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

Lompoc Valley Medical Center

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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 this5-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'sSpecial 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: PRIMEParticipating Entity Information

Health Care System/Hospital Name

Lompoc Valley Medical Center

Health Care System Designation(DPH or DMPH)

DMPH

Section 2: Organizational and Community Landscape

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

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.

Lompoc Valley Medical Center (LVMC) is located in the rural Santa Barbara County town of Lompoc. Unlike other parts of the county, Lompoc has a significantly higher percentage of low-income residents. As a result, health care disparities including access to care are evident throughout the community.

Physical Health. The most significant health concerns of the Lompoc Community include:

- *Pediatric Services*. Basic treatment has been diminished creating gaps relative to immunizations, asthma care and other child health and disability prevention. See Appendix 2 for population need.
- *Routine Specialty Care*. Certain basic medical specialty care has become more difficult for patients to access for surgical and non-surgical services. See Appendix 2 for population need.
- *Heart Disease*. Accounted for 25.9% of deaths in Santa Barbara County (SBC) for 2012; the leading cause of death overall, as well as the top for Whites (26.5%) and Hispanics (24.7%).
- *Obesity*. It is estimated that 35% of the children in Lompoc are overweight; this is 10% higher than any other city within the county. In 2012, 56.5% of adults in SBC were overweight or obese, which is slightly below the overall California average (59.8%).

Mental and Behavioral Health. Mental and behavioral disorders are the fifth leading cause of death in SBC, accounting for 4.8% of all deaths in 2012. The Department of Health Care Services estimates 5% of Santa Barbara County and 7.9% of households below 200% of the federal poverty level (FPL) are in need of mental health services.

Health Disparities. SBC's top 4 chronic diseases causing death include: vascular disease (heart disease and stroke) (25.9%), cancer (9.2%), lung disease (5.1%) and diabetes (2.3%). Prevention plays a role in combating these diseases. Each of the diseases varies by severity, based on ethnicity. Limited access to primary and specialty care compounds these disparities within the Lompoc Valley.

Coverage. LVMC is the service location for nearly 19,000 CenCal beneficiaries as of October 2015. This represents approximately 32% of healthcare district residents. Implementation of the Affordable Care Act has increased demand by Medi-Cal beneficiaries seeking services at LVMC and access to physician services has not expanded to accommodate this increase in demand.

Sources: U.S. Census Bureau, California Health Interview Survey, Community Needs Assessment 2014, and the 2014 Santa Barbara County Health Status Report

2.2 Population Served Description.*[No more than250 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.

Lompoc Valley Medical Center serves approximately 59,000 residents residing in a 600 square mile area. The Lompoc Healthcare District is comprised of Lompoc, Vandenberg Village, Vandenberg Air Force Base, the Federal Correctional Institution and the surrounding farmland areas.

Income. The per capita income for LVMC service area in 2014 was $69,292. In 2014, 47.5% of households had incomes below $50,000 per year. Approximately 46% of Lompoc's population falls below 200% FPL. The breakdown of FPL for the Lompoc population in 2010 is shown below:

- Below 100% of FPL: 21.1%
- Below 200% of FPL: 25%

Age. Nearly 43% of the Lompoc District is individuals aged 15-44 years of age, and 24.2% is 45-66 years old. About 11.5% of the population is aged 65 years or older and is projected to grow by 2.3% annually. 21.1% of the population is 0-14 years of age.

Race/Ethnicity. The majority of the Lompoc community is Hispanic. Race/ethnicity of the community is shown below:

- Hispanic: 48.7%
- Non-Hispanic White: 36.3%
- Non-Hispanic Black: 4.7%
- Asian/Pacific Islander/Aleutian: 5.1%
- All Others: 5.2%

Language. There are two common languages: English and Spanish. A small minority (less than 5%) speak a language other than English or Spanish at home.

Sources: U.S. Census Bureau and 2014 Community Needs Assessment

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

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

LVMC, the first healthcare district to be established in California, was formed in 1946 by the Santa Barbara County Board of Supervisors. LVMC is licensed as a general acute care hospital with 6 intensive care, 6 perinatal service and 48 general acute care beds. LVMC's license also includes a 110-bed skilled nursing facility, basic emergency medical services, nuclear medicine, physical therapy and respiratory care services. In addition, LVMC is licensed for the following outpatient services: sleep disorder center, diagnostic imaging, and a general surgery clinic.

