**2.2.7** Support patients and family caregivers in becoming more comfortable, competent and confident in self-management skills required after an acute hospitalization by providing: • Engagement of patients in the care planning process. • Pre-discharge patient and caregiver education and coaching. • Written transition care plan for patient and caregiver. • Timely communication and coordination with receiving practitioner. Community-based support for the patient and caregiver post hospitalization focusing on self-care requirements and follow-up care with primary and specialty care providers.
Not Applicable	**2.2.8** Engage with local health plans to develop transition of care protocols that ensure: coordination of care across physical health, substance use disorder and mental health spectrum will be supported; identification of and follow-up engagement with PCP is established; covered services including durable medical equipment (DME) will be readily available; and, a payment strategy for the transition of care services is in place.

Check, if applicable	Description of Core Components
Not Applicable	**2.2.9** Demonstrate engagement of patients in the design and implementation of the project.
Not Applicable	**2.2.10** Increase multidisciplinary team engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on care model.
Not Applicable	**2.2.11** Implement a system for continual performance feedback and rapid cycle improvement that uses standard process improvement methodology and that includes patients, front line staff and senior leadership.

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

LACDHS cares for a large number of patients with complex care needs including multiple chronic disease conditions, homelessness, mental health disorders and substance abuse disorders. The PRIME complex care management program will focus on the highest-risk patients to assist these patients and their caregivers in managing medical conditions and co-occurring psychosocial factors. The target population for this project includes PRIME-eligible adults with four or more chronic conditions and/or psychosocial risk factors.

LACDHS' complex care management program, has successfully reduced both disease burden and emergency department and inpatient costs for patients with ambulatory sensitive conditions and the highest burden of illness. This Fall, LACDHS will implement HealtheIntent in all of our patient-centered medical homes and will include all empaneled patients with a variety of chronic conditions. HealtheIntent is an add-on module for the new EHR system, and it will allow LACDHS to track patients, document the assignment of each member of the care team (including licensed and unlicensed staff), and provide clinical decision support to proactively alert staff to care gaps. In addition, LACDHS will develop interfaces between HealtheIntent and the following: 1) Already-developed and implemented risk stratification tools that help identify patient populations who would benefit from specialized medical homes, disease management programs, and complex care management; and 2) A chronic care management model that includes clinical protocol-driven, patient-centric interventions that emphasize care

coordination, remote monitoring, and telephonic communication. LACDHS will also continue to conduct provider training to ensure optimal use throughout the system.

LACDHS will perform patient outreach using multi-disciplinary complex care management teams, which will include community health workers. These community health workers will extend the reach of the care team outside the walls of the traditional health care settings. They will engage patients and if necessary, accompany them to services. The complex care management teams will provide the following: comprehensive biopsychosocial assessment and individualized care plans for each patent; social support and referrals; health coaching (including medication management support); health delivery system navigation assistance; and support for patients during transitions in care (e.g., hospital/skilled nursing facility to home).

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.
Not 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.
Not Applicable	**2.3.4** Conduct a qualitative assessment of high-risk, high-utilizing patients.
Applicable	**2.3.5** Establish data analytics systems using clinical data sources (e.g., EHR, registries), utilization and other available data (e.g., financial, health plan, zip codes), to enable identification of high-risk/rising risk patients for targeted complex care management interventions, including ability to stratify impact by race, ethnicity and language.

Check, if applicable	Description of Core Components
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.
Not Applicable	**2.3.7** Ensure that the complex care management team has ongoing training, coaching, and monitoring towards effective team functioning and care management skill sets.
Applicable	**2.3.8** Implement evidence-based practice guidelines to address risk factor reduction (smoking cessation/immunization/substance abuse identification and referral to treatment/depression and other behavioral health screening, etc.) as well as to ensure appropriate management of chronic diseases: • Use standardized patient assessment and evaluation tools (may be developed locally, or adopted/adapted from nationally recognized sources). • Use educational materials that are consistent with cultural, linguistic and health literacy needs of the target population.
Applicable	**2.3.9** Ensure systems and culturally appropriate team members (e.g. community health worker, health navigator or promotora) are in place to support system navigation and provide patient linkage to appropriate physical health, mental health, SUD and social services. Ensure follow-up and retention in care to those services, which are under DPH/DMPH authority, and promote adherence to medications.
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

The Los Angeles County jail system is the largest in the nation, with approximately 17,000 inmates in custody on any given day, and approximately 130,000 individuals incarcerated annually across seven custody facilities. Between 20-30% of the jail population is in need of mental health services, approximately 70% have a history of substance abuse issues, and an estimated 20% are homeless or likely to lack stable housing upon release.