According to the Office of Statewide Health and Planning Development (OSHPD) for 2014:

The inpatient reimbursement payer mix was comprised of:

- 23.3% Medi-Cal
- 43.9% Medicare
- 22.3% Private Insurance
- 10.5% for all others

The outpatient reimbursement payer mix was comprised of:

- 21.9% Medi-Cal
- 38.1% Medicare
- 32.5% Private Insurance
- 7.5% all other payer sources

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 supportPRIME clinical quality reporting requirements. Please specify any anticipated limitations or barriers to meeting thePRIME reporting requirements and describe your proposed strategies to address these barriers.

In 2011, LVMC began participation in the Centers for Medicare and Medicaid Services (CMS) health data Meaningful Use program.

LVMC uses Allscripts Sunrise Clinical Manager Enterprise electronic medical record, which enables the hospital to track, monitor and report on data collected by clinical staff.

Two of LVMC's most common pieces of software used for reporting include Clinical Performance Management and SQL Server Report Builder. In addition, LVMC uses Crimson Continuum of Care, which provides the ability to track a multitude of dashboards including but not limited to readmissions and frequent emergency department users. LVMC haspurchased case management software to better evaluate hospital utilization and track population health.

Data Collection. Building upon LVMC's experience through the meaningful use program, our clinical informatics team plans to create and implement the data system changes needed for participation in PRIME. LVMC's clinical informatics team will work with local independent medical groups to collect collaborative data.

Reporting. LVMC uses a number of dashboards to report on different data throughout the hospital on a monthly basis. In addition, the clinical informatics team will expand on monthly reporting requirements to include the external data captured from physician practices.

Monitoring. LVMC has multiple departments and committees that monitor the data produced each month. By monitoring the data, LVMC is able to see trends in the data and opportunities for improvement. LVMC can rapidly generate solutions and implement necessary changes as a result of the monitoring process.

LVMC will employ all of these resources to support PRIME clinical quality reporting requirements. Despite all the LVMC resources committed to supporting PRIME staffing levels will present a potential barrier that will be overcome through an increase in the number of FTEs assigned to data quality, monitoring and reporting.

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 presenteach entity's overall goals and specific aims for PRIME. This section should also describe how these efforts will evolve over the course of the five years.

3.1 PRIME Project Abstract [No more than 600 words]

Please address the following components of the Abstract:

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

LVMC's overall PRIME goal is to stabilize access to medical care through transformation of the local health care delivery system. The key objective is development of clinics integrated within the hospital operational structure. Hospital-based clinics will better enable physician retention and recruitment and alleviate emigration by the medical community. By maintaining and expanding services in the Lompoc Community, access will increase and the quality of care will be enriched.

Another important PRIME goal is growth of a care transitions program which follows the patient throughout the care continuum. Objectives include new linkages with patients, caregivers and local providers serving patients in the pre- and post-acute phase of care.

2. *List specific aims**for your work in PRIME that relate to achieving the stated goals;*
   Note:
   ** *Specific aims (generally 2-5) relate to the goals but provide more detail on how the goals will be achieved.*

LVMC has three specific PRIME project aims that relate to the goals outlined above:

(1) Increase access to care for low-income Medi-Cal patients. The number of patients with Medi-Cal coverage has increased, yet physician availability in Lompoc has decreased. As resources shrink, Medi-Cal patients suffer a reduction in appropriate access.

Development of hospital-based specialty care clinics will decrease the number of patient transfers to hospitals out of area. Transfers are costly to the patient's family and overall health system. Expanded use of telemedicine, for example teleneurology and telepsychiatry, will enable LVMC to diagnose and treat stroke and mental health patients, respectively, more quickly and possibly eliminate the need for transfer.

(2) Decrease avoidable emergency department utilization and readmissions through restructuring hospital discharge processes and developing a post-acute care follow-up program. The care transitions program uses a population management approach by following post-acute high-risk patients, providing clinical education and understanding needs of the patient once they are home.

(3) Increase obesity and heart disease screening through hospital-based clinics. Specialty clinics improve referral availability for patients to prevent the onset, advance or adverse outcomes from leading diseases. Project partnerships with other community-based physicians expands the population screened and shifts provider relationships from independent to collaborative.

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

LVMC selected Ambulatory Care Redesign for Specialty Care (4.1.3) as a platform for growth of hospital-based specialty clinics. This approach builds infrastructure and integrates multiple components of patient care within the LVMC delivery system. Realization of project goals also serves as the nexus for physician retention and recruitment.

The Care Transitions Project (4.2.2) extends community collaboration and integration efforts while also addressing the cost of care delivery. Introduction of a post-acute discharge follow-up program for high risk/utilization patients targets patient stability and reduction of emergency response. Coupling home visits with patient and caregiver education improves chances for success outside the hospital.

Collaboration with local independent medical groups on Obesity Prevention (4.1.7) and the Million Hearts Initiative (4.1.5) furthers unified management of local population health. Patients benefit from expanded screening for two important disease issues, and the delivery system benefits from the integrative approach to patient care.

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

The four projects we selected collectively advance delivery system transformation from independent role players to population focused collaborators. Hospital-based specialty clinics will integrate physicians more closely and resolve medical practice ownership concerns of many newer doctors. The Care Transitions Project will expand patient and community collaboration while also optimizing cost reduction opportunities. The Obesity Prevention and the Million Hearts Initiative will enable us to focus on exercising new integrated relationships while also providing potential early intervention opportunities for patients.

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

After five years of PRIME participation, the delivery system will be transformed due to greater integration of hospital and physician service to patients. Access will be improved through expansion of available physicians improving quality and reducing delays in treatment. Providers across the community will have learned to collaborate closely through experience with population-focused projects. Cost reductions will be realized through reduced emergency department utilization due to better support of patients at the home and community level.

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

Describe how your organizationwill address health needsat 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.

Lompoc has experienced the retirement and emigration of local specialists including orthopedics, otorhinolaryngology, general surgery and pediatrics. Lompoc's only oncologist planned to relocate due to increased demands to run a private clinic. LVMC recognized this to be a concern of other physicians looking for employment as well. PRIME will allow LVMC to develop the infrastructure to retain and recruit local and new specialists to the area. By participating in the PRIME specialty care redesign (project 4.1.3), LVMC will fill this gap and retain services for specialty care.

Medicaid expansion has impacted LVMC's emergency department utilization because primary care access has not proportionally expanded. PRIME will provide LVMC with the opportunity to develop a care transitions program that has a post-discharge follow-up and caregiver support program incorporated enabling case management to keep track and follow frequent discharges or emergency department (ED) patients, along with frequent ED users. The post-discharge follow-up program within the care transitions program will allow LVMC to take a population management approach by providing clinical care and case management once the patient is home.

By implementing Obesity Prevention (Project 4.1.7) and the Million Hearts Initiative (Project 4.1.5), LVMC will be able to address community health issues outlined in Section 2.1 by taking a population-based preventive approach to decreasing the incidence of obesity and heart disease through early detection and better management.

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).

LVMC's governing Board plays an active role in the decisions to develop and implement projects for the hospital. Based on the review of a 2014 Needs Assessment, LVMC's hospital administration identified recruitment and retention of physicians as a crucial component of a succession plan for the aging medical community. The changing environment where physicians do not want to own their own clinics has compounded this issue. Increased quality of care will be delivered by having the specialists and hospital linked together. LVMC's hospital administration brought the idea of developing outpatient clinics to the board of directors where it was strongly supported.

LVMC will have a PRIME Multidisciplinary Committee comprised of administration, nursing, quality improvement, physicians, and other community stakeholders who will monitor metric performance. LVMC has a project coordinator, who will facilitate the coordination, implementation and monitoring of data for all PRIME projects. LVMC's quality improvement department will play an active role in developing processes to improve the quality of care provided through each PRIME Project.

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.

LVMC will engage stakeholders and beneficiaries in the planning, implementation and process improvements for all PRIME projects. LVMC has a Patient and Family Advisory Council where community residents provide insights on various issues including hospital performance. These advisors will help prioritize improvements based on patient and family needs. LVMC's PRIME Multidisciplinary Committee will consider feedback from the Patient and Family Advisory Council and make appropriate adjustments. By obtaining feedback, LVMC will be able to make adjustments that may not have otherwise been identified.

LVMC's community stakeholders, including physicians, clinics, public health, first responders and others, have played a crucial role in the planning and development of each project. To continue receiving input from the community stakeholders involved, members of each project will be invited to the PRIME Multidisciplinary Committee meetings where they will be able to share input and develop new ideas for positive change.

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.

The majority of residents in the service area are Hispanic. Certain chronic conditions such as obesity and heart disease disproportionately affect this population. LVMC is addressing the two largest health disparities by integrating the PRIME programs into the Lompoc Community's Healthcare Delivery System. Both health disparities are being addressed through improved access to care, physician-developed chronic disease prevention programs, improving access bybringing medical specialties closer to the Medi-Cal population, and developing robust linkages between PCP clinics and specialty clinics. These measures improve the quality of care provided to the Medi-Cal population. Lompoc has a high rate of obesity within the Hispanic population, which is specifically targeted by the obesity prevention project. Heart disease, which is a co-morbidity of obesity, will be targeted by the Million Hearts Initiative. LVMC will target primary Spanish speakers by using bilingual staff and written documents to effectively communicate to the Spanish-Speaking community. This will enable better comprehension of educational and other program materials. By being culturally sensitive, LVMC will be better positioned to educate, treat and manage the health disparities within the community.