In June 2015, the County of Los Angeles initiated a new integrated jail health services structure that will move jail medical services previously operated by the LAC Sheriff's Department and jail mental health services previously operated by LACDMH under the direct operation of LACDHS. The new structure will provide a single point of leadership for integrated health services in the jail and will include the addition of a Substance Use Disorder director and Care Transitions director in order to improve services in these areas. Additionally, in August 2015, the County moved to create a new Office of Diversion and Reentry within DHS, with a mandate to redirect individuals with serious mental illness and substance use disorders from the criminal justice system to an integrated treatment system.

With these major institutional changes, DHS is poised to significantly improve care coordination and care transitions for justice-involved individuals. Efforts will include establishment of a jail discharge pharmacy to ensure medication continuity, development of a reentry health clinic to serve individuals returning to the community, integration of community health workers in the jail to facilitate linkage to medical homes and social services upon release, and continued efforts in Medi-Cal enrollment and benefits establishment.

The target population includes patients in Los Angeles County jail system, soon-to-be released, or released in the prior six months, with at least one chronic health condition or over age of 50.

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

Check, if applicable	Description of Core Components
Not 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.

Check, if applicable	Description of Core Components
Applicable	**2.5.2** Develop processes for seamless transfer of patient care upon release from correctional facilities, including: • Identification of high-risk individuals (e.g., medical, behavioral health, recidivism risk) prior to time of release. • Ongoing coordination between health care and correctional entities (e.g., parole/probation departments). • Linkage to primary care medical home at time of release. • Ensuring primary care medical home has adequate notification to schedule initial post-release intake appointment and has appropriate medical records prior to that appointment, including key elements for effective transition of care. • Establishing processes for follow-up and outreach to individuals who do not successfully establish primary care following release. • Establishing a clear point of contact within the health system for prison discharges.
Applicable	**2.5.3** Develop a system to increase rates of enrollment into coverage and assign patients to a health home, preferably prior to first medical home appointment.
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.
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.
Applicable	**2.5.6** Provide coordinated care that addresses co-occurring mental health, substance use and chronic physical disorders, including management of chronic pain.
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

Check, if applicable	Description of Core Components
	treatment, individual and group peer support) as well as to ensure appropriate management of chronic diseases (e.g., asthma, cardiovascular disease, COPD, diabetes).
Applicable	**2.5.9** Develop processes to ensure access to needed medications, DME or other therapeutic services (dialysis, chemotherapy) immediately post-incarceration to prevent interruption of care and subsequent avoidable use of acute services to meet those needs.
Applicable	**2.5.10** Engage health plan partners to pro-actively coordinate long-term care services prior to release for timely placement according to need.
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.
Not Applicable	**2.5.14** Improve staff engagement by: • Implementing a model for team-based care in which staff performs t of their abilities and credentials. • Providing ongoing staff training on care model. • Involving staff in the design and implementation of this project.
Not Applicable	**2.5.15** Engage patients and families using care plans, and self-management education, including individual and group peer support, and through involvement in the design and implementation of this project.
Applicable	**2.5.16** Participate in the testing of novel metrics for this population.

☒ 2.7 – Comprehensive Advanced Illness Planning and Care

LACDHS operates 4 acute care hospitals and provides the full spectrum of specialty care. As a result, LACDHS providers routinely manage patients with advanced illnesses in both the inpatient and outpatient arenas. Incorporating comprehensive advanced care planning and proactive palliative care treatment plans would provide immense benefits to LACDHS patients. Project 2.7 would also help LACDHS reduce the use of unnecessary and high cost care for patients at the end of life who choose to prioritize palliation over aggressive diagnostics and therapies of limited benefit.

LACDHS currently has an inpatient palliative care service but not one that extends to ambulatory care where advanced illness planning is ideally performed. LACDHS will work to establish an ambulatory palliative care team that assists PCMH and selected specialty (hem-onc, heart failure, neurology, etc.) teams in developing and implementing advanced illness planning processes and procedures.

A key area of emphasis for the LACDHS project will be developing the skills of provider staff in engaging patients and families in education about advanced illness care options, eliciting treatment preferences, and meeting their emotional and spiritual needs. LACDHS will plan to launch training modules for staff on communication skills related to advanced illness planning and care. The target population includes patients with Stage 4 cancer or advanced end organ failure.