3.6 Sustainability. [No more than150 words]

Provide a high-level description of the systematic approach for quality improvement and change managementthat 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.

PRIME has provided LVMC with the opportunity to recruit and retain physicians through the development of the appropriate infrastructure necessary to sustain outpatient specialty practices. By creating a series of integrated medical clinics, LVMC will be in a position to sustain healthcare in the community beyond 5-year PRIME participation. Across the five years, LVMC will establish an integrated healthcare system by implementing hospital based clinics, and increasing collaboration at the community level. Through education, training and engaging LVMC staff and leadership in the design, implementation and improvements of the PRIME projects, LVMC will have the infrastructure and commitment to sustain the projects. At the end of year 5, new approaches will have been developed setting the stage for further integrative and collaborative healthcare delivery that is responsive to local population needs. PRIME allows for many components to be built out for sustainability in a post-PRIME environment.

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 (Projects1.1, 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 foreachselected project. Providenarrative 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.*

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

LVMC will require infrastructure for this project, details are in Appendix 1.

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]*

Shifting physician attitudes toward practice ownership and an increasing number of retiring physicians has created a drain on specialty care resources in the Lompoc Community. A recent community needs assessment (Appendix 2), established the immediate need for physician specialists to maintain appropriate community access. An alternative is to transfer patients 55 miles for services such as general surgery, orthopedics, otorhinolaryngology or psychiatry. This creates an undesirable patient hardship and an even greater burden on the Medi-Cal population.

Implementation and design:

- *Clinic Network:* To address a changing environment where younger physicians seek employment rather than practice ownership, during DY 11-12 LVMC will establish a network of clinics supported and operated by the hospital with physicians under long-term contract.

- *Telemedicine:* LVMC is increasingly focusing on telemedicine as a solution for specialty and sub-specialty medicine when it affords an appropriate alternative.

For example, LVMC recently added teleneurology improving care for stroke patients and permitting certification as an Acute Stroke Ready Hospital. Discussions are currently underway for development of resources to support telepsychiatry during DY 11.

- *Capacity Building:* By recruiting certain specialists and developing the physical space for outpatient services, LVMC will attract additional specialists. This enables LVMC to provide more integrated care to Medi-Cal patients and linkages to out-of-area care when necessary. Specialty care clinics maximize local access to appropriate acute hospital services and better serve the needs of patients. LVMC will complete construction by the end of DY 11.

- *After-Hours Pediatric Care Center*: To support local needs for pediatric services after hours, LVMC is implementing an after-hours pediatric care center. LVMC will implement the pediatric center during DY 12.

- *EMR Patient Scheduling System:* To increase the quality of care, LVMC will implement an ambulatory medical record and scheduling system by the end of DY 12.

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

Target Population. The target population is Medi-Cal beneficiaries and the uninsured. These populations are adversely affected as the number of community-based-physicians shrinks and private practices close to new patients. Development of specialty care clinics and additional telemedicine services expands access to Lompoc residents.

The after-hours pediatric clinic specifically targets low-income Medi-Cal and uninsured children. Many low-income parents are unable to miss work and take children to appointments during typical medical office hours. By expanding pediatric access, LVMC will address issues such as immunizations, child health and disability prevention and other common needs of children.

Vision for Care Delivery. Development of specialty care clinics to retain and recruit new specialists will decrease patient transfers to hospitals outside of the community. The hospital's development of orthopedic, otorhinolaryngology, general surgery, and neurology services provides infrastructure for emergency department coverage, while creating access for referral consultations. These project interventions prevent delays in patient care and reduce the need for patients and families to travel 55 miles to access basic specialty services. The neurology and psychiatry program combine the new clinic system with telemedicine expansion to improve access and services.

LVMC will execute processes to provide the highest quality collaborative effort involving both specialists and primary care physicians. Common pathways and workflows will ensure patient engagement in the plan of care. An ambulatory electronic medical record and patient scheduling system facilitates this integrated approach to care. Patients, the hospital and physicians will work together achieving better quality of care through a more efficient and lower-cost system.

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

Check, if applicable	Description of Core Components
Applicable	**1.3.1** Develop a specialty care program that is broadly applied to the entire target population.
Not Applicable	**1.3.2** Conduct a gap analysis to assess need for specialty care including mental health and SUD services (analysis to include factors impacting ability to access specialty care), and the current and ideal state capacity to meet that need. Benchmark to other CA Public Health Care systems.
Not Applicable	**1.3.3** For ideal state analysis, include potential impact of increased primary care capacity to manage higher acuity conditions either independently, or in collaboration with, specialty care, so as to reduce the need for in-person specialty care encounters (e.g., insulin titration, IBS management, joint injections, cognitive behavioral therapy (CBT) or MAT).
Not Applicable	**1.3.4** Engage primary care providers and local public health departments in development and implementation of specialty care model.
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.
Not Applicable	**1.3.8** Ensure that clinical teams engage in team- and evidence-based care.

Check, if applicable	Description of Core Components
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.
Not 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.
Not Applicable	**1.3.16** Implement population management strategies for patients in need of preventive services, with chronic conditions, or with recurring long term surveillance needs.
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.

Check, if applicable	Description of Core Components
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.

☒ 1.5 – Million Hearts Initiative

LVMC will require infrastructure for this project, details are in Appendix 1.

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]*

LVMC is developing a collaborative plan with community-based physicians to implement the Million Hearts Initiative. This cooperative effort expands the influence of PRIME projects beyond the hospital walls. Diseases of the heart are the leading cause of death in Santa Barbara County (SBC). Stroke is the second-leading cause of death.

Planning, design and implementation:

- *Care integration with independent medical groups* .LVMC plans to work collaboratively with local medical groups and integrate evidence-based medicine focusing on Aspirin when appropriate, Blood pressure control, Cholesterol management, and Smoking cessation (ABCS). LVMC will educate providers on the importance and successes of the Million Hearts Initiative. LVMC will complete these tasks during DY 11 with improvement in heart disease management and early recognition of risk factors between DY 12-15. LVMC will collaborate with one local independent medical group in DY 11, expanding the effort to other groups through DY12-15. LVMC is taking an integrative approach, implementing obesity prevention alongside the Million Hearts Initiative since obesity is a known precursor for cardiovascular disease. ABCS and obesity screening performed together benefits patients assessed by the project. Patient screenings begin mid-year DY 12.

- *Partnering with Community Resources*. LVMC will partner with CenCal Health and Visiting Nurse and Hospice Care (VNHC) to identify patients with heart conditions who have frequent emergency department (ED) visits and a history of non-compliance with their treatment regimen. Patients will be referred to the VNHC or CenCal telehealth program based need. Identification of high-risk patients and referral to alternative community services will decrease ED utilization. Project partnerships will operate throughout all PRIME DYs

- *Population Health Management*: LVMC will use case management software to identify and track Medi-Cal patients with heart disease who are high-risk and frequently utilize hospital services. Interventions will begin upon discharge beginning in DY 11 and continuing through DY 15.

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

Target Population. LVMC expects the Million Hearts Initiative to target the entire CenCal Lompoc population by providing preventive services that are clinically shown to reduce the chances of developing adverse outcomes associated with cardiovascular disease.

Vision of Care Delivery. By implementing the Million Hearts Initiative throughout the community, LVMC expects earlier detection of patients with heart disease. With a community-wide implementation of the initiative, LVMC intends to reduce race, ethnic and language disparities associated with heart disease. As a result, more community members with heart disease or associated risk factors will be identified and given the appropriate referrals to prevent disease onset. LVMC envisions that early recognition and mitigation of risk factors will decrease the number of avoidable emergency department visits and hospital readmissions in addition to reducing the number of deaths per year. By collaborating with VNHC and CenCal Health to recognize heart disease patients appropriate for their telehealth programs will further improve their ability to effectively manage their own disease and reduce the number of hospital visits and deaths per year. As a result, interventions will help better the self-management and early recognition of risk factors while decreasing the overall costs of healthcare.

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

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

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

☒ 1.7 – Obesity Prevention and Healthier Foods Initiative

LVMC will require infrastructure for this project, details are in Appendix 1.

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]*

In 2010, Lompoc's obesity rate was 20% higher than Santa Barbara which was 28%. Almost half of the Lompoc Community is Hispanic, an ethnic group that is at an increased risk for obesity. Community members frequent LVMC to visit patients, seek healthcare services or simply to enjoy a meal at the hospital's Oceans Seven Café. Improving preventive care through obesity education and offering healthier hospital meals will raise obesity awareness and provide new intervention options.

LVMC's planned design and implementation approach includes:

- *Obesity Prevention Program*: LVMC is developing an obesity prevention program to be implemented at hospital-based clinics. The program will develop a standard process including recommendations for clinical preventive services aligning with the USPSTF - A and B recommendations. LVMC will implement obesity prevention by mid-year DY 12.