Project 2.7 will help ensure that LACDHS empaneled patients who make-up the potential PRIME Eligible Population will have their treatment preferences documented in the event of an advanced illness. Further, this PRIME project will help LACDHS develop a structured approach and supporting infrastructure and process for ambulatory and inpatient care services to elicit and act upon treatment preferences and ensure the wishes of patients with advanced illnesses are optimally met. The end result will be improved palliative care plans and more timely use of hospice when patients' wishes dictate.

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

Check, if applicable	Description of Core Components
Applicable	**2.7.1** Establish or expand both ambulatory and inpatient palliative care (PC) programs that provide: • Total, active and individualized patient care, including comprehensive assessment, inter-professional care planning and care delivery. • Support for the family. • Interdisciplinary teamwork. • Effective communication (culturally and linguistically appropriate). • Effective coordination. • Attention to quality of life and reduction of symptom burden. • Engagement of patients and families in the design and implementation of the program.
Not Applicable	**2.7.2** Develop criteria for program inclusion based on quantitative and qualitative data: • Establish data analytics systems to capture program inclusion criteria data elements.
Not Applicable	**2.7.3** Implement, expand, or link with, a Primary Palliative Care training program for front-line clinicians to receive basic PC training, including advanced care planning, as well as supervision from specialty PC clinicians. Assure key palliative care competencies for primary care providers by mandating a minimum of 8 hours of training for front line clinicians in communication skills and symptom management.
Applicable	**2.7.4** Develop comprehensive advance care planning processes and improve implementation of advance care planning with advanced illness patients.
Applicable	**2.7.5** Establish care goals consistent with patient and family preferences, and develop protocols for management/control of pain and other symptoms in patients with advanced illness, including a holistic approach that includes spiritual and emotional needs.
Not Applicable	**2.7.6** Improve completion of Physician Orders for Life-Sustaining Treatment (POLST) with eligible patients and participate in the state-wide POLST registry.
Not Applicable	**2.7.7** Provide access to clinical psychologist on the palliative care team to address psychological needs of patient and the family members during the

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

Please complete the summary chart:

	For DPHs	For DMPHs
Domain 2 Subtotal # of DPH-Required Projects:	**3**	**0**
Domain 2 Subtotal # of Optional Projects (Select At Least 1):	**2**	
Domain 2 Total # of Projects:	**5**	

Section 4.3 – Domain 3: Resource Utilization Efficiency

☒ 3.1 – Antibiotic Stewardship

Inappropriate use of antibiotics is the most important factor in the development of antimicrobial resistance. Antimicrobial stewardship program aims to coordinate designed interventions to promote and measure the appropriate use of antimicrobial agents. The program aims to reduce the overall antibiotic use for non-bacterial diseases, and optimizing antibiotic use for bacterial infections, with a special emphasis on agent with board spectrum activity. Overall, the program will improve the quality of patient care, patient safety, and reduce excessive costs attributable to inappropriate antimicrobial usage. The target population includes LACDHS-empaneled adults and children with specified conditions.

We intend to:

- Develop and disseminate standardized protocols for ordering and obtaining cultures and other diagnostic tests prior to initiating antibiotics, and develop antimicrobial stewardship policies and procedures. In addition, communication tools will be developed to educate clinicians about unnecessary combinations of antibiotics.

- Develop standardized short course regimens for total antimicrobial Days of Therapy (DOT) for recommended agents by disease type based on published evidence (e.g., 3-5 days of therapy for uncomplicated cystitis).

- Implement a system to evaluate effectiveness of intervention efforts including monitoring of antimicrobial utilization and clinical outcomes. Conduct periodic risk assessments for multidrug-resistant organism acquisition and transmission.

- Participate in a learning collaborative program to share learnings and communicate outcomes of the stewardship effort to staff, licensed practitioners, patients and their families.

We expect that the antimicrobial stewardship program will increase the appropriate use of antibiotics across LACDHS hospitals and health care system and reduce hospital-acquired *Clostridium difficile* infections. The target population includes: 1) adults 18-64 years of age with the diagnosis of acute bronchitis; 2) adults with urinary tract infections with low bacterial colony count (less than 100,000 colony-forming units/ml) in a urinary culture; 3) surgical patients with prophylactic antibiotics administration after surgical closure; and 4) patients using hemodialysis devices, urinary catheters and respiratory ventilators.