- *Collaboration with Local Independent Medical Groups*: LVMC is partnering with a local independent pediatric practice in DY 11 to implement an Obesity Prevention Program. LVMC is also partnering with other independent physician practices to implement an obesity prevention program for the adult population. LVMC will

initially collaborate with one independent medical group, but will expand collaboration during DYs 12-15.

- *LVMC Nutrition Support*: LVMC is developing a nutrition support group where nutritional education and support will be provided. The group will be open to the public and meet on a monthly basis. LVMC will implement a nutrition support program by the end of DY 12.

- *Healthier Foods Initiative*: Following standards developed by the Partnership for a Healthier America Hospital Health Food Initiative, LVMC will implement and modify existing processes that more closely match requirements. LVMC plans to implement each requirement between DY 12 and DY 14, and demonstrate a sustainable healthier foods initiative program throughout DY15 and thereafter.

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

Target Population. LVMC intends to target all Medi-Cal patients including both adults and pediatric patients. Plans include implementation in to independent medical practices – one adult and one pediatric - by DY 12, and hospital based clinics will enable preventive care throughout the community. By doing so, LVMC will be able to test the program and work out any details before implementing into the rest of the community. By implementing into multiple medical groups, LVMC will be able to reach a larger proportion of the local population, who are at an increased risk for developing obesity. Screening will lead to early diagnosis and intervention reducing obesity and its effects on other health conditions.

The healthier foods initiative will positively impact all patients, their families or friends, employees and other community members.

Vision for Care Delivery. PRIME enables LVMC to develop and implement an obesity prevention project. Developing an obesity prevention project in a heavily Hispanic-based community will reduce the obesity disparity present in low-income, Spanish speaking families. PRIME is allowing LVMC to implement a health initiative into the hospital nutrition program demonstrating leadership in the community for healthy eating and healthy living. LVMC hopes that individuals interfacing with the hospital see the benefits of healthy nutrition, and will apply it to their own – and their families' – lifestyle. To further this aim, LVMC will develop community education programs focusing on nutrition programs and health.

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

Check, if applicable	Description of Core Components
Not Applicable	**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.
Applicable	**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.
Applicable	**1.7.3** Improve access to quality care and decrease disparities in the delivery of preventive services.
Not Applicable	**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.
Applicable	**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.
Applicable	**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.
Not Applicable	**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.
Not Applicable	**1.7.8** Provide feedback to care teams around preventive service benchmarks and incentivize QI efforts.
Applicable	**1.7.9** Encourage, foster, empower, and demonstrate patient engagement in the design and implementation of programs.
Applicable	**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:		**3**

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

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

LVMC will require infrastructure for this project, details are in Appendix 1.

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]*

LVMC selected this project to better serve complex care, high-risk and high-utilizing patients, many of whom are dual eligible. By partnering with other community providers, including the Lompoc Fire Department, LVMC nursing will monitor clinical needs while LFD will assess well-being and coordinate additional community resources. Providing patients and family's tools and support improves self-management of health conditions and patient safety at home. LVMC's care transitions program will improve outcomes; reduce hospital readmissions and unnecessary ED utilization.

Planning, design and implementation:

- *Patient Identification*: Medi-Cal patients at risk for readmission will be assessed using the LACE tool and a patient-centered approach. LACE is used to assess all patients upon admission. High-risk patients will be tracked and monitored using the case management software. Implementation by mid-year DY 12.

- *Care Transitions Program*: LVMC will modify current discharge planning to become patient transition-centered by developing standardized workflows for medication reconciliation and timely transmission of transition records. LVMC will employ AllScripts Care Management software to develop care plans, evaluate root causes and risk factors for readmissions, and track care transition program referrals. Care transitions implementation occurs during DY 12.

- *Post-Discharge Follow-up Program*: Patients identified in the Care Transitions Program will be enrolled into the post-discharge program. The program is being developed in collaboration with the Lompoc Fire Department. A qualified clinical professional will coordinate the program, which will include post-discharge phone calls and home visits where a physical assessment, home safety check and medication review will take place. See appendix 3 which lists duties for each agency. Care transitions program implementation occurs during DY 12.

- *Caregiver Support Center*: LVMC is collaborating with the Lompoc Valley Community Health Organization (LVCHO) to develop a caregiver support center

bringing benefits to Medi-Cal patients. The center's centralized location enables assessment of caregivers' needs for both themselves and care receivers. Referrals to appropriate community resources are deployed as needed. Caregiver support center will be implemented during DY 12.

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

Target Population. The primary target population is dual eligible, in addition to Medi-Cal beneficiaries who are high utilizers of the ED and patients at risk for hospital readmissions. PRIME will enable LVMC to develop a robust care transitions program for individuals with complex care needs when they transition from the hospital to home or other settings.The Caregiver Support Center is intended to reach those caregivers caring for a family member, friend or neighbor who needs education, support, referral and training to safely care for themselves and their care receivers.