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

Check, if applicable	Description of Core Components
Not Applicable	**3.1.1** Utilize state and/or national resources to develop and implement an antibiotic stewardship program, such as the California Antimicrobial Stewardship Program Initiative, or the IHI-CDC 2012 Update "Antibiotic Stewardship Driver Diagram and Change Package.[2] • Demonstrate engagement of patients in the design and implementation of the project.
Applicable	**3.1.2** Develop antimicrobial stewardship policies and procedures.
Applicable	**3.1.3** Participate in a learning collaborative or other program to share learnings, such as the "Spotlight on Antimicrobial Stewardship" programs offered by the California Antimicrobial Stewardship Program Initiative.[3]
Applicable	**3.1.4** Create standardized protocols for ordering and obtaining cultures and other diagnostic tests prior to initiating antibiotics.
Applicable	**3.1.5** Develop a method for informing clinicians about unnecessary combinations of antibiotics.
Applicable	**3.1.6** Based on published evidence, reduce total antimicrobial Days of Therapy (DOT) by providing standards and algorithms for recommended agents by disease type, focusing on short course regimens (e.g., 3-5 days of therapy for uncomplicated cystitis, 7 days for uncomplicated pyelonephritis, 5-7 days for uncomplicated non-diabetic cellulitis, 5-day therapy for community acquired pneumonia (CAP), 7-8 days for therapy for VAP or hospital acquired pneumonia).
Not Applicable	**3.1.7** Develop evidence-based computerized provider order entry (CPOE) algorithms and associated clinician training, to support antibiotic stewardship choices during order entry. These could include approaches such as guidelines for duration of antibiotics, within drug class auto-switching for specific antibiotics and doses, or restriction of specific antibiotics at the point of ordering (e.g., broad spectrum agents).

[2] The Change Package notes: "We do not recommend that any facility attempt to implement all of the interventions at once. There are a large number of interventions outlined in the Change Package, and attempting to implement too many at one time will likely create huge challenges. Rather, the Change Package is meant to serve as a menu of options from which facilities can select specific interventions to improve antibiotic use." (p. 1, Introduction).

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

Check, if applicable	Description of Core Components
Not Applicable	**3.1.8** Implement stewardship rounds focusing on high yield drugs to promote de-escalation after the drugs are started, such as regular antibiotic rounds in the ICU.
Not Applicable	**3.1.9** Improve diagnostic and de-escalation processes to reduce unnecessary antibiotic use based upon length of therapy or antibiotic spectrum, such as: • Procalcitonin as an antibiotic decision aid. • Timely step-down to oral antibiotic therapy to support early discharge from the hospital for acute infections. • Use of oral antibiotics for osteomyelitis to reduce prolonged IV exposures.
Not Applicable	**3.1.10** Evaluate the use of new diagnostic technologies for rapid delineation between viral and bacterial causes of common infections.
Applicable	**3.1.11** Adopt the recently described "public commitment" strategy in outpatient clinics to encourage providers not to prescribe antibiotics for upper respiratory tract infections (URIs).
Applicable	**3.1.12** Publish organization-wide provider level antibiotic prescribing dashboards with comparison to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.
Applicable	**3.1.13** Implement a system a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership.

☒ 3.3 – Resource Stewardship: Therapies Involving High Cost Pharmaceuticals

Historically, the drive to create new drugs and seek improved treatments has resulted in a broad and constantly evolving market for prescription drugs in the United States. Today, seven out of ten Americans are taking at least one prescription drug. The high rate of new drugs being introduced to the market influences increases in prescription drug spending. Today and in the near future, drug spending, high-cost entrants to the market and increases in the price of prescription drugs already on the market have resulted in increased cost for prescription drugs. LACHDS, through its hospitals and clinics, utilizes pharmaceutical agents to manage chronic illness and treat acute disease. As such, managing increasing pharmaceutical cost and the careful analysis of appropriate medication use is an ongoing challenge, leading to the selection of this project.

LACDHS plans on expanding its current high cost pharmaceuticals management program through a variety of components, including the expansion of an existing multidisciplinary pharmaceuticals stewardship team. This team will focus on evidence-based formulary decisions and identification of strategies to maximize use of Federal 340B drug pricing. Given that the majority of pharmaceutical increases are expected from a rise in specialty drug use, LACDHS plans to establish a central specialty pharmacy that will focus on managing specialty pharmaceutical care for all of its sites, maximizing the use of 340B drug pricing and access to limited distribution drugs to maximize pharmaceutical dollars for the safety net population. LACDHS also plans a focus on expanding review of patient medication adherence for chronic disease.

Through the use of provider dashboards, LACDHS is developing metrics to track the prescribing of high cost agents, as well as opportunities to maximize 340B drug access, with active review and engagement from both medical and pharmacy leadership.

Pharmaceutical management in the safety net population involves a focus on how best to manage resources to maximize patient outcome. By utilizing evidence-based formulary processes and prior authorization guidelines, increasing 340B drug pricing access, prescriber dashboards and metrics, LACDHS hopes to maximize the outcomes of existing resources. Focusing on medication adherence and strategies to improve adherence for chronic disease states will also lead to improved outcomes and more efficient use of resources.

Access to pharmaceutical care in the safety net has challenges, in that patients may experience issues with transportation to pick up medication refills, and may not remember to order to retrieve chronic care medications. LACDHS plans on utilizing increasing the role of pharmacists in an effort to manage the care of specific patients that may require additional support to obtain optimal pharmaceutical outcomes, including hospital readmissions. The use of a high cost medication, or the use of any chronic medication, is an investment in care that involves an engaged patient to

maximize therapeutic outcomes. Strategies to achieve this goal will be a focus of the multidisciplinary team that reviews pharmaceutical use across our healthcare system.

Development of provider and medical group metrics and dashboards will lead to increased transparency, and identify specific best practices that may be expanded to other sites. A specific focus will be placed on the use of high cost specialty agents given the impact to LACDHS resources. The target population includes patients empaneled to LACDHS facilities who require pharmaceutical intervention.

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

Check, if applicable	Description of Core Components
Applicable	**3.3.1** Implement or expand a high-cost pharmaceuticals management program.
Applicable	**3.3.2** Implement a multidisciplinary pharmaceuticals stewardship team.
Applicable	**3.3.3** Develop a data analytics process to identify the participating PRIME entity highest cost pharmaceuticals (high-cost medications or moderate-cost meds with high prescribing volume). Identify high-cost medications whose efficacy is significantly greater than available lower cost medications. • Using purchase price data, identify the top 20 medications and medication classes, focusing on the following: Analgesics, Anesthetics, Anticoagulants, Anti-Neoplastics, Diabetes, Hepatitis C, Immunoglobulins, Mental Health (Anti-Depressants/Sedatives/ Anti-Psychotics), Respiratory (COPD/Asthma), Rheumatoid Arthritis. o Exclude Anti-Infectives and Blood Products (addressed in separate PRIME Projects).
Not Applicable	**3.3.4** Develop processes for evaluating impact of high-cost, high-efficacy drugs, particularly drugs to treat conditions (e.g., HCV) or to address circumstances (e.g., oral anticoagulants for patients without transportation for blood checks) more prevalent in safety net populations: • Consider criteria that include ability of identified medications to improve patient health, improve patient function and reduce use of health care services.
Applicable	**3.3.5** Develop processes to impact prescribing by providers by establishing standards of care regarding prescribing of high cost pharmaceuticals, including:

Check, if applicable	Description of Core Components
	• Use of decision support/CPOE, evidence-based guidelines and medical criteria to support established standards. • Develop processes to improve the appropriate setting for medication delivery including, transitioning pharmaceutical treatment to the outpatient setting wherever possible. • Promote standards for generic prescribing. • Promote standards for utilizing therapeutic interchange.
Not Applicable	**3.3.6** Improve the process for proper billing of medications, through clinician education and decision support processes.
Not Applicable	**3.3.7** Develop formulary alignment with local health plans.
Not Applicable	**3.3.8** Implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff and senior leadership rapid cycle improvement using standard process improvement methodology.
Applicable	**3.3.9** Develop organization-wide provider level dashboards to track prescribing patterns for targeted high cost pharmaceuticals. Dashboard to include comparisons to peers and benchmarks. Contribute system level data for a similar dashboard across all public health care systems.
Applicable	**3.3.10** Develop processes for working with providers with prescribing patterns outside established standards, to identify and reduce barriers to meeting prescribing standards: • Develop guidelines and provide staff training on methods for engaging patients in shared decision making for developing treatment plans within the context of the established standards.
Applicable	**3.3.11** Maximize access to 340b pricing: • Share templates for contracting with external pharmacies. To improve program integrity, share tools for monitoring of 340b contract compliance.

Please complete the summary chart:

	For DPHs	For DMPHs
Domain 3 Subtotal # of Selected Projects (Select At Least 1):	**2**	
Domain 3 Total # of Projects:	**2**	

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 $ 447,417,600
- DY 12 $ 447,417,600
- DY 13 $ 447,417,600
- DY 14 $ 402,675,840
- DY 15 $ 342,274,464

Total 5-year prime plan incentive amount: $ 2,087,203,104

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

DPHs are required to commit to contracting with at least one MCP in the MCP service area that they operate using APMs by January 1, 2018.

☒ 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.