Vision of Care Delivery. The hospital case management department will initiate the care transitions program upon admission by performing a comprehensive patient needs assessment and assisting the patient and/or family with appropriate discharge planning. Comprehensive medication reconciliation will be performed on admission, during transfers between levels of care, and again at discharge to decrease medication errors and provide continuity of care with patients' outpatient medications. Patients, who are at-risk for readmissions, have multiple co-morbidities, or are frequent utilizers of the ED, will be enrolled in the post-discharge follow-up program. LVMCs overall vision of care delivery will decrease readmissions and avoidable ED utilization by using a patient-centered approach to promote patient knowledge and self-management of chronic conditions.

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

Check, if applicable	Description of Core Components
☒	**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.
☒	**2.2.2** Establish or expand on a system to track and report readmission rates, timeliness of discharge summaries, and other transition processes, and investigate system-specific root causes/risk factors for readmission, using quantitative and qualitative information to identify the key causes of readmissions, including physical, behavioral and social factors.

Check, if applicable	Description of Core Components
Applicable	**2.2.3** Develop and implement a process, including utilization of data and information technology, to reliably identify hospitalized patients at high-risk for readmission.
Applicable	**2.2.4** Develop standardized workflows for inpatient discharge care: • Optimize hospital discharge planning and medication management for all hospitalized patients. • Implement structure for obtaining best possible medication history and for assessing medication reconciliation accuracy. • Develop and use standardized process for transitioning patients to sub-acute and long term care facilities. • Provide tiered, multi-disciplinary interventions according to level of risk: o Involve mental health, substance use, pharmacy and palliative care when possible. o Involve trained, enhanced IHSS workers when possible. o Develop standardized protocols for referral to and coordination with community behavioral health and social services (e.g., visiting nurses, home care services, housing, food, clothing and social support). Identify and train personnel to function as care navigators for carrying out these functions.
Applicable	**2.2.5** Inpatient and outpatient teams will collaboratively develop standardized transition workflows: • Develop mechanisms to support patients in establishing primary care for those without prior primary care affiliation. Develop process for warm hand-off from hospital to outpatient provider, including assignment of responsibility for follow-up of labs or studies still pending at the time of discharge.
Applicable	**2.2.6** Develop standardized workflows for post-discharge (outpatient) care: • Deliver timely access to primary and/or specialty care following a hospitalization. • Standardize post-hospital visits and include outpatient medication reconciliation.
Not Applicable	**2.2.7** Support patients and family caregivers in becoming more comfortable, competent and confident in self-management skills required after an acute hospitalization by providing: • Engagement of patients in the care planning process. • Pre-discharge patient and caregiver education and coaching. • Written transition care plan for patient and caregiver. • Timely communication and coordination with receiving practitioner.

Check, if applicable	Description of Core Components
	Community-based support for the patient and caregiver post hospitalization focusing on self-care requirements and follow-up care with primary and specialty care providers.
Not Applicable	**2.2.8** Engage with local health plans to develop transition of care protocols that ensure: coordination of care across physical health, substance use disorder and mental health spectrum will be supported; identification of and follow-up engagement with PCP is established; covered services including durable medical equipment (DME) will be readily available; and, a payment strategy for the transition of care services is in place.
Not Applicable	**2.2.9** Demonstrate engagement of patients in the design and implementation of the project.
Not Applicable	**2.2.10** Increase multidisciplinary team engagement by: • Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. • Providing ongoing staff training on care model.
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.

Please complete the summary chart:

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

Section 5: Project Metrics and Reporting Requirements

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

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

DPHs are required to strengthen data and information sharing with MCPs under the PRIME. To support this requirement, DHCS will establish data and information sharing guidelines and/or mechanisms, which DPHs and DMPHs must follow, consistent with applicable state and federal data privacy and security law, to provide for timely sharing of beneficiary data, assessment, and treatment information, for purposes of identifying and treating the beneficiary for PRIME andWhole-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.

X 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.

X 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 learningcollaborative per PRIME year. Please acknowledge your understanding and acceptance of this responsibility below.

X I understand and accept the responsibilityto 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 $5,700,000
- DY 12 $ 5,700,000
- DY 13 $ 5,700,000
- DY 14 $ 5,130,000
- DY 15 $ 4,360,500

Total 5-year prime plan incentive amount: $26,590,500

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

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

Appendix 1- Infrastructure Building Process Measures

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
1.	Telemedicine, Neurology Services Contract Begins	• Signed Teleneurology Services Agreement • Teleneurologists approved for hospital privileges	1.3	January 1, 2016 – January 31, 2016
2.	Acute Stroke Ready Hospital Designation for telemedicine program	• Temporary Designation by Santa Barbara County Emergency Medical Services • Center for Improvement in Healthcare Quality (CIHQ) Certification	1.3	January 1, 2016 – May 31, 2016
3.	Telepsychiatry for Psychiatry Services Contract Signed	• Signed Telepsychiatry Contract • Telepsychiatrists approved for hospital privileges	1.3	February 1, 2016 – June 30, 2016
4.	Recruit Orthopedist and Otorhinolaryngologist	• Signed Professional Services Agreements for Orthopedist and Otorhinolaryngologist	1.3	January 1, 2016 – June 30, 2017
5.	Tenant Renovations Complete Oncology and General Surgery Clinics	• Occupancy Certificate	1.3	January 1, 2016 – April 30, 2016
6.	Licensure & Certification by California Department of Public Health for Oncology and General Surgery Clinics	• Train staff • Develop materials for L & C survey • Complete CDPH license survey • Achieve L & C Approval	1.3	April 1, 2016- May 31, 2016
7.	Operational in New Building for Oncology and General Surgery Clinics	• Move In Complete	1.3	April 1, 2015 – April 30, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
8.	Operational Orthopedic and Otorhinolaryngology Clinics	• Open for patients	1.3	July 1, 2016 – June 30, 2017
9.	Collaborative Services Agreements	• Drafting of Agreements • Signed Business Associate Agreement • Signed Professional Services Agreement	1.5, 1.7	March 1, 2016 – June 30, 2016
10.	Preparation of Clinical Informatics Systems	• Set-up clinical systems to track and Set-up reporting on clinical systems o Phase 1: Project 1.3 (Oncology/General Surgery), 1.5, 1.7 & 2.2 o Phase 2: Project 1.3 (Orthopedics and Otorhinolaryngology)	1.3, 1.5, 1.7, 2.2	March 1, 2016 - June 30, 2017
11.	Provide Education on Project Requirements for Metric Reporting at Outpatient Clinics	• Complete post-test for education on metric reporting for each outpatient clinic o Phase 1: Project 1.3 (Oncology/General Surgery), 1.5, 1.7 & 2.2 o Phase 2: Project 1.3 (Orthopedics and Otorhinolaryngology)	1.3, 1.5, 1.7, 2.2	March 1, 2016 – June 30, 2017
12.	Development of Post-Discharge Follow-Up Program	• Meetings regarding the requirements, patient population, and services to be delivered via the program • Job description and requirements agreed on	2.2	January 1, 2016 – June 30, 2016
13.	Recruit Qualified Clinical Professional	• Complete Human Resources (HR) Process or Agreement for Services	2.2	March 1, 2016 – October 1, 2016

	Proposed Process Measures	Proposed Milestones	Applicable Project Numbers	Process Measure Start Date – End Date
14.	Post-Discharge Follow-Up Program Launch	• Referrals being accepted	2.2	September 1, 2016 – October 1, 2016
15.	Development of Caregiver Support Center Plan	• Meetings regarding services to be offered and assessments • Location • FTE Requirements	2.2	January 1, 2016 – June 30, 2016
16.	Recruit Employee to run Caregiver Support Center	• Complete HR Process	2.2	April 1, 2016 – July 31, 2016
17.	Caregiver Support Center Open	• Operational	2.2	August 1, 2016 – August 31, 2016

Appendix 2: Community Needs Assessment of Physician Capacity

Specialty Care Physician	Number FTE Currently Available	Number FTE in Need
General Surgery	3.0	6.0
Neurology	0.5	1.4
Orthopedics	2.0	3.9
Otorhinolaryngology	1.0	2.0
Pediatrics	6.0	9.4

Source: Camden Associates, 2014

Appendix 3: Duties for Post-Discharge Follow-Up Program

Agency:	**Duties:**
Lompoc Valley Medical Center Nurse	• Perform in-home nursing assessment to high-risk patients within 2-3 days of referral. o Medication reconciliation o Confirm follow-up appointment with PCP o Provide referrals to community-based agencies as appropriate for needs • Perform home safety assessment and provide referral to LFD when appropriate.
Lompoc Fire Department (LFD)	• Fire Department employee will go to home upon referral from home nurse and provide modifications that include, but not limited to the following: o Replace batteries on fire and/or carbon monoxide detectors o Installation of new fire and/or carbon monoxide detectors o Provide referral to community for installation of railings and/or ramps